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'In line with the modern conception of much mental illness': psychiatric reforms and architectural design contributions in post-war England

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Abstract

This article examines the history of, and specialist design principles behind, two Admission Units that were added to two existing mental health hospitals in post-war England: Fair Mile Hospital, in Cholsey, near Wallingford, Berkshire (now Oxfordshire) and Fulbourn Hospital, near Cambridge, Cambridgeshire, completed in 1956 and 1964 respectively. Their commission and realisation fell within a period of critical psychiatric reforms, some of which first emerged in the first half of the twentieth century with further developments peaking after the Second World War. Although the two buildings preceded subsequent interdisciplinary advancements that specifically fed into the correlation between buildings and healthcare, namely, environmental psychology and evidence-based design, they

emerged at a time when prominent hospital architecture studies were embracing a research culture and aimed at merging an interdisciplinary approach with modernist architectural principles. Yet these two buildings, and numerous other similar units, have been virtually absent from existing scholarship, both general architectural historiography and studies of specialist healthcare architecture. The study here uses literature review of architectural historiography, historic policy and guidance documents, and archival material, as well as review of graphic material comprising photographs, architectural drawings and diagrams. The discussion opens with a brief overview of the general policy and psychiatric context within which the two units were commissioned and erected. This is then followed by a closer inspection of the two buildings, which brings to light both similarities and differences. Discussed in parallel to principles outlined in healthcare architecture guidance published at the time, this comparison highlights the complex and nuanced associations between architectural design and mental healthcare, as well as the way these evolved in this particular time period. Specifically, by looking closely at national and international guidance on healthcare architecture developed by the Nuffield Provincial Hospitals Trust, the World Health Organization and the Ministry of Health, key shifts in the role that architecture could play beyond a medical model of mental healthcare and in support of a psychosocial approach are discerned. Finally, the article also makes the case for further research that broadens and deepens studies of the post-war history of this field as well as comparisons both to the inter-war and to the contemporary periods.

Keywords: mental health; Admission Unit; post-war England; Nuffield Provincial Hospitals Trust; World Health Organization; Richard Llewelyn Davies; Paul Sivadon

Introduction

Despite the fervently championed double aims of deinstitutionalisation and the merging of mental and physical health in the post-war period and the late twentieth century, in recent years, an intensive building programme has been advancing within the English National Health Service (NHS) that aims to provide specialist, usually standalone, buildings that specifically cater for inpatient mental healthcare services (Acute Mental Health Units).[1] Similar trends are known internationally and the discourse on specialist mental healthcare design continues to draw from the areas of environmental psychology, evidence-based design and new technological developments that are employed to enhance sensory design or safety and security measures.[2] This emphatic assertion of the need for specialist inpatient mental health facilities invites a closer examination of the actual reality during the transitional period of the second half of the twentieth century. Of special interest in this connection is the period after the Second World War, when such a transition was taking critical steps and which has been widely recognised as a period of psychiatric reform.[3]

Indeed, despite the strong emphasis on deinstitutionalisation that led away from specialist mental hospitals and towards the incorporation of mental healthcare either within general hospitals, or in the community,[4] building activity in the 1950s and 1960s within existing mental hospital grounds resulted in a number of purpose-designed buildings. What is more, architects engaging in such commissions repeatedly expressed their aspiration to make their designs match positive developments in the field of mental health. The quote used in the title of this paper comes from an article on the then newly completed Admission Unit at Fair Mile Hospital, in Cholsey, near Wallingford, Berkshire (now Oxfordshire) (the first case study for this paper), published in the *Architects' Journal* on 19 April 1956. The article reveals the aspirations of architectural professionals to make their own contribution to the field of mental health: 'The general atmosphere of this admission unit is reassuring and optimistic, to be in line with the modern conception of much mental illness as a curable condition.'[5]

Similar language was used for the 'Admission Villa' at Fulbourn Hospital, near Cambridge (the second case study for this paper), in 1964. In addition to another confident assertion that the architecture

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can indeed match the principal aims of its specified use, here we also see a mention of the increasing openness of, and psychosocial approach to, mental healthcare: 'Modern treatment, with its emphasis on essential interaction, realistic activities and close links with the outside community, is well within the capabilities of this interesting new building.'[6]

In the eight-year period between these two quotes, however, the professional press also voiced the growing realisation that further support was needed so that architects were provided with the specialist knowledge required to design appropriate mental health facilities. In 1959, an article in the *Architects' Journal* discussing the new Admission Unit at St John's Hospital, in Stone, Buckinghamshire, stated: 'So little building has been done in this field since new ideas of treatment for mentally sick developed that it will clearly be the job of the health authorities to establish research teams in mental hospital building similar to the Ministry of Education's.'[7]

What actually followed, to what extent such calls were answered, in what ways and by whom has not been comprehensively addressed in existing scholarship. What is more, given the revived interest in specialist mental healthcare facilities at present, an in-depth understanding of these early attempts to address the specificities of this particular area of healthcare design is of renewed significance.

Historical background and policy context

Through its chronological framing, the investigation presented here is directly linked to the British welfare state. The launch of the NHS in July 1948 was one of the strongest manifestations of the British welfare state in the post-war period and also heavily focused on hospitals, both as buildings and as organisational entities. Not only did the NHS introduce healthcare provision to all that was to be free at the point of delivery but it also brought all hospitals under one administrative system.[8] Legal restrictions that separated mental from physical health were still in place and it would take more than another full decade before the Mental Health Act of 1959 eventually removed all legal separation between physical and mental healthcare provision. Nonetheless, mental hospitals had been included in the new administrative organisation under the NHS as early as 1948, placed under the newly formed Regional Hospital Boards but forming their own Hospital Management Committees.[9]

The NHS inherited hospitals that were in dire need of upgrade, while bed shortages also dictated the commission of new hospitals. Although these needs were pressing, there were also budgetary constraints. These meant that a substantial hospital building programme could not be put in place before 1962 when *The Hospital Plan for England and Wales* was published by the Ministry of Health.[10] Nonetheless, some limited activity was initiated in the 1950s and, as tuberculosis care became obsolete, mental hospitals featured among the top priorities.[11] Competing priorities outside the field of healthcare, however, further limited hospital rebuilding: the capital expenditure for 1954 prioritised housing and schools, with just £10 million budgeted for hospitals.[12] Most important for the discussion here was the 'mental million' (the name referring to the amount of funding approved), the 'meagre' funding allocated by Minister of Health Iain Macleod for additional psychiatric facilities in 1954–5,[13] which directly relates to the cases discussed here. As additional budgetary constraints delayed all major building projects, though, further policy changes were also introduced and mental hospitals effectively disappeared from new building programmes. What followed was indeed a gradual implementation of deinstitutionalisation that resulted in the closure of mental hospitals, the integration of inpatient mental and physical care through the introduction of psychiatric wings within general hospitals and the even slower implementation of community care. Notably, all this was a process that took several decades to complete and therefore more studies are required to uncover the rich granularity and significance of this period.

Existing scholarship

The investigation presented here first started in response to the virtual absence of post-war mental health facilities from architectural historiography. Although all evidence identified below demonstrates how post-war Admission Units[14] were seen as specialist hospitals in their own right and often attracted higher investment in actual funds and in architectural expertise (in comparison to other post-war buildings added to existing mental hospital grounds), they are virtually absent from existing scholarship. The policy changes outlined above meant that, despite the fact that the actual closure of mental hospitals took

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several decades to be realised, the second half of the twentieth century in England (and in most of the Western world[15]) has long been associated with deinstitutionalisation. As a result, and as the literature review below discusses, until recently, this period has been largely considered as of no particular interest regarding specialist architectural design developments in England.

Indeed, although numerous studies have firmly established the significance of spatial arrangements in the development of psychiatry and the social history of madness,[16] in addition to the wide-ranging scholarship on nineteenth-century asylums,[17] scholarship on mental healthcare facilities in the twentieth century remains largely fragmentary, even if it is slowly growing.[18] In particular, architectural historiography has virtually obliterated any purpose-built mental health facilities realised for the newly founded NHS. To date, there is no comprehensive survey of this period, nor has it been established how many commissions there were under the 'mental million' scheme, or how many were actually realised or survive. Recent studies have started highlighting the persistence of large institutions and inviting a closer inspection of reforms that were taking place within them, both in terms of care practices and as regards the adaptation of existing building fabric and furnishings.[19] This study maintains that this should also apply to new environments that were purpose-designed within the grounds of existing mental hospitals.

Building activity directly linked to the funding of the mid-1950s mentioned above can be identified in a small number of articles in the architectural press.[20] A few Admission Units can be traced in the architectural press originating both during the Second World War[21] and in the early post-war period, the latter including the two chosen case studies here. Yet systematic studies of post-war English architecture hardly mention design interventions relating to mental healthcare during the post-war period. Elain Harwood's 2015 *Space, Hope and Brutalism: English architecture, 1945–1975* touches upon the topic of post-war mental health facilities by identifying the Oxford Regional Hospital Board as 'the most architecturally ambitious' in commissioning and building 'several lightweight acute admissions units in the grounds of its Victorian institutions'.[22] Harwood specifically lists two units for the mentally ill that opened in 1956 – one at Fair Mile Hospital and one at St John's Hospital, that is, the two units already briefly mentioned above in connection to the first two quotes from the architectural press. These were designed by Powell and Moya and by Gollins, Melvin, Ward and Partners respectively. A third unit mentioned by Harwood was designed for the 'mentally handicapped'[23] at Borocourt Hospital, Oxfordshire, again by Powell and Moya, and opened in 1964.[24] All three buildings also featured in the architectural press of the time.[25] This limited recognition remains attached to prominent modernist architects and does not identify any significant developments from earlier asylum typologies, or other architectural or mental health developments.

Other notable studies that have examined realised healthcare buildings in England have either specifically focused on the period up to the introduction of the NHS, or simply omitted the post-war period. For example, an early 1990s survey of realised English hospitals, conducted on behalf of the Royal Commission on the Historical Monuments of England (RCHME), focused on the period 1660–1948.[26] Similarly, a brief 'Listing Selection Guide' by English Heritage (now Historic England) on 'Health and Welfare Buildings' hardly mentions twentieth-century mental healthcare buildings, with a single reference to a particular influence on design in the 1920s in just two sentences.[27] This is despite two substantial new hospitals for the mentally ill being built in the 1930s,[28] and several large new hospitals for the 'mentally handicapped' added considerably later.[29]

Existing studies of early-twentieth-century mental hospitals in other geographical settings have highlighted that generic design devices used broadly by architects can reveal several particularities of mental healthcare architecture when examined with this specific context in mind.[30] A few studies of the post-war period – again in other geographical settings – have focused on the collaboration between mental health professionals and architects, either in terms of direct collaboration for individual projects or in terms of broader research in the field.[31]

The discussion here leaves aside crucial ideological questions about institutions, whether there is such a thing as mental illness, or whether there should be treatments of any sort.[32] Instead, this study is embedded within the current official framework of mental healthcare, which includes spaces for inpatient treatment, and seeks to explore how developments in the two professional areas of architecture and mental healthcare have been informing, and potentially also affecting, each other. As regards the British context, in two earlier papers I have already focused on the first building discussed here, the Admission and Treatment Unit at Fair Mile Hospital. My first paper outlined an introduction to connections between English post-war Admission Units and the broader shift of the earlier areas of madness, custodialism and asylums towards a medical model of mental illness and treatment.[33] In

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my second paper I highlighted critical questions regarding any real or aspired associations between the built environment and mental healthcare.[34] Revisiting Fair Mile here, but this time in parallel with the post-war Admission Unit at Fulbourn Hospital, I aim to underline the multiple nuances both within mental healthcare and in its associations to (mental) healthcare architecture. A number of particularities as regards Fulbourn Hospital, as explained below, promise to make this an especially fruitful addition to my earlier analysis of Fair Mile.[35]

Scope and case studies

Despite the lack of research in this area and the exclusion of post-war buildings from the 1998 summary publication of the RCHME project, several projects similar to the two cases selected here can be identified through the original survey material that is deposited at the Historic England Archive in Swindon, Wiltshire.[36] A scoping exercise at this archive, undertaken by the author, was interrupted by the Covid-19 pandemic in early 2020 but resumed two years later. The files on mental hospitals in this archive consist of numerous mentions, photographic recordings as well as some architectural drawings of structures realised in the post-war period and surviving until the early 1990s when the RCHME survey took place. These not only include a number of Admission Units commissioned in the 1950s and 1960s, but also reveal that a similar building programme had started in the inter-war period: as suggested by a handful of 'admission wards'[37] published in the architectural press in the early 1940s,[38] the RCHME files confirm that numerous new buildings dedicated to new admissions were planned and built in the 1920s and 1930s. It is safe to presume that this building programme was boosted by practice and policy developments that had stressed the importance of early treatment since the 1920s[39] and also led to the Mental Treatment Act of 1930 that legally formalised voluntary admissions. The evidence examined so far firmly suggests that critical medical advances further speared the commission of those new buildings, namely, the introduction of 'physical treatments' in the course of the 1930s (insulin coma therapy and electro-convulsive treatment).[40] The distribution established so far further suggests that this building activity was widespread throughout England.

Although Admission Units were not the only additions, or conversions, within mental hospital sites in the post-war period, their representation in the architectural press as noted above demonstrates that they received higher funds and architectural attention. They were also regarded as playing a particularly critical role in the new direction that mental health was taking: away from custodial care and with a higher emphasis on treatment.

Out of this expanding list of Admission Units, the one at Fair Mile has been chosen as an example that was completed exceptionally early and designed by a very prominent post-war architectural practice that was also to make a significant contribution in post-war hospital design (Figure 1). Its importance is underlined by its presence in the limited existing scholarship in this area, as discussed above, which also offers a good initial knowledge base. The second case study is absent from Harwood's account, yet it did receive considerable coverage in the architectural press, presumably to a degree because of the contribution to its constructional design by leading post-war engineer Felix J. Samuely (Figure 2). Interestingly, Fulbourn also had a substantial inter-war Admission Unit,[41] which appears to have survived to date.[42] What is more, Fulbourn in the post-war period became quite famous for the exceptional contributions to social psychiatry by Dr David H. Clark, who served 'first as Medical Superintendent and then as Senior Consultant of the hospital for thirty years, from 1953 to 1983'.[43]

Admission and Treatment Unit, Fair Mile Hospital, Berkshire (now Oxfordshire) (1956)

Described as an 'Admission and Treatment Unit', and subsequently named the 'George Schuster Hospital', the new building for Fair Mile comprised four wings on a single level, in a cruciform plan. There were two separate single-sex wings with 30 beds for women and 23 beds for men, each one including its own single-sex dining and day rooms, and a third wing comprised a mixed-sex common room.[44] The second component of the building, the 'Treatment Hospital', housed insulin and electro-convulsive therapy (ECT) in the fourth wing and was to be open to inpatients as well as 'the ever-increasing number of out-patients requiring treatment' (Figure 3).[45]

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Figure 1. Admission and Treatment Unit, Fair Mile Hospital, Wallingford, Oxfordshire, corner detail of the common room showing the roof supported on a timber frame, 1956 (Source: Architectural Press Archive / RIBA Collections, RIBA Ref No: RIBA56471)

Figure 2. Post-war Admission Villa, Fulbourn Hospital, Cambridgeshire, front elevation, 1964 (Source: 'Photographs taken at the opening of Kent House by Princess Marina, Duchess of Kent, 1964', KHF/6/1/15, Cambridgeshire Archive Services, Ely, Cambridgeshire, UK)

As a particularly early post-war project, the design featured use of modest building materials and simple building techniques. Rather than constructional innovation, therefore, noteworthy here are the obvious distancing – physical and stylistic – from the main hospital. Also evident, is the influence on issues such as ward sizes and layouts, and interior lighting elements[46] of the landmark study on hospitals by the Division for Architectural Studies of the Nuffield Provincial Hospitals Trust, titled *Studies in the Functions and Design of Hospitals: report of an investigation* and published in 1955.[47]

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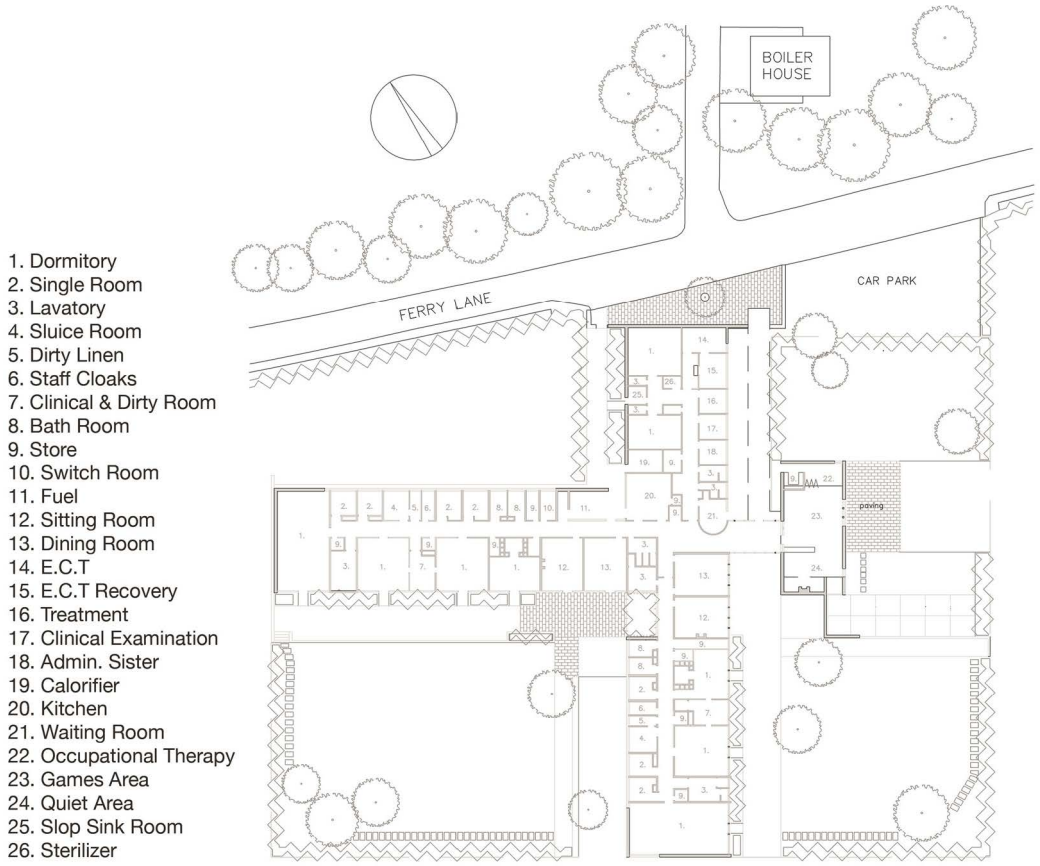
Figure 3. Admission and Treatment Unit, Fair Mile Hospital, Wallingford, Oxfordshire, floor plan, 1956 (Source: plan redrawn by Alex Wood)



Admission Villa, Fulbourn Hospital, Cambridgeshire (1964)

Named 'Kent House', the 'Admission Villa' at Fulbourn Hospital opened in 1964. That is, it was completed almost a decade later than the Unit at Fair Mile, and following the launch of the 1959 Mental Health Act and the publication of the 1962 *Hospital Plan for England and Wales*. Similar to the Unit at Fair Mile, it was designed to provide short-term psychiatric treatment, as well as residential accommodation. It could house 95 patients in four wards comprising single rooms, and four- and ten-bed wards in a two-storey linear block (42 beds for male patients, 51 beds for female patients, and two beds for either sex). This block intersected the bottom section of the 'leg' of a 'T'-shaped single-storey block that accommodated recreation and occupational therapy sections, whereas the 'head' of the 'T' accommodated administrative and treatment areas, with the dining hall and entrance areas occupying the link between those two parts (Figure 4).[48]

Chronologically more distanced from the building material shortages that had followed the Second World War,[49] this unit demonstrates more advanced constructional techniques as well as a consideration for future-proofing. For example, the designers anticipated further evolution of treatments: 'While the treatment area is at present subdivided into a special sequence of rooms it will be possible to re-arrange this in the future should the treatment system change.'[50]

Such functional flexibility was strongly supported by constructional solutions like 'the roof span[ning] clear over the whole area and rooflights, constructed on a modules system, provid[ing] daylight to the central areas'.[51] There were also special arrangements for the external appearance of the building that complemented the *in situ* reinforced concrete frame with ribbed precast concrete panels:[52] 'The outer wall cladding units and windows can be rearranged to suit the requirements of modifications to the rooms.'[53]

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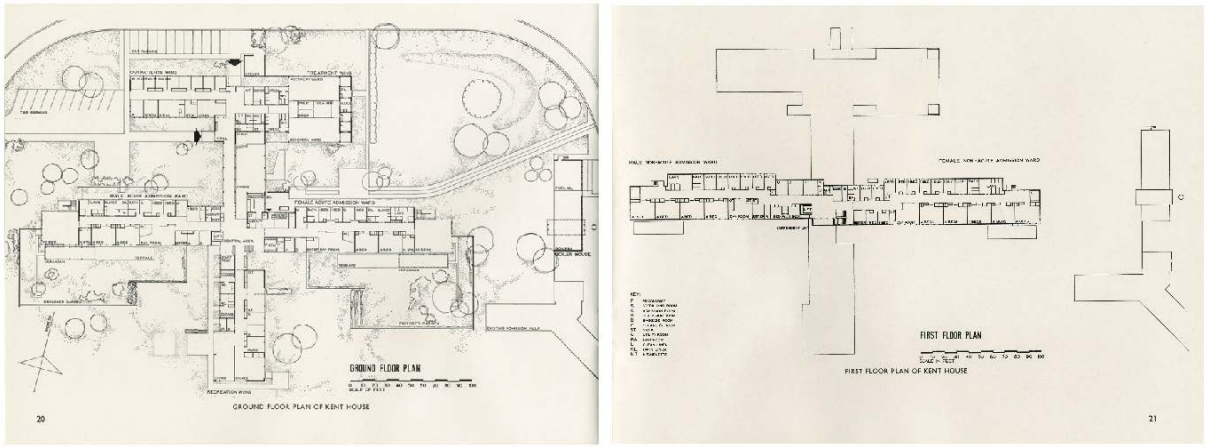
Figure 4. Post-war Admission Villa, Fulbourn Hospital, Cambridge, Cambridgeshire, floor plans, 1964 (Source: 'Programme for the opening of Kent House new admission unit, 1964', pp. 20–1, KHF/6/2/9, Cambridgeshire Archive Services, Ely, Cambridgeshire, UK)



Similarities and differences

Although different in size and times of completion, the two units bear significant similarities too: both buildings embrace a largely cruciform layout, which allowed the separation of male and female wards and their further separation from shared social and treatment facilities. They also allowed relatively short distances to reach those shared facilities as well as the provision of single-sex external spaces accessible directly from the wards (Figure 5), and the creation of well-lit and well-ventilated wings rather than deep floor plans. At Fair Mile, the cruciform plan includes the treatment wing, which was for outpatients too, whereas in the larger Kent House, the treatment wing is effectively an added element transforming the fourth wing of the cruciform plan (the one that housed a mixed-sex dining room) into a T-shaped wing.

The list of spaces included in each unit also presents close similarities: wards are of a similar size, both buildings include specialist treatment rooms that could also receive outpatients, as well as mixed-sex spaces that were used for social activities and occupational therapy (Figure 6). As regards catering, both buildings relied on the main kitchen of the hospital, although their floor plans also include small kitchens, with the one for Kent House specifically labelled as designated for 'patients' cooking' (Figures 3 and 4).

The respective siting of the two units is one of the most noticeable differences between the two cases: as already discussed elsewhere,[54] the Admission Unit at Fair Mile was distinctly located away from the main hospital and the two buildings were visually separated too. Conversely, at Fulbourn the new building was adjacent to the earlier inter-war Admission Unit, which in turn was also in close proximity to the original building of the hospital (Figures 7 and 8).[55] Another notable difference is the addition of a second floor at Fulbourn, an approach that was subsequently criticised by some of the nursing staff.[56] As mentioned above, the two buildings' construction was also quite dissimilar. Although the shift to more adventurous constructional methods was to be expected to a degree, as post-war material shortages were being overcome, a considerably greater investment in the actual construction of the building is evident at Fulbourn. Their consultant engineers Felix J. Samuely, one of the most influential engineers as regards English architectural modernism, and the connection of standardisation and pre-fabrication to functional flexibility and adaptability suggests a transition to a later phase of post-war hospital design that engaged with fast construction and future-proofing by enabling expansion or modifications as required.[57]

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Figure 5. Admission and Treatment Unit, Fair Mile Hospital, Wallingford, Oxfordshire, the south side of the female ward wing, 1956 (Source: Architectural Press Archive/RIBA Collections, RIBA Ref No: RIBA56473)

Figure 6. Admission and Treatment Unit, Fair Mile Hospital, Wallingford, Oxfordshire, common room, *c.* 1959 (Source: 'Into the Light', Fair Mile Hospital staff recruitment booklet, 1959, P/HA2/5/1, Berkshire Record Office, Reading, Berkshire, UK)

George Schuster Hospital, Patients' Common Room.

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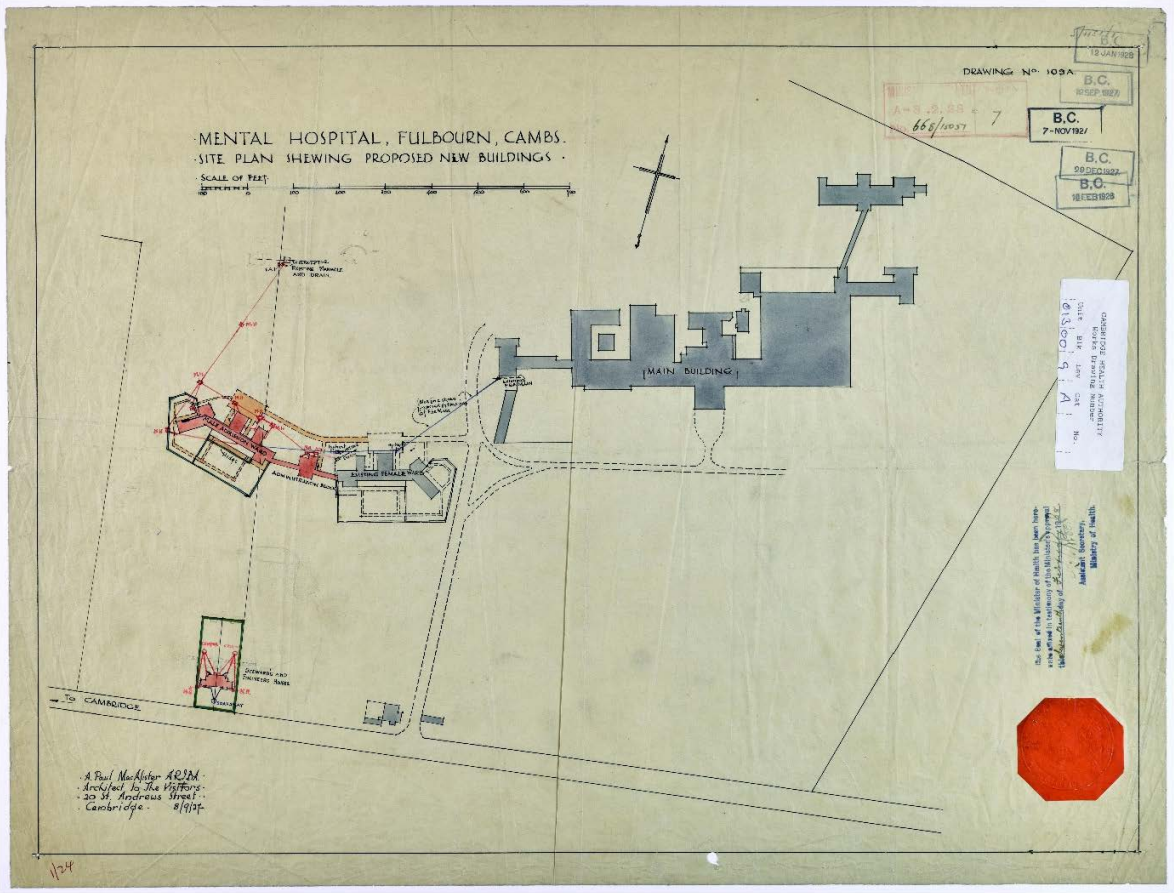
Figure 7. Inter-war Admission Wards, Fulbourn Hospital, Cambridgeshire, site plan, 1927 (Source: 'Plans of new admission wards', 'Site Plan Shewing [*sic*] Proposed New Buildings' [incl. Administration Block and new Male Admission Ward, as added to Existing Female Ward], 1927, KHF/5/1/11, Cambridgeshire Archive Services, Ely, Cambridgeshire, UK)



Nuffield Provisional Hospitals Trust, *Studies in the Functions and Design of Hospitals* (1955)

Most of the considerations discussed above can be easily linked to evolving practices in mental healthcare, such as the separation of early admissions from long-term patients or the increasing number of outpatients. Even when some points appear to be internal, possibly even insular, professional considerations of built environment professionals – for example, construction – there too one can trace connections to the fast-evolving field of mental healthcare as reflected in the aim to enable flexibility in the new building at Fulbourn. Similarly, although one might initially consider the adoption of a modernist approach to the appearance of the two buildings to be a purely architectural consideration with no connection to healthcare practices, visually matching modern approaches to mental health can be seen as a further step towards parity between mental and physical healthcare through the symbolic elevation of mental healthcare as an area worthy of attention and investment.

Beyond such general points, however, it is important to explore how specific guidance for specialist psychiatric spaces evolved in the post-war period, as was requested by the 1959 article in the *Architects' Journal*. As discussed elsewhere, there is evidence that the design of the Admission Unit at Fair Mile was influenced by the 1955 Nuffield report *Studies in the Functions and Design of Hospitals*.[58] The report was the principal outcome of research launched in 1949 by the Nuffield Provincial Hospitals Trust, with the

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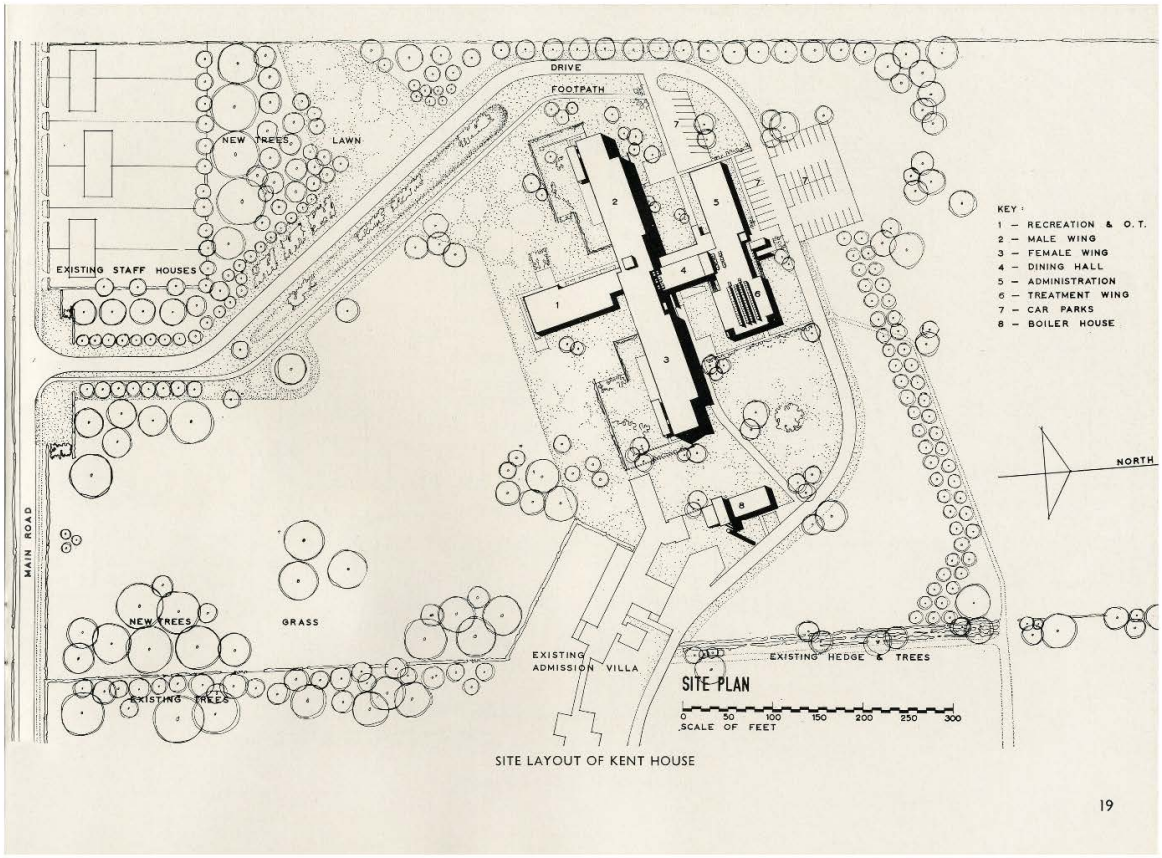
co-operation of the University of Bristol, and conducted by the Trust's Division for Architectural Studies, under the direction of Richard Llewelyn Davies and a multi-disciplinary team.[59]

Figure 8. Post-war Admission Villa, Fulbourn Hospital, Cambridgeshire, site plan, 1964 (Source: 'Programme for the opening of Kent House new admission unit, 1964', p. 19, KHF/6/2/9, Cambridgeshire Archive Services, Ely, Cambridgeshire, UK)



Among other points, the influence of the Nuffield study at Fair Mile includes the design of four- and six-bed wards (as well as ten-bed dormitories and single rooms).[60] This influence is particularly interesting as the report had been based on research conducted specifically on general hospitals and explicitly excluding mental hospitals. Some blurring between the two areas of mental and physical health, and related hospital guidance, could be seen as understandable in a period when the aim to achieve parity was at the forefront.[61] What is more, though, this same aim may have actually served as intentional motivation for embracing general hospital guidelines, rather than an oversight or a compromise, despite the parallel awareness that more specific guidance was also required.[62]

Considering the above, it is particularly noteworthy that the wards at Fulbourn also largely adopted the same layouts as those at Fair Mile. Remarkably, six-bed wards are missing here, but the single rooms, and four- and ten-bed wards match the pattern followed at Fair Mile.[63] Although completed in 1964, the 'Admission Villa' at Fulbourn Hospital was actually planned in 1957–8,[64] that is, not much later than the unit for Fair Mile. With this fact in mind, all the similarities listed above suggest the very likely influence from the Nuffield study of 1955, despite the completion of the building being after the publication of a report by the World Health Organization (WHO) that was published in 1959 and focused specifically on *Psychiatric Services and Architecture*.[65] A closer look at similarities and differences between the two documents and how these correspond to the realised designs of the two buildings is particularly rewarding. This comparison helps reveal critical elements distinguishing the medical emphasis followed in physical health models (but also of physical treatments adopted within mental healthcare) from the increasing emphasis on the psychosocial approach to mental health.

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Alex Baker, Richard Llewelyn Davies and Paul Sivadon, *Psychiatric Services and Architecture* (World Health Organization, 1959)

Published in 1959 to provide international guidance on the topic, the report on *Psychiatric Services and Architecture* appeared the same year that in England the 1959 Mental Health Act received royal assent (on 29 July). One can presume that it was in response to at least one, if not both, of these events that, two and a half months later, the *Architects' Journal* raised the pressing issue of specialist guidance for architects designing mental healthcare facilities, as mentioned in the Introduction above. What is more, the WHO report did not introduce completely new guidance as far as English architectural designers were concerned. The three leading persons behind the report involved one architect and two psychiatrists, the former being Richard Llewelyn Davies, the Director of the Division for Architectural Studies of the Nuffield Trust and therefore the same person that had led the 1955 Nuffield report *Studies in the Functions and Design of Hospitals*, too. The two named psychiatrists were the French Paul Sivadon and the British Alex Baker, but a larger team is acknowledged as having contributed: 'Twenty-nine psychiatrists from thirteen countries and four architects from three countries further commented on the first draft.'[66] Although no direct associations have been traced between this WHO report and the design of the two case studies here, it is fairly safe to assume that the study became well known to British architects practicing in the field of mental healthcare architecture, especially when considering Llewelyn Davies's leading role. What is more, comparing early design principles adopted in the two case studies to such a prominent international specialist publication is a worthwhile exercise in its own right in order to trace the principal directions in the field.

Although various points in this report that are largely representative of its time can be seen as highly problematic from our contemporary perspective,[67] the WHO report does document specific attempts to address architectural questions relating to psychiatry. It therefore further supports the position held here of the need to study the relationship between designed environments and mental healthcare in the post-war period. Dating the establishment of the principles that 'should govern the structure and function of psychiatric hospitals' as early as 1952,[68] the report sums up those principal requirements set out by the WHO Expert Committee on Mental Health as 'a strong therapeutic atmosphere' and a 'close liaison with the surrounding community'.[69] Taking into consideration further developments between 1952 and its preparation in the autumn of 1957, the report expanded beyond the psychiatric hospital to related services, such as 'out-patient departments, psychiatric wards in general hospitals, rehabilitation facilities, and other mental health services'.[70] In actual fact, no admission units are discussed in the WHO report and, interestingly, there is a strong recommendation against their use.[71] The type of facilities in the WHO report that are the closest to admission units and treatment centres, as documented in the two case studies here, are the 'out-patient clinic and early treatment centre' that were presented first in the WHO report and 'taken together as their functions overlap'.[72]

The opening paragraph of the main body of the report is particularly enlightening, as, not only does it specify the 'social' turn within psychiatry, but it also gives architecture a key role precisely within this psychosocial context:

> Architecture is an important part of man's environment and he creates it for himself. Buildings not only provide an immediate solution for his needs, but also reflect his culture and aspirations. In most cultures, buildings last more than one generation and therefore the architecture of one generation will affect the next. During recent decades, psychiatry has become more concerned with the influence of social factors on psychiatric patients, and among social factors architecture must be included. In this report we are concerned with the buildings and facilities that psychiatry needs if it is to treat patients successfully.[73]

It is in this context that the most notable difference between the Nuffield study and the WHO report can be discerned and this is not related to the optimum number of beds recommended, but to the rationale behind those sizes and to the actual layout and furnishings recommended. That is, the WHO report also recommended the range of four to eight beds as the best range, and specifically outlined examples of six-bed wards. However, the rationale behind the number of beds does not originate here on nursing requirements and efficiency, nor on natural lighting and the avoidance of glare as can be seen in the Nuffield report.[74] Instead, the rationale for the WHO report is very strongly based on the social element

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of the role of architecture: the specific examples provided in the WHO report promote a six-bed ward as a recommended size (in addition to single rooms), primarily based on the social dynamics for various group sizes considered in relation to psychotic patients.[75] Before it was reiterated in the discussion of patient spaces,[76] the significance of social dynamics was first introduced in terms of staff groups as follows: each therapeutic group, comprising doctors, social aides, nurses and so on 'should form a social field in the sense of Lewin's definition, that any individual in the group can influence the whole, and the whole will influence all the individuals.'[77]

What is more, the WHO report stresses the distinction between mental and physical healthcare requirements and specifically stipulates the need for some private space for each patient that extends beyond the limited scope of a bed. With this in mind, recommended ward furniture per patient includes a wardrobe as well as a desk for every one or two patients.[78] These are also used to subdivide wards into individual cubicles, that is, they served as dividers for additional privacy, as clearly stressed both in the text and the illustrations of the report and markedly distinct from only the small bedside cupboard and curtain provided in the two buildings studied here. The report also specifically presents alternatively arranged wards, encouraging the possibility of flexibility in furniture arrangements, and recommends windows in more than one wall. Although the floor plans presented in the WHO report are not very clear as regards the nature of the beds recommended, photographs of the wards at Fair Mile and Fulbourn clearly depict strongly recognisable metal hospital beds (Figure 9).

Figure 9. Post-war Admission Villa, Fulbourn Hospital, Cambridgeshire, ward, 1964 (Source: 'Photographs taken at the opening of Kent House by Princess Marina, Duchess of Kent, 1964', KHF/6/1/15, Cambridgeshire Archive Services, Ely, Cambridgeshire, UK)

Department of Health and Social Security (England), *Hospital Building Notes* series (1961–1966)

Further guidance specifically for the English context was to follow from 1961 onwards when the Department of Health and Social Security started publishing a number of specialist guidance notes on psychiatric facilities as part of its series of *Hospital Building Notes* (*HBN*). These comprised five separate issues: No. 5, on 'Short Stay Psychiatric Unit' (1961); No. 30, on 'Accommodation for Psychiatric Patients' (1963); No. 31, on 'Psychiatric Ward Type 1' (1964); No. 32, on 'Psychiatric Ward Type 2 and Pre-Discharge

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(Hostel Type) Ward' (1964); and No. 33, on 'Rehabilitation Centre for Psychiatric Patients' (1966). Similar to the WHO report, no direct associations have been traced between the *HBN* and the design of the two case studies here. However, here again, comparing early design principles adopted in the two case studies to new specialist guidance that was soon to follow within England is a worthwhile exercise in its own right if we are to throw light to the direction of travel in the field.

These guides broadly embraced the recommendations of the 1959 WHO report in terms of the general classification of psychiatric facilities and their siting closer to population centres, as well as general recommendations as regards the organisation of psychiatric services. These included the need to have teams responsible for a complete cross-section of patients, at different stages of care or in different care settings for a number of reasons, including training, appropriate care of long-term patients and continuity of care.[79] However, two differences are worth noting in relation to the discussion here. These relate primarily to the fact that the *HBN* series focused on hospital accommodation, with less emphasis on community services: first, the closest to what WHO had classified as 'out-patient clinics and early treatment centres' becomes in the *HBN* series 'short-stay psychiatric wards' that are incorporated in general hospitals;[80] and, second, the range of mental healthcare facilities in the *HBN* series diverts from the range discussed in the WHO report.[81]

Closest to the discussion here is therefore *HBN* No. 5 (1961), which, interestingly, adopts the recommendation for ideal groupings of four or six patients in wards (as well as single-bed rooms) and in dining tables,[82] albeit with a more flexible approach as regards the actual furnishings of the wards. What is more, a clear distinction can be seen here in comparison to general hospital wards as outlined in *HBN* No. 4 (*c.* 1961, rev. 1968), where there is simply a recommendation for a small sitting area within the bed space for appropriate groups of patients who would be able to use these, with separate day spaces for other activities.[83] By contrast, in *HBN* No. 5, there is substantially more emphasis in providing personal storage furniture (wardrobes), which is also seen as having the potential to provide more privacy by creating individual cubicles (or alternatively by using screens), as well as a bedside locker and a chair by each bed. Yet the guidance holds back from recommending a desk per one or two patients as essential, although it does mention the possibility of a small table.[84] Interestingly, separate day rooms for each sex and a general sitting room for mixed-sex use are also recommended,[85] as already applied in the Admission Unit at Fair Mile by 1956 and at Fulbourn by 1964, and in the latter we can also see a mixed-sex dining room too, as also recommended in *HBN* No. 5 (Figures 6 and 10).

Figure 10. Post-war Admission Villa, Fulbourn Hospital, Cambridgeshire, dining room, 1964 (Source: 'Photographs taken at the opening of Kent House by Princess Marina, Duchess of Kent, 1964', KHF/6/1/15, Cambridgeshire Archive Services, Ely, Cambridgeshire, UK)

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Concluding remarks

The analysis above touches upon only a handful of the issues around mental healthcare in the post-war period and their association to inpatient spaces. Out of the continuously expanding range of available treatments, whether following biological or psychosocial models, there is open reference to two types of physical treatments only, whereas there is vague mention only of the broader significance of social connections but no specific remarks on non-biological treatments such as psychotherapy, or rehabilitation therapies. Even with such a narrow sample of this multifaceted field, the potential but also additional complexities emerging from the field of architecture become apparent.

Although the particular requirements for insulin coma and ECT can become immediately visible to the non-expert eye, other specialist uses can be less fixed, or missed or misinterpreted, without additional evidence. Indeed, such lack of evidence allows very limited scope for accurate interpretation of influences that fed into the design of the two buildings discussed here, or their subsequent use. Some answers to the latter issues come from administrative papers by the hospitals, their management committees, and regulating bodies, as well as publications by mental health professionals. Limited information from administrative papers for Fair Mile, for example, reveal a range of uses accommodated in the Admission Unit during the course of its lifetime, beyond its original programme: it was temporarily used as a geriatric unit and even housed a therapeutic community from 1967 until 1975.[86] Architectural scholarship also reveals some partial clues only as regards influences during its design. Similarly, the extensive writings by Clark and scholars studying the history of Fulbourn reveal the enthusiastic embrace of the new building as the new base for progressive mental healthcare practices, yet they also reveal the expansion of such practices to the 'back wards' for rehabilitation and geriatric patients for which they had not been specially designed.[87]

The two cases analysed here, their new readings through partial exploration of available sources, the numerous similar post-war buildings identified to date and, finally, the current landscape as regards mental health inpatient units, all support the position that this is a very fertile and topical field for further research. Developments in the field of mental healthcare architecture during the course of the twentieth century can be seen to continue to date, despite some noticeable shifts in contemporary space planning practices (such as the definitive siting of Mental Health Acute Units closer to the communities they serve, or the marked shift to predominantly single en suite bedrooms). For example, the emphasis on single-level buildings[88] and outdoor recreation spaces continues to be highly valued, or more broadly, the emphasis on social aspects of mental healthcare environments persists to date. Seen therefore from our contemporary perspective, when the necessity of specialist mental health inpatient units has been widely adopted, the crucial gap in architectural historiography as well as the potential value of such research for contemporary practices become evident, in parallel to the imperative need for close consideration of critical changes in actual therapies or care practices. What is more, both the WHO report and the later *HBN* series made special references to the need and potential of building re-use, a particularly topical issue at present as linked both to financial constraints and to sustainability, and therefore invite further historical study of any surviving post-war specialist buildings with a view to their potential adaptive re-use.

Notes

[1]For example: Anonymous, 'Courtyard cultivates a sense of calm'; Anonymous, 'Environmental healing'; Malathouni and Khairi, 'Repurposing heritage buildings'; Anonymous, 'Construction starts'.

[2]For example: McCuskey Shepley and Pasha, *Design for Mental and Behavioral Health*; Verderber, *Innovations*.

[3]Hess and Majerus, 'Writing the history of psychiatry'.

[4]Jones, *Asylums and After*; Chrysikou, *Architecture for Psychiatric Environments*.

[5]Anonymous, 'Admission Unit at the Fairmile Hospital', 385.

[6]Anonymous, 'Hospital, Cambridge', 967.

[7]Anonymous, 'Hospital Extension', 362. This increasing realisation that there could be a correlation between distinctive characteristics of mental illness and associated care facilities was also strongly reflected in a 1961 memorandum of the Scottish Home and Health Department (Long, '"Heading up a blind alley"?', 118).

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[8]Rivett, *From Cradle to Grave*.
[9]Rivett, *From Cradle to Grave*; United Kingdom, Ministry of Health, *National Health Service: Regional Hospital Boards*, §1; United Kingdom, Ministry of Health, *National Health Service: The Development of Specialist Services*, §62.
[10]United Kingdom, Ministry of Health, *A Hospital Plan*.
[11]Harwood, *Space, Hope and Brutalism*, 283; Jones, *Asylums and After*, 143–4.
[12]Hughes, 'The Brutal Hospital', 39.
[13]Hughes, 'The Brutal Hospital', 41.
[14]'Admission Units', or 'Admission Villas', were primarily designed to accommodate newly admitted patients for assessment. They had started being widely introduced as separate buildings within mental hospital grounds from the inter-war period (although earlier examples have also been identified) and were effectively replacing 'admission wards' that used to be incorporated in the main mental hospital building.
[15]Kritsotaki, Long and Smith, eds., *Deinstitutionalisation and After*.
[16]For example: Scull, *Museums of Madness*; Topp, Moran and Andrews, eds., *Madness, Architecture and the Built Environment*.
[17]For example, Richardson, ed., *English Hospitals 1660–1948*; Taylor, *Hospital and Asylum Architecture*.
[18]For example, Soanes, 'Rest and Restitution'; Topp, *Freedom and the Cage*.
[19]Long, '"Heading up a blind alley"?'. See also Megan Brien's doctoral study of the psychiatric hospital interior in twentieth-century Ireland, funded by the Irish Research Council (Trinity College Dublin, University of Dublin, Ireland; in progress).
[20]For example: Anonymous, 'New Admission Unit'.
[21]For example: Anonymous, 'Asylum hospital [by Walter Alison]'.
[22]Harwood, *Space, Hope and Brutalism*, 283.
[23]The terminology relating to what is currently usually referred to as 'learning disabilities' varies during the long period examined here and includes terms such as 'mentally deficient', 'mentally defective', 'mentally subnormal' and 'mentally handicapped'.
[24]Harwood, *Space, Hope and Brutalism*, 283–4. The two buildings by Powell and Moya also feature in Powell, *Powell and Moya*, 87–98.
[25]See: Anonymous, 'Fair Mile Hospital'; Anonymous, 'Admission Unit'; Anonymous, 'Admission Unit at the Fairmile Hospital'; Anonymous, 'New Admission Unit'; Anonymous, 'St John's Hospital, Stone'; Anonymous, 'Hospital extension'; Anonymous, 'Sick and admission unit'.
[26]Richardson, *English Hospitals 1660–1948*.
[27]English Heritage, *Health and Welfare Buildings*.
[28]Jones, *Asylums and After*, 138.
[29]See, for example, the Ida Darwin Hospital, near Cambridge (adjacent to the second case study examined here, Fulbourn Hospital), and Fieldhead Hospital, in Wakefield, Yorkshire (designed by Yorke, Rosenberg and Mardall), that opened in 1970 and 1972 respectively. (See: 'Programme for the opening of Ida Darwin Hospital' (1970), KHF/6/2/13, Cambridgeshire Archives, Ely, Cambridgeshire, UK [hereafter: CA]; and 'Fieldhead at 50', South West Yorkshire Partnership NHS Foundation Trust, accessed 31 July 2022, https://www.southwestyorkshire.nhs.uk/2022/07/11/fieldhead-at-50/.)
[30]Topp, *Freedom and the Cage*.
[31]Published scholarship to date includes studies in relation to 1950s and 1960s work in Saskatchewan, Canada (Dyck, 'Spaced-out in Saskatchewan'), in 1960s France, in relation to Nicole Sonolet's work as well as the research collective CERFI – Centre d'Études, de Recherches et de Formations Institutionelles, or Centre for Institutional Studies, Research and Training (TenHoor, 'State funded militant infrastructure?), and in the United States in the 1960s, in relation to Community Mental Health Centers (Knoblauch, *The Architecture of Good Behavior*, chapter 2).
[32]See, for example, Jones's summary of the 'ideological attack' on 'asylums', 'mental illness', and 'madness' that took place in 1961, as exemplified by studies such as Erving Goffman's *Asylums*, Thomas Szasz's *The Myth of Mental Illness* and Michel Foucault's *Madness and Civilization* (Jones, *Asylums and After*, chapter 10).
[33]Malathouni, 'Beyond the asylum'.
[34]Malathouni, '"The general atmosphere of this admission unit"'.
[35]Malathouni, 'Beyond the asylum'; and Malathouni, '"The general atmosphere of this admission unit"'.

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[36]'Hospitals Project', RCH01/008, Historic England Archive, Swindon, Wiltshire, UK [hereafter: HEA].
[37]Although several new buildings, separate from the main hospital buildings, were introduced for the accommodation of new admissions to mental hospitals in the inter-war period and the early 1940s, the use of the term 'Admission Wards', rather than 'Villas' or 'Units', was still quite widespread during this period.
[38]For example: Anonymous, 'Asylum hospital [by Walter Alison]'.
[39]Richardson, *English Hospitals 1660–1948*, 180.
[40]Specialist wings for physical treatments, such as ECT and insulin coma therapy, were often combined with new admissions accommodation and aimed to provide treatment to new admissions, existing inpatients, and outpatients.
[41]'Plans of nurses' and superintendent's and other staff accommodation', KHF: KHF/5/1/10, CA; 'Plans of new admission wards', KHF/5/1/11, CA; and 'Fulbourn Hospital, Cambridgeshire,' RCH01/008: National Building Record Index Number 100241, HEA.
[42]The building appears to be currently used for the Forensic Psychiatry Service. See Elizabeth House, Fulbourn Hospital, Cambridgeshire and Peterborough NHS Foundation Trust, Cambridge CB21 5EF, United Kingdom, Google Maps, https://goo.gl/maps/E6SE3VnQhkdvWewr7. Accessed 31 July 2022.
[43]Clark, *Story of a Mental Hospital*, xii.
[44]Anonymous, 'Admission Unit at the Fairmile Hospital', 388.
[45]Anonymous, 'Admission Unit at the Fairmile Hospital', 394. The introduction of these treatments to Fair Mile pre-dated the new unit. ECT was introduced by 1951 ('General Nursing Council for England and Wales: Education, Hospital Inspectors' Reports and Papers', 8 March 1951, p. 4, DT33/1243, The National Archives, Kew, Richmond, UK [hereafter TNA]) and Insulin Coma Therapy by 1954 ('General Nursing Council for England and Wales: Education, Hospital Inspectors' Reports and Papers', 8 July 1954, p. 5, DT 33/1243, TNA).
[46]For a more extensive discussion of this connection, see Malathouni, '"The general atmosphere of this admission unit"'.
[47]Nuffield Provincial Hospitals Trust and the University of Bristol [hereafter: NPHT], *Studies in the Functions and Design of Hospitals*.
[48]Anonymous, 'Precast framework at Cambridge hospital building', 32; Anonymous, 'Hospital, Cambridge'.
[49]See Harwood, *Space, Hope and Brutalism*.
[50]Anonymous, 'Hospital, Cambridge', 970.
[51]Anonymous, 'Hospital, Cambridge', 970.
[52]Anonymous, 'Precast framework at Cambridge hospital building', 32; Anonymous, 'Hospital, Cambridge', 971.
[53]Anonymous, 'Hospital, Cambridge', 970.
[54]Malathouni, '"The general atmosphere of this admission unit"'.
[55]Further research is required here to be able to determine whether such a proximity was dictated by site limitations or other design or operational reasons.
[56]Adams, '"Challenge and Change in a Cinderella Service"'.
[57]Hughes, 'The Brutal Hospital'. Although such a trend is not evident in the Admission Unit at Fair Mile, it is particularly noteworthy that the Oxford Regional Hospital Board went on to develop its own 'steel-framed system for building quickly and economically – the "Oxford method"' (Harwood, *Space, Hope and Brutalism*, 292–3).
[58]Malathouni, '"The general atmosphere of this admission unit"'.
[59]The Nuffield Trust had been founded in 1939 by Lord Nuffield to promote the coordination of hospital and ancillary services in the provinces, as a provincial equivalent of the King Edward's Hospital Fund for London (McLachlan, *A History*, 9).
[60]Malathouni, '"The general atmosphere of this admission unit"'.
[61]For example, Anonymous, 'Future organization of the psychiatric services'.
[62]See fuller discussion in Malathouni, '"The general atmosphere of this admission unit"'.
[63]The Nuffield report especially promoted four- and six-bed wards, as tested at Musgrave Park Hospital, in Belfast, Northern Ireland, but placed particular emphasis on the potential of six-bed wards as a more compact planning solution that was common in continental Europe but so far received with scepticism in Britain (NPHT, *Studies in the Functions and Design of Hospitals*, xix and 30).
[64]'Programme for the opening of Kent House new admission unit' (1964), p. 3, KHF/6/2/9, CA.

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[65]Baker, Llewelyn Davies and Sivadon, *Psychiatric Services*.
[66]Baker et al., *Psychiatric Services*, 8. Note also the 'disclaimer' in the concluding paragraph of the Preface: 'It must be stressed that the opinions expressed do not necessarily represent the policy of the World Health Organization in this matter'. (8)
[67]For example, the leading team was restricted to three men from two European countries. In addition, although the main content of the report positively cites precedents from non-Western countries, for example, a mental hospital in Nigeria (Baker et al., *Psychiatric Services*, 12) or Soviet psychiatry (Baker et al., *Psychiatric Services*, 17), the section about 'tropical countries' reveals a strongly imbalanced outlook that presents temperate climate countries as the norm in comparison to which tropical conditions are effectively presented as 'the Other'. See, for example: 'In tropical countries, "gardens" replace the day rooms described for more temperate climates, and many of the social centre's facilities will be in the open air' (Baker et al., *Psychiatric Services*, 58). What is more, the language of the report is strongly gendered: male pronouns are used as the standard for patients, with limited exceptions when there is a 'need' for a specific reference to female patients, perceived as such in relation to the 'interior decoration of their living rooms' or a woman's role as a 'mother' (Baker et al., *Psychiatric Services*, 29 and 32). Similarly, with regard to professionals, a 'hostess' that is recommended as good practice upon the arrival of a patient at an outpatient clinic is suddenly specified as female (Baker et al., *Psychiatric Services*, 19 and 50).
[68]Baker et al., *Psychiatric Services*, 7.
[69]Baker et al., *Psychiatric Services*, 7.
[70]Baker et al., *Psychiatric Services*, 7–8.
[71]'Special admission units should be avoided. The building should be arranged so that the patient can be admitted and looked after by one person, preferably the nurse, who, acting as hostess, arranges his admission to the ward, escorts him to his bed, and explains the function of the ward' (Baker et al., *Psychiatric Services*, 50).
[72]Baker et al., *Psychiatric Services*, 19. In fact, 'early treatment units' are not addressed separately. These are considered to be simply outpatient clinics that also include some beds when these are deemed necessary due to their location far from a mental hospital.
[73]Baker et al., *Psychiatric Services*, 9.
[74]NPHT, *Studies in the Functions and Design of Hospitals*, 91–9 and figures 12, 76, 79–81, 83.
[75]Baker et al., *Psychiatric Services*, 25 and figures 1 and 2, 4–6.
[76]Baker et al., *Psychiatric Services*, 24.
[77]Baker et al., *Psychiatric Services*, 16.
[78]Baker et al., *Psychiatric Services*, figures 4 and 5.
[79]*HBN* No. 30, 1963, §7.
[80]*HBN* No. 5, 1961.
[81]An overview of mental healthcare facilities is included in *HBN* No. 30, which 'gives general advice on the planning of hospital accommodation for psychiatric patients' (*HBN* No. 30, 1963, §1), referring to 'patients suffering from all forms of mental disorder', i.e. both 'mentally ill' and 'mentally subnormal' (*HBN* No. 30, 1963, §2). These notes also address the practical need to consider siting accommodation for psychiatric patients in or adjacent to existing sites of district general or psychiatric hospitals, as well as the adaptation of existing buildings (*HBN* No. 30, 1963, §§10, 37.ii). The subsequent three volumes of the series also focused on spaces linked to psychiatry but diverted from the discussion here: *HBN* No. 31 (1964) and *HBN* No. 32 (1964) focused on two types of wards for the mentally subnormal, whereas *HBN* No. 33 (1966) discussed a *Rehabilitation Centre for Psychiatric Patients*. By the time *HBN* No. 30 was published in 1963, the need to have Note No. 5 revised is also noted, so as to address 'out-patient and day patient facilities for the mentally ill, and also for suitably sited short-stay beds' (*HBN* No. 30, 1963, §§35, 41). 'Separate (self-contained) psychiatric hospitals' were to continue existing for 'mentally subnormal' patients adopting 'a general layout comparable to that of a compact village or urban neighbourhood' (*HBN* No. 30, 1963, §42).
[82]*HBN* No. 4 also specified the size of multi-bed wards for general hospitals as being recommended between four and eight beds, and ideally six beds, on the basis of the social potential of such group sizes for variety of company and companionship (*HBN* No. 4, 1968, §4(a)(a)(ii)(4)).
[83]*HBN* No. 4, 1968, §§38(a)(a)(ii), 38(b).
[84]*HBN* No. 5, 1961, Section IV. §A(e)(ii).
[85]*HBN* No. 5, 1961, Section IV. §§A(d)(i), A(d)(iii).

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[86]'National Health Service Health Advisory Service: Reports and Papers', October 1971, p. 4, BN37/34, TNA; Wheeler, *Fair Mile*, 69. For a more comprehensive discussion of the building's history and further analysis of its design, see: Malathouni, 'Beyond the asylum'; and Malathouni, '"The general atmosphere of this admission unit"'.
[87]Adams, 'Challenge and Change in a Cinderella Service', 236–7.
[88]Some two-level examples have started emerging too. See, for example: Graham, 'New multi-level facility'.

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