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Heterotopias of control: Placing the material in experiences of mental health service use and community living

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In an era of community care, where social inclusion (Spandler, 2007; D.O.H., 2006; Wallcraft, 2001) and latterly personalisation (DH, 2011) are key buzzwords in mental health service provision, official mental health service sites (acute wards, community mental health buildings) can be seen as being given less prevalence in service provision rhetoric (Bowers et al, 2005; 2006; 2009; Quirk & Lelliot, 2001; Quirk, Lelliot & Searle, 2006). Yet, as Quirk & Lelliot (2001) argue: "no country has created a mental health system which can function without 'acute' psychiatric wards" (p. 1). Indeed, it has also been argued that limitations of community care policies have led to both 'trans-institutionalisation' (Priebe et al, 2005), particularly in the form of an increase of those with diagnosed mental health problems in prison (Fazel & Danesh, 2002; Priebe et al, 2005; Singleton, Meltzer & Gatward, 1999), and 're-institutionalisation', in the form of an increase in hospital admissions and supported housing (Priebe & Turner, 2003). Furthermore, Bowers et al (2006) identified an increase in the practice of locking psychiatric wards over the past ten years, whilst also noting an associated increase in violent behaviour in those wards which are locked. These observations perhaps stand as a counter to some of the more utopian discourses of community care (Symonds, 1998) conveying a narrative of escape from confinement, exemplified in such titles as 'Outside the Walls of the Asylum' (Bartlett & Wright, 1999), 'Beyond the Water Towers' (S.C.M.H., 2005), and even 'Beyond Buildings' (D.O.H., 2006).

Recent empirical research in both geography and social psychiatry (e.g., Bowers et al, 2006; Curtis et al 2007; 2009; Quirk, Lelliot & Searle, 2006) examining the detail of service user and staff experience of the 'therapeutic landscape' (Curtis et al, 2009) of the psychiatric ward, has worked to address the question of the continuing role of such spaces in ongoing experiences of mental distress, care and recovery. These studies have pointed to a complexity in the relationship between 'institutional' and 'community' spaces, with sites

such as psychiatric wards existing within a distributed system of inpatient, outpatient and community spaces negotiated by service users as part of service use. Quirk, Lelliot & Searle (2006), for instance, argue that rather than the 'total institution' described by Goffman (1961) in his classic study 'Asylums', contemporary wards operate more like 'permeable institutions', with no clear binary existing between 'institution' and 'community'. Evidence for this view included the observation that links are retained to the outside world through frequent visits, rather than the isolation and 'mortification of the self' described by Goffman (1961), as well as citing the wider availability of drugs and alcohol on psychiatric wards (Quirk et al, 2006).

This paper, therefore, aims to address the question of how service users experience the spaces dedicated to mental health care in the current mental health system, and how their experiences within these spaces might relate to their ongoing experiences in other, non-service specific, places in the community. In addition, to add to the current growth of empirical work focussed on experiences of the ward, the analysis presented here has a particular focus on the role of the detail of the materiality of these spaces in the production and negotiation of service user subjectivity. Before a description of the empirical approach taken to this question, two key concepts which have been drawn upon to help understand these experiences and relationships in the later analysis will be outlined below: the 'control society' (Deleuze, 1992), and the 'heterotopia' (Foucault, 1986).

Control societies and mental health care

Gilles Deleuze (1992) argued the 'enclosures' of disciplinary power, described by Foucault (1965; 1977), such as the prison, asylum and school were in the process of being replaced by systems characterised by dissipated, continuous mechanisms of control, not limited to

particular sites or periods of time. Education can hence be seen to have been extended from 'the school' into an ongoing process of 'lifelong learning' enacted across many sites and fashioned as an individual responsibility for constant re-skilling and improvement (Tuschling & Engemann, 2006; Olsson & Petersson, 2008). The criminal justice system can similarly be seen to have witnessed a move out from 'the prison' to include practices such as electronic tagging (Jones, 2000), and anti-social behaviour orders (ASBOs), which limit movement in community spaces, without physical enclosure or a fixed end point (Flint & Nixon, 2006). Deleuze (1992) further proposes that these newer forms of practice regulate subjects in a changed way to the disciplinary 'enclosures':

Enclosures are molds, distinct castings, but controls are a modulation, like a self deforming cast that will continuously change from one moment to the other, or like a sieve whose mesh will transmute from point to point. (p. 4)

The kind of 'modulation' talked about here can be seen in the practices detailed above; rather than 'molded', sequestered away in the prison to be disciplined and then returned to the community once made 'docile' (Foucault, 1977), practices like the anti-social behaviour order can be seen to act as a modulation on everyday movement and action, containing the threat of incarceration, but aiming to modulate the risk of criminal behaviour in the first place (Donoghue, 2008).

These concepts have been particularly influential in studies of technologically mediated experience, and particularly in the consideration of the increasing ubiquity of technologies of surveillance (e.g., Lyon 2006; 2009; Munro, 2000). The idea of modulated control can also, however, be seen to be useful in understanding contemporary services; service users now live 'in the community', but are monitored, through mechanisms such as regular contact with professionals, and regular medication use (Rose, 1998; Tucker, 2006;

2010a; 2010b). Nikolas Rose (1998) has indeed argued that most of mental health professionals' time is now spent on the:

assessment, prediction and the minimisation of risk to the community. The responsibilities of almost all psychiatric professionals have come to be redefined in terms of the assessment of risk (p. 180).

Concern with risk and safety has significantly intensified under the move to community care, where a corresponding increase in discourses of violence and safety (Moon, 2000; Phelan et al, 2000) has been argued to have led to "a growing pressure on psychiatrists to predict and minimise risk" (R.C.P., 2008, see also, Holmes & Warelou, 2007). This tendency can be seen in policy documents (D.O.H., 2007a; 2007b; Harper, 2004), emphasising the: "principle of empowerment through managing choice and risk" (D.O.H., 2007b, p. 3) and the centrality of risk to psychiatric practice more generally. Contemporary mental health care, therefore, can be seen to bear many of the features of the 'society of control': distributed centres of mental health care administered throughout institutional and community spaces (Rose, 1998; Spandler, 2007), and dominated by a concern for surveillance and the ongoing management of risk (Rose, 1998), rather than the site-specific 'molding' of service users in the 'enclosure' of the asylum.

The heterotopia

The second concept which will be drawn on in this paper is that of the heterotopia (Foucault, 1986). A widely applied concept in geography (e.g., Hetherington, 1997; 2011; Johnson, 2006; Lees, 1997; Lord, 2006; Lou, 2007; Soja, 1996; Street & Coleman, 2012; White, Hillman & Latimer, 2012), urban studies (De Cauter & Daheune, 2008), architecture (Chaplin, 2000; McCleod, 1996; Urbach, 1998), and to a lesser extent, psychology (Hook,

2001; 2007; Hook & Vrdoljak, 2002), heterotopias were described by Foucault (1986) as “something like counter-sites ... in which the real sites, all the other real sites that can be found within the culture, are simultaneously represented, contested, and inverted” (p. 24). Hetherington (1997) has interpreted this concept as meaning: “Places of Otherness, sites constituted in relation to other sites by their difference.. [which] organise a bit of the social world in a way different to that which surrounds them” (p. viii). Heterotopias, therefore, can be understood as spaces, located within a society, which are ordered differently (in terms of both their time and space) to their surrounding spaces, and yet still produced in relation to these other spaces.

Contemporary mental health service sites have indeed been argued to be ‘ordered differently’ to those spaces around them; Parr’s (1997) analysis of mental health day centres in Nottingham, for instance, argued that expressions of distress were received differently on the street than in the day centre, inviting less notice and censure in the institutional space. Everyday community spaces, in contrast, have been argued to be ‘purified’ (Sibley, 1995) of expressions of distress (Estroff, 1981; Knowles, 2000; McGrath, Reavey & Brown, 2008). At the same time, the presence of spaces, such as the day centres described by Parr (1997), where distress is more visible, can be argued to help highlight an opposing ‘purification’ of distress in public spaces. This relationship, of both difference and reflection, was argued to be a key feature of a heterotopia, and was explored by Foucault (1986a) through the metaphor of the mirror:

In the mirror, I see myself there where I am not, a sort of shadow that gives my own visibility to myself [...] But it is also a heterotopia in so far as the mirror does exist in reality, where it exerts a sort of counteraction on the position that I occupy” (p. 24).

The 'difference' of the day centre can hence be seen to also make visible the necessity of performing a rational, productive self in mainstream space (McGrath et al, 2008; Rose, 1999; Sibley, 1995; Parr, 1997; 2008; Walker & Fincham, 2011). In this way, the kind of sites described by Parr (1997), the still present, concrete sites of mental health care, can be seen to encapsulate and reflect the production of mainstream spaces and subjectivities. A heterotopia, then, can be seen as a place which both reflects and disrupts a vision, or version, of society, as a place which can be seen as: "reflecting mainstream society's selfness through its otherness" (Saldanha, 2008, p. 2085). Contemporary mental health service sites, at the same time 'other' (Parr, 1997) and 'permeable' (Quirk & Lelliot, 2006), will here be argued to be usefully thought of as a kind of heterotopia.

Empirical approach

Two sources of data have been drawn upon for the analysis presented in this paper. The first came from interviews conducted with service users utilising visual mapping techniques adapted from geographical and community development research (e.g., Chambers, 1994; Herlihy & Knapp, 2003; Herlihy, 2003; Lynch, 1960; Rambaldi, Kwaku Kyem, McCall & Weiner, 2006; White & Pettit, 2008; Wright & Fawcett, 2003). Visual methods were chosen to investigate service users' experiences of space because such methods have been argued to be particularly successful in enabling the discussion of the settings of participants' experiences (see, Bolton, Pole & Mizen, 2001; Gabb, 2009; Knowles, 2000a; 2000b; Knowles & Sweetman, 2004; Majumdar, 2011; Radley & Taylor, 2003; Reavey, 2011), as well as in helping participants to articulate aspects of experience which are hard to put into words, as has been established by work investigating experiences of embodiment (e.g. Bowes-Catton et al, 2011; Brown et al, 2008; Del Busso, 2009; Gillies et al 2004; 2005). In line with

Prosser's (1998) description of the different uses of visual materials in research, these drawings were mainly used as a means to elicit space-focussed accounts from participants, rather than analysed outside of the context given to them by participants. Some drawings are included below, but these are provided as illustrative of the accounts produced in the interview.

Seventeen interviews were conducted with current mental health service users. Participants were asked to draw two maps: one of service use places, and one of non-service use places. They were asked to discuss their activities, interactions and feelings located in each place, as well as rank the places they had drawn and discuss which places in which they felt most comfortable, and why.

The study was approved by London South Bank University ethics committee. Participants were recruited through service user networks, adverts placed in voluntary agencies, and snowballing. To ensure that participants were giving fully informed consent, participants were sent an information sheet with details of the format and content of the interview, and given up to a week to digest this, before agreeing a time for interview. Due to the sensitive subject matter of the research there was a risk that participants may have become distressed either during or after the research. To minimise this risk, it was made clear to participants that they were able to withdraw from the research at any time and could refuse to answer any questions that they might find intrusive. One interviewee did become distressed during the interview and nearly started crying, but wanted to carry on. After the interview, I offered to stay with her for a while but the participant instead preferred to leave alone. This particular participant also commented that the interview was less intrusive than she had anticipated as she had not been asked to talk about her past, in contrast to a clinical interview. This comment highlighted an advantage of the participatory

design of the interview, that allowed participants more control over the direction of the discussion than in a traditional semi-structured interview (Johnson & Mayoux, 1998; Kindon, 2003; McIntyre, 2003; Pain & Francis, 2003; Reavey, 2011). Most participants commented after the interview that they had enjoyed the process or at least found it interesting.

The participants ranged in age from 25 - 67, with a broadly equal gender balance. The primary criteria for recruitment was that the participants were living in the community and currently accessing services; this common spatial experience was determined to be more meaningful than differences in diagnosis. Participants were therefore not asked directly about their diagnoses, although most of them volunteered this information during the interview; eight were currently diagnosed with Bi-polar Disorder and six with Clinical Depression. To preserve the anonymity of the participants, pseudonyms were assigned at the transcription stage, and have been used throughout this paper.

In addition, eight first person accounts of distress were analysed, all in the public domain, and published by Chipmunka Publishing, which specialises in mental health. These were selected from Chipmunka's online catalogue; with the criteria that they should be first person accounts (rather than policy focussed, or family member/ carer accounts), detail experiences of the UK system, and be within a similar timeframe as the interviews conducted (i.e. published within the five years prior to the commencement of data collection).

These two sets of data were analysed together using Thematic Analysis, a method which Braun & Clarke (2006) argue is widely used in qualitative research yet less often explicitly acknowledged. Thematic analysis, they argue, can be carried out from a variety of epistemological and theoretical positions. For this research, a broadly social constructionist

epistemology was adopted, in that the accounts analysed by participants were seen as located in their particular context and not as representative of a stable 'truth'. The theoretical approach taken here departs from discursive social constructionism in that language is not taken to be ontologically primary (Cromby & Nightingale, 1999). In considering the relationship between space, experience, and subjectivity, arguably the central theoretical problem in consideration here, this paper will instead firstly draw upon insights from human geography, which posits that space is emergent from dynamic, situated inter-relations (Lefebvre, 1991; Massey, 1994). Such a position is relatively easily married with social psychological approaches to the self which propose relations and practice as similarly central (e.g., Henriques et al, 1984; Brown & Stenner, 2009). Particularly relevant here are social psychological approaches to materiality and embodiment (e.g., Brown & Stenner, 2009; Burkitt, 1999; Burr, 1999; Cromby & Nightingale, 1999), where materiality can be understood as a resource drawn upon in the active composition of subjectivity (Brown & Stenner, 2009). Further, to consider the specific role that materiality might play in the production of situated, actively constructed, experience and subjectivity, and to avoid 'flattening out' (Stenner, 2008) the human and the material, the work of Serres (1995) and Latour (1996; 2005) will be drawn on to provide a picture of how objects might 'participate' (Latour, 2005) in experiences by 'slowing down' or 'stabilising' (Serres, 1995; Reavey & Brown, 2009) interactions and experiences. The version of space considered here, therefore, can be seen as one produced by a complex web of ongoing material, social and discursive relations and forms of practice (e.g. Massey, 1994; Lefebvre, 1991), which in turn can be seen to form part of the production of experiences (Foucault, 2006; Latour, 2005; Serres, 1995) and the active composition of subjectivity (Brown & Stenner, 2009).

Risky materiality: making control visible

Several participants described the materiality of the inpatient ward as reflecting a concern with risk, safety, and observation, which would seem to support the contention that contemporary services have "come to be redefined in terms of the assessment of risk" (Rose, 1998, p. 180). Rachel, a woman in her 30s, for instance, described a room where she had been placed because she had been designated as 'high risk':

it was really near where the nurses were and it was a shared room and it had a curtain down the middle and the door was a curtain and then here [indicates on drawing] were windows so they could see in on you um and they were that sort of they were slightly frosted glass with that that non-smashable type so it wasn't like you could literally stare in but you felt kind of and then you had a bed either side and this [indicates drawing] was a curtain as well [...] it was so awful [...] I think the sort of lack of privacy like I didn't feel like I could change or anything in the room without people being able to see in (Rachel, l. 249- 259).

While Jimmy, the author of one of the narratives analysed, entitled 'I Thought I Was the King Of Scotland' (2008), also described his ward in similar terms:

as you looked at the building from the outside all the windows were tinted glass so when people walked by they could not see in [...] the nurses [sic] office was in the middle of the ward with glass windows which I used to call the goal [sic] fish bowl, so they could see what the patients were doing [...] there was a door leading out side [sic] to a small courtyard where you could go for fifth teen [sic] minutes everyday for [sic] escorted with a nurse. (K.O.S., p.43).

It can be seen from both Jimmy and Rachel's accounts that a concern with risk, monitoring and observation can be seen to be described as pervading the material set up of the ward.

Other participants also described the ward as being characterised by: "too much sort of managing patients and um observing patients" (Bryan, a man in his 60s, l. 377), and being a place where: "nobody has got five minutes to sit down with you". (Julie, a woman in her 50s, l. 892); these comments can be seen to support previous work which has contended that interactions on contemporary wards are often dominated by risk administration, observation, and a reduction in staff/service user interactions (Alexander & Bowers, 2004; Bowers et al, 2005; Ford et al, 1998; S.C.M.H., 1998; Stewart, Bowers & Warburton, 2009; Quirk & Lelliot, 2001). In addition, these accounts can be seen to lend weight to a view of the contemporary ward as part of a system of control, rather than an 'enclosure' of discipline (Deleuze, 1992; Rose, 1998). Observation practices constitutive of such a system of control (Stewart et al, 2009; Rose, 1998) can be seen, in the extracts above from Rachel and Jimmy, as contained and expressed through the material makeup of the ward; Jimmy describes a central "goal [gold] fish bowl" (p. 43) of an office, while Rachel's 'high risk' room is described as being designed for ease of staff observation, rather than her comfort or therapeutic benefit. The very walls of the room have been removed, replaced with "frosted glass" (l. 252) and a "curtain" (l. 254). It is here worth drawing on Bruno Latour's (2005) statement that: "[material] things might authorise, allow, afford, encourage, permit, suggest, influence, block, render possible, forbid" (p. 72) different actions, experiences and interactions. In Jimmy's account, the material barrier of the glass walls of the office, could be seen to "block" embodied interaction between service users and staff, and yet at the same time "allow" observation; any interaction with the outside world can be seen as at the same time "blocked" by the tinted glass and locked doors. In Rachel's account, the glass and curtain can be seen to be described as participating (Latour, 1996; 2005) in Rachel's feeling of "being constantly watched" (l. 266). Rachel and Jimmy's positioning as 'risky' individuals

in need of surveillance can hence be seen as being 'made visible' (Hetherington, 2011), materially apparent through the insubstantiality (translucent rather than solid walls; curtains rather than doors) of the material separation between themselves and the staff. The ward, as described here, can hence be understood as a heterotopia (Foucault, 1986) of control (Deleuze, 1992); the materiality of the ward can be seen to mirror, reflect back, Rachel and Jimmy's subject position as observed, to themselves, whilst at the same time also reflect out, 'make visible' (Hetherington, 2011) the practices of control and observation which are argued to characterise contemporary community care in spaces beyond the ward (Rose, 1998).

Material subjectivities of service use: danger, passivity and morality

The second major material feature of services which was widely commented upon in descriptions of both inpatient and outpatient facilities, was a preponderance of visible locks and barriers, as exemplified by these extracts from participants' drawings:

[Figures 1-3]

As well as being verbally described in the interviews:

this is the hospital and the erm there's like bars everywhere but they're not meant to look like bars so they're in this criss cross pattern (Lou, a woman in her early 30s, l. 37-39).

so there are locks on the doors there as well but it's more obvious that there's a big lock [l:mmm] with a pin number on it whereas I can't remember what that lock was

like [at private clinic] it could have it could have been that it was a key lock cos well it might actually have been a swipe card type lock so it's a bit more discreet that we're keeping you here and you're not allowed out whereas at the [NHS ward] [...] it's a lot more obvious that this is a lock and you don't come in here unless we let you (Zoë, a woman in her mid-twenties, l. 276-283).

And similarly emphasised by Jimmy in another part of his description of the ward discussed in the previous section:

I would like to explain a bit about the layout of the ward or prison I was now in [...] as you got to the front entrance there were two double doors which were locked at all times and you had to speak through an intercom to be let in, just inside was a waiting area with another locked door which you had to wait at to be let onto the ward and if you had any visitors they had a little glass hatch with sliding doors were you had to hand over all your belonging [sic] as you were not allowed anything on the ward it was just like visiting someone in prison the only difference was you did get searched before you went on the ward (K.O.S., p. 43).

The visibility of division and security in service use sites, both inpatient and outpatient, was hence a prevalent concern raised in both the interviews and narratives, concurring with research which has found that contemporary psychiatric wards are increasingly likely to be locked (Bowers et al, 2009). Following the argument that one role of the material layout of spaces can 'make visible' (Hetherington, 2011) a particular subject position, Lou described the prevalence of locks and barriers in their outpatient waiting areas as promoting a stigmatised, 'dangerous' and devalued subject position:

[...] and it's kind of a relief when whoever you're waiting to see the psychiatrist or the psychologist or whoever sort of comes in and calls your name and then you get

to go behind these big locked doors and go up you know into these tiny little rooms but it's it's just I dunno it's quite a bizarre space I think it's really could be more open [l:mmm] it's so enclosed and lock you're locked away like you're you're... don't know like hmm like you're dangerous or something I guess. (Lou, l. 338-345)

While Karl described his feelings upon an incident when he realised that a woman sitting with him in the waiting room, with whom he identified, was not a fellow service user but instead a prison officer accompanying a prisoner to the service:

I'm not in my mind you know I'm not one of those people [l:mmm] you know I'm not the transgressor [...] and I'm sitting there going oh it's you know I'm sitting here feeling sorry for myself in the waiting room but this person beside me also looks quite normal and you know normal so I guess it really can affect anyone no it's doesn't affect her except it's her job to look after the guy who's in prison. (Karl, a man in his early 30s, l. 563 – 577)

The contemporary association of mental health with risk, dangerousness and criminality (Harper, 2004; Moon, 2000; Phelan, Link, Steuve & Pescosolido, 2000; Rose, 1998) can here be seen to be participating in the imposition of a 'dangerous' subject position when located in the space of services. Accounted for as co-participating (Latour, 2005) in the production of this experience for service users are the material objects and layout of the space, placing Lou and Karl in the position of the "dangerous" "transgressor". In Lou's account, locks and the glass barrier do indeed literally enclose her in the space, dividing the staff (who are able to move freely between the different spaces in the service) from the service users (who are not). The barrier could also be seen as 'stabilising' (Serres, 1992) this distinction; because of its presence, persons entering the space will be placed on one side or another, ordered into either 'service user' or 'staff'. The position service users are placed in here can also be seen

to be passive; staff control access to the spaces of the services, the ability to pass through the "big locked doors" (l. 342). Passivity has been long described as a key part of the 'patient role' (Campbell, 1996b; Link et al, 1989; Scheff, 1974, 1999) argued to be inculcated through service use. Here, 'participating' (Latour, 1995) in the production of a passive subject position can be seen to be the materiality of these spaces: large, visible locks; staff controlled barriers and entrances.

A further implication of a preponderance of barriers, was also commented upon by Lou:

it's really quite scary because it's just you know that there's some really disturbed people come into this place and sometimes they're really smelly [...] you just never know what you're going to come across and there's a funny smell there as well and just the way that the other people are barriered you know barred off from you [l:mmm] like you're the plague I dunno I just really dislike it I think it's an awful space to wait um it's just like nobody really cares [...] it feels really like you know we're not worthy of a decent space you know [l:mmm] it's like this waiting room with these ancient magazines (l. 324 - 332)

Lou's comments on the tattered nature of her waiting room as producing a feeling of being "not worthy of a decent space" (l. 336) can here be seen to indicate a moral dimension ("the plague", l. 330) to the visible positioning of service users here described. Psychiatric labelling has long been argued to contain a moral judgement (Goffman, 1961; Scheff, 1999; Szasz, 1960), designating those labelled as morally inferior, or tainted. Here Lou seems to be describing the shabby nature of her waiting room with "a pile of old magazines in the corner so old they're ancient and there's a watercooler which I just wonder if anyone ever drinks water out of" (l. 320 – 322), as highlighting, again, making visible (Hetherington, 2011), this

moral judgement through the materiality of the space she is assigned as a service user. The tinted windows of the ward described by Jimmy, in the previous section, can similarly be seen as indicative of a value judgement; experiences on the ward are described as hidden from view, making the wider status of experiences of distress visible. Rachel also described her community mental health building as, while being "quite bright and new and things" (l. 51)," inside, having an entrance consisting of locked doors, which she described as "bare and concrete with no signage or anything" (l. 59), arguably presenting a similar message of distress as hidden and shameful. The shabbiness of these buildings (which was not described by all participants, it is worth noting) can also be seen to indicate a positioning in the economic order, which could be argued to make visible both the low economic power of many service users (Perkins, 2002; Warner, 1985; 2000), as well as a privileging of the 'productive citizen' (Walker & Fincham, 2011). What all participants here can be seen to be describing is the way in which the materiality of mental health service buildings help contribute to an experience of being positioned as dangerous, morally suspect and devalued; in other words, subjects in need of control. Mental health service sites, therefore, can be seen as heterotopic; highlighting, reflecting and making visible the control practices (Deleuze, 1992), risk management (Rose, 1998) and moral judgements (Goffman, 1961; Scheff, 1999; Szasz, 1960) argued to be inherent in the construction of contemporary mental health care, and indeed, present in wider social practices.

Managing modulated subjectivities in the community

A key feature of contemporary service use, however, is that service users do not spend the majority of their time in the kinds of service use sites described above. Several participants described the complexity of negotiating a residual, or in Deleuze's (1992) terms 'modulated'

subjectivity (of passive, stigmatised service user), argued here to be made visible in service use spaces, across the myriad community spaces within which they negotiated their everyday lives. Some participants, for instance, described using their home space to modulate their interactions with services, with Bryan commenting:

it makes a real difference to me that he [CPN] comes to into my space and talks to me and we kind of have quite an easy conversation and we sometimes talk about books or things that I'm doing and that makes a real difference [...] I kind of feel in control of the relationship because it's take because he's coming here er meeting me in meeting me in my own space it makes quite a bit quite a bit of difference.(Bryan, l. 44-55).

While Zoe said her in her interview:

I put a stop to people coming to the house bec in fact I've never had anybody in my house as in when I first got ill I was living with my mum and dad and there was a home treatment team that were assigned after one probably quite silly episode where something y'know when things had got quite bad and they would come here to mum and dad's house and I hated it because to me that's my space [I:yeah] and it I dunno I just I think that y'know you come home to your own space and to your safe place and to have that intrusion where people are coming in and saying how are you well how I'm not well but I could tell you that in a hospital [I:mmm] where ill people go [I:mmm] ill people aren't at home it's just for me it was always you're either ill or sad when you're at home you just feel a bit sad and when you're at hospital you're ill and the two for me didn't mix. (Zoë, l. 157-169).

Both Bryan and Zoe can here be seen to be describing using the space of their home to modulate their experience of subjectivity when in contact with services. Bryan can here be

seen to be using the 'personal territory' (Mallet, 2004) nature of his home space to shift the balance of the relationship with his CPN, so that he feels "in control of the relationship" (l. 53) rather than the passivity described above as produced in service use spaces. Zoë, on the other hand, could here be seen to be describing her exclusion of professionals from her home as a protective measure against the "intrusion" (l. 164) of a medicalised 'ill' subjectivity into her home space. Here she can be seen to describe linking the production of a global, ill subjectivity with the space of the hospital (where "ill people go, l. 166), whilst retaining a transitory, normalised conceptualisation of distress in her home (where "you just feel a bit sad", l. 168). Medicalised explanations of distress, and psychiatric diagnoses, have indeed been widely argued to confer such a global subjectivity on those who are diagnosed, designating people 'a schizophrenic', for life, rather than someone who has psychotic experiences at some points in their life (e.g., Campbell, 2007b; Bentall, 2003; Rapley, Moncrieff & Dillon, 2011). Being 'mentally ill' rather than 'sad', also, as seen above, also confers a necessity for control, and the kinds of subject position seen above as being made visible in service use spaces, of the stigmatised and morally devalued transgressor. Zoë can be seen to be describing a resistance to the extension of the kind of subjectivity into her home space, and hence being positioned in this way in parts of her life not directly associated with service use.

Other participants also described particular spaces and activities as enabling the expulsion of a 'service user identity' (Campbell, 1996b; Link et al, 1989; Scheff, 1974, 1999). Karl and Lou, for instance, both described sports activities and spaces as enabling the enactment of a positive, active, agentic subjectivity:

on the football pitch [...] I'm not a patient I'm an active participant [I:mmm] and I'm able to do and I'm able to keep up you know not keep up to excel and to do to do what I used to do and to do what I normally do. (Karl, l. 941-945)

I love the gym I love the gym [...] it's a place where no-one knows who I am [...] but I can just sort of be [...] I like I even like using the shower there and that kind of thing because I really hate being at home and anything that I can not do at home [I:mmm] is is really good so I really I like showering there and doing my hair there and you know [...] just you know eating lunch there I just really like the I really like the space [...] I guess this is a space that I don't mind being mine I don't I don't have any issues about being a member of a gym [...] it's like it's like I feel normal there I feel like I'm not in an institution I feel like I'm not special. (Lou, l. 572-598)

Whilst Lou made a similar point about her voluntary work:

you know you get to be happy [...] you get to chat with the customers and [I:mmm] [...] and feel like you're sort of I don't know contributing to somebody's day without investing too much [...] emotion in it [...] like having a clean slate and walking in and I could be anybody to them you know I didn't have to be stupid depressed Lou you know I could be happy Lou. (l. 543-563).

The agentic, active subjectivity described here is explicitly compared to that inculcated by service use, and argued above to be 'made visible' in service use buildings ("I'm not a patient", Karl, l. 943). Soja (1996) argues that integral to the construction of particular places are 'imagined spaces', the conjured meaning of a space, including its wider social and cultural meaning. Both Lou and Karl here can be seen to be drawing on the 'imagined' qualities of the spaces described in order to enact an agentic subjectivity; the kinds of

spaces described here can be seen as associated with activity, normativity and productivity. Exercise, for instance, is widely linked with the production of a functional self and normative appearance (Crawford, 1984; Lupton, 1995), whilst engaging successfully in workplace productivity has been argued to be the key marker of access to adulthood and citizenship in late capitalist societies (Warner, 2000; Walker & Fincham, 2011). Karl and Lou's descriptions of experiencing a more active subjectivity within these spaces dedicated to these two activities, therefore, can be seen to have a moral dimension; in participating in the embodied activities of sport and work, they can be seen to be accessing a different 'imagined' subject position to that perpetuated through service use, that of an active, productive citizen, in control of their body (Crawford, 1984; Lupton, 1995). Lou's transference of her daily activities, such as showering and eating, to the space of the gym, could be seen as an attempt to extend this experience of subjectivity beyond engagement in exercise activities ("this is a space I don't mind being mine", l. 585); the 'imagined space' of the gym, with a corresponding 'imagined' active subject position, can hence be seen as one which Lou uses to attempt to (temporarily) dispel the subjectivity afforded by her service use.

It is noticeable, however, that any dismissal of the modulated subjectivity inculcated through service use described by Lou and Karl here, is also accounted for as being highly located, and also fragile. Lou, for instance, described an incident when her positive experience of the gym was disrupted:

I did start crying when I was at the gym a few weeks ago and that was um because I had to look in a mirror [...] I didn't wanna look in the mirror because I didn't want to look I guess no I guess that's part of it because I didn't wanna see the reality I wanna be this like I could be anybody [l:mmm] while I'm in the gym and and and and I don't

have to be sad depressed Lou but when I look in the mirror that's what I see is sad depressed Lou so I I didn't wanna look in the mirror while I was at the gym because you know I'm somebody I I can be somebody else [l:mmm] I feel like I don't have to be this really sad person. (Lou, 613-622).

Here, Lou describes a puncture in the form of subjectivity described as engendered by her active involvement in the gym. She describes looking in the mirror as involving an insertion of "reality" (l. 616) into the space of the gym, more specifically of seeing in her reflection "sad depressed Lou" (l. 618) while her engagement in the gym is accounted for as enabling her to be "somebody else" (l. 621), not "this really sad person" (l. 622). Whilst the gym can usually be seen to enable Lou to access an 'imagined' subjectivity of activity and productivity, here the insertion of a visible reminder of her distress, and the kind of subject (and moral) position involved in being a service user, can be seen as puncturing her use of the 'imagined space' of the gym to dispel this devalued subject position from her experience. In a similar way to which the materiality of service use buildings can be seen as making visible to service users their subject position (dangerous, risky, in need of control), here the presence of the mirror can be seen as making Lou's status as a service user visible to herself, puncturing the subjectivity described as usually afforded by the gym. This can be seen as implying that the successful production of the kinds of active, productive subject positions described by Lou and Karl are in part contingent on the exclusion of distress, and hence the expulsion of their modulated service user subjectivity.

Conclusions

This paper has argued for a consideration of the role of materiality and space in service users' experiences of mental health care. Similarly to Bowers et al (2005; 2006; 2009), we

would argue that the concrete sites of mental health care, and the ward in particular, are in danger of being ignored due perhaps to a prevalence of utopian discourses of placeless 'community care' (Symonds, 1998). This paper has hence considered the role that these concrete, still existent sites of mental health care play in the production of service user subjectivity, when accessing services and living in the community. It has been argued that such service use sites can be understood as acting as 'heterotopias' (Foucault, 1986) of control; described as embedded in the relationships and material layout of service use sites can be seen to be intensified control practices, of surveillance, monitoring and risk management. This has been argued to make visible to service users a stigmatised, 'risky' subjectivity while in these sites, which then can be seen to 'modulate' service users' experiences and ongoing subjectivity in the community. The latter part of the paper described various strategies described by participants to moderate and dispel this modulated subjectivity in their everyday lives, through the use of spaces (home, gym, work) as a resource to help produce a more agentic subject position. The concept of the heterotopia is used here as a useful metaphor to help illuminate how the particular production of the spaces of mental health care can be seen to highlight this particular form of risky subjectivity to service users, as well as being held in relation to participants' negotiation of generic community spaces. This approach can be seen to demonstrate the importance of considering the continuous inter-relation of space and subjectivity, as service users move within and between multiple service use and non-service use spaces, rather than perhaps only focussing on isolated experiences of particular spaces (eg, the home, the ward, the workplace). It has here been argued that these accounts of experiences in the community can be seen as indicating that, despite an ideological (and practical) shift 'beyond buildings' (D.O.H., 2006), the remaining concrete sites of mental health care can

still be seen to have an ongoing impact on the experiences of service users living in the community. An attention to the makeup of these sites, and the subjectivity produced and negotiated within them, hence becomes a crucial and pertinent issue for contemporary service providers and users.

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