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New spaces of inpatient care for people with mental illness: A complex 'rebirth' of the clinic?

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ABSTRACT

This paper examines the implications for design of inpatient settings of community-based models of care and treatment of mental illness. The study draws on ideas from relational geographies and expands interpretations based on Foucault's writing. We analyse material from a case study which explored the views of patients, consultants, and other staff from a new Psychiatric Inpatient Unit in a deprived area of East London, UK. We discuss in particular: the tension between providing a caring and supportive institutional environment and ensuring that patients are returned to the community when they are ready; the links between an acute inpatient facility and its local community; the potential significance of the psychiatric hospital as a relatively stable feature in the otherwise insecure and unpredictable geographical experience of people with long-term mental illnesses. We discuss the relevance of these issues for design of new psychiatric inpatient facilities.

Introduction

By the end of the twentieth century, debate about the deinstitutionalization of psychiatric care had become prominent in the geographical literature on mental health care. Two themed issues in *Health & Place*, introduced by Park and Radford (1997) and Wolch and Philo (2000), focused on 'post-asylum geographies' which explored a wide range of community-based facilities such as out-patient clinics, sheltered accommodation, and informal support networks. While considered beneficial in many respects, deinstitutionalization was also associated with growing numbers of psychiatric patients relocated to the prison system or to a life of insecure housing or homelessness in poor urban areas (Dear and Wolch, 1987).

These post-asylum geographies paid less attention to the fact that, although the large long-stay hospitals have disappeared, significant numbers of patients still receive inpatient psychiatric care in hospital units (e.g. Priebe et al., 2005, 2008). Inpatient facilities appropriate for contemporary models of psychiatric care are 'acute' hospital units, designed to care for people during especially severe phases of mental illness, with the aim of helping them to recover sufficiently to return to life in a community setting. (Although some of these 'acute' inpatient stays may be for quite extended periods and patients with chronic mental illness may need to be hospitalized repeatedly.)

As Moon (2000) pointed out, in today's 'risk society' there is still strong public sentiment in favour of long-term, often involuntary, hospitalization for a minority of psychiatric patients who are perceived to be dangerous. However, one could argue that, for the majority, the 'asylum' has been re-invented, albeit in a new guise and within new configurations of care. In a study of three psychiatric wards in London, UK, Quirk et al. (2006) suggested that psychiatric hospitals have shifted along a continuum of 'institutional permeability', away from the model of the 'total', 'closed' institution, towards increasingly 'permeable' regimes. This increased permeability is reflected in relatively short patient stays and high user turnover and maintenance of contacts with the surrounding community. For the present study it is especially pertinent to note that the model of institutional change that Quirk et al., 2006 (p. 2115) propose includes: a shift in the geographical location of hospitals (from isolated, segregated settings to being part of a local community); a change of regime from locked to open wards allowing voluntary patients to exit the hospital freely; a blurring of the lines of authority in the hospital setting and a ward culture which becomes more 'coterminous with the outside world'.

Thus, while in the past, psychiatric provision was in long-term residential asylum facilities, which were often located in relatively isolated positions, on the city fringe, or in the countryside, the

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new generation of acute units are typically in locations similar to general hospitals, more accessible to main centres of population. In England, recent projects to create these acute psychiatric units include new buildings constructed through private–public partnerships under the *Private Finance Initiative* (*PFI*) (House of Commons, 2001), through which infrastructure for public services, including the National Health Service (NHS), are built and operated by private companies under contracts agreed with the government. This paper draws on material from a case study that explored the views of patients and staff from one of these newly constructed Psychiatric Inpatient Units in a deprived area of inner London. We illustrate some of the issues raised by use of PFI strategies for construction of this new infrastructure to support 'care in the community' and some of the issues that arise concerning the design of these new care spaces for mentally ill people.

We have argued elsewhere (Gesler et al., 2004; Curtis et al., 2007; Gesler and Curtis, 2007) that this case study can be interpreted in terms of conceptual frameworks of *therapeutic landscapes* that have been developed in geography in order to highlight aspects of hospital design that are important for the well-being of staff and users. We argue here that other aspects of our findings are consistent with Quirk et al.'s notion of a shift towards permeability. Furthermore, this shift can be interpreted through theoretical frameworks that have been developed by health geographers drawing on theorization of power relations and social control; notably by Philo and Wolch (e.g. Philo, 1989, 2004; Wolch and Philo, 2000), and also relational geographical perspectives (e.g. discussed by Cummins et al., 2007; Gatrell et al., 2004; Conradson, 2005) which draw on Actor Network Theory (ANT) and ideas about complexity in geographies of health and health care. We suggest that these bodies of theory complement each other quite effectively to help us understand our informants' accounts of ambiguities and tensions in the relationships between this new, more 'permeable' acute inpatient facility and its local community.

We are indebted to Chris Philo (personal communication, 2007) for pointing out to us that published work by health geographers and others (e.g. Smith, 1978; Rogers and Pilgrim, 1996; Parr et al., 2003; Philo, 2004, 2005) has repeatedly emphasized different aspects of the role of the psychiatric hospital and its response to risks and social stigma associated with mental illness. A role which is often emphasized in the literature is the 'carceral' function, analogous to a prison, designed to exert control over patients and to 'protect' society from contact with psychiatric patients who have been represented as 'dangerous' and 'undesirable' in their behaviour. This is a strong theme in theoretical frameworks proposed by Foucault, who describes how, as society developed a more 'civilized' attitude to psychiatric disorders (Foucault, 1967), it also refined ways to exercise psychological as well as physical restraint on the behaviour of people with mental illness. The process was associated with the ascendency of medical power in clinical settings (Foucault, 1973) and showed strong parallels to regimes in prisons which sought to 'transform' individuals using the technical apparatus of disciplinary regimes (Foucault, 1977).

However, this idea of the asylum as a 'prison' is also complemented repeatedly in the literature by the notion of the asylum as a 'refuge' or 'fortress' protecting people with mental illnesses against the risks of abuse, stigma or corruption to which they are vulnerable in the wider community and which might have an '*unprofitable effect upon the patients' minds…even corrupting them with vicious habits*.' (Foucault, 1967, p. 243, citing Tuke, the 19th Century founder of the progressive *York Retreat* asylum in England). Furthermore, even in discussion of disciplinary regimes in carceral systems such as prisons, Foucault (1977, pp. 246–247) argues that it is important for the authorities to vary, mitigate or interrupt prison penalties by allowing some reformed prisoners to be released into the community 'on license', showing that prison discipline could be extended outside the walls of the penitentiary. He also exemplifies the 'open prison' regime at some length. We will argue here that in the 'permeable institution' that we observed, the 'fortress' and 'asylum' function was strongly in evidence and at least as prominent as the 'carceral' role. Furthermore, strategies for the extension of psychiatric care into the community were frequently discussed.

This shift towards a more permeable institution and the 'fortress' function was also associated in our informants' accounts with ideas about complex, unbounded spaces of psychiatric care which were often seen to be difficult to predict and to manage, and where the distinction between what occurs inside and outside the hospital is blurred. Such accounts seem to invoke ideas from relational geographies of health care (e.g. Milligan, 2001) that see services as networks rather than as bounded and closed spatial units. Some of these approaches are based on ANT, which, for example, argues that: (1) places (such as hospitals) should be seen as nodes in networks or fields, influencing and being influenced by other nodes or places; (2) one cannot make a clear distinction between what is occurring 'outside' and 'inside' a place, and (3) non-living features of networks (such as buildings) as well as living elements (such as people) may be seen as 'actors' influencing the way the network functions (Latour, 1999; Murdoch, 1997). Relational geographies also draw on ideas about complex systems put forward by authors such as Cilliers (1998, pp. 2–4) who states that: "A complex system is not constituted merely by the sum of its components, but also by the intricate *relationships* between these components." As in ANT, complex systems consist of a large number of interacting elements that mutually influence each other, so it is not possible to understand the system by examining only one part of it. However, different elements of the system tend to respond to limited 'information', or influences, from nearby parts of the system, in the absence of 'perfect knowledge' or 'global influence' of all the system elements, meaning that no one part of the system can 'control' the whole. Complex systems are conceived as open, and it is hard to identify their borders, they are dynamic and their history affects their future development. Waldrop (1992) also describes how simulation models of change in complex systems suggest that there is a condition of creative, organized, 'organic' development that occurs when a certain critical point is reached between stasis and completely chaotic disorganization.

In the discussion that follows, we present our findings in light of these ideas. We discuss below three overarching, closely interrelated, themes that emerged concerning 'new spaces of care' for psychiatric patients. First, we consider the tension between providing a caring and supportive institutional environment and ensuring that patients are returned to the community as soon as they are ready. We discuss the complexity arising as the clinical space in this hospital is redefined as a '*space of transience*'. Second, we consider accounts of the ways that care staff and patients try to 'manage' the connections between the care environment 'inside' the hospital and the community 'outside', which we discuss in terms of ideas of '*managed permeability*' and protection of *patients* from certain external influences. These themes contrast with ideas of a 'carceral' model of psychiatric care and an emphasis on 'protecting society' from contact with patients. We suggest that this trend may be characterized in terms of a shift in symbolic interpretations of psychiatric hospitals from images of the old residential hospital as a '*prison*' to ideas of the new acute inpatient unit as a '*fortress*' offering users protection from external hazards outside. Third, we examine the view that this acute inpatient unit has significance as a relatively stable

feature in the otherwise insecure and unpredictable geographical experience of people with long-term mental illnesses, which we interpret here in terms of *new spaces of refuge and asylum*. Below we explain how data for this project were collected and analysed, and then expand on these three themes in the light of our case study material.

Our approach to studying the 'new spaces of inpatient care'

We report here on an exploratory study which collected information through unstructured discussions with a small sample of users, nursing and managerial staff, and consultant psychiatrists who had experience of a new psychiatric inpatient facility in London, UK, built under the PFI scheme. A local voluntary organization for psychiatric service users helped us recruit a sample of 7 people who had experienced mental illness, but were currently well. These informants all had direct experience of the new hospital, either as patients themselves, or, in one case, as a 'user advocate' on the design team when the hospital was built. The users taking part were invited to an introductory meeting about the study in which they were provided with details of the project before they decided to participate. The discussions with this group of service 'users' took place at the voluntary group premises, rather than inside the hospital. We also recruited 10 members of the nursing and managerial staff working at the hospital and 3 consultants as volunteers to participate in the study. We refer to the consultants below as a specific category of hospital personnel (by virtue of their particular status in the hospital as clinicians), while other, nursing and managerial personnel are referred to as 'staff' for brevity. A letter of invitation was sent to all consultants and other staff working in the new hospital at the time of the study. The participants in the study were self-selecting in response to this invitation and may have had a special interest or concern with hospital design. Our project did not include funds for translation, so we were not able to include non-English speakers in the sample. This may have excluded an important group of users in this part of London where the population is very ethnically diverse. However, the staff who participated belonged to a variety of ethnic backgrounds, although all were English speaking.

Participants took part in discussions with the researchers either individually or in groups. We convened separate meetings with service users, consultants and other staff. Selected quotes from the discussion are reported below and we have used notation which distinguishes between comments by users, consultants and other staff (nurses and hospital managers). The study was carefully vetted by the relevant medical research ethics committee and for reasons of confidentiality we are not able to report any personal details about the participants.

The study was primarily aimed at assessing understandings of what of the hospital design was perceived to contribute to the sense of the hospital as a 'healing' place or 'therapeutic landscape'. We therefore posed two simple questions to participants:

(1) What specific features of [the hospital] (in terms of physical layout, activities, etc.) do you think are good for the well-being of users and staff?
(2) What specific features of [the hospital] do you think are not good for the well-being of patients and staff?

We then let the discussion flow as freely as possible. Discussions were tape-recorded and transcribed. Both principal investigators read through the transcripts several times to identify major themes and then met to discuss their findings.

Our aims in interpreting the transcripts were: to (a) ascertain which specific aspects of hospital designs informants perceived to be significant in response to our two initial questions; and (b) to elicit their views on how and why these features of hospital environments were important. To achieve this we employed *attributional coding* (Sylvester, 1998) with the aim of understanding the informants' reasoning about *how* and *why* certain hospital features were important for wellbeing. Attributional coding aims to interpret discourses in terms of what is said about the '*agent*' (a person, group or entity seen to *produce* an outcome) and how this impacts on the '*target*' (a person, group or entity mentioned in the *outcome*). To clarify the points made by the respondents we have abbreviated their speech in some cases, as indicated by ellipses, and added clarifications in square parentheses.

Other results from this study, already reported elsewhere (Curtis et al., 2007) contributed to theories of therapeutic landscapes by showing how these ideas might apply to an acute inpatient facility of this type and how our informants understood and interpreted these different dimensions of the setting in which care was being provided. In addition to the findings previously published, we noted that there were many interesting observations about the function of this acute unit in the context of contemporary models of psychiatric care and the ways that the hospital setting related to the surrounding community. We present our findings in three sections relating to the three themes outlined at the close of the introduction above.

The rebirth of the clinic? New spaces of care at the transition from hospital to community

Several of our informants suggested that one of the key attributes of this acute psychiatric unit was its rather ambiguous character as a space of 'transition', where patients are prepared for the move from institutional care to community living. This was seen as an important goal for inpatient care, but one that presented challenges both for service users and for the nursing and clinical staff. The difficulties discussed included the risks run in achieving this transition and the uncertainties involved in judging the 'right time' for patients to leave the hospital. Also there was mention of the problems of engaging patients in the running of the hospital wards and creating a 'homely' and therapeutic setting for them, given that they were 'passing through' the hospital, rather than staying there as long-term residents.

Generally speaking, users tended not to discuss this issue as much as the consultants and other staff at the hospital. (Users were more particularly concerned about the relationships between staff and patients within the hospital.) However, one user clearly saw recovery from mental illness as one of the key objectives for hospital care and hinted at the risks involved in trying to achieve this for patients.

> …So what is the goal? Is it to get people better?…If that's the bottom line and everyone can agree on that then…Terrible things might happen-I hope they don't but they could-but in the event that they do you've at least got that as your approach point. You have to have that as the bottom line. If we can't agree on the overall aim of what a hospital is about then what is it? It might as well be, I don't know, some sort of post-modern adventure playground (user).

The same user also expressed the sense of a precarious care setting, which is difficult to manage, emphasizing the uncertainty involved in psychiatric care, and appeared to call on ideas from

complexity theory as formulated by Waldrop (1992) which suggest a critical state somewhere between rigid and static order and complete disorganization, in which it is important to recognize that new approaches to health care are likely to emerge.

> …if people who are making decisions don't start understanding that what we are dealing with is the frontier of order vs. chaos, then we are not going to make any advances (user).

Another user discussed the experience of this transition in terms of a sense of 'abandonment', and was critical of the limited aftercare that he felt he had experienced in contrast to the more 'protected' environment for inpatients. This made him sceptical about the advantages of facilities provided for patients within the hospital if they did not prepare the user to cope with the transition back to community living. This account also expresses a perception of a chaotic situation, lacking direction and support after discharge, making it difficult for the patient to manage in the community.

> …I've seen quite a lot of stuff that makes me wary of going back there [to the hospital].…It's about finding small activities that you can continue when you leave hospital. 'Cause when I got discharged from hospital, that was it, I was dropped like a wet rag. Didn't get no connection, there was no, like, ''Do you need a key worker, do you need a social worker? How can we best get you back into the community?'' It was just: 'Oomp, you're out there, you deal with it.'…And I think that is also a key element into how many people keep going back to hospital. Cause it feels like, you're shoved out there, you're not told which direction to go in. It's not as if life comes with maps. So you have to make your own way (user).

Possibly this type of experience was the outcome of a premature hospital discharge, before the patient was really ready for it. One of the consultants discussed the 'timing' of the transition back to community living as a delicate 'balancing act' between avoiding 'institutionalizing' patients by keeping them in hospital too long, as against exposing them too soon to the rigours of life outside the hospital, before they have recovered sufficiently to cope.

> The difficulty is, sometimes, the balance; between pushing them out too early, when they are still symptomatic and then quickly deteriorating, but then keeping them so long that the benefit of the hospitalisation becomes a hindrance, because they become so into the routine of the ward that [it] is very hard to adjust to outside. So trying to strike that balance, when is the right time to encourage them to move on…when is the right time of thinking: 'Has this person achieved as much as they are going to from our unit? (consultant).

The same consultant explained that the best timing of transition is difficult to assess and varies from one individual patient to another, depending on the complex characteristics of each individual patient and their circumstances. The objectives of the 'care plan' for a patient should include some scheme for a 'forward trajectory' which would ultimately lead back to life outside the hospital. This creates a tension between the idea of the hospital as a protected environment for healing as opposed to the vision of the hospital as a 'stepping stone' towards life elsewhere.

> [Discussing the aims of a patient's care plan]…wanting to facilitate people taking the next step whatever that is for that person, and that will vary from one person to another. Being able to be flexible and adapting to that, so sometimes it may be quite a long time before they actually go outside the unit, I have to say, even accompanied…We have, like, an art room, as well, so for the clients who are at the stage where it is not possible for them yet to take part in the more community-based activities; they can do it on the ward first of all and they can [do] cooking on the unit, but we have facilities on site as well (consultant).

To help patients prepare for community living, occupational therapy is provided which involves activities in the local neighbourhood. Thus the inpatient 'care space' is extended outside the hospital walls and into the community.

> …the OTs have been taking the clients out to the gym at the local leisure centre and I prefer that these people can go out. We like to encourage clients to get out. They have a café club going every week and they go down to [a local shopping] Street and have lunch out, and the library group as well, they go off to the library (consultant).

Thus ease of access and a sense of 'connectedness' to the local community is an essential aspect of these inpatient care settings. The staff suggested that more provision could be made for 'outside' activity of this sort, because it would help them retain their links with the world outside the hospital and would prepare them for the transition back to community living. However, they often seemed unsure about how far they could achieve ideal opportunities for this type of activity. Several of them commented on what they saw as a lack of resources and facilities to take patients outside the hospital space.

> …where I used to work in Central London, we had a van for the hospital…and staff would take a test to be eligible to drive the van, so at the weekend we would book the van to take them to the seaside, you know, to Southend.…You can't take patients in your car…OK you can watch videos or play CDs or whatever [inside the hospital], but still, getting out of the building…even go to the market or something…That would be nice. That's something missing (member of staff).

The fact that patients were viewed as having a transient existence in the hospital, was also seen by the consultants and other staff as an obstacle to their goals to create a physically 'homely' setting for users during their inpatient stay and facilitate the individual self-expression and autonomy of action that are seen as desirable in a 'homely' space. Consultants and other staff also discussed the difficulty they perceived in achieving active engagement of patients in design of the hospital space and planning of activities on the wards or outside.

> …How could it be made more homely? It's a good question actually. I suppose for people to be able to have more personal items of theirs in the room. Perhaps being able to chose what- or maybe being given the money themselves to go out and chose what-prints they want to put in. I have to say they were bought by some of the staff or the ward managers. I suppose it would be have been preferable for the clients themselves to have chosen what they would like, although the problem is that the client moves on and the next person wouldn't necessarily want to have the stuff they've chosen on the wall (consultant).
>
> …the OT's are looking more at what kind of specialised services can they provide, rather than just doing groups for the sake of it. And I think that discussion is in itself important, and service users, they do participate-but often when they're ill they don't because it's too much for them–it's a matter of participating as a form of rehabilitation.…I think in general

> they get something out of it, but I don't think it's really like, service users are saying 'Wow! This is all available and I think it's great!' Somehow they don't seem to engage [with] that which is available them, or see what they can get out of that. And that in itself is being reviewed, because if the service user doesn't actually see that, then you can wonder if it's useful doing it.…In fact, they did do something else…it was in fact a community group that got together a group of users from the community mental health team who took users from the ward, and they all went for a day out, which was very positive (consultant).

This last comment is interesting because it suggests that nursing and OT staff did not seem to find it very easy to facilitate user engagement. This informant suggested the difficulty was partly due to the patient's illness and also perhaps because of a certain sense of apathy on the part of patients towards activities that might be seen as 'regimented' parts of the formal care plan. The option of forging partnerships with voluntary organizations from the local community outside the hospital, to organize less 'formal' activities, was mentioned here as an alternative strategy that seemed promising. It is interesting to note this potential blurring of the division between the 'clinical space' in hospital, where a 'formal' care regime is determined by clinical and nursing staff, and the 'community space', where voluntary organizations may be seen as better placed to facilitate access to less structured, informal activity outside the hospital. It represents another perspective on the 'transitional' nature of contemporary inpatient facilities and it seemed to generate a certain sense of unease among care staff about how their role should be defined. This seems consistent with the idea of the patients interacting with different elements of a complex web of care, with partial, but incomplete connections and information flows and communication between different care sectors.

While consultants and other staff seemed to feel that there were constraints that limited the potential to involve patients in decisions about the hospital regime, users, on the other hand, were more inclined to emphasize the necessity of empowering patients within the hospital setting. They wanted to put the onus on care staff to be more open and proactive in eliciting patient's views:

> …If someone can't talk that well, they can't express things that well, either they should be helped by someone they trust, there and then, or they should be prompted…it is about honesty and openness and input and involvement and…just awareness of possibility (user).

These various comments from our informants therefore illustrate the sense of a complex, ambiguous, and transitional setting within the acute hospital we studied, raising uncertainty over perceived roles of the patients and health care professionals within this new space of care for mental illness. It puts into question the contemporary relevance of Foucault's (1973) argument about the 'birth of the clinic', through which, in the past, the hospital emerged as a 'clinically' defined space, dominated by clinicians for the operation of processes of diagnosis and medical treatment of 'passive' patients. The comments recorded here could be interpreted to suggest the '*rebirth* of the clinic', depicting the acute unit being recreated as a more 'chaotic' space of care, where a high priority for clinicians and other staff is to foster patient autonomy as part of the recovery process, while still having the responsibility for caring for patients, determining the nature of the hospital environment, and regulating its connections to the community outside.

'Managed permeability': controlling the interface between 'hospital' and 'community'

Associated with these conflicting aspects of the hospital care setting is a concern to find new ways of managing a 'permeable interface' between the hospital and the community in which it is set. On one hand, greater permeability is desirable, but this brings with it a number of potential risks that are seen as hard to manage. We noted in the introduction an important role for 'old', institutional spaces for long-term care of psychiatric patients was a 'carceral' function, to 'keep in' patients within the hospital grounds, separated from the wider community, partly to provide 'refuge' for fragile individuals from stresses of ordinary life, but also to 'protect' the wider community from exposure to people with mental illness. In the 'new' spaces of care for mental illness, represented by the hospital we studied, the balance between incarceration and refuge seems to have shifted and the main preoccupation seemed to be less to do with 'keeping in' the patients, than with 'keeping out' certain incursions from the wider community.

For example, this was particularly illustrated by the regime of 'unlocked wards', which was described by two of the consultants as follows:

> I really like the doors on the ward, because the doors are opened from inside so if I want to leave the ward, if anyone wants to leave the ward, patients or staff [s/he] just presses a button and the door is open.…Now the good thing about it is the patient doesn't feel locked up. Even though most of them are on 'section' [i.e. subject to compulsory hospitalisation under the relevant section of the mental health legislation]…if they are desperate to leave, they just walk out. And nurses might try to stop them, but if they run quickly they're out… (consultant).

Thus, although formally speaking, patients who are involuntarily admitted are not normally allowed to leave the ward, the suggestion here is that, at least in the short term, someone who was determined to leave would be able to do so. While this might seem to undermine the traditional role of staff managing the wards, at least one of the nurses we spoke to seemed to prefer it.

> …Its much less custodial, I think our feelings of power as nurses, and all those things we experienced, having an unlocked door was quite un-nerving, but actually its worked very very, very well and I wouldn't want to work on a key ward that's got a locked door now.…You can't walk onto a ward; there is controlled access, but you can leave without unlocking the door, it's totally different (member of staff).

While on the one hand, the hospital operated an 'open door' policy for egress, and this relaxed, 'non-custodial' attitude gave patients freedom to leave the ward, on the other hand, the regime for ingress is seen as quite 'prison-like'. Our informants discussed a 'hardening' of control of permeability of the hospital space in the other direction, with visitors to the wards being more strictly controlled than in more traditional hospitals. While this made it easier to 'keep out' undesirable visitors from the community outside, it created complications in facilitating 'desirable' visits from family and friends.

> When it comes to the wards, to start off with, the doors are closed because that's kind of the way they operate, but that does immediately make a kind of a barrier.…to get into the ward-you have to press the button or you have to have a swipe card and these are open wards actually…the problem with most open wards is that anyone can come in, so then you

have…the drug pushers coming to the ward. That's not possible here because everyone has to report. People can't just walk in and start doing their business. So we don't get prostitutes, we don't get drug pushers-which is a huge problem [elsewhere]. People always deny it, but in inner city areas, in mental health, this is what you get (second consultant).

Yes, on my security unit patients have to have their visits booked and we're only having one visitor, one patient's visitors, at one time and I think patients are finding that quite difficult (first member of staff).

It's like what we were saying about open door policy and being more restricted and prison-like. That's very prison-like; having to book a meeting-if they come on a bus, they're half an hour late, they've a baby and things… (second member of staff).

The need to more actively manage risks associated with people coming into the hospital from outside also seems to be reflected, in a different way, in the following comments from one of the staff. The discussion was about the informant's sense of insecurity about dealing with unplanned emergency admissions of patients (often in a highly disturbed state) who need to be admitted for assessment, without having any prior information about them.

…we should have an emergency clinic. We need a 24 h A&E for people with mental health problems where there's a section 136 suite [specialised observation facility]…It [this type of facility] is nursed, it's staffed, there are excellent assessment skills, there are doctors and nurses that know the people that frequently present to hospital.…[Here, in contrast] Every time a duty nurse has to get called to reception…for an [unplanned emergency] admission…We don't know if [the person admitted has] got a gun or not, we don't know if he's got a dagger on him. If we had an emergency clinic you could have a metal detector like they have at the Maudsley [major psychiatric inpatient facility in London]. Everyone passes through there-…They're screened, a thorough assessment before they get to the ward (member of staff).

It was recognized, too, that a balance still has to be maintained, within the 'protected' space on the ward, between the desire to create what seem like 'normal' social environments and the need to manage risks for patients. We have discussed elsewhere, for example, the design features of patients' individual bedrooms that were supposed to reduce the risks of absconding through open windows, or self harm by ligature on protruding door handles (Curtis et al., 2007; Gesler and Curtis, 2007). A different type of risk is considered in the following comment about the need to create separations between men and women on the wards.

…There is a balance in psychiatry; one should try to be as close to real life as possible. But then real life means unpleasant things. Real life isn't always nice and so if you want to reflect real life in a mental health institution then you get the unpleasant things as well.…we don't want [a] 'real life' situation, you want an 'ideal' situation and a 'safe' situation, so you enter a discussion about single sex wards (consultant).

It also seemed that part of the motivation for controlling visitors to the wards was inspired by a sense of 'protecting' some members of the public from 'exposure' to the more disturbing manifestations of mental illness. A representative from the user's voluntary organization, who was helping facilitate the discussion group with the users, approved of the way that the hospital had been designed to allow visits to patients to take place off the wards in a public refectory space by the main entrance. This suggests that 'new spaces of mental inpatient care' still retain some of their traditional function of 'distancing' people with mental illness from other people in society.

…we were saying about having a canteen that people could have their visitors use–because of children…coming to visit, rather than having to go up onto the ward-which would be very frightening for young children…but there'd be a safe place downstairs that everybody could use, and they did that (coordinator in user's voluntary organization).

On the other hand, the canteen space also reflects a more modern sense of openness and connection between this psychiatric hospital and its surrounding community. It is large and light and easily accessible from outside the hospital and is designed to be used by patients, staff or visiting members of the public.

This and other examples above exemplify 'new spaces of inpatient care' designed to create public spaces that 'blur' the division between the hospital and the community and create spaces within the walls of the hospital that are more like community settings than clinical environments, bringing the 'outside world' into the hospital space. Furthermore, unlike the 'carceral' analogy, often applied to old asylum hospitals, these new inpatient units may be better seen as 'fortresses' against unwelcome incursions from parts of the wider network of people and places in which the hospital is situated.

New spaces of refuge and asylum

The final theme considered here concerns continuity and perturbation of the traditional role of long-term asylum spaces as *places of refuge*. In one sense, the construction of a new psychiatric inpatient facility in this part of East London was seen to be breaking with the past and leaving behind the undesirable connotations of the 'old' spaces of care.

I know the old building but I've never been inside.…I think there was almost a need to be away from it as well, because there was just so many bad memories. And that there wasn't the wish to repair, more the wish to just forget and move somewhere else (consultant).

This was associated with a sense that the old hospital was being replaced in the new hospital by a more therapeutic environment of better quality for patients. One member of staff thought this promoted among patients an improved sense of self-worth and motivation for self-care (consistent, also, with the aim of treatment that helps patients regain their ability to live successfully in the community).

…maybe because the environment is nice, the patients themselves look better,…they do try to make the environment look tidy-unlike in the old buildings [where]…it…[didn't] matter because the environment itself…[was] not really attractive. But this one [the new hospital] looks better and they too are trying to treat it in that manner…I think is a positive…contribution (first member of staff).

It just encourages [patients to look after] the sort of basic needs, with having your own bed area that's your responsibility to look after, rather than what we saw at [the old hospital], dormitories and the person next door to you very being messy and untidy so what's the point really (second member of staff).

On the other hand, some of the comments from users and health care professionals suggested that these 'new spaces of care'

still have a more traditional, 'institutional' role in providing a beneficial sense of continuity in life experiences that are otherwise often insecure and unpredictable. One user seemed to find it helpful, for example, that she could recognize people in the hospital wards that she had met before:

> There was some new faces like…when I was there. There were some people I was knowing there (user).

Two of the consultants also expressed more explicitly their impression that users formed attachments to the hospital buildings as places of refuge and relative stability and became anxious when they were about to leave.

> …I think that the building is important in the sense that it's an attachment, an important thing for people.…Often people, services users who are in and out [of] hospital more often and see many doctors, they attach to the building; it doesn't matter about the staff and the doctors or whatever, it's the building that they go back to, because that's the most consistent of the lot (first consultant).
>
> …what I notice as well is that a lot of the clients become quite anxious a couple of weeks or months or weeks leading up to discharge, because a lot of our clients come from, you know, very secure institutionalised settings and have been four, five, ten years in hospital, so then the thought of actually leaving the hospital is really very anxiety provoking… (second consultant).

Some aspects of modern regimes for management of acute psychiatric units seemed, according to our informants, to make it more difficult for patients to find this security and continuity in the inpatient setting. One aspect is the emphasis on reducing inpatient services compared with provision in the past, and using inpatient facilities to full capacity.

> …Psychiatric beds have been diminishing…in the last…10–20 years. Obviously in an area like this with extremely high demands on the mental health services it's an incredibly awkward situation (first member of staff).
>
> …They expect, of course, patients,…that when they go on leave, their bed will still be there. There's no chance! As soon as they step out, we've got someone waiting to come in there. Like this afternoon we're full up. We've got 5 patients who are on leave, we've got 15 on the ward now, we've got [a new inpatient] coming up…So we have to 'create' a bed (second member of staff).

A therapeutic feature that was typical of older 'asylum' spaces was large hospital grounds where patients could walk outside while still within the refuge of the hospital space. Research in Scotland by Parr et al. (2003) showed that people who had been in residential care in long-term institutions retained a sense of attachment to these grounds and visited them even after the hospitals were closed. However, new spaces of inpatient care like the one in our study, are built in more densely populated areas and on smaller plots of land, which limits the available garden space.

> …this probably was quite a barren piece of land–so they have planted a whole lot of trees, but I do find it important to have a whole lot more greenery. What you just have, if a patient came out here, is a car park to walk on. I think you can walk behind the back or whatever, again, it's not a park, its not a lovely garden space that you can go and use…I think that's part of a need [to]…allow people to go out for walks and that they actually have a place to do that in (consultant).
>
> The ground floor wards were given access to the gardens, but in fact the gardens are a bit imposing because there's quite a high ring fence around them. They don't really look like gardens. I'm not sure who is maintaining them.…The gardens are very ward specific… (first member of staff).
>
> …The inner courtyard,…was meant to be got into by the upstairs wards. There was great debate about how they access that and what was suggested was that they put in a metal staircase, down from upstairs. OK, that would be fine. Well, that then came up as a cost implication. Well, I think we should be pushing that again… (second member of staff).

This last comment also illustrates a perception that the costs of changes to the hospital building have to be justified, and this may be rather complicated under the PFI, through which the NHS leases premises rather than owning them. Maintenance of hospital grounds is the responsibility of a company, rather than under direct control of the NHS, and this may make it more difficult to prioritize access to outdoor green space both because of cost considerations and the limits of contractual responsibilities.

Conclusion

We should preface our conclusions with some caveats about the limits of this study. This was an exploratory study with a small, self-selecting group of respondents and it concerned a single hospital, so that the findings may not be widely generalizable. The issues raised in this paper were incidental to the primary focus of the study, which was more directly concerned with features of hospital design affecting well-being, and this was not a study designed specifically to evaluate the hospital design or model of care in the hospital from a clinical perspective.

The respondents' comments suggest a strong sense that this inpatient unit was a space of *transition* from the hospital to life outside in the community. The hospital design and care model needed to reflect this. Related, though somewhat different findings are reported by Douglas and Douglas (2005) in a study of a non-psychiatry hospital, where they noted that 'spaces of transition' such as corridors and reception areas were important for hospital design. In our study, the impression was that this transitional character of the space was felt in the building as a whole, even on the wards. This transitional aspect of the acute inpatient unit has practical implications for the design of the hospital. The building is a piece of 'civic architecture' in a functional as well as an aesthetic sense and it needs to be designed to foster links with the community it serves. Transportation and staff resources that make it possible for patients to visit the community and for friends and relatives to visit the hospital have been shown here to be important to maintain connection to the community. The hospital also needs to include public spaces which allow mixing of those using services and working in the hospital as well as members of the public who are visiting. We have noted, in addition, a tension between creating a homely atmosphere for patients and creating the conditions to help them be discharged, in a timely fashion, into settings where the degree of medical control and 'discipline' is perceived to be weaker than in the hospital.

The roles of hospital staff are being brought into question in the 'permeable' hospital setting, and the clinical dominance of hospital spaces is less clear. We also noted above questions about how the clinical regime of the hospital should relate to services provided by informal organizations in the community. From a geographic perspective this is consistent with Milligan's (2000) discussion about complex geographies of mental health care that give more consideration to the informal sector operating 'beyond the asylum'.

The physical hospital building, the services provided within and around it, and the people using it interact together in ways that may be difficult to anticipate when planning and designing the building itself, which may partly explain why consultations over PFI constructions of this type are long and complicated. It is particularly challenging to plan for a psychiatric Inpatient Unit as part of a network of community-based psychiatric care, involving interaction of many living actors (e.g. users, visiting friends and relatives, staff, NHS managers and planners, and the public at large) as well as non-living actors (e.g. features of a hospital building that may include: door locks, outdoor garden spaces, cafes and shops visited by users in the nearby urban area; regulations concerning the sectioning of users).

The relational perspective we have used here leads us to emphasize transitional space of the hospital and its permeable interface with the community outside. Associated with this fluidity and connectedness of the inpatient space is a large degree of uncertainty and ambiguity, which has been noted in other studies of facilities for care of people with chronic health problems. Cutchin (2007) discovered that ambiguity can be created by the blurring of boundaries between home and institutional care and institutional spaces. These ideas are also reminiscent of the earlier work of David Sibley, focusing on the experiences of marginalized groups, who recognized 'zones of ambiguity' where one crosses boundaries between spatial and social categorizations (Sibley, 1995). Sibley (1981, pp. 190–4) also discusses the tendency for retreat by marginalized groups to 'residual spaces' and 'unfinished environments' where social exclusion and boundary maintenance are less rigorously imposed by the dominant authorities. In one sense these zones of ambiguity offer people with mental illness 'positive' opportunities for independent living, but they also present risks that are difficult to manage.

As DeVerteuil et al. (2007) found in their study of facilities for substance abuse treatment, staff must negotiate the difficult balance between sheltering patients and helping them maintain ties with the people and places outside to which they will eventually return. We would concur with Quirk et al. (2004, 2006) that positive aspects of permeability, such as a less rigidly institutional atmosphere, may have to be balanced against 'incursions' into the hospital space of undesirable influences from other parts of the hospital–community system, such as dealing in illegal drugs on the hospital premises. Staff were therefore as much preoccupied with *excluding* risky elements from the community outside, that might threaten their patients and themselves, as with *containing* the possible risks to the wider community posed by psychiatric patients themselves. We have suggested that this seems to correspond as much to a 'fortress' analogy as to a 'carceral' idea of psychiatric hospital.

These complex connections between users' experiences inside and outside the hospital make it all the more challenging to deliver a sufficiently multi-functional and flexible hospital infrastructure that will be well-suited to their care needs into the future. Such dynamic complexity may be incompatible with the rather rigid contracting processes of PFIs, which take some time to agree and can be difficult to renegotiate over time, as needs change. To deliver psychiatric inpatient facilities that are suitable for future care models will require flexible and responsive ways to negotiate between private and public sector partners, as well as 'third sector' service providers, service users and various other public interests.

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References

Cilliers, 1998. Complexity and Postmodernism: Understanding Complex Systems. Routledge, London.
Conradson, D., 2005. Landscape, care and the relational self: therapeutic encounters in rural England. Health & Place 11 (4), 337–348.
Cummins, S., Curtis, S., Diez-Roux, A.V., Macintyre, S., 2007. Understanding and representing 'place' in health research: relational approaches. Social Science & Medicine 66 (2), 1825–1838.
Curtis, S., Gesler, W., Fabian, K., Francis, S., Priebe, S., 2007. Therapeutic landscapes in hospital design: A qualitative assessment by staff and service users of the design of a new mental health inpatient unit. Environment and Planning C: Government and Policy 25, 591–610.
Cutchin, M., 2007. Therapeutic landscapes for older people; care commodification, liminality, and ambiguity. In: Williams, A. (Ed.), Therapeutic Landscapes. Ashgate Publishing Limited, Aldershot, pp. 181–198.
Dear, M., Wolch, J., 1987. Landscapes of Despair: From Institutionalization to Homelessness. Polity Press, Oxford.
DeVerteuil, G., Wilton, R.D., Klassen, S., 2007. Making clean and sober places: the intersections of therapeutic landscapes and substance abuse treatment. In: Williams, A. (Ed.), Therapeutic Landscapes. Ashgate Publishing Limited, Aldershot, pp. 77–94.
Douglas, C., Douglas, M., 2005. Patient centred improvements in health-care built environments: perspectives and design indicators. Health Expectations 8, 264–276.
Foucault, M., 1967. Madness and Civilization: A History of Insanity in the Age of Reason. Tavistock Publications Limited, London (First published 1961 as Histoire de la Folie, Paris, Librairie Pion).
Foucault, M., 1973. The Birth of the Clinic. Routledge, London (First Published 1963 as La Naissance de la Clinique, Paris, Presses Universitaires de France).
Foucault, M., 1977. Discipline and Punish; The Birth of the Prison. Penguin Books, London (First Published in 1975 as Surveiller et Punir, Naissance de la Prison, Paris, Editions Gallimard).
Gatrell, A.C., Popay, J., Thomas, C., 2004. Mapping the determinants of health inequalities in social space: can Bourdieu help us? Health & Place 10, 245–257.
Gesler, W., Curtis, S., 2007. Application of concepts of therapeutic landscapes to the design of hospitals in the UK: the example of a mental health facility in London. In: Williams, A. (Ed.), Therapeutic Landscapes. Ashgate, Aldershot, UK, pp. 149–164.
Gesler, W., Bell, M., Curtis, S., Hubbard, P., Francis, S., 2004. Therapy by design: evaluating the UK hospital building program. Health & Place 10 (2), 117–128.
House of Commons, 2001. The Private Finance Initiative (PFI). House of Commons Research Paper 01/117 〈http://www.parliament.uk/commons/lib/research/rp2001/rp01-117.pdf〉, accessed on 31.3.08.
Latour, B., 1999. On recalling ANT. In: Law, J., Hassard, J. (Eds.), Actor Network Theory and After. Blackwell, Oxford, pp. 15–25.
Milligan, C., 2000. 'Breaking out of the asylum'. Developments in the geography of mental ill-health: the influence of the informal sector. Health and Place 6 (3), 189–200.
Milligan, C., 2001. Geographies of Care: Space, Place and the Voluntary Sector. Ashgate, Aldershot, UK.
Moon, G., 2000. Risk and protection, the discourse of confinement in contemporary mental health policy. Health and Place 6, 239–250.
Murdoch, J., 1997. Inhuman/nonhuman/human: actor–network theory and the prospects for a nondualistic and symmetrical perspective on nature and society. Environment and Planning D: Society and Space 15, 731–756.
Park, D., Radford, J., 1997. Space, place and the asylum. Health & Place 3 (2), 71–72.
Parr, H., Philo, C., Burns, N., 2003. 'That awful place was home': reflections on the contested meanings of Craig Dunain asylum. Scottish Geographical Journal 119 (4), 341–360.
Philo, C., 1989. Enough to drive one mad: the organisation of space in nineteenth-century lunatic asylums. In: Wolch, J., Dear, M. (Eds.), The Power of Geography: How Territory Shapes Social Life. Unwin Hyman, London, pp. 258–290.
Philo, C., 2004. A Geographical History of Institutional Provision for the Insane from Medieval Times to the 1860s in England and Wales: The Space Reserved for Insanity. Edwin Mellen Press, Lewiston and Queenston, USA, Lampeter, Wales.
Philo, C., 2005. Sex, life, death, geography: fragmentary remarks inspired by Foucault's population geographies. Population, Space and Place 11, 325–333.
Priebe, S., Badesconyi, A., Fioritti, A., Hansson, L., Kilian, R., Torres-Gonzales, F., Turner, T., Wiersma, D., 2005. Re-institutionalisation in mental health care: comparison of data on service provision from six European countries. British Medical Journal 330, 123–126.
Priebe, S., Frottier, P., Gaddini, A., Kilian, R., Lauber, C., Martinez-Leal, R., Munk-Jorgensen, P., Walsh, D., Wiersma, D., Wright, D., 2008. Mental health care

institutions in nine European countries, 2002–2006. Psychiatric Services 59 (5), 570–573.
Quirk, A., Lelliott, P., Seale, C., 2004. Service users' strategies for managing risk in the volatile environment of an acute psychiatric ward. Social Science & Medicine 59, 2573–2583.
Quirk, A., Lelliott, P., Seale, C., 2006. The permeable institution: an ethnographic study of three acute psychiatric wards in London. Social Science & Medicine 63, 2105–2117.
Rogers, A., Pilgrim, D., 1996. Mental Health Policy in Britain: A Critical Introduction. Macmillan, London.
Sibley, D., 1981. Outsiders in Urban Societies. St. Martin's Press, New York.
Sibley, D., 1995. Border Crossings, in Geographies of Exclusion. Routledge, London, pp. 32–48.
Smith, C., 1978. Recidivism and community adjustment amongst former mental patients. Social Science & Medicine 12, 17–27.
Sylvester, J., 1998. Attributional coding. In: Symon, G., Cassell, C. (Eds.), Qualitative Methods in Organizational Research. Sage, London, pp. 73–93.
Waldrop, M.M., 1992. Complexity: The Emerging Science at the Edge of Order and Chaos. Simon and Schuster, New York.
Wolch, J., Philo, C., 2000. From distributions of deviance to definitions of difference: past and future mental health geographies. Health & Place 6, 137–157.