Social Theory & Health
https://doi.org/10.1057/s41285-023-00193-z

ORIGINAL ARTICLE

Negotiating body and power in forensic mental health care

Virve Repo[1] · **Päivi Kymäläinen**[1]

Accepted: 12 March 2023

Abstract

Since the beginning of the 2000s, the reduction of coercive methods has been a tendency in psychiatric care in Finland. Combined with the transforming ideas of healing, the reduction has changed practices in the institutions of forensic mental health care, by encouraging efforts to increase self-determination and individual responsibility. This article addresses the coexistence of the previous and current bodily regimes, and the resulting complex and contested spatial and bodily arrangements. We combine the discussions on biopower and bodily regimes in our analysis of the practices and negotiations related to the alternative methods to coercion (special observation and restricting garments), mundane practices (eating and exercising), and negotiations related to touch and sexuality. As our study shows, bodily regimes and care practices are constantly under negotiation, during which there may be inconsistences in what is or is not allowed. Moreover, what seems to be a positive tendency towards increased self-determination has led to new forms of pressure, resulting from the increased possibility to protest by using one's own body (e.g. by ignoring hygiene), or from the diminishing self-determination of the nurses (e.g. during special observation).

Keywords Forensic mental health care · Biopower · Bodily regime · Coercive methods

✉ Virve Repo
virve.repo@tuni.fi

Päivi Kymäläinen
paivi.kymalainen@tuni.fi

[1] The Unit of Social Research, Faculty of Social Sciences (SOC), Tampere University, 33014 Tampere, Finland

Published online: 30 March 2023

Introduction

In Finland, approximately 400 people (of 5.5 million people) are under involuntary care in the two state-owned hospitals[1] providing forensic mental health care. The main purpose of the hospitals is to treat criminals who have not been sentenced because of insanity. Since the beginning of the 2000s, a reduction in coercive methods has been the tendency in psychiatric care in Finland (Laukkanen 2021; Tuovinen 2017). Combined with the transforming ideas of healing, they have changed practices and spatial arrangements in the institutions of mental health care. This article addresses the coexistence of the previous and current bodily regimes in institutions, and how their coexistence has led to complex and contested spatial and bodily arrangements.

With the data gathered from the Niuvanniemi forensic hospital in Finland, we analyse in detail the transformation of the practices and techniques of controlling bodies. How does this transformation influence on the physical and social spaces in the institution? How are the negotiations conducted in relation to bodily control? As an alternative to studying individuals or institutions, our interest lies in the practices, techniques, and negotiations (Valverde 2017) through which bodily regimes are redefined and actualized in interactions with and among patients. Our research adds to previous studies by providing new information on how bodily regimes and biopower operate through bodies and space in forensic mental health care, how they are negotiated in the everyday life inside these institutions, and how they influence the spatial practices in forensic mental health care.

Biopolitics have been studied before, for example, in the context of nursing (Perron et al. 2005), health care (Fraser et al. 2019; Kivelä and Moisio 2017), care and custody (Minca and Ong 2016), risk and security (Fraser et al. 2019), and forensic mental health care (Holmes and Murray 2011). Biopolitical practices direct certain parts of the population in specific institutions, where the practices of care and control are targeted at bodies, who—as members of the society—are also social bodies (Holmes and Murray 2011). In addition to the body, space is also understood as both physical and social in this article. It does not merely refer to physical structures such as walls, fences, rooms, buildings and yards (that are significant in the execution of biopolitics and forensic mental health care (e.g. Nettleton et al. 2018; Nord and Högström 2017). Space also refers to social and relational spaces that are formed and altered in the relationships between people, or between people and nonhuman actors or objects (e.g. Massey 2005). Butler and Parr (1999) use the term 'body space' to refer to situated physical presence and bodies; body spaces are in space but also include the discursive, cultural, and spatio-temporal meanings that tell how to act, live, and cope. We interpret them here as bodily regimes (e.g. Pinkus 1995; Eves 2010; Alunni 2015; Willnott 2019; Demuru et al. 2021; Pile 2021) that are spatially manifested ways of implementing power over bodies.

[1] Psychiatric hospitals are usually run by municipalities. The two state-run hospitals, Niuvanniemi and Old Vaasa, concentrate on treating forensic psychiatric patients and on carrying out mental state examinations.

The first section of the article discusses the theoretical debates on bodily regimes and biopolitics, relating them to each other and to care practices. This is followed by the elaboration of the role of the Niuvanniemi Hospital in the context of Finnish forensic mental health care. The third part analyses the practices and negotiations related to bodily control including alternative methods to coercion (e.g. special observation and restricting garments), mundane practices (e.g. eating and exercise), and control over touching and sexual interaction. These themes appeared in the data as body-related practices that had been the subject of negotiations or complaints. The final part discusses the findings and the theoretical potential of the terms of biopower and changing bodily regimes.

Bodily regimes, biopower and bodies in space

Bodily regimes (e.g. Pinkus 1995; Eves 2010; Alunni 2015; Willnott 2019; Demuru et al. 2021; Pile 2021) are spatially manifested ways of implementing power over bodies. Previous research has studied, for instance, colonial (Willnott 2019), gendered (Eves 2010), immigrant (2015) and institutional (Demuru et al. 2021) bodily regimes, as well as the representations and creation of regimes in advertising and propaganda (Pinkus 1995). Steve Pile's book "Bodies, Affects, Politics" has been of especial influence for our study; the book investigates and conceptualises the coexistence and overlapping of different bodily regimes, as well as relationships and clashes that occur between them.

Bodily regimes become manifested in the everyday practices and negotiations over institutional power. Institutions like hospitals or prisons restrict body spaces in several ways, consequently the everyday life of individuals (inside and outside of institutions) may produce radical bodily expressions to fight against regimes that are considered natural or universal (Pinkus 1995). The 'naturalness' means that the bodily regimes and the power relations involved have the ability to produce certain kinds of subjects. Sometimes this requires punitive means, but usually people adjust to the socially and culturally learned ways of being and adopt the processes of self-government (Eves 2010). However, bodies may take control of their own boundaries in order to escape the assumptions of the regime. For instance, people may try to erase their gender or skin colour for security reasons (Pinkus 1995), or try to avoid 'body behaviour' that positions them part of a marginality. Examples like these show how bodies are, firstly, biopolitically managed, and secondly, how they are arenas for the boundaries that separate people from wider society (Alunni 2015).

The clashes of bodily regimes do not occur merely vertically—resulting from the order defined from above—but also horizontally, in the lived experiences between individuals (Pile 2021). Bodily regimes are not restricted to bodies, but they "shift through the body and the social" (Pile 2021, p. 25), thus actively producing bodies and becoming operative through affects and politics. The potential sites for the affectual moments and politics to emerge develop when bodies become apprehended in places to which they are not assigned.

As Pile (2021) notes, bodily regimes try to assign bodies to proper places by utilising not only bodies or senses, but also things associated with bodies, such as

clothes. In the institutional context, we understand this to be linked with the ways of controlling bodies, for instance, by banning patients' from wearing their own clothes, by using restrictive garments, by setting hygiene regulations and timetables, or by restricting touching and sexual interaction. The effects of control do not merely concern one individual but spread indeterminately through the affects that are transferred between bodies and lead to the shared experiences and the formation of community spirit (Pile 2021). As our material reveals, there are constant negotiations over bodily regimes and the efforts to define the patients' everyday practices and relationships with others.

We combine the conceptual understanding of bodily regimes to the question of how institutions utilise biopolitics and further biopower to enable the training, scolding, and adjusting of bodies (Foucault 1990). Biopower can be understood as power over life, divided into the anatomo-politics of the human body and the biopolitics (Foucault 1990; Griffiths and Repo 2018; Perron et al. 2005). While biopower (as a form of discipline power) concentrates on individuals, biopolitics are used to control populations (Holmes and Murray 2011). Anatomo-politics is founded on the procedures of power and discipline, and it regards a body as a machine that can be trained and disciplined towards becoming docile, productive, and useful. The biopolitics of the population, for its part, focuses on regulating populations e.g. through healthy bodies (Foucault 1990). In this article, we do not regard these aspects of biopower as separate from each other, but rather as mutually constitutive. The body can be regarded as an inscriptive surface on which discipline and its effects become sedimented through the regulation of the details of daily life and behaviour (Foucault 1990; Simonsen and Koefoed 2020). While the conception of biopower allows a wider and more general analysis of the constitution of norms in peoples' lives, the notion of bodily regimes allows deeper analysis of the effects of these norms on individuals.

The purpose of biopower is to maintain order by controlling individuals or populations that pose a threat to social order (Perron et al. 2005), or are regarded as body suspects or figures out of place (Simonsen 2013). Citizens may be interpreted as biological citizens (Rose and Novas 2005) who are defined by the determinants of the normal (healthy) and the deviant (unhealthy) (Brown et al. 2018). National health work and pharmacotherapy are used to guide, instruct, and control populations, and health is linked with success, beauty, happiness, and sexuality, thus creating a number of rapidly growing consumer markets (Rose 2001). The 'new' public health has moved from the 'old' sanitary requirements to health-related imperatives, such as safe sex, physical activity, non-smoking policies, and healthy diets (Brown et al. 2018).

The control over health has many forms, including (1) the norms and legitimation of normalising measures established in the law; (2) capitalist efforts to keep the population productive (Foucault 1990); and (3) the neoliberal managing of individuals by giving them more responsibility for their own health (see also Brown et al. 2018; Foucault 2004; Story 2019). The emphasis on responsibility is an excellent illustration of the pervasiveness and spread of biopower as individuals control themselves, e.g. by counting calories or behaving in other acceptable ways (Valverde 2017). Power over individuals is, thus, not only physical power as different forms of

power are dependent on each other; this means, for instance, that physical power is dependent on discursive practices (Barad 2007; Foucault 2006).

The Niuvanniemi hospital

The research data were collected at Niuvanniemi Hospital, Finland's largest state-owned hospital. The hospital was built in 1884 and, after WWII, was especially appointed to the care of forensic patients. The hospital can accommodate and treat 284 adults and 12 child/adolescent patients who (1) have committed a crime but are found not guilty because of insanity; (2) are undergoing forensic mental health examination; or (3) are too difficult to be treated in hospitals run by municipalities (Tuovinen 2017). Finnish mental health care has undergone changes since the 1980s, including de-institutionalisation, and new forms of medication and care (Ahonen 2019; Repo 2020). Niuvanniemi Hospital has renewed many of its care practices but has also kept some traditional care forms such as work therapy. In 2008, the hospital adopted a method employing six core strategies in order to reduce coercive measures. The main points of the strategy were as follows: (1) leadership towards organisational change; (2) using data to inform practice; (3) workforce development; (4) the reduction in the use of seclusion and restraint; (5) consumer roles in inpatient settings; and (6) debriefing techniques (Huckshorn 2005). A steering group (SGRCM)—that met a few times a year—was founded in 2008 in relation to the reduction of coercive methods consisting mainly of doctors and head nurses. A workgroup (WGRCM)—that met once in a month—was founded in 2011, consisting of doctors, nurses, head nurses, a psychologist, an occupational therapist, and patient member(s).

In our analysis, we use several kinds of data from Niuvanniemi Hospital: the memos of the SGRCM (2008–2019; 19 memos, 24 pages) and WGRCM (2011–2019; 70 memos, 83 pages); general instructions; the instructions for special observation; the Parliamentary Ombudsman's reports concerning inspections of the hospital between 2010 and 2019 (two reports, 39 pages); the complaints solved by the Parliamentary Ombudsman from 2010 to 2019 (four documents, 22 pages); and the report of the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) 2015 (59 pages). We conducted supplementary five semi-structured interviews with personnel active in the development of the hospital policies. The interviews were recorded and transcribed and are used as background material to help clarify the other material. One of the interviews was conducted by both authors, and the four others were conducted by one author only and all the interviews were conducted in the facilities of the hospital. Both authors visited these facilities to the extent allowed by hospital policies and since neither are professionals in mental health care, their observations tended also to discern details that may seem obvious and naturalised by the insiders of the institution.

Moreover, we carried out a webropol survey in 2019 of the whole personnel working in the hospital (approximately 400 person) and received 48 replies. The survey included similar themes to the interviews. We asked about the control of hospital spaces, the influence of a reduction in coercive methods when working, and the

threat and spatialities of work-related violence. There was also a possibility to make free comments about any topics. We acknowledge that the data are limited because only some employees were active in answering the questionnaire, and some did not want to communicate the details of their work. Moreover, the amount of information provided by the memos depends on the secretaries and the established practice of writing memos. All parts of the research data were analysed with content analysis, emphasising any expressed changes in the spatialities and policies of controlling bodies, and the resulting negotiations in the patients' everyday lives.

Ethical considerations were carried out throughout the research process. Permission for the study was requested from the head doctor of the hospital. This permission set ethical boundaries for the researchers, including a prohibition on contacting the patients and a requirement to anonymise the research data. We anonymised the interviewees, the participants in the Survey, and the members of SGRCM and WGRCM. Furthermore, following the Finnish legislation (Tietosuojalaki 5.12.2018/1050 2018), personal information on the patients was removed from the documented material before being used by the authors. We followed the guidelines of the Finnish National Board on Research Integrity (TENK) (2019) according to which no further ethical approvement was needed since we were not in contact with the patients.

We were aware of the complexity of the power relations in psychiatric hospitals: how, for instance, nurses exercise power over patients while acting themselves under the strict rules and being affected by the patients (see also Cisney and Morar 2016; Foucault 2006). Thus, the research material illustrates a certain perspective on power that could appear slightly different in another style of material (see Valverde 2017). The perspective of patients was somewhat included in WGRCM documents and in the complaints to the Parliamentary Ombudsman, but otherwise, the focus was on the practices and policies as experienced by the personnel.

Controlling the body in forensic mental health care

Forensic mental health care acts as a hybrid institution between care and incarceration (Holmes and Murray 2011) and its biopolitical purpose is to control a certain part of the population. Much of the life inside institutions is concerned with controlling the (unpredictable) body. Not only restricting and coercing the body but also using bodily therapeutic methods, such as work therapy, exercise, or ice swimming in order to calm the mind. Traditional coercive measures, such as seclusion, restraints, and involuntary medication (Laukkanen 2021), are directly targeted at the body, through isolating it, restraining it or the absorption of medication. Many of these methods are also spatially significant. They usually bind the patient to the same space for a long time, causing harm and detriment (Vierihoito Niuvanniemen… 2019). The Mental Health Act (1990) regulates the use of coercive methods, but alternative methods are not considered by the law. This provides the hospital with much freedom when deciding on the use of alternative practices, such as open area seclusion, observation, or using restricting garments.

Special observation

Special observation is used with patients who need monitoring due to physical illness, or because they pose the threat of absconding or endangering themselves or others (Chu 2016; Whitehead and Mason 2006). It is one of the options to seclusion (SGRCM 02/16/2012) as seclusion periods can be replaced with a method where a nurse observes a patient constantly. The purpose here is spatial: keeping the patient in an isolated space for a long period of time may be avoided if a nurse stays in proximity to the patient. Special observation thus gives patients more autonomy to move around the hospital. The instructions employed by the hospital (Vierihoito Niuvanniemen…2019) describe several observation methods, which can be quite specific. For example, the patient is observed every 15 min (intermittent observation), the patient is always within the reach of a nurse's hand (constant special observation), or a patient receives 'close care' which in Finnish (*vierihoito*) is the same term that is used in mother–baby care (rooming-in in English). The Finnish term has been used at least from 2009 onwards, when it was emphasised that it differs from observation in a sense that observation is ordered by a doctor and special observation can be done without a doctor's order but not without the patient's consent. While the term emphasises care instead of observation, the fact that the term is also used in mother–infant-related care may give a patronising tone to the setting.

The naming of observation in terms of care gives an impression of the strong role of professional knowledge in the use of observation methods (see also Stevenson and Cutcliffe 2006). The same tendency can be detected in the instructions that emphasise the hospital's transformation "from close observation to close care" (Vierihoito Niuvanniemen…2019). Nevertheless, the instructions do not specify the observation method used at Niuvanniemi Hospital, but simply mention that special observation in Finland is loosely understood as an active and goal-oriented action with the patient. In this paper, we use the term special observation which is commonly used in psychiatry and includes different levels of observation practices (Bowers et al. 2004; Chu 2016).

In Niuvanniemi, the longest seclusion periods can last for months, and they concern a small number of patients who are violent or otherwise challenging to treat (Parliamentary Ombudsman 2010, 2014). There is an effort to replace especially long-term seclusion with "intensive special observation" that—contrary to the physical restriction of seclusion—"leaves room for interaction" (WGRCM 09/01/2017; Vierihoito Niuvanniemen… 2019). However, the lack of resources and concerns about the ability of nurses to cope has diminished enthusiasm for using special observation (WGRCM 09/02/2016). In 2018, there were nine patients at Niuvanniemi Hospital under special observation on three different wards (Vierihoito Niuvanniemen…2019).

Since constant special observation restricts patients' self-determination, privacy, and the ability to regulate intimacy (Agamben 2015), it should only be used as a temporary solution. Alternative forms of observation include, for instance, a nurse being available when needed, or patients being observed when alone in their rooms (Vierihoito Niuvanniemen… 2019). There is no solid evidence of the effects of special observation on the patient's well-being (see Bowers et al. 2004), and the hospital

has also kept seclusion as an option to sedating patients (Parliamentary Ombudsman 2014).

Both in the Survey and interviews, the staff members mention special observation, seclusion, and using coercive measures as stressful and causing risky situations where the threat of violence is present (see also Stevenson and Cutcliffe 2006; Vierihoito Niuvanniemen…2019). Altogether, 85 per cent of the respondents in the Survey (2019) related that they had experienced violence at work. The threat of violence also influenced some employees' everyday life after working hours: "We spend the day together and never let the patient out of our sight [in special observation] […] If you know that the patient can be violent, you are much more alert […] When you leave work, you don't have anything to give at home anymore" (Interview 5). The description follows the findings of Whitehead and Mason (2006) who also acknowledged high levels of stress among nurses assigned to special observation in forensic settings.

Although patients may regard nurses as the means of their restrictions, the patients also restrict the nurses. The nurses may try to activate the patient to participate in work therapy or to be outdoors, but ultimately, the nurse and the patient share the same space where the patient is in control. Special observation, thus, retargets institutional (bio)power towards nurses and increases the risk that institutional experiences accumulate in the bodies and minds of the nurses and therefore have an impact on their well-being (cf. Repo 2020). Special observation transforms the spatialities of care in significant ways: in seclusion, the physical structures of the hospital control the patient, whereas in special observation, the nurses' presence and their bodies serve as tools of control.

Restricting garments

An infrequent method, which is sometimes used together with special observation, is the use of a restricting garment. Violent patients may be controlled by using the so-called hitter's vest after or between seclusion periods. The sleeves of the vest are sewn to the side seems, so that a patient cannot move their arms. This special garment enables a little pause in the seclusion (Parliamentary Ombudsman 2010) and allows a patient to be on the ward among the other patients. Thus, the spatial relevance of the restricting garment is somewhat similar to special observation: it allows the patient to move outside of the seclusion room. However, special garments can also be used in seclusion rooms for suicidal patients. A so-called rippers dress is used for women in order to prevent them from using their clothes as a means of strangling or suffocation, and a similar garment for men has been under design (Parliamentary Ombudsman 2014). In these cases, the patient is the subject of a double spatial restriction. Firstly, in the seclusion room by its physical structures and secondly in the body space by the restriction of bodily movement.

The Finnish legislation states that a secluded patient must be given suitable clothes (Ministry of Social Affairs and Health, 1990; Parliamentary Ombudsman 2010), but the conception of suitability is not explained. The CPT has found the restricting garment problematic as the patients perceive it as a punishment.

Furthermore, those wearing the hitter's vest are recognised as violent patients. The CPT regarded the hitter's vest as a modern straight jacket and advised that its usage should be discontinued in the near future (Gnatovskyy 2015). In a report, the Parliamentary Ombudsman (4553/3/15, 2015) agreed with the committee and recommended using other methods.

In 2018, the SGRCM (02/19/18) declared their intention to reduce the use of restricting garments, and the debate also occurred in the WGRCM (02/23/18). A member of the group stated that the use of the garment should be critically evaluated, however, noting that its usage enabled risky patients to be among other patients, by themselves, or under special observation. A patient member considered the restricting garment a better option compared to giving a general anaesthetic to the patient, a method used in some European countries. These negotiations as regards the techniques used try to define whether patients should be controlled by physical structures, restrictive garments, or medicinal barriers.

Some other members of the group emphasised that calming skills and controlling emotions should be taught to patients to the extent that restricting garments would no longer be needed. The patients were encouraged to monitor their own situation and recognise warning signs leading to self-harming, such as a tight feeling in the chest. After these debates, the use of restricting garments was reduced, and only one patient was restricted by this garment during the inspection of the Parliamentary Ombudsman in 2018 (Parliamentary Ombudsman 2019a). The tendency is to increase the agency of patients so that they can control their own body space instead of being restricted by external means.

Restrictive garments have yet other forms. The hospital has developed the use of alternative garments—such as ponchos and muffs—as an option to the hitter's vest. The Parliamentary Ombudsman (2019a) does not take a stand on whether these options are better but regards the reduction of the use of the restricting garment as a positive change. However, there was a complaint by a patient who refused to go outside while being obligated to wear a restricting garment. The Parliamentary Ombudsman noted in their report that although wearing the garment can feel humiliating and alternative ways should be created, the practice is not purely negative if it allows the patient to go outside (Parliamentary Ombudsman 2019a). The garment was seen as an enabler of freer mobility and use of hospital spaces compared to a seclusion room. Thus, restricting the body with a garment was considered more acceptable than spatial restrictions that would prevent patients from going outside.

Eating and smoking

The restrictions concerning eating can be regarded as strengthening the institutional regime and maintaining institutional power relations (Repo 2019). The members of WGRCM (04/12/2019) discussed scheduled dining as one of the practices implementing institutional power. The group noted that scheduled waking up, dining and tidying are both rehabilitative measures and needed to keep everyday life on the ward smooth and safe. In the hospital's survey concerning food, the patients indicated that restrictions concerning ordering food, the amount of food consumed,

and the usage of a refrigerator and freezer were an unnecessary use of institutional power. The WGRCM (05/17/2019) discussed the results of the survey and issues such as healthy diets, the patients' weight problems, and that ordering in food would give more outsiders access to the hospital area. They stated that it is sufficient if the hospital provides adequate and versatile meals five times a day and agrees individually about candy days.

The ideology of carceral nutrition can be traced back to prisons (McKeithen 2022) but the practices can be applied to forensic care. The two-way purpose of carceral nutrition is both to sustain and control the populations inside the institutions. The food is made by large suppliers and according to the American example, it may be difficult to maintain special diets (McKeithen 2022). Nevertheless, it has been decided from the top-down what is good food and how much people should eat (McKeithen 2022).

The Parliamentary Ombudsman (DNR 4553/3/15) has noted that the need for food should be estimated individually at the Niuvanniemi Hospital, and that the law does not allow limiting patients' eating. In one case, a patient complained about the lack of a refrigerator on a ward. The hospital answered that there had previously been problems with the refrigerator, and that in addition to the food offered five times a day, a patient can buy food from the canteen. Some patients can also go to other stores either by themselves or by using the hospital transport and, thus, "it is unnecessary to create a health risk with extra food" (Parliamentary Ombudsman 2019b). The Parliamentary Ombudsman (2019b) however, stated that as some of the patients must stay in the ward for a long time, some form of cold storage would improve their self-determination.

The weight of the patients was raised in the Survey (2019) as regards the question of self-determination and its ambiguity: "I wish for clear outlines for self-determination and if a patient is allowed to gain unhealthy weight during the care […] If a patient does not eat, the situation is intervened rapidly, but slow self-destruction by eating can continue". Previous studies have shown the high risk of lifestyle diseases—such as cardiovascular diseases and diabetes—among people with mental disorder. The possibilities of affecting the lifestyle of a patient in long-term forensic mental health care have also been noted (Pedersen et al. 2020). Gaining weight may indicate a failure to stay in control (Colls 2007), and the personnel may feel frustration if they are not able to control the lifestyle of a patient, since it means that they are not able to control the body space of the patient.

There have also been concerns about the high price level of the hospital's canteen products and about dining during seclusion. The Parliamentary Ombudsman (2010) found the prices in the canteen reasonable, but noted that contrary to prisoners' rights, there is no law defining mental health patients' right to purchase groceries. In addition to food, the canteen may provide a spatial variety to ward life. The significance of the canteen is thus not only a question of nutrition but also the opportunity to change scenery and relieve boredom. The location of dining, on the other hand, has raised concerns related to the safety of the nurses. Risky spaces and situations have developed in cases where secluded patients cannot dine with other patients, and the nurses have had to enter old seclusions rooms (with no hatches in the doors)

in order to bring medication and food (Survey, 2019; Parliamentary Ombudsman 2014).

The control of smoking has raised similar issues to eating. Smoking is allowed during seclusion (in a bathroom, smoking room or outdoors), if the condition of the patient and the tobacco laws allow it. The nurse supplies the cigarette, lights it, controls the smoking, and is responsible that no lighters, matches, or cigarettes are left in the seclusion room. The patients are encouraged to take part in nicotine replacement therapy and detoxification (Yleinen järjestys…2020, 9–10), and depending on the ward, nicotine products are either free or subject to a charge (WGRCM 05/17/2019). There is, however, also a social aspect to smoking. Many smoking rooms have been transformed into patients' rooms or care spaces, and they have been replaced by smoking shelters. This has "diminished the sociability" as the smoking rooms have served as important social spaces where some patients spend a lot of time (Interview 1; Survey 2019). This transformation has changed the spatial practices of the patients as the smokers are now more active as regards going outdoors despite the weather. Sometimes, however, cigarettes are regulated (e.g. a cigarette/hour) for health reasons, or because of a patient's financial situation (Interview 5). This has an influence on the activity and spatial practices of the smokers as, ultimately, control over their smoking is in the nurses' hands.

Personal hygiene

Personal hygiene is not important merely in the prevention of diseases, but also as a social question (Hyde 1997). Some patients are not interested in maintaining personal hygiene although it is one of the everyday coping skills learned in the hospital (WGRCM 02/23/2018). There are situations where maintaining hygiene is jeopardised, partly because of the lack of facilities. An inspection of the Parliamentary Ombudsman (2019b) revealed a case of a patient who did not want to use public toilets or showers and was therefore situated in a seclusion room including a bathroom. In the decision made by the Parliamentary Ombudsman (2019b), an increase in individual rooms with their own bathrooms was recommended.

In the prison context, creating private space includes, for example, being alone in a cell, decorating the cell, or claiming small private spaces, such as beds. However, the lack of private spaces and the resulting forced exposure is an acknowledge problem in prisons (Milhaud and Moran 2013). In Niuvanniemi, issues caused by the lack of sufficient rooms and spaces for patient has led to patients being situated in a seclusion room rather than using the shared spaces of hygiene.

Some nurses mentioned that the reduction in coercive methods had caused a decline in personal hygiene as the responsibility for hygiene has been shifted to the patients themselves. Due to the improvement in self-determination, the patients can no longer be required to maintain hygiene in exchange for outdoor activities or visiting the food shop: "Is it self-determination if a patient is dirty and has skin problems? Can a patient be forced to take a shower? You can motivate them, but if they do not feel the need for a shower, they cause a nuisance for others because of their smell" (Survey, 2019). Other patients—who cannot choose if they use the same

spaces or not—are affected by the decision. Ignoring hygiene can be regarded as a contestation of the biopolitical expectation to take care of the body. The lack of hygiene seems like an unethical act (de la Bellacasa 2017), as following hygiene regulations can be regarded as collective care that benefits all patients.

Exercise

Most patients have a right to exercise outdoors for at least one hour per day (Niuvanniemen sairaala 2022). This also applies to seclusion patients, if the exercise can be organized safely under observation of a nurse. Some of the patients can move freely in the hospital area or visit the city centre. Niuvanniemi Hospital is situated beside a lake, and there is a vast outdoor area with a beach, a forest, tennis courts, a frisbee golf track, and in winter, the possibility of ice swimming. In winter, however, most of the patients prefer exercising indoors, going to the gym or playing table tennis (Interview 1, Interview 5). There is also organised exercise with therapeutic aims; for instance, a yoga group that aims at reducing anxiety (WGRCM 03/24/2017), and a low threshold running group that enhances equal encounters between staff members and patients (WGRCM 09/29/2017). While exercise has wider biopolitical meaning in creating healthy citizens (Foucault 1990), the implication of exercise in restricted spaces varies. Some of the spaces of exercise in forensic settings, such as gyms, can be risky spaces for nurses and patients because of the available equipment (Repo et al. 2022). Nevertheless, exercising may create a sense of freedom and personal space, and help coping with unpleasantries in closed institutions (Norman and Andrews 2019).

According to the inspection of the CPT (Gnatovskyy 2015), exercising outdoors is limited to 50 per cent of the patients. The most restricted ward includes patients under mental state examination, those difficult to treat, and those at risk of escaping (Interview 1). The ward has a fenced yard including work-out equipment, and it is used for exercise, walking in a circle, sitting, and smoking. Bodily routines and repetitive exercises can be interpreted as signs of the development of prison culture (Interview 4), but equally as manifestations of power over bodies (Barad 2007 see also; Foucault 1995) as the restrictions affect the routines of using the body in spaces like a fenced yard.

Touch

A long-term stay in an institution may cause a loss of touch, both physical touch and touch to the outside world (Turner 2016). Dixon and Starughan (2010) argue that there is a need to regulate touching as it can be either good or bad. In mental health care, physical touching has a negative connotation as it is often associated with violence and coercive measures. The personnel are trained to hold violent or agitated patients (Gnatovskyy 2015), but the reduction of coercive measures has led to avoiding touching. Some of the nurses feel they have failed if they physically have to restrict a patient (Interview 2): “We try to avoid situations where we have to touch

people who do not want to be touched. […] We have training for restricting techniques […] but in the end those are not used much".

If a body is seen as a space (Butler and Parr 1999), touching may be seen as entering into someone's private space, especially if it is forced touching. The Finnish Mental Health Act (1990) specifies who can touch a patient. Care personnel are allowed to hold patients to prevent them from escaping, or from leaving a medical examination ordered by a doctor. Nurses do not have the right to seize a patient outside of the hospital unless they are attempting suicide. Furthermore, some situations—such as self-defence—may require touching or holding a patient. Such cases are, however, evaluated afterwards (Niuvanniemi Hospital 2020). At Niuvanniemi Hospital, touching is forbidden between patients (WGRCM 11/20/2015), which makes the hospital a space without voluntary touching.

Both the CPT (Gnatovskyy 2015) and the Parliamentary Ombudsman (2017) have noted the problems related to the fact that nurses or security guards are not allowed to hold a patient outside of the hospital. The police are expected to assist nurses in transportations, but only a limited amount of help is available. Taking patients outside is necessary when collecting an ID card or opening a bank account, for instance. The Parliamentary Ombudsman (2019a) rushed to have a bill approved (Ministry of Social Affairs and Health 2018) that would increase the power of nurses and guards, but at the moment, in 2023, the bill has not proceeded. The matter of touch is not only how and when to touch but also in which spaces the touch is possible.

The reduction of coercive methods has also had an impact on the practices of body searches (Interview 2). A body search was previously automatically carried out every time a patient returned to the hospital. Now the search can only be implemented by health care professionals, and with a doctor's permission "if there are reasonable grounds" to suspect that a patient carries forbidden substances or objects (Ministry of Social Affairs and Health 1990, p. 22 i amendment in 2001). This has not only worried the personnel, but also some patients' relatives who are afraid that the patients' may be using drugs during their care (Interview 2). Again, respect for a patient's personal body space is seen as a significant matter, although it may make control difficult.

Sex

Sexuality and interactions between patients are still taboos in mental health care (Deshays 2016), although it has been noted how the assumption of asexual patients (Gascoyne et al. 2015) or neglecting sexuality may lead to aggression (WGRCM 11/20/2015). Previous research has revealed that sexual relations between patients are common (Gascoyne et al. 2015; Quinn and Happell 2015a, b; Wright et al. 2012). Even though sexual health as a human right has been recognized (Gascoyne et al. 2015), there are challenges concerning the capacity to express consent (Wright et al. 2012), the risks of predatory sexual behaviour, and the effects of break-ups (Quinn and Happell 2015a). Some patients have sexual urges that are harmful to

others or have a history of sexual abuse. Thus, the hospital has forbidden touching other patients or entering other patients' rooms (WGRCM 11/20/2015).

The lack of a family meeting room has been discussed at Niuvanniemi. In the WGRCM (11/20/2015), a member of the personnel reported positive experiences from a ward where relatives were able to meet patients with the permission of the chief physician. A patient member noted that a new family room would not merely be for conjugal purposes but would also help patients connect with their family members. Visiting spaces are limited, and the visits take place for example in corridors. Due to a lack of private spaces, the patients had intercourse out in grounds, in the bushes of the yard, on the beach, and in the dressing rooms (WGRCM 11/20/2015). This was against the regulations, but instead of being intentional resistance towards institutional power, the actions could be interpreted as what Foucault (1990) called transitory manifests of resistance caused by individual reasons.

In the WGRCM (11/20/2015), critique was expressed towards the contradictory attitudes towards sexuality: "Dating and sexuality are restricted, but at the same time the patients are reminded about condoms and contraception". While there is an attempt to regulate sexual activity, controlling it completely appears to be an impossible task. A patient member, moreover, noted that in addition to enabling the patients to have sexual intercourse, a family room would help the personnel to control sexual activities. They also suggested that heterosexual and homosexual couples should have equal rights to use the family room. The discussion continued in the next meeting (WGRCM 12/18/2015) where it was suggested that both patients and personnel should have more education on sexuality, and that each patient should have a discussion on their sexuality.

In 2016, the hospital's sexual advisors were asked to write an article concerning the sexuality of the long-term patients (WGRCM 02/12/2016). The aim was to first gather information, and then prepare an initiative concerning the family room. The process was, however, slow and rigid, and a group of patients prepared their own initiative in 2017. When dealing with the initiative, the WGRCM (02/24/2017) related that, no safety concerns had occurred in the previous family room. It was also noted that family rooms should be regarded as significant places for supporting the relationships with the patients' children and other relatives, instead of simplifying them as places of sexual interaction between patients. The workgroup also noted the lack of a national outline concerning sexuality in long-term care. As a result of the meeting, the WCRCM (02/24/2017) recommended establishing a family room.

A year later, a patient made a complaint about the fact that a family room was still lacking. In the answer, the Parliamentary Ombudsman (2019b) pointed out that already the statement given in 2012 indicates that if there is sufficient space and no health obstacles, a hospital cannot deny uncontrolled meetings of couples regarded as family (Parliamentary Ombudsman 2012). However, according to the statement of the Legal Protection Center of Health Care,[2] a family room is not necessary as the patients can meet their families during holidays (Parliamentary Ombudsman 2004, 2012). This controversy illustrates well the significance of spatial solutions in bodily

[2] Since 2009 Valvira.

regimes: a hospital cannot deny uncontrolled meetings if there are suitable spaces. However, since a family room is not required by the law, the hospital can control a couple's meetings indirectly by controlling and making decisions about hospital spaces.

Discussion and concluding remarks

Niuvanniemi hospital represents a hybrid institution between care and incarceration. Even in the most restricted spaces, bodies still move, look, eat, drink, and think. These acts and movements are related to international and local laws and regulations, but also penal discourses as well as discourses of care (Fransson and Giofré 2020). The myriad and complex relations between biopower, space and the body can be seen in the everyday lives of patients and staff at Niuvanniemi Hospital. The reduction of coercive methods and the adoption of six core strategies can be regarded as processes that lead to the transformation of bodily regimes. Some previous practices, assumptions, and habits have remained in mental health care, but nonetheless, they are now accompanied by new working methods and ways of thinking. The changes have mainly influenced the use of coercive methods, such as mechanical and physical restraints and seclusion, which have been reduced by 50 per cent during the time the six core strategies have been in use (Parliamentary Ombudsman 2019a, b). Control over eating, smoking, touching and sexuality still remain and are still under constant negotiations. As our research shows, the institutional and biopolitical control of the body now occurs in more multiple and discreet ways in the mundane life of the hospital.

The transformation of bodily regimes (Pile 2021) occurs in line with the changes in psychiatric care due to medicalisation (Rose 2001), the development of psychopharmacology (Ahonen 2019), and the reduction of coercive methods. In the first two instances, the mind is treated by controlling the body, the last one highlights self-determination and reduced control. Although Niuvanniemi Hospital is a precursor as regards adapting new practices, the loss of bodily integrity is still a side product of care (e.g. Milhaud and Moran 2013). The research material reveals the awareness of the institutional power and its effects on the patients. Some debates that began from a very concrete everyday question, developed into a discussion on how institutional power persistently appears in the everyday life and how there remain rules for which nobody remembers the purpose. The discussion, finally, led to acknowledging the importance of the systematic acknowledgement and evaluation of the regulations.

Bodily regime and biopower are used to control unpredictable bodies that can harm themselves or others. The emphasis on self-determination has meant adopting methods such as special observation or wearing restrictive garments that are directly targeted to the body. The bodies are also significant in the patients' protests such as obesity, smoking, hunger strikes, the ignorance of personal hygiene, or having sex in inappropriate places. The use of hunger strikes is not unusual for example among prisoners and asylum seekers (Conlon 2013). However, in Niuvanniemi there have not been many hunger strikes, the food related issues tend to be more about using the body to cope with life inside institutions and controlling one's own body space.

The personnel's reaction to such protests is inconsistent: obesity may be considered a slow method of self-destruction, whereas smoking is not questioned.

The current bodily regimes are based on the discourses on self-help and the individualisation of care, as a patient is expected to self-monitor and self-assess risks (Stevenson and Cutcliffe 2006, p. 719). The debates on self-help have a neoliberal tone where responsibility of care is shifted towards patients themselves. The transformation is justified with the reduction of coercive measures and the increase of patients' self-determination. New methods like special observation have changed the spatiality of the hospital as the bodies of the nurses have replaced the role of physical walls that earlier served as obstacles to free mobility. New working methods—such as special observation—have also re-directed bodily control and the lack of self-determination from the patients towards nurses who are confined to spend their working days next to a patient.

Bodily regimes do not only concern individuals, but also they cause affects and affectual moments that travel throughout the community (Pile 2021). The negotiations over eating, touching, sex, or the usage of restrictive garments, appear in the complaints made to the ombudsman, making visible the experienced failures of bodily control. Some of the concerns may have appeared in the life of a few patients, but from their individual bodies, the concerns have spread to the larger community of patients. When bodily regimes appear through restricting garments, for instance, not many patients are actually wearing the garment, but still, the whole community becomes affected by the emotions and feelings related to the possibility of having to wear it. Such features of a bodily regime cause affects to spread through bodies, which is a relevant viewpoint for further examination in forensic mental health institutions.

Acknowledgements The authors would like to thank the personnel of Niuvanniemi hospital for co-operation and help during the research process. The authors thank also the editor and two anonymous reviewers for their helpful comments. This research was funded by Academy of Finland / Research Council for Culture and Society, grant number 308616.

Funding Open access funding provided by Tampere University including Tampere University Hospital, Tampere University of Applied Sciences (TUNI).

References

Agamben, G. 2015. *The use of bodies*. Stanford: Stanford University Press.

Ahonen, K. 2019. *Suomalainen mielenterveyspolitiikka: Julkisen vallan ohjaus mielenterveyden häiriöön sairastuneiden ihmisoikeuksien turvaamiseksi*.

Alunni, L. 2015. Securitan healing: Roma mobility and health care in Rome. *Medical Anthropology* 34: 139–149.

Barad, K. 2007. *Meeting the universe halfway: Quantum physics and the entanglement of matter and meaning*. Durham: Duke University Press.

Bowers, L., J. Alexander, A. Simpson, et al. 2004. Cultures of psychiatry and the professional socialization process: The case of containment methods for disturbed patients. *Nurse Education Today* 24 (6): 435–442. https://doi.org/10.1016/j.nedt.2004.04.008.

Brown, T., G.J. Andrews, S. Cummins, et al. 2018. *Health geographies. A critical introduction. Critical introductions to geography*. Chichester: Wiley Blackwell.

Butler, R., and H. Parr. 1999. New geographies of illness, impairment and disability. In *Mind and body spaces*, ed. R. Butker and H. Parr, 1–24. Oxon: Routledge.

Chu, S. 2016. Special observations in the care of psychiatric inpatients: A review of the literature and developments in practice. *ARC Journal of Psychiatry* 1 (1): 21–31.

Cisney, V.W., and N. Morar. 2016. Introduction: why biopower? Why now? In *Biopower—Foucault and beyond*, ed. V.W. Cisney and N. Morar, 1–28. London: The University of Chicago Press.

Colls, R. 2007. Materialising bodily matter: Intra-action and the embodiment of ´fat´. *Geoforum* 38: 353–365.

Conlon, D. 2013. Hungering for freedom: asylum seekers' hunger strikes—retihinking resistance as counter-conduct. In *Carceral spaces—mobility and agency in imprisonment and migrant detention*, ed. D. Moran, N. Gill, and D. Conlon, 133–148. Farnham: Ashgate.

de la Bellacasa, M. 2017. *Matters of care: Speculative ethics in more than human worlds*. Posthumanities; 41. Minneapolis: University of Minnesota Press.

Demuru, P., F.P.R. de Oliveira, and E.C. Calderón. 2021. Bodily regimes and meaning production in Bolsonaro's visual discourse: A sociosemiotic perspective. *Communicacion y Sociedad* 2021: 1–27.

Deshays, C. 2016. Sexuality in psychiatric institutions: Initiating some ethical reflections. *Sexologies* 25 (3): e47–e50. https://doi.org/10.1016/j.sexol.2016.05.004.

Dixon, D.P., and E.R. Straughan. 2010. Geographies of touch/touched by geography. *Geography Compass* 4 (5): 449–459. https://doi.org/10.1111/j.1749-8198.2009.00299.x.

Eves, R. 2010. Engendering gesture: Gender performativity and bodily regimes from New Ireland. *The Asian Pacific Journal of Anthropology* 11 (1): 1–16.

Finnish National Board on Research Integrity (TENK). 2019. *The ethical principles of research with human participants and ethical review in the human sciences in Finland*. https://tenk.fi/sites/default/files/2021-01/Ethical_review_in_human_sciences_2020.pdf.

Foucault, M. 1990. *The history of sexuality: An introduction*, vol. 1. New York: Vintage Books.

Foucault, M. 1995. *Discipline and punish: The birth of the prison, 2nd Vintag*. New York: Vintage Books.

Foucault, M. 2004. *The birth of biopolitics: Lectures at the Collége de France 1978–1979* (M Senellarted.). New York: Picador.

Foucault, M. 2006. *Psychiatric Power. Lectures at the Collegé de France 1973–1974*. New York: Picador.

Fransson, E., and F. Giofré. 2020. Prison cell spaces, bodies and touch. In *The prison cell- embodied and everyday spaces of incarceration*, ed. J. Turner and V. Knight, 261–282. Cham: Palgrave Macmillan.

Fraser, A., J. Baeza, A. Boaz, et al. 2019. Biopolitics, space and hospital reconfiguration. *Social Science & Medicine* 230: 111–121. https://doi.org/10.1016/j.socscimed.2019.04.011.

Gascoyne, S., E. Hughes, E. McCann, et al. 2015. Essays and debates in mental health. *Journal of Psychiatric and Mental Health Nursing* 22 (2003): 821–828.

Gnatovskyy, M. 2015. *Selonteko Suomen hallitukselle kidutuksen ja epäinhimillisen tai halventavan kohtelun tai rangaistuksen estämiseksi toimivan eurooppalaisen komitean (CPT) käynnistä Suomessa*. https://rm.coe.int/1680695f71.

Griffiths, M., and J. Repo. 2018. Biopolitics and checkpoint 300 in occupied Palestine: Bodies, affect, discipline. *Political Geography* 65: 17–25. https://doi.org/10.1016/j.polgeo.2018.04.004.

Holmes, D., and S.J. Murray. 2011. Civilizing the 'Barbarian': A critical analysis of behaviour modification programmes in forensic psychiatry settings. *Journal of Nursing Management* 19: 293–301. https://doi.org/10.1111/j.1365-2834.2011.01207.x.

Huckshorn, K.A. 2005. *Six core strategies to reduce the use of seclusion and restraint planning tool*. National Technical Assistance Center. https://www.ot-innovations.com/wp-content/uploads/2014/09/4._policy_and_procedure_on_debriefing_debriefing20p20and20p20with20cover207-05.pdf.

Hyde, A. 1997. *Bodies of law*. Princeton: Princeton University Press.

Kivelä, S., and S. Moisio. 2017. The state as a space of health: on the geopolitics and biopolitics of health-care systems. *Territory, Politics, Governance* 5 (1): 28–46. https://doi.org/10.1080/21622671.2016.1158122.

Laukkanen, E. 2021. *Coercive measures in Finnish psychiatric inpatient care—special emphasis on psychiatric nursing managers' attitudes*. Kuopio: University of Eastern Finland.

Massey, D. 2005. *For space*. London: Sage Publications.

McKeithen, W. 2022. Carceral nutrition: Prison food and the biopolitics of dietary knowledge in the neoliberal prison. *Food and Foodways* 30 (1–2): 58–81. https://doi.org/10.1080/07409710.2022.2030938.

Milhaud, O. and D. Moran. 2013. Penal space and privacy in French and Russian Prisons. *Carceral Spaces: Mobility and Agency in Imprisonment and Migrant Detention*: 167–182.

Minca, C., and C.-E. Ong. 2016. The power of space: The biopolitics of custody and care at the Lloyd Hotel, Amsterdam. *Political Geography* 52: 34–46. https://doi.org/10.1016/j.polgeo.2015.03.001.

Ministry of Social Affairs and Health F. 1990. *The Mental Health Act*. https://www.finlex.fi/en/laki/kaannokset/1990/en19901116?search%5Btype%5D=pika&search%5Bkieli%5D%5B0%5D=en&search%5Bpika%5D=mentalhealth.

Ministry of Social Affairs and Health F. 2018. *Säädösvalmistelu STM074:00*.

Nettleton, S., C. Buse, and D. Martin. 2018. 'Essentially it's just a lot of bedrooms': Architectural design, prescribed personalisation and the construction of care homes for later life. *Sociology of Health & Illness* 40 (7): 1156–1171. https://doi.org/10.1111/1467-9566.12747.

Niuvanniemen sairaala. 2022. Ulkoilu ja liikunta. https://www.niuva.fi/hoitotyo-ja-potilasasiamies/ulkoilu-ja-liikunta/.

Nord, C., and E. Högström. 2017. Introduction. In *Caring architecture—Institutions and relational practices*, ed. C. Nord and E. Högström, 7–18. Newcastle Upon Tyne: Cambridge Scholar Publishing.

Norman, M., and G.J. Andrews. 2019. The folding of sport space into carceral space: On the making of prisoners' experiences and lives. *The Canadian Geographer* 63 (3): 453–465. https://doi.org/10.1111/cag.12540.

Parliamentary Ombudsman. 2004. Potilaiden ja heidän omaistensa yhteydenpito valtion mielisairaalassa. Parliamentary Ombudsman. https://www.oikeusasiamies.fi/r/fi/ratkaisut/-/eoar/529/2003.

Parliamentary Ombudsman. 2010. *Niuvanniemen sairaalan tarkastus 19.–22.10.2010 DNRO2940*. https://www.oikeusasiamies.fi/r/fi/ratkaisut/-/eoar/2940/2010.

Parliamentary Ombudsman. 2012. *Ns. Perhetapaamisten järjestäminen valtion mielisairaalassa 903/2011*. https://www.oikeusasiamies.fi/r/fi/ratkaisut/-/eoar/903/2011.

Parliamentary Ombudsman. 2014. *Niuvanniemen sairaalan eristetyt potilaat 1220/2/11*. https://www.oikeusasiamies.fi/r/fi/ratkaisut/-/eoar/1220/2011.

Parliamentary Ombudsman. 2017. *Mielenterveyspotilaan kuljettamista ei saa antaa vartijan tehtäväksi 3445/2016*. https://www.oikeusasiamies.fi/r/fi/ratkaisut/-/eoar/3445/2016.

Parliamentary Ombudsman. 2019a. Niuvanniemen sairaala 3712/2018. https://www.oikeusasiamies.fi/r/fi/ratkaisut/-/eoar/3712/2018.

Parliamentary Ombudsman. 2019b. *Olosuhteet Niuvanniemen sairaalassa 5255/2018*. https://www.oikeusasiamies.fi/r/fi/ratkaisut/-/eoar/5255/2018.

Pedersen, A.L.W., C.R. Lindekilde, K. Andersen, et al. 2020. Health behaviours of forensic mental health service users, in relation to smoking, alcohol consumption, dietary behaviours and physical activity—A mixed methods systematic review. *Journal of Psychiatric and Mental Health Nursing*. https://doi.org/10.1111/jpm.12688.

Perron, A., C. Fluet, and D. Holmes. 2005. Agents of care and agents of the state: Bio-power and nursing practice. *Journal of Advanced Nursing* 50 (5): 536–544. https://doi.org/10.1111/j.1365-2648.2005.03432.x.

Pile, S. 2021. *Bodies, affects, politics: The clash of bodily regimes*. Hoboken: Wiley Blackwell.

Pinkus, K. 1995. *Bodily regimes: Italian advertising under fascism*. Minneapolis: Univeristy of Minnesota Press.

Quinn, C., and B. Happell. 2015a. Consumer sexual relationships in a Forensic mental health hospital: Perceptions of nurses and consumers. *International Journal of Mental Health Nursing* 24 (2): 121–129. https://doi.org/10.1111/inm.12112.

Quinn, C., and B. Happell. 2015b. Sex on show. Issues of privacy and dignity in a Forensic mental health hospital: Nurse and patient views. *Journal of Clinical Nursing* 24 (15–16): 2268–2276. https://doi.org/10.1111/jocn.12860.

Repo, V. 2019. Spatial control and care in Finnish nursing homes. *Area* 51: 233–240.
Repo, V. 2020. *Confined to space—Perspectives on carceral geography*. Turun yliopiston julkaisuja. Annales Universitatis Turkuensis. Sarja—Ser. AII Osa Toim. 371/Biologica—geographica—geologica. https://urn.fi/URN:ISBN:978-951-29-8103-8.
Repo, V., P. Kymäläinen, and N. Humalisto. 2022. "You can feel it in the air": The institutional atmosphere of the psychiatric hospital for prisoners. *Health & Place* 78: 1–7. https://doi.org/10.1016/j.healthplace.2022.102934.
Rose, N. 2001. The politics of life itself. *Theory, Culture and Society* 18 (6): 1–30. https://doi.org/10.1177/02632760122052020.
Rose, N., and C. Novas. 2005. Biological citizenship. In *Global assemblages: Technology, politics and ethics as anthropological problems*, ed. A. Ong and S. Collier, 439–464. Oxford: Blackwell Publishing. https://doi.org/10.1002/9780470696569.ch23.
Simonsen, K. 2013. In quest of a new humanism: Embodiment, experience and phenomenology as critical geography*. *Progress in Human Geography* 37 (1): 10–26. https://doi.org/10.1177/0309132512467573.
Simonsen, K., and L. Koefoed. 2020. *Geographies of embodiment: Critical phenomenology and the world of strangers*. London: Sage.
Stevenson, C., and J. Cutcliffe. 2006. Problematizing special observation in psychiatry: Foucault, archaeology, genealogy, discourse and power/knowledge. *Journal of Psychiatric and Mental Health Nursing* 13 (6): 713–721. https://doi.org/10.1111/j.1365-2850.2006.01023.x.
Story, B. 2019. *Prison land. Mapping Carceral power across neoliberal America*. Minneapolis: University of Minnesota Press.
Tietosuojalaki 5.12.2018/1050. 2018. https://www.finlex.fi/fi/laki/ajantasa/2018/20181050.
Tuovinen, S. 2017. *Reduction of seclusion and restraint and hospital violence during involuntary forensic psychiatric care*. University of Eastern Finland. Dissertations in Health Sciences. University of Eastern Finland.
Turner, J. 2016. *The prison boundary between society and carceral space. Palgrave studies in prisons and penology*. London: Palgrave Macmillan. https://doi.org/10.1057/978-1-137-53242-8_1.
Valverde, M. 2017. *Michel Foucault. Routledge key thinkers in criminology*. London: Routledge.
Whitehead, E., and T. Mason. 2006. Assessment of risk and special observations in mental health practice: A comparison of forensic and non-forensic settings. *International Journal of Mental Health Nursing* 15: 235–241. https://doi.org/10.1111/j.1447-0349.2006.00429.x.
Willnott, C. 2019. Visual assimilation and bodily regimes: protestant programmes and Anishinaabe everyday dress in North America. In *Dressing global bodies: The political power of dress in world history*, ed. B. Lemire and G. Riello, 1830s–1950s. London: Routledge.
Wright, E.R., H.A. Mccabe, and H.E. Koorman. 2012. Institutional capacity to respond to the ethical challenges of patient sexual expression in State Psychiatric Hospitals in the United States. *Journal of Ethics in Mental Health* 7: 1–5.

Virve Repo is a Post-doctoral researcher fellow in Tampere University, Finland. Her research interests include institutions, carceral geography and ageing and care.

Päivi Kymäläinen is an Associate Professor at Tampere University's Unit of Social Research. She has specialized in the relations between society, space and law, and in urban marginality.