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Compassionate containment? Balancing technical safety and therapy in the design of psychiatric wards

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ABSTRACT

This paper contributes to the international literature examining design of inpatient settings for mental health care. Theoretically, it elaborates the connections between conceptual frameworks from different strands of literature relating to therapeutic landscapes, social control and the social construction of risk. It does so through a discussion of the substantive example of research to evaluate the design of a purpose built inpatient psychiatric health care facility, opened in 2010 as part of the National Health Service (NHS) in England. Findings are reported from interviews or discussion groups with staff, patients and their family and friends. This paper demonstrates a strong, and often critical awareness among members of staff and other participants about how responsibilities for risk governance of 'persons' are exercised through 'technical safety' measures and the implications for therapeutic settings. Our participants often emphasised how responsibility for technical safety was being invested in the physical infrastructure of certain 'places' within the hospital where risks are seen to be 'located'. This illuminates how the spatial dimensions of social constructions of risk are incorporated into understandings about therapeutic landscapes. There were also more subtle implications, partly relating to 'Panopticist' theories about how the institution uses technical safety to supervise its own mechanisms, through the observation of staff behaviour as well as patients and visitors. Furthermore, staff seemed to feel that in relying on technical safety measures they were, to a degree, divesting themselves of human responsibility for risks they are required to manage. However, their critical assessment showed their concerns about how this might conflict with a more therapeutic approach and they contemplated ways that they might be able to engage more effectively with patients without the imposition of technical safety measures. These findings advance our thinking about the construction of therapeutic landscapes in theory and in practice.

Introduction

This paper presents findings from an evaluation of a newly constructed psychiatric hospital building, part of the National Health Service (NHS) in England. We show how the geography of risk management was perceived by participants in our study, many of whom problematised the socio-spatial relationships between the material environment in hospital buildings, the social practices of risk governance and the wellbeing of patients, staff and informal carers. The findings reported here contribute to the international literature by demonstrating the connections between theories regarding: the nature of therapeutic landscapes; the exercise of social discipline through surveillance; and the social construction of technical safety. This paper makes an original contribution by using a research design based in therapeutic landscape theory to demonstrate empirically how institutional risk governance seeks to impose 'technical safety' through security of the physical environment, but how in practice risk governance operates through the exercise of critical judgement by its staff and by patients.

A conceptual framework for examining the 'placement' of responsibility for risk governance through 'compassionate containment'

This paper highlights the connections between socio-geographical theories of therapeutic landscapes and other social theories concerned with the social interactions and power relationships involved in surveillance and risk governance.

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We explain below how the issue of risk governance emerged in the discourses of participants in research that was initially grounded in the concept of therapeutic landscapes (Gesler, 2003; Gesler, Bell, Curtis, Hubbard, & Francis, 2004). This concept of therapeutic landscapes has informed significant developments in the geographies of mental as well as physical health (Curtis, 2010). Theories included in the therapeutic landscape framework show how health, wellbeing and healing are associated with the complex interactions between people and their material, social and symbolic environments. This geographical perspective is not limited to assessment of regional or community level factors; it also applies to more specific spaces such as individual care facilities.

Our findings elucidate how theories of safety and security are relevant for therapeutic landscapes research in health geography. We make links to the work of authors such as Foucault (1995/1977) and Beck (1992) who construe risk governance as a socially and culturally constructed process, through which society seeks to 'govern' risks to create what is seen as a 'safer' environment, and to maintain social order through hegemonic power structures. Foucault's 'Panopticon' model describes how risk governance is often pursued through disciplining members of society by means of surveillance and regulation. Most applications of this theory emphasise the ways that subordinated groups (including psychiatric patients) are controlled by dominant groups (such as hospital staff). However, particularly pertinent to our research was Foucault's (1995/1977, p. 204) suggestion that '*The Panopticon may even provide an apparatus for supervising its own mechanisms*', reflecting on how institutions also exert surveillance and regulation over their own agents. Stevenson and Cutcliffe (2006, p. 718) also allude to this point when they comment that '*…power is practiced as a set of actions upon actions*', exemplified by the risk governance protocols, which management requires nursing professionals to follow in psychiatric settings. Our analysis below contributes to this debate through a discussion of the potential for a critical, potentially transformative response to institutional discipline on the part of its own agents.

Beck emphasises even more strongly the *limitations* of institutional risk governance strategies, arising not only from resistance, but also from the inadequacy of 'linear', expert knowledge about the nature of risks and how to control them. 'Non-linear' notions of risk reviewed by Beck (1999), imply that different social and professional groups vary in their perception of what constitutes risk. Also, lack of awareness and unpredictability are key features of risks that are difficult to address through the institutions of modern society, especially since, as Towl (2005) emphasizes, hazards and risk are not stable, but dynamic and emergent through time. Beck describes a state of collective anxiety in modern society about risks that we are ill-equipped to control. He argues (Beck, 1999, p. 56) that *'security degenerates into mere technical safety'* as risk governance operates through manipulation of inanimate, material features of the environment and technologies, with comparatively little attempt to modify the fundamental, but more intractable, human and social components of risk. 'Technical safety' may also be reflected in the emphasis on legal liability, rather than social or moral responsibility (Douglas, 1990).

Contextualising our research in the interdisciplinary literature concerning security of psychiatric hospital design

We explain below how our work relates to an interdisciplinary literature on security in psychiatric care and here we briefly summarise this literature.

Public discourses often conflate 'madness' with high risk, feeding public perceptions of a growing problem of violence and assault and the need to maintain safety and security (critiqued by: Moon, 2000; Jeffers, 1991; Morrison et al., 2002.; Trenoweth, 2003; Cowman & Bowers, 2009; Deacon, 2004). Aggressive behaviour can also lead to costs from workers' compensation, insurance, and repairing damaged property (Meehan et al., 2006) which further motivates health care institutions to show that they are exercising risk governance. Research in Europe, North America and Australia has addressed the practical problems of managing perceived risks in this sector (e.g., Bowles, Dodds, Hackney, Sunderland, & Thomas, 2002; Cardell, Bratcher, & Quinnett, 2009; Fluttert et al., 2011; Halleck & Petrilla, 1988; Manna, 2010; Meehan et al., 2006; Nijman, Merckelbach, Allertz, & a Campo, 1997; Quirk, Lelliott, & Seale, 2004; Stubner, Gross, & Nedopil, 2006). Such concerns have led to *'the re-articulation of mental health work in the language of risk'* (Quirk et al., 2004, p. 2574) and the emergence of a new emphasis on confinement within secure buildings, which is of special interest in this paper.

'Expert' definitions of risk in psychiatric hospitals draw on 'linear' knowledge of the 'risk factors' that might be involved (Daffern, Mayer, & Martin, 2004; Hage, Meijel, Van Meijel, Flutterts, & Berden, 2009; Secker et al., 2004). These risk factors include the personal characteristics of users (e.g., age, gender, personality traits, diagnosis, attitudes and behaviours) and environmental factors (e.g., family background, social disadvantage, physical characteristics of wards, and staff attitudes and behaviours). Risk management in psychiatric hospitals involves decision-making, risk reduction, monitoring, and evaluating the effectiveness of a hospital's management plan. Technical safety features strongly in measures to reduce risks of absconding or self harm. It includes attention to the physical layout of the hospital wards and identification of high-risk areas (Jeffers, 1991). Commentators also note an increasing trend towards locked wards to reduce the risks that patients who are legally detained in hospital will abscond, presenting a risk while unsupervised (Cleary, Hunt, Walter, & Robertson, 2009, p. 644). Potentially suicidal users should be protected by architectural barriers (Cardell et al., 2009), including secure, non-breakable windows and breakaway shower rods; and by routine searches to eliminate potentially harmful objects such as cords, razors, and other items brought in by visitors. We present evidence below on the awareness and interpretation of these issues by the English NHS as an institution, and by its agents and clients at the 'front line' of service delivery.

In addition, there is an extensive literature examining the importance of surveillance for risk governance in psychiatric hospital settings. Much of this cites Foucault's interpretation of the *Panopticon* and its relevance for psychiatric buildings and practices. For example, Philo (2004) has extensively researched historical geographies of psychiatric institutions and post-asylum geographies from these perspectives. In this paper we extend this discussion to contemporary hospital design, using an example of the new generation of purpose built psychiatric inpatient facilities in England.

This influential rhetoric emphasizing risk governance and increasingly technical methods of observation and control is also contested in the literature, partly due to tensions between this model of risk management and other aims of mental health care (Bowles et al., 2002; Cleary et al., 2009; Cowman & Bowers, 2009; Deacon, 2004; Morrison et al., 2002). An emphasis on technical procedures and rules to enhance security and safety for staff and service users and the general public, may make it difficult to provide recreational, psychotherapeutic, educational, spiritual, and occupational therapies (Leader, 2011, p. 296). For example, the use of CCTV cameras may create problems for patients with paranoia (Leader, 2011). Coercion, control measures, and issues of legal liability collide with patients' rights to privacy and to make their own treatment choices. Locking wards may be seen as paternalistic,