Civilizing the 'Barbarian': a critical analysis of behaviour modification programmes in forensic psychiatry settings

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Aim Drawing on the works of Erving Goffman and Michel Foucault, this article presents part of the results of a qualitative study conducted in a forensic psychiatry setting.
Background For many years, behaviour modification programmes (BMPs) have been subjected to scrutiny and harsh criticism on the part of researchers, clinicians and professional organizations. Nevertheless, BMPs continue to be in vogue in some 'total' institutions, such as psychiatric hospitals and prisons.
Method Discourse analysis of mute evidence available *in situ* was used to critically look at behaviour modification programmes.
Results Compelling examples of behaviour modification care plans are used to illustrate our critical analysis and to support our claim that BMPs violate both scientific and ethical norms in the name of doing 'what is best' for the patients.
Conclusion We argue that the continued use of BMPs is not only flawed from a scientific perspective, but constitutes an unethical approach to the management of nursing care for mentally ill offenders.
Implications for Nursing Management Nurse managers need to be aware that BMPs violate ethical standards in nursing. As a consequence, they should overtly question the use of these approaches in psychiatric nursing.

Keywords: adverse event, behaviour modification programme, ethics, forensic nursing, management, psychiatry

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The disciplinary institutions secreted a machinery of control that functioned like a microscope of conduct; the fine, analytical divisions that they created formed around men an apparatus of observation, recording and training.

Foucault, 1979, *Discipline and Punish*

Medicine is a power-knowledge that can be applied to both the body and the population, both the organism and biological processes, and it will therefore have both disciplinary effects and regulatory effects.

Foucault, 2003, *Society Must Be Defended*

Introduction

The present study examines the management of forensic psychiatric nursing care and the use of behaviour modifications programmes (BMPs) in the discipline and regulation of patient behaviour. As the name suggests, BMPs are schemes designed to improve or correct particular micro-behaviours to bring them into line with macro-social norms and expectations. More euphemistically, they are sometimes called 'Rewards Programmes' or 'Incentives and Earned Privileges' (Liebling 1999). BMPs are a form of psychological conditioning based on the work of the American behaviourist B. F. Skinner. Theoretically, the patient is (re)socialized through a system of positive and/or negative reinforcement, usually on the basis of a token economy, where 'points' (for example) are earned or lost, and can be exchanged for 'rewards'. Forensic psychiatry settings are 'total institutions' which provide the perfect laboratory because environmental conditions can be tightly controlled. In these settings, simple 'life rewards' and basic necessities can be offered or withheld as a 'reward' or 'punishment', positive or negative re-inforcers. While Gendreau (1996) argues that the most effective ratio of positive to negative reinforcement is 4 : 1, in total institutions we suspect that the inverse ratio obtains, as operant conditioning extends and adapts the punitive model already in place at the prison. In any case, in these settings it is often difficult to distinguish positive from negative re-inforcers in any unequivocal sense (there might be a negative 'rewards' scheme, for instance). As we shall demonstrate, even relationships themselves are invested and mobilized as tokens of exchange in the everyday complexities, networks and discrepancies of prison/hospital life. As nursing staff are enlisted to implement and supervise these programmes, they too become caught in the practical dispositions of power, privilege and punishment: they become agents of a moral orthopaedics.

Prisons, penitentiaries and psychiatric hospitals (including their related nexus) are thought to be signs of modernity and civilization. These institutions help to mediate the individual's relation with the state and society, performing managerial roles through sanitary and political techniques, ideally for the benefit of those being managed. While forensic psychiatry settings are meant to provide care for mentally ill offenders, at the same time they are places where captive patients are held against their will and where penal sanctions hold sway. Forensic psychiatry patients therefore exist in limbo, between care and incarceration – between largely incommensurable techniques and objectives. Given their broad social function and legal mandate, in Foucault's sense of the term, forensic psychiatry settings operate as an integrated State apparatus (*dispositif*) that comprises multifaceted and interrelated administrative, social, political and ethical systems (bringing together the healthcare system and the penal system, for instance). State apparatuses are carefully designed to achieve specific macro-social objectives (treatment, education and punishment, etc.) while being permeated by webs of power relations. Although the macro-social functions of these institutions are publicly known, in the present article we suggest that a critical analysis of BMPs in forensic psychiatry settings will help expose the manner in which institutional power is wielded, calling into question the scientific and ethical basis of the micro-practices we see at work.

The present article therefore hopes to shed light on the tensions that arise when therapeutic ideals operate within the punitive setting of a prison, when care comes face to face with incarceration. The implementation and management of BMPs provides a prime instance where two contradictory ideals collide. Here, we might say that the body of the condemned (in Foucauldian parlance) is doubled: known as 'patients' to allied health professionals and 'inmates' to correctional staff, a new, apparently neutral, term had to be invented to describe these individuals: 'residents'. But it is not just the 'neutralized' body that is doubled through the various identities or roles that it takes up: the 'resident's' body is not just the body of a patient subjected to medical and nursing knowledge and not just the body of a prisoner subjected to incarceration and punishment; while the body of the condemned is undoubtedly the target of a disciplinary apparatus (nursing management, medical science and corrections), the 'resident' is also – and perhaps foremost – a member of a society, a social body, a being who shares in the lives of other residents, building relationships with them and with the prison's correctional officers, as well as with allied health staff (indeed, psychotherapeutic rehabilitation requires this). It seems to us that while BMPs appear to shore up a resident's autonomy, rational decision-making or even his individualism and entrepreneurialism, in actuality BMPs target distinctly social behaviours that are relational, value-laden and that take place in context.

As we argue below, these relations extend beyond the function of 'discipline', in Foucault's sense of the term, to treat the population in its generality. According to Foucault, we suggest that this second form of power should be understood as biopolitical, it is power's hold over life itself, and it must be distinguished from disciplinary power:

this technology of power, this biopolitics, will introduce mechanisms with a certain number of functions that are very different from the functions of disciplinary mechanisms. The mechanisms introduced by biopolitics include forecasts, statistical estimates, and overall measures. And their purpose is not to modify any given phenomenon as such, or to modify a given individual insofar as he is an individual, but, essentially, to intervene at the level at which these general phenomena are determined…. [R]egulatory mechanisms must be established to establish an equilibrium, maintain an average, establish a sort of homeostasis, and compensate for variations within this general population and its aleatory field. In a word, security mechanisms have to be installed around the random element inherent in a population of living beings so as optimize a state of life. (Foucault 2003, p. 246)

So we have two axes of bio-power at play: disciplinary power, which takes the individual as its object, and biopolitical power, which takes the life of the population as its means and its end, 'life as both its object and its objective' (Foucault 2003, p. 254). Thus, while BMPs seem to act directly on the individual, in a disciplinary sense, they must also act biopolitically – a dimension that is rarely discussed in the literature. We cannot say that these two axes of bio-power map neatly onto the two management 'styles' found in forensic psychiatry settings (i.e. care and incarceration), but rather, that nursing staff in particular find themselves imbricated in both axes of bio-power, just as they find themselves involved in practices associated with corrections, and not just healthcare (the line between 'corrections' and 'healthcare' is often fluid). BMPs are located at this complex juncture, they provide an allegory for the tensions of prison/hospital life, and so we must complicate this scene in order to give a more just account of the myriad factors at play as well as the ethical implications of BMPs as they feature as part of a treatment plan.

Throughout the 1970s and 1980s, BMPs were used widely in the psychiatric domain after being developed and popularized by psychologists in the post-World War II period (Rothman 1975). Interventions aimed at correcting deviant behaviours were regarded and continue to be regarded (in specific settings) as a 'proper use of authority' (p. 17); as a consequence, many total institutions have made BMPs one of their preferred techniques to correct deviance and to reform patients/prisoners. Indeed, we commonly associate total insti-

tutions with the use of BMPs. Although this intervention was (and is still to a certain extent) celebrated as the new and more humane treatment strategy, critical literature has raised concerns regarding this practice, labelling it as inhumane, debilitating and infantilizing. One professional organization after another has 'recounted the abuses and denounced the barbarisms' (Rothman 1975, p. 18) of total institutions where BMPs are deployed. Despite this criticism, BMPs continue to be used within psychiatric and correctional settings. Some psychiatrists, psychologists, social workers and nurses continue to believe that operant conditioning holds the key to effective treatment.

In brief, our research design involved ethnographic principles, including semi-directed interviews, field notes and document analysis (mute evidence). In the present article our analysis is limited to the mute evidence gathered in the course of our fieldwork. Drawing on Foucault's double understanding of bio-power as disciplinary and biopolitical, coupled with Erving Goffman's sociological analysis of total institutions, this article emerges from qualitative research conducted in a 'state-of-the-art' secure forensic psychiatry institution operating under the authority of a provincial justice system in Canada. Using a number of key documents gathered in the course of data collection, we assess the use of BMPs from a political and an ethical standpoint, demonstrating not only how a disciplinary bio-psychiatric model permeates several aspects of the management of nursing care in forensic psychiatry, but also how, in the quest of doing 'what is best' for the patients in terms of care and rehabilitation, nurses become part of a machine that harms rather than heals.

Theoretical framework

In this section we turn to the work of Goffman and Foucault to describe how power operates in forensic psychiatry settings, one instance of what Goffman calls 'total institutions'. These perspectives offer a strong framework for analysis (Lagrange 1976). Hacking (2004) suggests that Foucault's 'archaeology' and Goffman's interpersonal sociology are complementary. Using a 'bottom-up' approach, Goffman (1961) studied the internal structure and function of 'total institutions' but did not situate them within a larger (macro) perspective. Goffman's micro-sociological perspective is thus useful in describing and analysing social relationships between the many different actors of 'total institutions', especially the interactions between staff and patients/inmates.

From a Foucauldian 'top-down' or systemic perspective, practitioners such as psychiatrists, psychologists, social workers and nurses might be understood as bolstering state apparatuses by implementing and providing crucial power/knowledge in order to shape and transform human material (Ransom 1997). As such, health care professionals working in forensic psychiatry settings are directly involved in what Foucault calls the discipline of individuals at the anatomo-political level (at the level of the body) (Foucault 1978). In his discussion on discipline, Foucault deploys the model of Jeremy Bentham's panopticon, a prison structure organized around a central watchtower, with prisoners' cells arranged concentrically so as to afford the guard(s) a direct line of sight into the cell, while preventing prisoners from seeing the guard(s) or seeing and communicating with each other. While the panopticon serves as a metaphor for the ways that disciplinary power operates, we found this architectural structure duplicated in the forensic psychiatry setting, where a centrally-located glassed-in nursing station (which nurses call 'the bubble') affords views down radiating corridors and into the shared Common Room. The architecture is significant for its effects on the prisoner/patient, as Foucault describes: 'He who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself; he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection' (Foucault 1979, pp. 202–203). Because the inmate never knows if or when he is being watched, he becomes the object of his own surveillance, internalizing the disciplinary gaze in his 'soul': 'The soul is the effect and instrument of a political anatomy; the soul is the prison of the body' (Foucault 1979, p. 30). This process does not require consent; the question of consent is pre-empted from the start because these disciplinary systems are defined as self-justifying, as 'legitimate and unobjectionable' (Ransom 1997).

The disciplinary system's legitimacy is tied to the scientific knowledge that the apparatus enables, deploys and produces, in an almost circular fashion. Power and knowledge form a unitary structure: 'the Panopticon was also a laboratory; it could be used as a machine to carry out experiments, to alter behaviour, to train or correct individuals' (Foucault 1979, p. 203). Here we see that discipline works by individualizing. Not only are individuals separated from each other, the individual's symptoms and behaviour are observed, taxonomized and classified (according to *DSM-IV* diagnoses, for instance); he is medicated, he is organized (in individual 'units' or cells or seclusion rooms, for instance) through the analytical arrangement of architectural space; he is measured against a norm. Discipline, Foucault writes, 'tries to rule a multiplicity of men to the extent that their multiplicity can and must be dissolved into individual bodies that can be kept under surveillance, trained, used, and, if need be, punished, (Foucault 2003, p. 242). Knowledge and power operate to justify and legitimate one another, forming a practically unitary phenomenon Foucault calls 'power/knowledge'.

While disciplinary bio-power treats the individual body and 'individualizes' that body anatomo-politically, as we mentioned above Foucault also points to a second axis of bio-power that he describes as biopolitical – that is, a power that treats the life of the population or 'mass' more generally, according to weights and measures, the principles of risk management, statistics and probabilities, management techniques and policies to control random events, etc. not so much as to discipline individuals but to regulate and regularise a specific group and its social relations. And while disciplinary power is 'the easier and more convenient thing to adjust' (Foucault 2003, p. 250), biopolitics is more subtle and diffuse because it intervenes ontologically, at the level of life itself. Under biopolitics, then, the function of medicine and nursing is regulatory, turning to 'public hygiene, with institutions to coordinate medical care, centralize power, and normalize knowledge' (Foucault 2003, p. 244). What emerges is 'a new body, a multiple body, a body with so many heads that, while they might not be infinite in number, cannot necessarily be counted' (Foucault 2003, p. 245). For an extreme example of biopolitical intervention we might look to eugenics programmes, with their reticulate and capillary vectors of political power and moral duty – intersecting State, biomedical and popular discourses on race and hygiene (Nazi *Rassenhygiene*), on the high socioeconomic 'costs' of preserving the unproductive lives of the weak, the mentally handicapped, the homosexual, the Gypsy, the Jew and other 'life unworthy of life' (*Lebensunwertes Leben*). And ironically enough, it is in the name of 'life' that all manner of atrocities can be justified and legitimated. The point here is that biopolitics relies on complex, interrelated and totalizing technologies and techniques, coupled with a deeply moralistic understanding of 'life'.

In 'total institutions', pervasive disciplinary and biopolitical technologies and techniques ultimately strip individuals of agency through a complex and powerful 'mortification process', where they 'die' from their old lives and are 're-born' (as it were) into the life of the institution. This process is said to be successful when inmates have internalized institutional rules (Goffman

1961). The mortification process is not a matter of acculturation or assimilation of one group under the auspices of the total institution, but is something more pernicious still. In effect, the forensic psychiatry patient comes into the institution with a specific representation of himself; upon admission, he is stripped of his 'domestic' reference schemes and mortified through procedures and standardized plans of care. 'In the accurate language of some of our oldest total institutions, he is led into a series of abasements, degradations, humiliations, and profanations of self… and his self is systematically, if often unintentionally, mortified' (Goffman 1961, p. 14). The mortification process is a standard(ized) procedure in total institutions epitomized in prisons and psychiatric institutions. Inmates' personal belongings are taken away from them while institutional substitutes are provided (Goffman 1961). In short, standardized defacement occurs.

The encompassing or 'total' character of total institutions is symbolized by the barrier to social intercourse with the outside world that is often built into the architectural design: locked doors, high walls, barbed wire, cliffs and water, open terrain and so forth. In forensic settings, for instance, almost every aspect of the patients' daily life is strictly controlled and monitored. And yet, these are also social environments, which presents another problem for management to devise techniques to control and monitor sociability itself. We have suggested, then, that not only is disciplinary bio-power at play in these settings, but the logics of biopolitical power are pervasive, as the social life of the population is both an object and an objective, always with an eye to rehabilitation and reintegration into the 'normal' population, 'on the outside'. Nowhere is this tension more palpable than in the implementation and management of so-called 'scientific' regimens and treatment plans, such as BMPs.

Research findings

The wider research project took place in a (forensic) psychiatry unit of a Canadian provincial correctional institution.

At the outset, it is important to note that, according to the *Policies and Procedures Manual*, the facility is 'first and foremost a correctional institution' and that 'the operational needs of correctional services and the administration of justice… *will have priority* in the manner in which the Ministry of Correctional Services approaches its relationship with the hospital' (Institution Name, *Policies and Procedures Manual*, 1997/2010, p. 1; emphasis added). This statement speaks to the hybridity of the setting under study. When

healthcare is subordinated to 'correctional services', does the quality of that care suffer? In its discussion of 'priority' and its promotion of a two-tier system, the *Policies and Procedures Manual* clearly defines the goals of 'corrections' and the goals of mental health care as incommensurable – or, if they are commensurable, we are led to believe that such a plan is worth neither the effort nor the expense.

In the same manual created by the institution, the stated objective of the forensic psychiatry facility is to provide care and treatment for mentally ill or disordered offenders. However, the specific objectives are as follows: 'to improve reintegration into the community on release and to reduce re-offending rates and/or further admissions to mental health facilities' (Institution Name, *Policies and Procedures Manual*, 1997/2010, p. 1). Here, a 'correctional' language once again takes priority, and mental illness is linked explicitly to 'offending rates', suggesting that a patient's mental health care is not the unit's primary concern. Under the rubric of the *Program Description*, the following assumptions are outlined:

- hospital standards of health care will allow offenders to receive needed (psychiatric) care;
- development of all aspects of the forensic psychiatry facility programme will be synergistic with Research and Education to create a rich environment for health care delivery and advancements;
- standards of practice will include standards specified in the legislation (Mental Health Act), the standards of practice set by each discipline's College; and the patient's care set by the hospital;
- the staff will be employees of the hospital and will be subject to credentialing and peer review;
- the mental health services provided by the unit will be subject to external review through the Canadian Council of Health Services Accreditation process.

In addition to these principles, a strict code of ethics (Institution Name, 1997/2010) applies to all individuals who work, volunteer or study at the hospital (as part of a large university-teaching hospital). Despite the rhetorical purpose of these official documents, however, it is difficult to explain the following passage from an internal document, which stands at odds with the principles presented above:

> The Ministry of Justice and Corrections (MJC) will continue to be responsible for all offenders and will contract the hospital for the provision of mental health assessment and treatment services…. In summary, the responsibility for provision of treatment services will fall under the

jurisdiction of the hospital as outlined by the Ministry of Justice and Corrections in its contract; while the MJC maintains ultimate responsibility for the care, safety, and security of all offenders. (Institution Name 1997/2010, p. 6)

In other words, once again we see that mental health care is subordinated to correctional services. This tension is dramatized in those departments of the forensic psychiatry facility where BMPs are privileged. The BMPs presented in the present article reflect disciplinary and biopolitical techniques used by nursing and correctional staff in order to eliminate what are deemed inappropriate or dangerous behaviours and to inculcate new behaviours deemed more acceptable.

The deployment of BMPs within the forensic psychiatry units

Our data revealed that three out of four units were sites where BMPs are employed (not including the admission/evaluation department). Not all patients were subjected to this medical/nursing regimen but the potential for large-scale application of this form of treatment was sufficient enough to develop 'behaviour plans' for each of these departments. The behaviour plans for departments X, Y, and Z have been developed to 'assist residents in managing appropriate behaviours interfering with their treatment and treatment of co-residents' (Hospital Institution, Internal Document, 2009, p. 1). Although all departments were bound by this objective, slight differences were found amongst them.

BMPs constitute a regimen that specifies how the residents' time, access to other parts of the unit and specific rewards are managed. Problematic behaviours are categorized as Type 1, Type 2 or Type 3, as the behaviours escalate. Type 1 behaviours are listed under general designations, some of which are left to the discretion of correctional or nursing staff, such as 'inappropriate dress code', 'horse play' and 'teasing'. Others include arm wrestling, gambling, tapping the window of the nursing station to capture the staff's attention, trading food and 'crossing the yellow line', which refers to a mark on the floor behind which patients are to stand at all times when interacting with staff. Type 1 behaviours lead to an 'Administrative Segregation' (essentially, a 'time out': a number of hours spent alone locked in the resident's cell, with no permission to leave until directed to do so by staff) and counselling by nurses in order to address the behaviour and suggest alternative behaviours. If, despite counselling and Administrative

Segregation, the patient persists with Type 1 behaviour, it is then considered as Type 2.

Type 2 behaviours include 'refusing to comply with a direct order', 'verbal aggression', 'damage to government property', 'interfering with other residents' treatment', 'sexual activity', 'touching' and 'creating or inciting a disturbance likely to endanger the institution'. These behaviours lead to segregating the patient in his cell for 24 hours, with permission to come out restricted to meals, medications and assigned programmes. The patient is then submitted to a 'Reintegration Programme' during which time he remains in his cell at all times for the first 72 hours, except for 1 hour in the morning and 1 hour in the afternoon or evening, during which time he may go to the Common Room. During the next 96 hours, this is upgraded to 2 hours in the morning and 2 hours in the afternoon or evening. If there are no further incidents, the patient can then reintegrate into the unit's routine.

Type 3 behaviours include 'threats to others' and 'physical aggression', which leads to confinement until a psychiatrist can perform an assessment. If the patient is clinically determined not to require seclusion, and if the correctional staff do not place him in segregation, he is then confined to his cell for 48 hours except to attend therapeutic programmes. He begins the Reintegration Program described above. If, at any step, the patient engages in inappropriate behaviours, he returns to the previous step.

Internal documents state that patients need to recognize the unit 'as a good experience, which will be helpful' to them. BMPs are thus presented as a way to defuse situations, to avoid acting out and to promote alternative behaviours. Patients are also encouraged 'to make suggestions' and to work together with staff 'to avoid trouble'. However, these documents go on to state that cooperation is expected. Time outs, which are reminiscent of children's discipline, 'will be used by staff whenever they feel the situation needs it at their discretion'.

Discussion

It should be relatively easy to see how BMPs strategically deploy an 'individualizing' disciplinary bio-power, while the biopolitical aspects of this management strategy may seem somewhat more abstract. But BMPs are designed to intervene at the level of a resident's social life, reshaping his social relationships, his sociality in general and to modify it to fall within the accepted norms of the population at large. BMPs rely on a token economy, an economy of exchange that operates according to the principles of the market economy – so this is a particular kind of socialization. It is no surprise,

then, that Foucault devotes a large part of his lectures on biopolitics (Foucault 2008) to neoliberal economies, as neoliberalism has become the dominant ideology governing our democratic populations. BMP strategies undoubtedly look beyond the forensic setting towards macro-social values and norms, as the stated goal of the unit is 'to improve reintegration into the community on release and to reduce re-offending rates and/or further admissions to mental health facilities' (Institution Name, *Policies and Procedures Manual*, 1997/2010, p. 1). Therefore, these do not constitute neutral institutional settings in which care takes place free from the larger influences that operate within society. And it is no surprise that management strategies have silently appropriated the biopolitical logic that governs our neoliberal democracies – where individuals are seduced into seeing themselves as 'human capital' within a system that calculates, quantifies and otherwise measures all manner of human relationships according to the terminology of the 'free' market. In Foucault's words, neoliberalism 'extends the economic model of supply and demand and of investment-costs-profit so as to make it a model of social relations and of existence itself, a form of relationship of the individual to himself, time, those around him, the group, and the family' (Foucault 2008, p. 242). The extent to which we 'freely' appropriate this model is questionable, although it is now the 'norm'; however, it is worth repeating that the token economies of the forensic setting are imposed absolutely on residents, they are coercive rather than 'incentive' programmes, and residents have not been involved in their creation.

Thus, while BMPs might appear to 'individualize' residents in a positive way, compelling them to be responsible for themselves, to foster a deeply 'entrepreneurial' spirit in relation to their own self-management, as well as to better socialize themselves, we must bear in mind that these are not workers freely joining an employee incentive programme, nor are they consumers signing up for a retailer's rewards scheme. Indeed, workers are rewarded for their productivity or outcomes, which might bear little relation (or perhaps even an inverse relation) to their social skills or sociability in general. Similarly, retail rewards schemes are based on a customer's loyalty, and customers are free to shop elsewhere. Here, instead, the residents' social behaviours are being regulated according to a points system that is standardized, one-size-fits-all: the same number of points is lost for the same offence, and these rules apply equally to every resident in the population, while the severity or leniency of enforcement is at times arbitrary ('discretionary') for Type 1 violations (and less explicitly

for Type 2) – depending on a particular nurse's reaction in a given instance. Is this arbitrariness a positive or negative reinforcer? And what are the wider (counter-) therapeutic effects when the interpersonal relationship between nursing staff and residents is shaped 'economically', through the threat of punishment and the loss of 'rewards'? Will this build trust and confidence in the resident's sociability, or will it not encourage him to 'work the system' through the cold, economic calculation of a cost–benefit analysis (something we praise in the business world)? A hegemonic theory of consumption is presumed throughout, and 'criminal' activity is redefined as any behaviour that is an 'investment', where a certain 'profit' is hoped for, but that carries a certain measurable 'risk' of penal sanctions understood in economic terms (Foucault 2008, p. 253).

The management of nursing care, as far as BMPs are concerned, participates in the 'building of a world around these minor privileges', according to Goffman, which 'is perhaps the most important feature of inmate culture, and yet it is something that cannot easily be appreciated by an outsider, even one who has previously lived through the experience himself' (Goffman 1961, p. 50). BMPs therefore cannot and do not work as part of a 'care plan' if mental health care involves restoring the patient's sense of autonomy, real or symbolic; BMPs are infantilizing, they work through petty privileges. While BMPs allow the forensic psychiatry patient to exercise some control over acquiring rewards and privileges, or avoiding punishments, this infantile world is hardly analogous to the real world, and hence at cross-purposes with 'nursing care' if the ultimate objective is 'to improve reintegration into the community on release'. Any autonomy the forensic psychiatry patient does experience is a false autonomy, as it is clear that his submission to institutional order is total.

Certainly, some will argue that BMPs are therapeutic, even if they are from some perspectives 'infantilizing'. By analogy, one might argue, parents must take some rather unpopular – even punitive – decisions with regard to the care of their children. But in the wider context, in the fullness of time, children come to realize that these decisions are usually loving and protective, guiding the child as she or he develops into a fully autonomous being in her or his own right. It is questionable, however, to what extent the parent–child analogy holds in the context of a prison, where the relationship is between keeper and kept, or in the context of a therapeutic relationship, between a healthcare provider and his or her mentally ill or disordered patient/client. These residents are not children. Where the child grows and learns to interpret a parent's decisions

as she or he gains experience in her or his own decision-making processes, the resident lacks that luxury, he has neither the time nor the place to experience something similar; he is apt to experience nursing staff as inconsistent, if not cruel. He will not see beyond the prison's walls. As Foucault writes, 'It is not the family, neither is it the State apparatus, and I think it would be equally false to say, as it often is, that asylum practice, psychiatric power, does no more than reproduce the family to the advantage of, or on the demand of, a form of State control organized by a State apparatus' (Foucault 2006, p. 16).

Consequently, we must call into question the functional notion of 'autonomy' that circulates in the discourse on the effective management of residents in forensic settings and in the use of BMPs to foster ethical comportment amongst residents and in relation to those with whom they share – and will share – a social life. Mainstream biomedical ethics tend to privilege one notion of autonomy as the founding principle of ethics (Beauchamp & Childress 2008). But forensic psychiatry settings are not places where autonomy is encouraged. In effect, as Goffman clearly states, 'total institutions disrupt or defile precisely those actions that in civil society have the role of attesting to the actor and those in his presence that he has some command over his world – that he is a person with 'adult' self-determination, autonomy, and freedom of action' (Goffman 1961, p. 43). But a critical approach to ethics will delve further still, asking what we mean by 'autonomy' as we continue to use the word so freely: a critique would question the ideals of neoliberalism, calculative reason and 'rational choice theories', and it would look beyond the kinds of 'individuals' produced by disciplinary bio-power to begin, instead, with the intimate and often fragile social relationships without which 'ethics' is meaningless, without which it is reduced to just one more management strategy. It is for this reason that we have emphasized the biopolitical valences of BMPs, for it is here, where one intervenes in the life of a population, a life that is first and foremost a shared life, that we must begin again if we hope to imagine an ethics that would be commensurable with the lives of these inmates, patients – 'residents' – and the lives of those who care for them. In light of the 'life' that is produced biopolitically, we must imagine an ethical life, a life that would be the domain of bioethics.

Conclusion

The popular view of forensic psychiatry patients – and possibly of any other recidivists – is that they merely lack sufficient autonomy and willpower: they do not want to change. But this view ignores the wider forces at play in the formation of the individual; it refuses to begin to take account of the myriad socioeconomic, political and environmental factors – the conditions – that have contributed to the patient being where he is today. In most cases, these individuals lack infrastructural support, the conditions in and through which an act of sovereign will seem possible. To speak of these individuals as 'autonomous', to hold them to the 'principle of autonomy', could itself be regarded as a violent demand, one that might be incomprehensible to someone who lacks the mental and emotional – not to mention financial, institutional, familial, etc. – resources necessary for comprehension. It would be an unethical practice, then, to place this individual in a situation in which 'autonomy' is demanded, and, as we stated above, perhaps it is time to question the normative force of this term as desirable in and of itself (for instance, how ethical is the economic model that it presumes?). But it is perhaps worse to place him in an institutional context governed by BMPs. Even if BMPs give the illusion of fostering a sense of autonomy, they understand 'autonomy' only in a limited and impoverished sense, and they fail to acknowledge or to begin to redress some of the wider infrastructural conditions of mental illness, crime and their connections. BMPs represent the perfect example of a bio-psychiatric model that has gone uncontrolled, where symptoms are treated and underlying causes ignored. Not only is this treatment unethical and ineffectual in the real world, not only is its refusal to see the underlying causes tantamount to professional negligence, we assert that this form of 'treatment' undoubtedly exacerbates certain forms of mental illness while causing others – what Illich (1976/1995), in his classic text, has called clinical and social iatrogenesis.

'The barbarian…is someone who can be understood, characterized, and defined only in relation to a civilization, and by the fact that he exists outside it' (Foucault 2003, p. 195). Civilization needs its barbarians; indeed, civilizational norms are defined in contradistinction to barbarism, and *vice versa* – barbarism is civilization's constitutive outside. Civilized, barbarian, these concepts are deeply related. They are dialogical, even as the latter term is suppressed, silenced, hidden away and institutionalized to shore up the 'naturalness' or evidentiary 'goodness' of the first. We might think of these as two populations, governed by two, nevertheless related, sets of tactics, strategies, and knowledges. We hope that this paper has raised some ethical questions concerning the ways that nurses have been co-opted to police the border

between these two populations, and to maintain a *cordon sanitaire* in the name of security and effective management – a moral hygienics as much as a moral orthopaedics that seek to instruct and reform observable behaviours. In our analysis of BMPs, we have argued that the 'individualizing' force of disciplinary bio-power must be understood alongside biopolitical power, which takes life itself as its regulatory object and objective. In one sense, of course it is true that BMPs constitute a form of disciplinary power, producing subjects who turn in on themselves, who internalize the strategies and techniques of surveillance and the so-called scientific 'truth' of who they are. But the disciplinary perspective is incomplete because these 'individuals' always already find themselves in a shared world with others, and it is here that BMPs wield their greatest – albeit invisible – power to regulate interpersonal behaviour and to intervene in the social lives of others. Ethics must address this 'new body' of biopolitics and the complex conditions that authorize, legitimate and support it. The ethical and political analysis of the forensic psychiatry setting would be incomplete without attention to sociality and relationality – and from here, towards identity and community. This ought to be the domain of bioethics, in the promise of living together.

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