UNIVERSITY OF SOUTHAMPTON

FACULTY OF SOCIAL, HUMAN AND MATHEMATICAL SCIENCES

Geography and Environment

Towards a Conceptual Understanding of the Continuing Presence of the Psychiatric Asylum in Contemporary Urban Britain

by

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Thesis for the degree of Doctor of Philosophy

July 2016

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ABSTRACT

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TOWARDS A CONCEPTUAL UNDERSTANDING OF THE CONTINUING PRESENCE OF THE PSYCHIATRIC ASYLUM IN CONTEMPORARY URBAN BRITAIN

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In the latter half of the 20th Century there has been a policy of mass psychiatric asylum closure in the United Kingdom, North America, Australasia and much of Western Europe. In the aftermath of this psychiatric asylum sites have experienced five key 'fates': 'Retention' – those asylum sites which have been retained within the health care profession; 'Residential' - those sites that have been converted into housing; 'Redevelopment' - those sites which have been reused in a separate institutional capacity; 'Dereliction' those sites that have been abandoned; and 'Demolition'- those sites that have been destroyed.

In this thesis the focus has been on the former psychiatric asylum sites which have been retained within the National Health Service in England and Wales. Only approximately 12 former county psychiatric asylum sites have had retention as their main 'fate'. After uncovering the extent of psychiatric asylum retention, this thesis looked to answer two key questions: how have they been retained?; and what has led to their retention?

This thesis utilised a wide variety of qualitative research methods performed at four case study sites: Cefn Coed Hospital; Kingsway Hospital; St Nicholas' Hospital; and St James' Hospital. The key methods used in this thesis were: semi-structured interviews; multi-sensory autoethnography; archival research; and content analysis. The semi-structured interviews were performed as face-to-face interviews and were with a variety of participants including MPs, AMs, local councillors and NHS staff amongst others.

This thesis found was that there are three key forms of retention: those former psychiatric asylum sites which have been retained for mental health care purposes; those which have been retained for National Health Service administrative purposes; and those which have been retained for both of the previous two purposes. It was found that the sites have been retained largely due to inertia; and that it would take only an imbalance in the multitude of factors affecting psychiatric asylum retention for this situation of inertia to be broken and the sites to be closed. This inertia was caused by a variety of factors, which included: NHS Estates and planning policy; stigma (or lack thereof); and conservational factors. What we see from this is that it makes financial sense to continue to utilise former psychiatric asylum sites. One of the key hurdles to this in the past has been the stigma surrounding the spaces; however this thesis has found that these sites are accepted by the communities in which they stand. In addition to these, various factors, especially those relating to conservation, have made the sale of such sites by the National Health Service unappealing to buyers, with restrictions on development at the sites.

This thesis shows that former psychiatric asylum sites which have been retained within the National Health Service can function well if they are maintained and if they are utilised appropriately. However this is not always possible, as some sites are restricted in their development options by aspects of heritage management. It also shows how policy in relation into mental health care can be protracted in its enactment; with some policies taking decades to take shape.

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DECLARATION OF AUTHORSHIP

I, Joshua James Green, declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research: Towards A Conceptual Understanding Of The Continuing Presence Of The Psychiatric Asylum In Contemporary Urban Britain. I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;

2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;

3. Where I have consulted the published work of others, this is always clearly attributed;

4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;

5. I have acknowledged all main sources of help;

6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;

7. [Delete as appropriate] None of this work has been published before submission [or] Parts of this work have been published as: [please list references below]:

Signed: .....

Date: .....

Acknowledgements

I acknowledge the contribution my supervisor Professor Graham Moon has made to this study; his guidance has been invaluable to the completion of this thesis.

I would also like to acknowledge the academic contributions of Andy Power and Geoffrey DeVerteuil as secondary supervisors; as well as to Kate Boyer and Bradley Garrett for their contributions.

In addition I would like to thank my parents, grandparents, brother and friends for their support, be that financial or emotional, throughout this thesis. Without them it would have not been possible.

Definitions and Abbreviations

ABM (UHB) – Abertawe Bro Morgannwg (University Health Board)

AM – (Welsh) Assembly Member

BBC – British Broadcasting Corporation

CPA – Care Programme Approach

DECC – Department of Energy and Climate Change

DEFRA – Department for Environment, Food and Rural Affairs

ERGO – Ethics and Governance Online

HC – House of Commons

HIW – Health Inspectorate Wales

ICU – Intensive Care Unit

IEA – International Energy Agency

IMF – International Monetary Fund

IOW – Isle of Wight

IRAS – Integrated Research Application System

LDP – Local Development Plan

MEP – Member of European Parliament

MP – Member of Parliament

NAO - National Audit Office

NETRHA – North East Thames Regional Health Authority

NHS – National Health Service

NISCHR PCU – National Institute for Social Care and Health Research – Permission Coordination Unit

NTW (NHSFT) – Northumberland, Tyne and Wear (NHS Foundation Trust)

OCD – Obsessive Compulsive Disorder

PFI – Private Finance Initiative

RMG – Research Management Group

SA – Sustainability Appraisal

TAPS – Team for Assessment of Psychiatric Services

TPO – Tree Preservation Order

Chapter 1: Introduction

This thesis is as a result of curiosity and stubbornness. Curiosity into the subject matter and stubbornness that I would find answers to the questions I wanted to ask, regardless of the obstacles in the way. Whilst first exploring this topic, I found it surprising that any former psychiatric asylums were still open and in use, and from this three sources of curiosity arose: could I uncover the extent of psychiatric asylum retention?; how have former psychiatric asylum sites been retained?; and what has led to their retention? It was clear from the beginning that not many former psychiatric asylum sites were still owned by the National Health Service (NHS) and providing services and the question of 'why?' was one which piqued my interest. Why, when so many of these sites were sold off or demolished, do these few sites remain? This thesis will therefore cover the contemporary former-psychiatric asylums, with the main focus being post-1961; the year of Enoch Powell's water tower speech which marked the beginning of the end of the asylums. However despite this this thesis will examine the history of psychiatric asylums and of mental illness prior to this in order contextualise the thesis. This was the question my curiosity wanted an answer to, and I was stubborn enough to decide to try and answer it.

The psychiatric asylum can be defined as: *"an institution for the shelter and support of afflicted or destitute persons, in particular, for the insane"* (Rutherford, 2008: 1); and it was the globally-dominant modality in mental health care for over a century. Asylums were typically located on the urban fringe occupying sites of significant size and offering removal from the social stresses of urban society. During the last quarter of last century there was a policy of psychiatric asylum closure in the UK, North America, Australasia and much of Western Europe. Asylums were no longer seen as an acceptable standard for mental health care.

A summary of the history of psychiatric asylums will be set out in the next chapter: 'Post-Asylum Geographies'; after which the methods and approach utilised within this

thesis will be discussed in 'Methodology'. Within the early period of research into this thesis the question of 'how many?' was key and this will be explored in the first part of Chapter 4: 'Case Study Sites. The second question of 'how?' will also be explored later on in Chapter 4 through an analysis of the four case study sites which are the focus for this thesis: Cefn Coed Hospital in Swansea; Kingsway Hospital in Derby; St Nicholas' Hospital in Newcastle; and St James' Hospital in Portsmouth.

This leaves the question of 'why?' Why have these psychiatric asylum sites been retained within the NHS, when so many of their counterparts have been sold off or demolished? The focus of this thesis is therefore on those former psychiatric asylum sites which have been retained within the National Health Service for either healthcare use; administrative use; or both. The aim of this is to discover how these sites have been retained and why they have remained, looking into the multitude of factors which have contributed to these anomalies. This will include explorations into: mental health care policy and planning policy in Chapter 5; stigma, memory and the community in Chapter 6; and heritage management issues in Chapter 7.

The following section details the theoretical framework which preceded this thesis. This examines the history of mental health care framed using extracts from the work of Claude Lévi-Strauss on 'cannibalism and bulimia' and including the works of Foucault; covering topics from anthropophagia and anthropoemia to heterotopias.

Theoretical Perspectives

"*Claude Lévi-Strauss, the greatest cultural anthropologist of our time, suggested in Tristes Tropiques that just two strategies were deployed in human history whenever the need arose to cope with the otherness of others: one was the anthropoemic, the other was the anthropophagic strategy*" (Bauman, 2000a: 101).

The theories of Claude Lévi-Strauss with regards to cannibalism and bulimia (anthropophagia and anthropoemia respectively) can be used to outline the history of

society's attitudes towards mental health. In Tristes Tropiques Lévi-Strauss sets out the concepts of anthropoemia and anthropophagia. When Lévi-Strauss discusses cannibalism, an aspect of some societies that we generally consider to be 'uncivilized', he alludes to the method of absorbing deviants into themselves as a method of neutralizing them (Lévi-Strauss, 1961). Lévi-Strauss' argument illustrates the assimilation of deviants into the social norms and values of the society which they inhabit; the following quote recounts an example of what we shall term 'social cannibalism':

"Take the Plains Indians of North America: they are doubly significant first because some of them practiced a moderated form of cannibalism, and second because they are one of the few primitive peoples who were endowed with an organized police force… an Indian who broke the laws of his tribe would be sentenced to the destruction of all his belongings his tent and his horses. But at the same time the police became indebted to him and were required, in fact, to compensate him for the harm he had been made to suffer. This restitution put the criminal, once again, in debt to the group… Not only are such customs more humane than our own, but they are more coherent, even if we are to formulate the problem in terms of modern psychology" (1961: 386-7).

This has been termed as 'anthropophagic'- whereby deviants are absorbed by the community (Young, 1999). In this manner: *"criminals are rehabilitated, madmen*[1] *and drug addicts cured, immigrants assimilated, teenagers 'adjusted', dysfunctional families counseled into normality"* (Young, 1999: 4). In this way individuals are assimilated to fit in with the society which they occupy; 'eaten' in that they are absorbed into the community and become a part of it, whilst their unsavoury characteristics are excreted out. The

[1] In this thesis, and in particular in the 'Post-Asylum Geographies' and the 'Stigma, Community and the Surviving Asylum' chapters, there are a number of terms and phrases which today would be seen as offensive; terms such as 'insane' or 'mad'. However they are terms which, at the time they were used, were in common usage. No offence is meant by their usage in this thesis. Additionally, in this thesis quotes from participants appear as they were spoken and have not been modified.

deviants, who are in the context of this thesis psychiatric patients, are assimilated into the community.

Foucault discusses in 'Madness and Civilization' (1992) the concept of 'nomadic madness', whereby, in the latter part of the middle ages, 'madmen' were driven outside of city limits and subsequently either wandered the countryside, or alternatively, ended up on a 'ship of fools' (Foucault, 1992; Dear and Taylor, 1982). These ships "*conveyed their insane cargo from town to town"* (Foucault, 1992: 8). One criticism of Foucault's work is the lack of a stable terminology. Within the first four pages the same men are referred to as 'deranged minds', 'fools' and 'insane', before Foucault settles on 'madmen' as the preferred term. Not all cities and towns however expelled these 'madmen' indiscriminately, in some places only 'foreign' madmen, those expelled from other cities, were driven away, as they 'looked after their own' (Foucault, 1992). Even in this age of 'nomadic madness', the concept of place is seen to have an effect upon the fates of those termed 'madmen'. The 'dumping' of these madmen by merchants and mariners in 'other' cities, thus ridding their native cities of them, is described by Foucault as a 'counter-pilgrimage', which he contrasts to places of pilgrimage where madmen were willingly accepted as pilgrims (Foucault, 1992).

The exclusion of madmen here is achieved via expulsion. The methods of exclusion then moved on from expulsion to that of confinement in total institutions such as asylums and prisons (Goffman, 1961). This trend began towards the end of the 16th century and was in full force during the 17th and 18th centuries with the rise of workhouses and asylums. The exclusion of deviants is an 'anthropoemic' reaction – whereby deviants are excluded from society and, in modern society, this is usually achieved via confinement (Young, 1999). This is a result of social worlds becoming more complex and diverse, and total assimilation becomes impossible (Young, 1999). This has been related to bulimia, in that: "*modern societies are anthropoemic; they vomit out the deviant, keeping them outside of society or enclosing them in special institutions within their perimeters"* (Lévi-Strauss as cited in Young, 1999: 2).

Society acts as a form of bulimia, 'vomiting out' the deviant (in this instance illness is seen as a form of deviance, see Ablon 1981) and incarcerating them outside of society; in the case of the psychiatric patient this is incarceration inside asylum walls. However the policy of community care can be related to an anthropophagic system promoting, at least theoretically, the assimilation of former mental hospital residents into wider society. In this way society has moved from an era of anthropoemia and into one of anthropophagia, as the deviants (psychiatric patients) are 'absorbed' back into the wider community (Lévi-Strauss, 1961; Young, 1999). The following figure (1.1) shows the switch in policy in relation to mental health care over the last millennium.

Figure 1.1: History of Anthropoemic and Anthropophagic trends

To summarise, nomadic societies have been shown to assimilate deviants back into society through various processes. This begins the graphic above with the anthropophagic assimilation period. This has been shown to have shifted into the phase of anthropoemic expulsion whereby deviants, including 'the mad', were excluded and cast out from society; the most dramatic example of which is arguably the 'ship of fools' (Foucault, 1992). This began to change with the introduction of the workhouses in the late 17th century, which signalled the move toward a phase of anthropoemic incarceration; which with regards to mental health care was cemented with the rise of the asylum system in the 19th century. The current shift to community care shows the latest stage in the evolution of mental health care; with the emphasis returning to anthropophagic assimilation of patients.

This can also be linked to the concept of heterotopias. Heterotopias, literally meaning 'other places', are what Foucault describes as "*places that exist (unlike utopias), but that somehow disrupt, undermine or challenge existing spatial orderings*" (Garrett, 2015: 8). In other words: "*sites which are embedded in aspects and stages of our lives and which somehow mirror and at the same time unsettle or invert other spaces*" (Johnson, 2013: 790-791). To Foucault, heterotopias take varied forms, and "*perhaps no one absolutely universal heterotopia would be found*" (1986: 24). In spite of this Foucault outlined six defining characteristics of heterotopias (Foucault, 1986; Garrett, 2015): they are transcultural; they may be reappropriated; they often juxtapose multiple spaces in one place; they are linked to slices of time (heterochronies); they are spaces of isolation and exclusion; and they function in relation to other spaces.

Foucault outlines two categories for heterotopias: crisis heterotopias; and heterotopias of deviation (1986). Crisis heterotopias are those which were more common in so-called 'primitive societies': where there were privileged or forbidden places reserved for individuals in that society who were in a state of crisis. For Foucault this included adolescents, menstruating women, pregnant women and the elderly amongst others. Some examples which he gives of crisis heterotopias are boarding schools and military service for young men (Foucault, 1986). It was the opinion of Foucault that these crisis heterotopias were being increasingly replaced in modern society by heterotopias of deviation. Heterotopias of deviation are "*those in which individuals whose behaviour is deviant in relation to the required mean or norm are placed*" (Foucault, 1986: 25). This includes criminals, mental patients and, strangely, the dead. Foucault's examples of this are 'rest homes', prisons, cemeteries and, aptly, psychiatric hospitals. Generally these heterotopias of deviation are not publically accessible and entry is either compulsory or determinate on the submission to 'rites and purifications' (in the case of psychiatric asylums these would cover voluntary admissions) (Foucault, 1986). The heterotopias of deviation which exists in society function in counterbalance to the strain toward a societal utopia. This is whereby undesirable aspects are removed from society (in other words vomited out) and placed into heterotopias of deviation: institutions such as prisons and psychiatric hospitals amongst others. Street and

Coleman stated that: "*like asylums and prisons, hospitals are what Foucault calls 'heterotopias of deviance' designed to deal with persons whose bodies are considered to diverge from society's norms relating to health. The hospital is the actualization of a utopian vision of scientific order, cleanliness, and rationality, existing in opposition to and separated from the messy reality of everyday social space*" (2012: 8).

Conclusion

This historical framework of society's treatment of mental health shows a cyclical nature (as seen in figure 1.1) and that, due to a decline of the asylum mode of care and a shift towards community provision, we are therefore currently in a stage of anthropophagia characterised by community care. This is whereby patients are removed from large institutions (heterotopias of deviance) and placed into the community. This paradigm however is not total. There are a few examples which run opposed to the current anthropophagic paradigm. First there are what Dear and Wolch titled 'landscapes of despair' – "*the discharge of dependent populations from large – scale institutions and their subsequent fate in the community*" (as cited in DeVerteuil and Evans, 2010: 278). This led to former patients becoming homeless and/or criminalised and subsequently fall victim to transinstitutionalisation- often being "*misassigned to inappropriate social settings and reinstitutionalized (for instance, in prisons) because they lack other shelter options*" (Dear and Wolch, 2014: 4). Secondly the asylums which form the focus of this thesis are another antithesis of the current paradigm. What makes the continued use of the asylums particularly odd is that they are an official part of the healthcare system running opposed to the current healthcare paradigm; making their continued retention all the more curious. They continue to confine patients through anthropoemic incarceration when the vast majority of patients are now seen in community care facilities. This thesis will attempt to answer the question of why a small number of former psychiatric asylum sites have been retained within the NHS when we are in an era of anthropophagia characterised by community care.

Chapter 2: Post-Asylum Geographies

Introduction

"In the later-twentieth century, fuelled by numerous new ideas and practices bound up with what have become known as deinstitutionalisation and care in the community, the older asylum geographies have started to 'crumble' (Cornish, 1997) throughout much of Western Europe and North America, if less so elsewhere. They are being replaced, albeit very unevenly, by a much more complex network of post-asylum geographies entailing a rich amalgam of new spaces and places which are occupied by, sheltering of, caring for and offering diverse kinds of assistance to today's people with mental health problems (including many people decanted from the closing mental hospitals)" (Philo, 2000: 135).

This chapter reviews literature on post-asylum geographies which, as stated above, are the complex network of new spaces and facilities which offer care to mental health patients. They also include the previously dominant healthcare spaces, such as former psychiatric asylums, which may or may not still be in use for mental health care purposes. The first section will focus on an historical analysis of the healthcare system. It will include an analysis of the asylum when it was in use as the predominant form of mental health care, the advent of the asylum closure programme and, briefly, the move to community care. This will be done to provide a context for the arguments surrounding psychiatric asylum re-use. The second section will focus on the literature surrounding the fates experienced by asylum sites. Moon (2014) - drawing from work from Joseph, Kearns and Moon- introduces an overall framework of four fates which can be applied to asylum buildings and their landscapes following closure. These four fates are transinstitutionalisation, dereliction/demolition, conversion (usually to housing) and retention for health care use.

I propose an advancement on this classification to a five fate model; incorporating five key fates: 'Retention' – those asylum sites which have been retained within the health

care profession; 'Residential' - those sites that have been converted into housing; 'Redevelopment' - those sites which have been reused in a separate institutional capacity; 'Dereliction' those sites that have been abandoned; and 'Demolition'- those sites that have been destroyed. These are supported by a small number of sub-fates which are included within those five categories. These include transinstitutionalisation and commercial redevelopment as sub-fates of redevelopment, and public retention and private retention as sub-fates of retention. This advances on the Moon (2014) framework in that the fates of dereliction and demolition are separated out, and transinstitutionalisation is replaced by, and becomes a sub-fate of, redevelopment. These fates are not mutually exclusive. They can overlap and succeed each other; they can also co-exist on individual sites. What they have in common is a distancing from the past: the stigmatised asylum heritage is repackaged and re-imagined. This area of work will be explored in this section in an effort to identify gaps within the current literature on post-asylum geographies with regards to the facilities themselves.

A Brief History of Psychiatric Asylums

The Asylum

The origins of the asylum can be traced to the erection of Bethlem Hospital in 1246, stated in 1784 to have been *"[re]founded by Henry VIII for the cure of lunatics"* (Bowen, 1963: 430). However a statement from 1632 indicates that the use of the Hospital as a mental institution began in the second half of the 14th Century (Jones, 1993). According to Hunter and MacAlpine: *"Bethlem Hospital was the only 'receptacle' for the insane in England until the opening of Bethel Hospital, Norwich, in 1724 and St Luke's, London, in 1751, and therefore occupies an unique place in the history of the insane in the British Isles"* (1963: 306).

The Poor Law in England was in effect between 1795 and 1834, and relied largely on the parish as the unit of government. The Poor Law provided relief for the poor in the parish, and as those who were responsible for the administration of that relief knew

the recipients personally it has been considered more humane. However, application of the Poor Law varied greatly and it was inconsistently applied, especially between geographical areas (Bloy, 2013). Families often sought the support of the Poor Law when they found themselves unemployed.

It was the 17th Century which gave rise to the building of these 'houses of confinement'; Foucault notes that one out of every hundred Paris residents were confined within them within the first few months of their opening. These buildings, for example the Hôpital General, were not medical facilities but rather sites of order and control (Foucault, 1992). These sites were not specifically for sufferers of mental illness, they were all purpose institutions designed for all 'undesirables' (Jones, 1993). These 'houses of confinement' were "*first and foremost factories of discipline – more precisely, factories of disciplined labour… whatever their declared long-term purpose, most panoptical institutions were, right away, workhouses*" (Bauman, 2000b: 210). To put this into a health care context, at this time medical treatments were still dominated by Galen's 'four humours' theory, and the only public 'madhouse' was Bethlem- which housed the more difficult patients (Jones, 1993).

In the UK in the latter part of the 17th century it was workhouses that began to thrive, the first workhouse in England being built in Bristol in 1697. By the end of the 18th Century the number had grown to 126 (Foucault, 1992). The workhouses were not designed for any medical concept, and it had even been stated that *"to keep workhouses from becoming hospitals, it is recommended that all contagious invalids be turned away"* (Foucault, 1992: 44). Foucault suggests the mad were the most problematic of the workhouse inmates, as they were resistant to work and *"disruptive to good time-space order and even embodying, with their noisy animality, an unjust extra penalty for their fellow inmates"* (Philo, 2012: 6). The sites began to acquire their own new meaning as time passed, as they became not just about giving the idle work, but giving work to those confined for the prosperity of everyone involved. Foucault sees the motives here as clear; cheap manpower in times of full employment and high wage and work for the idle and protection against uprisings in times of high unemployment (shown by the

locations of the English workhouses- in the most industrialized areas of the country) (Foucault, 1992). In this way Foucault believed that: *"what began as a moral requirement became an economic tactic"* (1992: 52).

Foucault states that *"it is not immaterial that madness were included in the proscription of idleness"* (1992: 57); they were placed alongside the poor and the idle and subject to enforced labour; and *"no attempt was made to separate lunatics from other paupers"* (Jones, 1993: 10). Though some of the larger workhouses had infirmaries on site, they were for individuals suffering from infectious diseases. Workhouses were a symbol of dread; an institutional regime feared as much as (if not more than) the asylum in the later 20th century. St Peter's workhouse in Bristol was one of few that treated 'lunatics' differently to the average pauper, and the only workhouse which provided 'treatment' rather than just confinement (Jones, 1993). The mad began to be confined due to an *"inability to work and to follow the rhythms of a collective life"* (Foucault, 1992: 58); which made them both unprofitable and costly to keep, as well as potentially disruptive to the rest of the 'inmates'. This "*mounting pressure on the workhouse led Guardians and Poor Law officers to seize on the new county asylums… to dispose of those inmates whose sickness and awkward behaviour posed a threat to the smooth running of the Union*" (Adair et al., 1998: 1).

Up to this point in time mental health care had largely been a custodial practice. Edginton stated that: "*the purpose of these institutions [county asylums] was not to heal but to confine and separate: bars, high walls and locked doors were not treatment since madness was not thought to be a temporary condition but a constant state of a person. Security not treatment was built into these institutions*" (1997: 92). In this way the design of the buildings within which mental health patients were being held were designed to be carceral. In fact the links between prison architecture and early asylum design has been noted, with Bethlem and St Luke's both being used as examples of institutions which were criticised as early as the 19th century for their prison-like appearance and lack of proper classification of patients (Edginton, 1997).

Private asylums in the UK developed slightly earlier than their public counterparts. In the late 18th and early 19th century there began a flow of patients into the county asylums; however both the public and private systems ran in tandem. It was in the private asylums that the non-restraint movement began: *"some philanthropists in the late 18th Century had shown that it was possible to treat lunatics as human beings and that such treatment was in itself often curative but the few experiments (for instance the Retreat at York) were dependent on privately subscribed funds and could not become the basis for a national service"* (Bursell, 1972: 1).

Moral treatment was a product of the Enlightenment which affected western society in the late 18th Century. The non-restraint movement is said to have begun in the relatively small Lincoln Lunatic Asylum (which was itself a private asylum), where instances of restraint were lowered and eventually entirely abolished by 1838. This however was met with scepticism and opposition to the extent that Mr Gardiner Hill, who received a large proportion of the credit for the non-restraint practices at the asylum, resigned. Gardiner Hill, and Conolly after him (who, incidentally, also left his job because of the asylum committee's negative responses to his progressive ideas) both saw that the non-restraint movement depended upon high standards of nursing and ways to occupy patients' time (such as through occupational therapy, agriculture etc.) (Jones, 1993). In 1806 Pinel stated that 'lunatic hospitals', through *"unlimited confinement and barbarous treatment [create] the appearance of order and loyalty"* (1963: 606). He felt that giving patients a degree of freedom not only made them happier, but could reduce violent symptoms and even remove the affliction altogether (Pinel, 1963). What we see from both Tuke (of the York Retreat) and Pinel is the treatment of the insane as *"mentally sick human beings"* (Hunter and MacAlpine, 1963: 603) rather than as dangerous individuals to be confined much like a prisoner. Despite the rise of moral treatments, it was common practice to restrain patients up until the mid-19th century.

This system of moral treatment was apparent in the structure of the York Retreat. The building of The Retreat was overseen by architect John Bevans; however as he had no experience in asylum construction, he had worked largely from plans developed by

William and Henry Tuke themselves (Edginton, 1997). The building was "*laid out with walks, wooded glades, gardens and orchards the original eleven acres of land had been extended to twenty-seven by 1839: this formed a tranquil setting in which patients could hope to regain their serenity*" (Digby as cited in Edginton, 1997: 94). The asylum was also designed with the idea that patients would be classified and separated along the lines of gender and severity of illness amongst other factors.

As Gesler states: "*there is a long tradition that healing powers may be found in the physical environment, whether this entails materials such as medicinal plants, the fresh air and pure water of the countryside, or magnificent scenery*" (1992: 736). In this vein, one of the key concepts to be developed in relation to asylum care is arguably that of the 'therapeutic landscape'; often described as 'healing places' (Williams, 2010) or 'bucolic locales' (Gesler, 1992). The therapeutic landscapes can be, simply, described as 'places with health promoting properties'; and can include both natural and, in the case of asylums, specifically built locations (Williams, 2010). These spaces "*sought to promote the recovery of mental health by the removal of the 'client' from the stresses of everyday life through confinement in an ordered, harmonious and calming place of sanctuary*" (Moon et al., 2006: 1). In fact: "*park-like grounds, seclusion and healing through removal from society and exposure to the positive properties of particular places were deeply embodied in traditional notions of 'asylum' as a care delivery modality*" (Moon et al., 2006: 134). The concept of the therapeutic landscape is rarely associated with the asylum, and Moon et al. theorise that this may be a result of "*the erasure of the positive therapeutic element in the history of the asylum in favour of a focus on its more recent negative image*" (2015: 39).

The imposition of therapeutic landscapes shows the more care-orientated side of the asylum over history, in which individuals are cared for as patients rather than inmates. Therapeutic landscapes include both internal and external spaces; where the internal includes the design of rooms and spaces such as airing courts. External spaces depended much on the siting of the asylum, which tended to be in more rural, 'pure', spaces; Foucault linked this to the banishing of madness from urban spaces, in an 'out of sight, out of mind' mind-set (Philo, 2012). Though the term 'therapeutic landscape'

was not coined by Gesler until 1992; the concept can be seen as early as Pinel, as well as Tuke and the York retreat, in the 18th Century.

In France, Pinel introduced moral treatment at the Bicêtre hospital in Paris. He felt that "*insane people did not need to be chained, beaten, or otherwise physically abused. Instead, he called for kindness and patience, along with recreation, walks, and pleasant conversation*" (Trent Jr., n.d.). The Tukes at the York Retreat felt that patients could be both rational and controllable as long as they were not aggravated by hostility (Jones, 1993). The Tukes had exercised non-restraint long before it became commonplace, and a book written by Samuel Tuke (published in 1813) has been described as follows: *"this book by a layman did more to improve the care and treatment of the insane in asylums and indirectly also to stimulate the development of psychiatry than many a 'scientific' tome written by a physician"* (Hunter and MacAlpine, 1963: 684).

Patients at The Retreat were never punished for failing to control their behaviour, and methods were used which utilized trust. Medical methods were replaced with a prescription of good food, fresh air and exercise; as a direct contrast to the restraint, confinement and semi-starvation offered elsewhere at the time. Occupational therapy was also encouraged at the Retreat, such as caring for animals or tending the garden, so that the patients may learn self-control (Jones, 1993); in contrast to the *"brutalising coercion and restraint"* (Hunter and MacAlpine, 1963: 687) practiced in the vast majority of asylums at the time. As Dr Abercrombie stated: *"as soon as the situation of the patients admits of it, mental occupation should be deemed of the first importance"* (as cited in Brigstocke, 1844: 12). The Retreat used almost entirely moral practices in the treatment of their patients: "*moral treatment was a profoundly social form of treatment. The experience of madness was to be corrected by placing people in humane and caring social environments that emphasized social interaction and the cultivation of latent faculties and healing processes*" (Sanctuaryweb, n.d.). There was one exception to moral treatment which was advocated by Samuel Tuke: *"there is, however, one remedy, which is frequently employed at the Retreat, and which appears to have been attended with the happiest effects; and that is the warm bath…"* (Tuke, 1963: 688).

However, it must be said that both private and public asylums had the same goals. The asylum ideal was not just one for the private asylums. But although both systems did run in tandem, the key difference between the two were that public asylums were put under pressure from early on by issues of overcrowding (discussed in the 'Asylum Closure' section later in the chapter) which severely limited their capacity to provide either a therapeutic landscape or even suitable care to their patients.

In 1800 the foundations were laid out for the incarceration of criminals and the insane in separate institutions as opposed to being kept together as they were within the poor law system. This was in the form of the Criminal Lunatics Act of 1800, which provided indefinite detention of those offenders found to be guilty, insane, or deranged and purposeful. However the Act did not specify where these separate offenders would be housed (Jones, 1993). This act was thought to have been passed in response to James Hadfield's assassination attempt on George III, whereby the resulting court case was the origin of the insanity plea (Moran, 1985) non-compos mentis, during which his attorney stated: *"…I must convince you, not only that the unhappy prisoner was a lunatic, within my own definition of lunacy, but that the act in question was the immediate, unqualified offspring of the disease…"* (Erskine, 1963: 567).

In 1807 Stark, an architect who planned the Glasgow Lunatic Asylum, pointed out that no matter how good the system of management *"no such system can be prosecuted with effect in an ill-contrived building"* (as cited in Hunter and MacAlpine, 1963: 627). It was not just architects who put an emphasis upon asylum architecture, as a number of *"nineteenth-century psychiatrists considered the architecture of their hospitals, especially the planning, to be one of the most powerful tools for the treatment of the insane"* (Yanni, 2007: 1). His design of the Glasgow Lunatic Asylum, much like The Retreat at York, allowed for separation of patients according to a number of factors, including sex, social class and

degree of insanity (Hunter and MacAlpine, 1963). This went a crucial step further than the 1800 Criminal Lunatics Act in the separating out of patients. It was also designed so that every motion of the patient could be watched, using a form of Panopticon[2]. The level of observation which this provided allowed for a greater degree of liberty on the part of the patient, and all but removed the need for restraint (Hunter and MacAlpine, 1963). Stark also suggested social intercourse between patients with the use of 'day rooms', and the fifth annual report of the asylum contained the first account of the effects of community life upon the patients with regards to socialising and therapeutic landscapes (Hunter and MacAlpine, 1963).

There is a view that the psychiatric asylum buildings became a form of scapegoat, with all the failings on the system being placed on facilities that were 'not fit for purpose'. In this way all of the "*blame [was] levelled at dilapidated piles of bricks and mortar*" (Reuber, 1996: 1188) rather than at the chronic understaffing and other such issues which plagued asylum history.

The county asylums, which are the focus of this study, began to be founded shortly after the introduction of the County Asylums Act of 1808 (Jones, 1993); sometimes referred to as Wynn's Act (Bursell, 1972). This act came to parliament when a committee in 1807 found that the only law that could be seen to apply to pauper lunatics was the Vagrancy Act of 1744; which was occasionally used to confine criminals (Jones, 1993). It was also felt that: "*the practice of confining such lunatics and other insane persons as are chargeable to their respective parishes in Gaols, Houses of Correction, Poor Houses and Houses of Industry, is highly dangerous and inconvenient*" (HighRoydsHospital.com, n.d.). The recommendations of this committee were that an asylum should be set up in each county, to which all the county's lunatics should be sent (Jones, 1993). Such recommendations had however been made as early as 1693 by

[2] See Glossary of Terms

Daniel Defoe (Defoe, 1963), again in 1700 in an anonymous letter to parliament (Anonymous, 1963) and such methods of the separating out of the 'insane' were championed by Tuke and the York Retreat in the 18th and 19th Centuries. Under the 1808 County Asylums Act it was stated that individuals may be admitted under either the 1744 Vagrancy Act or the 1800 Criminal Lunatics Act (Jones, 1993); and it was the first Act *"permitting counties to levy a rate to build asylums"* (1808 County Asylums Act, n.d.). However it must be stated that though its main purpose was to move lunatics from workhouses and prisons, and into buildings designed to help manage their needs, there was no evidence in the preparation of the Bill which referred to county asylums as a place for cure (1808 County Asylums Act, n.d.). Foucault explains how: *"specialist confinement was demanded for this mad cohort, which was henceforth to be ushered into the asylum as a set-apart space charged with 'persuading' the insane back into sanity"* (as cited in Philo, 2012: 6).

"Wynn's Act was a very permissive act and very few counties showed any inclination to involve themselves in the increased expenditure which a county asylum would entail" (Bursell, 1972: 1). Nevertheless the first county asylum was Nottinghamshire County Asylum, opened in 1811, followed in the subsequent years by asylums in: Bedford (1812); Norfolk (1814); Lancashire (1816); Staffordshire (1818); and West Riding (1818). These asylums were built with no discernible architectural plan (but these were often later converted into a corridor plan, discussed below) (Asylum Architecture, n.d.). The 1808 act also included the idea of the therapeutic landscape, with specifications regarding an *"airy and healthy situation, with a good supply of water"* (Jones, 1993: 61); yet specified no regulations regarding the treatment of patients (Jones, 1993). What the original asylums did in terms of patient care was to introduce a more hospital-like structure; with large single-sex wards becoming the predominant mode of psychiatric in-patient care. These: "*wards were able to house up to 50 patients, in very close proximity and little personal space*" (The History of the Asylum, n.d.).

Subsequent to the 1808 Act the 1828 County Asylums Act was set up in order to: *"amend the Laws for the Erection and Regulation of County Lunatic Asylums. And more*

effectually to provide for the care and maintenance of Pauper and Criminal Lunatics in England" (1828 County Asylums Act, n.d.). This acted to increase the accountability of county psychiatric asylums, and brought in the requirement for local magistrates to present annual reports of the asylums to the Home Office. At this time the 1828 Madhouse Act was also passed. This replaced inspection by the Royal College of Physicians by that of a metropolitan Lunacy Commission comprising 20 members, and was arguably a reaction to prevent the patterns of abuse, maltreatment and neglect found in London's private madhouses by the lunacy reform movement (Andrews et al., 2013).

Asylum architecture between the 1830s and the 1890s was dominated by asylums built in the corridor plan. These were "*typified by a… central block including admin and former officers quarters, flanked by long wings either side, each with appropriate working areas and segregated by sex. Built to two or three storeys in height. Typically (as the name suggests) a corridor or passage of communication would run the length of the building to ease access*" (Asylum Architecture, n.d.). An extract from Jacobi's 'On the construction and management of Hospitals for the Insane' from 1841 showed how the use of therapeutic landscape was seen as key to the construction of psychiatric asylums in the mid-19th century: "*the establishment should be situated, then, under a mild sky, in an agreeable, fertile, and sufficiently dry part of the country, where the surrounding scenery, diversified with mountains, valleys, and plains, is calculated to enliven the spirits of the beholder, and invite him to wander and explore its beauties*" (Notes on Asylum Architecture, n.d.). It was these ideas which led to the construction of psychiatric asylums in large grounds and isolated from large populations- in order to instil calm and tranquillity as a treatment method.

The next significant piece of legislature was the 1845 County Asylums Act. The 1845 Act marked a significant progression in mental health history as it turned mentally ill people from prisoners into patients. These acts provided a *"shift from 'private misfortune' to 'public concern'"* (A History of County Asylums, n.d.), and was hailed as one of the great steps towards compassionate social reform and public benevolence (A History of

County Asylums, n.d.). This went hand-in-hand with the 1845 Lunacy Act, which set up the lunacy commission; which was a regulatory body designed to regulate both the conduct of and treatment within mental hospitals. These acts required all hospitals to be registered with the lunacy commission and visits to these hospitals would be made at least once a year (The Lunacy Commission, n.d.). The 1845 Act therefore had the overall effect of bringing asylum care much more under public control.

"*In their rural settings and surrounded by high walls to prevent escapes, asylums were a self-contained world. The grounds were designed by some of the finest landscape gardeners; they contained farms, orchards, workshops, bowling greens, croquet lawns and cricket pitches. Leading off the wards were 'airing courts', walled gardens with shelters where patients could safely exercise*" (The Growth of the Asylum, n.d.). Despite this, as seen previously, early asylum design was often criticised for being too close to the design of prisons, with an overemphasis on carceral features. The sites were criticised for being prison-like in appearance and for lacking proper systems of classification (Edginton, 1997). However asylums designed and built subsequent to 1845 "*rejected the prison model and the earlier asylums were transformed throughout the nineteenth century so as to have little resemblance to their original designs*" (Edginton, 1997: 93). Brigstocke (1844: 4) made the following observation of county psychiatric asylums in a message to the Magistracy of the town and county of Derby: *"as the general improvement in the treatment of the Insane can be most effectively promoted through the the instrumentality of large public establishments, in which right principles are adopted, and where proper means of government and discipline can be best carried into operation; it is much to be lamented, that with a large expenditure, and an earnest desire to promote the desired and, such buildings should have been erected as our present county asylums, not one of which is adapted in its structure, and consequently in its arrangements, to the avowed purpose (the means of accomplishing which are yet but imperfectly understood) of restoring to health and sanity those who are deprived in whole or in part of these inestimable blessings* [sic]".

Despite the 'prison-like appearance' discussed above, it has been stated that at the time the designing of Pauper Asylums was largely copied from the designs of county

infirmaries and public hospitals, and the *"more prominent features are to accommodate the greatest number of patients in the smallest amount of space, consistent with proper ventilation, due surveillance, and the safe custody of patients"* (Brigstocke, 1844: 4). Also it is suggested that no patient rooms should be above two stories high to reduce the risk of patient injury (Brigstocke, 1844).

Asylum design in the nineteenth century was varied. There was an emphasis in the designs on relative isolation; Dr Thomas Kirkbride, described as "*the preeminent medical doctor in asylum medicine as well as the leading authority on the design of mental asylums in America*" (Bristow, 2009), wrote that asylums: "*should always be located in the country, not within less than two miles of a town of considerable size*" (as cited in Bristow, 2009). There was also an emphasis on what can be described as 'monumental' architecture, and it was felt that these secluded asylums would be "*the monumental symbol[s] of the confidence of psychiatry in treating the burgeoning mental illnesses of a new and prosperous country*" (Bristow, 2009). However, as also seen in the UK, the United States asylums became "*monumental monasteries of the mad*" (Deutsch as cited in Bristow, 2009); as overcrowding and understaffing caused them to become largely custodial institutions.

The 'transport revolution' of the nineteenth century saw a succession of technological innovations which changed the nature of urban population; this is known as 'urbanisation' or colloquially 'urban sprawl' (European Environment Agency, 2006). These developments included steam ferries, commuter railroads and the cable car; and they made it practical for large populations of people to commute into the city from larger distances. These advances were coupled with traditional values concerning land and rural living- as these factors were traditional markers of wealth and a high social class (Frumkin et al., 2004). Urbanisation in modern Europe has been driven by a number of factors (outlined by the European Environment Agency, 2006) organised here into both 'push and pull' factors and 'enabling' factors:

Table 2.1- Factors Affecting Urbanisation

Push/Pull Factors	Enabling Factors
Inner city air pollution	Economic growth
Inner city noise pollution	Globalization
Unsafe inner city environments	Private car ownership
Green open space	Transport links
Quality of schools	

This process of urbanisation has acted to bring residential properties to within the vicinity of psychiatric asylums, effectively acting to urbanise the asylum, transforming them from distant horrors into parts of the local communities. This has made these former psychiatric asylums more familiar and a level of trust has built up over time via exposure to the sites. This has led to a situation where the sites themselves are arguably accepted as a part of the local communities in which they lie, effectively negating the stigma which the sites garnered over their history. Goffman stated the following in relation to stigma: "*the central feature of a stigmatized individual's situation in life is acceptance and the lack of it. It is often put into words as the 'failure to accord him respect'. Here we can see the clash between a virtual identity based on stereotypes and imputed attributes and the actual identity. Where there is a negative 'gap' Stigma exists*" (as cited in De Paoli, 2004: 6). Psychiatric asylum buildings have traditionally been stereotyped as being dark, looming buildings on the hill in the distance, and due to aspects of their history they have been generally vilified both as individual sites in their local communities and nationally as a whole. Asylum scandals in the '60s and '70s in particular, relating to cases of ill-treatment of patients, did significant damage to the reputation of the asylum system; and the lack of funding for maintenance, resulting in facilities which were 'not fit for purpose', only acted to reinforce the idea that the asylums were an old-fashioned and outdated treatment modality. These stereotypes created and maintained a stigma attached to psychiatric asylums which has persisted throughout the process of mass asylum closure, and affects both current and former psychiatric asylum sites to the present day.

Over time, the psychiatric asylum itself evolved. Growing awareness and understanding in the 20th Century of micro-organisms and infectious disease led to a new model of psychiatric asylum, based upon the villa principle: "*gradually the practical virtues of the echelon plan gave way to the perceived therapeutic benefits of a dispersed layout. Other factors may be infection and economy. The dispersed plan coincides with growing awareness of mic[r]o-organisms as the cause of diseases and the plan may have been thought to reduce this*" (Notes on Asylum Architecture, n.d.). This is known as a 'colony' layout, described as blocks and known as villas, with buildings being dispersed around the asylum complex with no corridor attaching them together. Villas were increasingly popular at the beginning of the 20th Century; and though few psychiatric asylums were actually built in this time period, St Ebba's in Epsom being one of the few (Asylum Architecture, n.d.), a number of asylums began to expand using the villa principle. This included Severalls (Severalls Lunatic Asylum, n.d) and Kingsway amongst many others. This style of extension to psychiatric asylums was simple, as the asylums themselves had large grounds with plenty of space for these developments. Villas were constructed for a number of reasons: growing awareness of infectious disease; the separating out of chronic or epileptic patients; and the establishment of acute blocks for recently admitted cases rather than admitting them straight into the main building (Notes on Asylum Architecture, n.d.).

In 1948 Aneurin Bevan announced the launch of the National Health Service (NHS), as a climax of the plan to provide healthcare for all of society. "*The central principles are clear: the health service will be available to all and financed entirely from taxation, which means that people pay into it according to their means*" (NHS, 2015). For the first time this meant that all healthcare was brought together under one organisation to provide services that are free at the point of delivery (NHS, 2015). From this point the county psychiatric asylums were under the control of the NHS in England.

Chapter 2

Asylum Closure

In the 1950s and 60s there was a considerable policy of 'general hospital' building in Britain, and the topic was a key aspect of the 1959 general election campaign. This was seen as a way of "*improving uneven distribution of health services across the country*" (Enoch Powell (1912-98), n.d.). The election brought the Conservative party to power and the appointment of Enoch Powell as Health Minister. Powell pressed for progress in hospital building programs, aiming to both modernise and rebuild hospital facilities across the country as well as change the way in which health care was organised (Enoch Powell (1912-98), n.d.). It is this process which eventually signalled the decline of the asylum; which was made official policy in 1961 with Powell's famous 'water tower speech'. This made the decline of the asylum part of the government's policy moving forward and the stance was clear, the asylum was no longer seen as an acceptable standard for mental health care in the UK. This: *"transformation of the mental hospitals [was] not only a matter of buildings, the change of a physical pattern, it [was] also the transformation of a whole branch of the profession of medicine, of nursing, of hospital administration"* (Enoch Powell's Water Tower Speech 1961, n.d.). As a part of the process of deinstitutionalisation, "*regional boards were asked to ensure that no more money than necessary is spent on upgrading and reconditioning*" (The History of the Asylum, n.d.). The plan was to reduce the number of psychiatric hospital beds by 50%, and as an aid to deinstitutionalisation into community care services wards were to be set up within general hospitals (Enoch Powell's Water Tower Speech 1961, n.d.). Gleeson and Kearns suggest that deinstitutionalisation, from the perspective of its supporters, was "*a `liberation struggle' that would free people in custodial care from the brutal and dehumanising conditions that prevailed in asylums, hospitals, and other institutions"* (2001: 61). From this perspective it was seen an imperative to close institutions immediately "*even before a comprehensive relocation programme had been formulated for residents*" (Gleeson and Kearns, 2001: 61). The two key challenges which deinstitutionalisation created for the asylum were a) how to ensure that former asylum patients had adequate housing and care provisions in the community and b) what to do with the large institution's architecture, grounds and landscapes which were deemed surplus (Moon et al., 2015).

The downfall of the asylum began with the loss of the 'asylum ideal': defined as *"one of fresh air and a rural setting that offered patients peace and quiet"* (Gittins, 1998: 9). This was caused largely by institutional overcrowding, itself caused by a surplus of admissions over discharges and an accumulation of long-stay patients (Gittins, 1998); which was not helped by the limited number of beds due to an inaccurate belief on the part of doctors that 70-90% of patients could be cured (Yanni, 2007). To return to the quote from Stark: *"no such system can be prosecuted with effect in an ill-contrived building"* (as cited in Hunter and MacAlpine, 1963: 627); this is certainly true, and since the buildings were designed to house far less patients than were being housed mental health care within them was always going to suffer. The serious overcrowding of asylums led to a decline in the quality of care and inevitable understaffing (Rothman, 1980); partially due to the poor staff-to-patient ratios which resulted from the overcrowding (Gittins, 1998). Overcrowding was a major problem in asylums as early as the 1860s, and in 1876 the Commissioners in Lunacy reported that 23 out of the country's 49 county asylums were overcrowded whilst most of the others were pushing the limits of their capacities (Ewing, 2009). As Rothman states: *"overcrowding had reached scandalous proportions, making even the most rudimentary form of patient classification impossible"* (1980: 319). Overcrowding eventually restricted the asylums to largely custodial roles, and the loss of the 'asylum ideal'.

Fiscal conservativism is one reason which frequents much of the literature on asylum closure (Wolch and Philo, 2000); highlighted by some as being the key reason behind reform, described in one instance as *"saving money…by getting people out of hospital"* (Jones, 1993: 225). The key stance behind financial reasoning for closure seemed to be that asylums were 'wastes of resources' (Jones, 1993). This massive potential financial outlay meant that: *"the opportunity cost of neglecting community care in favour of asylum treatment – inevitably far more costly than the most generous scheme of welfare payments – rose sharply"* (Scull, 1977: 135). Decarceration therefore became the more financially viable option. Other proposed reasons for asylum closure range from anti-psychiatry ideologists (Wolch and Philo, 2000); geographical reasons- such as close proximity to

other sites; and even the management structure of the asylum and its NHS trust (Chaplin and Peters, 2003). What can be shown is that there is little variation in closure rates in terms of either the location or speciality of the asylums (Chaplin and Peters, 2003).

Developments in drug therapies made the move to community care, and the widespread closure of psychiatric asylums, possible. Pre 1950s the main treatments for psychiatric conditions were insulin induced comas, ECT and lobotomy (Lawton-Smith and McCullock, n.d.). This began to change with the development of Lithium and Chlorpromazine. Lithium is a mood stabiliser, and has in fact been around since the 1870s (in the form of Lithium Bromide), but was a subject of much debate over the years with opposition to its use, which included opposition from a small group of opponents at Maudsley Hospital (Shorter, 2009). Chlorpromazine is a phenothiazine antipsychotic medication which was first synthesised in 1951 in the laboratories of Rhône-Poulenc. Chlorpromazine was available on prescription as early as 1952 in France and had reached the rest of the world by 1955 (Ban, 2007). The risk threatening patients has been much reduced since the development of these psychotropic drugs, enabling a decentralised system of care. The problem of incurability of a large number of patients led to the mass overcrowding which signalled the beginning of the downfall of the asylum. These drug therapies made deinstitutionalisation possible, as chemical treatments made living in the community a possibility for patients who otherwise would have needed 24-hour care.

One other aspect of the asylums that reoccurs as a reason for closure relates to the 'old-fashioned' Victorian buildings seen as 'unfit' to care for patients in the modern era. This can be alleviated to an extent by modernisations to the buildings in the late 20th and early 21st centuries; however, this is not always an option and can be costly; for example if the buildings are under some form of heritage protection. In addition to the high cost of modernisation, there are also significant costs involved just for the maintenance of old buildings, which may have had an effect on decision whether to retain or close these sites. What is easy to forget is that at the time of their

establishment, county asylums were at the *"very forefront of modern medical treatment"* (A History of County Asylums, n.d.), and the first buildings to be specifically designed for the care of the insane. The asylums have been described as an "*altruistic intervention by society in behalf of the welfare of the insane through legislation and the founding of hospitals for beneficial care and medical treatment*" (Grob, 2012: 33). In this vein it has been stated that: *"whatever our negative views are of the Victorian asylum today, the attempt in the 1840s to improve the care of the mentally ill were a stark contrast to the treatment they had previously endured. Victorian theories on mental health were far more benevolent than their predecessors"* (A History of County Asylums, n.d.). But despite the original intentions and modernness of county asylums, they were increasingly viewed as virtual prisons; places which inspired fear in the general population, perpetuating the stigma already surrounding mental health (A History of County Asylums, n.d.).

There have been multiple scandals across asylum history which have negatively impacted upon their image. The scandal that arguably received most attention was at Ely Hospital in 1967. Reports about poor conditions at the hospital alongside allegations of ill-treatment, and even stealing, against the staff led to public outrage. Evidence came to light which showed an isolating institution that was chronically understaffed, and the few staff that they did have were often undertrained. The inquiry heavily criticised the management of the system rather than focusing on Ely itself, which acted as a catalyst for asylum closure and the furthering of community care (Drakeford, 2012). Subsequent to this was the 1972 Whittingham Hospital Report, which revealed allegations of ill-treatment and an inquiry into the manslaughter of a patient. The inquiry reported that almost half of patients had no occupation during the day, and sat around 'becoming cabbages'. It was also reported that one ward had 6 nurses to care for 126 patients. The inquiry states that the mental health system had been divided into the well-staffed acute units and 'long stay dumps' (1972, n.d.).

Another factor that may have contributed to the decline of the asylums is the anti-psychiatry movement, spearheaded by R.D. Laing and David Cooper. They felt that: *"whenever and wherever psychiatry has been recognised and practiced as the medical speciality*

dealing with the treatment of insanity, madness, or mental disease, then and there persons have been incarcerated in insane asylums, madhouses or mental hospitals" (Szasz, 1975: xv). Laing challenged the idea that mental illness was an entirely biological phenomenon, and felt that the *"biochemistry of a person is highly sensitive to social circumstance"* (1967: 95). Cooper objected to the methods of treatment employed for mental health problems when he stated: *"tens of thousands [of people] in this country have their brains surgically mutilated or battered by successive courses of electro-shock and, above all, their personalities systematically deformed by psychiatric institutions"* (1967: 14). He put this under the category of 'psychiatric violence', which also incorporated the removal of an individual's rights, such as under the 1959 Mental Health Act; removing the patient's rights to leave a hospital of his or her own volition (Cooper, 1967). This deprivation of liberty was justified in two ways: the claim that mental health was more important than personal freedom, and that the liberty problem is so small that it is insignificant (Szasz, 1975). This paraphrasing of George Orwell describes the anti-psychiatry movements succinctly: *"all hospitals are medical, but some hospitals are more medical than others. Some- mental hospitals, for example, are medical in name only; actually, they are prisons disguised as hospitals"* (Szasz, 1975: xix).

Scull (1977) discusses the process of decarceration in mental health, and states that in both England and the United States it was being implemented at an advanced rate. He notes that the process of decarceration ran counter to over a century's trend of incarceration and institutionalization. A look at hospital statistics shows a decline in mental health residents in the 1950s and 1960s, but an increase in admissions over the same period; in this way it can be surmised that it was the way in which mental health was being treated that was changing, not the number of overall patients. This, coupled with the state of physical decay some of the Victorian asylums were in by this point (possibly due to financial restrictions put upon the NHS), a convincing argument was put forward for a move away from traditional asylum care (Scull, 1977). Also: *"it was widely assumed that a massive capital investment program would shortly be required, both to rebuild and replace the most rundown portions of the existing physical plant, and to relieve the overcrowding then… endemic in the system"* (Scull, 1977: 66). The criticism of the old

Victorian asylum buildings were all too frequent; as they generally became to be thought of as being *"fundamentally antitherapeutic institutions [that were] having a detrimental impact on their inmate populations"* (Scull, 1977: 77).

A final factor which can be regarded to have had an impact on the decline of the asylum in the UK was the introduction of the welfare state. The development of capitalism meant that labour was an ever-increasingly important asset, and *"social insurance became one of the means of investing in human capital"* (Scull, 77: 131). Although this was somewhat delayed by the persistence of a classical liberal ideology, the rise of the welfare state did act to make *"segregative modes of social control… in relative terms, far more costly and difficult to justify"* (Scull, 1977: 135). Previously there had been no alternative to residential care, as the patients could not provide for themselves and there was no real alternative; the welfare state provided the opportunity for support (Scull, 1977), which enabled the community care system to take over.

The Fate of Asylum Sites

Following Enoch Powell's speech a period of rapid asylum closure began. The 1962 Hospital Plan envisaged the cutting of mental illness beds by approximately one third by 1975 (1962 Hospital Plan, n.d.). The direct closure of thirteen large mental hospitals before, and nine after, 1975 were announced; alongside provisions to reduce the size of most of the 87 remaining (1962 Hospital Plan, n.d.). In the first half of the 1970s the populations of mental hospitals fell dramatically, by approximately 20,000 patients (26,000 including mental handicap patients); though there was debate over what this actually meant (1976, n.d.). This led to a situation where the majority of psychiatric asylums were subsequently closed:

"After a century or more of service, nearly all Victorian asylums have now closed and their sites and buildings have been sold; most have been lost or changed beyond recognition. Few people outside the local communities near the asylums noticed or cared about the loss of such a rich

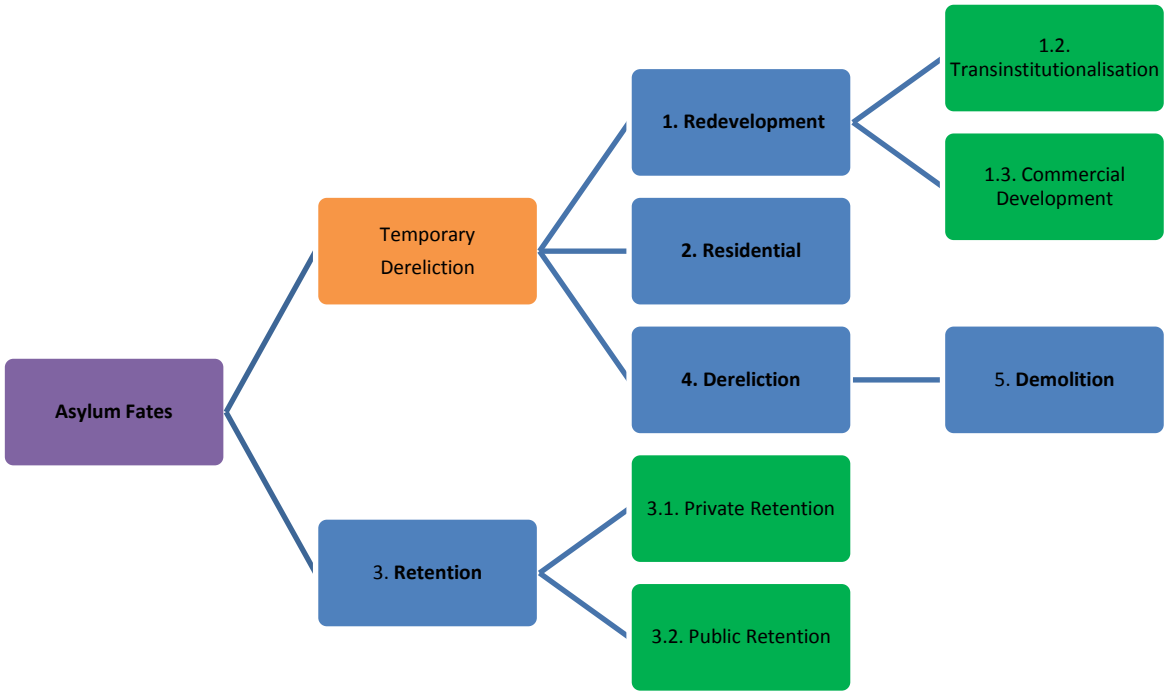
strand or Britain's social, medical, architectural and landscape heritage" (Rutherford, 2008: 3).

During this establishment of community care as the predominant mode of health care in the UK, the former asylum sites and buildings (those that had not been demolished) still stood. The continued existence of the asylum, an anthropoemic institution in an era of anthropophagia, leaves a question hanging over them with regards to their fate. *"Many hospitals will…continue to be lived in long after the last patients are discharged and will stand as monuments to those who lived, worked, and died there"* (Chaplin and Peters, 2003: 228-229). Chaplin and Peters in 2003 set out to identify asylum fates at a number of case study sites around the London, Oxford and West Midlands areas; and they found that in these areas there were a total of 71 hospitals, including 44 mental hospitals, 26 specialising in learning disabilities and one 'special hospital'. What they found was that a large number of these sites had been transformed into either 'luxury housing' or as 'gated communities'. However what they also found was that many of these asylums were still open despite decades of deinstitutionalisation and policy of closure (Chaplin and Peters, 2003). Similarly Dolan, in a survey of the reuse of US state mental hospitals (which involved sending questionnaires regarding changes to real estate to 258 hospitals), found that "*surplus state hospital property has been put to a wide variety of uses by many types of organizations*" (1987). This is outlined as including reuses associated with education, recreation, office spaces, and housing (Dolan, 1987). Dolan found that 32% of the hospitals in the survey had "*undertaken property transfers involving 370 buildings and 20,000 acres of land*" (Joseph et al., 2009). Of the hospitals in question a large number were found to include the fates of residential and redevelopment, whereas 26% of usages were mental health related.

The following section will analyse the ways in which these asylum sites were re-established as useful parts of society, firstly by looking at the background of asylum re-use and then by looking at the different fates of ex-asylum sites under the broad headings of: Redevelopment; Residential; Retention; Dereliction; and Demolition. Figure 1 shows the proposed five-fate model for former psychiatric asylum sites; key

fates are shown in blue and sub-fates are shown in green (with temporary dereliction in orange). It is pertinent to note that despite the location of the dereliction and demolition boxes, it is also possible for those former psychiatric asylums which have been publically or privately retained to subsequently go through a period of dereliction and then demolition. This will provide an overview of issues surrounding the fates of the asylum, analysing the three categories for continued use: Redevelopment; Residential; and Retention. In addition to this are the additional fates of dereliction and demolition.

Figure 2.1: Five Fate Model of the Fates of Former Psychiatric Asylums



In 1961 Enoch Powell described mental asylums as 'shells' and 'frameworks' that merely contain certain processes, Powell stated that when those processes changed the framework must 'be dismantled' (Enoch Powell's Water Tower Speech 1961, n.d.). In his direct stance against retention, redevelopment and residential uses for the old asylum buildings, it is not hard to see what asylum fate Powell preferred, demolition:

"well, let me here declare that if we err, it is our duty to err on the side of ruthlessness. For the great majority of these establishments there is no appropriate future use, and I for my own part will resist any attempt to foist another purpose upon them unless it can be proved to me in each case that, such, or almost such, a building would have had to be erected in that, or some similar, place to serve the other purpose, if the mental hospital had never existed (Enoch Powell's Water Tower Speech 1961, n.d.).

What many would consider a last resort was Powell's indiscriminate starting point, and he wanted to foster this feeling among all of society, and dismantle any and all forms of positive memorialisation connected to the sites, and to destroy the *"built-in tendencies to perpetuate the old"* (Enoch Powell's Water Tower Speech 1961, n.d.). However it is fair to surmise that: *"the stigma associated with the psychiatric asylum—the almost universal characterisation of it as an inhumane and outdated treatment modality—was accentuated in debates that occurred during the years immediately prior to closure and has remained salient in debates over reuse"* (Joseph et al., 2013: 5).

Redevelopment

Redevelopment as a category describes those asylum sites which have been reused in a separate institutional capacity, as transinstitutionalisation or as sites of commercial redevelopment. The possibilities within this category are great, some of the more common examples of re-use being: educational; light industrial; and carceral uses. More outlandish re-uses include as a Buddhist monastery and as a community centre.

As pointed out previously, the vilification of asylums does not necessarily mean that the sites themselves are vilified (although many are); and the nature of re-use of asylum sites affects directly the forms of remembrance and memorialisation which are experienced. Consequently, the re-use of asylum sites in a capacity substantially different from those original uses (i.e. outside the healthcare sector) should aid the neutralisation of stigma on the site through reduced instances of memorialisation. The architectural merits of the asylum provide an adaptable infrastructure with which

architects can use in the redevelopment of a new facility. The large main buildings and the excess of grounds are two such features which allow for much flexibility in the redevelopment of the sites (evident in the numerous different reuses of asylum sites listed above).

As Franklin states, there are a number of influences on the design and use of a building over time, which includes: ideological positions; political interventions; societal attitudes; technical knowledge; economic conditions; spatial contexts; and public perceptions (2002). Following widespread closure, the actual disposal of the psychiatric asylums was the responsibility of the health authorities who owned and managed them. There was a general recognition of the issues involved in the disposal of these sites, and there was a need to reconcile tensions between achieving value for money, preserving the historic environments and maintaining public accountability. In the early years of asylum redevelopment the UK was in the midst of a housing market depression, and therefore these asylum sites, when they were developed at all, came under the fate of redevelopment (either transinstitutional or commercial) (Franklin, 2002).

There are a number of difficulties involved in redeveloping former psychiatric asylum sites, not least of which being that developers are unsure what to do with a place which has been stigmatised. This was due to the difficulty of redeveloping the stigmatised space for use by the general community, who may perceive it to exist "*as a place for the 'other' and not for 'us'*" (Cornish, 1997: 105). With reference to St Lawrence's hospital in Cornwall (now mostly demolished with one block redeveloped into housing) Cornish states that it had been difficult to find a use for it, as "*there are immense 'difficulties of redeveloping a place with institutional associations throughout the county of Cornwall'*" (Cornish, 1997: 106).

Kearns et al. (2010) look specifically at the redevelopment of asylum sites within higher education, focusing on New Zealand and Canada, and even more specifically on the sites at Carrington (Auckland) and Lakeshore (Toronto). Kearns et al. note that

examples of memorialisation at the Lakeshore site is largely seen at a physical level, in the architecture itself. They also state that during the discussions on redevelopment, the emphasis was largely on the architectural merits of the site as opposed to the previous use (Kearns et al., 2010). A formal (and inevitably controlled) form of memorialisation appears in the form of art-work and plaques in the third garden attached to the assembly hall; one of which reads: *"they're closing the hospital soon . . . We're been taken to a place we don't know. Some cried* [sic]*"* (Kearns et al., 2010: 739). Chaplin and Peters, in their study of psychiatric hospitals, note that of the 32 redeveloped sites the only examples of memorialisation were the sites of remembrance, limited to "*a memorial garden dedicated to the patients of Cell Barnes and Hill End Hospitals, St Albans, a plaque at Littlemore Hospital, Oxford, and photographs of the former Bethlem Hospital at the Imperial War Museum*" (2003). The forms of memorialisation provided here, such as the ones noted above, are all controlled- in that they all proffer a positive outlook towards the site; however as Kearns et al. point out it is the buildings and staff that are celebrated rather than the residents themselves. In the case of Carrington Hospital there were limitations to the manipulation of memorialisation on the site, due to the protection of the historical buildings (Kearns et al., 2010). However there are two formal examples of memorialisation relating the former use of the site; one being a plaque that *"acknowledges the past and looks forward to the future"* (Unitec as cited in Kearns, 2010: 740), and the other being a formal plaque recognising the former use of the site and distancing the current site from the previous use, one phrase used being: *"from the shadows of the past Unitec is building pathways to tomorrow and has established this place as part of a centre of learning"* (Kearns et al., 2010: 740). In these two cases formal memorialisation is either limited to physical or positive aspects of their previous use (Lakeshore); or focused on the contrast between the previous use and the new direction which is being undertaken; often using binary notions such as dark and light. Chaplin and Peter's analysis of advertising brochures for redeveloped sites show the way in which they are memorialised. This included references to 'tastefully converted period buildings', 'sanctuary' and 'original 19th Century Elegance' (2003). However, as Chaplin and Peters so aptly put it:

"*Residents at the redeveloped site of Nethern Hospital will be greeted by 'the gentle bounce of tennis balls on private courts' and 'the distant voices of children'. They will, however, remain unaware of the 1976 inquiry (Martin, 1984) into high levels of suicides that found serious understaffing and unsatisfactory conditions on the wards. At St George's Park in Oxfordshire, prospective buyers were informed of the 'original 19th century elegance' and 'original features including high ceilings'. They are not informed that the original psychiatric hospital has been newly built over the road*" (2003).

Residential

Residential as a category describes those asylum sites that have been converted into housing and it is the joint largest category to be discussed here. With an ever growing population resulting in an almost constant need for new housing, former psychiatric asylum sites, in their role as brownfield sites, are prime sites for conversion into housing. *"There was recognition at the highest levels of government that as much as possible demands for urban growth should be met from previously used ('brown field') sites"* (Joseph et al., 2013: 5). Brownfield sites are defined as: *"abandoned or underutilized industrial and commercial sites that are, or are perceived to be, chemically, physically, or biologically contaminated"* (Greenberg, 2002: 703). This push for sustainable development has been central to development policy since the mid-nineties, and the utilisation of brownfield land over greenfield land is central to that policy (discussed in Chapter 5). Asylum sites have significant development potential, as they tend to be in secluded areas and surrounded by land, aspects which are highly sought after in the current housing market.

The use of brownfield sites, such as asylums, for redevelopment is arguably the result of a policy of gentrification (often rebranded as 'urban regeneration') (Smith, 2002). Gentrification has been defined by the American Heritage dictionary of 1982 as the *"restoration of deteriorated urban property especially in working-class neighborhoods by the middle and upper classes"* (as cited in Smith and Williams, 1986: 1). Gentrification has also been described by Glass: *"one by one, many of the working-class quarters of London*

have been invaded by the middle classes—upper and lower… Once this process of "gentrification" starts in a district it goes on rapidly until all or most of the original working-class occupiers are displaced and the whole social character of the district is changed" (as cited in Smith, 2002: 438). It has previously been stated that although property developers, in their advertising, use a similar terminology to that used for the original sites themselves- such as 'secluded' and 'sanctuary'- the former use of the sites was generally not referred to (Chaplin and Peters, 2003). This is shown partially by this observation from Joseph et al., in relation to the former Sunnyside mental hospital: *"on the Internet, virtual visitors to Linden Grove would hear of the proximity of the development to the central city, of its array of established exotic trees, and generous park and reserve areas. What they would not learn is that the site was originally part of Sunnyside Hospital and that it is flanked on two sides by the successor mental health care institution"* (Joseph et al., 2013: 10).

In relation to arguments around stigma, it can be surmised that in the UK although stigma has had an impact on the ways in which asylum sites are developed into housing, the need for housing provisions and heritage legislation can be argued to be a more prominent factor in the site's residential redevelopment. It has also been argued that the advantages to the asylum sites in terms of location and quality of housing far outweighs the perceived stigma attached to asylum sites. Victorian asylum sites are often highly prized as housing as they tend to include a security wall, which previously satisfied the need to keep patients in, now is the perfect setting for those who treasure gated communities and wish to keep the world out (Joseph et al., 2013). As it has been pointed out by Chaplin and Peters, it was the paradoxical nature of the asylum sites evolution, whereby rather than keeping individuals within, they can now be bought into as a self-contained community, in order to keep society out (Chaplin and Peters, 2003).

Retention

Retention as a category describes those asylum sites which have been retained within the health care sector, be that private or public health care. The focus of the literature available has been on the survival of private asylums as continued sites of healthcare. The extent to which the current community care system has moved away from an era of confinement is however debatable; with the survival of public institutions (such as Broadmoor) and secure units as a provision to combat dangerousness. It can be said that the survival of these institutions indicates a latent public support for residential forms of mental health care and their therapeutic potential. Also, it has been seen that asylums can act as a symbol of public identity; and closure can be met with nostalgia and sadness, as well as relief, and this could aid institutional survival (Moon et al., 2005). One argument could be that the survival of asylums (private and public) indicates a lack of stigma, as demand for their use would not be sustained if asylums retained the stigma they once did (Moon et al., 2006).

Private Retention

Private Retention as a sub-category describes those asylum sites that are in use within the private health care sector. Private forms of residential care for individuals with mental health problems which have persisted despite the focus on public health care and in particular community care. Also, the adaptability of private providers of residential health care could serve as a method of institutional survival; for example by diversifying into other areas of care. This was seen as one of the key factors in the survival of the private facilities at Homewood (Guelph, Ontario) and Ashburn (Dunedin, New Zealand); with expansions into treatment for addictions, including alcoholism treatments. Moon et al.'s analytical framework matrix has four cells: private asylum; public asylum; private community; and public community. The framework shows how these two sites evolved over time by expanding from private asylum into neighbouring cells; both started off in the private asylum cell before expanding into the public asylum and private community and even into the opposite public community cell (2005). An example of the use of the analytical framework matrix can be taken from

Homewood and Ashburn, where the private asylums expanded: into the private community cell with the development of outpatient services; into the public asylum cell with the acceptance of publically funded patients: and into the public community cell with the offering public funded community care programmes. Moon et al. state that: *"survival in the asylum-private cell of the matrix means that an institution has to reach out to the community-care paradigm for legitimacy and to the public sector for financial support"* (2005: 170).

A key feature of the survival of private asylums has been their ability to tap into a latent public demand for private residential care; which is achieved using *"an implicit (re)mobilization of ideas of 'therapeutic landscape'[s]"* (Moon et al., 2006: 132). This has been achieved through, essentially, advertising- as the creation and control of the image of the asylum, often as secluded and concealed, acts to sell the asylum to potential consumers (Moon et al., 2006). Place-centred care has seemingly survived as a notion, despite an emphasis on community care, de-hospitalisation and pharmaceuticals. The modern-day Priory Hospitals, in their approach, echo those of the historic asylums- promoting aspects such as seclusion, security and above all 'asylum' (Moon et al., 2006). The places themselves are promoted as being safe and secure, and the: *"landscape is portrayed as a key element in the promotion of better mental health and ordered, highly designed park-like settings are a characteristic of many of the Priory Hospitals"* (Moon et al., 2006: 137).

Added to this is the feeling of exclusivity which is achieved partially due to the private nature of the health care being received. The advertising attached to Priory Hospital's seems to replicate those of a hotel, with the emphasis on the facilities and what you can be offered (Moon et al., 2006); exemplified by the promise that *"each patient has the privacy of their own comfortable bedroom with television, telephone and en-suite facilities"* (Priory Group as cited in Moon et al., 2006). The focus on physical fitness, often seen in the historic asylums, is also a key element of the Priory Group Hospitals- with the availability of recreational facilities and activities such as horticulture. The key theme of the Priory Hospitals is arguably one of choice (Moon et al., 2006). This is all part of

the new private asylum being defined through consumer-led marketing. With image being a key part of the survival of the private asylum, promotion of the asylums has become an important aspect. Moon et al. state that: *"promoting (private) asylum facilities must involve countering the legacy of the poor reputation of the historic asylum. It must also counter both the positive and the negative images of community care"* (Moon et al., 2006: 145).

Public Retention

Public Retention as a category describes those asylum sites that are still in use within the public health care sector; be it as a form of residential care or for other uses, such as offices. Rothman discusses the concept of 'enduring asylums' and the varying ways in which American mental hospitals attempted to redesign themselves in the face of impending decline. The question was, *"why were proposals for change so rarely put into effect?"* (Rothman, 1980: 324); as mental health care in asylums persisted rather than moving into the community. The key method of continuation resided in linguistic changes; with 'asylums' becoming 'hospitals', and 'institutional attendants' becoming 'nurses'. Within these changes state mental hospitals, as a method of avoiding stigma, often did not designate in their names the types of disease the hospital treated. These changes have been described as being akin to 'grand larceny' as these institutions, though rebranded, were practically the same as before and remained largely custodial institutions (Rothman, 1980). Moon et al. put forward the suggestion that the retention of former psychiatric asylum sites could be a "*tacit recognition of its locational advantage, ownership and historical associations*" (Moon et al., 2015: 6).

Serra (2005) felt that the asylum continued because it was being held up by three pillars: a lack of understanding of psychiatric patients; the risk which threatens psychiatric patients; and incurability. A lack of understanding of psychiatric patients creates an environment where stigmatized images become prevalent and normalised. It leads to widespread 'othering' characteristic of an anthropoemic society. This stigma attached to mental health also effects psychiatric asylums, as they are seen "*as a place for the 'other' and not for 'us'*" (Cornish, 1997: 105). The government has attempted to

counteract this stigma with its 'No Health without Mental Health' campaign (Department of Health, 2011); and charities such as 'Time to Change' campaign to dissipate the stigma surrounding mental health (Time to Change, n.d.).

One factor thought to have elongated the life of the asylum system was, what has been termed, a 'public fascination with confinement'. The removal of the insane from the community and confining them inside the walls of the asylums created an 'otherness', through a process of othering which provided a dichotomy of 'sane' and 'insane' (Canales, 2000). Once this stigma is attached to the 'insane' person, they are subsequently stigmatised (Canales, 2000); and therefore: *"by definition…we believe the person with a stigma is not quite human. On this assumption, we exercise varieties of discrimination"* (Canales, 2000). In this way *"the possibility of ordinary people misperceiving and exaggerating the most common features of mental disturbance was greatly exacerbated"* (Scull, 1977: 126). This misperception served to reinforce the general belief that asylum patients should remain incarcerated. This was similar to the United States situation discussed previously, where the proposed decarceration of patients into the community was problematic due to *"some towns [not wanting] any type of ex-inmates in their midst"* (Rothman, 1980: 361). Jodelet (1991) tells of a number of discriminatory practices towards assumed mental health patients, including the quality of service given, the quality of product sold to them and where they were allowed to be in public settings.

Asylum sites can be retained in two categories: for health care use; and for administrative use. These two categories are definitive but not mutually exclusive. This area of study is important because, currently, no research has looked into the current forms in which former county psychiatric asylums are retained within the National Health Service. This is important as it could provide insight and recommendations as to the future use of these sites, as well as providing a base for a comparative analysis comparing these sites to a) new build facilities and b) non-specialist facilities (i.e. mental health incorporated into general health sites).

The continued use of asylum sites for health care purposes, specifically in the public sector, is the topic which this thesis will be based around. Little has been previously written about the retention of asylum sites within the health care system- particularly within the public health care system, namely, the National Health Service. My aim therefore is to study, within the category of retention, the use of asylum sites within the public health service in the UK. This study will look at asylum sites that have been retained and how they are being used within the National Health Service.

Dereliction

UK asylum sites, for the most part, have been either redeveloped, demolished or stand derelict- awaiting one of the former. Dereliction covers a not insignificant proportion of former psychiatric asylum sites. Dereliction occurs as a temporary status usually between closure and the decision as to the future of the site. Some sites *"have been left derelict for several years whilst their future has been debated"* (Franklin, 2002: 174).

These spaces have alternatively been given the name 'edgelands': *"an incomprehensible swathe we pass through without regarding; untranslated landscape"* (Farley and Roberts, 2012: 5). These edgelands are not lasting; they are in a constant state of flux (Farley and Roberts, 2012), for example, derelict psychiatric asylums are eventually redeveloped after a period of dereliction. The following quote from Edensor, although not writing about psychiatric asylums, is nevertheless apt: *"these places often exist in a hiatus between the end of one industrial era and potential future redevelopment. As such, they become non-places, quite literally off the map – 'an impossible designation of space as terra nullius, which suggests they are spaces of and for nothing'. And they atrophy because their blood supply is cut off"* (as cited in Farley and Roberts, 2012: 151). Abandoned asylums are just this, the remnants of a previous era of healthcare provision awaiting future development (or demolition). They are anthropoemic institutions surviving in an era of anthropophagic care. They 'atrophy' as a result of the lack of maintenance and, as we have seen in some cases, the buildings themselves deteriorate so much that redevelopment is not an option. Alternative to this, through their redevelopment (residential or otherwise) or

demolition, these sites become an entirely different place/space altogether. They can become a form of residentialised space, a public space (in the form of educational facility etc.), or an 'empty space' through abandonment; with only a small number being retained within the health care sector.

Through their dereliction and status of 'non-place' former psychiatric asylum sites arguably maintain a lingering stigma attached to their prior usage. Where sites which are redeveloped or 'residentialised' can be said to be somewhat 'cleansed' through a process of selective remembrance attached to their new uses; derelict sites are left as shadows of their former selves, maintaining the stigma attached as a result of what were seen as inhumane and outdated treatments (Joseph et al., 2013). The asylums have been described by Joseph et al. as "*liminal spaces between the old and the new, zones of ambiguity stigmatised by the shadow of their former use*" (2013: 136). Stigma is a key factor in relation to derelict former psychiatric asylum sites. Abandoned asylum buildings are most frequently discussed in relation to urban exploration, whereby abandoned structures are entered and explored, with photographs being taken of the sites in question. It could be argued that urban exploration reinforces the stigma attached to these sites by keeping their previous usage in the public eye and mind. Rather than these spaces going through a process of strategic forgetting and selective remembrance (Joseph et al., 2012); urban exploration has meant that these sites remain as monuments to asylum history, meaning that the spaces remain stigmatised. Strategic forgetting can be defined as: "*the minimisation of reference to past uses and events in publicity and signage*" (Kearns et al as cited in Joseph et al., 2013). Selective remembrance is seen in the ways sites make reference to their former usage; whereby the site's former usage is largely glossed over and focus put on factors such as the architecturally distinguished buildings. An example of this would be through the acknowledgement of the sites history as a hospital, but not of the sites specialisation as a mental health institution (Joseph et al., 2013).

Demolition

Demolition (alongside Residential) is the joint most common fate for psychiatric asylum sites; and is the most final of the fates discussed. For the most part these sites, following demolishment, fall into Bauman's concept of empty spaces: *"empty spaces are places to which no meaning is ascribed. They do not have to be physically cut off by fences or barriers. They are not prohibited places, but empty spaces, inaccessible because of their invisibility"* (Bauman, 2000a: 103). The chief motivation behind the demolition of psychiatric sites appears to be financial, as Franklin states: *"in some cases, they have demolished the buildings, as a cleared site is potentially more profitable* (2002: 174). In this way, the longer the asylum site is left derelict (seeking a decision for future use), the more likely that site is to be demolished. This has been explained by Kearns et al.: *"the run-down condition of most psychiatric hospital buildings at the time of closure, and subsequent further deterioration, has resulted in potential owners generally regarding buildings as an obstacle rather than an asset to redevelopment"* (Kearns et al., 2012: 9).

Demolition of former psychiatric asylum sites allows developers to create an almost 'clean slate' with which to develop the space. This may in fact not only be more profitable, but also easier. The demolition of the buildings on these sites, therefore, is fairly common; with the only real incentive to keep the buildings being when they either have an impressive or attractive façade, or if they have some form of heritage protection attached to them. There are a number of heritage protections which may prevent the demolition of former psychiatric asylum buildings and the development of their sites: listed building status; conservation areas; Tree Preservation Orders; and town/village green status. These protections act directly to remove demolition as a possible fate for the sites concerned. The concept of heritage has evolved significantly over time, as initially it was dominated by ideas of preservation, which focuses on the idea of "*buildings as monuments, selected according to sets of supposedly objective and obvious intrinsic criteria, such as age or beauty, preserved by legally protective designations, imposed by 'experts' in public taste who defined their role as being guardians of public cultural assets*" (Ashworth, 1994: 15). The focus in this was solely on aspects of tangible

heritage. In the 1960s the shift was more towards the concept of conservation, which widened the focus to include not just the 'monuments' but also the surrounds and the context in which they stood. The well-known definition of conservation being 'preserving purposefully', this approach elevated functional qualities alongside traditional selection criteria surrounding beauty and form. In this way aspects of intangible heritage began to be considered, rather than just the form of the buildings their functions within society were elevated to equal status. The goals also shifted to include the regeneration and rehabilitation of areas through land-use management (Ashworth, 1994). A more recent development of the concept of heritage has been towards marketability, with heritage becoming a commodity (Ashworth, 1994; Hardy, 1988): "*history is the remembered record of the past: heritage is a contemporary commodity purposefully created to satisfy contemporary consumption. One becomes the other through the process of commodification*" (Ashworth, 1994: 16). This also combines both tangible and intangible heritage, as the past is marketed in specific ways in order to best sell the properties through processes of selective remembrance (Kearns et al., 2010).

Within the National Health Service there is a mixed policy regarding former psychiatric asylum sites. A previous NHS Estates document from 2001 (on sustainable development within the NHS) directly mentions former psychiatric institutions, when it states that: "*some redundant estate, such as former psychiatric institutions, may be on very valuable building land. However, the sustainability benefits of re-using such sites may be nullified by their remote location, which creates unsustainable traffic movements. Such sites may be large enough to accommodate mixed-use development in a sustainable way*" (NHS Estates, 2001: 27). This puts forth a negative view of psychiatric asylum sites, and the emphasis appears to be on demolition and sale rather than retention; with reference to their 'valuable building land' (note land and not buildings, or even site) and 'unsustainable traffic movements'. However, the same document goes on to say that: "*most people would think that there is greatest potential to build sustainability into design when beginning with a clean site. However, great benefit can also be achieved from renovation of existing buildings (avoiding the need for expensive and resource-intensive new construction), and the renovation and modernisation of an existing building should always be the first*

consideration. Although some techniques require particular building configurations that cannot be retrofitted, many approaches will work as well within an existing building as in a new one" (NHS Estates, 2001: 29).

Conclusion

This review has covered the existing literature on psychiatric asylums and Post-Asylum Geographies. It has provided a brief overview of asylum histories, ultimately focusing on the fates of county asylum sites in the era of community care; the survival of anthropoemic institutions in an era of anthropophagia. What we have seen is the original purpose and aim of the asylums, to treat those with mental health problems, with ideas surrounding non-restraint and therapeutic landscapes. We have also seen this ideal crumble under the pressures of overcrowding, leaving psychiatric asylums as purely custodial institutions employing less than ideal methods and standards to the patients under their care. We have seen the factors which led to the closure of psychiatric asylums, a combination of: fiscal conservativeness; negative remembrance-caused by scandals and political pressures; and the development of drug therapies amongst other reasons. This directly led to five situations: a switch to a system of community care; the redevelopment of asylum sites for other, non-healthcare uses; the dereliction of asylum sites; the demolition of asylum sites; and the continued use of asylum sites for health care purpose. The switch to the community care system played a key role in the widespread closure of psychiatric asylums. The system as it stands works on the principle that psychiatric patients no longer require large residential facilities as part of their treatment regimes.

The continued use of asylum sites for health care purposes, specifically in the public sector, is the topic which this thesis will be based around. Little has been previously written about the retention of asylum sites within the health care system- particularly within the public health care system, namely, the National Health Service. In fact the reason why some former psychiatric asylums have been retained when the vast majority have been redeveloped, residentialised, left derelict or demolished is unclear.

My aim therefore is to study, within the category of retention, the use of asylum sites within the public health service in the UK. This study will look at asylum sites that have been retained and are being used within the National Health Service, and the reasons behind their retention. What we can see from this review is a number of key issues which have arisen with regards to former psychiatric asylum retention, namely: planning policy; mental health care policy; urbanisation; sustainable development; and heritage amongst other issues. These issues will be discussed at length later in this thesis: the next chapter will outline the methodology which this thesis utilises; including the research design and research methods.

Chapter 3: Methodology

Introduction

This chapter outlines the methodological approach taken in this thesis. It will outline the research design and methods used within the study. The research methods section is split into three parts: archival research and content analysis; interviews; and walkthroughs. The chapter then goes on to discuss ethical considerations, including the governance process which was undertaken as part of the research and issues concerning positionality.

Research Design

This section outlines this study's research questions as well as going on to discuss the case study format adopted. Following this the process of identification and selection of case study sites is discussed, outlining the methods used to identify former psychiatric asylum sites which have been retained within the NHS and the decision making process involved thereafter with respect to the selection of case study sites.

Research Questions

In order to answer the questions of how former psychiatric asylums have they been retained and what has led to their retention, a number of hypotheses were developed about what may have affected the state of retention; although as the methods in this study were reflexive issues which arose as part of the methodological process would also be investigated. The following are the original research questions which the methods in this thesis sought to answer:

- Considering the general move to community care and the decentralization of mental health care in the UK, what factors have contributed to the retention of mental health care on county asylum sites?

- To what extent have different aspects of NHS Estates policy and planning policy affected the retention of psychiatric asylum sites?

- To what extent have heritage management issues affected the retention of the sites?

- What effects has urbanisation had on the geography of the site?

- What effect has sustainable development policy had on the retention of psychiatric asylum sites?

- To what extent has stigma affected the retention of psychiatric asylum sites?

- Do these sites suffer from any form of stigmatisation due to their history?

- What are the opinions of the local communities surrounding the psychiatric hospitals regarding them?

- Do the general public make use of the hospital sites in any way (not necessarily for medical purposes)?

Case Studies

The approach which has been applied to this thesis is that of case studies. Yin states that 'case study' "*refers to an event, an entity, an individual or even a unit of analysis. It is an empirical inquiry that investigates a contemporary phenomenon within its real life context using multiple sources of evidence*" (as cited in Noor, 2008: 1602). Case studies were chosen for this thesis as a method in order to collect data from multiple evidence sources. This is so that both a larger dataset could be attained and also so that cases could then be compared and contrasted to each other. Also: "*this approach is useful in situations where multiple sources of evidence can be gathered, the problem is complex and*

poorly understood" (Welsh and Lyons, 2001: 302). This ability to utilise multiple case-sites makes case studies an ideal methodology for this thesis, especially considering that the topic area is one which is largely unstudied and therefore 'poorly understood'.

As Bryman points out case studies are most commonly associated with particular locations; and research done in a case study format tend to involve intensive research into those locations (2014). Case study design is a continual process as it evolves during the study. It is my intention to include multiple case studies during this project, in order to collect varied data to analyse, compare and contrast. This will make the results more analytically generalizable (Welsh and Lyons, 2001). As Robson states: "*ideally case study calls for well trained and experienced investigators, but other aspects are also important. Personal qualities such as having an open and enquiring mind, being a 'good listener', general sensitivity and responsiveness to contradictory evidence are needed*" (1993: 162).

I have applied case studies within this thesis due to the nature of the topic of research. As multiple sites needed to be utilised in order to gain enough data for this study, splitting into case studies based on sites was the most logical way forward. In order to identify potential case study sites a spreadsheet of all former county psychiatric asylums in England and Wales was created. This was initially created from an amalgamation of existing databases: primarily Timechamber and Simon Cornwell. Then this was modified with the input of other websites, including Studymore and NHS Choices.

At this point a number of sites had contradictory accounts of their usage. So the next stage involved ringing the Trusts involved to enquire as to the situation of the sites. As a final step the remaining hospitals were contacted by phone and asked directly about the status of healthcare on the sites. As the focus of this process was to identify those sites which reportedly remain open within the NHS; the fates of other sites have been based solely on the amalgamation of data from websites with no further research into their situations. Through this process ten psychiatric asylum sites which were still in

use within the NHS were identified; be that as sites of medical provision or as largely administrative sites within the NHS. These sites were as follows:

Table 3.1- Former Psychiatric Asylum Sites and their Current and Original Names

Hospital	Original Name
Cefn Coed	Swansea and Merthyr Tydfil Joint Asylum
Glanrhyd	Glamorgan County Lunatic Asylum
Hellesdon	Norwich Borough Asylum
Kingsway	Derby Borough Lunatic Asylum
St Bernard's	First Middlesex County Asylum
St Cadoc's	Newport Borough Mental Hospital
St Clement's	Ipswich Borough Asylum
St David's	The United Lunatic Asylum for Cardigan, Carmarthen, Glamorgan and Pembroke
St James'	Portsmouth Borough Asylum
St Martin's	Canterbury Borough Asylum
St Nicholas'	Newcastle Borough Lunatic Asylum
Whitchurch	Cardiff City Mental Hospital

These sites are shown on the following map made using Google Maps (n.d.); what we see from this is the geographical spacing of these retained former psychiatric asylum sites:

Figure 3.1- Geographical Location of the 12 Former Psychiatric Asylums Retained Within the NHS

From this the aim was to choose four sites to act as case studies for the purposes of this thesis. It was decided that four sites was the ideal number, as it would provide enough data which would be comparable without providing too much of a time constraint. The choice of case studies was based on a combination of criteria. The sites were divided into three categories: sites in use for patient care; sites in use for administrative purposes; and sites which combine the two. The aim of this categorisation was to make the sites chosen more diverse across these categories. Access was also a key consideration, so there has also been a preference for sites where more information has been readily available; and for sites where physical access would be more practical. This being said, there was also a conscious decision not to choose multiple sites in similar locations, so as to have a more diverse set of case studies with which to work; this ruled out the use, for example, of all three of the Welsh sites (Cefn Coed, St

Cadoc's and Whitchurch) as it was felt they would not provide a varied enough sample. To this end Cefn Coed, Kingsway, St James' and St Nicholas' Hospitals (see Table 3.1) were chosen as the four sites which would be utilised in this thesis.

Research Methods

Qualitative Research

The nature of this thesis requires the use of qualitative methods as its primary data collection method. Qualitative methods are much more attuned to explore the "*meanings, emotions, intentions and values that make up our taken-for-granted lifeworlds*" (Clifford and Valentine, 2003: 5). Qualitative methods fit into this study well as the data is largely focused on the intentions, meanings and emotions of the participants, institutions and Trusts involved.

This study has been largely designed as an ethnography (with the addition of content analysis), as reflected in the following definition: *"ethnography is a process of creating and representing knowledge (about society, culture and individuals) that is based on ethnographers' own experiences. It does not claim to produce an objective or truthful account of reality, but should aim to offer versions of ethnographers' experiences of reality that are as loyal as possible to the context, negotiations and intersubjectivities through which the knowledge was produced"* (Pink 2007: 22). Pink's argument illustrates that ethnography does not claim to be searching for an 'objective truth', but to offer up an experiential account of reality through reflexive research. This is through what Pink describes as *"a reflexive and experiential process [through] which understanding, knowing and (academic) knowledge are produced"* (2009: 8). However, it must be maintained that ethnography is "*far more than a complex of fieldwork techniques* [it is] *part of a total programme of scientific description and interpretation*" (Blommaert, 2006: 7) with underpinnings in cultural relativism. This illustrates how ethnography does not only refer to a methodological approach incorporating a wide range of qualitative research practices including: interviews; participant observation; and walkthroughs etc., but also an epistemological approach. Ethnography was chosen for this study as it is a wide-ranging and flexible

methodological approach which produces, as stated above, understanding, knowing and academic knowledge of the research subject(s) (Pink, 2009). This research has incorporated a number of research methods, discussed below in three sections: stage 1- archival research and content analysis; stage 2- interviews; and stage 3- multi-sensory autoethnographies (walkthroughs).

The section on archival research and content analysis outlines the background of the methods and the ways in which they will be utilised within this thesis. These methods have been utilised in an analysis of both secondary archive sources such as newspapers, as well as for material such as tweets. The following section on interviews outlines the key aspects of interview methodology and explains the use of semi-structured interviews as the main research method in this thesis. Interviews have been utilised to gather data from participants ranging from members of the public to NHS senior staff and politicians. The final of the three stages will cover multi-sensory autoethnographies (otherwise referred to as walkthroughs) which were utilised during visits to selected former psychiatric asylum sites. This methodology is chosen to provide a separate and contrasting perspective from which to gather data regarding the retention of former psychiatric asylum sites.

Stage 1: Archival research and content analysis

Archival research can be defined as "*the locating, evaluating, and systematic interpretation and analysis of sources found in archives*" (Corti, 2004: 1). This was enacted within this thesis through the examining of local newspaper archives for each of the four case study sites in order to establish a site history and provide a context for further analysis. This was done using a mixture of both physical and online sources. Content analysis has examined social media in an attempt to analyse public opinion regarding the sites.

Archives

An archive is defined by the Oxford Dictionary as "*a collection of historical documents or records providing information about a place, institution, or group of people*" (n.d.). Archives

therefore are "*a place where public records or other historical documents are kept*" (Archive, n.d.). For the purposes of this research local newspaper archives, located in local libraries in the locality of each of the four case study sites, have been utilised in order to collect data in the form of newspaper articles. These were Swansea Central Library, Derby Local Studies Library, Newcastle Central Library, Newcastle Discovery Museum and Portsmouth Central Library. The local newspapers researched include: South Wales Evening Post; Herald of Wales; Derby Evening Telegraph; Derby Advertiser; The Journal (Newcastle); Evening Chronicle (Newcastle); The News (Portsmouth); and the Hampshire Telegraph. In addition to this online newspaper archives and sources have also been analysed with the same goal in mind. The newspaper archives have been used to piece together histories of each the sites to provide a context for each of the case studies. Content analysis of these newspaper archives served to outline the background and history of each of the case study sites and as such, where they were collected manually, articles were taken from the dates just before the asylum originally was built through to the end of the archive material. Added to this were online articles found in online newspaper archives. Articles were included which highlighted the instances of investment (and lack thereof) on each of the sites, that highlighted the changing landscape of the sites and that covered any major events at the sites. Mason states that: "*the idea of documentary evidence used to conjure up a mental image of a researcher digging around in a dusty archive among historical documents*" (2002: 103). In reality this image is still relevant, without as much dust as is imagined in the above quote. There were varying methods of archiving at each of the archive sites ranging from the fully digital to the purely analogue; including full digitalisation, microfilm plus card arrangements and also books of newspaper clippings. The difference from this and the quote above appears to be that instead of sifting through the original copy of the historical documents, you search through cards and microfilms; through newspaper cuttings and old books. Until full digitalisation this image of researchers in an archive will continue to be relevant.

There has been a varying level of difficulty involved in gaining access to specific items in these newspaper archives, which got exponentially more difficult as the research

went on. Swansea's newspaper archives are fully digitised; Derby's have a catalogued microfilm set up; Newcastle have an un-catalogued microfilm set up plus books of newspaper cuttings; and Portsmouth only a partially catalogued microfilm. These difficulties were largely tackled with a degree of persistence and patience, working through the archives logically to find relevant data.

In addition to the use of newspaper archives, an online archive of historical maps has been utilised within this thesis, using old-maps.co.uk and google maps. Maps were taken from different points in history- firstly from old-maps.co.uk the maps most recently after the asylums construction were taken, then the latest of the maps available. In cases where the asylums had undergone major changes a map was also taken from the next available map to these changes. Lastly the google maps image of each of the sites was taken as the current comparison. This process was done in order to provide visual evidence of urbanisation at former psychiatric asylum sites, and equally showed the evolution of the communities surrounding the sites.

Content Analysis

Content analysis is "*a systematic, replicable technique for compressing many words of text into fewer content categories based on explicit rules of coding*" (Stemler, 2001). This study is what Hsieh and Shannon would refer to as a 'conventional content analysis', which is "*generally used with a study design whose aim is to describe a phenomenon*" (2005: 1279). Content analysis has been utilised in this thesis in an analysis of relevant tweets via Twitter, and of posts on specific pages on Facebook. With regards to sampling, due to the limited nature of the sources and data, all relevant posts and tweets (all tweets that were confirmed to be related to one of the four case study sites) were collected and analysed- the collection method for each being discussed more below.

There are many advantages to using content analysis, not least that since the researcher is not present at the time of data production it is what has been frequently described as an unobtrusive method, in that there is absolutely no Hawthorne Effect. The

Hawthorne Effect can be described as: "*the impact of the researcher on the research participants or setting, notably in changing their behaviour*" (United Lincolnshire Hospitals, n.d.); and was first identified in a study of productivity in a factory in Hawthorne, Chicago: "*in sum, it was apparent that the observer (who had tried valiantly to maintain no more than a gently cooperative attitude among the girls, an attitude which would be the same, at the end of the experiment as at the beginning) had neither anticipated nor been able to completely avoid certain dramatic and continuous changes in the total psychological climate in the test room*" (Landsberger, 1961: 10-11). In addition to the lack of Hawthorne Effect other advantages of content analysis include flexibility, cheapness and ease of access (Bryman, 2014); which makes it an ideal method for utilisation in this thesis.

However disadvantages of using content analysis can include that it is not entirely neutral as the researcher selects the content which is to be analysed and the criteria used in its analysis (Sociology, n.d.). This has been partially accounted for in the data collection process, with all articles related to the sites being collected, but the articles presented in the final analysis have been used to analysis specific aspects of local asylum history.

I have also utilised a content analysis of Twitter to analyse tweets relating to the four hospital sites that are the focus of this study. Twitter is a microblogging website with over 1 billion users- of which 271 million are active on a monthly basis- who send an average of over 500 million 'tweets' per day (Twitter, n.d.). These users share their opinions, thoughts and feeling through Twitter- making it an ideal resource for qualitative research (La Rosa, 2013). Twitter has the potential to be 'mined' for spatiotemporal data (Widener and Li, 2014); and the geolocation of tweets has been a key feature of this research. One of the main advantages of Twitter is the fact that its content is largely public and therefore readily accessible: "*[twitter] is easy to access and the conversations between users are relatively easy to follow*" (Tinati et al., 2014: 666). One issue that can be raised with the data collected is that there may be a heightened level of performativity involved in their publication. It has long been said that: "*cyberspace [is] a realm of anonymity and pseudonymity*" (Greenleaf, 2003: 90). The internet is a space

where we, as users, control our image. Social networks combat this to an extent as, especially with Twitter, we connect with both those we know in First Life[3] as well as those we only know in Second Life[4] (Online), and those whom we do not know at all. It can be argued that performativity exists in interviews as well; however the online format itself allows a level of analysis and retrospection before our words are even broadcast. Another issue with twitter may be that its population is not representative of the general population. For example the age demographic of Twitter's regular 271 million users is made up of: 35% 18-29 year olds; 20% 30-49 year olds; 11% 50-64 year olds; and 5% 65+ year olds. This leaves 29% of users under 16 years old. This shows that the age demographic of twitter is weighted towards a younger population, but it must be noted that there is not an insignificant number of 30-49 year olds (1/5 of all users) using the site (Brodzky, 2014).

The approach to Twitter utilised in this thesis can been described as 'small-scale content analysis'. Tinati et al. believe that small-scale approaches do not make the most of Twitter research and the potential for 'big data'; however this research topic is so specific that a large-scale approach would be disproportionate and likely ineffective. Small-scale analysis allows for more in-depth analysis; but at the cost of abstracting much of the data collected from its wider context within Twitter (Tinati, 2014). The initial aim of the content analysis of Twitter was to see how much could be gleaned on public opinion of the hospital sites using Twitter searches. This involves searching Twitter using various forms of names for the hospital sites, sometimes in combination with area restrictions. This process involves utilising the Twitter 'search' function. First, key words were searched for and results collected by typing search terms into the Twitter search bar (hospital names, including slang variations) and adding location-based parameters (e.g. wards, cities). However a general issue with using Twitter for

[3] First Life: a predominantly Second Life term referring to the 'real'/offline world.
[4] Second Life: a virtual metaverse created by Linden Labs. "*Second Life is…a virtual space inhabited by tens of thousands of individuals from all walks of life. All content is user-created through the game's built-in software*" (MMOhut, 2010). Used in this instance to refer to our online presence.

social research is the difficulty in finding what you set out to look for. Tweets which use hashtags relevant to the research will always be easiest to find and those that include keywords can be found without much issue. The difficulty lies in non-specific tweets which can be difficult to contextualise. For example there are 3 St James' Hospitals which appear frequently in searches (Portsmouth/Leeds/Dublin), many without context, so to confirm relevant tweets searches have to be modified to only show results which are geolocated as being 'near Portsmouth'. The issue here is that then you lose all tweets which have no geolocation attached to them. As a result the findings from the Twitter searches are limited to geolocatable tweets including a reference to one of the four case study hospitals within their 140 characters. These tweets are subsequently coded using Nvivo into the same nodes as used for interviews.

Since this process started a number of additional aims were added as more data were found. First, the aim of seeing how much information could be found on site usage via Twitter has been incorporated- following the discovery of a tweet related to dog walking. Second, the theme of 'language' has been added: the aim here was to see how various names for the hospital made their way into everyday language; this was prompted by the discovery of a tweet which used a hospital name as a hashtag as a synonym for 'mad'. The Twitter search has been an ongoing process throughout the thesis and collection has taken place up to May 2015. All relevant tweets found through searches before this time were collected and although there has not been as much data generated as hoped, there is still an adequate amount considering the relative ease of access. However, despite this difficulty a number of tweets were collected for each of the case study sites. It is pertinent to note that the population of Twitter and the general population, whilst they overlap, are not identical. Therefore the data collected via Twitter is likely to be from a limited and unique subpopulation- most likely over-representing younger people and professionals. This approach was boosted by the identification of the Keep Milton Green campaign, and a Twitter and Facebook page set up for the campaign was used as a source for information and opinions. Tweets have been utilised within the 'Case Study Sites' and 'Stigma, Memory, Community and the Surviving Asylum' chapters.

Stage 2: Interviews

Interviews are the most widely deployed method in qualitative research, partially due to its flexibility as a research method. Qualitative interviewing tends to: be less structured; focus on participants opinions more; be flexible; and gather rich and in-depth data (Bryman, 2014). Semi-structured interviews were incorporated in this thesis' approach, which are discussed by Britten in the following: "*semistructured interviews are conducted on the basis of a loose structure consisting of open ended questions that define the area to be explored, at least initially, and from which the interviewer or interviewee may diverge in order to pursue an idea in more detail* [sic]" (1995: 251). This is ideal for this particular study as the aim has been to gather as much data regarding the case study sites as possible with a limited number of possible participants; so as much information as possible needs to be collected from each interview.

As Robson states *"the interview is a kind of conversation; a conversation with a purpose"* (1993: 228). But this leaves the question: what kind of conversations are interviews? According to Cannell and Kahn, one that is: *"initiated by the interviewer for the specific purpose of obtaining research-relevant information and focused by him on content specified by research objectives of systematic description, prediction or explanation"* (1968: 527). It was decided that face-to-face interviews would be the most appropriate form to undertake in this study, as they offer a higher degree of flexibility in comparison to other methods of data collection (such as postal/telephone interviews); and are also more economically viable for low-budget research (Silverman, 2011).

These face-to-face semi-structured interviews have been utilised to extract data from a variety of participants. In this instance this study used purposive sampling; a non-random form of sampling which does not attempt to recruit participants on a random basis. Rather, purposive sampling attempts to recruit participants relevant to the research in a strategic manner; whilst ensuring that there is variety in the sample

(Bryman, 2014). The main advantage of using purposive sampling lies in the limited number of participants available, so in order to gain enough relevant and in-depth data it is essential to be able to contact all those individuals in certain positions who can provide this data. However the main disadvantages of this approach are the potential bias- as there is no randomisation involved in the process; and an inability to generalise findings due to the non-representative sample (Explorable.com, 2009).

The participants in this study were split into two binary categories: NHS; and non-NHS. Those non-NHS respondents targeted included councillors, MPs, AMs and members of the public-including chairs of residents' associations. The councillors targeted were those who were either on a relevant committee (either health or planning related) and those whose ward encompassed one of the case study sites. In addition to this, MPs and AMs representing residents in the local area were also targeted. NHS respondents were to be chosen for their role within the targeted trusts. Targeted respondents were to include the trust's Chairmen, Chief Executives, the Site Managers, Heads of Estates, the Medical Directors/Lead Clinicians and NHS Doctors and Nurses. The above individuals were identified for each site, with help from the NHS Trusts. There would also be a possibility of using a snowball sampling method to recruit additional respondents. These individuals were subsequently be contacted initially by email, then by a follow-up telephone call to confirm willingness to participate and arrange a data and time for an interview. The snowball sampling method was utilised with effect and led to the interviewing of participants who would otherwise have not been contacted. Approximately 20% of participants were recruited using snowball sampling.

As the study progressed, and using both traditional and non-traditional snowball sampling (as suggested above), other respondents were also targeted. This included trust's Head of Partnerships, local planners and local GPs. The snowball sampling was chosen, not for the traditional reason that the population was difficult to reach, but in order to maximise the sample size. It was also felt that it might lead the researcher down paths which were not immediately apparent, which proved to be true on a

number of occasions. Below (Table 3.2) is a list of interviews conducted in this study (the coding system can be found under Confidentiality and Anonymity).

The overall sample did not aim to be representative in a statistical sense. In the circumstances and with the limited size of the target population the priority was to maximise the number of participants within this field and the aim was to gather detailed and in-depth data from each. The sample size for these interviews was therefore not a precise target number due to the fact that a number of the targeted interviewees were either the sole individuals in their role, such as the Chief Executive, or were of a limited number, such as Ward Councillors. The sample sizes for each site varied due to the varying response rates, with some groups (such as MPs) having very low response rates and others (such as local councillors) having relatively high response rates. The aim of this study has been to be representative in a discursive sense, and the purpose of this (and most) qualitative research is depth of understanding- rather than representativeness- the sample collected was ideal for the aims of this study in providing what Gilbert Ryle called 'thick description'. "*From one point of view, that of the textbook, doing ethnography is establishing rapport, selecting informants, transcribing texts, taking genealogies, mapping fields, keeping a diary, and so on. But it is not these things, techniques and received procedures, that define the enterprise. What defines it is the kind of intellectual effort it is: an elaborate venture in, to borrow a notion from Gilbert Ryle, 'thick description'*" (Geertz, 1973: 5). Thick description therefore is the ascribing of intentionality to an individual's behaviour. As Denzin states: "*a thick description … does more than record what a person is doing. It goes beyond mere fact and surface appearances. It presents detail, context, emotion, and the webs of social relationships that join persons to one another. Thick description evokes emotionality and self-feelings. It inserts history into experience. It establishes the significance of an experience, or the sequence of events, for the person or persons in question. In thick description, the voices, feelings, actions, and meanings of interacting individuals are heard*" (as cited in Ponterotto, 2006: 540).

Table 3.2- List of Interviews

Location	Interview
Swansea	A1
Swansea	A2
Swansea	A3
Swansea	A4
Swansea	A5
Swansea	A6
Swansea	A7a
Swansea	A7b
Swansea	A8
Swansea	A9aN
Swansea	A9bN
Derby	B1
Derby	B2
Derby	B3
Derby	B4
Derby	B5
Derby	B6
Derby	B7N
Newcastle	C1
Newcastle	C2
Newcastle	C3
Newcastle	C4
Newcastle	C5N
Newcastle	C6N
Newcastle	C7N
Newcastle	C8N
Portsmouth	D1
Portsmouth	D2
Portsmouth	D3
Portsmouth	D4
Portsmouth	D5

This thesis necessitated travel to the four case study sites and their locales for the purpose of the interviews. It was slightly more difficult to control the interview setting than was ideal. All interviews took place in a public place for health and safety reasons; and the vast majority of interviews took place in council or trust offices which was the

preferred location. Two early interviews took place in public cafés, but this was discouraged further due to background noise interfering with the recordings.

For the most part interviews were conducted with one individual at a time. This was the plan at the outset so that one respondent's answers could not shape another's. This idea was confirmed when one interviewee brought a colleague to an interview, which was felt not to be an ideal interview dynamic; as the respondents did appear to shape each other's answers.

Data Analysis

Interviews were recorded on an Olympus WS-811 Digital Voice Recorder with the permission of the interviewee's involved (only 1 interviewee declined to be recorded). These recordings were transcribed into text, with disruptions being included in the transcription. The entirety of the recordings were listened to, although irrelevant chatter was not fully transcribed; this included both chatter and minor interruptions during the interviews.

Using Nvivo software the data received during interviews was coded into themes in order to organise the data into topics for discussion. Themes were added whilst coding, rather than starting with a set of themes into which to code, in order to attempt to avoid prior bias in the coding process. This led to a large number of themes, which were later organised and compiled into wider thematic areas.

Stage 3: Multi-sensory autoethnographies (walkthroughs)

The aim of the walkthroughs was to walk around each of the case study sites, recording both experiences and observations. This was to be done as a multi-sensory autoethnography. The basis of this technique is 'autoethnography'. Autoethnography has been defined as: "*an approach to research and writing that seeks to describe and systematically analyze personal experience in order to understand cultural experience*" (Ellis et al., 2011). Ellis and Bochner stated that autoethnography is a research method which

seeks to connect the personal to the social and the cultural (2000). This approach is that which was used towards the four case study sites. Pink has stated that autoethnography is: "a *method that allows ethnographers to use their own experiences as a route through which to produce academic knowledge*" (2009: 64). Autoethnographies therefore, in addition to describing the author's experiences, are also analytical. As Mitch Allen states in a personal interview, an ethnographer must: *"look at experience analytically. Otherwise [you're] telling [your] story—and that's nice—but people do that on Oprah [a U.S.-based television program] every day. Why is your story more valid than anyone else's? What makes your story more valid is that you are a researcher. You have a set of theoretical and methodological tools and a research literature to use. That's your advantage. If you can't frame it around these tools and literature and just frame it as 'my story,' then why or how should I privilege your story over anyone else's I see 25 times a day on TV?"* (as cited in Ellis et al., 2011). In this way it is the methodologies which are utilised which set autoethnographies apart from everyday stories; they both frame and add credence to the information which is presented.

A key aspect of autoethnography is the concept of situated knowledge. This emphasises the contextual nature of all knowledge: "*knowledge is always connected with a certain time, place, situation and, above all, certain people*" (Uotinen, 2010: 163). The plan for this study was to use walkthroughs (autoethnographies) on each of the sites involved in order to analyse personal experiences; sensory ethnography has been utilised to collect data on a multi-sensory experience which can be used to critically analyse personal experiences of the site. Walkthroughs have been chosen to provide a different approach to researching the site which would complement the other aspects of the research design.

The walkthroughs used in this chapter have, inevitably and obviously, included walking. Wylie states the following regarding the act of walking: "*clearly there is no such thing as 'walking-in-itself', no certain physical motion which is, as it were, elementary, universal and pure. There are only varieties of walking, whether these be discursive registers (pilgrimage, courtship, therapy, exercise, protest), or particular modes of engagement (strolling,*

hiking, promenading, pacing, herding, guiding, marching)" (2005: 235). As such, walking itself is a deliberate action and not a passive one. When it comes to these walkthroughs walking, where the pace was set by me, was slow and leisurely so as to take in the multisensory environment. As Pink states: "*while the idea of urban walking is not new to academia, existing approaches are limited in their focus on walking in the city rather than on walking in urban contexts*" (2008: 180). With walking one of the issues which often appears is that of access. However access is not just about physical barriers to the spaces themselves; it has been said that "*access and use are determined by more than physical proximity. The size, attractiveness and appropriateness of the green space are likely to be important and personal perceptions of safety and many other factors may modify the effect of physical parameters*" (Kessel et al., 2009: 36).

Adams states that "*to walk through a place is to become involved in that place with sight, hearing, touch, smell, … proprioception, and even taste*" (as cited in Pink, 2008: 180). The act of walking in a place is itself a form of engagement with the physical environment (Pink, 2008); and is in itself a multisensory experience with the inherent use of sight, hearing, proprioception, equilibrioception and thermoception amongst others. As stated above the walkthroughs in this study have been sensory autoethnographies. Work on sociology of the senses can be traced back to Georg Simmel in 1907, and this methodology will be utilised in order to collect data on multi-sensory experiences which has been used to critically analyse personal experiences of each of the case study sites. This was done with the following quote in mind: "*the human body is not principally a text; rather, it is consumed by a world filled with smells, textures, sights, sounds and tastes, all of which trigger cultural memories*" (Seremetakis, 1996: 119). This is because the quote reminds us that the world is made up of multiple sensory experiences, and as such the following senses in particular have been recorded: sight; hearing; smell; and touch. 'Touch' in this thesis has been used to refer to all of what Paterson termed 'somatic sensations' (2009); and will therefore include, most notably, thermoception. "*Indeed, the idea of walking as multi-sensory experience has been discussed increasingly across the social sciences and humanities*" (Pink, 2008: 180). As stated in the previous chapter, this study has made use of visual ethnography, in the sense that the aim is to be "*studying society*

by producing images" (Pink, 2001: 36). To this end photographic images have been taken of the sites and incorporated in the analysis. The inclusion of photographic images adds an extra dimension to the text which is valuable both for the research itself (by providing evidence for the observations and analysis of the chapter) and act to situate the reader within the psychiatric asylum sites themselves. The photographs utilised within this chapter, in a similar vein to DeSilvey et al. (2013), tell their own stories; they are pieces of research in their own right. The text which accompanies these pictures acts to tell a story of the walkthroughs; and the final analysis acts to bring together the themes which can be seen through both text and the photographs.

Walkthroughs largely involved walking around the sites whilst taking jotted notes. This involved both internal and external spaces- taking notes based on a multisensory approach and taking photographs of the sites on the way around (sensory and visual ethnography discussed below). On a couple of occasions, for Kingsway and St Nicholas', walkthroughs included accompaniment by a guide. This in itself had both advantages and disadvantages. For instance, having a guide who worked on site opened many doors and granted access to places that would have been unavailable otherwise- largely the building interiors; and they had information about the site and were able to answer questions as to the nature of the buildings and spaces. However it also means that the pace of the walkthroughs was partially dictated by the guide. Overall the guides have definitely been a positive for the research.

Autobiographies do not need an introduction as they are a common phenomenon in everyday life. As stated previously the autoethnographies were a later addition to this thesis; and as such two of the sites had already been visited before the decision to use walkthroughs was made. It has been decided to include a short write up (autobiography) of the Portsmouth 'visit' within the introduction because the first visits will have inevitably affected the second visits in some ways; be that affecting my own perceptions, preconceptions or even through structuring.

Sensory Ethnography is described by Pink as "*a way of thinking about and doing ethnography that take as its starting point the multisensoriality of experience, perception, knowing and practice*" (2009: 1). She goes on to state that: *"one might argue that sensory experience and perception has 'always' been central to the ethnographic encounter, and thus also to ethnographers' engagements with the sociality and materiality of research. This makes it all the more necessary to rethink ethnography to explicitly account for the senses"* (Pink, 2009: 10).

My intention was to engage in walkthroughs at each of the case-study sites, whilst specifically attempting to pay attention to all sensory details throughout. It was previously noted how: *"the human body is not principally a text; rather, it is consumed by a world filled with smells, textures, sights, sounds and tastes, all of which trigger cultural memories"* (as cited in Pink, 2009: 38). Cultural memory has been described by Assmann as: "*a kind of institution. It is exteriorized, objectified, and stored away in symbolic forms that, unlike the sounds of words or the sight of gestures, are stable and situation-transcendent: They may be transferred from one situation to another and transmitted from one generation to another*" (2008: 110-111).

In this way certain sights, sounds, smells, tastes and touches can trigger our cultural memories. For example the sounds of certain bells remind us all of Christmas. An early example of work on the sociology of the senses can be traced back to 1907 and Georg Simmel's essay 'Sociology of the Senses'. Simmel states that all interactions we have with others (and by extension anything outside ourselves) is not only mediated by but dependent on the senses. *"Among the individual sensory organs, the eye is destined for a completely unique sociological achievement: the connection and interaction of individuals that lies in the act of individuals looking at one another. This is perhaps the most direct and the purest interaction that exists"* (Simmel, 1997 [1907]: 111).

Although Simmel's description as the *"most direct and purest interaction"* (Simmel, 1997 [1907]: 111) is apt, and the vast majority of ethnography includes sight within its framework; although it has been argued that it is often over-relied on. These

walkthroughs, of course, incorporated sight as its main sensory method. This is not to say that other senses have not been taken into account but sight is such an important tool in this research that it would be neglectful not to acknowledge its importance.

"Our experiences of other people and places, including the home, inevitably involve smell. While domestic odours often escape the control of human agents, the intentional addition of scents, production and concealment of smells (e.g. of cooking, cleaning and more) is equally important to the constitution of place" (Pink, 2009: 145). During the walkthroughs it has been my intention to pay attention to smells; and to pay specific attention to the olfactory experience which resulted in what Simmel (1997 [1907]) has called a 'sense impression'; the forming of an opinion based on the experiencing of smells. Simmel also states that: *"the impressions of the sense of smell resist description with words to quite a different extent than do those of two former senses; they cannot be projected onto the level of abstraction"* (1997[1907]: 118). However this is not necessarily the case. It is true that it is not possible to write an exact description of a smell in words on a page but, for the most part, smells are largely universal, or at least well known, and if described the reader can imagine or at least relate to the smell which is being alluded to.

Sound is often overlooked in ethnography; as Clifford stated in 1986 and echoed by Erlmann in 2004: "*but what of the ethnographic ear?*" (2004: 1). For the purposes of this thesis, and specifically these autoethnographies, each site's soundscape has been analysed. The term 'soundscape' was conceptualised by composer R. Murray Schafer as a sound equivalent to landscapes. Schafer's soundscapes were to identify sounds that: *"describe a place, a sonic identity, a sonic memory, but always a sound that is pertinent to a place*" (Wagstaff as cited in British Library, n.d.). The soundscape of the asylums originally would have been full of noise; "*they were anything but silent spaces*" (MacKinnon, 2003: 74). In America psychiatric asylums were known colloquially as 'giggle houses', and it was not uncommon to be able to hear laughing and screaming (MacKinnon, 2003). The soundscape of the asylum however was irrevocably changed in the 1950s with the introduction of "*wholesale chemical straitjacketing of patients*" (MacKinnon, 2003: 74); transforming the soundscape from one of activity and noise to

one in which the primary sound was the constant sound of televisions (MacKinnon, 2003). These soundscapes are explicitly described as phenomenon which are experienced in both space and time, and grounded in their surroundings. My worry would be that soundscapes are different in each specific point in space and time; so one area's soundscape may vary massively depending on where you are within it. Each site's wider soundscape (i.e. of the whole site) has been evaluated during the autoethnographies. Although the drawback of this is that each point of the soundscape has then only been analysed at a specific temporal point.

Haptic geographies, or geographies of touch, are described by Crang as 'touchy-feely' methods (2003). Haptic geographies have been described by Paterson as: "*responding to bodily sensations and responses that arise through the embodied researcher*" (2009: 766). Lund makes the claim that "*touch, as one of the five senses, has so far been under examined in the ethnographic context*" (2005: 28). Touch may seem like a simple thing; however Lund identifies touch as not just reducible to tactile sensation, but to include other bodily experiences such as muscular tensions, balance, movement and sensitivity to temperature and pain (Lund, 2005). In this way senses not traditionally included in the header of 'touch' are so grouped, such as thermoception (temperature), nociception (pain), proprioception (kinaesthetic sense), equilibrioception (balance), pressure and tension (Hiskey, n.d). Paterson collectively refers to all of these sensations as 'somatic sensations' (2009). The initial visits, discussed above, threw up multisensory 'epiphanies' before sensory ethnography was added as part of this thesis. The walkthroughs were a suggestion which arose as part of the upgrade process, as was the idea of using specifically using sensory ethnography as a research method.

Prior to the walkthroughs, visits were made to the asylum sites. These visits lacked the detail of the full walkthroughs as field notes were not taken to detail the account of the experiences. The visits were mostly to get a feel for the spaces, and took place before walkthroughs were introduced to the study. Only an account of the first visit was included in the final thesis, and this is a retrospective account; in contrast to the walkthrough's contemporaneous account. The write-up for this visit is based around

'epiphanies'; around one or two ideas which are remembered from the initial visit which I believed were too important to omit.

The walkthrough's in this thesis were planned to coincide with interviews in the area where possible. These walkthrough's were undertaken as much as was possible during the day, so there would be adequate light for the pictures and so that the site could be experienced in traditional working hours. The aim was in order to encapsulate the usual day-to-day life of the site. The walkthroughs would begin at the entrance to the case study sites and encompass the whole of the sites. The route taken at each site was determined largely by what felt logical at the time, and the pace was slow and deliberate in order to take in as much information in relation to senses as was possible. Where the walkthroughs included a guide, the direction of the walkthrough was determined by the them; this was especially true of the internal of the sites.

Clifford has stated that "*there can be no rigorous definition of what exactly constitutes a fieldnote*" (1990: 52). For the purposes of this thesis the following from Geertz has been followed: *"the ethnographer 'inscribes' social discourse; he writes it down. In doing so, he turns it from a passing event, which exists only in its moment of occurrence, into an account, which exists in its inscriptions and can be consulted"* (as cited in Clifford, 1990: 57). This research has utilised a number of different types of field notes as shown in the table below:

Table 3.3 – Field Notes

Types of Field Notes	
Mental notes	*"Particularly useful when it is inappropriate to be seen taking notes"**
Jotted notes (also known as scratch notes)	*"Very brief notes written down in pieces of paper or in small notebooks to jog one's memory about events that should be written up later"**
Full field notes	*"Detailed notes, made as soon as possible, which will be your main data source. They should be written at the end of the day or sooner if possible. Write as promptly and fully as possible"**
*(Bryman, 2014: 450)	

My intention has been to incorporate all three styles of field notes into my autoethnographies. Notes were kept of the experiences and observations of the four research sites in a small notebook. Jotted notes were taken during the walkthroughs where possible, where this was deemed inappropriate mental notes were used. Both of these were written up as soon as is possible, depending on the situation at the time. These notes were then written up soon after, so that memory did not have chance to fade, in the form of full field notes.

Although the use of a notebook was definitely useful, it was surprisingly cumbersome despite its small size, and on the occasion when the walkthroughs were being guided it was not ideal as it discouraged interaction. Also on the one occasion when it began to rain it became clear that note-taking in this manner could be dependent on good weather conditions. It is the best option available when added to photographs (discussed below) but it is definitely not ideal. Other issues with notetaking include that, when guides are present (as have been on two occasions within this research) note-taking becomes more difficult, as the notebook becomes a barrier to communication between the researcher and the guide through the discouragement of communication. In these instances it is felt that it is better to write less thorough notes and encourage interaction with the guide; and then make sure that the write-up occured soon afterwards.

"Photography, video and electronic media are becoming increasingly incorporated into the work of ethnographers: as cultural texts; as representations of ethnographic knowledge; and as sites of cultural production, social interaction and individual experience that themselves form ethnographic fieldwork locales" (Pink, 2001: 1). The form of visual ethnography utilised in this thesis is that which concerns *"studying society by producing images"* (Pink, 2001: 36). Although Farber stated that: *"proponents of the disciplinary uses of photography [operate] under the presumption that people may lie but photographs tell the truth"* (2010).

This is the idea that photographs do no lie; it is the act of interpretation from a photograph which can be misleading. In this manner photographs need to be used carefully, so as not to misrepresent the information which it possesses. This is however not true in all cases as not only can the subject of a photograph be staged, but in the modern era the rise in the availability of software designed for the manipulation of photographs, such as Photoshop, mean than even unstaged photographs can lie (Greer and Gosen, 2009). It has even been argued that such software is not needed, as even the act of cropping a photo, which can be done on standard cameras and computers (or if you are old school, with scissors), can significantly alter the content of a photograph (Greer and Gosen, 2009).

It has also been argued that: *"no image or photographic practice is essentially ethnographic 'by nature', but the 'ethnographicness' of photography is determined by discourse and content"* (Pink, 2001: 50). Within geographical research photography has only been accepted fairly recently, but it has been argued that it is not yet a 'celebrated' medium within the subject. There is still a large amount of trepidation with regards to photography as a geographical method in itself, rather than as a supplement to textual discourse (Garrett, 2010). It has been argued that "*images should be regarded as an equally meaningful element of ethnographic work and therefore visual images, objects or descriptions should be incorporated when it is appropriate, opportune or enlightening to do so*" (Pink, 2007); and Garrett has stated that: "*even 'visual geographers' seem to harbour some reservations about photography's ability to be singularly situated as a method, usually viewing it as supplementary to text*" (2010: 2).

Videos have the potential to show images of a locale not just in space but also in time. They also have the added advantage over photographs in that they have audio attached to their images; with the possibility of adding an extra dimension to any ethnography- especially a sensory ethnography. However video still has many of the drawbacks that photographs do; for example they are still 'staged' by the researcher. It has been the intention of this thesis to utilise photographic images within my research as examples to further my analysis of individual sites. These included utilising these

images to show the nature of the sites' layout; the existence of certain aspects of the sites which encourage their (both medical and non-medical) usage; and the quality of the estate which remains on the site. In short, photographs have been used as evidence. The idea of using video is one which was considered but the costs involved in obtaining equipment was too high to justify the arguably somewhat limited gain from its use.

In summary, the walkthroughs have been designed with both visual and sensory ethnographies in mind. Having decided to use jotted notes during the walkthroughs the aim was to note down what was felt to be pertinent, with regards to all the senses (the outcome is a focus chiefly across sight, sound and smell- though both touch and taste do appear) whilst taking photographs of the sight in the traditions of a visual ethnography. Walkthroughs involved walking around the external spaces of the sites and taking notes and photographs during them.

The advantages of using this multisensory approach and visual methods include that it is a comprehensive way of collecting multisensory data. This could have been done more intensely with the inclusion of video, however for reasons discussed above it was decided to stick to still photographs. Possible disadvantages of this combination is that sensory experiences are likely to vary dramatically, so each walkthrough individually cannot be extrapolated to be representative of its site. Ideally, this could have been initially combatted with multiple walkthroughs at each location, but budget and time restraints attached to this thesis have meant that this was not possible. Hopefully however this issue will be, at least in part, counteracted by the analysis of themes which run across each of the walkthroughs.

Ethical Considerations

Ethics and Governance Process

During any research project there will be a number of ethical considerations which need to be addressed. The aim of this section is to outline the ethics and governance

process which this study went through. This was a process which threw up significant problems and issues throughout its course. The purpose of this section is to detail this process, highlight the major issues and evaluate ways in which such lengthy delays could be avoided in the future. The following is a tabulated account of the ethics and governance processes.

Table 3.4- Outline of the Ethics Process

Ethics Process	
11th May 2013	Beginning of the ethics and governance procedure
10th June	First submission of ethics documents to ERGO
14th June	First rejection of ethics documents. Study to be split into 2: one non-NHS based and one NHS based
31st July	All NHS references removed from the initial submission and resubmitted
14th August	Second rejection of ethics documents. One of the forms submitted (which was submitted on all the previous occasions) was found to be the wrong version of the form. A reference to NHS patients was removed
19th August	Resubmitted after changes
24th August	Third rejection.
9th September	Met with supervisor to try to push the forms through. Limited changes are made.
10th September	Submission resubmitted and approved

Table 3.5- Outline of the Governance Process

Governance Process	
3rd September 2013	It was confirmed that the separate NHS approval would go through NHS Research and Development and not NHS Ethics
10th September	Had a meeting for the NHS submission and we began the process of attained NHS Research and Development approval. To be done by contacting the 4 NHS Trusts individually and seeking approval by each one in turn
4th October	Hampshire & IOW Comprehensive Local Research Network agreed to talk to the trusts to persuade them to accept a single submission, and also to contact Southampton Ethics to iron out some issues surrounding forms.
22nd October	3 additional forms were requested by the Shared RMG Service at University Hospital Southampton NHS Foundation Trust
16th December	An email was sent to the 4 trusts involved from the Shared RMG Service, alongside the comprehensive documentation.
27th December	A response from Abertawe Bro Morgannwg (ABM) Research and Development was received in response to contact made before we were working with the Shared RMG service.
6th January 2014	It was confirmed by the Shared RMG service that an IRAS account was to be set up and permission had to be sought from proposed participants before it was submitted.
Mid-February	A joint email sent to all 4 trusts to chase up the progress of the application, requesting completion dates for the processes
24th February	A response from Solent NHS Trust indicated their unwillingness to be involved directly in the study
4th March	Derbyshire Healthcare Foundation Trust requested a study protocol. This information was prepared and sent the same day
14th March	Northumberland, Tyne and Wear NHS Foundation Trust (NTW) indicated their intention not be involved in the study due to the unavailability of the Trust Chief Executive
25th March	An email sent to NTW indicating that the Chief Executives involvement was not vital to the research
31st March	NTW redirect contact to another member of staff
2nd April	The Shared RMG Service sent an email to ABM in an attempt to move things forward. The need for individual permissions before the study was approved was proving difficult. Correspondence revealed that there was nothing that could be done on this front
11th April	The application was submitted to National Institute for Social Care and Health Research – Permissions Coordinating Unit (NISCHR PCU)
16th April	NTW got in touch regarding the permissions
23rd April	NTW request more information
24th April	The NISCHR PCU application was rejected and modifications made

	before resubmission
25th April	Discussions begin with NTW with regards to identifying the right individuals to be involved in the research
12th May	University contacted asking where an insurance letter could be obtained
15th May	Follow up email sent to university with regards an insurance letter after a period of non-response. An email is later sent to 2 others from initial contact requesting I be supplied with an insurance letter
21st May	Another follow up email sent after a second period of non-response. I am later told I can find the form myself via ERGO. An approval letter was provided by Derbyshire Healthcare Foundation Trust
22nd May	The NISCHR PCU confirmed that global governance checks had been completed for my study in Wales, but that NHS permission was still required from ABM. Further delays in this respect are avoided by the fact I happened to have a recent CRB check for supply teacher work
23rd May	A letter of access from ABM was received
30th May	A letter of access was provided by Derbyshire Healthcare Foundation Trust

The main issue regarding the NHS governance permissions was thus: although this study is one based in human geography which did not involve patients in any way- the ethics and governance processes are set up by the NHS with patient safeguarding in mind.

In retrospect the first thing that I should have done is to immediately sit down with my supervisors and fill in the ethics and governance forms together. This could potentially save weeks of back and forth suggestions and editing.

The second thing is persistence. There were times at the start I was worried about being rude and unreasonable, and was therefore hesitant to send a follow-up email. Too much time was wasted on faux-politeness in this thesis. The number of participants who I eventually reached only after phoning and emailing a multitude of times is high and persistence from the beginning would have saved time.

And finally third, the whole process would have taken much longer had we not had help. One thing which made our process much easier was the help from the Shared RMG Service at University Hospital Southampton NHS Foundation Trust in the filling out of NHS ethics forms and in communication with other trusts. Also a number of individuals, both NHS staff and others, during the process of this research have been really helpful in helping contact participants and especially in organising pieces for the NHS ethics approval.

Other Ethical Considerations

For interviews the respondents were given a Participant Information Sheet which outlines what the research is about, interview procedure, foreseen risks, confidentiality, and provides contact details. Participants are given time to read this and are then provided with a consent form to sign. The consent form covers that participants have read and understood the Participant Information Sheet and that they: agree to take part in the research; understand that their participation is voluntary and they may pull out at any time; and that they agree to be audio recorded.

With regards to the walkthroughs permission to do so was attained during the governance process at each of the four sites. Letters of access were provided by each of the four sites. Permission to take photographs of the site was granted on the condition that the photographs were of buildings and surroundings only and did not capture patients or staff.

Confidentiality and Anonymity

"In a research context, confidentiality means (1) not discussing information provided by an individual with others, and (2) presenting findings in ways that ensure individuals cannot be identified (chiefly through anonymisation)" (Wiles et al., 2008: 418).

Confidentiality is a key part of any social research project, and needs to be rigorously maintained. Confidentiality is often operationalised using anonymity (Wiles et al., 2008). As Longhurst states: *"participants need to be assured that all the data will remain secure under lock or on a computer database accessible by password only; that information supplied will remain confidential and participants will remain anonymous… and that participants have the right to withdraw from the research at any time without explanation"* (2003: 127). Confidentiality has been a difficult issue in this thesis. A decision had to be made as to the level of confidentiality which could be both effectively and realistically applied. The final decision was to largely anonymise individual participants but not the sites to which they were attached. Identifiers attached to responses include to which site they are affiliated and then a NHS/non-NHS binary classification only. For example:

- A1 – A indicates Cefn Coed Hospital and 1 indicates that it was the first interview at that site.
- A1N –This is as above with the addition of 'N', which indicates that this interview was with an interviewee who worked for the NHS.
- A1a –As before with the addition of the 'a', which indicates that the interview involved more than one respondent and that this was a quote or paraphrasing from respondent 'a' from that interview.
- A1aN – Combining all of the above with the inclusion of both 'N' for NHS interviewee and 'a' to indicate first respondent in a multi-participant interview.

Positionality, Personality and Reflexivity

One main criticism of intensive research techniques is that of researcher bias; through the inadvertent shaping of interviewee responses, meaning that data obtained *"are as likely to embody the preconceived ideas of the interviewer as the attitudes of the subject interviewed"* (Rice [1931] as cited in Hoggart et al., 2002: 223). All researchers are arguably both gendered and culturally situated to approach research from a particular

ontology (Hoggart et al., 2002); in other words 'positioned'. Positionality is a key concept in social research, as Moser points out: *"the move towards embracing the personal has brought about a significant shift in how research is conducted and considered. The recognition that we belong to various social categories that position us differently within power structures has helped researchers move away from traditional views of impartiality and claims to neutrality in fieldwork"* (2008: 384).

It may also be beneficial to note that our personalities may also have an effect upon our research interactions. It is Moser who also states: *"I observed that the ways in which we were treated and talked about by the locals in our field site varied significantly and were based less upon our biographies and more upon our unique individual social and emotional qualities – our personalities rather than our positionalities"* (2008: 383). One way to neutralise issues of positionality and personality is to embrace reflexivity, defined as *"self-critical sympathetic introspection and the self conscious analytical scrutiny of the self as researcher"* (England [1994] as cited in Hoggart, 2002: 224). England also states that although *"reflexivity can make one more aware of asymmetrical or exploitative relationships, but it cannot remove them"* (as cited in Hoggart et al., 2002: 224). Therefore it has been my intention to attempt to be as reflexive as possible whilst thinking about issues of positionality, personality and the ways in which they may have an effect on this research. This has included how positionality and personality may have affected the research process and the knowledge generated; as well as the consideration of effects such as time, space and power dynamics on various aspects of research. There will always be instances where reflexive thinking with regards to issues of positionality and especially personality is limited in its effect; as it is difficult to judge how personality affects interview interactions. Most reflexive thinking is likely to provide estimated effects.

With regards to this thesis, my own positionality has had a large impact upon the outcomes, whether that is through my own personal interest in the topic or through my own prior experiences, or through others' perception of me. My own experiences and interests have guided this thesis from the start, with my own fascination with the

topic, as outlined at the beginning of Chapter 1, alongside my own personality traits such as inquisitiveness and stubbornness. Examples of how other's perceptions of me may have had an impact upon this thesis are probably too numerous to count. My position as a: working class; white; male; student; relatively young etc. has likely had an enormous impact. Similarly my position as an 'outsider' at each of these institutions is likely to have also had an impact; not just with regards to access to the spaces but also in the attitudes of the interviewees. An example of how positionality may have affected this thesis comes with the interactions with MPs: I believe that my position as a student closed a number of doors with MPs, who have other prior commitments and are reluctant to take time out for a student project. In this way they may not see my research as being important to contribute to in comparison with more established academics or organisations. However I also believe that in some cases my relative youth may have opened doors, with some being comfortable to speak to me openly as a result.

Conclusion

To conclude, this chapter has set out the methodology which this study will deploy in its research into former psychiatric asylum sites. The methods this study has utilised have been qualitative in nature, making use of case studies at four research sites: The main methods which will be utilised in this research are: archival research and content analysis of local newspaper archives, online newspaper articles and social media; semi-structured interviews with individuals at each of the case study sites- ranging from councillors and MPs to NHS staff; and multisensory ethnographies at each of the case study sites. The next chapter will be the first of four empirical chapters, and will cover the background on the case study sites before focusing on the multisensory ethnographies of those sites.

Chapter 4: Case Study Sites

Introduction

This chapter is the first of four chapters which aim to use empirical methods to answer the key questions which were the inspiration for this thesis. As stated in Chapter 1 these three central questions are: how many psychiatric asylums are still in use in the public sector?; how have they been retained?; and why? This chapter sets out to first answer the question of 'how many?' through an exploration of the general background of the psychiatric asylum, before going on to choose which of the retained sites will be utilised within this thesis as case studies. Subsequently, this chapter will explore the latter two questions of 'how?' and 'why?' via site-specific histories and the current contexts of the four psychiatric asylum sites, as well as outlining and analysing the four case study sites using the 'walkthrough' (multi-sensory and auto-autoethnographic) method. This will be used to show, amongst other things, the history of investment (or lack thereof) on the sites.

With regard to the analysis of the use of old retained buildings and new builds on the case study sites, the framework set out by Evans and McCoy in an analysis of the effects of architecture on human health will be utilised (1998). Evans and McCoy identify five interior design elements that may influence stress: stimulation – which is the amount of information in a setting that impinges upon the human user; coherence – the clarity of building elements and form; affordances – the ability to readily discern the functional properties of the space; control – the ability to alter the physical environment or regulate exposure to one's surroundings; and restorative – the potential of design elements to function therapeutically, reducing cognitive fatigue and other stress factors (1998). Aspects of this framework can be used to analyse the use of old and new buildings for psychiatric care, as these factors may have effects upon suitability and use-value of the buildings themselves. Some of these factors will permeate through both old and new buildings, such as 'odour' which will be the same

throughout the NHS; but with others there is a marked difference between old retained buildings and new builds. The key issues which may arise are those of: 'floorplan complexity', 'flexibility' and restorative factors generally (Evans and McCoy, 1998). The assumption here is that the trusts cannot for one reason or another modify the older buildings on their sites; this may be due to heritage factors such as listed status or conservation areas, or due to financial restrictions.

Psychiatric Asylums – General Background

Figure 1 shows the number of open psychiatric asylums between 1960 and 2015. What we see is a dramatic decrease in open asylums between 1985 and 2015; as a result of numerous factors which were encapsulated in Enoch Powell's water tower speech. This *"determined programme of hospital closures"* (Parkinson Report, 1976, n.d.) left only 12 psychiatric asylums retained within the National Health Service in 2015.

Figure 4.1- The Number of Open County Asylums 1960-2015

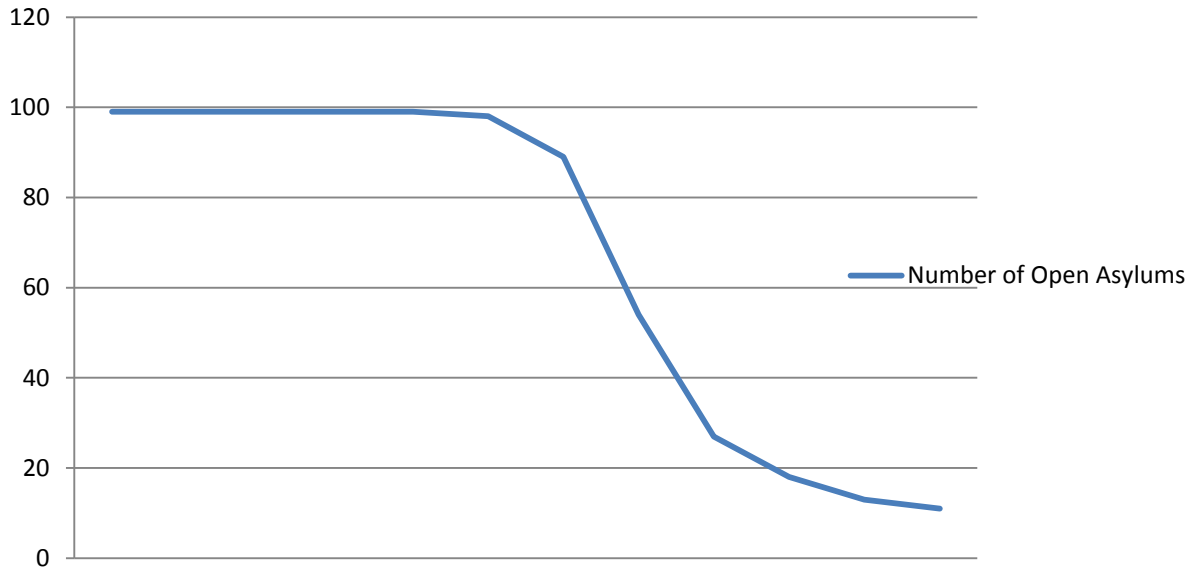
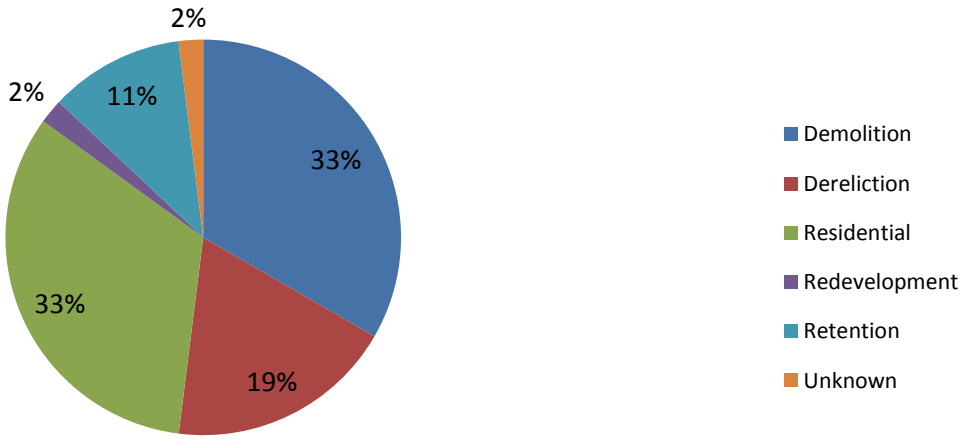


Figure 4.2 shows the frequency of asylum fates in England and Wales. As we can see the most common fates for psychiatric asylum sites is to be transformed into residential use (33%) or Demolished (33%); followed by Dereliction (19%); Retention (11%); and Redevelopment (2%). All of these fates are discussed in detail in the Literature Review chapter.

Figure 4.2: Frequency of Asylum Fates in England and Wales 2015



However the fate of former psychiatric asylum sites may be partial; as it is unusual for these sites to only exhibit one of these fates. Given the size of former psychiatric asylum sites it was always likely, and possibly inevitable, that many of the sites incorporate multiple fates within their original grounds. This is due to a number of pressures, some of which are evidenced below, but the most prominent is likely to be the process of deinstitutionalisation which began in the 1960s. The percentages of former psychiatric asylum sites to contain each fate within their top two most prominent fates is shown here:

Table 4.1- Percentage of Asylum Sites to Contain Each Fate within their Top Two Most Prominent Fates

Fate	Percentage of Asylum Sites to Contain Each Fate Within their Top Two Most Prominent Fates
Demolition	47%
Residential	43%
Dereliction	23%
Retention	20%
Redevelopment	10%
Existing but Unknown	11%

What we can see from the pie chart and the table above is that whilst most fates increase at a relatively similar level there is a significantly larger rise in the redevelopment and 'existing but unknown' fates. This is likely due to the sheer number of possibilities which are available within these categories.

Site Histories and Walkthroughs

This section will focus on each of the case study sites chosen above. This will involve outlining the background of each of the case study sites, in order to outline the context of each site, before discussing the walkthrough (multi-sensory autoethnography) at that site. However before this it would be apt to discuss the first visit made to a former psychiatric asylum site, and that was to St James' Hospital in Portsmouth. This was the first visit of my thesis, and it took place over a year prior to the decision to include walkthroughs, so is based largely on memory, a small amount of notes and a few photographs taken on the day. Needless to say, the account of this visit is not as detailed as accounts of other visits or walkthroughs. This initial visit to St James' offers a retrospective account; in contrast to the walkthrough's contemporaneous account. Inevitably the visit lacked the detail of the full walkthroughs, but, for the purposes of this study it is pertinent to take note of Ellis et al. when they state that: *"most often, autobiographers write about 'epiphanies'"* (2011). As field notes were not taken on the visits there is no detailed account of the experiences, especially for those which were further in the past, so the write-ups for this visit is based around 'epiphanies'; around

one or two ideas which are remembered from the visit which are believed to be too important to ignore.

The St James' visit was a guided tour led by Professor Graham Moon. This visit was in the early stages of my thesis. We walked around the entirety of the current site, as well as having a brief look at the interior of the main building. As stated above, the write-ups of these visits is focused on a number of 'epiphanies' which stuck in the memory after each of the visits; which then went on to shape future walkthroughs and research design.

The first thing that I noticed at St James' was how normal everything seemed. We walked around the grounds of the Hospital (guided by Professor Graham Moon and accompanied by a member of the Trust), observing the spaces as they are today and noticed that there was a sense of normalness that is hard to define. There was nothing much on the initial part of the tour which stood out as being, definitively, 'of a mental hospital'. There was however a play area in the large green space to the right of the main driveway (which I later found out was bought from the hospital by the local council in order that the green space may be maintained for the community).

The second thing that I noticed, after a walk around the outside of the main traditional asylum building, was that a number of dog waste bins had been placed around the surrounding paths. This surely indicates two things: the first being that dog walkers use the site regularly in their activity; and the second that the Trust made provisions for those walkers. This is not an interaction I had envisioned beforehand and was in fact the jumping off point for a large proportion of this thesis- the relationship between the former psychiatric asylum and the community.

The third thing I noticed on the tour was inside of the main building. It smelled like a hospital. Now that may seem like an inane and obvious thing, and when writing it down it seems silly, but it smelled exactly like any 'regular' or 'general' hospital. It smells like a place of healing, and that I believe is important. Technically the smell is of

Iodoform[5], but in our minds it is associated invariably and interconnectedly with 'hospital'.

Swansea and Merthyr Tydfil Joint Asylum - Cefn Coed Hospital

Origin

Cefn Coed Hospital is located within the Cockett ward (on the border with the Sketty ward) of Swansea, Wales. Cockett became part of Swansea when the town's borders were extended in 1918 to include Cockett, Fforestfach and Sketty. This means that the hospital (and health in general) is now controlled by NHS Wales and the devolved Welsh Government rather than by NHS England and the British Parliament. This is the main factor which sets apart Cefn Coed from the other psychiatric asylum sites in this thesis. The effect it has had includes AMs being interviewed in place of MPs- who are not available to discuss devolved issues.

Although the planning process which resulted in the building of the Swansea and Merthyr Tydfil Joint Asylum began in 1904 there were multiple delays in the planning and construction process. The site was first suggested in 1908 when the Cockett, Fforestfach and Sketty areas were all outside of Swansea: with Cockett not becoming a part of the Parish of Swansea until 1914 (GENUKI, n.d.). The reason for the first major delay is suggested by the Clerk of the Swansea Council in 1912, when he stated in a letter to the architect G.T. Hine: *"I quite appreciate what you say about the long delay but I have the greatest difficulty in getting my committee together and obtaining instructions…"* (Davies, 1982: 13). The foundations began to be laid in 1914, when construction was delayed due to a lack of labour as a result of World War 1. The building was eventually erected in 1929, and the asylum was opened in 1932 (Davies, 1982).

Site History

[5] Iodoform: A compound of carbon, hydrogen and iodine (The Human Touch of Chemistry, n.d.).

When the site was first built it included the main hospital building, plus houses for: the medical superintendent; the clerk of the committee; the engineer; eight houses for married members of staff; and a nurse's home designed to accommodate 69 nurses. There was not originally a chapel but this was added later.

In 1936 it was reported that a Child Guidance Centre was being established as part of the hospital's outpatient services. The Board of Control of Lunacy and Mental Deficiency put emphasis on the importance of outpatient services and stated that: *"early treatment…is essential if better results are to be secured and the out-patient centre is not only the surest means to secure the patient's confidence, but it will save many from the need of in-patient treatment"* (Herald of Wales, 1936). The Board also stated that: *"out-patient centres cost very little to maintain and, from the financial point of view, they are the best investment a visiting committee can make"* (Herald of Wales, 1936).

The farm at Cefn Coed Bach (mentioned above) was in use up until 1956. In the late 1950s Cefn Coed Bach was sold, but the 23 acres of land attached to the farm were retained by the hospital (Davies, 1982). Around this time central government was pushing for widespread closure of farms attached to psychiatric hospitals (House of Commons, 1956); and Cefn Coed's was one of the farms which closed shortly after this. Another factor may also have been that, according to hearsay within the hospital in the 1980s, the farm had been the location of a number of suicides (A6).

The 60s was a decade of change for the Asylum. It was rebranded as Cefn Coed Hospital following a nationwide rebranding of psychiatric facilities, an electroencephalography department was opened in 1961, and an occupational therapy unit was opened in 1963. In 1965, Swansea Town Council made two houses available for ten ex-long stay patients; and in 1967 Ward 7 was converted into a mixed-sex ward for long stay patients (Davies, 1982). This period of change continued into the 1970s, and in 1971 a Psychogeriatric and rehabilitation unit was opened with a view to patients being able to return to the community rather than undergoing long-stay treatment. The Mayor of Swansea (Councillor Ken Hare) stated that *"there is never*

enough cash to go around, and the HMC does not control it's purse strings, but as much as possible always has and always will be available to Cefn Coed" (South Wales Evening Post, 1971). This is an early example of investment at the Cefn Coed site, with the added statement that the site will always be invested in.

In 1972: *"a considerable sum of money was obtained from the Welsh Hospital Board…so that two wards (4 and D) in the main building could be emptied to create two new mixed-sex admission wards"* (Davies, 1982: 34). This shows further investment at services at the hospital in an attempt to modernise facilities. In this period of the 1970s the clinical teams decided that the number of beds was to be drastically reduced on these wards. At the end of the 1970s the hospital had approximately half the number of beds which it had in 1960, even though the number of admissions had doubled in the same period (Davies, 1982).

The hospital celebrated its 50th anniversary in 1982 and as the South Wales Evening Post stated: "*the gates and high fences are gone. So too, 70 in a ward and locked doors every few yards. Swansea's Cefn Coed psychiatric hospital- 50 years old next month- has changed more than a little in today's more enlightened times"* (1982). Since its opening over 21,000 patients have been treated at the hospital as in-patients; and over 100,000 being treated as out-patients; *"and where 70 people once slept in rows of beds, 28 patients now live in privacy and comparative comfort"* (South Wales Evening Post, 1982). This shows us the stark contrast between the inpatient care of the 1930s and the 1980s, with the upgrade from dorm-style wards to individual rooms. The new system also acts to distance the hospital from its origins as an asylum, and the stigma which comes with such a label. This is another example of investment in the infrastructure at Cefn Coed, with a view to the modernisation of the hospital's facilities. This is possibly as an attempt to negate the stigmatised perception of the hospital as an 'asylum' and highlight a change to a more modern site.

In 1987 a proposal for a new 15-bed secure unit at Cefn Coed was dropped by the Welsh Secretary. The decision to drop these plans was reportedly due to the running

down of Cefn Coed Hospital's psychiatric service. The unit would have been a secure unit which took patients too serious for local psychiatric hospitals but were not serious enough cases for high-security sites such as Broadmoor (South Wales Evening Post, 1987). This is the first of many reports of proposed closure at the Cefn Coed site. It is particularly interesting that rumours of closure at Cefn Coed began as early as 1987, especially considering the site remains open to this day- albeit with new rumours of closure.

In 1991, after multiple incidents of arson and vandalism, it was deemed that the lodge on the site would be too costly to renovate, and the site was declared surplus to requirements and subsequently demolished (Mosley, 1991). At the same time 16 acres of land attached to Cefn Coed was put up for sale by the West Glamorgan Health Authority. There was another rumour of closure at Cefn Coed, as it was reported in 1992 that the hospital was to be sold. The article stated that the 'prime site' was to be sold off for a high profit for development (Mosley, 1992).

In 1996 a garden was built on an area of wasteland on the Cefn Coed site. The South Wales Evening Post reported that *"the area is being used to provide patients with a peaceful and safe environment to relax in"* (1996). This acted to provide a form of therapeutic landscape to the patients at the hospital.

In 2001 a report by a Swansea University team found that the lay-out at Cefn Coed was outdated and made patients, particularly female patients, vulnerable (South Wales Evening Post, 2002a). This included mixed-sex wards, a lack of privacy and a lack of basic amenities. Also the hospital lay-out meant that there were 'blind spots' which made patients feel particularly vulnerable (South Wales Evening Post, 2002a). These are some of the issues which arise as a result of the retention of old psychiatric asylum buildings, as they were designed with a different regime of psychiatric inpatient care in mind. As a direct result of this report, in 2002 there was a large refurbishment of two hospital wards following on from major refurbishment of 3 others wards at the Hospital. The total cost of the refurbishment was approximately £2 million (South

Wales Evening Post, 2002b). In this instance Ward 6 and Ward B were to be renovated (South Wales Evening Post, 2002a). There were also plans to refurbish the (previously mentioned) hospital gardens, in the hope that *"peaceful surroundings could help with patient therapy"* (Davies, 2002b). This shows the large costs involved in the renovation of former asylum buildings in order to modernise them to be sufficient for modern standards. What we also see here is that despite multiple reports over the years that Cefn Coed was to be closed and sold off, investment was still being made in the hospital through refurbishment and modernisations.

There have been a number of scandals at Cefn Coed hospital in recent years. One concerned the death of a patient in 2002. The schizophrenic patient was detained under the Mental Health Act, restrained for an hour, and was found with what were described as 'horrific' injuries to his face (Psychminded, 2008). The restraint was deemed excessive by a jury in 2008 and the case got national newspaper coverage (BBC News, 2008b).

Also in 2002 a long-term plan to replace Cefn Coed Hospital was revealed by Swansea NHS Trust. Plans were agreed which involved the hospital's demolition and replacement, a process which was estimated to take up to 10 years and £40million to complete. The decision followed a damning report on conditions at the hospital (Davies, 2002a). This is the third instance in which it has been reported that Cefn Coed will be closed.

In 2005 there was a large-scale remodelling of Cefn Coed Hospital. Wards B and 6 had undergone 'facelifts', with £324,000 and £150,000 being spent respectively. A spokesperson for the trust stated that *"the series of improvement works represents efforts to ensure our psychiatric facilities are in line with current patient and staff expectations"* (South Wales Evening Post, 2005a). One article in the South Wales Evening Post stated that prior to the remodelling *"[Cefn Coed] was almost like something out of the cult movie One Flew Over the Cuckoo's Nest"* (2005b), and that the subsequent £2 million had been invested into the hospital since 2001 to improve and upgrade facilities on the site

(South Wales Evening Post, 2005b). This again shows that despite renewed rumours of closure, the hospital site continues to receive funds in order to improve the facilities.

In 2008 it was reported that a new £80million facility would replace the current Victorian buildings at Cefn Coed Hospital. The proposed 200 bed hospital would reduce the number of in-patients, with focus being switched to care in the community, and 2 four-bedroom halfway houses would also be built to act as a stepping stone between inpatient care and independent living (Perkins, 2008). This is the fourth report relating to closure of the Cefn Coed hospital buildings in 21 years.

In October 2009, local health authorities from Swansea, Neath, Port Talbot, Bridgend and western parts of the Vale of Glamorgan were merged with the Abertawe University NHS Trust to form the Abertawe Bro Morgannwg University Health Board (ABM). ABM is currently the largest local health board in Wales.

In 2010 construction of a new unit began on the site. This 60-bed unit, opened in 2012, was to be dedicated to providing elderly patients with dementia specialised assessments, treatments and rehabilitation (Perkins, 2010). The facility, named Ysbryd y Coed, *"has been built using the latest research to provide an ideal environment for those living with [dementia] who need hospital care"* (Perkins, 2012). In order to build this new facility the chapel was demolished. Welsh Health Minister Lesley Griffiths has stated that: *"it is not just about bricks and mortar. The jewel in the crown for the NHS is our staff. We need buildings, but it is the staff that really count"* (Hall, 2012). In this instance the focus is taken away from the older facilities, which is fairly novel in debates surrounding asylum closures.

There was another scandal at the site in early 2010 with the death of a patient after being admitted in November 2009. The Public Services Ombudsman found that the hospital made 3 major failings leading up to the death of the 77-year-old patient, not least the development of a gangrenous pressure sore. The other failings noted were insufficient pain management and insufficient nutritional assessment. The

Ombudsman stated that *"Cefn Coed hospital is due for closure [and] for the time that it remains open it should be expected to deliver the highest standards of care to those patients who continue to need its services"* (BBC News, 2013).

There was another scandal in 2010 involved an instance of sexual abuse; as a member of cleaning staff was convicted of sexually abusing a patient at the Hospital (This Is South Wales, 2011). The member of staff was not tried with rape due to having learning difficulties. This led to the Health Inspectorate Wales Report, which stated that Cefn Coed was: *"no longer fit for purpose and its design compromises care standards"* (Henry, 2012)

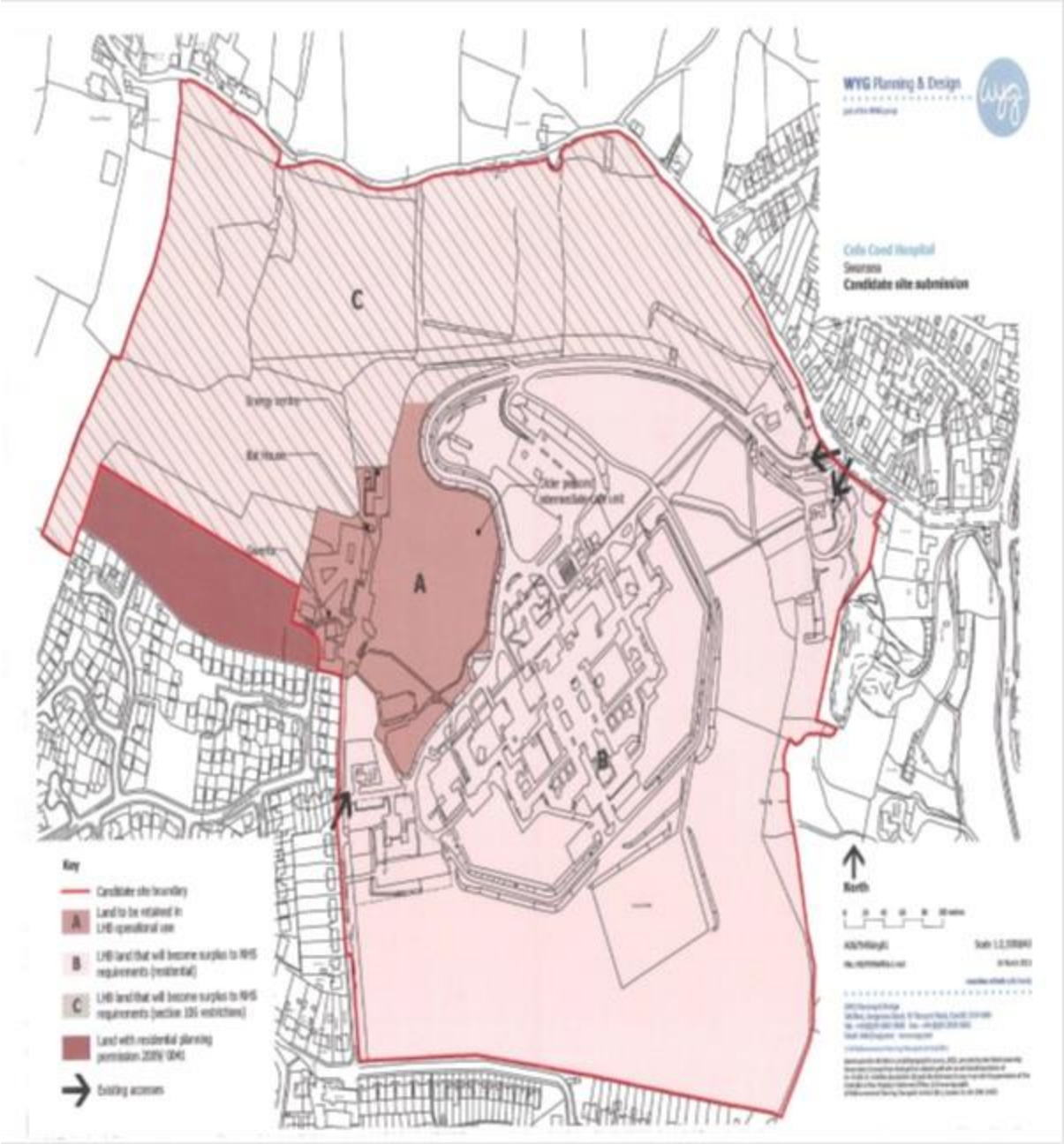
Over the course of Cefn Coed's history there has been evidence of investment and expansion through to the late 1980s. However, subsequent to this, there was a running down of services, and although there has been some renovations of hospital wards there has been a general lack of investment as a result of a decision to close the hospital site. Subsequent to this there was a brief influx of investment into new facilities at Cefn Coed, with a view to the replacement of the older buildings on the site. The catalyst for this change was the Health Inspectorate Wales (HIW) Report (discussed above), which was ordered as a response to scandals at the hospital, stated that: *"Cefn Coed Hospital is no longer fit for purpose and it is evident that its design compromises standards of care"* (Health Inspectorate Wales, 2012).

"Replacement of the old fashioned building with new modern facilities has been emphasized since the psychiatric hospital was described as 'not fit for purpose'" (Wales.org.uk, 2012). Even though older wards operating in the main hospital building are steadily being replaced by new modern facilities; the old asylum building still stands at the centre of the site. The current retention of this building could be argued to be a form of informal memorialisation of the history of the site as a psychiatric asylum. Therefore it may act as a site of remembrance through the survival of the asylum's physical presence (Chaplin and Peters, 2003). Much like Kearns et al. note at Lakeshore (Toronto), examples of memorialisation at Cefn Coed are limited to the physical environment-

namely the architecture itself (2010). The HIW report emphasised how the Cefn Coed Hospital main building was unfit for purpose, and led to the plans to remove the majority of services from the Cefn Coed site. NHS Estates policy in Wales is focused on the disposal of buildings which have no long-term future, with the aim to use resources gained form sales to reinvest in new facilities (NHS Wales, 2013). Therefore since the site is no longer seen as having a long-term future, plans for sale of the site fit directly into Welsh NHS Estates policy. Outline plans for the site indicate that up to 73 new homes are set to be built on the site (South Wales Evening Post, 2014). If the main building at Cefn Coed is demolished, that would remove the largest memorial on the site to its history as a psychiatric asylum.

There are currently planning applications in place for the Cefn Coed site (Figure 4.4). On the map: Area A is set to be retained; Area B is to be developed into housing; and Area C is land which has usage restrictions, so may only be used in a greenspace capacity. The only services under these plans which would remain on the site would be: Gwelfor (18 bed rehabilitation centre); Ysbryd y Coed (60 bed unit); Trehafod (Child and Family Clinic); and the Swansea Psychiatry Education Centre. All other existing NHS services would be relocated elsewhere. The main former asylum building, in Area B, is allocated as surplus to requirements.

Figure 4.3 – Cefn Coed Hospital Site Designation



Walkthrough

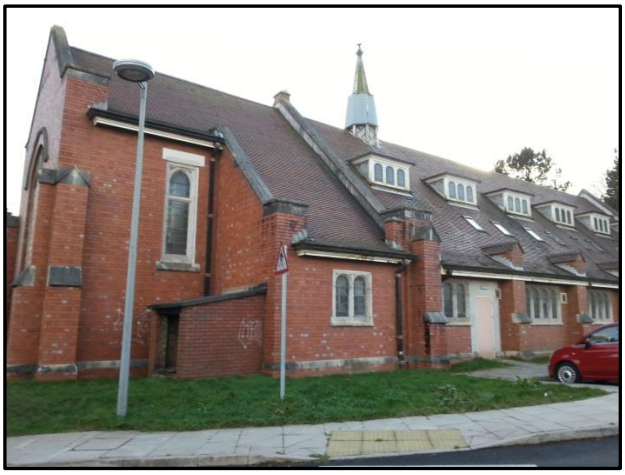
Coming up the main driveway gives you the sense you are leaving the city and winding into the countryside. The winding tree-lined road, despite being fairly short, takes you from a busy Swansea neighbourhood into what feels like an isolated countryside retreat in approximately a minute. Despite the process of urbanisation which has made Cefn Coed, and other sites, part of the local urban landscape- Cefn Coed has maintained a level of separation from the surrounding housing which has meant that it maintains a form of therapeutic landscape and an illusion of isolation.

Walking into the site from the car park you first notice all the old red brick buildings, including the sprawling main block. Walking around the main block there are many benches dotted around, and SOME green space, not large open green spaces as seen at other sites but more like a small border of green around the buildings. However the views out from the site are amazing (and would be better if it was not for the weather (see Picture 1 below). There are windows boarded up on the 1st floor of the main block, on what appear to be Wards A and D, giving a sense of abandonment. This may be as a result of the decision by ABM not to invest in the current site, with the long-term goal of demolishing and replacing the current facilities.

Picture 1: Cefn Coed Hospital – View out from the hospital grounds

The site is fairly quiet and tranquil throughout the visit, with the occasional traffic movement on site and the distant sound of cars on the main road. There are a few dog walkers around the site, despite the relatively small amount of green space. Walking along I come across some green metal fences, similar to those used in schools, which indicate a ward (the Heddfan Unit) in an old building being modified for health and safety reasons (see Picture 2 below). These fences are another example of the reluctance to invest money in the site, and the number of examples of this on the site would seemingly indicate that Cefn Coed's days are numbered. I walk up towards the old chapel (see Picture 3 below) which is now the Education Centre, which looks from the outside to be poorly maintained, and the road curves right towards the new build blocks.

Picture 2: Cefn Coed Hospital – security fences



Picture 3: Cefn Coed Hospital – Chapel/Education Centre

Ysbrid Y Coed (a 60 bed psychogeriatric unit) looks particularly modern but lacks external space- which is largely taken up by concrete car parks (see Picture 4 below). There is also a step-down unit Ty Gwanwyn. Both of these new builds have wooden panel exteriors and large windows, giving them a modern look. These buildings were built in 2010 as part of the site's modernisation. This area is also quiet all around except

for a faint sound of distant traffic. There are houses close to the back end of the site, and there is a metal gate and fencing on the boundary. There is a significant amount of the site taken up by parking yet there are still cars parked on the sides of roads surrounding the site. This shows just how busy the Cefn Coed site is.

Picture 4: Cefn Coed Hospital – Ysbryd Y Coed

I had a brief walk inside the main building's entrance and immediately notice that it is hospital temperature even here, but there is no hospital smell. From the outside the main building looks largely unmaintained, not in a structural sense but more in a general run-down sense; and it also looks somewhat dirty. This was true of a number of buildings on the site (see Pictures 5 and 6 below). The most surprising thing I find is how small the site is- and how short the walkthrough is as a result: it is definitely the smallest of the sites included in this study.

Picture 5: Cefn Coed Hospital – Buildings on site looking generally 'dirty', particularly the building on the right.

Picture 6: Cefn Coed Hospital– Buildings on site looking generally 'dirty'

Chapter 4

Derby Borough Asylum - Kingsway Hospital

Origin

Kingsway Hospital is located within the Littleover ward of Derby, England. Littleover was originally an independent parish outside of the city; however it began to merge in 1890 when Warburgh became a part of Derby. This continued in 1928 when another part of the parish was transferred to be part of Derby. Despite this Littleover remained independent until as late as 1968 when the rest of the parish was absorbed into the Derby borough (Craven, 1996). Even though Littleover is now a suburb of Derby, and despite its increasing size, locals still refer to it as 'the village' (Discover Derby, n.d.). The population of Littleover increased from 497 in 1841, to 3387 in 1931 (Craven, 1996), and at the present the Littleover ward has a population of 14370 (B2); a huge increase in population in the area. The hospital is controlled by NHS England and the British Parliament.

The pre- and early history of the asylum is mired in a theme of short arms and deep pockets. The following was quoted in an article in the Derby Mercury in 1846: *"I Bryan Thomas Balguy, Clerk of the Peace for the Borough of Derby do here give notice: That it is the intention of the Justices of the said Borough to appoint at a special meeting to be held at the Guildhall on Tuesday, the 8th day of February, 1846, a committee of the Justices either to superintend the erecting and providing of an asylum for the pauper lunatics, of the Borough alone, or to enter into agreement with Justices of some other county or counties, boroughs, or with the subscriber to some lunatic asylum, therefore, established by voluntary subscription for the erecting and providing of an Asylum for the pauper lunatics of the said Borough of Derby"* (Thornhill, 1966: 12). Plans were subsequently submitted to H.M. Commissioners, which did not receive a response for months. When a response was received it came in the form of a list of objections to the plans, which included the following: that the hospital was planned for 360 when the number of pauper lunatics in the area was 216; that the styling of the proposals were 'too good' for the residence of pauper lunatics; that the size of the cells and rooms were bigger than necessary for pauper lunatics; and

that the plans to render the asylum 'fire-proof' were too expensive (Thornhill, 1966: 12). These objections can be used as a near-perfect example of how poor people with mental illnesses', the 'pauper lunatics' of the time, were viewed and treated; and also as an indication of rate-payers willingness to spend on public works.

Although these plans were submitted in 1846 Derby Borough Asylum was not ready to receive patients until 42 years later in 1888; as Thornhill puts it: *"it was most surprising that the institution was ever built at all"* (1966: 13). Part of the reason for the delay appears to have been that those in authority considered it cheaper to export their patients to nearby asylums, such as those in Leicester and Nottingham, than to build an asylum in the borough. Thornhill states that: *"the fact that it would be much better for the inmates to be near their relatives and friends if an asylum was built in the Borough did not enter into the discussion"* (1966: 13).

In 1863 the 'Lunatic Asylum Committee' held a number of meetings with an aim to choosing a site for the asylum to be built, and although a site in Rowditch was chosen the project did not make any advances forward. This may have been because of strong objections from various locals that the cost of building an asylum for 'pauper lunatics' was too high. As a result, patients continued to be exported to neighbouring areas until 1871, and even then it was not so much a change of policy but a situation of necessity, as the neighbouring asylums could not continue to accommodate patients from the area (Thornhill, 1966).

Following this there were many administrative issues regarding various proposed sites and the issue dragged on for years, to the extent where in 1880 the Home Secretary attended a meeting of the Asylum Committee. Eventually, after many years of bureaucracy the site at Rowditch was chosen, and it was decided that an asylum be erected to accommodate 300 patients with space for an expansion to accommodate a further 200 patients. There was however time for one more delay when the Lunatic Asylum Committee decided to write to the architect and the contractor regarding

dissatisfaction with the progress of the works, which was blamed on a delay of supply of bricks (Thornhill, 1966).

Site History

The site was eventually opened in 1888. There was no official opening ceremony but the asylum admitted 27 female patients. Shortly after this, after a near miss outbreak of smallpox in 1894, existing plans for an isolation block in the grounds were brought forward; although the Committee decided that the cost should not exceed £2000 (Thornhill, 1966).

In 1901 the boundaries of Derby borough was extended, adding 10,000 to the population. This made the Committee consider an extension to the asylum and resulted in a new building known as Albany House for 30 female private patients. This freed up room in the main building for more pauper patients to be admitted. Another structural alteration made in 1901 was the erection of glass-roofed verandas on the south side of the infirmary, as well as the provision of alternative exits- including an external stone staircase attached to the Tideswell Ward. Later, in 1911, a new block was added to the site with a capacity of 128 patients and the surrounding grounds were drained and levelled. This included 2 new female wards, and the completion of a new male ward (Yougreave) was completed later in the year. More additions were added in 1912 in the form of a new coal shed. This building was later the male occupation centre. Not long after this open air verandas were added to the Peveril and Edale wards (Thornhill, 1966).

In 1925 the former Isolation Hospital (which had housed the school of nursing before a period of dereliction) was repaired and decorated to be occupied by 16 parole patients. This is a good example of how old buildings at this time were utilised, with a policy of maintenance over one of demolition and rebuilding. Also at this time Thornhill house was acquired for the hospital, and in 1929 it was converted for use as an institution for 'mental defectives' (Thornhill, 1966).

In 1933 a new nurse's home was opened. Then in 1938 a new admissions unit was opened in the form of Kingsway House, which was built at a cost of £40,000. The block was opened as a result of 10 years of planning by the mental hospital committee (Derby Advertiser, 1938). At this time the hospital was "*so overcrowded that all new beds were already spoken for, although now it would be possible for the 'borderline' patients to be separated from the more serious cases*" (Derby Advertiser, 1938: 12).

Post-1948 and nationalisation *"there [were] many major improvements, each playing a part in transforming what was once an 'institution' into a modern psychiatric hospital"* (Thornhill, 1966: 48). This included the addition of a patient's canteen overlooking the cricket pitch. In the 50s there was repainting and even structural alterations of the main building as well as the addition of new furniture. The hospital's corridors were also upgraded; and a new geriatric unit was added to the hospital (Thornhill, 1966).

The hospital hosted an event known as the 'Kingsway Show' annually for 20 years starting in 1955 and ending, in that format, in 1974. The show was large, taking place in the hospital grounds and including a variety of events (Derby Advertiser, 1963). Attendance figures for the show varied (for a variety of reasons, not least the weather) but the number reached as high as 8000 (Derby Advertiser, 1968). The main purpose of the show was, according to publicity officer Mr. C. C. Clarke, to: *"attract the people of Derby and district into the hospital grounds and to encourage an interest in the work of the local psychiatric hospital… [they] may have had their interest stimulated to the extent that they now belong to our increasing band of volunteers who help on the wards and in the rehabilitation departments… [the] main purpose has been achieved"* (Derby Advertiser, 1974: 4). This is a prime example of how psychiatric asylum sites can, as part of the local community, become familiar and eventually are accepted by local residents through the abolition of otherness and eventually stigma.

In 1956, subsequent to a decision made by the Minister of Health, the Management Committee disposed of Rough Heanor Farm and the dairy herd attached to the

hospital (Thornhill, 1966). An advert in the Derby Advertiser in August 1956 advertises the farm land as available for lease: *"the ministry of health invite to lease for agricultural purposes. All that the farmhouse land and out buildings known as Rough Heanor Farm extending in all to 167.64 acres, or thereabouts and farming part of the Kingsway Hospital estate at Derby adjoining the main Derby-Uttoxeter Road"* (1956: 6). It was around this time that central government was pushing for widespread closure of farms attached to psychiatric hospitals (HC, 1956). In the few years after this all but one ward was upgraded to be light and airy with large clear windows and bright cheerful colours. Whereas the pre-history of the site was marred by a reluctance to spend, the early history of the asylum (from 1901 through to the 50s) is littered with examples of investment and improvement; with additional buildings being acquired and others built in order to expand the site.

In 1993 the building of a new mental health unit at Kingsway began, to include 5 bungalows in a 'village-type setting', which would each house 20 patients. These units are known as the Cherry Tree Bungalows. This would be accompanied by the building of a 20-bed mental health Intensive Care Unit (ICU) (Derby Evening Telegraph, 1993b). These developments both opening in November 1993 and the projects cost a total of £1.7m (Derby Evening Telegraph, 1993a). The bungalows signalled a new era of psychiatric care, with small separate buildings similar to the villa principle utilised.

In 1994 the Chatsworth ward at the hospital was due to close. An article in the Derby Evening Telegraph states that this is due to the health authority's investment in various community care programmes within Derby; funds needed to be released from Kingsway (1994). Subsequently in 1996 it was announced that the hospital (in its current state) was to close in the year 2000. New facilities were being searched for to rehouse 200 long-stay patients, and the health board were half-way through a scheme to move patients out of the hospital. The article states: *"Kingsway has been due for closure for the past 15 years and the decision to shut it by the year 2000 was taken three years ago"* (Derby Evening Telegraph, 1996a). Also in 1996 the closure of the Mansall Ward

sparked controversy, as it was claimed that it breached local and national guidelines (Derby Evening Telegraph, 1996b).

In 1997 the hospital opened a new £2.1m site at Derby General Hospital to replace two of the 1930s wards. Anne North (the Ward Manager at Kingsway Hospital) stated that: *"sometimes you feel that you're fighting a losing battle with these old buildings"* (Derby Evening Telegraph, 1997). This shows a shift in NHS Estates policy, from reuse (as seen in the 1920s) to replacement. What the 1990s shows is a distinct shift in emphasis from investment in maintaining and modernising existing facilities to the closure of existing wards and the investment in new facilities. We also see the mention of possible closure at the Kingsway site.

In 2008 it was announced that 700 new houses would be built on the Kingsway hospital site. Officials stated that "*the development was designed to be locally sustainable with many residents working nearby and having access to local amenities*" (BBC News, 2008a). Despite this however outline planning permission for the site was not given until 2010 (Derby Telegraph, 2010). The new development is set to be completed by 2015 (Stride Treglown, n.d.).

In 2009 the new £25m mental health unit, The Ashbourne centre, opened. The centre has the capacity to house 58 patients and 160 staff as well as incorporating a coffee shop, a library, a hairdresser, a bank, a restaurant, a chapel, a multi-faith centre and a physiotherapy centre. The new facilities replace the former psychiatric hospital buildings built in the 1860s (Derby Telegraph, 2009b).

The 2000s again reinforces the shift in emphasis from refurbishment to replacement, as land sales are used in order to fund new facilities on the Kingsway Hospital site. As it stands today on the Kingsway site, the hospital is in the ownership of a fair number of new buildings used for both clinical and administrative purposes. This was in an effort to replace the old buildings on the site, which were deemed to be not fit for purpose: *"the investment by the previous government has provided new state of the art buildings which*

deliver modern NHS mental health services. The old Victorian buildings were outdated and not fit for purpose… They were extremely poor and did not meet modern needs. The buildings were designed when society had a very different view of mental health, and so made delivery of modern services extremely difficult. They were stigmatising and not a welcoming or friendly environment" (B5).

The building of Kingsway Hospital was a story of unwillingness to invest. Subsequent to this however the 20th century held many examples of investment into the hospital site's buildings and their expansion. However in the 1990s there was a mixed approach of ward closures (Chatsworth and Mansall wards) in order to release funds from the site to go towards community care schemes, and investment in the upgrading and replacement of some wards on the site. This included the building of the Cherry Tree Bungalows and a mental health ICU unit. The same approach continued into the 21st century with the sale of land for housing (including the current large land sale), and the building of new units on the site. As the site now stands, many of the old asylum buildings have been replaced with modern facilities. In this way the Trust has acted to remove many of the physical aspects of informal memorialisation at the site, and the site may experience a reduced level of stigma as a result (Kearns et al., 2010).

A large section of green space on the Kingsway site has been allocated for future housing development (see Figure 4.4 below). Under these plans a new road would be constructed through the centre of the Hospital site. The effects which this will have upon the site are unknown but potentially this has the possibility of negating the calm and quiet atmosphere which contributes to the therapeutic landscape which the site has, up to now, offered.

Figure 4.4: Kingsway Hospital Plans (Stride Treglown, n.d.).

Walkthrough

My initial walk through Kingsway was a little bit eerie. After previously walking around St Nicholas' and finding not a busy site but a used and inhabited site, the lack of people around Kingsway was slightly unnerving. I walked up the main drive of the site. The first thing on the right is the Trust Headquarters in Bramble House (See Picture 7 below). Bramble House is a less grand headquarters compared to others I have seen and, for this and other reasons, one interviewee was critical of its use as such.

After you pass Bramble House, to the left there is an open space with a collection of trees, which I have been told has been designated for a future housing development. This is likely the development which was discussed in 2008 (as seen in Figure 4.4). There is a sign attached which claims it to be private land. On the right further up there are a couple of new-looking buildings including the Centre for Research Development which looks sleek and stylish- making use of a widely favoured wooden panelling. Also here is the Ashbourne Centre (built in 2009); and then Albany House- although it

was later divulged that Albany house was not in fact new (it had however been sandblasted and the effect is to make it *look* newly built). This shows how investment in maintenance can make a site look more inviting and professional, as opposed to those which are left to look run-down.

Around a corner and to the front stands Kingsway House. I met my guide inside for a brief chat and then we set off for a wander around the site. First we passed the collection of wards just off Kingsway House (Tissington, Melbourne and Cubley wards) (see Picture 8 below); the buildings looked relatively modern in appearance, with wood panelling on the exteriors much like the Centre for Research and Development. Here we encounter a group of patients and staff walking around and into the building. This area was generally fairly quiet, with only distant traffic noises and the occasional movement of staff and patients around the area. This comfortable use of the site by staff, patients and the local public seems to show a level of integration between the site and the local community.

Picture 7: Kingsway Hospital – Bramble

Picture 8: Kingsway Hospital - Melbourne

We wandered over to a set of modern mental health buildings; the Cherry Tree Bungalows. As we have seen these were built in 1993 to house 20 patients. These buildings seem nice from the outside, just like a small community set apart from the rest of the site with a grassy incline by the road (see Picture 9 below). As we pass a fire alarm goes off in one of the bungalows and my guide has to attend. I follow him towards the bungalows and hang around outside. I now notice that the bungalows have their own outside spaces, including a small amount of grassy space and a small allotment. I can imagine that this area would be nice, quiet and relaxing if there were not a fire alarm sounding loudly by my head.

With the emergency (read: minor malfunction) over we wander around back past Bramble House and towards the driver mobility centre. On the way we pass the site's two listed buildings (the nurses and doctors houses) as well as a couple of abandoned house-like buildings. These are built of multi-coloured reddish brick and fenced off with greenery beginning to reclaim the edges of them (see Picture 10 below). In this direction we can see across the huge green space which is going to be used for housing in the near future (See Picture 11 below), as noted earlier by a sign on the road and, as discussed in the backgrounds section, which will accommodate 700 houses in 2015.

This sale of land shows how NHS estates policy is pushing for the sale of assets in recent years, in order to save money as a result of large budget cuts.

Picture 9: Kingsway Hospital – Cherry Tree Bungalows/Villas

Picture 10: Kingsway Hospital – Abandoned building

Picture 11: Kingsway Hospital - Land earmarked for development

We arrive at the driver mobility centre. The building in which this is based is almost surrounded by a boarded up building in a state of minor disrepair (see Picture 12 below). Another abandoned building further on shows signs of attempted break in (see Picture 13 below), and my guide tells me that it is not uncommon for urban explorers to break into buildings on the site. The presence of abandoned buildings on the site shows the financial difficulty the NHS has in funding the costs of maintenance and repair, especially with regards to buildings which are listed. As noted above there are increasing financial restrictions on the NHS and NHS Trusts and as a result decisions have to be made on where that money will come from. It appears that in this instance these buildings are the necessary sacrifice in order to maintain levels of patient care. It can also be noted that this area is much noisier, due to the driver mobility centre in operation with cars moving, people wandering around and the ever-constant noise of traffic in the distance (which will in the near future be made much worse by a main

road through the centre of the site, not to mention the population increase from hundreds of new residences in the area).

Picture 12: Kingsway Hospital – Building in minor disrepair

Picture 13: Kingsway Hospital – Signs of attempted break-in

We walk to a small abandoned section on the edge of the site, where there is an old coal shed and piles of abandoned scrap (see Pictures 14 and 15 below). According to

my guide the boundary of the hospital is right on the edge before the scrap. This part of the site is relatively quiet, but its general untidiness and unmaintained appearance make it a less than pleasant place to be; not to mention the health and safety issues raised by the scrap lying around in the open.

Picture 14: Kingsway Hospital – Old coal shed

Picture 15: Kingsway Hospital – Edge of the site, site boundary just to the left of the heap of scrap.

Chapter 4

Newcastle Borough Lunatic Asylum - St Nicholas' Hospital

Origin

St Nicholas' Hospital was originally constructed in the 1860s and is located in the West Gosforth ward of Newcastle upon Tyne, England. Prior to 1884 Gosforth consisted of a number of Townships; and from 1895 Gosforth was a separate entity run by the Gosforth Urban District Council (Ewles, 2012). Gosforth did not officially become a part of Newcastle upon Tyne until 1974 (Gosforth Life, n.d.). According to the 2011 census West Gosforth has a population of 9991 across 300 hectares (UK Census Data, n.d.). The hospital is controlled by NHS England and the British Parliament.

Originally 33 acres was to be bought for the asylum, but this was increased as the Commissioners in Lunacy felt it to be insufficient. Therefore 52 $\frac{468}{1000}$ acres of land were bought from a Mr Dunn for £10,000 and the land consisted of: a house; an outbuilding; yards; gardens; a paddock; a garth[6]; and 3 rigs (Ewing, 2009). Councillors were unhappy about this decision as they felt that *"the reason for purchasing so much land for patients to live and work on, was so that they could become 'experimental agriculturalists at the expense of the general public'"* (Ewing, 2009: 37).

In 1864 Mr William Moffat was appointed as the asylum's architect, though this was also met with controversy as the feeling was that a *"foreign architect employed from a distance – had been made at the expense of Newcastle architects"* (Ewing, 2009: 40). Mr Moffat was subsequently instructed to prepare plans for an asylum with accommodation for 250 patients whilst being mindful of the cost and making sure the building had potential for future expansion. Further controversy bloomed when the architect's estimated cost of the new asylum was set at £18,000- and the subsequent

[6]Garth – "*an open courtyard enclosed by a cloister*[4]" (Dictionary.com, n.d.).
[4]Cloister – "*a covered walk, especially in a religious institution, having an open arcade or colonnade usually opening onto a courtyard*" (Dictionary.com, n.d.).

tenders submitted for the contract were around and over £25,000. This led to a lengthy dispute over the quality of the materials that Moffat planned to use and eventually, after the input of 'consulting architects' and a change to the roof design was resolved, and the plans were ready by October 1865 (Ewing, 2009).

The Newcastle-upon-Tyne Borough Pauper Lunatic Asylum annual reports began in 1865, five years before the asylum buildings were completed. The first reports relay information about the planning and construction of these buildings as well as the care for patients in the temporary hospital at Bensham- which was costing the board £400 in annual rental (Ewing, 2009). The delays to the building of the asylum led to the maintenance of a temporary asylum at Bensham, which by this time was already overcrowded and *"perceived as having undertaken the character of a mad-house typical of the previous century rather than a 'modern hospital for the insane poor'"* (Ewing, 2009: 49). An 'operative masons' and bricklayers strike further delayed the construction of the asylum resulting from the fact that the building materials, especially the bricks, were deemed *"bad and unfit for purpose"* (Ewing, 2009: 53). By 1866 the asylum building had only been staked out and had a foundation stone placed. By 1868 the construction of the new asylum was making good progress, but the lease on the overcrowded Bensham was due to expire within the year (Ewing, 2009).

Site History

The new asylum was eventually opened in 1869 as Newcastle Borough Lunatic Asylum. The total cost of the new asylum, including the land and the buildings, came to around £65,000 (Ewing, 2009). *"The asylum, with its 'various corridors, day and sleeping rooms' was deemed to be clean, well-warmed and properly ventilated with male and female patients assembling together in the dining hall to enjoy meals"* (Ewing, 2009: 60). By 1878 the asylum population already consisted of 261 patients, more patients than the asylum was originally designed to accommodate.

In 1954 it was announced that the hospital was to undergo a £250,000 extension, adding 110 beds to the existing 1200 already on the site. The new admissions unit was believed to be a *"step taken to ease overcrowding in mental hospitals"* (Evening Chronicle, 1956: 6).

In 1957 the hospital was in a strange situation when the hospital itself was overcrowded, but 40 beds were empty and a villa was closed. This was due to the inability to hire an adequate number of staff to cover the wards as a result of full employment. This left a situation where patients were crowded into open wards (Evening Chronicle, 1957).

In 1961 potential land sales were rebuffed by the hospital: *"private builders and other developers who have cast covetous eyes at 20 acres of land in the grounds of St. Nicholas' Hospital, Gosforth, must look elsewhere. The land, which is required for future development at the hospital, plays an important part in the recovery of patients. Says Dr. J. P. Child, the Medical Superintendent: This land is most valuable as a therapy for the patients, many of whom work in the vegetable gardens"* (Evening Chronicle, 1961). The land was described as *"absolutely necessary for the hospital"* (Evening Chronicle, 1961).

In the 1960s and 1970s brochures were produced for prospective and existing patients of the hospital. The first of these, from the 1960s, states that: *"St Nicholas' Hospital is mainly for the treatment of nervous illnesses with people coming here from Newcastle, West Gateshead and the Consett area. The main part of the building is situated in large grounds with a great deal of open space, including cricket and football pitches"* (Newcastle Area Health Authority, n.d.). A second leaflet, from the 1970s, stated: "*this Hospital is a place for which to find enjoyment and pursue, and indeed to widen, outside interests. During your stay there is both time and opportunity to take part in a busy social life. The grounds of the hospital not only afford a means of pleasant relaxation but also facilities for outdoor games"* (Newcastle University Hospital Management Committee, n.d.). These leaflets offer a description not only of the hospitals facilities, but the ways in which mental health treatment was perceived at the time.

In 1972 it was reported that the Hospital's boilers would be converted to natural gas at the cost of £47,000 (Evening Chronicle, 1972), and the hospital also received investment in the form of £113,000 for an alcoholic and drug abuse unit (The Journal, 1972). Then in 1974 a new unit for elderly patients at St Nicholas' was announced. The 25-bed villa, plus supporting services, would cost £152,000 and was set to be the first of its kind in the region. This is in addition to a new £1 million catering unit and the drug and alcoholics unit opened in 1973 (McKiernan, 1974). There were plans for the Hospital to build a secure unit in 1975, which was met with consternation and protests from the local communities surrounding the hospital (McKiernan, 1975a; 1975b). Councillor George Trice stated that: *"one views this sort of proposal with extreme disquiet, St Nicholas' Hospital is in a very heavily built up area…there are lots of children in the area and it would seem to me to be quite an unsuitable place for such an institution. I am quite certain that when the residents become aware they will be extremely worried"* (Evening Chronicle, 1975: 1).

In January 1976 began a long running dispute over staffing at the hospital. A group of male nurses began what the newspapers described as a 'war of the sexes' by disputing the under-representation of male nurses amongst the staff: *"half the patients are men and only a third of the nurses are male, so this means we are overworked... we think the answer is to take on more male staff"* (The Journal, 1976a: 8). This continued to be an issue later in the year when female nurses were being asked to staff the male wards (The Journal, 1976b). This dispute continued into February 1977 when 450 nurses at the hospital began industrial action over the 'totally inadequate' staffing levels at the hospital, also described as 'critical understaffing' (The Journal, 1977a; Evening Chronicle, 1977a). In March the staff on all the wards and in all the departments were operating on a work-to-rule basis (The Journal, 1977b); the action ended approximately a week later when it was agreed that 47 extra staff would be hired, and industrial action at a national level would be used to fight for the remainder of the 70 which were requested (Evening Chronicle, 1977b).

Talks regarding the secure unit, previously mentioned in 1975, were again mentioned in 1982. In this instance initial talks were reportedly underway into the setting up of *"a special unit for potentially violent psychiatric patients"* (Lutz, 1982: 11). However in 1983 plans for a new psychogeriatric day hospital on the St Nicholas' Hospital site were approved in principle. The building was expected to cost £450,000 (£350,000 for construction and £100,000 for furniture) and was expected to be finished in two years (Lutz, 1983). Then in 1984 a long wait for a new pharmacy on the St Nicholas' site came to an end after 10 years of planning. The new pharmacy, built at the cost of £350,000, was eventually completed after the bankruptcy of two of the original contractors (Bennington, 1984b).

Also in 1984 the Hospital was at the centre of a huge land deal. 20 acres of land at the St Nicholas' Hospital site, which had been leased out as a commercial market garden for more than 20 years prior to the deal (Evening Chronicle, 1985a), were to be sold off for £3 million. This sale shows a change in policy, after the rejection of a similar sale in the early 60s. The land sale funded the demolition and replacement of a 118 year old, 680-bed hospital with modern buildings. The buildings at both the St Nicholas' and the general hospital sites were considered to be out of date; with approximately £2 million needed to bring them up to modern standards (Bennington, 1984a). The administrator of mental illness services stated that *"a lot of the ward areas look like barns, and this means the buildings can become more homely and lose the institutionalised look and feel"* (Bennington, 1984a: 5). The Chief Nursing Officer Anthony Carr also stated that: *"the board found very poor, overcrowded and inadequately staffed facilities for long stay and psychogeriatric patients, totally inadequate dining facilities for some patients- and too many locked doors"* (Bennington, 1984c: 3). The plan was to reinvest money from the land sale into building *"small community units for the mentally ill"* (Bennington, 1984c). District Manager and Administrator Chris Spry stated at the time that: *"we have excellent staff working in buildings that are now extremely old and unsuitable. The money released by land sales will make it possible to carry through a radical policy of replacing existing mental illness facilities in the next few years…The scheme will be of great value to patients. We can finally plan the demise of the Victorian buildings which were designed for a very different kind of*

treatment of and attitude to mental health care, compared with those existing today" (Evening Chronicle, 1985b: 10).

On the 2nd September 1991 the St Nicholas' Hospital site was designated as a conservation area. The site was designated: "*as an area of distinctive architectural, environmental and historic character, which includes a number of substantially unaltered buildings, it was considered that there was potential for enhancement and preservation and that conservation area status would help attract funding to achieve this. The character of the area was at risk from pressures for change and development and it was intended to achieve a controlled programme of change which was sympathetic and complementary to the existing fabric and landscape*" (Newcastle City Council, 2009: 1).

In 1998 a new £1m unit, Collingwood Court, was built to replace the old Derwent ward. The new unit comprised of 16 beds, 10 partial hospitalization places, outpatient facilities and home-support services (Evening Chronicle, 1998).

In 2004 the Bamburgh Clinic was built on the site on brownfield land, which was formerly a fish factory, costing a total of just over £22 million. This shows a continued willingness to invest money into the St Nicholas' Hospital site as a centre for mental health care in the region. The history of the site, from the 1950s through to the 2000s, has largely been one of continuous investment and upgrading of facilities.

The site, as it currently stands is different from how it used to be, with much of the original asylum land now taken up by housing and private companies. The core of the site remains and is partially listed, with some green space accompanying the hospital buildings. St Nicholas' Hospital received investment from the 1950s through to the 1980s, including the rebuff of a land sale in the 60s. However in 1984 land on the site was sold, in order to fund the replacement of the buildings on the site defined as 'old' and 'unsuitable'. In the 1990s investment was made in a new ward, Collingwood Court, on the site to replace one of the older units. This was extended into the 2000s with a second new ward, the Bamburgh Clinic, built on a brownfield site in the

hospital grounds. The physical changes on the St Nicholas' Hospital site have been significant; however the main asylum building remains. As at Cefn Coed, it could be argued that the survival of the asylum's architecture at St Nicholas' acts to informally memorialise the site (Chaplin and Peters, 2000; Kearns et al., 2010). However in the instance of St Nicholas', much like seen at Carrington Hospital (Auckland), there were limitations to the manipulation of memorialisation on the site, as a result of the heritage protections afforded to the site (Kearns et al., 2010); this being in the form of listed buildings and the conservation area. As it stands there are no plans in place with regards to any site closure or sale of land. The hospital appears to be seen as a "*jewel in the crown of the trust*" (C1) and as such it will remain open and in use.

Walkthrough[7]

The first thing you notice of the site is the boundary wall, which envelops the vast majority of the original asylum site (See Picture 16 below). On this walkthrough I walked all the way around the outside of the wall, which stretches for just less than two miles around the original asylum site's periphery. Nowadays the site is much smaller than it originally was, so the internal of the boundary wall is lined with housing (and some industrial and retail developments) for almost the entire circumference. The wall itself still stands as part of the conservation area which protects the site. At the entrance to the site it feels, especially in the places where the wall remains at its original height, somehow off-bounds. This is even though houses can be seen on the other side of the wall in many places. In other places the boundary wall has been modified to make it smaller (see Picture 17 below).

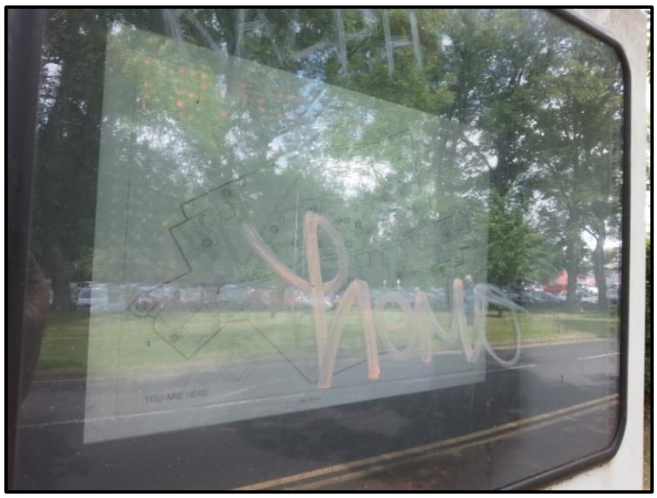
[7] Some of the pictures in this section were taken on a previous visit shortly before this walkthrough.

Picture 16: St Nicholas' Hospital – The boundary wall at full height

Picture 17: St Nicholas' Hospital – The boundary wall as it has been modified

The main drive is lined with trees. The first building you see is a nice house on the left, which you then find to be an office for the Northumbria Police. There is a large car park on the right hand side, and a sign containing a map on the left of the path which has been graffitied (See Picture 18 below). I emerge to a crossroads with a large green space to the left between the trees (See Picture 19 below); which is in complete contrast to the 'industrial use' post office building on the right hand side. The impression which

I got here was one of integration and coexistence between formal and informal usage of the site, which helps create a more open and friendly atmosphere.



Picture 18: St Nicholas' Hospital – Graffitied map

Picture 19: St Nicholas' Hospital– Green space

Further up in the far right is the modern Bamburgh clinic- the acute forensic unit at the hospital which, as we saw above, was built on the site in 2004. This can be seen from the exterior, which looks modern with wood panelling; which contrasts to the older brick buildings on the left hand side. If it were not for the signs dotted around the site

you would not know that it was a hospital let alone a former psychiatric asylum site. The first sign that the site used to be a psychiatric asylum comes from the main building and its clock tower (see Picture 20 below) which stands in the centre of the site.

Picture 20: St Nicholas' Hospital – Main building clock tower

The main building's reception area can only be definitively identified as a hospital of any sort due to the combination of signage and the hard floors. There is a faint smell of hospital, and it is also set to a typical hospital temperature. It is here that I meet my guide for the day, who has kindly agreed to show me around both the interior and exterior of the hospital site. I am escorted along the corridors decorated in a scheme of white, pale blue and peach; calming colours though an odd mix. The corridors smell

slightly stronger of hospital. Some of the corridors are long and echoey (see Picture 21 below); and there are few people around.

I am shown to human resources, which used to be one of the old wards. The dayroom would have been huge and completely lacking in privacy in comparison to the newer wards. The rest of the space would have been split into 4 multi-bed wards accommodating 6 patients each. The conversion into offices seems to have been done with an adequate, if not ideal, use of the available space.

Picture 21: St Nicholas' Hospital - Corridors

From there we went across to look at the Ashgrove ward. The ward currently stands empty due to refurbishment; the communal areas smell of decorating; specifically of cut wood and paint. The bedrooms look standard (see Pictures 22 and 23 below) and not dissimilar to student accommodation- except for the vinyl floors, which are presumably for infection control. The building has tough security with code-locked doors plus dual-handled doors. Upstairs the space is open with large windows lighting up the area. There are smaller quiet lounges up here which, surprisingly in modern times, are separated into male and female.

Pictures 22 and 23: St Nicholas' Hospital – standard room in the Ashgrove Ward

The Greentrees wing has been converted into a bedroom wing. The large exterior windows are fitted with one-way glass to ensure privacy and maximum light. I am told that conversions can work well if you "*throw enough money at it*" (C8). Entering Greentrees from the back, you go through an external space between buildings which has security fences on either side. The security fence surrounding the outside space of Greentrees has been mildly disguised using branches weaved into the fence; on the other side no such nicety has been attempted (See Pictures 24 and 25 respectively). It reminds me of a school fence. This fencing is a result of the need under health and

safety regulations to have internal courtyards separated off at a certain height, and the inability on the part of NTW to build a permanent solution as a result of the heritage protections which are in place on the St Nicholas' main building. As a result NTW are left with a carceral appearance which in not ideal in a mental health environment as it gives the feel of incarceration and imprisonment.

Pictures 24: St Nicholas' Hospital – security fences outside Greentrees

Pictures 25: St Nicholas' Hospital – security fences opposite Greentrees

As you walk into the Greentrees external area through the gate to the allotments, I notice that the external spaces utilise AstroTurf instead of grass. I am told this is due to the problems of lawnmower access. There are nets above this outside space which are not much higher than the top of my head at one side, sloping up towards the building; it makes it feel slightly claustrophobic. Once inside Greentrees we pass an internal courtyard (see Picture 26 below) which looks like a nice space. There are seating areas and a mini AstroTurf football pitch (all the grass in this space is also AstroTurf). The ward is designed as such that vision is limited and the rooms are small-ish (although I am told that originally the space would have accommodated two single bedrooms, evidence of vast improvements from the original layout). Crossing into the new-build area I notice that all the rooms here are standardised. The rooms also have personalised name plates outside each room so that the patients can design their own. All the doors in this area are locked, and walking down a corridor seems to take forever.

Picture 26: St Nicholas' Hospital – Greentrees internal courtyard. Football pitch behind wooden panel in the front

After walking back through the corridors and through the main reception (which smells of acidic urine), we walk along to Willowview. This is a long-stay ward, which has small single bedrooms due to the fact that they have been converted from dormitories. The problems here, I am told, is that the rooms are non-standardised; they are all different shapes and sizes, and even the corridors have 'cubby-holes' in which to hide. The layout would make observation and management incredibly difficult, and is another result of the inability to modify the structure of the building because of the heritage protections afforded to the building itself.

We walk across to the estates department, and the first thing you see is barbed wire which I am told is to deter thieves from stealing scrap metal. This contrasts with the site's general feeling of openness; the use of barbed wire projects an image of conflict (especially of war) and seems out of place on what appears to be a quiet hospital site. There are a number of portable cabins and garages in this area and when entering the offices it feels enclosed, with a number of winding corridors.

The outside spaces of St Nicholas' are fairly mixed. The exterior of the buildings has lots of green, open space; including a large field to the rear of the main building which also incorporates a cricket pitch. The whole site is quiet- despite the large number of cars moving around on the site. I must mention that half of the time we spent in outside spaces it was raining, but still we encountered dogs (with dog walkers) and people exercising in spite of the weather.

There is one incident, which occurred on a prior visit to St Nicholas' Hospital, which I believe to be relevant here. After wandering around the site I came to a dead end next to some small villas, where a member of staff came out to ask me pointedly if I was lost. It would have been difficult to get lost whilst still in sight of the main road so the assumption is that he was making a point. I got the impression that 'people do not come this way': it is not closed off, but you do not go there. This had unfortunately been one of the last impressions I got of the site before I left on that occasion. The walkthrough however reassured the view that the site is largely open to the public; but

it served as a reminder that St Nicholas' is a site still in use for mental health care and as such there are safeguards in place.

Portsmouth Lunatics Asylum - St James' Hospital

Origin

St James' Hospital was originally constructed in 1875, and is located in the Milton Ward of Portsmouth. At the time of construction Milton was an independent village, but expanded greatly in the latter part of the century before being consumed by Portsmouth in the early 20th Century. The hospital is controlled by NHS England and the British Parliament.

75 acres of land was bought at the cost of £14,000 for the building of the Portsmouth Borough Asylum just to the east of the village of Milton (Carpenter, 2010). The land was chosen with the aim of being suitable for cultivation (Gange, 1988); this was as it was well drained, "*fertile and suited to spade labour*" (Carpenter, 2010: 56). The Portsmouth Borough Asylum was designed by famous Victorian architect George Rake (Memorials and Monuments in Portsmouth, n.d.); who designed the building in the corridor-pavilion style (Carpenter, 2010). The hospital was originally designed to accommodate between 410 and 424 patients. The total cost of the land and buildings was £120,000 (Gange, 1988).

Site History

Portsmouth Borough Asylum was built between 1875-79 in the corridor design with an 'integral entertainment hall' and a chapel in the grounds (Pastscape, n.d.). The first patients were admitted on the 1st October 1879, and the report from the Hampshire Telegraph states that "*there seems something incongruous at first sight in the festive celebration of the opening of a new lunatic asylum. A solemn service, or perhaps better still, no service at all, would appear to be more in harmony with the event"* (1879: 2). The article goes on to state that: *"the deeper humanity of the age render it certain that increased care will be*

bestowed upon the insane, and the new edifice at Milton is not unfit memorial of this benevolent spirit. Considering the shocking cases of cruelty which almost daily disfigure the papers, it is at least pleasant to think that a tender pity is excited towards those whose mental affliction leaves them entirely at the mercy of others. It is a bright spot in a sufficiently dark background, and we shall do right to cherish it" (Hampshire Telegraph, 1879: 2).

The last quarter of the 19th Century proved to be one of construction and improvement. In 1884 two new infirmaries were built on the site. The ward wings of the hospital were extended in the 1890s (Pastscape, n.d.). In 1893 training was provided for the nurses at the hospital, and rules put in place for nursing practice. Also in 1893 a further fourteen acres of land were bought and a sanatorium was built for the care of infectious cases- although this did little to relieve the overcrowding which the site already suffered from at this early stage (Gange, 1988). It was in 1896 that electricity was installed at the asylum at the cost of approximately £554 (Gange, 1988).

In 1904 an article states that the Portsmouth Lunatic Asylum considered the building of two new blocks housing up to 100 private patients in order to capitalise on their profitability to the hospital. The majority of the asylum's profits of £950 in the previous year are said to come from private patients (Hampshire Telegraph, 1904a). Later in the year there is an article praising the asylum, as it states that the padded rooms had not been used for approximately seven and a half years: "*this is due to the fact that nowadays drugs, including the well remembered Chloral, are employed to sooth obstreperous patients who, a few years ago, were allowed to thrash themselves to exhaustion in the padded room*" (Hampshire Telegraph, 1904b: 2).

In December 1905 the hospital was already overcrowded. A meeting of the town council to discuss the matter revealed that space was so tight some patients were forced to sleep on the floor. There was resistance to extending the asylum and an alternative put forward by the article was to reduce the number of patients accepted from outside the district, notably from Southampton (Hampshire Telegraph, 1905). However, apparently the former was decided on as 6 months later, in June 1906 it was

revealed that the Asylum Committee has submitted plans for four new blocks at the Asylum. Each of these blocks would house 36 private patients and be based on the 'villa principle'. The total cost of this proposal was estimated to be approximately £24,000 (Hampshire Telegraph, 1906).

In 1926 the hospital was still overcrowded. The building originally designed for 450 patients now housed 1000; this reportedly led to an over-ordering of mechanical treatment methods as the humanity dropped out of patient's treatment (Gange, 1988).

In November 1960 the Mental Health Act 1960 changed St James' from a 'mental hospital' to a 'psychiatric hospital' (The News, 1960a). The article in The News which reported on this stated that the hospital now housed 1200 patients of which 150 were 'compulsory' residents (1960a). This was a step forward in improving the image of psychiatric hospitals and patients, and later in 1960 this was built upon when an article announced that St James' was 'dreary no more': "*once-dreary wards and cell-like rooms are rapidly being changed into bright cheerful places*" (The News, 1960b: 29).

Funds allocated to the hospital by the Wessex Regional Hospital Board allowed the hospital to upgrade the buildings and their rooms, bringing them up to date. The 'dreary fittings' were being replaced with new furniture and decorated rooms and corridors. However one side effect of this general upgrading of the hospital was the problem of where patients would stay whilst their wards were being upgraded: "*these maintenance and capital allowances are not helping us with our overcrowding, and it is difficult to know where to put patients during the up-grading of their wards*" (The News, 1960b: 29). Just after these modifications, in 1961, the hospital's padded rooms were removed. This shows how treatment had advanced at the time with more focus on drug treatments rather than restraint. This was also shown in 1962 when The News reported on "*a revolution of humanity*", stating that "*if they wanted, most of the patients here could simply walk out*" (The News, 1962a). The article goes on to describe the transformation of the hospital itself under the Minister of Health's ten year building programme: "*walls have been plastered and painted in charming pastel shades, floors have been laid with bright*

linoleums and carpets, and, perhaps most important of all, low, false ceilings have been fitted" (The News, 1962a).

In 1963 it was announced that St James' would have a new children's unit, including a big extension to the hospital building. It states that "*the new unit at St James's to strengthen psychiatric services in the Portsmouth area is expected to be started by 1968*" (The News, 1963b). The new unit was given a £100,000 boost from the amended ten year plan for Britain's hospitals, and a new building was expected to be built in the grounds; which would replace two smaller units- one on the St James' site and one in Kimpton House in Southsea (The News, 1963c). These plans would also include the building of a day hospital on the St James' site as well as the remodelling of three of the villas within the hospital grounds (The News, 1963a).

The Hampshire Telegraph reported in December 1965 that negotiations were under way between the hospital board, on behalf of the Ministry of Health, and Portsmouth City Council to sell off most of the farm land to the council (1965). It was stated that "*it would be wrong to assume that the farm has been a huge white elephant, serving no useful purpose*" (Hampshire Telegraph, 1965). 160 acres of land were sold leaving 60 still under cultivation at the hospital (Gange, 1988). Although later than at other sites this is still likely to as a result of the central government push for the sale of farms attached to psychiatric hospitals (HC, 1956).

In 1980 moves to close wards at St James' Hospital were branded as "*a disgusting and cynical attack on people who are not able to argue*" (The News, 1980: 1). This is after instructions to save £65,000 a year in psychiatric services in the Portsmouth District: the closure of Kimpton House and wards in the main building are efforts to make this saving. Mr Ken Hill, Chairman of the Confederation of Health Service Employees (COHSE), stated that "*in the name of economy we are going to end up with 60 to 70 people in wards with only two or three nurses*" (The News, 1980: 1). This signalled the shift from a history of investment and improvement, to one of budget cuts and decline. This is also perfectly shown in 1981, when it was reported that St James' planned to sell off

redundant land in an effort to make more money for the Portsmouth health district. The hope was that the land would first be designated for housing in order to make it more valuable and bring in the maximum profit for the district, and with this in mind the trust had applied for planning permission for residential development from Portsmouth City Council (The News, 1981).

In 1983 it was announced that there were plans to close St James' Hospital. Portsmouth Health Administrator Chris West stated that although St James' is "*one of the leading psychiatric hospitals in the country… the plan is for medical services at St Mary's to be concentrated in its West Wing, leaving the East Wing empty. St James' 'institutional' services would move to the East Wing*" (Gardner, 1983: 3). It is stated that proceeds from the sale of the hospital would be reinvested into building new hospital buildings and also community hospitals. Other reasons given included that the owning of multiple smaller sites added to the cost of the health service in maintenance, rates and overheads (Gardner, 1983).

Portsmouth City Council, described as 'land-starved', stated that they would be "*very interested in the chance to buy St James' Hospital' acres at Milton when they come on the market*" (The News, 1983a: 3). Following this, leading conservative councillors were heavily criticised for 'gathering like vultures' over the St James' Hospital site (Wingham, 1983). This was after one was quoted as stated that the grounds of the hospital becoming available would open up "*tremendous opportunities*" (Wingham, 1983: 3). In the aftermath of this a movement began *"to save St James"* (Drummond, 1983: 11); and the message was put forward at a public debate on the revision of health services in Hampshire. It was believed that "*the 'therapeutic' environment of St James could not be reproduced in the 'backyard' of St Mary's, as envisaged under the proposal*" (Drummond, 1983: 11).

In 1987 The News stated that the Area Health Authority would unveil a major scheme for St James' Hospital in the New Year. This was to include plans for a science and business park, housing and open space. The St James' Hospital site is described as

'redundant', and the health authority was to retain approximately 25% of the site's 75 acres. According to its District General Manager Chris West, the plan was to "*sell off the rest with the best planning status in order to make as much money as possible for the health authority*" (Beddoes, 1987: 1).

The Portsmouth City Local Plan stated the following in 2006: *"it is anticipated that part of the grounds of the Hospital will become surplus to the requirements of the Primary Care Trust during the currency of the local plan. The land involved will be suitable for housing development"* (Portsmouth City Council, 2006: 135). Yet, despite this in recent years there has been investment into the St James' Hospital, with the building of new facilities at The Orchards and The Limes on the site (Health Overview and Scrutiny Panel, 2014).

The current site is comprised of the following: residential care facilities; community care facilities (in the form of villas); administration; new builds; Lowry day centre; housing; derelict buildings; and university buildings. "*There are very few wards left there now, the main block is mostly offices as it is the headquarters for Solent and Portsmouth health*" (Wallace-Cook, 2012: 7).

There is evidence of investment on the St James' site throughout its history up until the 1980s; which included the expansion of the hospital's wards and facilities. This included the upgrading of existing wards in the 1960s, the additions of a new children's unit and a day hospital on the site. However in the 1980s there began a string of closures and land sales at the hospital, with the closures of Kimpton House and a number of wards in the main building. Talk of closure at St James' began as early as 1983 and discussions over the sale of the site began in 1987. This reduction of investment in the site may be related to the timescale of mass hospital closure following Powell's water tower speech.

The site was listed in 1998 and in 2001 the land to the south of the hospital building was designated as a 'town green'. The protection of the site and its green space has

been a focal point of discussions recently due to the hospitals winding down, closure and potential sale. Local residents have shown they are passionate about the preservation of the site as a local commodity through the Keep Milton Green campaign (discussed in detail in the next chapter).

In February 2014 it was announced by Solent NHS Trust that plans had been drawn up to move the medical services at St James' Hospital to another location, possibly to St Mary's Health Community Campus (The News, 2014a). The merger of St James' with St Mary's is considered as both hospitals have large amounts of surplus space- St James' now accommodates 20 patients in a building that was built for 450 and has housed 1000. In a letter inviting residents to a consultation event it states that in the future: *"St James' will still house services but in the modern buildings in a smaller area of the site"* (NHS Letter, 2014). Much like at the St Nicholas' Hospital site (and Carrington Hospital) there are limitations to the manipulation of memorialisation as a result of the listed status of the main hospital building. As a result the main ex-asylum building will remain as a form of informal memorialisation to the site's past use.

"Plans are now coming forward to release further surplus land on the St James' site in two phases" (NHS Property Services, 2014b). Phase one concerns the land in the South East of the site, which has been identified as suitable for housing. It is the intention of NHS Property Services to sell this area of land to help meet the Government's commitment to release surplus public sector land for housing (NHS Property Services, 2014a). Phase two is a more long-term plan. It consists of vacating the occupants of the main hospital block (the former main psychiatric asylum building) and its ancillary buildings by the year 2016 with the plan of selling them soon after (NHS Property Services, 2014a).

The head of planning and development for NHS Property Services stated that *"we need to get the best price for the estate, and that might be housing"* (The News, 2014b). The plans went on display to the public and one resident was quoted as saying: *"it's a waste of money to develop housing on this site, they should keep it as having health services in the area…There were talks years ago about having an A&E in the south of the city – they could look*

at that…It should have some health facilities on it as too much is moving out of the area" (The News, 2014b). Another stated: *"I do have some concerns, but I also understand there needs to be a change… I know there will be some open space that is protected, but I want to know if a garden that is cared for by mental health patients will remain… But I also understand the building itself is expensive to maintain because of the size of it"* (The News, 2014b).

Walkthrough[8]

The St James' visit may have been the first, but the St James' walkthrough was the last. Despite it having started to go dark when I began this walkthrough, the first thing I encounter is a dog walker on the driveway leading up to the hospital. The driveway is lined with trees (which are protected by Tree Preservation Orders) on both sides, all the way from the main road to the main building. On the left there is a large green space which is a cricket pitch. On the right there is another large green space which has been designated as a 'village green'- land which was originally hospital land but was bought by the local council to preserve it as a local green space (see Picture 26 below). There are four dogs and dog walkers utilising different areas of this space, which includes a small children's play area. Walking up the drive the main contributor to the soundscape is traffic noises from the main road behind me. Although as I walk further up the drive those sounds become fainter to have birds replace them as the dominant noise.

[8] Some of the pictures in this section were taken the next day due to the bad lighting on the first trip.

Picture 26: St James' Hospital– The village green

As you arrive at the top of the drive you are immediately faced with the former asylum building which is still the main building of St James' Hospital, with the iconic clock tower (see Picture 27 below). From here the traffic noise is faint but has not completely faded. To the right of the main building there is a sign that suggests multiple walking and jogging routes, as well as providing facts, tips and suggestions for those using the routes (see Picture 28 below).

Picture 27: St James' Hospital - Main building with clock tower

Picture 28: St James' Hospital – Sign suggesting walking and jogging routes on the site.

Moving around right from the main building, on the aptly named 'woodland walk', I pass a couple of cyclists. On the right I pass Fair Oak House, which has a mini wooded area in front of it, giving it a sense of tranquillity and secludedness (see Picture 29 below). I then come to the former asylum chapel (see Picture 30 below) on my left, which still stands and is grade II listed just like the main building. Next on the right is

Yew House, which is similar in appearance to Fair Oak House, including the small wooded area in front of it.

Picture 29: St James' Hospital – Fair Oak House

Picture 30: St James' Hospital – The Chapel

Walking around the corner and to my front is now The Limes, a red brick block with wooden panelling, which is arguably typical of more modern mental health facilities (see Picture 31 below). Here it is quiet, with only distant traffic noises and much more

prominent bird sounds. Next is the Kite Unit which is similar to The Limes in red brick; it has a nice grassy area in front of it and the path up is lined with trees.

The gazebo still stands at the side of the main building, although now it is fenced off, presumably to protect it. Moving round the back of the main building there is a surge in traffic, though as it has just turned five o'clock this is to be expected. I walk past a couple more dogs and dog walkers on this stretch. There are a large number of dogs on the site compared to previous walkthroughs on other sites, which may have something to do with the dog bins found on the site (See Picture 32 below). At the back of the site there are a number of abandoned buildings and scrub land, and on the back stretch housing lines the road and is pressed up to the site boundary. This is all land which originally belonged to the hospital and evidence of the large-scale sale of NHS land on the site. The back of the site is quite dark now as there is little to no lighting on this part of the site. The bottom end of the stretch is tree lined and aesthetically pleasing; the whole site is very green.

I walk past the Langstone Centre and the Turner Centre on the left; they are very NHS looking, much like entrances to Accident and Emergency departments. I come back to the cricket pitch on my right (see Picture 33 below). The site is much smaller than it was originally but it does still have a fair amount of green space, which has been utilised well to provide cover and tranquillity (even if not all of this green space belongs to the site- such as the village green).

Picture 31: St James' Hospital – The Limes

Picture 32: St James' Hospital – Dog Bin

Picture 33: St James' Hospital– The cricket pitch

Evaluation

This chapter began with a general asylum background and the choice of case study sites to be studied for this thesis. It was decided that four sites would be the ideal number, providing adequate data to be comparable and yet manageable in relation to time. The retained former psychiatric asylum sites were then split into three categories in order to diversify the case studies: sites in use for patient care; sites in use for administrative purposes; and sites which combine the two. Key considerations during the decision process involved factors around access to the sites and an aim to feature geographically diverse sites. The four sites chosen were: Cefn Coed Hospital, Kingsway Hospital, St James' Hospital and St Nicholas' Hospital.

What we see from the asylum histories is a general trend of upgrading for the most part of the early history through until the later 20th century. Each of the hospitals invested resources across this period into renovating and modernising or replacing the older facilities on their sites. After this time is when the majority of land-sales and closures began occurring. This can arguably be put down to a reduction of funding at

each of the sites, and the policy of mass asylum closure begun by Enoch Powell in 1961 (Enoch Powell's Water Tower Speech 1961, n.d.). As has been stated: "*regional boards were asked to ensure that no more money than necessary is spent on upgrading and reconditioning*" (The History of the Asylum, n.d.); and therefore the psychiatric asylums were inevitably going to decline. Land-sales are one method in which the Trusts can attempt to combat funding cuts, as it creates extra revenue which can be used to fund services and maintenance. All four of the case study sites have undergone land-sales and ward closures. Talk of closure have also occurred at each of the case study sites, at: Cefn Coed (1987, 1992, 2002, 2008, 2013); Kingsway (1996/97, 2009); St Nicholas' (unspecified date); and St James' (1983, 1987, 2006, 2014-present).

With regards to the Walkthroughs each of the sites are relatively open to the public, though to varying extents. Cefn Coed is the most set apart site but there are no physical barriers to entry at any of the sites. There are a few external areas which are no-go zones, such as the side-road on the St Nicholas site (shown above by the disapproving queries of staff), on any of these sites. Of course internal spaces are not open access; however this is understandable for any health care facility. The sites in general are easy to gain access to, and there are no barriers to entry for the public (or indeed the researcher) on the sites themselves. There are a few derelict buildings on some of the sites which may be considered as difficult to access spaces, but even these are evidently not difficult to gain entry to, an example being the visual evidence of entry on the sites (Picture 29) and the pictures available on a number of 'urban exploration' websites. To return to the quote previously referenced from Kessel: "*access and use are determined by more than physical proximity"* (2009: 36). In this manner there are a number of factors which come into play with regards to 'access', including the more physical factors of distance, availability of public transport and busy roads. In addition to this there are more abstract factors such as the perception of safety, size of the space itself and the attractiveness of the space (Kessel et al., 2009). With regards to the former psychiatric asylum sites, these factors possibly disadvantage Cefn Coed. As stated above Cefn Coed is the most isolated of the sites, and it is also fairly difficult to get to on foot. However many of the other sites are, though of varying levels, fairly easy to access on

foot; St Nicholas, Kingsway and St James' have all even been described as being used as thoroughfares by local residents.

As stated previously: *"the human body is not principally a text; rather, it is consumed by a world filled with smells, textures, sights, sounds and tastes, all of which trigger cultural memories"* (Seremetakis, 1996: 119). There are 4 senses which have been utilised throughout these walkthroughs; sight, hearing, smell and touch (mostly in the form of thermoception). The findings as a result of this multisensory approach are shown below.

Sight is the sense most utilised by ethnographers, and it has almost been elevated over the other senses (Sparkes, 2009). It has been stated that "*the emphasis on empirical observation raised sight to a privileged position, soon replacing the bias of the 'lower senses' (especially smell and touch)*" (Stoller, 1989: 6). In this way empiricism created this two-tier sensory system, elevating the visual above the other senses. Sight has been described by Georg Simmel as "*perhaps the most direct and the purest interaction that exists*" (1997 [1907]). In the walkthroughs sight as a sense has produced some interesting findings. It has provided evidence relating to public use on each of the case study sites. This includes dog walkers observed at St Nicholas' and Cefn Coed (see Picture 13), with dog waste bins at St James' (see Picture 7) alluding to the existence of dog walking on the site. In addition to this a number of exercisers have been observed at St Nicholas'.

Varying amounts of green space have been observed at St James' (Pictures 1 & 8), Kingsway (Pictures 25 & 27) and St Nicholas' (Picture 15); but not so much at Cefn Coed. This green space is theorised to act as a form of therapeutic landscape- both for patients and for local residents. Therapeutic landscapes, discussed previously, "*sought to promote the recovery of mental health by the removal of the 'client' from the stresses of everyday life through confinement in an ordered, harmonious and calming place of sanctuary*" (Moon et al., 2006: 1): and are described by Gesler as 'bucolic locales' (Gesler, 1992). These therapeutic landscapes are seen as an example of 'place-as-therapy'; whereby the

properties of the asylum sites act as a form of 'milieu therapy' (Davis as cited in Moon et al., 2006). As stated previously: "*park-like grounds, seclusion and healing through removal from society and exposure to the positive properties of particular places were deeply embodied in traditional notions of 'asylum' as a care delivery modality*" (Moon et al., 2006: 134). Included in the green spaces at a couple of sites were sports pitches, which could be described to act to almost institutionally encourage recreational activity at the sites. Examples of this include the cricket pitch at St Nicholas' and the village green and cricket pitch at St James'. This space can act as a therapeutic landscape not just for patients, but also for local residents, and these spaces are important to local communities (as shown by the Keep Milton Green campaign). As stated above by Kessel et al. (2009) the perceived attractiveness of a green space can affect the levels of public access to those spaces. In this way it can be noted that those sites with more attractive green space have been those where more public use has been observed; with Cefn Coed, having little open green space, being the site at which the least public activity was observed.

Whilst walking around each of the sites it was very noticeable how quiet it was. The soundscapes of these four former psychiatric asylum sites is made up of a small number of cars moving around the sites and distant traffic noises at various times of day. That is their 'sonic identity' (Wagstaff as cited in British Library, n.d.); one centred around concepts of quiet and calm- but which is nevertheless not wholly isolated from the surrounding community. This lack of noise can be theorised to contribute to the therapeutic landscapes offered on each of the sites; providing a calm environment for patients, staff and visitors. The negative health and wellbeing effects of 'noise' is a well-covered topic area (Spreng, 2000; Bluhm et al., 2004; Ising and Kruppa, 2004 amongst others). The noises which are most frequently ascertained to have these negative effects are that of traffic noises; which in modern times have permeated through society almost completely and are considered to be an important environmental health problem (Bluhm et al., 2004). The availability of a space therefore where you can, at least for the most part, escape from 'noise' and the negative effects this may have is a valuable resource to a local community. This in turn may increase

public usage of these sites and therefore the public familiarity towards them. Therapeutic landscapes are maintained on these sites for the most part through the maintenance of green space; these create more rural and 'pure' spaces which survive despite the encroachment of urban space to the edges of the asylum boundaries (Philo, 2012). It can also be argued that the quiet nature of these sites as therapeutic landscapes can have an effect on the level of public access on these sites.

At Kingsway however, much of the green space is either currently being developed, or is earmarked for development, into housing (see Picture 27). In addition to this there are plans for a main road to be constructed through the centre of the Kingsway site. This would have the double blow of vastly reducing the amount of green space on the site, and has the possibility of also vastly increasing both traffic noises- due to both an increase in the number of cars in the area and the new road– and other noise due to the vast amount of new housing in the area. This double blow could significantly damage the therapeutic landscape offered on the site. Therapeutic landscapes are places of healing, or 'bucolic locales' (Gesler, 1992); however their effectiveness as places of healing is doubtful when this space, which is meant to provide a space away from the hustle and bustle of everyday life, experiences major housing encroachment and the construction of a main road through the centre of the site; which is likely to bring he hustle and bustle right onto the site; undermining it's therapeutic landscape completely.

Smell is a less common sense used in ethnography, but in this ethnography it has been the focus of a key idea. What I noticed during each of the visits and walkthroughs which involved building interiors (St James' and St Nicholas'), is that mental hospital sites tend to smell of Iodoform- or traditional 'hospital smell'. As Blackson notes, "*to know something by its scent alone, as a pure 'olfactory image' is a rare event*" (2008: 7), but this is the case with hospitals- including mental hospitals. In this way it can be linked back to Seremetakis and Assmann and the idea of cultural memory (Seremetakis, 1996; Assmann, 2008). The smell of Iodoform as an olfactory image transcends situations and generations and unequivocally triggers the cultural memory of hospitals. In this way I

believe that people's feelings towards general hospitals may subconsciously affect their feelings towards mental hospitals, though this is unconfirmed. In this way I believe that it is possible that the Iodoform smell acts as a comforter to patients and visitors who will inextricably associate the smell, consciously or subconsciously, with a place of healing: although the converse is possible if those individuals have negative feelings associated to general hospitals.

Related to this were findings in relation to touch. Touch may not be the most obvious of senses to be included in an ethnography, even a sensory one, however it does play a small part in this analysis in the form of one of Paterson's 'somatic sensations': thermoception- or temperature (Paterson, 2009). At the two sites where the walkthroughs included the inside spaces (however brief), St Nicholas' and Cefn Coed, it was noted that they were both kept at a fairly high temperature, that can and has been described as 'hospital temperature'. I hypothesise this to be approximately 18˚C due to a parliamentary briefing paper from 2010 which states that the Chartered Institute of Building Services Engineers recommendation of temperature in hospital wards is 18˚C (Smith, 2010). This is another aspect of mental hospitals which can be linked, consciously or subconsciously, to experiences of general hospital sites through our cultural memory; much like they were with the olfactory image of general hospitals discussed above. With regards to the experience of 'hospital temperature' as well as the olfactory image of a hospital discussed above, the association of mental hospital sites with largely non-stigmatised general hospital sites may have a positive effect on the stigmatisation of retained former psychiatric asylum sites.

The level of access on the sites by the public, for a number of uses listed above, may act to build a relationship between the sites and the general public. This building of a positive relationship between the NHS Trusts and local residents may be an important factor in relation to the retention of these former psychiatric asylum sites (which is apparent in the fixtures at St James', see Pictures 3 & 7); this is through the notion of 'familiarity and acceptance'. The concept of familiarity and acceptance is in essence that familiarity with the site and a level of trust which has built up over time, via

increased exposure to the sites, has led to a situation where the sites themselves are accepted as a part of the local communities in which they lie. This level of access is made possible through the process of urbanisation, which has led to these former psychiatric asylum sites being located in urban and suburban areas. It is theorised that the level of public access to the sites increases the public's familiarity with them, which may increase their trust of the sites and their facilities- as the traditional asylums were set apart and given an almost mythic status (Gefen, 2000). The continued retention of many of the old asylum buildings across the four case study sites may have acted as a form of informal memorialisation, acting as a form of memorial to the *"long shadow of the stigmatised asylum"* (Joseph et al., 2012: 13). There is also the argument that the splitting up of the former sites into mixed-use developments may have 'watered down' the negative connections to the sites former visage (or 'decaffeinated' it as Žižek (2014) may have put it) largely stripping the sites of their status as 'the Other' (Žižek, 2009).

In addition to the public access and sensory sides of the ethnography, another issue which was raised in these walkthroughs was that of 'old vs new'; wards in old asylum buildings vs new build wards. This was most apparent at St Nicholas', where I was escorted through wards in both the old and the new buildings. What was apparent to me, and to my guide, was that maintaining wards in the old asylum buildings posed a great deal of problems in comparison to wards specifically designed for modern mental healthcare. To go back to the framework by Evans and McCoy (1998), there are a few factors which are relevant in this situation, they are: 'floorplan complexity' and restorative factors. Under 'floorplan complexity', we can include the non-standardised room sizes and shapes which, although they provide individuality, cause problems when it comes to healthcare and in particular supervision. The same was true of the corridors (one of which even had a person-sized nook in one corner). These layouts provide staff with difficulties, making their jobs harder and arguably increasing risks for both patients and staff. In addition to this the effect of restorative factors, which are described above as the potential of design elements to function therapeutically, on reducing cognitive fatigue and other stress factors (Evans and McCoy, 1998) may be less effective in old facilities compared to new facilities. One example of this is the use

of security fencing around wards, which occurs as a result of the combination of two factors: firstly the need to stick to health and safety regulations regarding the height of walls around the exterior to inpatient areas; and secondly the inability to fix this with a permanent fixture due to heritage and planning issues. These fences are evident at both St Nicholas' (Pictures 20 & 21) and at Cefn Coed (Picture 33). The Greentrees facilities at St Nicholas' show how interior wards can be refurbished to restore the therapeutic effects of the asylum design; with standardised facilities which look out onto the courtyard (Picture 22). However the older buildings definitely suffer in this aspect, at least in comparison to newer facilities. The general consensus appears to be that mental health care can be better provided in specifically designed new build facilities.

Conclusion

This chapter, after a general background and a brief history of each of the case study sites, focused on multisensory ethnographies of each of the sites in question. The general background outlined the situation nationally with regards to the prominence of former psychiatric asylums within the NHS and found that only 12 of 109 of these sites have been primarily retained. Subsequently this chapter went on to outline the choice of which of these retained former psychiatric asylum sites would be used as case studies for this thesis with Cefn Coed Hospital; Kingsway Hospital; St Nicholas' Hospital; and St James' Hospital chosen.

What the walkthroughs showed was that there were a variety of factors which may affect the retention of these former psychiatric asylum sites. Within this chapter these factors were categorised via sense, chiefly: sight; hearing; smell; and touch (largely in the form of thermoception). Factors found to have had a possible impact included issues surrounding: access to the sites- in relation to familiarity and acceptance; availability of green space; therapeutic landscapes; olfactory imagery; haptic imagery via thermoception; and concepts of old vs new facilities. These factors combine and mingle to have various effects on the retention of the sites, through perceived 'fitness

for purpose' to public perceptions of the spaces. The next chapter will be the first of three thematically based chapters, and will focus on NHS Estates and planning policy.

Chapter 5: Policy, Planning and the Surviving Asylum

Introduction

This is the first of three thematic chapters which will explore different aspects of retained former psychiatric asylum sites through empirical fieldwork- largely utilising semi-structured interviews. The focus of this chapter will be on policy and planning, and their impacts upon former psychiatric asylum retention. The next chapter will then focus on issues around stigma, memory and public access; and the third will focus chiefly on aspects of heritage management. This chapter will focus on the themes of mental health care policy and urban planning policy before exploring the issues surrounding each of these topic areas at each of the case study sites.

Mental Health Care Policy

As noted in Chapter 2, mental health care policy has changed dramatically over the last century. We can see how "*the underling structure of the mental health services has been transformed*" (Busfield, 1986: 288). During the 19th century the asylum was the predominant mode for psychiatric care, whether public or private, and was set apart from the community and designed to give a refuge way from the pressures and stresses of everyday life through the provision of a therapeutic environment. In this period county asylums were the locus of asylum care and the only real alternatives were private providers (Busfield, 1986). Mental health care in the first half of the twentieth-century was also dominated by the psychiatric asylum.

'Community care' as a term was first used in the 1930s, and was referred to as a supplement to the psychiatric asylum system which was intended to ease the pressure on the overcrowded asylums (Busfield, 1986). The downfall of the asylum began with the loss of the 'asylum ideal' (Gittins, 1998); and the policy which developed as a result

of this was that patients should be treated in the community wherever possible. The royal commission in 1957 stated the following: "*The recommendations of our witnesses were generally in favour of a shift of emphasis from hospital care to community care. In relation to almost all forms of mental disorder, there is increasingly medical emphasis on forms of treatment and training and social services which can be given without bringing patients into hospital as in-patients, or which make it possible to discharge them from hospital sooner than was usual in the past*" (Busfield, 1986: 341-2).

In the latter half of the twentieth-century mental health services started to become more fragmented. The asylum began to decline as the dominant mode of care as community care became preferred. "*The asylum, though it continues to exist, is but one component of a range of services, many of them provided by the state. This general pattern of services can be described as one of community care, a loose term, often largely defined negatively to mean all forms of care other than residential care in asylum, but one that can embrace the diversity of services now available for the mentally ill*" (Busfield, 1986: 288).

Much has been said previously in this thesis with regards to Enoch Powell and his 'water tower speech'; and how this marked the beginning of the decline of the psychiatric asylum (Enoch Powell's Water Tower Speech 1961, n.d.). The policies of deinstitutionalisation championed by Powell were subsequently reaffirmed by Sir Keith Joseph- who was the Minister of Health in the 1970 Conservative administration. In fact his 1971 memorandum titled 'Hospital Services for the Mentally Ill' made the argument that the eventual levels of psychiatric inpatient beds could be even lower than previously suggested; he expressed the hope that there would be a substantial increase in psychiatric facilities in general hospitals (Busfield, 1986).

In 2001 the World Health Organisation published its 'World Health Report'. Within this report there was an analysis of the global situation in relation to mental health; and this highlighted the significance of mental health to well-being (Curtis, 2010). The report made a number of recommendations for mental health care policy, which included: "*educating the public about mental health and mental illness through campaigns to*

reduce stigma and discrimination and foster more positive attitudes towards people with mental illnesses; linking with partners in non-medical sectors to promote mental health through school and work place programmes; and monitoring mental health in the community" (as cited in Curtis, 2010: 216). One of the key recommendations of the report is to "*give care in the community*" (WHO, 2001: 110):

"*Community care has a better effect than institutional treatment on the outcome and quality of life of individuals with chronic mental disorders. Shifting patients from mental hospitals to care in the community is also cost-effective and respects human rights. Mental health services should therefore be provided in the community, with the use of all available resources. Community-based services can lead to early intervention and limit the stigma of taking treatment. Large custodial mental hospitals should be replaced by community care facilities, backed by general hospital psychiatric beds and home care support, which meet all the needs of the ill that were the responsibility of those hospitals. This shift towards community care requires health workers and rehabilitation services to be available at community level, along with the provision of crisis support, protected housing, and sheltered employment*" (WHO, 2001: xi-xii).

Care in the community in the UK has been on the rise since Enoch Powell's speech in 1961 (Enoch Powell's Water Tower Speech 1961, n.d.); but in 2000, just prior to the WHO report, there were still a number of asylum buildings in use for mental health care. It has been argued on a number of occasions that deinstitutionalisation was enacted prior to community care being adequately provided (Jones, 1998; Gleeson and Kearns, 2001); rather than the 100% coverage which the report suggests (WHO, 2001).

The recommendations made in the 2001 report were reiterated in 2005 when the World Health Organisation published 'Mental Health Declaration for Europe' which embraced developments in mental health care policy (Curtis, 2010). Mental health care policy and practice now included: "*i. the promotion of mental well-being; ii. the tackling of stigma, discrimination and social exclusion; iii. the prevention of mental health problems; iv. care for people with mental health problems, providing comprehensive and effective services and interventions, offering service users and carers involvement and choice; v. the recovery and*

inclusion into society of those who have experienced serious health problems" (WHO, 2005: 2). The report also reiterated the recommendation to "*develop community-based services to replace care in large institutions for those with severe mental health problems*" (WHO, 2005: 5).

NHS Estates policy is the NHS's policy for the management and maintenance of their estates. This involves the maintaining of owned sites, the procurement of new estates and the offloading of unneeded estates. NHS Estates Policy can be construed as an internal factor in the retention of psychiatric asylum sites; this is because it is a factor which is controlled by the NHS, which owns the site. The NHS released guidelines for developing an estates strategy in 2005, which stated that all NHS trusts, foundation trusts and primary care trusts should have in place an estates strategy that covers five to ten years into the future (NHS Estates, 2005). It states that: *"the starting point for developing an estate strategy is to identify the current and future healthcare service needs of your local population and the current condition of your healthcare service needs of your local population and the current condition of your healthcare estate"* (NHS Estates, 2005: 2). Among the list of benefits to an estates strategy, this document includes such things as: *"the provision of safe, secure and appropriate buildings"* and *"an opportunity to dispose of surplus/or poorly-used assets and reinvest released resources"* (NHS Estates, 2005: 3). Amongst the criteria laid out for the monitoring of estate performance are energy efficiency levels (NHS Estates, 2005).

As previously discussed, NHS estates policy has contained seemingly contradictory policies relating to the retention of former psychiatric asylum sites. One document from 2001 states that the demolition of former psychiatric asylums is preferable (which puts emphasis on demolition as a fate); but then goes on to also state that renovation and modernisation should always be the 'first consideration' for existing buildings (NHS Estates, 2001: 29). These seemingly contradictory statements make it rather difficult to ascertain the NHS's standpoint when it comes to former psychiatric asylum sites. The general approach appears to be that of reusing and redeveloping buildings rather than sale or demolishing and building anew. The specificity of the NHS Estates

document from 2001 regarding psychiatric asylums and their potentially limited value of sustainability however is redeemed by the final sentences about their potential as mixed-use developments. This may have had an effect not just on the retained status of former psychiatric asylum sites, but also the ways in which these sites have been managed, had land sold off and have had mixed-developments from housing to educational facilities built on their former grounds.

However it is not only on a national level that health policy is determined, as local NHS Trusts are the ones who are tasked with implementing change. The following quote from the Department of Health (2001: 86) highlights the main challenge regarding a 'whole system approach': "*the issue of culture has been consistently highlighted as the main determinant for the successful implementation of any developments within an organisation. Culture - the beliefs, values and customs of the organisation - affects every part and function of the organisation*". In additional to the challenges which the NHS may face applying policy nationally, it must also be noted that local Trusts have a degree of flexibility in the implementation of this policy: "*it is always difficult in any national publication to achieve the correct balance between clarity over what is to be done and local flexibility over how it is to be achieved*" (Department of Health, 2001: 3). This is as it is local trusts who engage with and know and understand the needs of the local populations, and that mental health services are at their most effective when they are enacted within the context of the service users' local communities (Department of Health, 2001).

There are a number of barriers in place which can act to restrict the implementation of national health policy locally. Hunter (2003) outlines a number of these barriers, including policy stances which are more concerned with 'gesture politics' rather than policy implementation, and an absence of clear boundaries distinguishing which policies are whose responsibility. This appears to indicate issues relating to a lack of clear policy on a national level, and a lack of a clear structure for the implementation of policy both nationally and locally. It is possible that this lack of clarity could lead to a situation whereby local authorities have, as stated above, a high degree of flexibility within the existing framework.

Following Welsh devolution in 1999 the NHS in Wales has been under the control of the Welsh Minister for Health and Social Services. Therefore the site is subject to a different estates policy to those in England, which the above relates to. In 2002 the Welsh Assembly's plan for future healthcare estate was encapsulated in the following: *"to develop accessible, modern, comfortable and adaptive environments where patient-care can be delivered safely and efficiently"* (NHS Wales, 2002: 10). This showed a commitment on the part of NHS Wales to invest in the infrastructure of healthcare, be that with the redevelopment of current properties or the move to newer, purpose built facilities. In 2013 NHS Wales released an estates document which stated that: "*the identification of essential and non-essential buildings, based on whether or not they have a health use exceeding five years, is designed to encourage NHS organisations to dispose of stock with a short-term future as quickly as possible*" (2013: 9). The rationale behind this was that: "*early disposal of the non-essential estate is vital if scarce resources are to be directed where they can be used more effectively*" (NHS Wales, 2013: 9). In this way NHS Trusts in Wales are almost encouraged to sell off older pieces of real estate in favour of redevelopment and upgrading of existing facilities. This can be used to analyse the status of retained former psychiatric asylum sites within Wales, as those facilities which have survived in light of this approach may either be in the process of being sold to fund newer facilities, or may have other factors affect their subsequent retention.

One policy which has been increasingly common in recent years is that of the Private Finance Initiatives (PFIs). PFIs consist of "*long-term arrangements between the public and private sectors, in which the latter finances the design and build of new or substantially upgraded public facilities*" (Hellowell and Pollock, 2009: 13). "*The PFI involves collaboration between the commercial companies who build and service the new facilities, and the government, which has committed to long term leases to occupy the buildings in order to deliver medical care. The PFI scheme illustrates how the national political-economical context of health care policy frames the development of psychiatric care in particular countries*" (Curtis, 2010: 195). The British Government has, since 1992, favoured the financing of large public services projects through the PFI. In relation to health care, this includes the designing, building, financing and operation of hospitals, with the NHS paying an annual fee over

the life of the contract (Pollock et al., 2002; Hellowell and Pollock, 2009). The Department of Health was estimated to spend £517.8 million on PFI schemes from 2015-16 onwards; the second highest of all government departments only behind the Department for Transport (HM Treasury, 2014).

It has been argued that there is no evidence to suggest that the PFI scheme has increased the level of service within the NHS. In fact, it has been suggested that PFIs have had a negative effect on NHS trusts. This is in a few key ways, firstly through the creation of an 'affordability gap' as a result of the high costs of the PFI (Pollock et al., 2002), and secondly through the displacement of the burden of debt from central government to NHS trusts (Pollock et al., 2002). The National Audit Office (NAO) in 2015 stated that: "*in the short term using private finance will reduce reported public spending and government debt figures… additional public spending will be required to repay the debt and interest of the original investment*" (as cited in Owen, 2015). Also the movement from public finance to private finance increases the burden of risk on NHS trusts as governments, unlike private companies, are unlikely to go bankrupt or default on payments. In addition to this interest rates for government financing are generally lower (Hellowell and Pollock, 2009). Hellowell and Pollock claim that, as a direct result of the imposition of PFIs, there has been a consistent level of underfunding in the trusts involved (2009).

With regards to healthcare, the PFIs' rigidity' and the long timescales involved have resulted in an inability to modify aspects of new hospital design, to alter the provision of non-clinical services and ultimately an inability to react to changing situations (Curtis et al., 2007). This inevitably effects service provision at the hospital and prevents the local NHS Trust from adapting and providing the best service to the local population. This was because the nature of the commercial developments and contractual agreements meant that the design had to be agreed upon at a fixed point in time and was not flexible; not allowing modifications to the plans subsequent to this date (Curtis, 2010). The authors indicate an example of this in relation to mental health care, as they "*report discussions concerning the problems of reconciling the need to keep*

windows securely closed, the decision to provide patients with south facing rooms so that they can enjoy plenty of natural light, and the lack of air conditioning in the new hospital (presumably to reduce costs and make the building more energy efficient). Individually, these might have been seen as advantages of the design, but given the high temperatures recently experienced in the summer in London, these factors combined to produce an uncomfortable environment when the wards overheated" (Curtis, 2010: 198). Similar issues with the design of psychiatric facilities are detailed in relation to patient and staff security and patients' freedom (Curtis, 2010).

An NHS Estates report from 2003 examines the effects which the architecture of health environments have on both patients and staff in those spaces. "*Most hospital patients may get the personal attention of a doctor for only a few minutes a day and slightly longer periods of personal care from nurses and therapists. However they may remain in bed or, if they are more fortunate, sit for many hours with little to do. This may well make them even more susceptible to the environment and more sensitive to it. It is reasonable, therefore, to assume that their environment may be a contributory factor to their sense of well-being and actual recovery. So we ask here whether the architectural environment of the hospital can contribute to the treatment of patients and significantly influence their health outcomes. This study clearly indicates the answer is 'yes'*" (Lawson and Phiri, 2003: 2). What the study found is that, regardless of the accommodation type, patients who were in their preferred environment felt that that environment helped them to recover. It also found that "*patients appear to make significantly better progress in the new purpose-designed buildings than in their older counterparts*" (Lawson and Phiri, 2003: 3). This would seemingly indicate that new build facilities are preferable to older, refurbished facilities- such as former psychiatric asylum buildings.

Urban Planning Policy

This section will look at the concepts related to urban planning policy, including: urbanisation and sustainable development. These topic areas will each be discussed in

relation to publically retained former psychiatric asylum sites and set out a foundation for their discussion in relation to the four case study sites later in the chapter.

Urbanisation

In contrast to the internal factor of NHS Estates, urbanisation is an external factor in the retention of former psychiatric asylum sites as it is outside of the control of the NHS. Urbanisation affects the psychiatric asylum's geographical positioning in relation to residential properties and cities; originally asylums would have been isolated in the countryside, whereas now they are in the midst of urban and suburban communities. It is theorised that this could affect the status of retention of former psychiatric asylums and in particular the level of stigma attached to them. Urbanisation is discussed in the following quote from the European Environment Agency: *"in this modified landscape, a powerful force is at work: cities are spreading, minimising the time and distances between and in-and-out of the cities. This expansion is occurring in a scattered way throughout Europe's countryside: its name is urban sprawl"* (2006: 5). Urbanisation (also known as urban sprawl) can be defined as *"the tendency toward lower city densities as city footprints expand"* (Nechyba and Walsh, 2004: 178). Similar concepts include: edge cities, enclaves, junkspace, negative space[9] and polynucleation[10] (Farley and Roberts, 2012). Urbanisation can take different forms, including 'edge-cities': *"clusters of population and economic activity at the urban fringe"* (Nechyba and Walsh, 2004: 178); or planned communities with their own local 'centre' (Nechyba and Walsh, 2004).

Urbanisation has been linked to mental health, as moving to suburban areas can be seen to improve an individual's mental health in a number of ways, including: providing an escape form overcrowding, sanctuary from stress and the prospect of contact with nature; which can be described as a therapeutic landscape. However it can

[9] Negative Space – *"the empty space around the subject or focus"* (Panic, 2010).
[10] Polynucleation – *"spatial dispersal of population and economic activities from the largest towards smaller cities"* (Lambooy, 1998: 457).

also have a negative effect on mental health due to increased isolation, linked to a loss of social cohesion, and the stress involved in commuting (Frumkin et al., 2004). This second strand of thought can be linked to a loss of social capital, which can be defined as: *"connections among people- social networks and the norms of reciprocity and trustworthiness that arise from them"* (Putnam as cited in Frumkin et al., 2004: 163). This loss of social capital can be said to be caused by a loss of traditional community values resulting from an increased isolation in a suburban setting. The above factors of moving to suburban areas seem similar to those which were associated with treatment in a psychiatric asylum. Themes of sanctuary, escape and therapeutic landscapes are all aspects of the original aims for psychiatric asylum care; whereas aspects such as isolation and loss of social cohesion (institutionalisation) were subsequently major issues with the asylums due to massive overcrowding and understaffing.

Another effect which urbanisation has had on former psychiatric asylum sites is the urbanisation of the asylum itself. Psychiatric asylums were traditionally based in rural settings, and designed in such a way so as to benefit from a therapeutic landscape with the health benefits discussed above. Urban growth and sprawl has led to these asylums being located in urban areas and surrounded by residential properties. What this has led to is former psychiatric asylums being located within local communities, rather than being the isolated place of legend. Implications of this include the concept of familiarity and acceptance. This is best described in the following quote: *"familiarity and trust complement each other as complexity-reduction methods. Familiarity reduces uncertainty by establishing a structure: trust reduces uncertainty by letting people hold relatively reliable expectations"* (Gefen, 2000: 727). Using this as a jump-off point, the fact that retained psychiatric asylum sites have been so long-lasting may be self-reciprocated. These sites have been in their locality for generations, and therefore there is a level of familiarity which may have been created about them due to prolonged exposure. This may have led to a degree of trust because, as Luhmann states: *"familiarity is a precondition for trust"* (as cited in Gefen, 2000: 725). This familiarity acts to break down barriers and eradicates 'the Other', the 'stranger'. As Žižek states: *"the Other is fine, but only insofar as his presence is not intrusive, insofar as this Other is not really*

Other" (2009: 35). This is perfectly interpreted in the following passage from Terry Pratchett's Unseen Academicals: *"'well, what I'm saying is' started the man who had nothing against Dwarfs, 'we don't mind anyone, so long as they mind their own business and don't do any funny stuff'"* (2009). Basically, as long as the Other is stripped of its otherness and assimilated into our society (in an anthropophagic manner) then we are happy for it to be there. The Other stops being Other once they have been 'detoxified' (Žižek, 2014). Žižek uses a number of examples to outline this process of detoxification: decaffeinated coffee; alcohol free beer; fat free cream; and virtual sex- all "*experience[s] of the Other deprived of its otherness – the decaffeinated other who dances fascinating dances and has an ecologically sound holistic approach to reality, while features like wife beating remain out of sight…*" (Žižek, 2014). In this way, for the most part, these retained sites have been scaled down and therefore the number of in-patient services on the sites is dramatically lower than at their peak; they have been partially 'decaffeinated' (Žižek, 2014).

To relate this to former psychiatric asylums these spaces, when they were isolated and separate they were unknown spaces to be feared. In the aftermath of urbanisation and in particular the urbanisation of the asylum, public access to psychiatric asylum sites creates a familiarity within the local community and acts to dispel the otherness of the psychiatric institution through familiarisation, stripping the asylum of its otherness and detoxifying the space. This may act to reduce the level of stigma attached to these sites over time.

Sustainable Development

In what was possibly a direct response to urbanisation and its effects there has been pressure for sustainable development projects. This affects the retained status of former psychiatric asylums as it adds an external pressure, in this instance one for land to be developed into housing. This section will discuss the major areas within sustainable development which may have an effect on the retention of the former psychiatric asylum. One of the major policies promoting sustainable development in the UK is the green belt. A green belt is an area of land which is kept in reserve for open green space;

they are usually found surrounding the UKs larger cities (Politics-Green Belt, n.d.). The main purpose of green belt policy is defined in a number of ways, as illustrated in the following quotes: *"the main purpose of the green belt policy is to protect the land around larger urban centres from urban sprawl, and maintain the designated area for forestry and agriculture as well as to provide habitat to wildlife"* (Politics-Green Belt, n.d.). *"The purposes of Green Belts in planning policy are clear – to protect the countryside from urban sprawl and to retain the character of towns and cities. To this end they have been effective"* (Campaign to Protect Rural England, 2010: 1).

The concept of the green belt originates from the 1930s when a metropolitan green belt around London was proposed. Despite this it was not until the 1950s that green belts began to be designated; and today approximately 13% (1,639,090 hectares) of land is designated as belonging to a green belt (Politics-Green Belt, n.d.; Smith, 2014). *"Green belt policy in the UK has shown to be highly effective in halting the urban sprawl"* (Politics-Green Belt, n.d.).

This green belt policy may have led to the focusing of developments onto brownfield and greyfield land. In 1997 brownfields began to be considered as prime sites for redevelopment for a number of reasons. First, brownfield sites were a ready supply of available land for building on, and with the high demand for housing they became favourable locations for redevelopment into residential properties. Second, in some cities brownfield sites were the only readily available redevelopment sites. Third, redeveloping brownfield sites was seen as a way of combatting crime and physical decay in some areas, combatting urban decay with affordable housing, a school or a community centre etc. (Greenberg, 2002), reducing as potential 'broken windows' effect[11].

[11] Broken Windows Theory, attributed to Wilson and Kelling but previously tested by Zimbardo, states that "*vandalism can occur anywhere once communal barriers—the sense of mutual regard and the obligations of civility—are lowered by actions that seem to signal that 'no one cares'*" (Wilson and Kelling, 1982: 3).

Capner (2003), in a letter to K. Barker, notes that John Prescott[12] stated failure to supply sufficient housing as one key failure of previous governments; and the reasons for the undersupply of housing in the UK are, chiefly, related to problems with the planning system. The introduction of the 'brownfield first' policy, whereby brownfield sites were prioritised for redevelopment (though the government recognised that only 60% of housing could realistically be built on brownfield sites) only succeeded in delaying Greenfield redevelopment, meaning that 40% of housing allocations are unspecified. This was in addition to problems specifically in redeveloping brownfield sites (Capner, 2003); identified as a lack of preparation when taking on these sites, and problems surrounding land contamination of the sites themselves (Greenberg, 2002). In October 2014 it was announced that thousands of houses would be built on brownfield sites, approximately 2/3 of all homes to be built. This was done in tandem with new guidelines to safeguard against urbanisation and to protect green space. The Housing Minister Brandon Lewis stated: "*this government has been very clear that when planning for new buildings, protecting our precious green belt is paramount. Local people don't want to lose their countryside to urban sprawl, or see towns and cities lost to unnecessary development*" (Department for Communities and Local Government et al., 2014)

There is also a need to examine the idea of 'greyfield' land. 'Greyfield' is a term largely associated with the United States which can be defined as: *"real estate or land which is underutilized, typically producing far less revenue than it would if properly managed…Often it includes buildings which are obsolete or poorly maintained"* (Wisegeek, n.d.). The use of greyfield land as a concept is largely associated with shopping 'malls'. 'Greyfield' comes from the fact that these sites are often (if not usually) surrounded by *"large asphalt parking lots"* (Wisegeek, n.d.). It has been stated that the redevelopment of greyfield land can be profitable for both the property owner, the developer and the

[12] The Deputy Prime Minister when the letter was written in 2003.

local community- by increasing the site's financial performance, creating new jobs and revitalising the local community (Merritt, 2006).

The relevance of some of these problems are limited where former psychiatric asylum sites are concerned. Neither definition really incorporates the old psychiatric asylum sites. The focus of greyfields is too much around financially motivated services such as shopping 'malls' and with brownfields the question of 'contamination' arises. However if we go back to the urban brownfield definition; those converted to residential properties tend to have been previously abandoned and although they are not contaminated in the above sense they are, in a sense, 'socially contaminated' sites. Asylum closures left these large *"zones of ambiguity stigmatised by the shadow of their former use"* (Joseph et al., 2012: 2). The following demonstrates the relevance of this area of urban residential redevelopment to discussions surrounding post-asylum geographies: *"across the globe, population growth and allied pressures for urban expansion have seen many of these sites recast as housing development opportunities and subsequently reintegrated into the built environment of cities"* (Joseph et al., 2012: 2).

Swansea and Merthyr Tydfil Joint Asylum - Cefn Coed Hospital

Mental Health Care Policy

There are a number of clinical issues associated with the use of the old asylum buildings on the Cefn Coed site. This is partly down to the age of the buildings in question which is alluded to a number of times in interviews. The old asylum buildings were not designed with modern mental health care in mind, and lack some aspects which are to be expected of modern facilities; this includes details such as internal courtyards and en-suite facilities (A9bN). These issues, amongst others, led to a number of 'unfavourable' inspection reports from Health Inspectorate Wales with regards the standard of the estate at Cefn Coed Hospital. The Health Inspectorate Wales report stated that Cefn Coed Hospital was "*no longer fit for purpose and it is evident that its design compromises standards of care*" (2012). This was an opinion mirrored by staff working for Abertawe Bro Morgannwg and the NHS, but the question is

whether, as Reuber states, the blame here is being placed wholly on the facilities when other factors, such as understaffing and underfunding, could equally be blamed (1996).

"*It's also very difficult for our staff to deliver effective care in these and acute assessment services as well/ you know in these very difficult buildings"* (A9bN)

"*I think redevelopment of existing asylum accommodation is very difficult if you want to provide modern purpose built facilities, there are so many constraints in terms of the buildings, we've tried it before on an interim basis, and you can only go so far, you can never. Even in terms of stuff like you know the environmental impact of the new space is never as good as a new building. And there's the stigma, that's associated with the old buildings*" (A9aN)

"*A number of infavourable inspection reports from Health Inspectorate Wales all of which focus in many ways on the poor standard of the estate. The health board at the moment is considering a further reinvestment plan, and maintaining this estate has a cost which is necessary in order to maintain our patients in buildings that are up to a certain standard. But because the wards are located in such disparate locations across the building we need to maintain almost the whole of the building, there's an enormous cost attached to maintaining this asylum which is, which really shouldn't, we shouldn't be where we are, but we are where we are and we're trying our best to make progress as soon as we can and minimise the impact on our patients. That's why we hope that at some stage we'll be able to demolish half the site, sometime soon if we can reconfigure some of the wards*" (A9aN)

"*Oh everything's wrong, privacy and dignity, not single bed, haven't got their own en-suite facilities. Very very basic things too, some being provided upstairs when really you know being able to have access to outside spaces, it's very very simple things like that*" (A9bN)

During interviews it became clear that there were multiple attempts to move services from the Cefn Coed Hospital site and spread them across various other locations; including Baglan and Morriston. This fits in with the Welsh NHS's aim, discussed above, of disposing of stock without a long-term use in order to redirect the NHS's

scarce resources elsewhere (NHS Wales, 2013). Regardless, all these plans have failed in their fruition for various reasons, including that there was 'a strong body of clinical opinion' at the hospital that the premises should have been rebuilt on the Cefn Coed site (A9aN). This lack of support for a move offsite combined with a 'lack of solid leadership' (A9aN) may have contributed to the prolonged retention of Cefn Coed. However, following the establishment of the Abertawe Bro Morgannwg University Health Board in 2008 the plans to move services off the Cefn Coed site had become more of a priority- in line with the Welsh NHS'. This began with the reprovisioning of services from the site's main building into the new build Ysbryd y Coed facility in 2012 (Perkins, 2012). Subsequent to this Ward F (an 18 bed mixed rehabilitation ward) and the low secure unit have been replaced by a ward at Glanrhyd Hospital (Bridgend); and the Psychiatric Intensive Care Unit (PICU) was scheduled to be transferred to the Princess of Wales Hospital in Bridgend in 2015 (A9aN).

One of the key factors in the current retention of Cefn Coed is the system in place for the sale of assets. The Cefn Coed site as it stands is valued at approximately £40 million (A9aN). In the current system, capital returns for the sale of assets is capped at £500,000. Any returns after that go to the central Welsh Government. So for any sale of assets on the Cefn Coed site, only the first £500,000 would go to the Abertawe Bro Morgannwg University Health Board and be directly available for reinvestment.

"So they get up to £500,000 and then it is capped for sale of assets" (A8)

This means that there may be limited financial incentive for the ABMU board to actually sell off the Cefn Coed site; which is likely to have been the key factor in the retention of the site. However, it is thought the current move towards closure at the site is helped in part by a potential brokerage agreement with the Welsh Government, subsequent to the submission of business cases for new developments:

"*It's thought that there would be some brokerage arrangement, the Welsh, the capital will come from the Welsh government. We need to submit business cases for the remaining two new*

developments. One the centralised acute admission unit in Neath Port Talbot and we hope a, older peoples assessment unit in Singleton Hospital. Once that has been confirmed we do business cases [and] submit to the Welsh government who would then allocate we hope the capital which will then allow for the demolition of the hospital site at a sub-stage in the future" (A9aN)

Alongside this, there are other financial factors which also come into play. This is due to the fact that, as was seen in early asylum history and despite advancements in drug therapies etc. (Moon et al., 2006), there will always be a need for some form of acute service provision within mental health, as not all cases can be treated on an outpatient-basis as has be seen through Trieman and Leff's discussion of TAPS and observations around 'difficult to place' or 'new long stay' patients (1998). Additionally this includes, as stated below, the need for beds for patients who have been detained under the mental health act.

"I think there's always a need for some, in-patient beds, especially for acute mental illness care, and the usual alternative is to site the ward or wards of that kind in a major general hospital… and they are far less appropriate in that setting" (A6)

"But there will always be a need for acute admissions, for example, when people are admitted under the mental health act, so there has to be a hospital base for that" (A7b)

"But the fact that the demand for mental health acute admissions and long term hasn't gone away, and that there was no reasonable alternative" (A7b)

If Cefn Coed were to be closed it would seem that an alternative would have to be found to re-accommodate the patients who continue to need inpatient care. Alongside this need for acute services the hospital has branched out into elderly services and providing long-term care for elderly patients. This has been in the form of the new modern Ysbryd y Coed building. By diversifying into other areas of care on the site

Cefn Coed may have guaranteed some form of institutional survival in the same manner as has been seen in the private sector (Moon et al., 2005).

"One factor I think the other major factor is that in the last maybe 30 years a big core of the services has been the elderly services, so a lot of the wards are long-term, either long-term continuing care or long-term elderly services" (A6)

So with this ongoing need for acute services, alternatives must be in place before the old buildings are closed. Add this to the long-term elderly service provision on-site and it makes the site in general likely to be retained, in some capacity, for service provision, if only because of the newness of the dementia unit. There were multiple respondents who pointed to the lack of resources as a major issue, and the cost of building a new facility may have caused a situation of inertia.

"The challenges [of retention]? Well it's like anything these days it's resourcing" (A4)

"The cost of building a new one. I mean the situation you always end up with in an organisation you may have a site which is unsuitable, but it's the site you've got. To move from the site you've got to one more suitable, the cost of that would take money out of other services" (A8)

"I think yes it should be retained, we do need a modern building, and until we've got a modern building then I don't think it should go until we've got some place better for people to be allocated into. But until such times then I don't think people should just be shunted out and just shoved anywhere while all of this is going on" (A2)

The original thought was that the services cannot be moved out of the current building until a new building is in place, and in a catch-22 situation, the only funding that would likely to come is from the sale of land at the site. This however can be accounted for with the possible brokerage deal with the Welsh Government (discussed above). This has inevitably led to a situation of inertia on the site, and until the services which

remain in the main building are all reprovisioned elsewhere (which is not expected to be achieved prior to 2020) then the site and its main building are likely to remain in use for healthcare purposes. NHS estates policy in Wales in recent years has prioritised the disposal of non-essential estate (NHS Wales, 2013); but previously the renovation of existing buildings has been favoured over new-builds (NHS Estates, 2001: 29), and has been apparent in the previous renovation work on the building in 2000/2001 (see South Wales Evening Post, 2002a; 2002b). So it is likely that this estates policy was being upheld with the investment in the renovation of Cefn Coed's main building. However subsequent to this:

"There was a decision made that no longer would there be any investment on the old site" (A7b)

Therefore at some point in the last decade, most likely in 2008 when the Abertawe Bro Morgannwg University Health Board was formed, a decision was made that the site was going to receive no more investment into the maintenance of old buildings. This may have spurred the plans towards a new-build site rather than retention and development of the old site. This is seen in the NHS Wales Estates Condition and Performance Reports, whereby the backlog of maintenance has been increasing since 2007 and has been at almost £7million since 2008 (2008; 2009; 2010; 2011; 2012; 2013). The reports also show that Cefn Coed has been designated as a 'non-essential building' since 2010, which means that the trust were planning on selling the site within 5 years. This could have been swayed by, as we have seen above, the Health Inspectorate Wales report, which stated that Cefn Coed was:

"No longer fit for purpose and its design compromises care standards" (Henry, 2012)

However in order to maintain the standard of healthcare at Cefn Coed for the patients who remain there some maintenance costs must be met, as well as the costs involved in the general running of the hospital such as the heating of the building. There is a worry that the boiler system may soon be in need of replacing in the next few years, and that

is not a cost which the health board will want to invest in with plans in place to demolish the building shortly afterwards (A9aN).

Urban Planning Policy

Urbanisation

Over time, the geography of the Cefn Coed Hospital site has changed, which is shown by a comparison of maps of the site. The maps shown are of the site in 1938 (Figure 5.1), in 1964 (Figure 5.2) and a google earth image from 2013 (Figure 5.3). What we can see is that Cefn Coed has gradually become increasingly more urban, as the surrounding land has been developed for housing. The increasingly urban location of Cefn Coed has left it in a position where it is more in the public eye than it was when it was originally built (see Public Access/Community Familiarity below). The hospital is no longer as isolated as it once was.

Figure 5.1: Cefn Coed Hospital 1938. Source: www.old-maps.co.uk

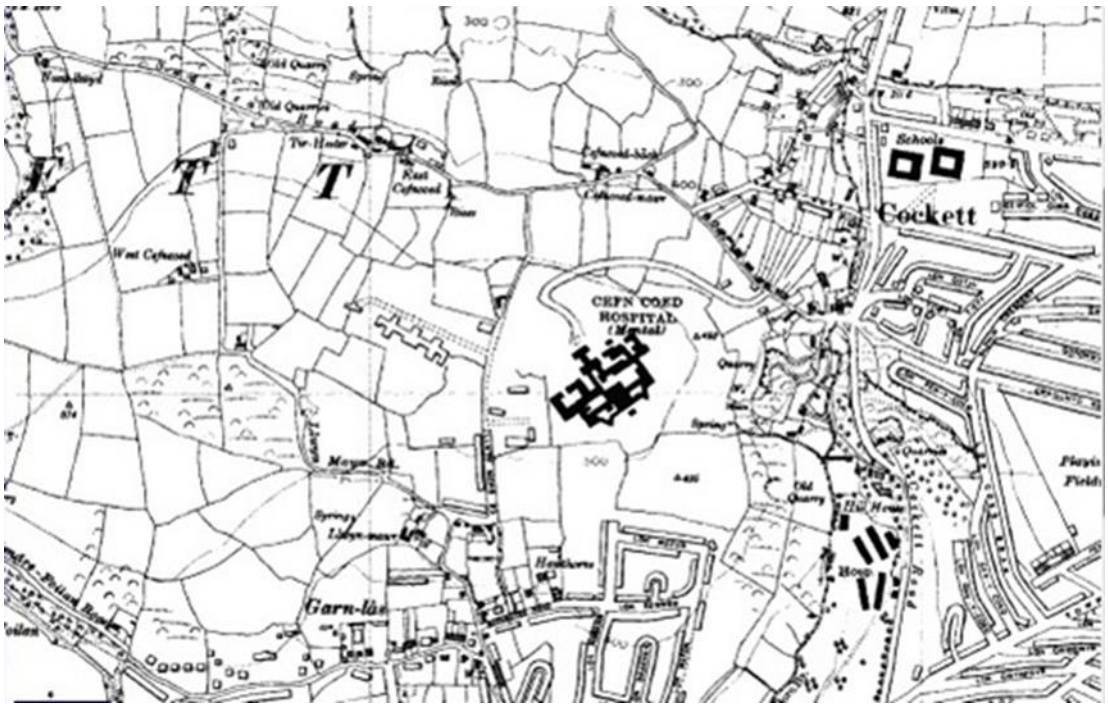


Figure 5.2: Cefn Coed Hospital 1964. Source: www.old-maps.co.uk

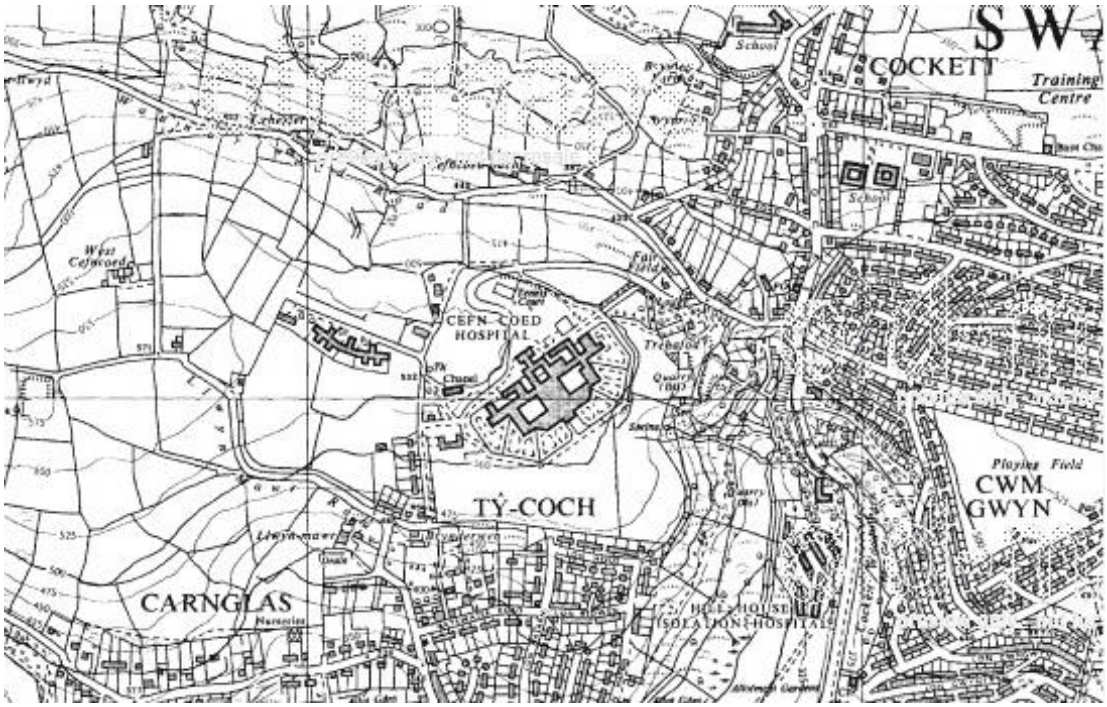


Figure 5.3: Cefn Coed Hospital 2013, Source: Google Maps

"Well actually I, I think originally of course it would have been quite isolated, but as Swansea has grown the residential area have surround the development now, so I think in many ways, this hospital… is in the community in some ways. But the community not make much use of it" (A9aN)

As alluded to in the above quote, there is still a certain level of isolation from the community which now surrounds Cefn Coed Hospital. This is an unusual occurrence, as the majority of former psychiatric asylum sites seem to have become entirely urbanised. This may have had an effect upon the retention of the site as it is not entirely in the public eye.

"But it's not something you can see from the road so you're not necessarily totally aware; all you see is the water tower" (A3)

"St David's in Carmarthen has got a main road running near the entrance, which has got… the University of St David's on the other side of the road. And I think it's slightly nearer the main town, in a way the land is more visible, Cefn Coed is more tucked away, that is one factor [behind retention] I think" (A6)

So urbanisation has not had a massive effect upon Cefn Coed, though the housing has over time moved closer to the site; Cefn Coed has maintained a barrier between itself and the local community. This means that Cefn Coed is not entirely in the public-eye and therefore it is possible that it does not attract wide-spread attention, either positive or negative, that could affect the site's stigma or it's continued us as a psychiatric hospital.

Sustainable Development

In Swansea, as in all other local areas, there is a Local Development Plan (LDP- otherwise known as Local Development Framework) which is designed to *"provide a revised framework to inform planning decisions and guide development across the City and*

County" (City and County of Swansea Council, 2012b: 3). Among the LDP's goals are to 'promote sustainability and equality' and to develop *"direct new housing to economically developable sites close to supporting employment, retail, leisure, education and other community facilities"* (City and County of Swansea Council, 2012b: 4). Part of the LDP is the Sustainability Appraisal (SA): *"the purpose of the SA is to promote sustainable development through the better integration of sustainability considerations into the preparation and adoption of the plan"* (City and County of Swansea Council, 2012a: 13). The LDP has been noted by some interviewees as playing an important role in development in Swansea, as there is a need for housing and a distinct lack of space; particularly brownfield land to develop on. The below quote identifies the land at Cefn Coed as being ideal for development. It highlights the desirable geography of the area and the potential high value of the land, making the site a more attractive prospect both for the Trust to sell and for potential buyers; as well as an attractive reserve of land for the realisation of the LDP.

"Swansea council has an obligation in the Local Development Plan to find sites capable of taking another sixteen to twenty thousand houses by the year 2020. So that would make an ideal site, … in Swansea West, on top of a hill, overlooking the bay and overlooking valleys a desirable area which could be bringing a lot of capital receipt" (A1)

There is however the argument that former psychiatric asylum sites should not be categorised as 'brownfield', with arguments that there are large quantities of green space on these sites which cannot logically or realistically be dubbed as 'brownfield' and as such should be designated as greenfield spaces- and development on them restricted. These issues are coupled with the geographical constraints faced in Swansea. Swansea is limited in space, and especially developable space (with much of the space under heritage protections, especially on the Gower Peninsula). Therefore finding new land to build houses on to meet the targets set by the Local Development Plan is difficult.

"We are not making any more land. Swansea as you know is bordered with the bay, there's one way in and one way out, you've got Townhill which is a 600ft wave cut platform, these are big hills, you've got Kilvey Hill, not easy to build houses around" (A1)

In this instance Swansea, as is stated above, is in a difficult situation as a result of geographical limitations on space in the region. This lack of space results in less available developable land and therefore, as a direct result of this, Swansea is under pressure to build housing on brownfield sites. One argument would be that although the Cefn Coed site in planning terms is designated as a health care site, the site has a fair amount of green space. Developing on this land would not necessarily be sustainable development (and it may not even be largely classed as a brownfield site), but the destruction of what is largely a green space.

"It's a green lung in the west of Swansea" (A8)

Issues around space may have had a large impact on the decision to retain the Cefn Coed Hospital site and is arguably one of the major external factors pushing the site towards closure. The question here is how much of a pressure has this provided up until now? The majority of the Cefn Coed site is scheduled to be closed in the near future and subsequently sold off for housing; and the land potentially available at the site for redevelopment appears to be one of the major factors in that closure. So considering that this is only now happening, one would assume that either a) there was not previously as much need for housing (which is unlikely) or b) the majority of alternative development land has now been used.

Derby Borough Asylum - Kingsway Hospital

Mental Health Care Policy

Derbyshire Healthcare NHS Foundation Trust has up to now retained the Kingsway Hospital site, but in doing so they have demolished the majority of the original

psychiatric asylum buildings and reprovided the services in modern, purpose-built facilities on the same land. The old buildings were demolished because of the:

"Costs associated with repairing to an acceptable standard" (B5)

"*There was the demolition of the old hospital that was a fairly major project and I think sort of it had the inevitable asbestos problem so there was those sorts of technical issues and the drains and things like that*" (B7N)

When the main building closed there was not much of a clamour from the local community to save it from demolition. It has been theorised that this is because the building was built much later than other examples, having been erected in the 1930s; as a result it was built in a fairly minimalistic style. The result of this is that it was not as aesthetically pleasing as its 19th century and early 20th century counterparts and there was little architectural merit to the building.

"*I don't think it was regarded as a classic in that sort of sense so, there was no sort of church or clock tower or anything like that really that was an obvious focus for architectural interest really, and I don't think people saw it as a nice façade that would translate into flats and so on and this sort of thing*" (B7N)

When asked about the retention of the site, respondents alluded to a number of factors including the age of the buildings. The age of the buildings is a common factor when discussing former psychiatric asylum sites and the phrase 'not fit for purpose' is often thrown in. This is partially due to the fact that psychiatric inpatient care has changed dramatically over the decades; with more of an emphasis on privacy and a greater awareness of factors relating to safety, such as ligatures and 'cubby-holes'. A lack of investment in recent years makes it even harder for these facilities to be made suitable for modern mental health care. However many of the buildings on the Kingsway site are either new builds, or have been refurbished in recent years. With regards to the

small number of older buildings which remain on the site, their suitability varies dramatically.

"*There's not that many retained of the older buildings. A lot of it's new build and there's a big PFI, erm, there's the Kingsway house which is up the driveway here which was designed on a circular basis, I think they were originally wards and there's a certain, and it can be quite disorientating, I don't know what it was like for the patients at the time but if you try to find a particular office and you're walking 'round in a circle it's surprisingly difficult to orientate yourself as to where you are. But that's been renovated and was made I think comfortable accommodation and what seems to work well as offices, once we worked out which entrance to go to and how to navigate yourself 'round…"* (B7N)

"…The Bramble House is trust headquarters I think's more difficult, that's where we are now. And as you can tell it's more of an antiquated sort of run down slightly seedy type of design entirely. I think this used to be the old nurses home so, this was designed as sort of accommodation I think basically for nurses with large sitting rooms and things like that. And I don't think it lends itself particularly well to a headquarters I don't think it's got a welcoming or impressive façade, I don't know what you thought when you came up to it. So the car park that are all tennis courts are all sort of crumbling, and I think it gives the impression of sort of a bit seedy, run down, crumbling, faded former grandeur type of impression so as a headquarters I think it's got its problems. But people say some of the rooms smell. I've been here so long I can't tell anymore" (B7N)

"*Part of what we were doing is developing a PFI project to build some new wards and the research and development centre which of course is effectively taking out a mortgage for 30 years for about £30m or something, and, which was what obviously the government were encouraging at the time in order to do exactly what we were doing which was to close redundant stock, sell some land off, get some demolition on the site and then build fit-for – purpose building which would take us to the future. The unfortunate thing of course that's created a big legacy of a mortgage for 30 years to buildings which we couldn't easily vacate. So of course it sort of then, tie everybody up for this length of time both financially and with*

regards the, their estate… coz whatever you do you've got to service the mortgage and you've got to stay in the estate for the foreseeable future, so it's sort of cemented us in to various sort of places both financially and in terms of the estate so although it seemed a good deal at the time and a way of moving forward and a way of escaping the shabby accommodation that we've been talking about which wasn't acceptable" (B7N)

In this respect the older buildings which are in use on the site are not necessarily looked upon favourably by the staff. What we also take from the above is that the push towards replacing the 'redundant stock' of buildings on the site was a priority to the trust, which led to the replacement of older buildings on site with new premises. This acts to remove objects of memorialisation on the site, as older facilities are slowly phased out and replaced, which may have a hand in the reduction of stigma on the site (Kearns et al., 2010). The trust saw fit to replace some of the older facilities with the large £34m PFI (Private Finance Initiative) building as well as three PFI wards (Derby Telegraph, 2009a; WhatDoTheyKnow, 2013). This has had the side-effect of tying the trust to the site for the next 30 years, restricting their future options and almost guaranteeing the site's retention for the foreseeable future. Another financial factor is that the fact that the Trust already owns the land and to move would require additional land purchases as well as planning permissions:

"I would suggest that they have maintained healthcare on the site because they've got the site, and they've got the buildings. They did have an enormous site there at Kingsway, some of which has been sold for housing development. But there's still a substantial mental health operation and a substantial site remaining. And I guess that they've stayed there because their resources are there, the buildings that they need are there, otherwise they've have had to buy another piece of land somewhere else and build" (B4)

This is an indication that there is a form of inertia resulting from not only the financial but practical issues with moving the trust off the site, as a result of there being a substantial mental health presence on the site. This stems from a number of factors,

which includes both the need for services in Derby and the fact that there is no obvious replacement for the Kingsway Hospital site in Derbyshire:

"The ongoing need for a site from which to deliver mental health services in Derby. Ownership of the site already belonging to the Trust thus avoiding costs of land purchase. Other financial and project management benefits of keeping provision on an existing site" (B5)

"But that site itself is a sensible site to use, there wouldn't be any other obvious site at all, I mean I know that the mental health trust have got a, just historically, have got numerous little sites dotted all over the county and I can think of quite a number in the city. Old buildings, perhaps not totally suitable to the way treatment is given now" (B3)

It is also argued that the lack of finances available within the trust may have compounded the situation of inertia on the site. This is due to the fact that the trust simply cannot afford to move the entire operation onto a new site, so services therefore remain on the Kingsway Hospital site. The lack of finance has been argued to be a result of the underfunding of mental health services in comparison to physical health services.

"The challenge for the mental health service is that they are trying to run a service on a shoestring. The health service is a poor relation and they're a poor relation of a poor relation. So, they've got to use what they've got to the best advantage" (B4)

Although the National Health Service has not had its funding cut, it having been ring-fenced in the latest budgets, the budget is also not being increased. With factors such as health inflation and increases in costs (as described below) are added into the equation, cutbacks and real-time budget cuts are being enacted.

"*There is a sort of legacy issue which is going to become a big factor for the NHS going forward really coz we're sort of, NHS is to a significant extent is in hoc for the next few years really, so whatever we do, with this big financial, when we were getting year on year increase in*

investment in the NHS then that was sort of, you could work with that quite nicely, but now because although the NHS cash is so called ring-fenced, because of health inflation, increase in costs… increasing demand it effectively we're having to make efficiency savings every year. All of a sudden it's looking like a liability to be locked into financial arrangements for certain estates; consequence there's limited room for manoeuvre. We're not too badly affected as a trust, coz it's a relatively small part of what we're doing overall" (B7N)

The financial benefits of remaining on the Kingsway site therefore are paramount in the retention of the site, in addition to the trust's financial ties to the site with regards to the PFI.

"So having a view of the car park and sort of being able to stroll 'round the grounds in an acute hospital isn't a particularly relaxing and calm environment and often the green spaces have been converted into car parks and the trees aren't mature and things like that and I don't think it's a conducive environment for sort of relaxation… acute hospitals are full of hustle and bustle aren't they? Not particularly calming environments so I think you've got big advantages with regards to technical aspects of medical care, and in an acute hospital big disadvantages in terms of its environs and therapeutic [landscapes]" (B7N)

What the above quote shows is that there are a number of advantages to retaining the current site rather than merging with the general hospital nearby. This is due to factors around the notion of therapeutic landscapes, and the inability to offer a calm environment which is seen as beneficial to psychiatric care. However there are also advantages involved with a merger relating to the providing of general healthcare and economies of scale.

Urban Planning Policy

One factor which may have an effect on the future manifestation of the hospital is aesthetics, as buildings which have a form of grandeur or are particularly attractive are more likely to be preserved for future use. In this way hospital buildings which have this grandeur about them may be more likely than their less grand counterparts, to be

either retained or redeveloped rather than being demolished. The main building at Kingsway Hospital was built between 1886 and 1888 and was built in what appeared to be the Queen Anne Revival style; as stated below it was described as 'utilitarian', 'bare' and 'cold'. In addition to this, the building was presumably not thought to have historical (socially or economically) or architectural merit (East Hampshire District Council, n.d.; Town and Country Planning Act, 1947; Suddards, 1982) worth preserving through the designation of heritage protections such as listed status. Other asylums built in the earlier part of Victorian times for example are often built to be grand and elaborate with ornate decoration and as such the style is deemed worthy of preservation (Sennott, 2004) , although several later examples, especially from the early 20th Century, are listed also.

"*Yea, although likes of a building in that period dated very quickly really, you know some of the very old ones have got some sort of grandeur about them haven't they? Whereas the old Kingsway site was a quite utilitarian but sort of bare and cold, you know, it wasn't, there was nothing to attract you to it in a way it was sort of shabby but not grand, but not grand shabby just shabby full stop. <> like Middlewood hospital that was sort of, that had a grandeur about it with the clock tower and various other, the church and various other architectural features that I think have been preserved haven't they?*" (B7N)

Urbanisation

Over time the geography of the Kingsway site has changed, which is shown by a comparison of maps of the site. The maps shown are of the site in: 1901 (Figure 5.4); 2010 (Figure 5.5); and a google earth image from 2013 (Figure 5.6). It is apparent from these images that the site has become increasingly urban over time, and as a result the Kingsway site is more in the public eye than when it was originally built. The hospital is not as isolated as it once was, however it is still maintains a certain level of isolation

to the community which surrounds it. In the immediate sense this is due to the land which separates it from the nearest housing on the site, and the surrounding triangle of the Uttoxeter New Road, the A38 and the A5111 create a barrier to the rest of the area. This may have had an effect on the retention of the site, as the majority of psychiatric asylums have become urbanised.

Figure 5.4: Derby Borough Asylum. Source: www.old-maps.co.uk.

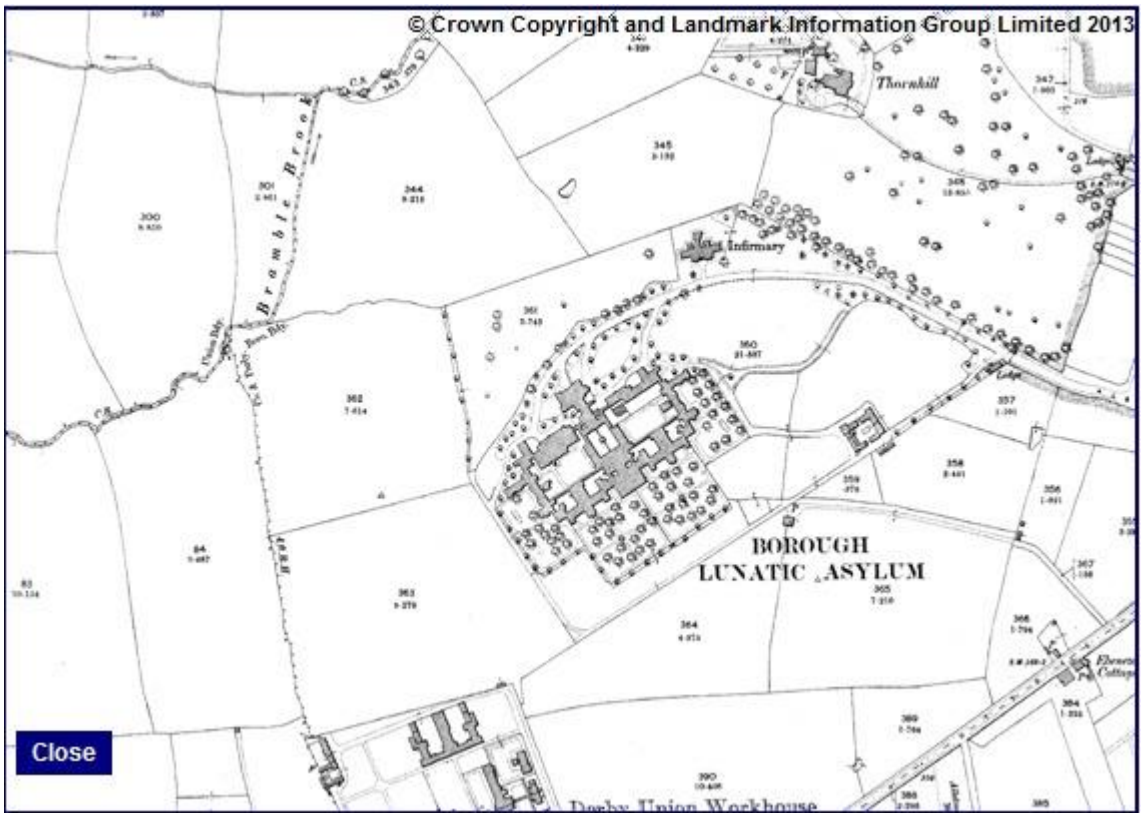


Figure 5.5: Kingsway Hospital. Source: Google Maps.

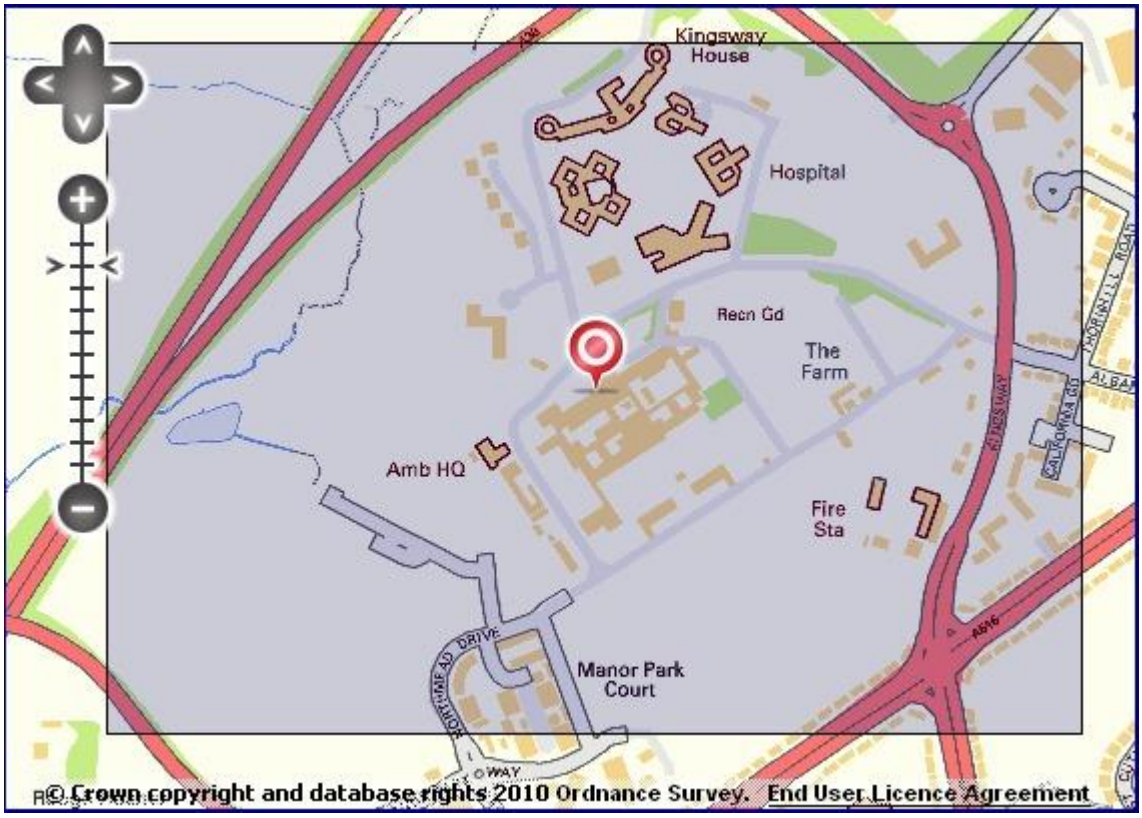


Figure 5.6: Kingsway Hospital. Source: Google Maps

"No, it's separated slightly, coz it's reduced enormously since it was a large mental hospital in a traditional sense, they've gradually disposed of large sections of the site in terms of the buildings" (B2)

"The site that's operating as a mental hospital now, is set well away from any of the roads and is largely unseen" (B4)

"*It's like, erm what's the word, it's like a lacuna in… Derby isn't, it's sort of shielded in the grounds and behind trees and sort of behind the fences really so it's like this little lacuna in Derby that my impression is people aren't all that aware of it or what goes on here really*" (B7N)

As stated in the quote directly above the site is 'like a lacuna', and as such acts as a form of therapeutic landscape for the patients and staff on the site as well as the local residents surrounding it. This is as a direct result of the slight separation that the site has from the surrounding population, and therefore acts as an escape from the press and stress of everyday urban life. However, as noted in the previous chapter, there are plans underway to construct a road through the centre of the Kinsgway Hospital site (see Figure 4.4.). This could potentially destroy the therapeutic landscape which the site currently offers, negating the positive effects for patients and staff. There would also presumably be some level of integration between the hospital and the community as a result of the building of housing on the site.

Sustainable Development

"Every local authority has to demonstrate that they have a 5 year supply of housing sites, and at the moment Derby can't do that so we have to share what we call the Derby Housing Market Area with 2 of out neighbouring authorities for housing targets. We're supposed to have room for about 12,000 and we can't, we're about 2,000 short so there'll be a bit of a bun-fight going on at the moment about the sites because one of the things that's happening is the local, the nearby local authorities are developing sites right on our boundary, which they will take all the

money for, and the loadings will all go on to our services, coz people who live on the edge of a big city tend to gravitate into that city, but they're paying their council tax to the nearby local authority which is a bone of contention" (B2)

This is a particularly interesting situation, as there is an immense pressure for housing and developable land in Derby. As noted above, Derby is 2000 houses short of their target of 12000, so the pressure to develop on the Kingsway Hospital site is large. This may be as a direct consequence of the 2014 announcement from the Department for Communities and Local Government that confirmed a push towards more housing development on brownfield land, with the target being 2/3 of all housing to be built on brownfield sites in the future. This was partly as a result of the aim to tackle urban sprawl, with MP Brandon Lewis stating that "*local people don't want to lose their countryside to urban sprawl, or see towns and cities lost to unnecessary development*" (Department for Communities and Local Government et al., 2014). This is more so true considering that the Kingsway Hospital site is one of the sites in the city which is earmarked for, and currently undergoing, development.

"I mean it's for some years now been on the local plan that a good deal of the site would be given over to quite a lot of housing. Hasn't really raised any eyebrows at all" (B3)

The building of these houses has already caused a vast array of problems relating to a lack of infrastructure including a lack of school places, roads unsuitable for the increase in traffic, school routes which are deemed unsafe and also the inappropriate placement of new build houses in relation to the local fire station's smoke house. In January 2014, the trust authorised the sale of a portion (0.8 hectares) of green space at the Kingsway site for a proposed housing development. The space was described by the Department of Health as "*former sports field, grassed area*" (2014). This was estimated to be providing '20 units' of housing in a mixed-use development as well as a road to be built through the centre of the site. This will have the effect of making the Kingsway Hospital site much busier as a result of an increase in population in such close proximity to the rest

of the site. This development arguably puts further pressure on the Trust as it means that the hospital has limited its own possible expansion:

"*Limited scope for further expansion due to sale of land in the grounds for housing*" (B5)

Newcastle Borough Lunatic Asylum - St Nicholas' Hospital

Mental Health Care Policy

A key factor in the site's retention is the financial costs and restrictions that the trust encounters. This is both in relation to maintaining the buildings on site as well as practical issues relating to parking etc. Although, as previously stated, Scull claims that *"complaints about the dullness and destructiveness of routine simply did not possess the same impact as allegations of the chaining, flogging, rape, and murder of inmates"* (1977: 125). However, these day-to-day, relatively inane factors such as building condition and parking can be the cause of much tension and ill-feeling on the part of local residents in the vicinity of former psychiatric asylum sites.

"Another challenge has got to be cost to the health service, or the trust in these stretched times" (C3)

"*I think there's challenges obviously you can see the fabric of the building is, as fit for purpose in the era it was built but things like windows you know, here you need to do any work it's quite expensive to do and so there's operational challenges as well. It's a fairly cramped site so you know in terms of parking etcetera etcetera that is an issue because you just, the Victorians wouldn't have planned for hundreds and hundreds of cars being strewn all over the site*" (C7N)

One of the ways in which the trust (and other trusts across the country) deals with financial pressures is to sell off their excess of land. In fact in November 2014 the Health Secretary Jeremy Hunt stated that the NHS had to save £10bn a year: "*by using fewer temporary staff and management consultants, selling off unused buildings and reducing drug errors*" (Campbell, 2014).

"Yea I think anybody who's in charge of any organisation like that is bound to have an eye on [budget cuts], whether they're 100% serious about [selling off excess land] or not. Development of that land is like, would almost certainly be a conservation area issue but then again there is that building that you've pointed to just on the corner, yea on the western part of the site" (C3)

This is not an uncommon strategy for trusts under financial strain. In the case of St Nicholas' there are parts of the site which had already been sold off, large sections of which are occupied by housing, and other parts which may be sold off in the future. This is made more viable when, as stated below, the land is not viewed as an asset by the local community.

"I would imagine there's a piece of prime real estate, what we'd call real estate there by the side of Salters Road. And I wouldn't be at all surprised if there had been and I didn't know about them or there about to be proposals to build on, to develop that land. As far as I'm aware it isn't used as a community asset" (C3)

The selling off of real estate by the trusts is largely financially motivated. However it is the government policy of a push towards community care which enables the selling off of excess land by the trust, as patient numbers are declining as a result of the move away from institutionalised care.

"Well I think government policy is moving more towards delivering more community provision isn't it so, erm, what that means in the long term I don't know, for the hospital itself, erm, I know the hospital trust has at least, well it has a number of sites, maybe it'll have less sites in the future, but it seems that to me that St Nicks seems to have this sense of being the grand centre of activity for the trust, so whether the St Nicks site would be at risk or not I don't know" (C1)

One argument has been that since the main building at St Nicholas' is a grade 2 listed building, the options for redevelopment and sale are slightly limited, with issues

around the inability to fully modernise the facilities and high costs related to the low energy efficiency of the buildings:

"It must be quite an expensive building to keep, just even to heat and to power and you know...The difficulty is it's a grade 2 listed building and what on earth can you do with a grade 2 listed building if it's not that you know, what happens to it…" (C1)

It has been stated that because of the progression of mental health care, and the fact that the vast majority of patients are now treated on an out-patient basis in the community. With this in mind the patients who remain at St Nicholas' are therefore more serious cases, and as such are not free to wander the grounds on their own:

"*So the grounds possibly are diminishing in terms of value to the services that we provide because patients can't get out as much*" (C5)

"*Well if erm. Well so we've configured a couple of wards and the bill costs for that are probably upwards of 50% more than you could built something from the ground up, so, you know you've just got to look at the wall there it's a foot and a half thick and, erm, you know so that poses engineering problems when trying to knock down walls to make them bigger because you know, what in general in terms of an environment which promotes recovery you want light you want them to be spacious, airy, you know lots of breakout spaces, so folk aren't on top of each other. The old wards were very very different to that, they were nightingale wards, you know they were fairly compact people ate and lived in very compact dining areas and lounges etc.*" (C7N)

If Northumberland, Tyne and Wear NHS Foundation Trust sees the land as not having a significant use-value for the trust or the NHS, then as a result the potential sale of the site's land is made much more likely. This may be due to the fact that although the use-value to the NHS is relatively low, the value of the land as a commodity can be taken advantage of as a source of incoming capital for the trust. However this does not appear to threaten the site entirely, as the main building at St Nicholas' is not only

listed and in the confines of a conservation area, it has also been described as the trust's 'jewel in the crown' and the centre of their activity:

"But I do know someone who works there, and she seems to think that St Nicks is very safe because it's, from her point of view, it's the trust's erm, the jewel in the crown of the trust, the showcase that they want to show everyone. And the other bits that perhaps aren't quite as good they're the ones that are more vulnerable, when I say not quite as good I mean maybe performance statistics aren't as good or whatever do you know what I mean? And St Nicks is seen as a, as an exemplar nationally of good healthcare for that particular sector, erm, so I think it's unlikely to close, but you never know what's around the corner do you?" (C1)

In addition to this, the trust has previously made attempts to move services from psychiatric sites to general hospital sites. The ideology behind this was to integrate mental and physical health services, with the practical benefits of having general healthcare available if needed and the financial benefits of running the services together. However the unforeseen problems arose around the seeming unpreparedness of the general hospital staff for mental health patients, not to mention possible issues around the general hospital site not being specifically designed for mental health care, giving rise to issues such as ligatures.

"*The theory behind moving off-site was about destigmatising individuals with mental health problems and moving them into more normative environments, so if you went into hospital, you know, you were going onto a hospital site, I don't think it's quite worked, … I think individuals who move., in terms of the general hospital sites, they tend to be less accepting of individuals with mental health problems so we often get phone calls from the canteen saying 'one of your patients is in the canteen', they're not necessarily doing anything other than having their lunch, and there's some concepts around asylum now, which are starting to, if you like, re-emerge, peace, quiet, the ability not to be hassled or, to have really nice grounds is really important, er, and the grounds here are really nice compared to the RVI or the general hospital so there's, there's been a move away but I think there's some value in absolutely having an asylum, not perhaps with the aesthetics we have but that core place where people can be accepted, be, feel*

more relaxed, have a hark of the hospital. You can, you know if you looked at the old asylum really, you have, we still have a theatre there was a… cinema, there was almost a whole community you could access without even having to leave the grounds. Some of that's not right, some of that promoted institutionalisation but some of it for our clients, sometimes you think you have lost a little" (C7N)

Urban Planning Policy

Urbanisation

Over time the area around St Nicholas' Hospital has changed dramatically. We can see that in 1898 the hospital is largely isolated (Figure 5.7), with a few houses to the North-West of the site. By 1920 the housing to the North-West has expanded and there is housing creeping in from the South but the hospital still remains fairly isolated (Figure 5.8). In the 2010s housing has crept up, surrounds the site on all sides and has even infiltrated the site in the South-East, South-West, West and North (Figure 5.9; though this can be seen more clearly in the google earth image of Figure 5.10).

Figure 5.7: Newcastle-upon-Tyne City Lunatic Asylum 1897-8. Source: www.old-maps.co.uk

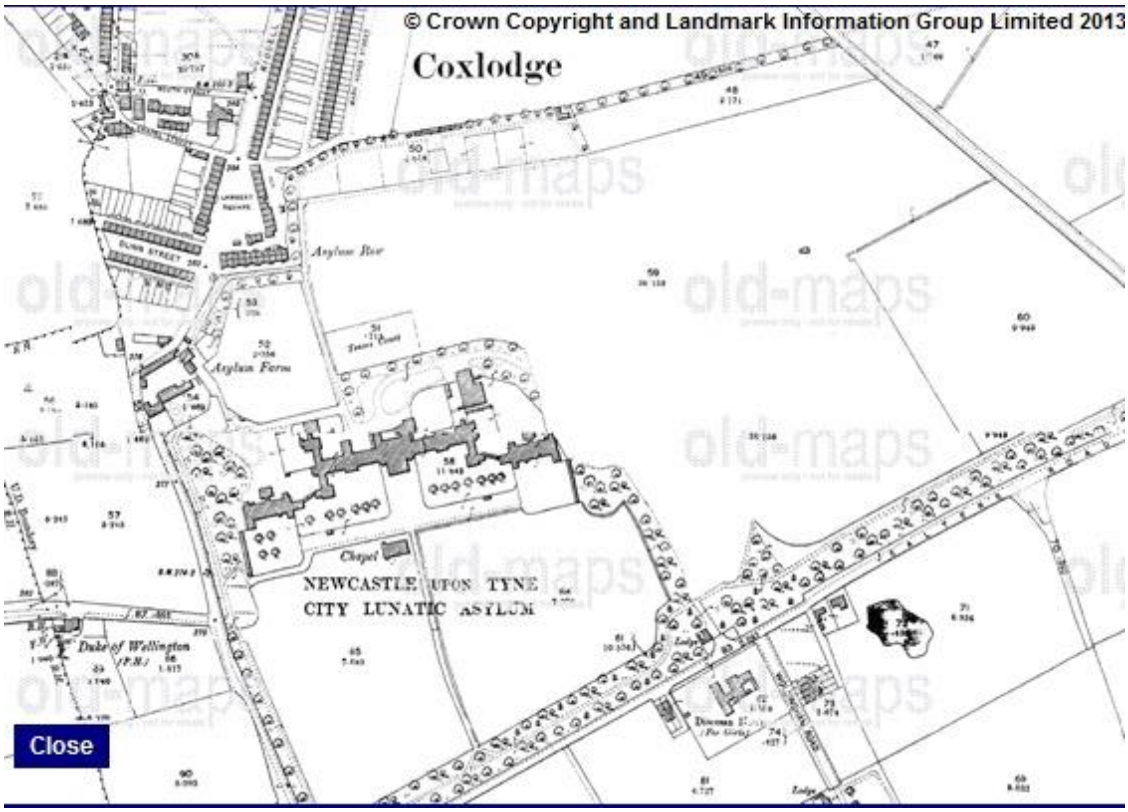


Figure 5.8: Newcastle upon Tyne City Lunatic Asylum 1919-20. Source: www.old-maps.co.uk.

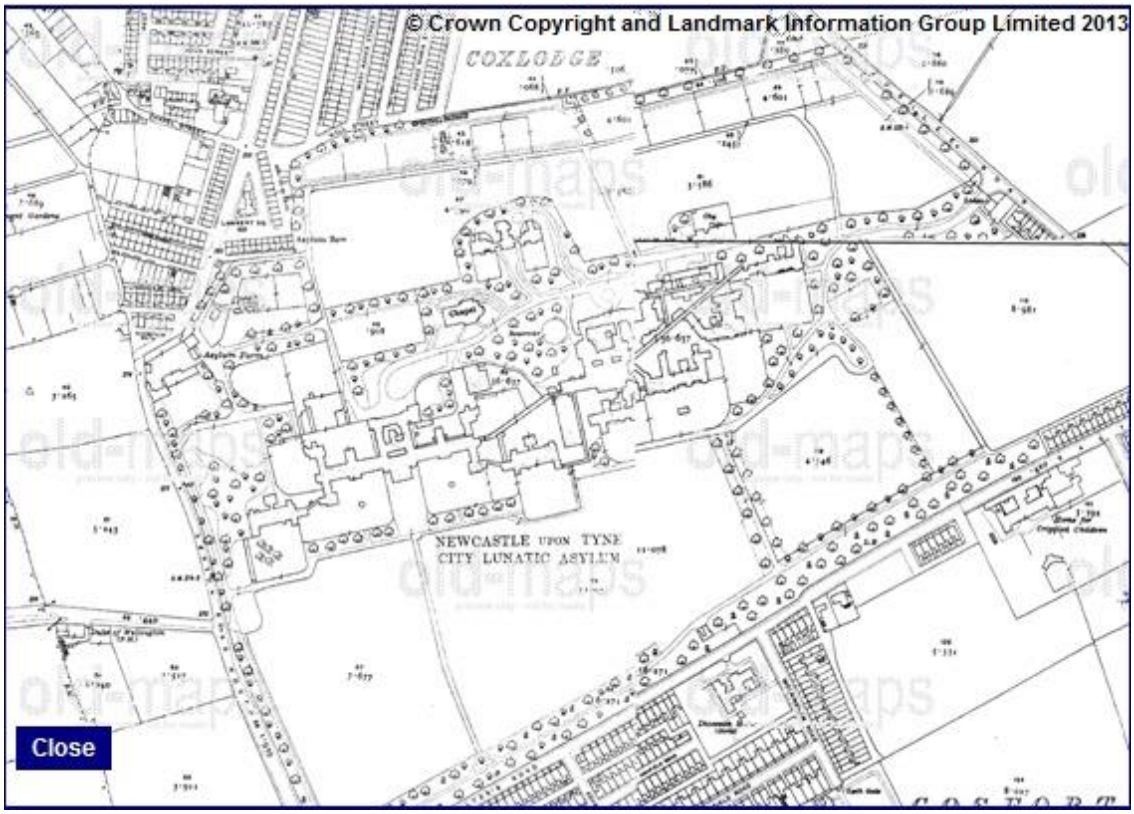


Figure 5.9: St Nicholas' Hospital 2010. Source: Google Maps

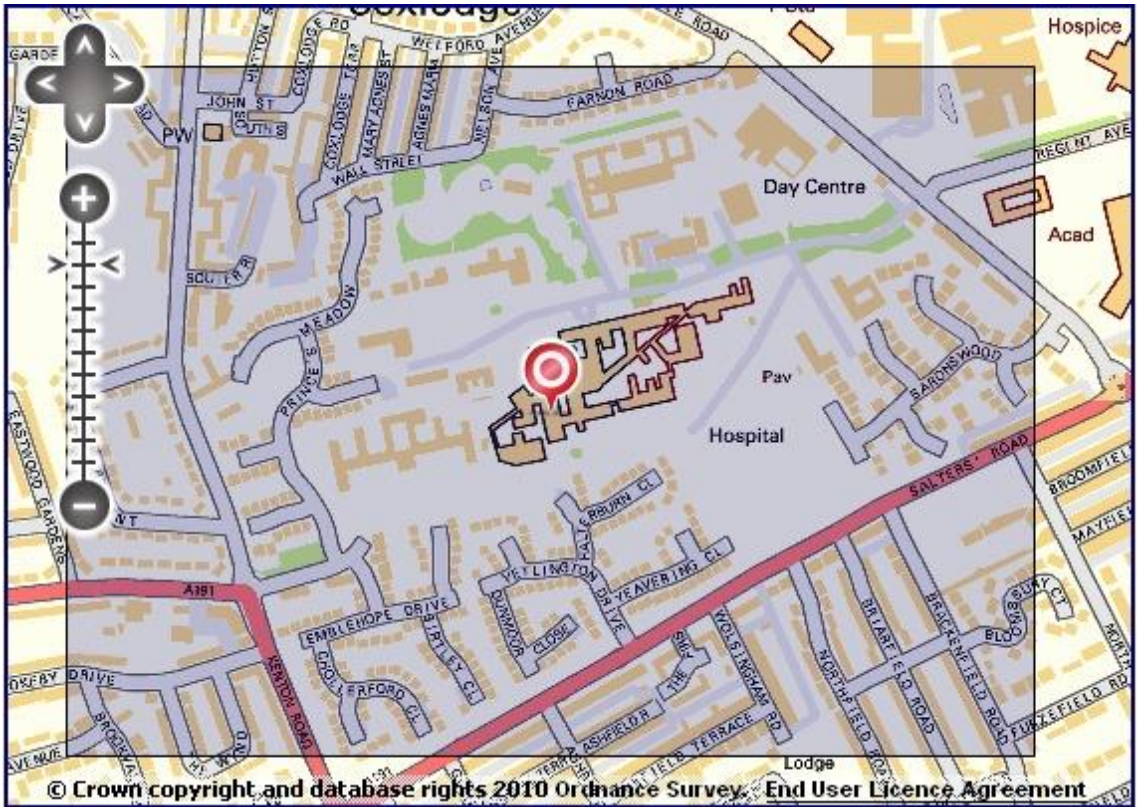


Figure 5.10: St Nicholas' Hospital 2014. Source: Google Maps.

From this we can see how the site has become more urbanised over time, as the surrounding populations and housing have gradually crept towards and onto the asylum/hospital site as it has become a part of the local community:

"Not an isolated place…it is what it is" (C4)

"St Nicks doesn't have high walls, they have public footpaths in the middle of it… it doesn't give the impression of being an enclosed scary place. Kids playing on green fields in front of the hospital" (C4)

"Has been a fixture of the community for as long as I have lived in the community, that is 25 years" (C4)

However most of the issues relating to the site's relationship with the community appear to be non-clinical ones, such as problems around parking: "*car parking probably represents the greatest challenge to the management of the Conservation Area, especially within the hospital precinct… at present, every available space, legal and illegal, is likely to have a car parked on it during office hours*" (One Core Strategy NG, n.d.).

"*The problems that were had were over the parking*" (C1)

"*If you took the local community, what they would say is, and it's the same for any hospital, parking. Overspill of parking. So that pees them off. However with mental health you don't get a lot of visitors so it isn't as bad as the acute hospitals, so parking is an issue, because there always gonna be that, you know our staff are gonna park next, in front of the houses and they cannae get parked"* (C5N)

Sustainable Development

The pressures of sustainable development that has been placed on local governments in the form of the Local Development Plans arguably, if not putting pressure on the trust, provides the heightened possibility of land being sold off at a competitive price. The Local Development Plan for the Newcastle area has set the following targets:

"*21,000 houses in 20 years- 15000 on brownfield sites*" (C2)

"It's 21000 homes in the next 20 years, 15000 of which are to be on brownfield sites" (C3)

This puts pressure on local governments to find space for 15,000 houses on brownfield sites, which mental hospitals are often controversially included in. With regards to this designation there is however some argument as to whether mental hospital sites

should in fact be classed as 'brownfield sites'; with some arguments about whether they instead should be classed as greyfield sites (as discussed previously in this chapter) or even as greenfield sites due to the amount of green space which these sites tend to incorporate within their grounds:

"That site I don't think would qualify in the definition of a brownfield site" (C3)

When categorising land, mental hospital sites do tend to be included in the category of brownfield sites. This high pressure for housing developments across Newcastle, alongside a limited amount of land for development, leads to the local government highlighting potential brownfield locations, such as St Nicholas' Hospital, as a potential site for housing development.

Portsmouth Borough Asylum - St James' Hospital

Mental Health Care Policy

The predominant feeling among respondents was that St James' Hospital had surpassed its usefulness. It seems that Solent NHS Trust agreed with this sentiment, and made it clear that it's their intention is to sell off the site sooner rather than later:

"*My honest answer is I honestly don't know. If I were to completely speculate, and this is completely personal, this isn't a professional opinion purely a personal one but I would say it's probably not been the most useful site for a good 10/15 years. That is purely speculation*" (D1)

"*Well the NHS have made it clear that they don't want the site, it's very much a case of their challenge is how they get rid of it as opposed to how they retain it"* (D1)

One respondent stated that they felt this to be the case due to the decrease in need for mental health services in Portsmouth. Therefore the future plans for St James' seem to be to relocate the few services which are still located on the site in a merger with St Mary's Hospital. This would then allow for the sale of the St James' land.

"*Well it's primarily a decrease in the need for mental health services in the city, it was as you know a Victorian mental asylum and that's not, it's not its current use today. Over the years successive governments have wanted to centralise and scale down the NHS in various shapes and forms particularly the last 30 years. So in Portsmouth we've got a situation where Queen Alexandra hospital was built and is known as the super-hospital and the original concept is that it would service the whole city, it became clear that the other 2 hospitals in the city, St Mary's and St James' would still have to stay but it turns out that realistically only one is needed because of modern technology, the way modern services are delivered. And for various reasons including location, access, the how recently built the other hospitals were St Mary's has become a community hospital and my belief is that the NHS plans to move all the services which are currently in St James', which is only really a small amount now, and there were no inpatients at St James', to St Mary's which is only 5 minutes away from the site*" (D1)

However the view that there was less demand for psychiatric services in the Portsmouth area was disputed by another respondent, who felt that there was a shortage of inpatient mental health beds in the city, especially related to psychogeriatric care.

"*I think it's the size of the problem we face here. Particularly with psychogeriatric care, there is a shortage of beds nationally. The retention of the unit at Langstone House and the other facilities there, the case was made to keep them, and long let that be the case. Because I think it's the sheer pressure that we have in this area, and by this area I mean the greater part of Hampshire really, and there are a lot of people who are cared for, with mental illness, a long way from home, and so there is a dramatic shortfall. And the retention of part of the site at St James' was inevitable*" (D5)

However, it appears that the main push towards the closure of the St James' site is financial. Multiple sources have stated that the site costs £2 million just to run, and the feeling appears to be that it is not justifiable to spend such a large amount of public money on a property which has little clinical use.

"*They are hoping to save in total I think something like £2 million a year by just knocking out the running costs basically so that's the main driver. It's a building which has got little clinical use in it now, they told me this when I went round it and I couldn't believe it, the clinical use only accounts for 3% of the building, most of it is either empty or it's admin. And the admin staff could be moved to another building elsewhere that's cheaper to run*" (D4)

"*If you start just looking at the main building, the main listed building there it's barely used and it's not reasonable to spend public money on a building with very high running costs, it doesn't make sense. I certainly don't like to think £2 million is spent on running costs when it doesn't need to be. So I think that there is a strong argument for site rationalisation*" (D4)

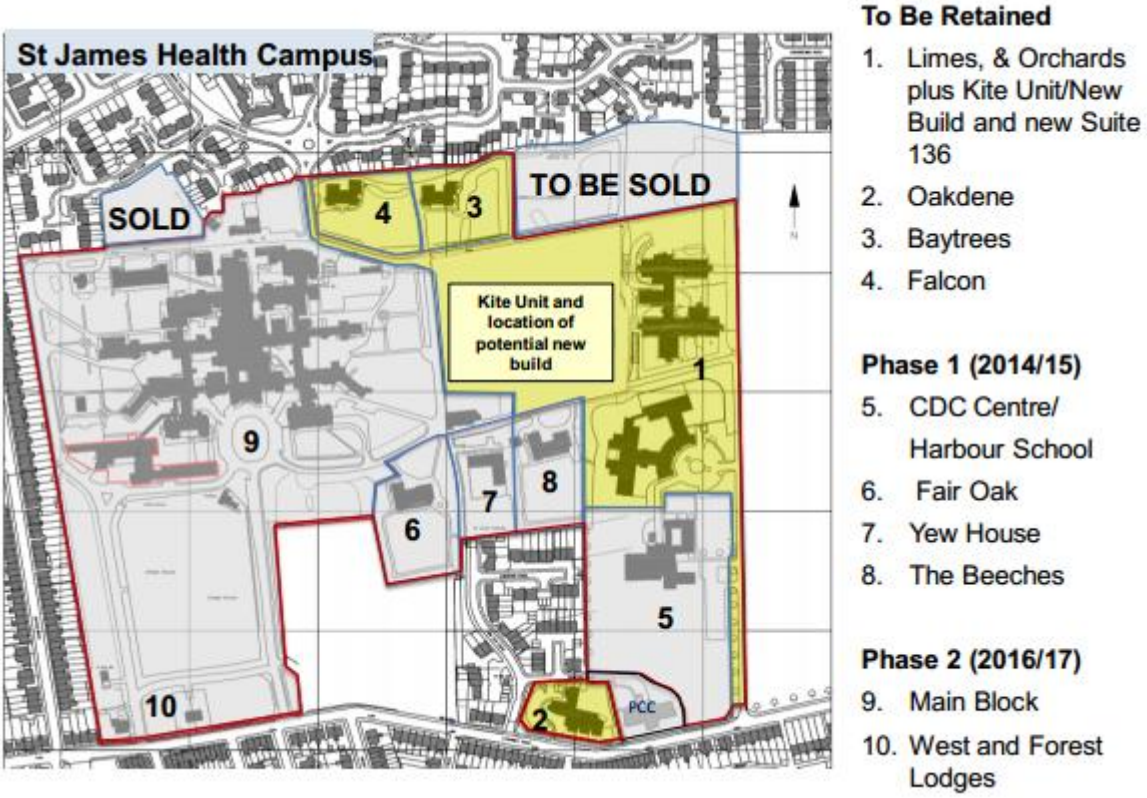
Additional financial factors are the pressures on all of the NHS Property Service to offload real estate deemed surplus to requirements before March 2015, presumably as a means of balancing out the NHS budget before the general election. This strict deadline has, as one respondent stated below, possibly led to the underselling of NHS property and land in order to meet the deadline

"*Oh, money. The need for realising, I think every health organisation in the country were left in no doubt that they would be expected to realise as much of their real estate value as it was possible to achieve in as short as possible time. Hence the reason why I think some sites are being undersold and they were sold at a time when the market was really depressed, and developers came in and bought very cheap land off these sites knowing that OK they weren't going to develop it straight away but they got the land at a very cheap price*" (D5)

"*They've given themselves targets and these targets have been pushed down to public bodies, and they've been told basically you have to make available this much land. So that is a bit of a driver, the NHS property services needs to complete a sale by March 2015*" (D4)

Figure 5.11 shows the NHS' planned Land Allocation for the St James' Hospital site, including the areas which have been/will be sold, those areas which are designated for future development and those which will be retained.

Figure 5.11: St James' Hospital Land Allocation (NHS Property Services 2014)



Urban Planning Policy

For Portsmouth Council there is a pressure to build more housing as laid out in the Local Development Framework. In addition to this, as stated previously, there are targets for the councils about how much housing is to be built on publically owned land by March 2015. In Portsmouth these targets are for 750 houses to be built every year, a target which is much higher than is currently being achieved.

"You've also got highway problems, most noticeably, there's not a great deal you can do about it really. We, I have been involved in no discussions at all about what they are going to do about

that but I would have thought, being realistic, at some point they would want to open Moorings Way as a through road. Although that's never been said. We also have constraints with school places. People think councils make profit out if development and it's not true. We, and I've just been in a budget meeting, and we are going to have to provide some extra primary school places in that location and the cost of providing them per pupil is between about 15 and 20 thousand pound. So when you think that the community infrastructure there will be for 100 houses, larger houses for the most part, would be something like a million pound. It doesn't go very far, you know coz you're going to have quite a few kids living in that sort of development, less so probably in the listed building coz you get many fewer kids in flats" (D4)

"*In a way, insofar as the government has set targets for the number of housing that can be built on public sector land before March 2015. Which, you know, is never said but it's obvious to anybody that's the general election, an. They've given themselves targets and these targets have been pushed down to public bodies, and they've been told basically you have to make available this much land. So that is a bit of a driver, the NHS property services needs to complete a sale by March 2015*" (D4)

There are added pressures to these targets for Portsmouth in that the geography of the area, much like Swansea, limits the amount of land available for development. As shown by the quote below Portsmouth City Council has already been facing issues with regards to meeting housing targets:

"Well we have a big problem meeting housing numbers yea absolutely… Our housing need number is going to be somewhere around 750 per year, and we've been averaging a level of completions of about 400" (D4)

Urbanisation

Over time, the area around St James' Hospital has, like in the other three case studies, changed dramatically. We can see from that in 1898 the hospital is fairly isolated, with a small amount of dwellings to the west in Milton village (Figure 5.12). By 2010 the

view has changed almost inconceivably, as the hospital is closed in by houses on three sides (Figure 5.13; this can be seen more clearly in the google earth image of Figure 5.14). From this we can see how the site has become significantly more urbanised over time, as the surrounding populations and housing have gradually crept towards and onto the asylum/hospital site as it has become a part of the local community.

Figure 5.12: Portsmouth Borough Asylum 1898. Source: www.old-maps.co.uk

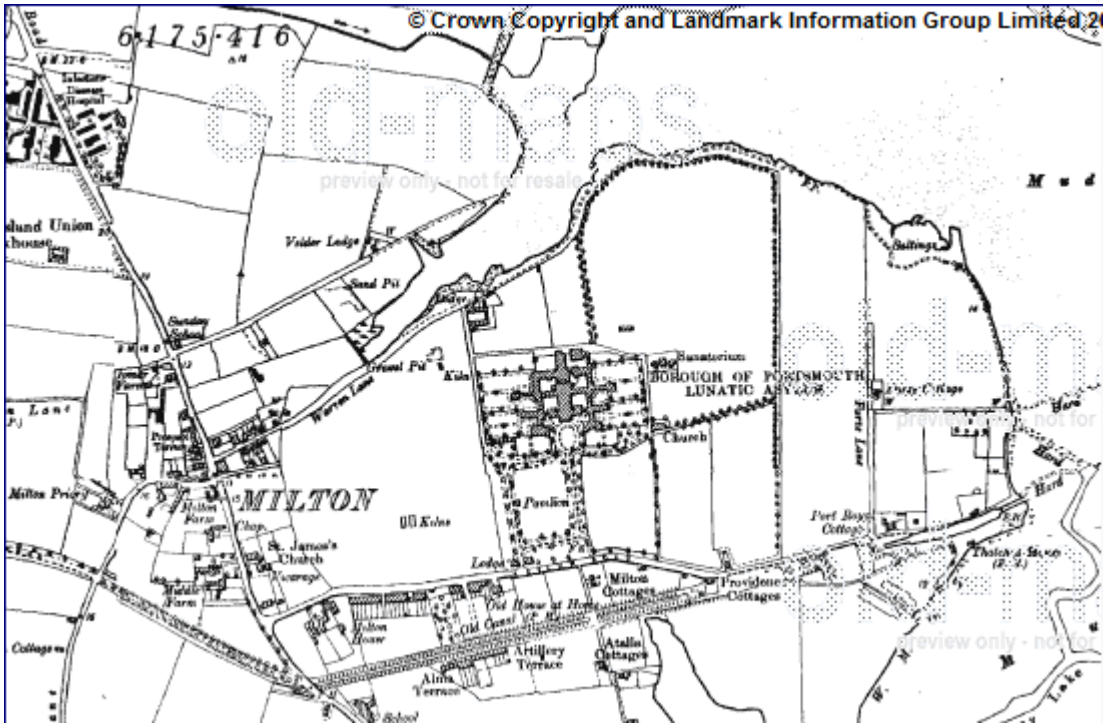


Figure 5.13: St James' Hospital 2010. Source: www.old-maps.co.uk.

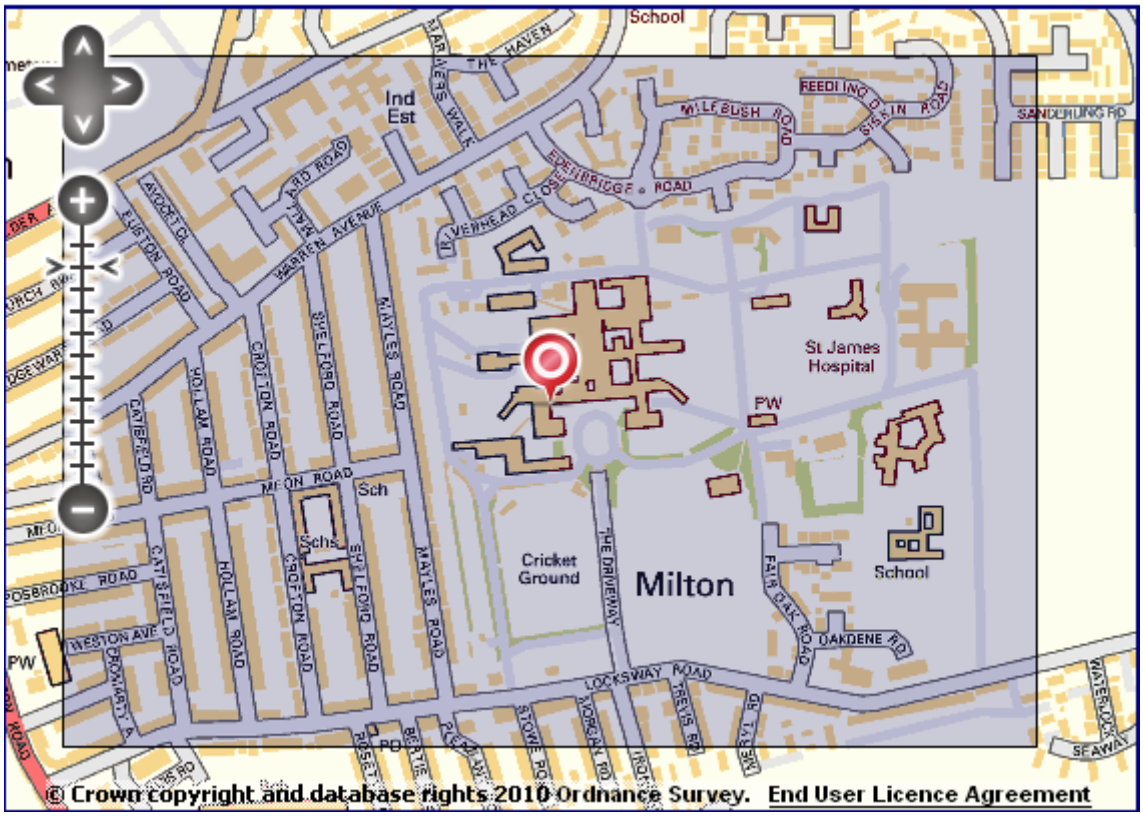


Figure 5.14: St James' Hospital 2013 (Google Maps 2013)

Sustainable Development

There are a number of issues with regards to sustainable development and the St James' Hospital site, mostly with regards to the future of the site. The Keep Milton Green group, comprised chiefly of local residents and councillors, has been campaigning in order to prevent the development of housing on the St James' Hospital site. The campaign raises a number of issues with regards to sustainable development, not least the protection of the green space in the Milton area, the inappropriateness of the 'brownfield' status which the land has been allocated and infrastructure issues in the area. With regards the infrastructure issues, one respondent stated the following about the Local Development Plan:

"*The site allocations plan feeds into the Local Development Plan, and the site allocations plan is, it does what it says on the tin, it looks at the site which are likely to become available in the next 10 to 15 years and say this should be for 'blah'. So for example 2 of the smaller sites on the St James' site are currently in the site locations plan for housing, but because of this development and the NHS saying 'we're going to move out entirely' that is being reopened for consultation which you've already mentioned, and that will run over the summer. And then it will be re-adopted by the council cabinet in the autumn theoretically. But infrastructure is going to be the biggest question on everyone's mind, without a doubt*" (D1)

With regards to the brownfield designation, in addition to the discussions around 'brownfield' and 'greyfield' sites earlier in the chapter, there is the following quote with regards to the St James' Hospital site, which outlines the issues of categorising the site as 'brownfield' considering the amount of green space: "*the problem comes in defining what brownfield actually is. For instance, the St James' Hospital site is deemed brownfield simply because it has been used as a hospital. However, anyone who has ever been there knows what a travesty this designation is. A precious green space, full of beautiful trees and a haven for wildlife (including rare species) can never be 'brownfield'*" (Simmons, 2015).

One major part of the way in which the St James' Hospital site is currently developing is the opposition to development on the site which is largely organised by The Keep Milton Green Campaign. The campaign began on the 17th September 2014 with the setting up of a Facebook group (and shortly after a Twitter page) under the same name by Kimberly Barrett. The Facebook group description was (and is) as follows:

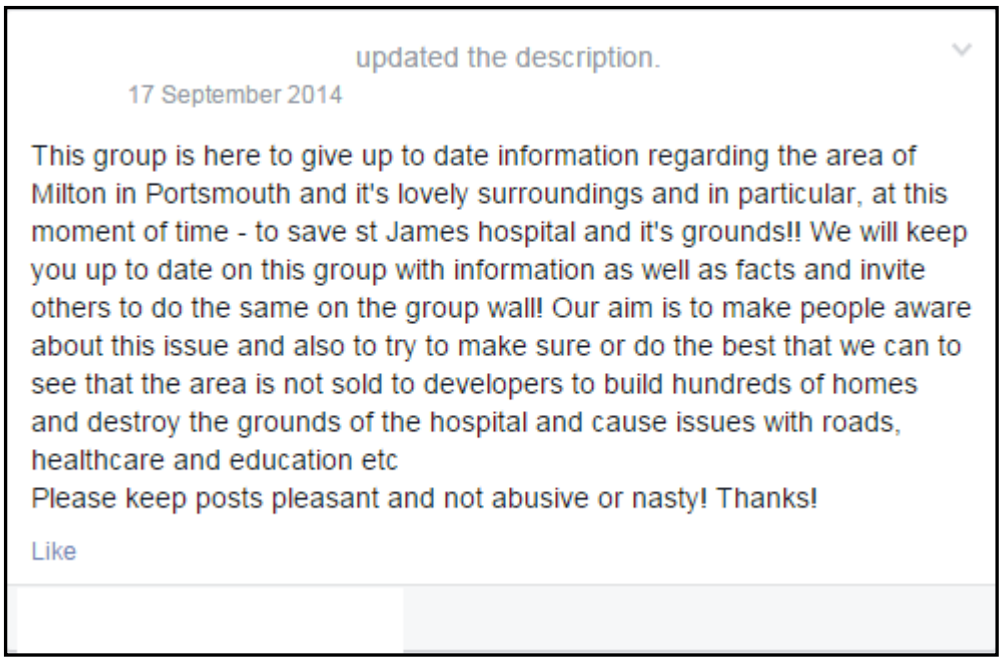


Figure 5.15: Keep Milton Green Facebook post- 17th September 2014

This group, as shown in the description above, aims to prevent the proposed development on the St James' Hospital site; with the idea of protecting the hospital's grounds and prevent strain on the local area's infrastructure. From reading through the page it is apparent that it is not just residents who are opposed to the development, with a number of local councillors frequenting the page as well as reported opinions of members of staff.

Keep Milton Green therefore is an example of 'community activism', "*public action designed to raise awareness around an issue usually related to matters of social, political or economic importance*" (Collins, 2013). In this instance, this relates to the proposed

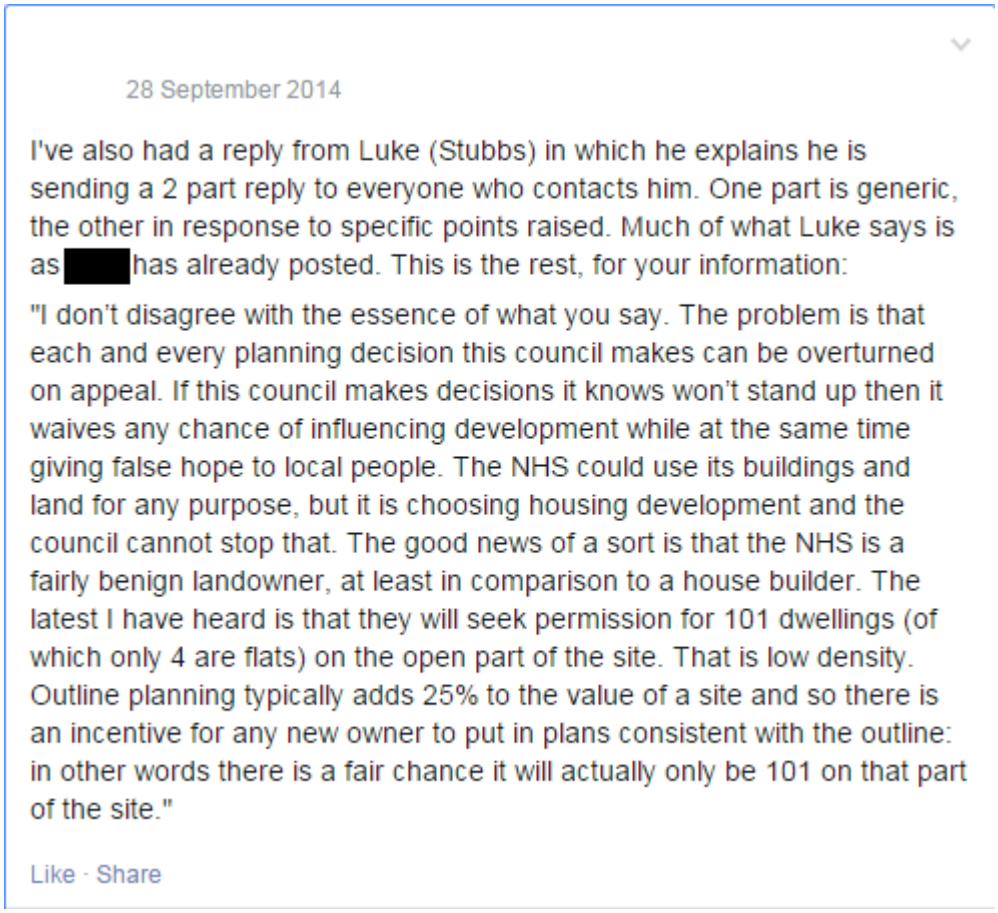
development of the green spaces on the St James' Hospital site and the local opposition to said development. It has been argued that it is the "*affective and social bonds between people and place… [which] frequently motivate[s] community opposition to development projects*" (Collins and Kearns, 2010: 438). In this way it has been noted by Devine-Wright that "*proposals for change frequently disrupt or threaten existing attachments to place, as well as the sense of self associated with the physical and social attributes of familiar environments*" (as cited in Collins and Kearns, 2010: 438). One issue is the attachment of the label of 'NIMBYism' (Not In My Back Yard) to all community opposition to local development, a term which implies blanket opposition to development in their communities (Cowan, 2003; Devine-Wright, 2009). As discussed above, this overlooks the ideas of spatial attachment and the contribution of place and space to local identity. This section will therefore outline the ways in which the Keep Milton Green campaign has attempted to preserve the St James' Hospital site and prevent large parts of the site being lost to proposed housing development. This section covers the time between August 2014, when the group developed an online presence, and February 2015.

On the 15th August 2014 an article in The News outlined the issues of traffic and congestion that would result from the building of 435 new homes on the St James' Hospital site. As the article states: "*if the scheme goes ahead, people fear it will pile more strain on the road network and cause problems for an already-struggling sewer system*" (The News, 2014c).

On the 5th September The News reported that a 'packed public meeting' reacted with hostility to proposed developments on the St James' Hospital site and the University of Portsmouth Langstone campus. Those in opposition to the plans included residents and councillors (including the head of the City Council). The key arguments against were centred around traffic issues and the lack of school places, as well as an opposition to the City's housing targets (The News, 2014d).

On the 28th September a post on the Keep Milton Green Facebook page contains correspondence received from Councillor Luke Stubbs. This outlines the issues with

the opposition to the development on the St James' site, and highlights the NHS as a 'fairly benign' land owner (see Figure 5.16 below). He explains that the NHS is a "*fairly benign land owner*" (Simmons, 2014), and therefore the development is likely to be smaller and less dense than it otherwise would be.



28 September 2014

I've also had a reply from Luke (Stubbs) in which he explains he is sending a 2 part reply to everyone who contacts him. One part is generic, the other in response to specific points raised. Much of what Luke says is as [redacted] has already posted. This is the rest, for your information:

"I don't disagree with the essence of what you say. The problem is that each and every planning decision this council makes can be overturned on appeal. If this council makes decisions it knows won't stand up then it waives any chance of influencing development while at the same time giving false hope to local people. The NHS could use its buildings and land for any purpose, but it is choosing housing development and the council cannot stop that. The good news of a sort is that the NHS is a fairly benign landowner, at least in comparison to a house builder. The latest I have heard is that they will seek permission for 101 dwellings (of which only 4 are flats) on the open part of the site. That is low density. Outline planning typically adds 25% to the value of a site and so there is an incentive for any new owner to put in plans consistent with the outline: in other words there is a fair chance it will actually only be 101 on that part of the site."

Like · Share

Figure 5.16: Keep Milton Green Facebook page – 28th September 2014

Subsequent to this, a post on the page from Councillor Darren Sanders stating that he and 4 other councillors had sent in a response to the consultation regarding the development:

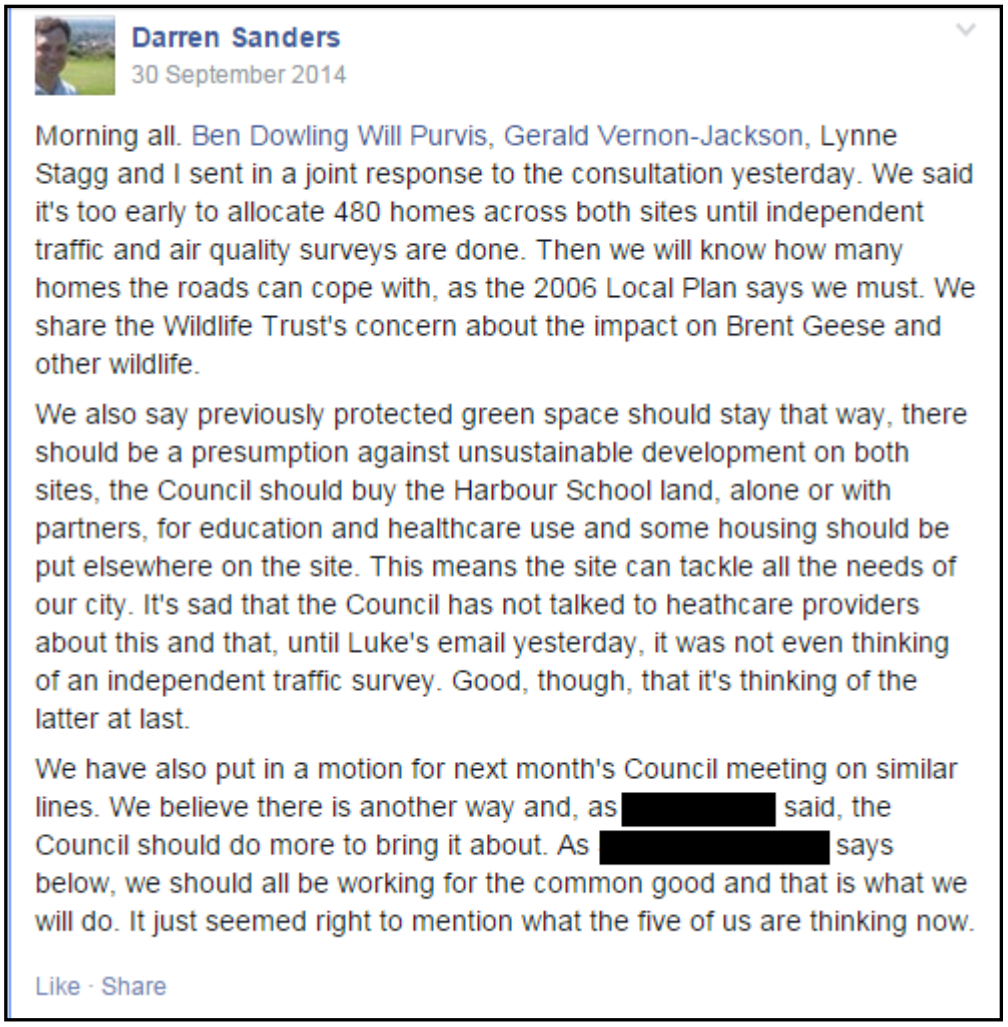
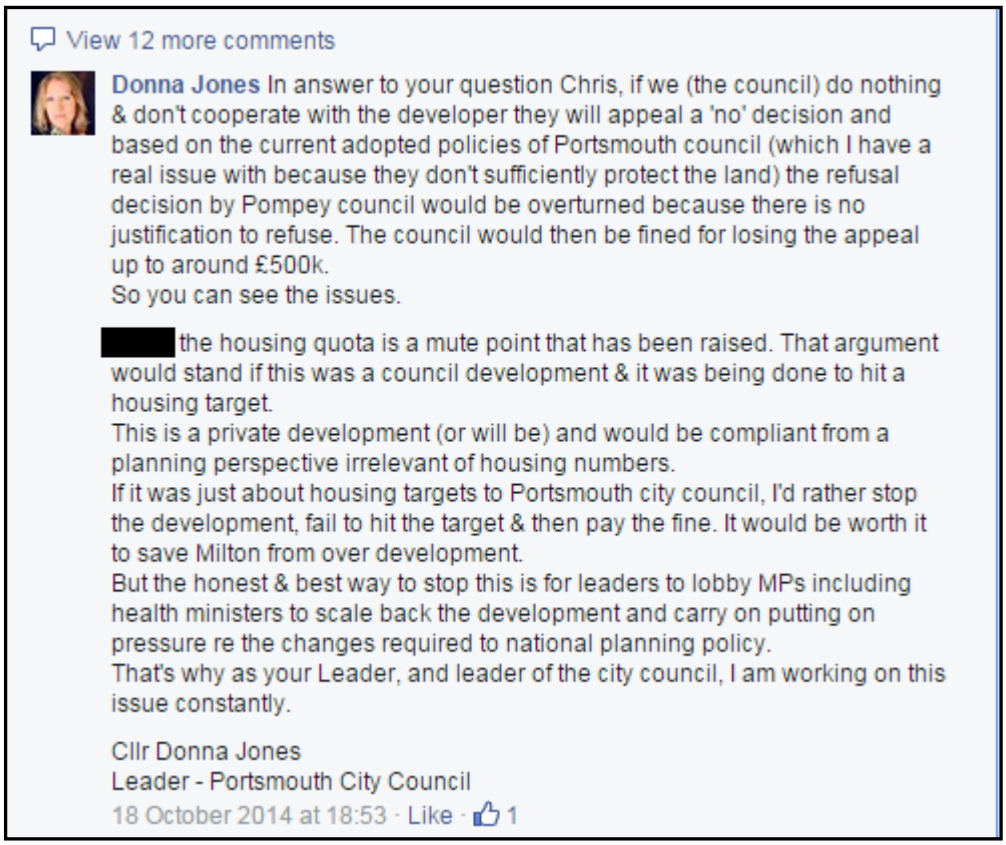


Figure 5.17: Keep Milton Green Facebook page – 30th September 2014

On the 9th October The News published an article which stated that MPs are moving to attempt to stop the loss of countryside and villages to housebuilding. George Hollingway MP stated: "*we have a housing crisis in the South of England and we must meet housing need but such development should not adversely affect the community in other ways i.e. they must be sustainable*" (The News, 2014e). The campaign against the development on the St James' site continued after it was announced that Portsmouth City Council planned to look into whether the green space on site could be saved. A quote from Kimberly Barrett of the Keep Milton Campaign stated: "*it makes us think the council is listening to the residents in the area. It's so important the site is protected, not just currently, but for future generations*" (The News, 2014f). In a comment on a post on the Keep

Milton Green Facebook page, the leader of Portsmouth City Council Donna Jones states the following: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Donna Jones In answer to your question Chris, if we (the council) do nothing & don't cooperate with the developer they will appeal a 'no' decision and based on the current adopted policies of Portsmouth council (which I have a real issue with because they don't sufficiently protect the land) the refusal decision by Pompey council would be overturned because there is no justification to refuse. The council would then be fined for losing the appeal up to around £500k.
So you can see the issues.

[redacted] the housing quota is a mute point that has been raised. That argument would stand if this was a council development & it was being done to hit a housing target.
This is a private development (or will be) and would be compliant from a planning perspective irrelevant of housing numbers.
If it was just about housing targets to Portsmouth city council, I'd rather stop the development, fail to hit the target & then pay the fine. It would be worth it to save Milton from over development.
But the honest & best way to stop this is for leaders to lobby MPs including health ministers to scale back the development and carry on putting on pressure re the changes required to national planning policy.
That's why as your Leader, and leader of the city council, I am working on this issue constantly.

Cllr Donna Jones
Leader - Portsmouth City Council
18 October 2014 at 18:53 · Like · 1

Figure 5.18: Keep Milton Green Facebook page – 18th October 2014

This highlights the issues which the council face in their opposition to the development, and the limitations affect that opposition. The key issue mentioned is the possibility of a £500k fine for an unsubstantiated refusal of permission for the development as a result of an appeal. Soon after this, the campaign was boosted by the news that the planning application from NHS Property Services would require a study into the effect of extra residents on the coastline, as a part of EU environmental rules. In addition to this the article states that nearly 1000 people have signed the online petition against the development of the St James' Hospital site, and Councillor Ben Dowling was quoted as stating that "*it provides more time for us to get more residents involved and for more people to have their say*" (O'Leary, 2014a).

On the 3rd of November it was reported that the campaign had gained the support of Care and Support Minister Norman Lamb. Milton Councillor Gerald Vernon-Jackson states in the article: "*this is a flawed decision. Mental health services are better provided in a quiet, calm and green environment like St James'*" (O'Leary, 2014b). The article also mentions the council training local residents to perform traffic surveys on the site, in order to check that the survey carried out by NHS Property Services was accurate (O'Leary, 2014b).

On the 10th November an article stated that a Portsmouth City Council report was recommending more research be done into the development on the St James' Hospital site. Councillor Luke Stubbs states within the article that: "*the key to this site is the level of infrastructure provision, and the report recommends that we do more research into this, and give council officers and residents the opportunity to come up with evidence on the scale of development that could reasonably be accommodated"* (AboutMyArea, 2014).

Following this, concerns were raised regarding the effects of the new development on the wildlife on the site. The site is known for the presence of grey squirrels, foxes and bats; but a response from the director of the Ecology Co-op stated that: "*foxes and grey squirrels are unprotected… bats are protected and after doing an assessment, Crayfern will leave the trees in the area to help the bats*" (The News, 2014g). Concerns continued to be raised over the development, and the Milton Neighbourhood Forum stated: ".t*he residents of Milton remain unconvinced... These are valuable local assets which have an essential function in the locality by offering feeding grounds to protected species, helping to maintain a wildlife corridor and offering healthy recreation to many local people who reside in cramped streets in other parts of the city*" (Barber, 2014).

In the new year it was reported that the Keep Milton Green campaigners were putting together a 'neighbourhood plan' with the aim of stipulating where new housing should be built and protecting plots of land from development which does not benefit the local community. The aim would be, according to Milton Resident David Jordan,

to: "*take a holistic view of the Milton Neighbourhood Forum area and it would provide protection against piecemeal applications and against application for the main hospital site and the university site*" (O'Leary, 2015a).

However on the 6th January Councillor Luke Stubbs stated that the neighbourhood plan was just giving residents false hope: "*neighbourhood plans don't mean much in urban areas because national planning policy already allows housing to be built on almost any brown field site anywhere in England*" (O'Leary, 2015b). In the same article Milton councillor Gerald Vernon-Jackson states that although the neighbourhood plan is useful, the traffic surveys carried out by the group would be more useful in stopping further development (O'Leary, 2015b). Despite this, Portsmouth North MP Penny Mordaunt declared her support for the neighbourhood plan, but urged the campaign to go a step further by producing a 'masterplan' for the area. She stated that: "*these sites are a rare and precious green lung in the city and their development, as one, would be an opportunity to retain green space and enhance its possibility for community use rather than simply provide more houses*" (The News, 2015a).

In February 2015 Portsmouth City Council voted to investigate the option of the buying of the St James' Hospital site from the NHS. The cost of purchasing the whole site would reportedly be approximately £8.25 million; and this option was chosen above that of purchasing just the Harbour School section of the site for approximately £3.25 million (O'Leary, 2015c). This was highlighted the day before by leader of the council Donna Jones via the Keep Milton Green Facebook group (see Figure 5.19 below, post partially visible).

On the 4th of February Mike Hancock MP asked the Secretary of State for Health "*if he will assess the potential merits of signing a covenant with Portsmouth City Council to prevent the land at the St James' Hospital site being developed*" (St James' Hospital: Written Question – 223416, 2015). The response on the 11th February stated that the matter was one for the NHS Property Services, who had advised that there is no operational rationale behind a covenant for the restriction of the development or future use of the

surplus land and buildings at the St James' Hospital site (St James' Hospital: Written Question – 223416, 2015). Shortly after this, The News reported that Councillor Gerald Vernon-Jackson had asked health minister Norman Lamb to consider areas which may help: the first being that he should agree to Portsmouth City Council buying the land at St James' Hospital itself, with a view to this being concluded before the end of the financial year; and the second that the NHS should be told not to divide the open spaces on the site using fencing, which blocks access for local residents who use the site (The News, 2015b). It was later reported on the 20th February that at a forum meeting regarding the St James' Hospital site, Councillor Gerald Vernon-Jackson voiced fears that the council had run out of time to purchase the site from the NHS, who were due to dispose of the site by March 31st 2015 (Moore, 2015).

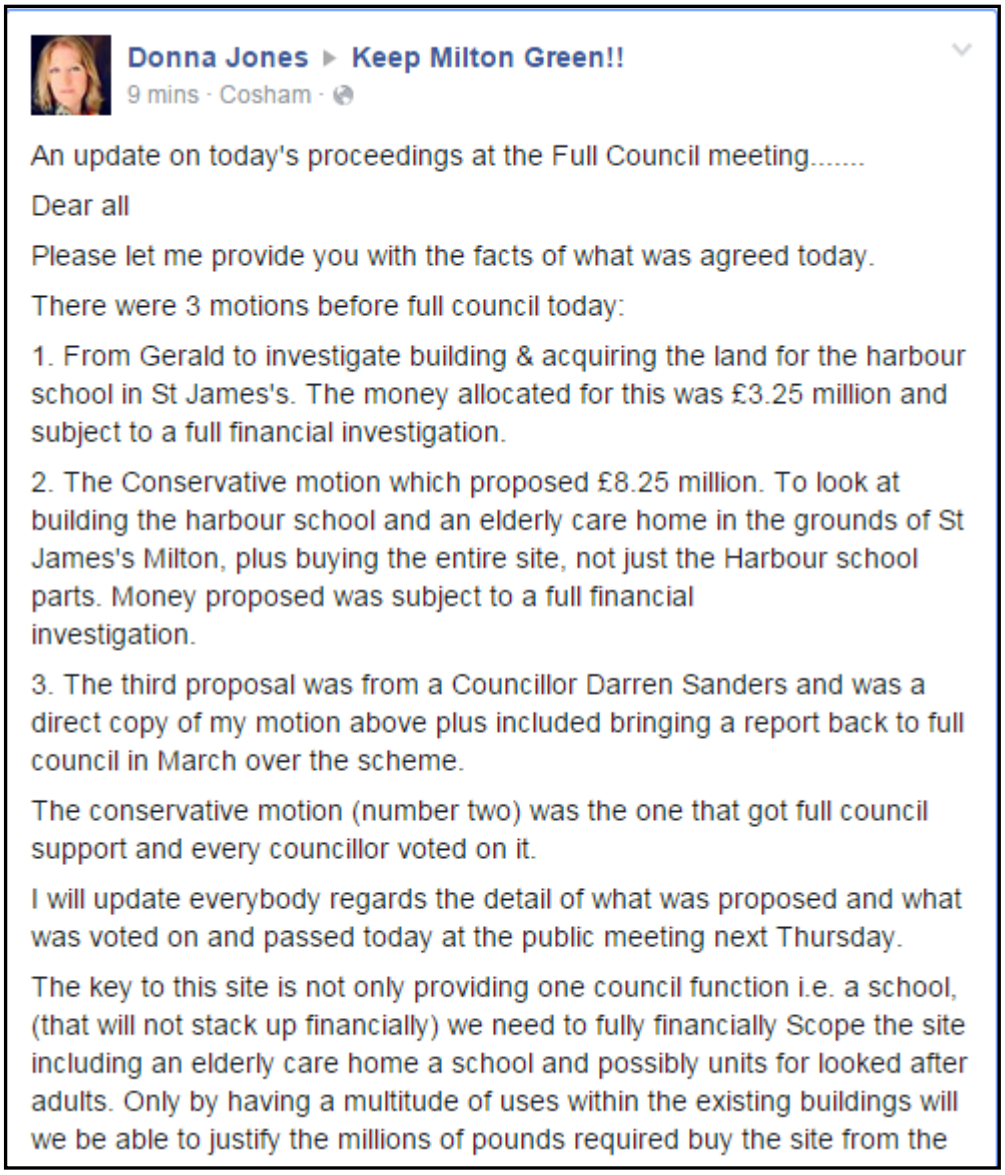

Figure 5.19: Keep Milton Green Facebook page – 10th February 2015

At this stage it is uncertain what the outcome will be with regards to the development on the St James' Hospital site. What we have seen is the attachment of the local community, via the Keep Milton Green campaign, to the hospital grounds in Milton.

Discussion

In this chapter the themes of mental health care policy and planning policy, the latter including urbanisation and sustainable development, have been discussed in relation to their effects on the retention of each of the four former psychiatric asylum sites that are the focus of this thesis. As we have seen previously NHS Estates Policy has a mixed approach when it comes to former psychiatric asylum sites, with a document from 2001 stating both that *"some redundant estate, such as former psychiatric institutions, may be on very valuable building land. However, the sustainability benefits of re-using such sites may be nullified by their remote location"* (NHS Estates, 2001: 27) and that "*great benefit can also be achieved from renovation of existing buildings (avoiding the need for expensive and resource-intensive new construction), and the renovation and modernisation of an existing building should always be the first consideration"* (NHS Estates, 2001: 29). Which of these approaches is utilised is a result of a number of factors that have been explored throughout this chapter, and although every site has a different combination of factors there are a fair number which span multiple sites. The major factors include those relating to finance, Local Development Plans, geographies and land sales, the age of buildings on the sites, the continued need for services, urbanisation and sustainable development.

Finances are a key factor in the retention of former psychiatric asylum sites. Each of the sites has at least one if not more financial factors directly affecting the retention of the former psychiatric asylum. At the time of writing the NHS is under pressure financially as a result of budget cuts which are occurring as a result of a freeze in the NHS budget and rising costs of medical supplies and pharmaceuticals. In fact, treasury figures showed that, once inflation had been taken into account there had been a fall in NHS spending between 2009 and 2012 (Merrick. 2012). As a result each of the trusts feels under pressure to save money in any way they can in order to not go over their budgets. This applies an external pressure on the NHS trusts to save money where possible. Literature on PFIs (Pollock et al., 2002; Hellowell and Pollock, 2009) has put forward the idea that these buildings act negatively on NHS trusts, through the

creation of an affordability gap and a displacement of financial burden from central government to NHS trusts themselves.

Finances have been shown to be major factors especially at St James' Hospital, where the buildings running costs alone amount to £2 million per year for Solent NHS Trust. This is an example of where financial pressures are acting to push the site towards closure and being sold off; although it must be added that St Nicholas' has similar problems with the Jubilee Theatre making a loss on the year, however it is unlikely that this is to the same extent. Kingsway Hospital and Cefn Coed Hospital do not have the same issues with regards to running costs due to the lack of buildings under heritage protection. However, financial factors may also restrict the options of trusts and put pressure on them to remain on their existing site. This is especially true in the case of Kingsway Hospital, where the new PFI building on the site has received heavy investment which ties the trust to the site for the next 30 years, and a move away would as a result be financially unviable. Evidence collected correlates to the views put forward by Pollock et al. (2002) and Hellowell and Pollock (2009) that PFIs have put more of a financial burden on individual NHS trusts. In contrast to Kingsway, Cefn Coed Hospital looks set to close, partially as a result of a lack of investment in the current site. As it stands at Cefn Coed the only part of the site which will be retained is the new Ysbryd y Coed building for older people and dementia care. In this vein St Nicholas' Hospital looks to be retained and has received investment to modernise its older facilities; and St James' looks to close with no notable investment being made in the site's infrastructure.

The Local Development Plans in place across England and Wales create a pressure for developable brownfield land for new housing. This pressure may create a high demand for developable land in areas which struggle to meet their targets. This is especially an issue in both Swansea and Derby, where the local authorities are failing to meet the targets set out by their areas Local Development Plan. These Local Development Plans outline for each local authority housing and developmental targets to be met within a certain timeframe and aim to promote sustainability, equality and to

"*provide a revised framework to inform planning decisions and guide development*" (City and County of Swansea Council, 2012: 3). These targets put pressure on local authorities to provide a certain number of houses in their local area, and a certain percentage of those which have to be built on brownfield (previously developed) land. These targets are as a result of a push for more sustainable development, which began with the introduction of the 'brownfield first' policy, whereby sites which were allocated as being 'brownfield' were prioritised for redevelopment (though even at the time of conception it was felt that realistically only 60% of developments could be built on brownfield land) (Greenberg, 2002; Capner, 2003).

"*There was recognition at the highest levels of government that as much as possible demands for urban growth should be met from previously used ('brown field') sites*" (Joseph et al., 2013: 5). As stated, Brownfield sites are defined as abandoned sites which have been contaminated (Greenberg, 2002: 703), and former psychiatric asylum sites, for the purpose of this study, have been defined as brownfield sites through the inclusion of 'social contamination' in the form of stigma. These sites have been described as "*monumental monasteries of the mad*" (Deutsch as cited in Bristow, 2009); and as Joseph et al. state the former asylums are "*zones of ambiguity stigmatised by the shadow of their former use*" (2012: 2).

Sustainable development policies are promoted through Local Development Plans (LDPs). The aim of these LDPs is to 'promote sustainability and equality' (City and County of Swansea Council, 2012b). The effect that sustainable development may have upon the retention of former psychiatric asylum sites within the NHS is less direct that other factors, and likely only comes into play after other factors have already played their part. In these cases prime sites, such as former psychiatric asylum sites, may be seen as ideal sites for housing developments. As stated previously this is not a direct factor contributing to closure of these sites; however it may be a factor which enables a closure due to the creation of demand for developable land and the financial opportunities which this could create. The focus on brownfield sites identified in the relevant literature has been seen in this research to exert pressure on the former

psychiatric asylum sites. The pressures of sustainable development are most notable in the two locations where the sites are currently set to close: Cefn Coed Hospital and St James' Hospital. In both of these areas there is limited land available for development, largely due to the local geography: Swansea and Portsmouth both have other population centres relatively close by, as well as physical geographical issues concerning surrounding coastlines and large hills in the area; both of these factors limit the expansion of the cities respective urban footprints. This puts additional pressures on local authorities who then have a much smaller number of sites which can be designated for and converted into housing to meet their targets. Portsmouth in particular has missed their housing targets a number of times in recent years, as has Derby- which may explain the current sale of part of the current site for housing to be built in the near future. St Nicholas' Hospital has previously sold much of the original grounds for housing and what remains is currently at little risk of closure. The sale on land on these sites, as well as the closure and subsequent redevelopment of a large proportion of the UK's former psychiatric asylum sites, does indeed show the focus in policy towards more sustainable development through the re-use of brownfield sites. The only issue that is found is the use of the 'brownfield' label with regards to former psychiatric asylum sites, as large proportions of these sites tend to be green spaces.

As stated previously these asylums were originally distant "monumental monasteries of the mad" (Deutsch as cited in Bristow, 2009); the 'asylum on the hill' which was a place to be feared. As Gefen has stated the traditional asylums were set apart and given an almost mythic status (2000). The concept of familiarity and acceptance are described by Gefen as complexity reduction methods; which act to reduce uncertainty through the establishment of a structure and by providing reliable expectations. (2000In this way the urbanisation of the former psychiatric asylum has acted to break down the sites' 'otherness' (Žižek, 2009); and are therefore assimilated (anthropophagically) into society. In this way in can be theorised that the increased urban location of former psychiatric asylums, and therefore through increased exposure, have become trusted institutions in the public sphere.

Urbanisation has led to these former psychiatric asylum sites becoming, in varying degrees, more urbanised; this is evident in the maps of the sites. St Nicholas' and St James' Hospitals have both been largely integrated into their local communities; however although both Cefn Coed and Kingsway Hospitals have been urbanised to an extent, they still retain an amount of separation from the communities around them. This was found and is evidenced by comparison of both historical and current maps of each of the sites as shown throughout the chapter above.

This thesis supports the correlation between urbanisation and community acceptance. The effect that urbanisation is theorised to have had is a move from view of the isolated asylum as distant and stigmatised, to one where they are more accepted by their local communities. In this way it would seem Each of the four former psychiatric asylums at some point in its history has sold off sections of their sites which have then gone on to be converted into housing. The physical evidence of this can be seen clearly in the form of urbanisation (see above). These land sales were made possible by the development of psychotropic drugs, and were hastened in recent times by the widespread move to a strategy of care in the community. The NHS land sales at each of the case study sites have had the effects of: reducing the size of each of the sites; urbanising and semi-urbanising them; and providing the trusts with lower costs and excess funds.

The increased urban location of each of the sites itself, as evidenced through the comparison of historical and present-day maps of the sites, may have played an important part in their retention, as they were no longer semi-mythic places out of the public eye, they became more visible as communities sprung up in the local areas. This is most notable in the case of St James' Hospital, where the local community and Solent Trust have a good relationship and the site is used daily by members of the local community. There are similar situations at both Kingsway Hospital and St Nicholas' Hospital. However in stark contrast to the other three sites, Cefn Coed remains partially isolated.

The rationale behind community care was based on the concepts of integration and 'normalcy'; and Dear and Taylor (1982) theorised a rejection of mental health facilities and hostility towards them- resulting in the undermining of any therapeutic benefits (1982). However this thesis found mixed levels of stigma at the sites, with some sites not showing significant signs of stigma from the community. The urbanisation of the asylum has, rather than moving patients into the community, moved the community around the patients, and as a result such hostility is not apparent at any of the sites. This may be due to the fact that community care acts to move facilities into established communities, which contrasts directly to communities forming around the asylums; and therefore it is theorised that NIMBYism does not have the same effect.

Parking and traffic are major issues at both St Nicholas' and St James' Hospitals. At St Nicholas' it was stated that every space both legal and illegal has a car occupying it; and that measures had been taken by the trust in an attempt to rectify the situation (One Core Strategy NG, n.d.). At first glance it would seem that the issue is caused by inadequate parking provisions on the site; but the trust are restricted in their ability to provide more by the conservation area which the site resides in. At St James' Hospital the issues were more focused around traffic, whereby the potential levels of traffic which would be caused by future development may curb said development much in the way that Tree Preservation Orders have. This is to the extent that Portsmouth City Council stated that proposals for the re-use of the St James' Hospital building would only be considered if *"the surrounding highway network can satisfactorily accommodate the additional traffic generation"* (2004: 4); and the Keep Milton Green Campaign has organised its own traffic surveys in an attempt to prevent overdevelopment on the St James' site (O'Leary, 2014b).

Lawson and Phiri in their NHS Estates report stated the following: "*we ask here whether the architectural environment of the hospital can contribute to the treatment of patients and significantly influence their health outcomes. This study clearly indicates the answer is 'yes'*" (2003: 2). The report concluded that "*patients appear to make significantly better progress in the new purpose-designed buildings than in their older counterparts*" (2003: 3). The age of

some of the buildings at each site has also been a factor which is often alluded to in discussions over whether they are 'fit for purpose'. At both Kingsway and St James' the age of the buildings were directly mentioned as a factor when it came to the state of retention. At Kingsway the replacement of some of the older buildings with new builds was cited as a possible reason for retention of the site for mental health care purposes; whereas at both St James' Hospital and Cefn Coed Hospital the age of the main building was cited as a reason for not continuing to use the buildings and the site for residential mental health care. This would indicate that Lawson and Phiri were correct in their finding that new build facilities are preferable to older, refurbished facilities- such as former psychiatric asylum buildings.

Conclusion

What we have seen in this chapter are the multitude of factors relating to mental health care policy and planning policy which have had an effect on the retention of each of the case study sites. This has ranged from financial factors such as maintenance costs and the lack of resources; to external factors such as urbanisation and sustainable development pressures. These factors combined, despite their multitudes of effects upon the states of retention at each of the case studies examined in this thesis, are but one perspective. The next chapter will go on to examine the effects of stigma and social factors relating to the retention of the four former psychiatric asylum sites.

Chapter 6: Stigma, Memory, Community and the Surviving Asylum

Introduction

"*How can a place which was created to be excluded from society become integrated back into the community, particularly after being identified for nearly two centuries as a space for the 'other', the misfit from normal society. Surely the question of stigma has a bearing?*" [sic] (Cornish, 1997: 105).

In this chapter the focus will be on stigma at each of the four case study sites. The basis for the definition of stigma utilised is taken from Goffman: *"the central feature of a stigmatized individual's situation in life is acceptance and the lack of it. It is often put into words as the 'failure to accord him respect'. Here we can see the clash between a virtual identity based on stereotypes and imputed attributes and the actual identity. Where there is a negative 'gap' Stigma exists"* (as cited in De Paoli, 2004: 6). The gap between the view of the asylum as a looming dark custodial nightmare and the actual identity of the remaining sites as places of health care provision is in this instance the gap where stigma exists.

The following themes are discussed in relation to each of the case study sites: stigma; language; and public access. The internal logic behind this is that the first section on 'stigma' will examine the perceived stigma attached to the site using the thesis' qualitative interviews as evidence. This section will focus upon aspects of stigma in relation to each of the case study sites, with a focus on interview responses. The second section will then analyse the site's existence in local vernacular, using a small scale content analysis of twitter to provide evidence of the stigma previously perceived in interviews. This section discusses language and twitter - discussing the ways in which the names of each psychiatric asylum have been used in the local vernacular. This includes an analysis of tweets in relation to each of the case study sites- with a search

for popular names for the hospital with an added geolocational search restriction limiting responses to the city in which the hospital resides. The third section regarding public access and community familiarity will aim to determine the levels of access at each of the case study sites and attempt to correlate this with the perceived levels of stigma and the evidenced stigma reported by participants and found through twitter searches at each of the hospital sites. This section will therefore focus upon the ways in which the local community make use of each of the case study sites, including both formal and informal usage and the correlation with this and stigma.

Stigma

Goffman's definition of stigma as a clash between virtual and actual identity can be related to psychiatric asylum sites as traditionally they have been stereotyped as dark, looming, entrapping etc. and generally not accepted within local communities. The gap between this view and the actual identity of the retained sites, as places of health care and 'healing', is the negative gap where stigma exists. As previously stated: *"the stigma associated with the psychiatric asylum—the almost universal characterisation of it as an inhumane and outdated treatment modality—was accentuated in debates that occurred during the years immediately prior to closure and has remained salient in debates over reuse"* (Joseph et al., 2012: 5). One example of stigmatised sites would be Sunnyside Hospital in New Zealand. The stigmatised past of Sunnyside was invoked on numerous occasions during debates about closure, with reference made to the change in use and also a deliberate change in name, as an attempt was made to distinguish the old from the new. The contrast between the previous use and the new use was frequently referred to, often in a binary notion of old/new, bad/good, dark/light that was common in the discourse surrounding deinstitutionalisation. The online advertising for the new development on the site, Linden Grove, did not mention the flanking successor mental institutions or the previous uses of the sites; this is an example of strategic forgetting and selective remembrance (Joseph et al., 2012). This has also been seen in the redevelopment at Graylingwell in Chichester as a housing development, where Linden Homes stated in relation to the proposed renaming of the site: *"we genuinely felt that given the site's former use as a psychiatric hospital, by naming the development Graylingwell it*

may have potentially negative connotations for local residents that might discourage potential purchasers" (Joseph et al., 2012: 12). This is an *"overt recognition of the potentially damaging commercial implications of the long shadow of the stigmatised asylum"* (Joseph et al., 2012: 12-13); and goes to show the long-lasting stigma of asylum sites.

Stigma in this way is linked to the negative image of both the asylum modality and its patients. The care which is associated historically with the asylum is one of overcrowded wards leading to the over-ordering of mechanical treatment methods, maltreatment of patients, and a generally low quality of life. This contrasts greatly with modern mental healthcare, where quality of life is significantly higher and safeguards are in place to prevent such situations from happening. It could be argued that stigma attached to mental health may have declined in part due to this advancement in mental health practice; which may have acted to destigmatise not only the patients but also the spaces.

It may be expected that the stigma of mental illness would have limited the types of re-use activities of asylum sites; however the large and diverse nature of the re-use of asylum sites and buildings shows the development potential of the sites (Dolan as cited in Joseph et al., 2012). This may be aided by the fact that, after a certain amount of time, *"the stigmatising association of the pre-existing use can begin to evaporate and be replaced by acceptance"* (Franklin 2002: 175). This is linked to the concept of 'familiarity and acceptance' discussed in the previous chapter.

Another concept within the bounds of stigma is that of language and stigmatised language. In Victorian times there was little regard for the feelings of mental patients, with terms such as 'idiot boy' in common use (Gange, 1988). However, as early as 1918 it was admitted that the use of the term 'pauper' to refer to the poorer classes under treatment at the hospital was offensive to those patients and their relatives (Gange, 1988). Despite this though there is much evidence which suggests that terms relating to mental health and psychiatric asylums have become commonplace in everyday

language to this day. It is in this way that they have been colloquialised, as shown by the following examples:

"Such phrases as 'going round the bend' originate from the fact that many an asylum, including Menston, could be found at the top of an impressive curved drive, effectively hiding the institution from the prying eye of the general public" (Davis, 2013: 4).

"Even school children in the playground would taunt each other with, 'you're mental! You're off to Menston', relating to High Royds Psychiatric Hospital" (Davis, 2013: 4).

There are a number of terms which have made their way into general usage which, at some point in their etymology, have been used to refer to mental patients or asylums. These terms are used in the modern day, but not necessarily with regards to people with mental health problems. Many of these are used in everyday language and can be heard on a near daily basis across the UK. In many cases they are not being used to refer to a mental patient, a mental disorder or a mental health facility. It has also been argued that terms such as 'autistic', 'OCD', and 'schizophrenic' are being used as a form of hyperbole (Kelly and Winterman, 2011): *"the neighbour who keeps his house tidy has Obsessive Compulsive Disorder (OCD). A socially awkward colleague is autistic. The weather isn't just changeable, it's bipolar. Such analogies are so familiar they surely qualify as clichés"* (Kelly and Winterman, 2011). There is also a widespread use of these terms as metaphors. The IMF in 2011 described the global economy as 'bipolar' while the Observer described Gok Wan's dress sense as 'schizophrenic'. In fact 11% of references to schizophrenia in UK newspapers were metaphorical (Kelly and Winterman, 2011).

History and Memory

This section will discuss 'history' and 'memory' in relation to former psychiatric asylum sites. With regards to these asylum sites and in particular their retention within the NHS in the 21st Century there is a certain amount of manipulation of both history and memory. Previously it has been the predominant theory that memory was "*the result of the impression of real events on the human mind*" (Nascimento and Sepúlveda,

2009). In this way memory is viewed as merely the recollection of history. Halbwachs however felt that memory is weaved through social interaction, and that individual memory cannot be separated from collective memory (1992). Nora stated that "*memory and history, far from being synonymous, appear now to be in fundamental opposition*" (Nora, 1989: 8). In this way there is a distinct contrast between the concept of history and that of memory: while history is universal and dispassionate, memory is meaningful and personal (Nora as cited in Kearns et al., 2010); in other, more simplified, terms- objective and subjective respectively. When discussing history, generally this will be covered by a form of 'collective memory'. Collective memory can be described *"as a shared memory – a tale of past events shared by members of a social group"* (Blokland, 2002: 276). Modern society has been said to have adopted a 'memorial culture' whereby *"memorialisation seems to be a slightly more common response than it once was"* (Foote, 2003: 166) and the process and spectacle of such memorialisation has intensified. This can be seen in the increasing politicisation of memory: *"more and more countries have laws saying you must remember and describe this or that historical event in a certain way, sometimes on pain of criminal prosecution if you give the wrong answer"* (Ash, 2008).

In this way political processes can effectively shape collective memory; making its version of events the norm against which other, individual/popular, forms of memory clash and become deviant/criminal. Examples of this include *"the use of popular music in the 'politicisation of memory' to create the ultra-patriotic, nationalist propaganda of the Mugabe regime*" (Thram, 2007); and also debates over the Armenian Genocide by the Ottoman Empire, whereby you can be prosecuted in different countries for stating different views on the matter (Ash 2008). In this way memory is being politically controlled, to the extent that Pierre Nora chaired the Liberté pour l'histoire movement in France against *"the criminalization of the denial of any legally defined genocide"* (Nora, 2012). This battle for the freedom of history and memory could define how current and future generations view reality. The politicisation of memory is relevant to the asylums as many arguments for their closure perpetuate and reinforce their supposed ineptitude with reference to the asylum scandals of the 1960s and 70s. This can even be seen in arguments relating to deinstitutionalisation today as David Nicholson, the newly

appointed head of the NHS Commissioning Board, recently: *"likened the current plight of elderly patients in hospitals to the 'national scandals' resulting from the treatment of mental health patients in large asylums in the 1960s and 1970s, and committed the NHS to massive expansion of community care"* (Wright, 2013). He also stated: *"I would compare it with where we got to with the big asylums. If you remember what happened in the 1960s and 1970s, there was a whole series of national scandals about care of mentally ill patients… The response was not just to say that the nurses who looked after these patients needed to be more caring but actually there was something about the way we treated these patients and the model of care that needed to change"* (Wright, 2013). The fact that in order to sell current plans for deinstitutionalisation to the public references to the asylum scandals of 40/50 years ago are still being used, is surely indicative of the way in which memory is utilised politically to gain support.

"Memory is invariably nuanced and affect-laden, connecting people whose lives have been shaped by common place-specific experience" (Kearns et al., 2012: 4-5). In addition to his social movement work with regards to history, Pierre Nora was also of the opinion that *"memory is attached to 'sites' that are concrete and physical"* (Hoelscher and Alderman, 2004: 349). In this way, memorialisation can be material presences, in the forms of memorials (of course) or plaques etc., while remembrance takes the form of narratives, often nowadays provided via the internet (though not exclusively) (Kearns et al., 2010). Hoelscher and Alderman state that *"as spaces explicitly designed to impart certain elements of the past—and, by definition, to forget others"* (2004: 350); which Pierre Nora would describe as 'lieux de mémoire' [13]- sites where *"memory crystallizes and secretes itself"* (Nora, 1989: 7). In this way memory is embodied in sites "*where a sense of historical continuity persists*" (Nora, 1989: 7). Joseph et al. stated that: "*the built environment abounds with elements that evoke memories, whether personal or collective*" (2009: 6); and Schama felt that the links between landscape and memory were pervasive (Schama,

[13] Lieux de mémoire – places of memory.

1995). The implication here is that the negative aspects of asylum history and the subsequent stigma attached to the sites will persist as long as the sites themselves stand in a form that intimates its previous use. However it is possible to control social memory, and this control over recollection of the past is used *"as a tool to bolster different aims and agendas"* (Hoelscher and Alderman, 2004: 348). This can be related to the concepts of strategic forgetting (minimisation reference to past uses) and selective remembrance (the ways sites make reference to their former usage).

There are therefore a number of ways in which history and memory can affect the retained status of former psychiatric asylums in the 21st Century. The manipulation of memory and the memorialisation of aspects of asylum history can be used effectively to promote whatever new use the asylum buildings are destined for, from residential properties to transinstitutionalisation into educational facilities etc.

Swansea and Merthyr Tydfil Joint Asylum - Cefn Coed Hospital

Stigma

As will be done for each of the sites the first thing which must be established is the levels of stigma at the Cefn Coed Hospital site. There seems to be a mixed opinion of stigma as a factor with regards to Cefn Coed. A number of respondents are adamant that Cefn Coed is not affected by stigma; one argument which was common being that the site has been there much longer than the housing around it, so those in the local community either grew up with the site or moved to the area knowing the site was already there. This can be explained by the theory of familiarity and acceptance; whereby exposure to the sites over time has created a familiarity which acts to destigmatise the site by the eradication of its 'otherness' (Gefen, 2000; Žižek, 2009).

"I guess it was the site it always was" (A7a)

"I'm neutral. It's the same as any other geographical site in the world really. Stigma is one of the things people talk about but as I say, you can use a building in whichever way you want. It'll probably be very nice flats in the future" (A5)

But in contrast to this there is also the opposing view that the site does in fact suffer from some form of stigmatisation. One respondent felt that there was a form of stigma attached to the older facilities on the Cefn Coed site, as well as the names and the site's history. This may be due to a remaining stigma attached to these older buildings due to an association with the previous asylum model of care, creating what Goffman would call a 'negative gap' where stigma is formed and exists (as cited in De Paoli, 2004).

"And there is a stigma in my opinion to Cefn Coed. And I personally feel it should be closed, got rid of" (A1)

"*And there's the stigma, that's associated with the old buildings*" (A9aN)

"*I think it's everything about it [that is stigmatised]: the site, the buildings, the names, the history*" (A9aN)

There was also the argument that since the hospital has been renovated and has upgraded its facilities, it is less associated with its former manifestation, i.e. Victorian psychiatric asylum. So the renovation of the wards and the addition of new, modern, units on the site had helped to improve its image; controlling the memorialisation of its past through the control of the built environment. As Hoelscher and Alderman stated "*memory is attached to 'sites' that are concrete and physical*" (2004: 349); so the building of new facilities and the renovations of the older facilities may have reduced the levels of stigma attached to the site. Respondents almost all felt that the site had been stigmatised in the past, but that it was not an issue anymore. Stigma was a factor which affected the site in the past and which had been overcome.

"So Cefn Coed's had a stigma about it unfortunately, but I think with its kind of relaunch and its current form, it's recognised as being a place which is far more suitable for people in, and meets modern day demands" (A4)

"I think from in a way from the older generation and certainly I've been working in mental health for a long time and when I started stigma was far more prevalent but, over the years I think that has diminished. And people are generally more relaxed I suppose" (A7b)

As has been stated above the links between landscape and memory are prevalent (Schama, 1995); this means that the modern facilities on the site, and to an extent the renovations of existing wards, may act to distance Cefn Coed from its past usage as a psychiatric asylum, making the site itself more accepted within the local community. This may also have been achieved through a process of strategic forgetting and selective remembrance (Joseph et al., 2012), whereby evidence of aspects of the site's history are consciously removed; such as through the demolition or modification of the original asylum buildings. This manipulation of memory may have acted to diminish the links between these sites and the "*long shadow of the stigmatised asylum*" (Joseph et al., 2013: 12).

Language

Another factor which needs to be mentioned is the use of Cefn Coed in local language. This was alluded to in interviews, and backed up by a social media analysis of twitter. The twitter search included a search of the hashtag '#cefncoed' and the terms 'Cefn Coed' and 'the Coed'. As stated previously an additional geolocational factor was also added which limited tweets found to those published in the Swansea area.

Figure 6.1: Cefn Coed Tweet

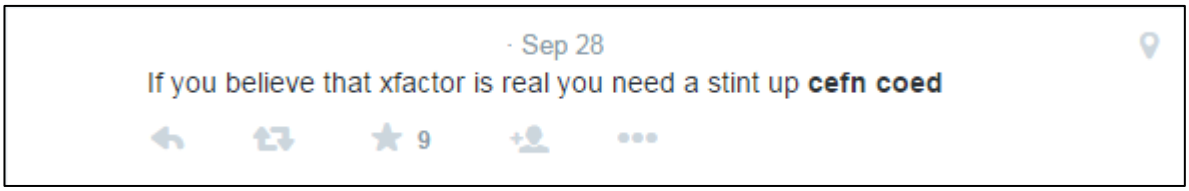

Figure 6.2: Cefn Coed Tweet

Figure 6.3: Cefn Coed Tweet

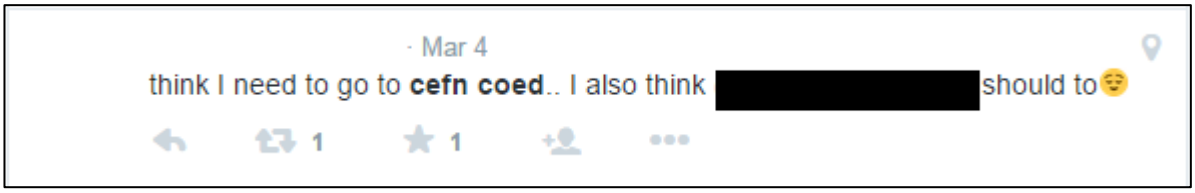

Figure 6.4: Cefn Coed Tweet

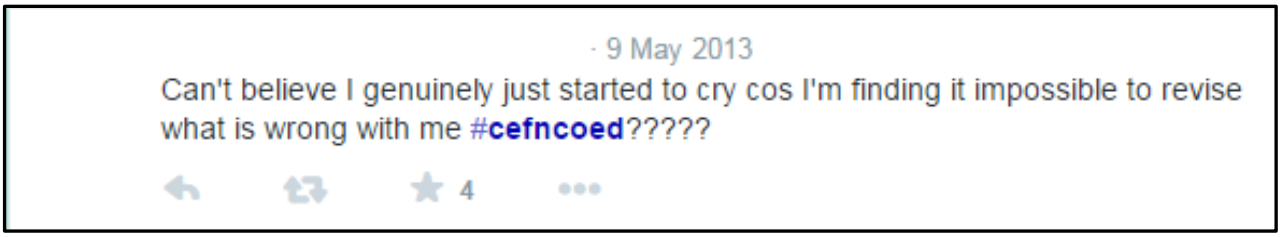

Figure 6.5: Cefn Coed Tweet

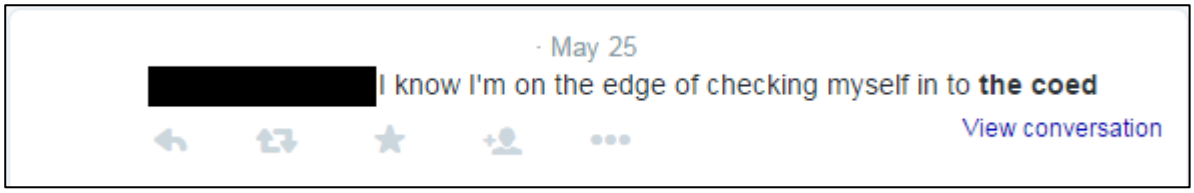

Figure 6.6: Cefn Coed Tweet

These are examples of a fairly commonplace trend in which Cefn Coed appears to have become common in colloquial language as a negative term stigmatising mental illnesses (Steele, 2012), in what Rose et al. would categorise as a 'popular derogatory term' (2007). These examples, which use Cefn Coed as a form of hyperbole, show the way in which the name of the hospital itself has become part of local vernacular. This is as a form of hyperbole, in that "*analogies are so familiar they surely qualify as clichés*" (Kelly and Winterman, 2011). This indirect, language based, stigma is both the hardest to combat and the most likely to perpetuate stigma within the local communities.

*"The stigma of '*sigh* look at poor old Johnny, he's in the nuthouse' or 'he's in Cefn Coed' and you know we've all, people who live in Swansea we have heard that over the years, and, there is a stigma to it and it's an embarrassment for the patient, an embarrassment for the family when they go visiting. Now it shouldn't be a stigma but nevertheless, it is"* (A1)

The use of Cefn Coed in the language of the local population is also shown in the quote below, which shows the common abbreviation of the hospital's name and the attitude of stigma which is often associated with it.

"*Oh definitely. I mean, it's called the Coed by in local population, and you know everyone knows the Coed's on the top of the hill and it's for people who have got mental health problems. Yea*" (A9aN)

However seeing as there appears to be little stigma surrounding the Cefn Coed site in the present, it may be that it is either a minority of people who refer to the site in this way. It may also be that the term 'Cefn Coed' when used in this way is no longer connected with the site, in the same way that when people say 'mental' or 'crazy' they no longer necessarily cognitively relate it to its original meaning. They have been colloquialised. As previously stated, it may be that after a certain amount of time, *"the stigmatising association of the pre-existing use can begin to evaporate and be replaced by acceptance"* (Franklin 2002: 175).

Public Access

Public access to the site appears to be mixed, with stark contrasts between informal and formal usage of the Cefn Coed site and grounds. In terms of informal use, various individuals spoke of the site's usage by dog walkers, which appears to be a fairly common happenstance.

"In general you do see locals walking through there" (A3)

"I've just come from Cefn Coed and yes you do see people walking their dogs" (A7b)

"*I suspect that some local residents may use the open spaces to walk their dogs. That's often something that happens with these sites but, there's no formal use being made of any of the facilities that we have here by the general public*" (A9aN)

Figure 6.7: Cefn Coed Tweet

With regards to formal use there are examples of organised events which take place on site, namely the annual fête. One example of former formal usage was via the rental of the lodge; however the usage by the community has been dismissed as coincidental (A3). Plus, as previously noted, this lodge was subject to attacks of vandalism and arson and was eventually demolished anyway, thereby removing the source of community access.

"There was a small hall here which was used by the community but it had fallen into disrepair, but it was purely coincidental that it was no longer used by the hospital so it was available for other people to use but in other ways" (A3)

"*So we've got the William Owen Hall, which is used by some local community groups such as the fencing club, and some of the local children used to use the football pitch on an informal basis. But there's no formal, that hasn't really continued up until the present*" (A9aN)

There was at some point in recent history a football pitch on the site, which encouraged both informal and formal usage. Local football matches would be arranged there and it was open for public use for the rest of the time. However, at some point, this pitch was removed and this may have had a negative impact on the site's usage by the local community.

"They used to have a football pitch there which was used by the community, as far as I'm aware" (A8)

"I used to run a football team and we played football against Glantawe Football Club and Glantawe used to be the Glantawe Hospital management Committee, we actually won 17-1 up there. Was a terrible day, it was raining but there was a football pitch up there so" (A1)

These uses act to build a familiarity between the site and the local communities, creating trust and reducing uncertainty (Gefen, 2000). As previously stated: *"the Other is fine, but only insofar as his presence is not intrusive, insofar as this Other is not really Other"* (Žižek, 2009: 35). Essentially as long as the 'Other', which in this instance are the former psychiatric asylums such as Cefn Coed, is stripped of its otherness through a process of detoxification (Žižek, 2014); then it can be assimilated into our society in an anthropophagic manner. As we have seen, the public access to the site in the form of both informal (such as dog walking) and formal (such as fêtes) usage creates a familiarity within the local community and acts to dispel the otherness of the psychiatric institution, through familiarisation. This may have acted to reduce the level stigma attached to the site over time. This can also be related back to concepts of integration and normalcy- which were raised in the previous chapter as part of a discussion on NIMBYism. The process which breeds acceptance of the asylum on the part of the local residents is in stark contrast to the reports of NIMBYism with regards to community care facilities; whereby new facilities in the community are met with resistance and have been perceived to be 'noxious' (Dear, 1992; Gleeson and Memon, 1994).

Derby Borough Asylum – Kingsway Hospital

Stigma

There appears to be a consensus amongst interviewees that there was no great stigma associated with the Kingsway Hospital site; and that there no issues have been found in relation to the site and its relationship with the local population. This appears to largely be down to the fact that the site is not in the public eye, and as such it is not in the public's consciousness.

"It doesn't bother me…it doesn't cause any problems; those that live nearby don't complain even if they do have problems, I've not heard anybody at all in 10/11 years as a councillor say anything adverse about the Kingsway site" (B4)

"I don't think they have any, it's been there as a mental hospital for so long I don't think it impinges on peoples conscious, it's never caused a problem that I'm aware of" (B2)

"I've not heard any comments at all, adverse or positive about it" (B4)

It has been raised by a respondent that Kingsway does not suffer from major stigma as it has been overshadowed historically by the nearby Pastures Hospital. Originally Derbyshire County Asylum, Pastures Hospital preceded Kingsway in Derby by 27 years- opening in 1851. Pastures Hospital subsequently closed in 1994 and has since been largely redeveloped into flats. Pastures Hospital has drawn much of the stigma associated with psychiatric asylums in Derby and as such possibly acts to take the focus away from Kingsway.

"*The, I don't think as regards stigma, that it's got a particularly powerful, sort of, stigma attached to it as a site in Derby although I'm not a Derby man so, perhaps not living here it's more difficult to gauge that. But certainly Pastures Hospital was the big asylum type of hospital which was in Derby. And to a certain extent Kingsway had a different reputation and possibly a different sort of function and anyway it doesn't, when people used to talk about the asylum in Derby they used to talk about Pastures Hospital and sort of Kingsway didn't have that same sort of… It didn't have the same sort of emotional baggage perhaps, so I think that's one factor*" (B7N)

"*You know I think it's. I think Kingsway although it's a big site, it didn't have the emotional place in the public mind like Pastures Hospital did, and to a certain extent bit invisible, you know being off the roundabout and so on I think there hasn't been a focus on it at all. I think that the public mind will very much be focused on the big acute hospital across the road which*

would sort of dwarf this doesn't it so, so I think all, when the public think of this area and hospitals they think of the Derby Royal Hospital" (B7N)

There has been some concern with regards to the age of the buildings on the Kingsway Hospital site; with some of the older facilities being seen as unfit for purpose. However the replacement of these older buildings with the new build modern facilities which now occupy the site has meant that the site itself benefits from a better public image; distancing them from the image of the Victorian psychiatric asylum. This is not necessarily an act of memorialisation, but as an attempt at modernising the site it has had the side effect of removing the evidence of the site's previous life. If the links between memory and landscape are pervasive, then the changing landscape at Kingsway Hospital presumably acts to gradually reduce the memories of the site's stigmatised past (Schama as cited in Joseph et al., 2012). This is through a form of strategic forgetting, whereby the older facilities, as evidence of the history of the site as an asylum, are gradually removed (Joseph et al., 2013). In this way Kingsway, despite the fact that it has been retained for psychiatric care, acts to distance itself from its past as an asylum.

"*I think it's, the old site if anybody did come onto it as a visitor for patients perhaps or for the odd public meeting would be a very negative image of it, very shabby, run-down, it wasn't even faded grandeur really because as I say architecturally it was pretty brutal as well. So I think people would have got sort of subliminal message that mental health services are old fashioned, shabby and very institutionalised just by, that's the sort of the message the buildings, we'll give 'em away. I'm sure that visiting the site in its modern form and the new builds on the site will have been a far better image*" (B7N)

There is also evidence that the Kingsway site benefits from a form of therapeutic landscape- also known as 'bucolic locales' (Gesler, 1992). The asylums, as therapeutic landscapes, "*sought to promote the recovery of mental health by the removal of the 'client' from the stresses of everyday life through confinement in an ordered, harmonious and calming place of sanctuary*" (Moon et al., 2006: 1). Kingsway benefits from a form of therapeutic

landscape because the site is 'hidden away' by trees and fences which act to provide both a calm environment and also a degree of separation from the local community. This separation has led to Kingsway being described as a 'lacuna' in the city:

"*It's like, erm what's the word, it's like a lacuna in sort of Derby isn't, it's sort of shielded in the grounds and behind trees and sort of behind the fences really so it's like this little lacuna in Derby that my impression is people aren't all that aware of it or what goes on here really*" (B7N)

The lack of stigma associated with the site may have contributed to the site's continued existence as a psychiatric facility within the National Health Service, as there is little to no public apprehension or pressure to close the facility.

Language

Another factor which needs to be mentioned is the use of Kingsway Hospital in local language. Whereas at other sites there have been multiple examples of the use of the hospitals name in local language, often with negative connotations, at Kingsway these examples were fairly limited. The twitter search utilised searches for 'Kingsway' and 'Kingsway Hospital', with the previously discussed added geolocational search restriction limiting responses to those published in Derby.

Figure 6.8: Kingsway Tweet

This usage as a form of hyperbole is seen fairly frequently in relation to psychiatric institutions, as stated previously this is in the form of clichéd analogies (Kelly and Winterman, 2011). However this comment is more of a hyperbole aimed at the person and their actions rather than Kingsway itself, and the usage does not necessarily have

negative connotations attached to it. One tweet from Mad Pride is interesting for its use of clichéd mental health metaphor- a 'mental health resistance network' reinforcing the aforementioned hyperbole of mental health language with such terms as 'mad' and 'a sandwich short of a picnic'. This is arguably used to increase 'resilience', defined as "*the capacity of people to confront and cope with life's challenges; to maintain their wellbeing in the face of adversity*" (Mind, n.d.). In this way mental health terminology and indeed mental health spaces are reclaimed in order to increase resilience in local service users. The only other twitter mentions of the site are fairly mundane.

Figure 6.9: Kingsway Tweet

Figure 6.10: Kinsgway Tweet

Public Access

Public access, or at least opinion on public access, appears to be mixed with regards to Kingsway Hospital. There are accounts of those who have seen people informally access or have personally informally accessed the site themselves for recreational means, and there are also those who maintain that such access does not happen. No correlation was found between the respondents' position in relation to the NHS and their knowledge of access to the site.

"They are a bit vulnerable to people getting into the site, because it's a very big and open site that's not perimeter fenced, and I know people use the site for cycle training with their youngsters because it's not a busy site, whether that bothers the health service staff I don't know but nobody ever seems to come out and say 'go away'" (B4)

"In a very limited way. Mainly dog walking or access through the grounds" (B5)

"[Do the public use the site?] Not as far as I know, not legitimately" (B7N)

With regards to formal access, we have seen in Chapter 4 the site has held large fêtes in the past which are open to the community, and accounts suggest that this continues to be the case for the time being. But with regards to specific facilities which are open for use by the public, be that in the form of sports facilities or public meeting spaces, the site reportedly has none.

"To some extent yes. I mean I know they have community events like, every year a sort of a summer fair, and that obviously used to take place on the sort of the open land grass, which won't be able to happen in the future, or not in the same way. It may well be able to but on a smaller portion of land" (B3)

"No, it's not used, it doesn't have any community, it may have under the new planning but at the moment there are no community facilities on that site" (B2)

When respondents were asked about the relationship between the trust and the public, the responses indicated that public access on the Kingsway Hospital site was discouraged by the trust. This discouragement was largely due to issues surrounding security and crime on the site, with security problems relating to the stealing of scrap metal from the estates services.

"*Erm. Well I say if anything it's sort of discouragement really coz there's been the odd sort of mini-crime wave on the site, and particularly people breaking into cars, so if anything there's a sort of discouragement of that and then sometimes you get people like racing through down the driveway at, you know driving too fast and so on. So erm, no there's been no encouragement, apart from the fayre, there's been some fayre and public events and so the ground lend itself to the, I think the summer fayres coming up. So erm, it lends itself like that, so but erm, increasingly moves to destigmatise mental health problems but we've tried, the tendency to conceptualise that by us going out to talk to groups or meet people rather than people coming to see us interestingly. So apart from the fayre which is very long standing, we tend not to do that, interestingly*" (B7N)

The site itself has been linked to the destigmatisation of mental health in that the therapeutic landscape of the site, which is created by the green space on site and the calmness which it brings, is helping to destigmatise mental health. This calmness is a factor which defines therapeutic landscapes, and enables them to be what Williams called 'healing spaces' (2010); whereby individuals can feel 'removed' from the stresses of everyday life (Moon et al., 2006). This however is under threat following the development of housing on, and the construction of a road through the centre of, the site.

"*I think Headquarters apart, because of the nature of the building, that the plans, it's a good plan really and I think it's, I quite like the mix of the longer stay psychiatric units and the more domestic proposals to develop the site as long as there's a reasonable amount of green space and*

a reasonable amount of calmness about the place then that's a good sort of mix really. That helps with the destigmatisation of mental health problems" (B7N)

"*Yes. Yea but the old age wards further down and the rehabilitation wards and the forensic units where people might be staying for 18 months at a time have got reasonably green surrounds and so on. And it's an open airy site which isn't too busy. It would be difficult to know what it's like when it's got the housing and the industrial developments on it; presumably it'll be a lot busier. But I think it will still much more calming area being green than being on an acute hospital site or example*" (B7N)

Newcastle Borough Lunatic Asylum - St Nicholas' Hospital

Stigma

Respondents in Newcastle largely believed that St Nicholas' Hospital did not suffer from stigmatisation as a result of its history. One respondent who worked for the trust stated that they had never encountered stigma in relation to St Nicholas' hospital, and that this may partly be due to the large number of staff and ex-staff which live in the area around the site (C6N). However there was thought to be a limited amount of stigma thought to be associated with mental health patients generally; and the ramifications of living in close proximity to them. One respondent who worked for the trust felt that there was a form of inherent stigma attached to the site, but that it was 'pub talk' and possibly a more internalised opinion rather than a public opinion.

"Well, I'm not uncomfortable with it being there if that's what you mean, erm, I think that the services are managed very well, if they weren't managed very well I'd have some concerns" (C1)

"I don't think [it suffers from stigma] significantly. I think that people are very comfortable with St Nicks and I've never heard anybody call St Nicks the asylum or the looney-bin or any of those terms that people use. I've heard people use those terms about some of our other sites, but not particularly St Nicks, and I think that's probably to do with the fact that a lot of people have worked here as well over the years, and known people who have worked here over the years. I

think sometimes the service users get some stigma in terms of that's, you know, commenting on their behaviour or where they must be getting services or whatever but, you don't hear that about the site which is quite interesting really isn't it. Yea I think St George's Park you hear a lot about some of those buildings but also we get, I hear a lot of stigma about those wards on general hospital sites. Where they, the services do kind of stick out like a sore thumb a little bit, but no, here, maybe it's because of the community maybe it's because of the, where, where it is rather than some of the others are in maybe more deprived areas where there might be less understanding about mental health I don't know I'm speculating but, it's interesting" (C6N)

"Erm. I wouldn't have thought it was so much related to the architecture, I would say it was more about the perceptions of people with mental illness or and how safe it is for them to be located in this area, erm. I suppose the main building does have a sort of institutional sense of something of a bygone era so maybe in certain respects it could do but I tend to think the building looks very attractive actually" (C1)

"*However I would think it, does it suffer from [stigma] though. There's probably the stigma, we're probably still known to a lot of people as the loony bin, where the loonys go, where the nutters go. And all that sort of stuff. And some people probably still refer to us as asylums and things like that yea. However, I think that's probably the bar conversation. I don't think it suffers from the stigma in terms of anything that would be said publically*" (C5N)

However the counter argument has also been made, with one respondent claiming that St Nicholas' was in fact affected by a form of stigma even if this stigma was not universal. Significantly this was apparently also true of the patients themselves, who see a move to the Hospital as a 'retrograde step' in their treatment. In this way the asylum could be argued to be suffering from its image "*as an inhumane and outdated treatment modality"* (Joseph et al., 2012: 5). Another factor which was mentioned was the fact that at one time the trust did plan to close the hospital, and residents moving into the area at that time may have been under the presumption that the site would not be there for much longer. This is an example of where debates over closure may have acted to destabilise the sites relationships with the local community. Gefen stated that

"*trust reduces uncertainty by letting people hold relatively reliable expectations"* (2000: 727). The rise of uncertainty over the sites future may have reduced the levels of trust with the local community, negating the positive effects of a heightened familiarity between the two parties (Gefen, 2000). Also mentioned was the history of absconsions and 'high profile incidents' at the site, and the fact that negative public stigma could be directed specifically at the medium secure unit on the site.

"*I guess for a lot of people there's still a stigma attached to St Nicholas' Hospital and and and the old asylum for want of a better word so it's, it is the case that often when you speak to service users who are receiving the services say across at Newcastle General for instance, they see a move to St Nicholas' as somewhat a retrograde step or they're becoming more unwell so they need the old, the old asylum well they'll come here and never see the light of day again so there's, there's challenges in relation to that*" (C7N)

"*We have a crèche just across the road there, a nursery and so a lot of local people use that. I think erm, I think like most things that's not a universal acceptance. And I know we've had concerns raised when we developed the forensic services for instance. We had to do a lot of work to do with local groups and local individuals and I think when some folk bought their houses, particularly on that side of, they were all kind of new build and most people were informed that the hospital was closing at that point, and it was you know, kind of that was the move in the kind of late 80s to close down psychiatric institutions. And on the odd occasion we'll have a high profile incident, or an absconsion which kind of raises peoples anxieties and we might get a flurry of complaints or or or or calls in and around that*" (C7N)

"*So I think from a mental health point of view I don't think there's a massive amount of stigma I think the issue is more about when people talk about medium secure coz they know, you just click on the website and go to medium secure and you say 'well what sort of people are these', and these are people who've you know, coz it's a forensic medium secure unit, people who have committed crimes who are no longer in gaol because they need treatment not containment, and these are the people who may have raped, may have murdered etc. etc. some very very sad stories though of how their lives, their lives tend to be really really traumatic, and you sometimes see*

some of the stuff that they've had to, and you just think, I might have done that, you know if I'd have suffered the way they'd suffered, would I be sat here? So it's, yea" (C5N)

It was also stated by one respondent that the lack of stigma at the St Nicholas' site could be down to the successful management of the site in its healthcare capacity. In this way it was thought that the vast majority of concerns surrounding the site were related to administrative concerns rather than clinical concerns. In this instance the major concerns about the site were related to non-mental-health related complaints such as traffic and parking issues related to the hospital.

"[Concerns?], yes... only in the most mundane administrative sense" (C4)

"Local residents they do have anxieties around all of that, we do from time to time get concerns and complaints raised with us about those things but they are again very rare and I think that's because generally speaking the site is managed very well, in fact to put it in another way the main thing that we get complaints about are actually parking of staff in the local, in the streets surrounding the sites they're not actually about these services at all" (C1)

It was an almost unanimous opinion that this comparative lack of stigma was due to the hospital being a 'fixture' of the community, having been there for approaching 150 years. So since the hospital pre-dates the local residents, and even residencies, people have either grown up with St Nicholas' Hospital or moved into the area by making a conscious decision to move into the vicinity of the psychiatric hospital. This means that it is likely that residents are likely familiar and comfortable with the hospital being in their local area. This, again, is related to the concept of familiarity and acceptance (Gefen, 2000) discussed previously.

"The place is quite well embedded in the community, it is a fixture, people don't worry about it" (C4)

"People accept the fact it's been there for decades…that's what people bought into" (C4)

"*I think it's obviously a well-established site, so it's been a site in Newcastle for something approaching 100 years in terms of providing some form of service from the poor house through until now so it sits within a community which is, accepts that as an asylum in the midst of it*" (C7N)

"*I think on the whole they're positive because most people have grown up with it in their midst*" (C7N)

This could be said to show how the familiarity between the St Nicholas' site and the local community, through a prolonged exposure, acts to create a level of 'trust' between the two (Gefen, 2000); this acts to break down the site's 'otherness' (Žižek, 2009) and as a result the stigma. However it was accepted that not all residents who live in the area around St Nicholas' Hospital will have grown up in the area and therefore may not have had the time to become familiar with the site. As a result there is still a level of uncertainty within the community with regards the hospital site. This means that there is not a level of 'trust' between these particular residents and the site and therefore they do not accept the site as it is. It has been noted that despite the different opinions of these two groups of local residents, the public has had little to no influence on the running and development of the site. It was proposed that this was due to an acceptance on the part of the residents regarding the site and its usage.

"*I said complaints, probably more anxiety and concern when we went out to meet with them. I don't, but, yes I think that there's probably quite a marked difference between individuals who have grown up with it in the area and those that have moved into the area*" (C7N)

"*I don't think it has ultimately no because we've developed the services on the site we wanted to, I think probably if anything because of the historical nature of the building being here people have just accepted that it's a mental health hospital and therefore that's, we've probably had much much less opposition here than we have when we've built units that haven't had that tradition or haven't been there as long*" (C7N)

It was also touched upon that the replacement of St Nicholas' with a new hospital would be difficult. However the St Nicholas' Hospital site has undergone major refurbishments. This has been in the form of both upgrading of existing facilities and the building of new modern facilities which have been built specifically for modern mental healthcare in mind. This is despite the site's limitations in terms of refurbishment as a result of the site's heritage protections; namely the conservation area and the listed buildings on the site.

"Good care, 'well established' facility that, despite its age, and therefore the difficulty in keeping the thing going… establishing a new hospital in the NE would be difficult" (C4)

"I think it has because when we've done them we've invited the local residents in to see them, and they see 'em, and think, aye you go in these units and let's face it mental health now is probably a template, in 2006 we set the template with the Bamburgh clinic. Most of them are replicated on that nationally now. It's properly like a hotel bedroom, you've got your en-suite I know you haven't got toilet seats and things like that but you've got your en-suite, you've got your bedroom, you've got lovely gardens, you've got places for, so we invite 'em in and probably when, have you ever see the film Shutter Island? You know, that's the image a lot of people will have of an asylum. Then they come into here and you think, how do I even get them out of these places? And that's one of our problems now. We're making facilities so good, and the care they are getting, ah, we do like ward visits every month so every month I spend a day on a ward. And just, I'm not there like observing and watching I'm just, interacting. Just interacting, just try to observe some interaction" (C5N)

Language

As with other sites there was evidence of the use of the psychiatric hospital's name in colloquial language. When asked whether St Nicholas' Hospital was used in colloquial language, one interviewee responded that:

"Yes it does. In Sheffield you'd be talking about Middlewood wouldn't you in the same terms? It's St Nicks in Newcastle" (C3)

"'And we'll be taking you to St Nicks', something like that" (C3)

A search of twitter utilised searches for 'St Nicholas' Hospital' and 'St Nicks' and, like previously, these were limited to those tweets published in the local (Newcastle) area. These tweets followed a similar pattern to the previous sites- the use of the name of the hospital in hyperbole (see Kelly and Winterman 2011).

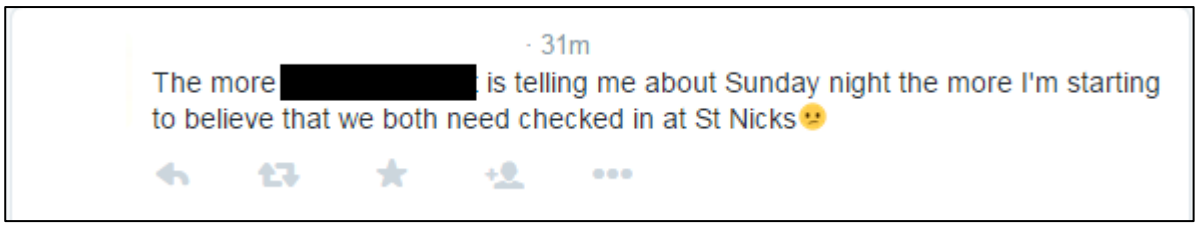

Figure 6.11: St Nicholas' Tweet

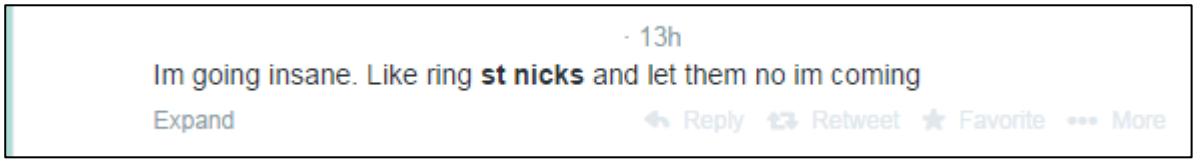

Figure 6.12: St Nicholas' Tweet

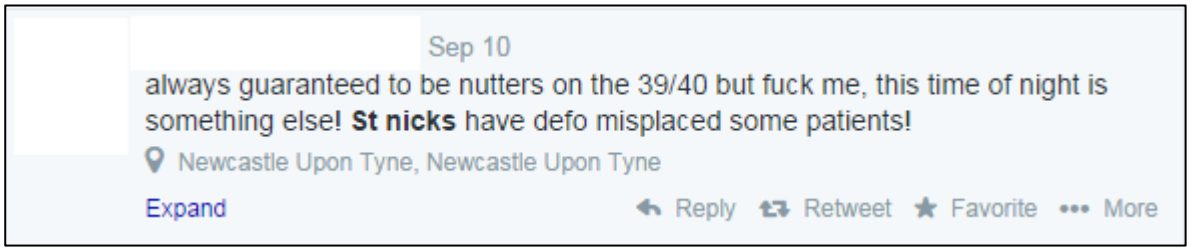

Figure 6.13: St Nicholas' Tweet

Public Access

The relationship between the hospital and the community appears to be strong. The hospital itself appears to actually take positive steps to attempt to involve and engage the local community with the activities at the hospital in the form of liaison meetings.

"Well the trust certainly has done stuff to encourage [use,] *they used to hold a regular liaison meeting we don't have them regularly now unfortunately but, that's not to say we can't have meetings, the last meeting we went to they introduced this idea of us asking residents whether they'd like to be community governors, which I thought was very positive. Erm, maybe they could do a bit more of that I don't know, erm, I suppose it depends how much time and resource it takes up but, I'm in, very much in favour of the community being involved and I think the hospital has made an effort ever the years to engage with them"* (C1)

With regards to public access to the site itself the site is open to the public and apparently in frequent, if not constant, use by members of the community. This was in the form of use as a thoroughfare as well as a resource for accessing activities such as dog walking and exercising. This relationship between the trust and the public has been described as 'organic', in that it has not been directly encouraged by the hospital but has occurred naturally.

"St Nicks doesn't have high walls, they have public footpaths in the middle of it… it doesn't give the impression of being an enclosed scary place" (C4)

"Shall I tell you about? The hole in the wall project basically, the wall that goes around the hospital site is still there. About 15 years ago the council allowed planning permission to cut a hole in the wall to enable residents to walk through it to, you know the wildlife park? To walk through to the wildlife park, and then through as an access, through the hospital grounds down to where, well, the central part of Gosforth. Erm. And the adjacent area is known as Coxlodge, erm, and there were a number of residents who weren't very happy about that and from time to time they complain about anti-social behaviour of youths that come through into that area, I'm happy to say though I think it's really important for the community to be able to access the wildlife park and, I've always been very reluctant to have a discussion about blocking that up" (C1)

"The hospital grounds people can walk through them as well, so, it's actually for residents in that area it's actually a good way down through into central Gosforth and to the high street which is obviously where there's a lot of commercial activity. And you know, I, as a ward member, it's a way of getting round my ward on foot. I live, sort of the other side of the hospital, not actually very far from the hospital itself and I can cut through there and it's a useful way through" (C3)

"Yea. I don't know fully how much it's used but I do know that theatre is used occasionally in there, it's used as an amateur, I know that as I've been to see Gilbert and Sullivan there myself. The Gosforth group, Amateur Dramatic Group use it" (C3)

"*Well I suppose the access has been an organic thing. I don't think we've actually said 'oh come and walk your dog' at St Nicholas' in fact, in fact some of the feedback we've had from patients is that they don't particularly value that sort of access. So it can cause some friction at times. Erm. In terms of things like the cricket pitch, yes we've had things like car-boot sales on there, and there is a cricket team, a local cricket team that plays on there, and it is, the cricket pitch is protected anyway… so. That has to be provided. I think it's brought benefits in that folk realise it isn't you know, it isn't full of demons or somewhere to be afraid of, so we have a lot of activities. I just mentioned the theatre, so there's a local theatre group that uses that quite often, we run, there's a yearly pantomime run from there that, you know so there's quite a bit of access to this site and people do utilise it, I think it's grown up over a number of years rather than necessarily being strategy about inclusion*" (C7N)

This public access however is seen as a natural and positive thing for the site, and may act to increase the levels of familiarity and therefore trust on the site; leading to the site being accepted as part of the local community (Gefen, 2000). However though the view of public access as a positive for the site is a prominent one, it is not universal. One respondent stated that the public access on the site was met with a mixed response from patients, and although it was generally seen as a positive thing, there were some negative results of community access to the site.

"I don't think all patients would not want, some patients like to see dogs being walked and people around, some don't, I think overall it's a positive thing I just think sometimes there's a danger we assume that access and inclusion and all those other things are always seen as positives by our patients but they're not always, but in general it's a positive thing yea" (C7N)

Portsmouth Borough Asylum - St James' Hospital

Stigma

There appears to be a consensus that the St James' Hospital site does not suffer from a stigmatisation at the present time. However, there are one or two accounts which indicate that the site did in fact have a stigma attached to it at some point in the not too distant past. This stigma, which was attached to the site in the 1960s and 1970s, no longer appears to be an issue with regards to the current St James' Hospital site. As at other sites this dissipation of stigma could be due to a number of factors, which may include a more progressive attitude to mental health in general and a certain amount of memorialisation with regards to the sites as they are (Kearns et al., 2010).

"I think, I don't think it does now. I think my mother's generation felt that there was a stigma about it. I know when I worked on drug rehabilitation and it was the centre point for rehabilitating addicts in the late 60s and early 70s, it wasn't the best environment for that treatment to take place. But I think the stigma has gone away from the site, I think mental health still has an unwanted stigma attached to it but I'm trying to do my best to tell people that it's an illness like anything else and there should be and mustn't be stigma attached to it or to the buildings where people with a mental illness are being cared for" (D5)

"It may well have done, but I'd say any stigmatisation that was there has certainly dissipated in the last 10/15 years. I imagine if you were to ask some of the older residents in the area that have been there for 40/50 years they may say otherwise but, certainly if you were to walk the streets of Milton now and say 'do you have any concern about St James' Hospital?' they would say 'we don't want it knocked down' rather than anything to do with its past or patients or anything like that" (D1)

"Well, no I wouldn't really. I mean I suppose there's things you can say, I believe one time Locksway Road was called Asylum Road and you know they renamed it presumably because the other residents didn't like that, erm. I suspect that once the development goes in that people will soon forget what it used to be" (D4)

The site as it is today is popular with local residents, as can be evidenced from the Keep Milton Green campaign previously discussed in Chapter 5. The site stands as a green lung in the Milton area which is used daily by local residents who are passionate in their opposition to development on the site. However it must be mentioned that the Keep Milton Campaign do not use the retention of the hospital buildings themselves within their campaign, but more so the grounds which are attached to it.

"It's a very popular site for the local residents because they like the green spaces, it's a nice walk through but particularly concerned about the prospect of having 400 new homes built, the road access is already considered to be very busy and infrastructure will have to be considerably improved" (D1)

Language

No evidence collected via this study's interviews suggested the use of St James' in the local vernacular. Although twitter searches (as discussed in the methods chapter) were difficult to find for this site, one or two tweets relating to the site have been found. The twitter search consisted of searches for 'St James' and 'St James' Hospital' which were published in the Portsmouth area. The tweets which were found mostly relate to closures at the hospital site. Despite this limited amount of evidence found on twitter relating to St James' Hospital, there was one tweet which referenced the hospital's external appearance. The tweet was in relation to the external appearance of the hospital's main building.

· Jun 28

PORTSMOUTH: Older people's unit at **St James' Hospital** closes j.mp/1mphEES #Hampshire

Portsmouth, Portsmouth

Expand Reply Retweet Favorite More

6.14: St James' Tweet

· Feb 24

It may be all change at **St James' Hospital**, **#portsmouth** as @SolentNHSTrust announce plans to move some services bit.ly/1leljZO

Expand Reply Retweet Favorite More

6.15: St James' Tweet

· Jul 30

Delivering coaching skills training today @portsmouthCCG and **st James hospital** is looking pretty fine pic.twitter.com/xYAxDNCx5T

Expand Reply Retweet Favorite More

Portsmouth, Portsmouth

Figure 6.16: St James' Tweet

Public Access

There are two kinds of public access to the St James' Hospital site: formal access and informal access. Formal access comes in the form of official engagements on the site, most notably in the case of St James' meetings of the local neighbourhood forum.

"*For example they allow the local neighbourhood forum to use their rooms free of charge for committee meetings, they often, they allow neighbourhood forums to hold consultations in the main hall within the hospital, they've never had issues in relation to that. They provide various resources for the community events that happen on what is now Milton village green or St James' Park depending on who you ask. I'd say the community feel fairly open to going there. I know they have an operating restaurant in there, I don't know how, I don't think it's well advertised but I know that it is open access and that I do know some people who do go there for lunch occasionally and it is a pleasant experience so*" (D1)

"*Yes, meeting rooms and using the nopen space [sic]*" (D2)

In addition to this formal access there are also examples of informal access which come in the form of walkers, dog walkers and exercisers using the hospital grounds. The green space on the site, designated as a 'village green', is ideal for these individuals and the space may be one of few in the local area.

"*Yea I mean it's used as, people certainly walk 'round it quite a bit. I mean you already have the land which was, which has now got village green status, which is popular with dog walkers, coz in a lot of the southern part of the city if you've got a dog it's difficult to walk it off lead coz there isn't anywhere really to go. So for a lot of people that's their nearest part of open space they can go and walk the dog, and so it is used for that, and, yea people do walk around and through it*" (D4)

This informal usage occurs on a daily basis, as evidence by the Keep Milton Green campaign (Keep Milton Green, n.d.). The site's green spaces are highly valued by the

local community as a space for walking and dog walking, as well as exercisers and nature-enthusiasts. The hospital itself actually encourages this interaction with the public in a number of ways which can be seen in physical manifestation on the site. This includes dog waste bins and signs which suggest walking and jogging routes around the site. This relationship between the hospital and the local community is a strong one, which may have contributed to the strong feelings of local residents with regards to the plans for redevelopment.

"*No well I think the reason they've done that is that they accept as I do that by custom and practice people in that part of the city have enjoyed that facility. I've played cricket in the grounds there, on a very good, in those days, a very good cricket wicket, and so I think the trust are enlightened enough to know that whatever they do they've got to carry the local community with them. So it's in their interest to make access for local people a positive thing*" (D5)

The site is currently in the process of being wound down and sold off for housing, and as a result the Keep Milton Green campaign has protested and is fighting the development on the site in order to save the green space for the local community. This shows how the site has the support of its local community, for whom the site is a part of their local community; it is more than just 'familiar' (Gefen, 2000), it is a fixture.

"*I think the majority of people don't want it to change. I think the local residents who live around it are quite happy with it. They are happy that they can have access through it; they can actually drive through the hospital grounds and out the other side, and local residents that know that route use it regularly. And they enjoy walking their dogs over there and they feel that it's a good environment. I know from being a patient there, and it's not a bad place for patients to be, it's not a bad environment, I've been in far worse and seen far worse*" (D5)

The importance of preserving the green space on the St James' Hospital site was highlighted in an article from The News, which reported on a demonstration by local residents in Milton. Janice Burkenshaw, chairwoman of the Milton Neighbourhood Forum, stated that: "*people live in very narrow streets with cars everywhere. They feel under*

pressure. A place like this you can walk around and the children can come and collect conkers. You can take the dogs for a walk. You can observe mature trees which are rare in Portsmouth. Without all this we are all the poorer. Every opportunity has to be taken to demonstrate how deep the feeling is locally that this is a valuable space. It shouldn't be built on" (Scammell, 2015).

As can be seen from the Keep Milton Green campaign, the protests focus on the retention not of the hospital buildings, and not even on the retention of services (although that does feature) but on the retention of the green spaces which the site offers the local community and the pressure on local infrastructure. The former is summarised well by the following letter sent to The News: "*the problem comes in defining what brownfield actually is. For instance, the St James' Hospital site is deemed brownfield simply because it has been used as a hospital. However, anyone who has ever been there knows what a travesty this designation is. A precious green space, full of beautiful trees and a haven for wildlife (including rare species) can never be 'brownfield'… and people feel passionately about this issue. They recognise how vital to our physical and mental well-being spaces like the St James land are*" (Simmons, 2015).

Discussion

In this chapter the theme of stigma has been examined across the four case study sites. This has included: an analysis of the levels of stigma attached to each site; a look at the use of the hospitals' names in colloquialised language; and an exploration of the levels of public access at each of the sites. Each of these three topic areas will be discussed in further detail below, and the effect that each of these factors has had upon the retention of each of the case study sites will be further examined. . Interestingly throughout this chapter no correlation was found between the respondent's positon, be that NHS or non-NHS, and their opinions.

The literature related to stigma and former psychiatric asylum sites has previously made the assumption that these sites experience high levels of stigmatisation.

Psychiatric asylums across England and Wales have suffered from varying levels of stigma over the course of history due to issues around overcrowding and maltreatment. As previously stated: "*the stigma associated with the psychiatric asylum—the almost universal characterisation of it as an inhumane and outdated treatment modality—was accentuated in debates that occurred during the years immediately prior to closure and has remained salient in debates over reuse*" (Joseph et al., 2012: 5). This is as the link between the landscape of the sites and people's memories are said to be pervasive and prevalent, and the perpetuation of the former asylum sites is argued to also perpetuate the stigma attached to the sites as a result of their history (Joseph et al., 2012).

What this thesis has found is that the levels of stigma were varied across the case study sites, and largely that stigma in the present is much diminished compared to in the past. Cefn Coed Hospital appears to suffer from high levels of stigma, St Nicholas' Hospital experiences some stigma and Kingsway and St James' Hospitals' appear not to suffer from stigma in any significant manner. The stigma at Cefn Coed is thought to have diminished over time with redevelopment at the hospital; however since a decision to stop investment in the hospital (around 2008 with the formation of the Abertawe Bro Morgannwg University Health Board) the estate has become 'unfit for purpose'; and the levels of stigma at the site remain as a result. This contrasts with the approaches taken at St Nicholas' and Kingsway where investment into the sites' infrastructure was made- redeveloping older facilities and building modern facilities in order to bring services up-to-date. This acts to sever the pervasive link that exists between landscape and memory of the stigmatised asylum (Schama, 1995); as the modifications of the sites landscapes can be argued to also have an effect on how people remember the site, and may act to remove the "*long shadow of the stigmatised asylum*" (Joseph et al., 2013: 12). The levels of stigma associated with the St Nicholas' and Kingsway hospital sites are therefore much diminished in recent times. St James' Hospital on the other hand does not appear to suffer from stigmatisation at the present time; with no evidence found of stigma which may be a result of the site having a good relationship with the surrounding community. This thesis' finding of diminished stigma runs counter to the prevalent theoretical opinion regarding stigma at former

psychiatric asylum sites which was found in the literature in relation to dormant administrative use.

As Kelly and Winterman state, general terms such as 'mad' and more specific terms such as 'OCD' and 'schizophrenic' are frequently used as a form of hyperbole (2011). Names have been seen to be important in the redevelopment of sites, and a concerted effort to nullify stigma has been made when re-developers of former psychiatric asylum sites decide to rename the new development, such as in the case of Graylingwell: "*we genuinely felt that given the site's former use as a psychiatric hospital, by naming the development Graylingwell it may have potentially negative connotations for local residents that might discourage potential purchasers*" (Joseph et al., 2012: 12). The use of the hospital's name in local vernacular as a term or phrase of similar use as 'crazy' and 'mental' is found at three of the four case study sites. This was researched using a small scale content analysis of twitter utilising twitter searches, though it must be noted that due to the age-demographic of twitter being weighted towards those aged 49 and below, it is therefore not wholly representative of the general population (Brodzky, 2014). Use of the hospital's name in this manner, as a 'popular derogatory term' (Rose et al., 2007), was most prominent at Cefn Coed Hospital and St Nicholas' Hospital, was found in a limited way at Kingsway Hospital, and not found in the case of St James' Hospital. In the cases of Cefn Coed and St Nicholas' the public used more informal names with reference to the sites; the Coed for the former and St Nick's for the latter. As stated previously a number of terms have made their way into general language which refer to either asylums or mental health. It could be argued that the use of the hospitals' names in local vernacular is an example of a form of internalised, institutionalised stigma. This may explain why this usage corresponds with the reported levels of stigma thought to be associated with each site. Incidentally it must be mentioned that the usage of these hospital names in local vernacular is not limited to sites that are still open; even sites that have been closed for years and subsequently redeveloped remain in language of the local area. These findings confirm the ideas set out by both Kelly and Winterman and Joseph et al., in that the names of the sites have been found to be stigmatised in their own right. This theory is found to be accurate

with regards to the names of psychiatric hospitals within their localities, as shown by the usage of the names of the case study sites, examples of which can be found in the tweets reviewed earlier in the chapter.

Public access to the case study sites comes in two forms- formal and informal access. The literature on familiarity and acceptance, discussed previously, puts forward the idea that public access to the case study sites is thought to act to destigmatise the asylums. As discussed previously Gefen stated that familiarity and trust act to reduce uncertainty, through the establishment of a structure and by providing reliable expectations. (2000). It is thought that this is done through the eradication of 'the Other'; and that the Other is deprived of its otherness (Žižek, 2009) and is therefore assimilated (anthropophagically) into society. In this way once the asylums become familiar, in contrast to their history of isolation, the spaces are detoxified and, over time, the levels of stigma associated with those sites is reduced. Alternatively there is also the concept of NIMBYism, whereby the development of facilities within communities receives blanket opposition (Devine-Wright, 2009). This level of opposition towards community facilities has been theorised to have negative effects for the care which patients receive in those facilities and acts to add to the stigma from which mental health patients and facilities already suffer (Dear and Taylor, 1982; Gleeson and Memon, 1994).

With regards to formal access there was frequent formal access at both St Nicholas' Hospital and St James' Hospital with limited formal access at Cefn Coed Hospital and Kingsway Hospital. This formal access was in a number of forms, including: fêtes (Cefn Coed; Kingsway); bookable rooms/public meeting spaces (Cefn Coed; St James'); and liaison meetings (St Nicholas'). Historically there have been fêtes at all the case study sites, as well as access to sports pitches, but over time these traditions have for the most part faded away. With regards to informal access, all case study sites were reported to be used informally by the general public, most frequently at Cefn Coed Hospital, St Nicholas' Hospital and St James' Hospital. This access comes in the forms of: dog walking; walking; jogging; cycling; and use as a thoroughfare. This access was

evident from interview responses and backed up by visual observation during the visits and walkthroughs (see Chapter 4).

It is theorised that the high levels of public access which was reported at St Nicholas' Hospital and St James' Hospital are likely to be directly related to the lower levels of stigma also reported at these two sites; whereas at the two sites where lower levels of public access were reported, Cefn Coed Hospital and Kingsway Hospital, higher levels of stigma were reported. This would confirm the concepts surrounding familiarity and acceptance, and contrasts with reports relating to community care facilities where, as a result of NIMBYism, the intentions of providing integration and normalcy through community care programs was negated by the hostility towards the facilities by the local residents of the locales in which they were placed (Dear and Taylor, 1982; Gleeson and Memon, 1994). This contrast of, on the one hand the acceptance of large psychiatric institutions by the local community, and on the other rejection of new community care facilities, in itself shows the effects of familiarity on the eventual integration, acceptance and perceived 'normalcy' of these facilities within the community. In this way, paradoxically, the asylum may be the more accepted form of mental health provision by local communities.

Conclusion

What this chapter has shown us is how various factors relating to stigma have affected the ways in which former psychiatric asylum sites have been retained. Key themes which have emerged from this chapter are the effects of: perceived levels of stigma; use of language; and public access and community familiarity- on the retention of the four case study sites. These effects have varied by site, for example the perceived levels of stigma at Cefn Coed were high, at St Nicholas' Hospital they were low and both Kingsway and St James' Hospitals' appear not to suffer from stigma in any significant manner. The next section will be the final of the three thematic chapters and will focus on the effects of heritage on former psychiatric asylum retention.

Chapter 7: Heritage Management and the Surviving Asylum

Introduction

"After a century or more of service, nearly all Victorian asylums have now closed and their sites and buildings have been sold; most have been lost or changed beyond recognition. Few people outside the local communities near the asylums noticed or cared about the loss of such a rich strand or Britain's social, medical, architectural and landscape heritage" (Rutherford, 2008: 3).

In this chapter the focus will be on heritage management at the four retained former psychiatric asylum sites which make up the case studies for this thesis. This chapter will include background on heritage, including outlining the different forms of heritage protections: listed buildings, conservation areas, Tree Preservation Orders and town and village green status. Following this there will be discussion on heritage management issues at each of the case study sites in turn, which will contain the ways in which the above forms of heritage management have affected the retained status at each of the sites, as well as the effects on the way the sites are retained.

Heritage is defined by Oxford English Dictionary as: *"'property that is or may be inherited; an inheritance', 'valued things such as historic buildings that have been passed down from previous generations', and 'relating to things of historic or cultural value that are worthy of preservation'"* (as cited in Harrison, 2010: 9). In addition to this Oxford Dictionaries also define heritage as: "*denoting or relating to things of special architectural, historical, or natural value that are preserved for the nation*" (Heritage, n.d.). The emphasis of the initial definitions is on inheritance and preservation, where heritage is something which can be passed from one generation to the next, can be conserved, and has historic and/or cultural value (Harrison, 2010); the additional Oxford Dictionaries quote adds the dimension of 'natural value'.

Heritage can be either tangible or intangible. Tangible heritage refers to physical objects and places of heritage, with a focus on the material (Harrison, 2010); whereas intangible heritage refers to those 'practices of heritage' which are conserved and inherited (Harrison, 2010). Intangible heritage therefore covers "*the practices, representations, expressions, knowledge, skills – as well as the instruments, objects, artefacts and cultural spaces associated therewith*" (UNESCO, n.d.). It has been stated that for every piece of tangible heritage there is an intangible heritage wrapped around it, such as the language used to describe it or even the way in which it is viewed and used by the public (Harrison, 2010). This is similar to Anderson's concept of 'traces', specifically of 'material remnants' (tangible heritage) and 'non-material consequences' (intangible heritage) and the way in which the 'heritage value' is determined "*by the way in which their original use revives recollections of past feelings for place*" (Moon et al, 2015: 23).

The concept of heritage has evolved significantly over time. Heritage was originally dominated by ideas of preservation, and the focus here was solely on aspects of tangible heritage. Subsequently, during the 1960s there was a shift towards conservation. In this way aspects of intangible heritage began to be considered, rather than just the form of the buildings; their functions within society were elevated to equal status (Ashworth, 1998). After this the concept of heritage has shifted again, this time towards the idea of marketability. In this way heritage is seen as becoming a commodity (Hardy, 1988; Ashworth, 1994), and Ashworth stated that "*history is the remembered record of the past: heritage is a contemporary commodity purposefully created to satisfy contemporary consumption. One becomes the other through the process of commodification*" (1994: 16). The commodification of heritage combines both tangible and intangible heritage, as the past is marketed in specific ways in order to best sell the properties through processes of memorialisation and selective remembrance (Kearns et al., 2010). In relation to this, Hewison states the following:

"*Heritage ... has enclosed the late twentieth century in a bell jar into which no ideas can enter, and, just as crucially, from which none can escape. The answer is not to empty the museums*

and sell up the National Trust, but to develop a critical culture which engages in a dialogue between past and present. We must rid ourselves of the idea that the present has nothing to contribute to the achievements of the past, rather, we must accept its best elements, and improve on them ... The definition of those values must not be left to a minority who are able through their access to the otherwise exclusive institutions of culture to articulate the only acceptable meanings of past and present. It must be a collaborative process shared by an open community which accepts both conflict and change" (1987: 144).

There are limits to the study of heritage management using this thesis' case studies, as not all of the case study sites are affected by heritage protections. For both Cefn Coed Hospital and Kingsway Hospital heritage management has little to no effect upon the sites: Cefn Coed has no heritage protections on the site; and Kingsway has only limited heritage protection on the site- in the form of two locally listed buildings on the periphery. In contrast at St Nicholas' Hospital and St James' Hospital heritage management plays a key part in the way in which the site is retained and maintained. Therefore this chapter is more limited than its previous counterparts in the conclusions it can make, as it is largely based on just 2 case study sites. Nevertheless the data collected from St Nicholas' and St James' Hospitals do provide some fascinating results and the topic is worthy of its own, if slightly shorter, chapter.

Heritage and the Asylum

"*Heritage results from a selection process, often government-initiated and supported by official regulation; it is not the same as history, although this, too, has its own elements of selectivity. Heritage can be used in positive ways to give a sense of community to disparate groups and individuals or to create jobs on the basis of cultural tourism. It can be actively used by governments and communities to foster respect for cultural and social diversity, and to challenge prejudice and misrecognition. But it can also be used by governments in less benign ways, to reshape public attitudes in line with undemocratic political agendas or even to rally people against their neighbours in civil and international wars, ethnic cleansing and genocide. In this way there is a real connection between heritage and human rights*" (Logan and Smith, 2009: xii)

The above quote outlines the concept of heritage in relation to history and community. Concepts of history and memory have previously been discussed primarily in connection with stigma using the works of Pierre Nora amongst others (see Chapter 6), and fit nicely into this discussion also. The ways in which the community interacts with the asylum are also discussed in the previous chapter, however within this chapter the relationship between concepts of heritage and the community will be discussed in relation to the St James' Hospital site and the Keep Milton Green campaign.

One pressure on former psychiatric asylum sites has been an increasing priority for the conservation of the built environment. The increasing concern for the built environment can be seen through the founding of English Heritage (originally titled the Historical Buildings and Monuments Commission) in 1983 as a non-departmental branch of the government (English Heritage, n.d.).

English Partnerships was established in 1999 following the merger of The Commission for New Towns and The Urban Regeneration Agency (The National Archives, 2007; Rhead, n.d.), and described as a national regeneration agency on Gov.uk (n.d.). Joseph et al. note that in 2005 English Partnership began to actively promote the financing of heritage conservation via housing developments- and acquired 96 former hospitals, including psychiatric hospitals, for this purpose (2013: 140). This is made possible as "*in the UK the former asylums have been reappraised, not as containers of madness, but as unique works of architecture*" (Franklin 2002: 183). This in turn is made possible through the manipulation of memory in the form of memorialisation of the former psychiatric asylum sites as discussed in the previous chapter. To summarise, Schama felt that the links between landscape and memory are pervasive (1995); so as long as the sites themselves stand in their original form they will continue to be associated with the negative aspects of asylum history. Therefore the redevelopment of these sites may act to, as Žižek would put it, detoxify the sites (2014) through a process of strategic forgetting, selective remembrance and exposure to the public.

Psychiatric asylums are inarguably imposing buildings. It is often thought that these buildings were built in a brutalist fashion, with the cheapest possible building being constructed for a strict custodial purpose. However it may surprise some that for the most part, "*during the nineteenth century most lunatic asylums were the subject of architectural competitions, attracting new talent and new ideas*" (Binney, 1995: 1). If nothing else these sites were the result of a large effort of construction within huge acreage (Taylor, 1995). These sites were often set in large grounds in prime development spots, with large green spaces and south-facing views (Binney, 1995), in fact at one stage the commissioners advised that there should be at least one acre for every four patients (Taylor, 1995). SAVE Britain's Heritage stated the following: "*the desperate crying need now is not so much for an assessment of these asylums as architectural specimens but on evaluation of their quality as places. Listing can mark out some of the most imposing, but equally it can overlook which places are simply attractive, in pleasant surroundings or have potential for reuse*" (Binney, 1995: 2). This plea for extra heritage protection of psychiatric asylum sites was made as: "*at stake are a series of the largest most remarkable and little known public buildings in England built at great expense and set in superb landscape grounds which are often now in the full splendour of maturity. The quality of these buildings is greater as so many were the subject of architectural competitions. Yet at present too many are at the mercy of agents and planning consultants who, in flagrant disregard of the latest government guidelines, often insist that the buildings must be demolished and the sites are broken up, brushing off approaches from experienced developers and architects, with imaginative and viable proposals of alternative use which will be of great benefit in local communities*" (Binney, 1995: 8).

Heritage Protections

Heritage sites act as gateways to history, and as discussed in the previous chapter, can be used to control and manipulate memory. A number of former psychiatric asylum sites are affected directly by issues of heritage; be that in the form of a listing, being situated in a conservation area or even subjection to Tree Preservation Orders (TPOs). The following section discussed these different types of heritage sites, and explores the

law and concepts in relation to those sites. *"Heritage does not engage directly with the study of the past. Instead, it is concerned with the ways in which very selective material artefacts, mythologies, memories and traditions become resources for the present"* (Graham, 2002: 1004). Heritage has many links to the discussions surrounding history and memory (See previous chapter). Graham states that: "*meanings and functions of memory and tradition are defined in the present"* (2002: 1004) - using heritage sites and artefacts as physical manifestations of the past in the present.

Table 7.1- Legislative Instruments

Legislative Instrument	Description
Listed Building: Grade I	*"Buildings of exceptional interest (approximately 2% of all listed buildings)"*[1]
Listed Building: Grade II*	Buildings of *"particularly important and more than special interest (approximately four per cent)"* [1]
Listed Building: Grade II	*"Buildings of special interest, warranting every effort being made to preserve them (94%)"* [1]
Conservation Area	*"Areas of special architectural or historic interest the characters and appearance of which it is desirable to preserve or enhance"* [2]
Tree Preservation Order	*"A written order made by a local planning authority (e.g. a borough, district or unitary council or a national park authority) which, in general, makes it an offence to cut down, top, lop, uproot, wilfully damage or wilfully destroy a tree protected by that order without the authority's permission"*[3]
Town/Village Green Status	*"Small areas of land, they are usually in or on the edge of settlements and they are traditionally areas where local people indulge in pastimes or sports"*[4]
[1] (PlanningPortal.gov, n.d.). **[2](Suddards, 1982: 4).** **[3]Department for Communities and Local Government, 2012: 1).** **[4](Our Green Space Project, 2010: 9).**	

Listed Buildings

Listed buildings were introduced "*during World War II as a way of determining which buildings should be rebuilt if they were damaged by bombing*" (Listed Buildings, n.d.). This culminated in the Town and Country Planning Act 1944 which states that: "*orders may be made for the cessation of development carried out without permission or contrary to the conditions of the grant (there is a right of appeal to Petty Sessions), and for the preservation of trees and woodlands and buildings of special architectural and historical interest*" (Kahn-Freund, n.d.). Listed building legislation was first outlined in the Town and Country Planning Act 1947: "*with a view to the guidance of local planning authorities in the performance of their functions under this Act in relation to buildings of special architectural or historic interest, the Secretary of State shall compile lists of such buildings, or approve, either with or without modifications, such lists compiled by other persons or bodies of persons, and may amend any list so compiled or approved*" (1947: 52). A listed building therefore is a building which has been put on the 'Statutory List of Buildings of Special Architectural or Historic Interest'; and these buildings are preserved and protected by this listing from major alteration and demolition. A building must fall within the following categories in order to be listed: the building is of special value, either architecturally or for reasons relating to social or economic history; the building displays technological innovation or virtuosity; the building is associated with well-known characters or events; or the building has a group value, especially as an example of town planning (East Hampshire District Council, n.d.; Suddards, 1982; Planning (Listed Buildings and Conservation Areas) Act 1990, 1990 [2002]).

Conservation Areas

Conservation areas were first introduced by the Civic Amenities Act 1967 which was "*an Act to make further provision for the protection and improvement of buildings of architectural or historic interest and of the character of areas of such interest; for the preservation and planting of trees; and for the orderly disposal of disused vehicles and equipment and other rubbish*" (Civic Amenities Act 1967, 1967). A conservation area is generally of special architectural or historic interest, and it is deemed desirable to

preserve the character or appearance of said areas (Campbell, 2001). They take into account more than just buildings and emrace a variety of factors including: layout; open spaces; boundaries; and materials amongst other factors (Newcastle City Council, 2005). Trees within conservation areas are also protected as long as they have a trunk diameter of 75mm or more. This acts as a form of protection a little less than a full Tree Preservation Order (discussed in detail below). As with buildings modifications to trees within the confines of conservation areas requires permission from the local council. Within conservation areas 'permitted development rights' are restricted, meaning that development which in other areas may not require planning permission may do so within the confines of a conservation area (Historic England, n.d.). It is important to note that planning applications within conservation areas are not always rejected, and some works are permitted. Retained psychiatric asylums within conservation areas are affected in a number of ways. Although restrictions are not as severe as they are with listed buildings, conservations areas still provide significant barriers to development within their boundaries. Development within conservation areas is however still possible, but it requires an extra level of planning permission from the local council and the development must be shown to be in keeping with the aesthetics of the conservation area as a whole. In this way, any developments within conservations areas which are focused around former psychiatric asylums must be in-keeping with the architectural style of that area.

Tree Preservation Orders

If a local planning authority wishes to make provision for the preservation of trees, usually with the aim to protect those trees which bring significant amenity benefit to the local area, they may make a Tree Preservation Order regarding: individual trees; groups of trees; or woodlands (Department for Communities and Local Government, 2012). Tree Preservation Orders make provision for: the prohibiting of damage to or destruction of protected trees except with the consent of the Local Planning Authority (LPA); the securing of replanting; and the procedural matters regarding consent to fell or carry out other works to protected trees (Campbell, 2001). Tree Preservation Orders

affect retained former psychiatric asylum sites surprisingly often, as the institution and its grounds are often from the 19th or early 20th Century there are a large number of old and protected trees. Development on these sites is often either curtailed or halted as a result.

Town and Village Green Status

Elaborating on the definition above, the Department for Environment Food and Rural Affairs (Defra) defined town and village greens as: "*areas of land where local people have for many years indulged in lawful sports and pastimes, which might include organised or informal games, picnics, fêtes, dog walking and similar activities*" (n.d.: 1). The Commons Act 2006 states that anyone can apply to have land designated as a village green "*if it has been used by local people for recreation 'as of right' (i.e. without permission, force or secrecy) for at least 20 years*" (Defra, 2010). Town and village green status fits into heritage through the application of the concept of 'natural value' (Heritage, n.d.); with the preservation of these spaces of 'natural value' for future generations. Where listed buildings cover the built environment, and conservation areas the built environment and its surrounds, town and village green status is a form of heritage protection which protects green space for the local community.

This section has so far acted to outline the legislation with regards to the forms of heritage protection which may have had an impact on the retained status of former psychiatric asylum sites, in the form of: listed buildings; conservation areas; Tree Preservation Orders; and town and village green statuses. There are a number of issues with these heritage protections which act to limit the buildings in their function and harm the trusts which own them. One of these ways in which the latter occurs is that by protecting the buildings in their current form the buildings are unable to be modernised for new usage in the same way other properties would. This limits both the use value of the buildings to their owners as well as limiting their exchange value, providing problems for both the retention and the sale of the site. The issues which affect the use value of the sites are raised during the discussion of individual case studies below and range from, but are not limited to, issue surrounding: energy

efficiency, the use of temporary modifications (required due to the inability to make permanent modifications) and the relationship between the trusts and the local community. The next section will look at each of the case study sites in turn, and the ways in which heritage management have affected their state of retention.

Swansea and Merthyr Tydfil Joint Asylum - Cefn Coed Hospital

Heritage has had a minimal impact on the retention of the Cefn Coed Hospital site, although it could be argued that its absence may have contributed to the site's impending closure. This is because the site has no listed buildings, is not within a conservation area and no on-site trees are the target of a tree preservation order (as defined in East Hampshire District Council, n.d.; Suddards, 1982; and Campbell, 2001). The following quotes show that not only is the building not subject to any form of heritage protection, but that it was thought that the general public would not particularly want the main building to be retained. In addition to this, it is the opinion of some that the Cefn Coed main building should not be protected; and that it should be sold off or even demolished:

"I personally feel it should be closed, got rid of" (A1)

"I don't think there would be any clamour to retain the building, but I might be wrong" (A7a)

Derby Borough Asylum - Kingsway Hospital

Heritage has also had a minimal impact on the retention of the Kingsway Hospital site, However the absence of heritage protections on the site his may have contributed to the sites closure and certainly it's demolition; which was as a result of the site was not viewed as architecturally significant (described below as 'mundane'); This is because the site is not a conservation area and no on-site trees are the target of a preservation order. The main asylum building at Kingsway was built in 1888 in the Queen Anne Revival style; however it was never listed and the building was demolished following closure in 2009. There are, however, two locally listed buildings on the Kingsway site

in the form of former nurse's homes. These buildings lay abandoned at Kingsway Hospital, but their presence has minimal effect on the rest of the hospital site. In fact, as the below quote alludes to, most are not aware of the existence of the locally listed buildings:

"I pretty sure there are no listed buildings, not even any locally listed, so I'm almost certain there's nothing nationally listed and I'm pretty sure there's nothing locally listed. It's all fairly mundane, just immediate post-Victorian architecture" (B2)

Newcastle Borough Lunatic Asylum - St Nicholas' Hospital

St Nicholas' Hospital has a number of heritage protections on the site. As seen previously, in 1991 the St Nicholas' Hospital site was designated a conservation area through the local planning and Local Development Framework (as can be seen in Figure 7.1 below). The site was designated: "*as an area of distinctive architectural, environmental and historic character… [that] was at risk from pressures for change and development and it was intended to achieve a controlled programme of change which was sympathetic and complementary to the existing fabric and landscape*" (Newcastle City Council, 2009: 1).

Figure 7.1: St Nicholas' Hospital Conservation Area (Newcastle City Council, 2009)

The St Nicholas' Hospital site "*is a distinctive area which is a clear representation of the period of Victorian hospital development in the city. The buildings are set in a mature landscape setting with open spaces and planting which complements the uses of the buildings. The character of the conservation area has changed in the last decade following housing developments within the grounds of the hospital*" (Newcastle City Council, 2009: 1). Officers stated that: "*in the case of St Nicholas, the purpose of the Conservation area would clearly not be to preserve the status quo, but to achieve controlled change, which is sympathetic and complimentary to the existing character. This would mean retention and incorporation of the most attractive features and pursuing high standards in the design of new developments*" (Bernard Thorpe, 1992: 23). Officers also stated that: "*I do not foresee Conservation Area status impeding the hospital in the management of the core area, where selective demolition of less important or significant buildings may be necessary to improve the accommodation.*

Similarly, some selective demolition may be desirable in the disposal sites to secure good development" (Bernard Thorpe, 1992: 23). "*When the Trust recognised that it no longer required all the land currently occupied by St Nicholas' Hospital and Collingwood Clinic, it asked Bernard Thorpe to undertake a Development and Planning Study to identify the most suitable way of disposing of surplus land*" (Bernard Thorpe, 1992: 6). In addition to the conservation area the site has two listed buildings- the original asylum building designed by WL Moffat and dating to 1867 (Lanesborough Court); and the Jubilee Theatre hall designed by JW Dyson and dating to 1896 (One Core Strategy NG, n.d.; Timechamber, n.d.). The designated conservation area and the sites listed buildings are shown in Appendix D. The decision to give extra heritage protection has appeared to be one which is approved of by respondents, but this is not an opinion which is held by everybody:

"[*The conservation area] means that somebody in their wisdom has decided that it does need some extra protection short of being listed yea*" (C3)

The site and its conservation area is described as being important for the area for a number of reasons, including that "*the area is of local significance in terms of style and history, as well as providing a green lung for the surrounding area*" (One Core Strategy NG, n.d.). The green areas of the St Nicholas' Hospital site act as a form of therapeutic landscape both for the local residents who live in the area and the hospital's patients alike.

"*I think it's been very positive I think it's at least its retained a nice green pleasant piece of land if you look at the other bits of land, you know the post office, there's a food processing factory, there's housing in various other parts so I think it's had quite a positive aspect and I think service, our patients quite value being able to walk through that area*" (C7N)

The St Nicholas' site is reportedly managed well, which limits the difficulties posed by the heritage restrictions that the site is subject to as a result of both the conservation area and the listed buildings.

"*Erm, well no I think actually the, err, retaining the old building is a very positive thing. There may be issues internally about how it's managed but they have done, over the years they have done quite a number of conversions and some of them look really nice, erm, there's a theatre inside which houses local theatre groups and things, the jubilee theatre which is nice. So I wouldn't have necessarily said, certainly from an aesthetic point of view it causes any problems, in fact they've, the one bit that, the two bits that they sold off- the Dodds Farm bit, was converted into houses and then Lanesborough Court was converted into, into flats and houses as I mentioned. They've all been done very sympathetically and look really nice, in fact Lain borough Court looks really nice if you go in there, it's gated but it's actually quite nice because it's a very pleasant environment to live I would think*" (C1)

"*Well it must do because there'll be limitations to what you can actually do with it. I'm not sure whether it's internally listed I think parts of it probably are but I'm not sure if all of it is. There have been some alterations made so, presumably these things aren't unsolvable and I'm just trying to think about any planning applications we've had, erm, we have, over the years there have been some but I can't recall any particular difficulties, not internal or external to the building*" (C1)

A second non-clinical issue which affects the St Nicholas' Hospital site relates to the site's trees. The conservation area protects all of the trees on the St Nicholas' Hospital site from "*cutting down, topping, lopping, uprooting, wilful damage or wilful destruction of trees*" (Town and Country Planning Act, n.d.) without permission from the local council. Local residents in the houses surrounding the site have previously made complaints against the site due to the fact that the trees on the site's periphery are blocking all of the sun from their gardens. Northumberland, Tyne and Wear NHS Foundation Trust however has been unable to rectify the situation due to the protection placed upon the trees on the St Nicholas' site due to the conservation area and as such this taints the trust's relationship with the local community (see C5N quote below). The concept of 'familiarity and acceptance' was discussed previously; whereby familiarity between sites and their communities, through prolonged exposure, act to

create a level of 'trust' between the two entities (Gefen, 2000). This is theorised to work through the breakdown of the site's 'otherness' (Žižek, 2009). Negative interactions, such as the situation relating to the trees discussed above (and in the quote below) may have a negative impact upon the relationship between the trust and the community through an imposition of separation through a conflict of interest.

"The type of site is, all our trees have got TPOs on them, Tree Preservation Orders on them, and so we've got a lot of trees at the back end of our site that are just growing and growing and growing and that's south, yea, well that's south and the housing estate over there has all these 80/90 foot trees say, and none of them are getting sun into their back garden. Now I cannae cut them, because they've got TPOs on them the local authority environmental department won't let us do it, but they're peed off with me because they're my trees, but I cannae do anything about it. So trees are a bit of an issue on, having this type of site, clearly you wouldn't do that again" (C5N)

The listed buildings and the conservation area act to restrict the options of Northumberland, Tyne and Wear NHS Foundation Trust with regards to development on the St Nicholas' Hospital site. The listed buildings require consent from the local planning authority for works carried out on them and the development must be done in a manner which maintains the building's character (Historic England, n.d.). One side-effect of this is that on some wards the patient's courtyards are ringed with temporary fencing, giving them a much more custodial look about them and making the site feel closer to a prison than a hospital- an issue which brings back memories of psychiatric asylums largely custodial histories and may add to the stigma associated with the site.

"*The issue about the conservation area is that you, there are rather less things that you can do to it without planning permission*" (C3)

"*Right, what it means is that any change that was wanted to be made to it would have to be more than simply planning consent it would have to have conservation area consent, it would*

be looked at very more closely with those heritage issues examined with a concentration on, the word the planners always use is 'harm' to the appearance of the conservation area" (C3)

"*I think it is quite constraining in reality, you can't get permission for additional parking spaces, or, certainly if you look at our other sites in general if we decide it's a good idea then we can pretty much crack on and get it done, within this site it is very very limiting. Which is why I think it's slowly crept towards being more of an administrative base than for services*" (C7N)

"*Well I think if you're a service user, a nicely landscaped inner courtyard feels much less oppressive for want of a better word than, you know, a 5 metre fence, chain link fence, anti-climbing, and I think, you know, for those individuals who are in locked environments, it just kind of reinforces the stigma a little bit of that. I think externally as well if you're just passing through you might make a judgement about those individuals who are behind the fence for want of a better word. In terms of their levels of risk or dangerousness I think it does have quite a significant impact on. And it feels more prison-like and less of a healthcare environment which of course it is*" (C7N)

The conservation area has also caused issues with the local public (in addition to the disputes surrounding trees blocking sun to their gardens). The public in general support the conservation area, however they tend to see it as an absolute and there is opposition to any building works approved within the conservation area by the local council. The local residents have felt that, on a couple of occasions, the conservation area has not been upheld to the extent that it should have been. This is possibly due to a misunderstanding over the nature of conservation areas, and a belief that they prevent all development rather than imposing an extra layer of protection by forcing the need for planning permission (Historic England, n.d.).

"*There have been issues where residents have perceived that the council hasn't been tough enough in terms of its requirements in enforcing development control issues within the conservation area. Sometimes residents believe that conservation areas mean that there should be no development whatsoever, and sometimes it is possible that the council isn't tough enough,*

because it's always thinking about what would happen if it went to appeal. So there may be issues around that and sometimes, and recently residents, well some residents were quite concerned about one particular property, I won't name it but, there is one particular property where some alteration were made and the residents adjacent to that believed that that was a real issue because they thought it meant there was no real point in the conservation area at all, may as well just get rid of it. Erm. This issue about windows" (C1)

"*Shall I tell you about? The hole in the wall project basically, the wall that goes around the hospital site is still there. About 15 years ago the council allowed planning permission to cut a hole in the wall to enable residents to walk through it to, you know the wildlife park? To walk through to the wildlife park, and then through as an access, through the hospital grounds down to where, well, the central part of Gosforth. Erm. And the adjacent area is known as Coxlodge, erm, and there were a number of residents who weren't very happy about that and from time to time they complain about anti-social behaviour of youths that come through into that area, I'm happy to say though I think it's really important for the community to be able to access the wildlife park and, I've always been very reluctant to have a discussion about blocking that up. Particularly when we approached the police the police said well it isn't a major issue in terms of crime and community safety but residents disagree and I think some of them got a bit upset with us because we weren't taking more action about it*" (C1)

There has also been an argument made against the listing of the St Nicholas' Hospital main building, as it is deemed to lack architectural value. As such the retention of a building seen as being 'not fit for purpose' as a result of the retention of the architecture is viewed negatively.

"*Yea so that would be. One challenge is that it may be listed. Even if it's not it's of an architecture which people value. And there's always a move to retain architecture of that time even though it may not be fit for purpose in the modern age*" (C3)

The buildings on the St Nicholas' Hospital site do suffer from one major issue, and that is the cost of heating and powering the protected buildings on site. The impact of the

energy efficiency of hospital buildings can have a subsequent impact on the retention of former psychiatric asylum sites. Energy Efficiency can be defined as "*a way of managing and restraining the growth in energy consumption*" (International Energy Agency, 2014). Within this study the concern surrounding energy efficiency is to do with the costs to the NHS of running their estates; specifically running the old Victorian asylum buildings. This is because the energy efficiency of those buildings, unless they have been modified and brought up to modern standards (which in the case of buildings under heritage protection may not be possible), is likely to be low, and therefore costly to run. The energy efficiency of a building is measured using an energy performance certification and these certificates are needed whenever a building is bought, sold or rented. This certificate contains information about a property's energy use and typically includes energy costs and recommendation on how to reduce energy costs. It must however be noted that listed buildings are not required to have an Energy Efficiency Certificate (International Energy Agency, 2014). In 2012 the Department of Energy and Climate Change (DECC) planned to nationalise the initially London based RE:FIT programme (DECC, 2012). The RE:FIT programme designed to: "*help public sector organisations achieve substantial financial savings, improve the energy performance of their buildings and reduce their CO2 footprint*" (RE:FIT, n.d.).

An NHS Estates publication titled 'Developing an Estate Strategy' laid out criteria for monitoring estate performance, and energy efficiency was one of the key factors included (2005). The NHS has in place "*mandatory targets… to reduce the level of primary energy consumption by 15% or 0.15 million tonnes of carbon from March 2000 to March 2010 and for existing premises to achieve energy efficiency levels… by 2010*" (NHS Estates, 2005: 8). Energy efficiency particularly relates to former psychiatric asylums retained within the NHS, especially those which are protected by listed status or conservation areas, as the energy costs of running the buildings may be especially high. This is due to the combination of the building's age and the inability to make modifications such as double glazing and insulation, as well as other long term cost saving methods such as the addition of solar panels. Older properties tend to have both low current and potential ratings due to limitations with the structure itself (which may include a lack

of space for insulation to be placed etc.). In this way former psychiatric asylum buildings are never going to be highly energy efficient, however the gap between current and potential efficiency is likely to be fairly wide due, as stated above, to the inability to make modernisations. In this way the effect of low energy efficiency on the state of retention of former psychiatric asylum sites is a direct result of the heritage protections which are present on these sites- as it is the inability to adapt, which makes these buildings less desirable.

The Grade II listed buildings on the St Nicholas' Hospital site were built in 1867 and 1896 and as such were not built to be energy efficient like modern buildings. The Grade II listed statuses on the buildings have meant that it has not been possible to improve the energy efficiency of these buildings on the St Nicholas' Hospital site. Installation of improvements to energy efficiency, such as insulation, double glazing and solar panels are not possible due the conservation area- which restricts development on the entire site and the listed status which prevents development and additions to some of the buildings on the site. The end result of this is that these buildings have become expensive to operate and maintain. In fact the main asylum building on the St Nicholas' Hospital site consumed, in the 2014/15 financial year, £413,525 of energy in the form of: £264,398 of electricity; and £149,127 of gas. This is slightly down on the previous year's cost of £428,907 (Proud, 2015). Also the following has been reported regarding the Jubilee Theatre in recent times: "*the listed Jubilee Theatre at present costs more to maintain than the present usage supplies in income*" (One Core Strategy NG, n.d.).

"*It must be quite an expensive building to keep, just even to heat and to power and you know...The difficulty is it's a grade 2 listed building and what on earth can you do with a grade 2 listed building if it's not that you know, what happens to it*" (C1)

"*I know we revamped the unit probably 4 or 5 years ago, and in terms of some of the requirements around carbon footprint and insulation, just couldn't. Some of it's much better of course, if you look at the thickness of walls and things like that but some of it's, because of*

windows and doors and all sorts of things is much much worse so yea I think it's an issue for the architects and the contractors definitely" (C7N)

Portsmouth Borough Asylum - St James' Hospital

"*Portsmouth is a city where we don't have that many buildings of quality. And I believe that the retention of buildings like that are essential for the ongoing fabric of the city, the built environment*" (D5)

St James' Hospital also has a number of heritage protections on the site. The main asylum building was Grade II listed in 1998 after a fourteen year campaign which began in order to prevent the site's closure and sale with help from Hampshire Building's Preservation Trust, whose vice-chairman Major Keith Egleston stated that "*it is interesting for two reasons. It has great architectural merit and it is set in a very historical landscape*" (Ball, 1984: 8). Listing covered the hospital's main building, the chapel and all attached piers and lamp posts. The trees on the site have also been under the protection of Tree Preservation Orders as of 1995. It is subsequent to both of these that the green space on the Hospital site, following a public enquiry in 2001, was designated as a town green in 2002 (Hansard, 2002; Portsmouth City Council, 2004). This was done as part of an exchange deal whereby development on-site was accepted by the local community. The cricket pitch on the hospital site is also a protected green space.

"*Erm, Yea. I think [the village green] probably does now belong to the council. Yes it's, it was part of the hospital site, there is housing a bit further to the east and basically some form of deal was done over that, where residents accepted that part of the development in exchange for the green the site*" (D4)

"Following a public inquiry in 2001, part of this area was designated as a 'Town Green' under the Commons Registration Act. That, in turn, included an area set aside for public open space in the planning obligation relating to the outline permission for housing… The historical

setting of the private grounds to the hospital fulfils an essential recreation and amenity role for the local community. The extensive Tree Preservation Order and unspoiled natural habitat is a haven for wildlife and is appreciated both by residents and those from further afield. The City Council therefore feels that there is sufficient justification in extending the area to be retained as open space beyond that designated as the Town Green. Further studies will be undertaken to determine whether the site should be designated as a site of local importance to nature conservation" (Portsmouth City Council, 2004: 2-3).

The heritage protections on the St James' Hospital site act to preserve the site's building and surrounds in their current form; with the listed status protecting the main asylum block, the chapel and the piers and lamp posts, the Tree Preservation Orders and the village green protecting the green space at the front of the hospital grounds. It is stated by Portsmouth City Council that *"proposals that retain and re-use the main building at St. James's Hospital will be permitted, provided that: (i) they preserve the integrity and appearance of the listed main building and… are sympathetic to its appearance and setting; and (ii) the surrounding highway network can satisfactorily accommodate the additional traffic generation"* (2004: 4). So development will be permitted if it is sustainable and sympathetic to the aesthetics of the current site. However the listed buildings and Tree Preservation Orders have also played a significant part in curbing development on the St James' site, with plans for housing being changed as a result of the heritage protection that they provide. These protections resulted in plans for the site being restricted, with planned housing numbers on the site being reduced from approximately 135 units to, at most recent estimate, 101 units of housing.

"[Tree Preservation Orders] will stop development" (D2)

"*A fair bit yea, I mean. So far as the Harbour School south eastern part of the site's concerned the numbers have been, the number of units in discussion with the NHS have been coming down, they started at about 135 I think and now down to 101. That's a latest I'd heard. And the reason for that is twofold. It's the context of the listed chapel, and its protected trees. Now of course if and when this is sold to a developer a developer might take a harder view because the*

NHS property trust is really quite a benign land owner, it doesn't really defend its interests in the way that a large property developing company would do, and they might just not take no for an answer. But it has made a difference to date definitely" (D4)

As shown in Figure 5.11 the heritage protections in effect on the site act to limit future possibilities for the trust. This is in a number of forms, including: limiting development on the site's listed buildings which may harm the integrity of those buildings; limiting the development on the green open spaces of the site; and limiting development through the placement of protected trees.

"*And then there's a main building which is also a listed building so they have to keep certain characteristics and they can't bulldoze it or anything like that*" (D1)

"*The chapel is also listed, but the chapel is within the first stage of the, of the selling off, but as you say the building itself is listed and so will stay and any building development will have to be in-keeping with that in the surrounding area*" (D1)

"*Well it's a substantial listed building, and it's not just the building itself, but it's the setting that goes with it. So for an example you also have a small chapel to one side of it, separate from it, which is also a listed building. And part of what's affected the possible layout of housing on the site is that it has to step back so as not to affect the planning context around the chapel, you also have a very substantial cricket field in front of it and I think that's a most important vista for the building so that, and that's protected space anyway. So there are a considerable number of challenges in the immediate part of the site*" (D4)

"*It's, I mean the plan obviously has some effect on these things, we have quite a strong policy on protected open space, which is why the cricket field can't be developed because that is protected open space*" (D4)

There are a number of ways in which these heritage protections restrict Solent NHS Trust's options with regards to development on the St James' Hospital site. Alongside

issues with the listed buildings and Tree Preservation Orders, whereby future developments on the site are restricted, there are mundane day-to-day restrictions around traffic and parking (as discussed in detail in chapter 5).

"*Neither had I about a year ago and then when they put down the, a couple of year ago when they sold off the first section just North of the current site there were lots of trees there and Tree Preservation Orders became a hot topic. So there are elements, trees, listed buildings and potential traffic are probably 3 of the biggest barriers or positive depending on how you look at it*" (D1)

"*And so it's always been seen, that landscape, those trees that open space, as part of something that was important to retain in Portsmouth, so I think the TPOs and other restrictions on the removal of trees there is a good thing, and I think any development has to work around that rather than work over it*" (D5)

It is possible that the listed status of the St James' Hospital building is the cause of the site's retention by Solent NHS Trust. One respondent stated that they felt the Grade II listed status attached to the main asylum block was the only reason it had not been demolished for redevelopment. It has also been stated that listed buildings do not have a high sell on value. This may have resulted in the site's retention, as Solent NHS Trust, if they wish to leave the site, have to first sell the listed main hospital building. This is compounded by the apparently widespread view that the hospital building as it stands is 'not fit for purpose' and is therefore only fit, and is currently only in use for, administrative purposes. Considering this limited use value, the sale of the main building will remain high on the trust's list of priorities, especially considering the buildings substantial running costs of £2m per year (D4). This high running cost is linked to the inability to modify the buildings to be more energy efficient as a result of heritage protections on the site.

"*The listed building aspect of it is obviously a significant one, I imagine if it wasn't a listed building we would see the whole thing flattened. That is very much not the case though. And I*

believe, I'm not certain, but I believe the driveway aspect of it is also protected so the driveway and the trees" (D1)

"*Oh a great deal, for one thing it won't be worth much. And listed buildings aren't worth a lot of money really if they're in poor condition because the cost of actually sorting them out is so great. And if it wasn't listed, let's face it, if it was a brick building from a later date with little value it would have been demolished, and you would have a more valuable site and you would have had the opportunity to do more generic housing I suppose. So yea, it's only been retained because it's listed*" (D4)

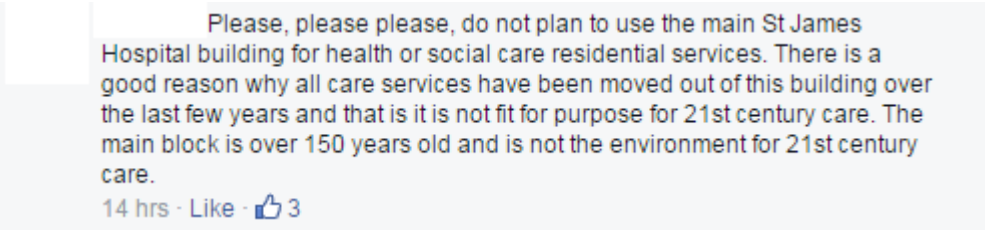

Figure 7.2: Keep Milton Green Facebook Page comment

"*As far as I am aware there haven't been those attempts (at improving energy efficiency). Again if I were to speculate I'd say that it's a mixture of the building isn't compatible with certain forms of insulation but at the same time the costs of insulating such a large building in the design that it is would probably be less cost efficient than purely moving all the services to a more modern building*" (D1)

Discussion

What we have seen in this chapter are a number of factors relating to heritage management which have had an effect on the retention of each of the case study sites. This has ranged from the effects of: conservation areas; listed buildings; Tree Preservation Orders; and town and village green status on the state of retention of the four former psychiatric asylum sites which make up this thesis' case studies. These factors have the most effect in St Nicholas' Hospital and St James' Hospital, both of which have multiple heritage protections on their sites; in contrast to this Cefn Coed

Hospital has no heritage protections and Kingsway Hospital has two listed site buildings on the site which do not appear to have an effect on the retained status of the site as a whole.

Although heritage has little effect upon the Cefn Coed Hospital and Kingsway Hospital sites, it has a large impact on the St Nicholas' Hospital and St James' Hospital sites. Between these two sites there are multiple examples of heritage protection in place. St Nicholas' Hospital has two listed buildings on the site, the main asylum block and the Jubilee Theatre, and is the subject of a conservation area. The St James' Hospital site also has two listed buildings, the main asylum building and the chapel, it has a number of Tree Preservation Orders on the site and it also hosts two protected green spaces- including one designated village green. However, both of these sites (as well as Cefn Coed Hospital) have been described as 'not fit for purpose' with regards to acute psychiatric care, which may be related to the presence of old heritage protected buildings on the sites. One way in which this may be the case, primarily the St Nicholas' Hospital site, is through the restriction of development on the site imposed by both the conservation area and the listed buildings. This means that the trust is unable to erect permanent modifications to listed buildings within the conservation area. This has led to the erection of temporary fencing around some of the wards in the older buildings in order to comply with health and safety regulations. This however has meant that the site in places has a custodial appearance, and may act to stigmatise the patients within those wards. To return to Schama, the links between landscape and memory are pervasive (1995). Therefore the custodial appearance of the St Nicholas' site, in addition to the tangible heritage remaining on the site in the form of the old asylum buildings (Harrison, 2010), may act to preserve the memory of the "*long shadow of the stigmatised asylum"* (Joseph et al., 2012: 13). The main difference between the issues at St Nicholas' Hospital and those at St James' Hospital in this regard is that Solent NHS Trust no longer houses patients in the old asylum building as they have been reprovisioned elsewhere; this acts to limit the effect of the heritage restrictions on the St James' Hospital site to an extent. However this may not necessarily be an improvement upon the old facilities- as Barham stated it may just be "*the creation of old*

problems in new places" (as cited in Jack, 1998: 31). As Joseph and Kearns state: "*this vilification of the asylum in the era of deinstitutionalization is ironic given that the small-scale residential components of contemporary community care initiatives often take on a custodial form reminiscent of the asylums they have replaced*" (as cited in Moon et al., 2006: 134). It is thought that, by and large, the inpatient care on the St Nicholas' site is of a good standard due to the site being well managed and investment in the wards within the protected buildings; however the heritage restrictions imposed on the trust have meant that there are instances, such as the security fences, which remain that may harm both St Nicholas' and St James' images and consequently the patients' wellbeing through the proliferation of carceral imagery on the site. This is a good example of the landscape of the site, in this instance caused directly by its heritage protections, invoking stigmatised memories (Schama as cited in Joseph et al., 2013).

An NHS Estates publication from 2005 laid out criteria for monitoring estate, an included performance and energy efficiency was one of the key factors included (NHS Estates, 2005). The energy efficiency of former psychiatric asylum buildings, unless they have been redeveloped and brought up to modern standards (which in the case of former psychiatric asylum sites under heritage protections may not be an option), is likely to be poor and the buildings therefore costly to run. Between 2000 and 2010 the NHS set itself a target to reduce the level of energy consumption by 15% and achieve higher energy efficiency (NHS Estates, 2005). Heritage protections have had a major effect upon the cost of running the buildings on the St Nicholas' and St James' sites. This is due largely to the poor energy efficiency of the old asylum buildings on these sites. These buildings were built solidly, but without provision for modern energy efficient modifications such as insulation; and the heritage protections affecting them prevent the additions of energy efficiency measures such as double glazing and solar panels. This leaves the cost of running the buildings at both sites extraordinarily high, with St Nicholas' Hospital's main building costing upwards of £400,000 a year in energy costs alone (Proud, 2015), and the Jubilee Theatre reportedly costing more to maintain than it makes in revenue (One Core Strategy NG, n.d.); and St James' reportedly having energy bills of approximately £2m per year (D4). These costs are a

major drain on the trust's resources and as such may act as a push towards sale and a move to more modern facilities. However these high energy costs may also put off potential buyers who, in addition to the cost of acquiring the site and the massive costs entailed in redeveloping the listed buildings, would then have massive running costs to pay on buildings with limited development options.

Another way in which aspects of heritage management have affected St James' Hospital is by curbing the planned development on the site; in particular Tree Preservation Orders have had a major effect on the St James' Hospital site (as mentioned above). This has been in the form of gradually reducing the number of housing units planned to be built on the site. This has in part been in the form of limiting the number of housing units which the site can provision due to the Tree Preservation Orders on the site. It is thought that at present the number of housing units planned for Phase 1 of the planned sale of land on the St James' Hospital site, incorporating the Harbour School (Figure 5.11), has been reduced from 135 to 101. Though there are a few Tree Preservation Orders on the St Nicholas' site there are less than there could be, and there have not been any reported incidents or restrictions imposed on the Northumberland, Tyne and Wear NHS Foundation Trust. This is likely because the conservation area acts to protect the trees on the site without the need for Tree Preservation Orders to be assigned. Tree Preservation Orders have therefore, up to the present time, not been necessary at St Nicholas' Hospital. The St Nicholas' site is at present not affected by heritage restrictions in this way- largely due to the continued plans for retention by the Northumberland, Tyne and Wear NHS Foundation Trust.

With regards to the retention of the sites, the various heritage protections on each of the case study sites act to prevent the dereliction or demolition of the sites. Therefore the buildings have to either be retained or sold for future development. The heritage protections may also affect the ability of each of the NHS trusts to sell the sites, with multiple restrictions to development. This includes restricting the ways in which the buildings are developed, maintained and modified and applies to the buildings with either listed building status or, in the case of St Nicholas' Hospital, that are within the

boundary of a conservation area. In addition to this are the limiting effects which Tree Preservation Orders and green spaces can have on potential development as seen at St James' Hospital with the reduction of planned housing units from 135 to 101[14] (D4). Returning to a quote from NHS Estates (2001: 29): "*great benefit can also be achieved from renovation of existing buildings (avoiding the need for expensive and resource-intensive new construction), and the renovation and modernisation of an existing building should always be the first consideration. Although some techniques require particular building configurations that cannot be retrofitted, many approaches will work as well within an existing building as in a new one*". This may well be the case in general, and this strategy is one which must be applied at St James' due to the main asylum building's listed status. However due to this status not only are the renovation and modernisation of the building limited, they will also be much more costly than for general, non-heritage protected, buildings.

One issue that has arisen as part of this study is that not everyone is convinced by the heritage protections afforded to former psychiatric asylum sites. There is support for the listing of these sites, but there are also issues which arise as a result of heritage protections which some are opposed to. The St Nicholas' Hospital site for example has had issues around developing a more suitable site for service users which has led to non-ideal aspects of the sites landscapes, i.e. temporary fencing (discussed in detail above). As a result it has been stated that this may have a negative impact on service users, and this may have contributed to a push towards the site having a more administrative role (C7N). There are also issues with the local community around Tree Preservation Orders, and trees on the site blocking sunlight from neighbouring residents gardens (C7N). All of these factors make people question the heritage protections which are afforded to the site, as in some cases they act to lower the quality of life of service users, staff and local residents.

[14] Most recent estimate

Finally we have also seen how local residents can have a large impact upon the heritage protections afforded to a site. In the case of St James' Hospital this was firstly in the form of the village green on the site, which was reportedly assigned as a result of a deal with local residents; and then subsequently the Keep Milton Green campaign has been actively involved in opposition to the current housing developments on the site. Local communities therefore, particularly through the imposition of town and village greens and through general opposition to overdevelopment, can have an impact upon the heritage protections on former psychiatric asylum sites and this has an impact upon the retention at these sites.

Conclusion

This chapter has focused on the effects of heritage management on psychiatric asylum retention. What we have seen is that heritage protections, from listed buildings to Tree Preservation Orders, have had major effects on the ways in with former psychiatric asylums have been retained, the major factor being the restriction of development which reduces both the use-value and the sell-on value, through an inability to make modifications to the building. These factors combined, despite their multitudes of effects upon the states of retention at two of the case studies examined in this thesis, are but one perspective. As we have seen in the previous chapters the effects of mental health care policy and planning policy and also factors relating to stigma have also played a major part in the state of retention at each of the case study sites. As such the next, and final, chapter 'Conclusions' will discuss the effects related to policy and planning, stigma and heritage management together; and the interconnected nature of the factors involved.

Chapter 8: Conclusions

The aim of this chapter is to summarise all of the possible factors which have been discussed in previous chapters relating to: Lévi-Strauss' theories of anthropophagia and anthropoemia; policy and planning; stigma, memory and the community; and heritage management. This will be done in the contribution to knowledge section, where the interconnected nature of these factors will also be discussed. Following this, the implications and limitations of the study will be discussed, then reflections will be made on the methodology utilised. Subsequently recommendations for future research will be discussed before concluding remarks are made with regards to the thesis as a whole.

Contribution to Knowledge

In Chapter 1 Lévi-Strauss' theories of anthropophagia and anthropoemia were discussed in relation to the history of mental health care. A cycle was identified across history: from a method of anthropophagia, assimilating deviants into society's norms and values; to one of anthropoemia, first through expulsion and then through incarceration. This period of incarceration is highlighted first through the introduction of the workhouse and subsequently through the imposition of the asylum as the first institution specifically designed to incarcerate the mentally ill. The psychiatric asylum as an anthropoemic institution was also what Foucault would define as a heterotopia. The asylums were identified specifically as being heterotopias of deviation: "*those in which individuals whose behaviour is deviant in relation to the required mean or norm are placed*" (Foucault, 1986: 25). This included prisons and asylums amongst other examples.

Lévi-Strauss' theory was extended and applied to this thesis in terms of mental health care. This was achieved through the extension of the historical examples of anthropophagia and anthropoemia into the present day, establishing an historical cycle and updating the theory to cover the present. This was done by applying the theory to

the current mental healthcare landscape, and identified the current system as a period of anthropophagia defined by the policy of community care, and complemented by the limited retention of a small number of former psychiatric asylum sites which exist as an antithesis to the current community care paradigm. As such what this thesis has also shown is how anthropophagia and anthropoemia are not exclusive. The two approaches to mental health care may be more or less dominant than the other, with the dominant approach providing the paradigm for the era, however both approaches exist simultaneously. Anthropophagia dominates the current mental health landscape through the proliferation of care in the community and a focus on outpatient services; whereas anthropoemia, though no longer the dominant model, persists in the existence of inpatient facilities- of which some in-use former psychiatric asylums are one example. The persistence of inpatient facilities can be argued to be as a result of the continued need for psychiatric inpatient services, meaning that anthropoemic institutions will always exist in some respect.

There were three areas which I wanted to explore in this thesis. After exploring the extent of psychiatric asylum retention, this thesis addressed two key questions: how have these psychiatric asylums been retained?; and what has led to their retention? The first of these areas was explored in the 'Case Study Sites' chapter with ten sites found to have been primarily retained within the NHS- although twenty were found to have been retained in some form (as seen in Table 4.1). The second question of 'how?' was also tackled within this chapter and an analysis of the four case study sites showed that the sites have been retained to an extent, with services still being provided at each of the sites but much of the original asylum grounds had been sold off and used in a number of other sectors- including housing and education.

What we can see is that the 'fates' of psychiatric asylum sites are never whole. Each site has examples of multiple fates on their sites, whether that includes: residential; redevelopment; retention; dereliction; or demolition. At the time of writing, of the four case study sites examined in this thesis Cefn Coed, St Nicholas' and St James' have been primarily retained- in that their main buildings are in use for either health care or

administrative purposes within the NHS; whilst the main building at Kingsway has been demolished- with a substantial amount of health care still available on the remainder of the site. This being said, both St James' Hospital and Cefn Coed Hospital have plans to close in the near future- St James' is in the process of being sold and Cefn Coed has plans to wind down over the next few years. Despite this it is likely that all four sites will be at least partially retained: Cefn Coed has the newly built Ysbryd Y Coed building for dementia care (built in 2012); Kingsway has the new long term PFI building which ties them to the site for upwards of 30 years; St Nicholas' show no signs of relinquishing their former asylum building at present; and there are a number of secondary services on the St James' site which are likely to remain even if large sections of the site are sold off for housing development.

This left the question of 'why?' This was dealt with in Chapters 5, 6 and 7; which explored a variety of themes in order to find an answer. There were a multitude of factors which affected the states of retention at each of the case study sites, which varied from site to site, which led to a state of inertia. Newton's first law of motion stated: "*corpus omne perseverare in statu suo quiescendi vel movendi uniformiter in directum, nisi quatenus a viribus impressis cogitur statum illum mutare*" (Newton, 1962: 644). Or roughly: 'every body perseveres in its state of being at rest or of moving uniformly straight forward except insofar as it is compelled to change its state by an unbalanced force'. This is the law of inertia, and it can be used in this context to analyse former psychiatric asylum sites. Take the 'body' as the asylum building. Without significant external pressures, such as issues around: heritage; stigma; sustainable development policy; urbanisation; and financial pressures etc., these retained former psychiatric asylum sites remain in a state of inertia and therefore continue to be retained. Until a significant and unbalanced external force impacts upon it, such as the factors discussed throughout this chapter, an asylum building will be retained. It must be mentioned that even if a force, such as stigma, is inflicted upon the asylum, significant counter-pressures such as issues around heritage can act as a counterbalance and maintain the state of inertia. Factors impressed upon the asylum's state of being must be unbalanced in order for it to change its state. In this way former psychiatric asylum sites continue

to be retained, and will do so until the pressures for and against retention become grossly unbalanced and the last of the asylums finally closes its doors for service provision.

As a result, inertia has become the default state for former psychiatric asylum sites; with multiple factors balancing out in favour of the sites' retention. We have seen from asylum history that asylum closure took approximately 25 years to begin to take effect (see figure 4.1.); this is because such large scale closures takes time to plan and enact- not least through the initialising of an alternative mode of care (i.e. community care). But it is not only time which has delayed the closing of the former psychiatric asylums discussed within this thesis, there has also been a number of parties with a vested interest in the asylums remaining open, which includes: staff; patients; relatives; and the local community. For example Parr et al. discuss the closure of Craig Dunain asylum and the fact that many patients regretted having to move to a new facility: "*that awful place was home to hundreds of people and it was their community and they loved it*" (2003: 353). One reason given for the continued retention of Cefn Coed was the support of staff, 'a strong body of clinical opinion', that the site should remain in its current location (A9aN). Also, we can see from the interviews at Kingsway, St Nicholas' and St James' that the sites are valued within the local community in a number of ways; be it as a provider of green space or through pride in the modern institution. It can be argued that this support for the retention of former psychiatric asylum sites is a result of a conservative resistance to change. These sites, which over history have been vilified for their negative aspects, are now being supported for their positive aspects. In this way people are hanging on to certain aspects of the site which they do not wish to lose; such as the access to open space or the availability of local mental health care. In fact we can see that there is indeed popular support for asylum care through the survival of the private asylum system, for example the Priory Group alone has more than 100 centres across the UK (PrioryGroup, n.d.).

Another issue promoting inertia is the policy of the NHS with regards to these former psychiatric asylum sites. As we have seen previously, NHS Estates policy is in two

minds with regards to former asylum buildings; seemingly promoting both retention and sale simultaneously (NHS Estates, 2001). It can safely be said therefore that the NHS is not wholly clear on its objectives with regards retention or closure. These sites are in many cases described as unsuitable and 'unfit for purpose'; as the older facilities are no longer adequate for modern mental health care provision. Added to this there appears to be some residual stigma around the sites as a result of their continued retention. As stated previously the re-use of asylum sites in a capacity substantially different from psychiatric care should aid the neutralisation of memorialisation on the site; so the retention of these sites as mental health facilities may have acted to prolong the stigma attached to these sites. Despite this, there is a need for facilities and space within the NHS. The financial climate means that the purchase of additional sites is not plausible, so despite the feeling that these sites should be replaced the NHS continues to utilise the space which they have through the renovation of older facilities and the building of new ones. This ties the NHS Trusts to the sites, an example of this being at the Kingsway Hospital site, whereby the Trust is tied to the site for the foreseeable future due to being financially invested in the new build PFI building (B7N).

Financially, it makes sense for asylum buildings to be utilised, as they have large initial set-up costs, and: "*once they are in place… they can potentially be used for a very long time. They represent a durable form of capital. However, this capital tends to be institution-specific to some degree. It cannot easily be transferred. Infrastructures built to the specifications of one institution have to be remodelled in order to fit the specifications of another*" (Genschel, 1995: 8). In this way, it makes financial sense to continue to use the buildings, in the same way that the construction of a new building would incur another large set-up cost.

So, with regards to inertia at the four case study sites (Cefn Coed, Kingsway, St Nicholas' and St James') at each there have been counterbalancing factors which have prevented the closure of the anthropoemic institutions (psychiatric asylums) despite the fact that we are largely in an era of anthropophagia characterised by community care. These factors act as either: push factors- which drive towards closure; pull factors- which drive for retention; or factors which can act as both or either. Examples of these

would be as follows: push factor- government push for sale of assets- which is a pressure specifically to sell non-vital commodities; pull factor- listed buildings- this makes buildings much more difficult to both run and develop and therefore makes sale of the sites much more difficult; both/either- level of stigma- one of a number of factors which can push either way depending, in this instance, on whether there are high or low levels of stigma present.

These factors have been discussed in their respective chapters, however there are many cases where the factors interact and cross between chapter boundaries. Examples of this include 'traffic/parking' and 'energy efficiency' which whilst raised in the heritage management chapter could also come under the heading of policy and planning. Likewise 'urbanisation' is discussed in the policy and planning chapter but is strongly linked to the concept of 'community familiarity' and has more of an effect with regards to stigma; and 'sustainable development' has strong ties to heritage management. Additionally 'community pressures' is highlighted in the heritage chapter but could just as easily be part of the stigma chapter; likewise 'scandals' have had profound effects on mental health care policy.

The interconnected nature of the topic areas occasionally made the splitting of topics into chapters difficult, and some may not agree with the placement of one or two of them, but what we see overall are a plethora of factors which when combined lead to a situation of inertia which has kept the four case study sites open and in use up to the present date, prolonging the lives of the psychiatric asylum as a space for mental health care; and enabling the survival of the asylum as an anthropoemic institution in an era of anthropophagia defined by community care as the prominent health care modality. This may not be the case in the near future however, as both Cefn Coed and St James' Hospitals are reportedly due to close in the near future.

What we have seen in this thesis therefore are the multiple factors which have affected the retention of those few sites which have remained as an antithesis to the anthropophagic paradigm, these have included: NHS policy; planning policy; stigma;

public opinion; public access; and heritage management amongst other factors. These factors have combined to produce a situation of inertia regarding former psychiatric asylum sites, which has resulted in the current mental healthcare landscape, with anthropophagia and anthropoemia as the dominant and subordinate approaches respectively.

Implications of the Study

There are a number of potential implications for policy as a result of this research; most notably with regards to asylum closure. Firstly we can see that political policy takes a long time to be enacted. The process of deinstitutionalisation began as policy in 1961 with Enoch Powell's water tower speech (Enoch Powell's Water Tower Speech 1961, n.d.). Despite the scaling down of some institutions in the 1960s it took almost 25 years to begin to close large asylums (as seen in figure 4.1); and it was not until over a decade later in the mid-to-late-1990s that psychiatric asylums began to close en-masse. This long delay was despite the pressure as a result of the rise of community care as the predominant mode of mental health care. The former psychiatric asylums which to this day are in use within the NHS have been retained against a backdrop of 50+ years of a policy of asylum closure and community care; they continue to survive as anthropoemic institutions in an era of anthropophagic care.

Secondly we can see that when it is decided that former psychiatric asylum sites will be sold by the NHS, there needs to be clear policy in place for the provision of mental health care in the area. There is still a need for both inpatient and outpatient mental health care, and in some cases it has been suggested that deinstitutionalisation has been rushed; leaving patients with no suitable alternative (Jones, 1998; Gleeson and Kearns, 2001). This has led to what Dear and Wolch have called 'landscapes of despair'; whereby former psychiatric patients become criminalised and are subsequently transinstitutionalised- often being "*misassigned to inappropriate social settings and reinstitutionalized (for instance, in prisons) because they lack other shelter options*" (2014: 4).

There has been a sense at the case study sites that there is a pressure on the local authorities to provide a large amount of housing; especially on brownfield sites. This is in the form of Local Development Plans (LDPs); which outline targets for local authorities with regards to the number of housing units which are required to be built in the area and the percentage of these which are to be built on brownfield land (City and County of Swansea Council, 2012b). At each of the case study sites, particularly at Cefn Coed and St James' Hospitals, there is a struggle to meet the targets set out in the LDPs. As a result there is pressure on the local authorities to utilise the former psychiatric asylum sites as brownfield sites for housing; even though their status as 'brownfield', considering the amount of green space at the sites, is questionable. The increased need for housing, and the lack of land to expand into, has led to a process of urban densification (Broitman and Koomen, 2015); however there is still an ever-growing need for additional housing in these areas and across the country. There is therefore a struggle between the need for housing in densely populated cities and the desire for green space within local communities. This can be seen in particular in Portsmouth through the Keep Milton Green campaign; whereby the local community is campaigning to keep the green space at St James' Hospital rather than see it developed into housing.

It has been established that in a number of cases the sites as they stand are for the most part, valued assets within their communities. This is partially due to the long-standing relationship between the asylums and their communities which in some cases have run for over a century. In this way there is a residual support for these asylums within the local communities in which they stand, again despite over 50+ years of community care as the predominant treatment modality. It may also be partially due to the provision of grounds and green spaces which provide an important amenity for the community and may otherwise be lacking in the area. As a result these sites should be protected as important local assets and focal points of the community; and protections, such as those seen at St James' Hospital with the village green, should be installed and expanded to prevent the loss of these spaces to the local community through overdevelopment.

What we can see also is that, with investment, psychiatric asylum spaces can provide effective care to mental health patients. However, it has also been seen that hospitals which are subject to heritage protections may, as a result, be unsuitable for inpatient facilities- due to the restrictions in place with regards to modifications to the buildings. An example of this is the use of temporary fencing, seen at St Nicholas' Hospital, where there are restrictions on the building of permanent additions due to the conservation area and health and safety protocols. This means that despite the effort which NTW has gone to in order to refurbish the internal spaces and courtyards, the external courtyards and other spaces unfortunately appear custodial as a result of restrictions to development. These spaces may have a negative effect on patients, their friends and relatives, and other visitors to the site, through the imagery which they conjure up. It would be my recommendation that such areas should be considered for exemption to heritage protections in order that a permanent, less custodial, barrier- which could be built in-keeping with the style of the hospital- could be erected for the safety of patients on the site.

The Private Finance Initiatives (PFIs), "*long-term arrangements between the public and private sectors, in which the latter finances the design and build of new or substantially upgraded public facilities*" (Hellowell and Pollock, 2009: 13), have been argued to have had negative effects on NHS trusts. This is through the creation of an affordability gap and the displacement of the burden of debt to NHS trusts (Pollock et al., 2002). This thesis found that the PFI at Kingsway Hospital acted to tie the hospital to the site for the 30 years of the PFI contract, which limits the trusts ability to adapt and evolve to a changing healthcare environment.

Limitations

This study has had a number of limitations for a number of reasons. One of these has been as a result of the ethics and governance process. Due to restrictions put in place early on by the university it was not possible to interview patients within the confines of this study. This created an inability to obtain a key viewpoint on the retained status

of former psychiatric asylum sites, which had the potential to be a key component of the research.

Similarly there were many hurdles with regards to interviewing NHS staff which were mostly traversed, with the exceptions of Solent NHS Trust which denied access to interview NHS staff at St James' Hospital. This unfortunately limited the interviews at St James' substantially and meant that it was not possible to get that added perspective in relation to St James'. This meant that the interviews for St James' lacked a key component, as at the other case study sites the NHS interviews provided key information and viewpoints. It may have been possible to use an alternative case study site to replace St James' but due to the convenience of access to the site both geographically and through the availability of documentary data, and the intention to maintain a balance between sites retained for health care and administrative purposes, the decision was made that St James' would remain a part of the study.

Another limitation was one of time. A longer study could have incorporated more case studies and more in-depth research methods, for example the inclusion of a survey of local residents, more semi-structured interviews etc. to increase the amount of data collected. However that being said, this thesis has been researched and written over a three year period, so it may be the case that the topic is too large to examine in one study. In this way it is felt that future work could expand on this thesis' findings.

Reflections on Methodology

During this thesis a number of research methods have been used to gather information. Semi-structured interviews have been the main method of data-collection, complemented chiefly by: archival and content analysis; and multi-sensory ethnographies. The Semi-structured interviews were performed to gather data regarding the sites retention. These interviews took place with individuals divided into two categories: NHS; and non-NHS. The main drawback of the use of semi-structured interviews in this thesis was the inability to interview NHS participants at St James'

Hospital (as detailed above), but overall the method produced in-depth qualitative data which provided evidence to answer this thesis' main questions.

The archival and content analyses were performed using local newspaper archives (both analogue and digital), national news websites, Facebook and Twitter. The newspaper archives provided an abundance of context through providing detailed site histories from the perspective of the public, and highlighted the major events at the sites as was intended. The content analysis of Facebook was primarily done as part of research into the Keep Milton Green campaign, and acted to catalogue the process which the group were going through in order to save the St James' Hospital site from residential development. This provided much detailed and in-depth data regarding public opinion towards the St James' site. The 'mining' of Twitter for data regarding public opinion of each of the case study sites was however more limited. The intention of this method was to garner evidence of public opinion of the former psychiatric asylums; however the search was limited by practical issues. Due to the difficulty in attributing tweets to certain sites it was decided that a geolocational factor would be added to the searches which would limit the tweets found to those within the cities of the asylum sites. However as not all tweets are geolocated, it is thought that this drastically limited the already small number of tweets available. As a result not many tweets were collected, and as a result of this their use in the thesis took a different path to what was intended. These tweets eventually were used to theorise the use of sites names in local vernacular but on a very limited level. They were useful as evidence to back up other parts of the thesis through evidence of site-usage by the community but only as individual examples.

Ellis et al. (2011) defined autoethnography as "*an approach to research and writing that seeks to describe and systematically analyze personal experience in order to understand cultural experience*". The use of multi-sensory autoethnography (with a multi-sensory dimension) within this thesis takes a proven research method and applies it to a new area of work. The application to the former psychiatric asylum sites within this thesis provided much more data than was expected at first. The original 'epiphanies' were

around apparent normalcy and interactions between the sites and the public, whereas additional evidence was collected in relation to: the levels of access at the sites; the sites' provision of therapeutic landscapes; the level of development at each of the site- both in terms of new mental health facilities and of land sale for residential developments; the limitations provided by the imposition of heritage protections; and the interior layouts of the facilities. As such, much more pertinent data was collected and analysed (in Chapter 4) than was originally conceived.

Overall whereas some methods used within the thesis were much less useful than anticipated, such as the content analysis of twitter; others provided more relevant data than was originally conceived, such as the walkthroughs. This resulted in different aspects of the thesis being more useful than others in ways which were not anticipated, e.g. the walkthroughs became a much more prominent part of the thesis and the twitter data became much less prominent than was planned.

Recommendations for Future Research

There are a number of areas which could be examined in the future within this topic. A study which includes the view of patients would provide an interesting new perspective on the retention of former psychiatric asylum sites; as would a large-scale questionnaire regarding the views of the general public. Another area which could be studied would cover the process of closure- which was unfortunately not possible to study in depth in this study as access to the one site which was undergoing closure, St James' Hospital, was limited.

Similarly this study could be extended through the exploration of similar themes at other sites. This would naturally include the other six sites which were identified within this thesis (Hellesdon, St Bernard's, St Cadoc's, St Clement's, St Martin's and Whitchurch); but also to extend to asylums in other countries- in order to gain an international perspective on psychiatric asylum retention. This could be done in countries with similar systems in place such as: the USA; Canada; or New Zealand, or could be extended to mental healthcare spaces in other areas such as Eastern Europe or

South America. Each of these studies would provide different and varied perspectives on the retention of psychiatric asylums globally.

Concluding Remarks

With regards to the fates of former psychiatric asylum sites, especially those within this thesis, is that they are fluid. Fates come and go, and intermingle with each other at each of the sites throughout their history. At the present time a number of the remaining retained former psychiatric asylum sites have been earmarked for closure: this includes St James' Hospital and Cefn Coed Hospital. It is unlikely that retention as a fate will be immediately abolished from the sites; however it is increasingly unlikely that retention will be the major fate on the sites, as fragmentation splits the sites up across each of the five fates.

"*Only when the last patient has left, do the gardeners depart and nature takes over*" (Binney, 1995: 2)

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Glossary of Terms

Anthropoemia– "*Rejecting – 'vomiting', incarcerating people in camps or ghettoes, or rounding them up, packing them back into a boat or into a plane and sending them back 'where they came from'*" (Bauman, 2012).

Anthropophagia– "*The anthropophagic strategy consists of "devouring" and "digesting" the stranger, transforming thereby an alien substance body into a cell of one's own organism. In short, in "assimilation": renouncing whatever distinguishes you from the "genuine stuff". If you want to be a French citizen you have to become a Frenchman in your behaviour, your language, the way you act, your ideas, preferences and values*" (Bauman, 2012).

Chloral – "*Chloral hydrate, also called chloral, the first synthetically produced sedative-hypnotic drug, commonly used in the late 19th century to treat insomnia and still occasionally used to reduce anxiety or produce sleep before surgery*" (Encyclopaedia Britannica, n.d.).

Chlorpromazine – "*A phenothiazine antipsychotic medicine… used for…Schizophrenia and other psychoses; to ease agitation and severe restlessness; persistent hiccups; for sickness in palliative care*" (Chlorpromazine, n.d.).

Cloister - "*A covered walk, especially in a religious institution, having an open arcade or colonnade usually opening onto a courtyard*" (Cloister, n.d.).

Cultural Relativism - "*a concept that cultural norms and values derive their meaning within a specific social context*" (Cultural Relativism, n.d.).

Decarceration – "*The process of removing people from institutions such as prisons or mental hospitals—the opposite of incarceration. In the middle of the twentieth century, this became a central feature in the reorganization of social control, and is closely allied to programmes of community care and community control***"** (Decarceration, n.d.).

Equilibrioception – Sense of balance.

First Life - A predominantly Second Life term referring to the 'real'/offline world.

Four Humours Theory - A theory that the body had 'four humours' of blood, phlegm, yellow bile and black bile; and that "*a good balance between the four humours was essential to retain a healthy body and mind, as imbalance could result in disease*" (Humours, n.d.).

Garth - "*An open courtyard enclosed by a cloister*" (Garth, n.d.).

Gentrification – "*[The] restoration of deteriorated urban property especially in working-class neighborhoods by the middle and upper classes*" (Smith, 2002).

Gymkhana – "*A field day held for equestrians, consisting of exhibitions of horsemanship and much pageantry*" (Gymkhana, n.d.).

Hawthorne Effect - "*the impact of the researcher on the research participants or setting, notably in changing their behaviour*" (United Lincolnshire Hospitals, n.d.).

Heterotopia - "*There are also, probably in every culture, in every civilization, real places— places that do exist and that are formed in the very founding of society— which are something like counter-sites, a kind of effectively enacted utopia in which the real sites, all the other real sites that can be found within the culture, are simultaneously represented, contested, and inverted. Places of this kind are outside of all places, even though it may be possible to indicate their location in reality. Because these places are absolutely different from all the sites that they reflect and speak about, I shall call them, by way of contrast to utopias, heterotopias*" (Foucault, 1986: 3-4).

Iodoform – "*A compound of carbon, hydrogen and iodine*" (The Human Touch of Chemistry, n.d.).

Lithium – "*A mood stabiliser… used for… mania, recurrent depression, bipolar disorder, aggressive behaviour… also called… Camcolit®; Liskonum®; Priadel®; Li-Liquid®*" (Lithium, n.d.).

Negative Space - "*The empty space around the subject or focus*" (Panic, 2010).

NIMBY – 'Not in My Back Yard'. "*Used to express opposition by local citizens to the locating in their neighborhood of a civic project, as a jail, garbage dump, or drug rehabilitation center, that, though needed by the larger community, is considered unsightly, dangerous, or likely to lead to decreased property values [sic]*" (NIMBY, n.d.).

Nociception – Sense of pain.

Panopticon - Jeremy Bentham's Panopticon is possibly the most notable example of using architecture to control behaviour. Foucault described the architecture of the Panopticon as follows: "*At the periphery, an annular building; at the centre a tower; this*

tower is pierced with wide windows that open onto the inner side of the ring; the peripheric building is divided into cells, each of which extends the whole width of the building; they have two windows, one on the inside, corresponding to the windows of the tower; the other, on the outside, allows light to cross the cell from one end to the other" (Foucault, 1995: 200). The Panopticon is one form of controlling a populace via architecture; and disguises the inability to see all by "*fostering in the minds of its [occupants] the strong impression that they are under constant surveillance*" (Otto, 2011: 45).

Phenothiazine Antipsychotics – "*Phenothiazine antipsychotics are dopamine-2 (D2) receptor antagonists therefore decrease the effect of dopamine in the brain. Phenothiazines are classed as typical antipsychotics and are used to treat schizophrenia or psychosis*" (drugs.com, n.d.).

Polynucleation - "*Spatial dispersal of population and economic activities from the largest towards smaller cities*" (Lambooy, 1998: 457).

Private Finance Initiative (PFI) – "*The PFI involves collaboration between the commercial companies who build and service the new facilities, and the government, which has committed to long term leases to occupy the buildings in order to deliver medical care. The PFI scheme illustrates how the national political-economical context of health care policy frames the development of psychiatric care in particular countries*" (Curtis, 2010: 195).

Proprioception – Sense of movement.

Second Life - A virtual metaverse created by Linden Labs. "*Second Life is…a virtual space inhabited by tens of thousands of individuals from all walks of life. All content is user-created through the game's built-in software*" (MMOhut, 2010).

Thermoception – Sense of temperature.

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Ethics Approval

From: ERGO [ergo@soton.ac.uk]
Sent: 10 September 2013 14:58
To: Moon G.
Subject: Your Ethics Submission (Ethics ID:6208) has been reviewed and approved

Submission Number: 6208
Submission Name: Post-Asylum Geographies
This is email is to let you know your submission was approved by the Ethics Committee.

You can begin your research unless you are still awaiting specific Health and Safety approval (e.g. for a Genetic or Biological Materials Risk Assessment)

Comments
1.This seems OK. Good luck.

2.Feedback has been addressed.

Click here to view your submission

ERGO : Ethics and Research Governance Online
http://www.ergo.soton.ac.uk

DO NOT REPLY TO THIS EMAIL

This version updated May 2013

SSEGM ETHICS SUB-COMMITTEE APPLICATION FORM

Please note:

- *You must not begin your study until ethical approval has been obtained.*
- *You must complete a risk assessment form prior to commencing your study.*
- *It is your responsibility to follow the University of Southampton's Ethics Policy and any relevant academic or professional guidelines in the conduct of your study. This includes providing appropriate information sheets and consent forms, and ensuring confidentiality in the storage and use of data.*
- *It is also your responsibility to provide full and accurate information in completing this form.*

1. Name(s): Joshua Green

2. Current Position: Postgraduate Researcher

3. Contact Details:

Division/School Geography and Environment

Email jg7g12@soton.ac.uk

Phone xxxxxxxxxx

4. Is your study being conducted as part of an education qualification?

Yes ☒ **No** ☐

5. If Yes, please give the name of your supervisor

Graham Moon

6. Title of your project:

The Public Retention of County Psychiatric Asylums

7. i) What are the start and completion/hand-in dates of your study?

01/09/12 – 01/05/15

ii) When are you planning to start and finish the fieldwork part of your study?

01/02/14 – 01/10/15

8. Describe the rationale, study aims and the relevant research questions of your study

During the last quarter of last century there was policy of psychiatric asylum closure which saw 90% of asylums in England and Wales close. These asylum sites were subsequently developed into housing, left derelict or demolished, publically retained, or redeveloped for a separate use altogether. Retention as a category describes those asylum sites that are still in use within the public health care sector; be it as a form of residential care for people with mental health problems or with other health or social care need, or for other uses such as offices. There is currently no literature examining the public retention of asylum sites. This thesis will address this gap in knowledge.

It is my intention to investigate the reasons behind, and the challenges posed by, the retention of mental health care on those retained hospital sites in the context of the wider policy of community based care.

Key Research Question:

What are the views of those involved in the land use planning process towards the continued use of asylums ?

9. Describe the design of your study

This thesis will use a triangulation of research methods, including semi-structured interviews, observations of the sites involved, visual ethnography and documentary research. My intention is to use semi-structured interviews as the main research method within this study. They will be utilised to gather information from a variety of participants, and while collecting data about specific topics and gaining answers to specific questions, I believe the flexibility of the method will make possible the possible collection of more in-depth data than a more structured method would allow.

This will be backed up using a discourse analysis of local newspaper archives to provide a local background and provide an insight into opinions surrounding the sites. This will have the advantages of simultaneously maintaining anonymity and being a cost-effective method of collecting opinions.

10. Who are the research participants?

The proposed sample of this study includes individuals working for the local health board who have links to the sites to be studied.

11. If you are going to analyse secondary data, from where are you obtaining it?

12. If you are collecting primary data, how will you identify and approach the participants to recruit them to your study?

Please attach a copy of the information sheet if you are using one – or if you are not using one please explain why.

Participants will be recruited via email and telephone. Individuals will be identified using public records and with the help of the health boards themselves.

13. Will participants be taking part in your study without their knowledge and consent at the time (e.g. covert observation of people)? If yes, please explain why this is necessary.

No.

14. If you answered 'no' to question 13, how will you obtain the consent of participants?

Please attach a copy of the consent form if you are using one – or if you are not using one please explain why.

I will ask the participants to sign a consent form before the interviews begin.

15. Is there any reason to believe participants may not be able to give full informed consent? If yes, what steps do you propose to take to safeguard their interests?

No.

16. If participants are under the responsibility or care of others (such as parents/carers, teachers or medical staff) what plans do you have to obtain permission to approach the participants to take part in the study?

This will not be an issue. There are no plans in the present study to interview any participants who are in care in any way.

17. Describe what participation in your study will involve for study participants. Please attach copies of any questionnaires and/or interview schedules and/or observation topic list to be used

Participants will be interviewed once using a semi-structured format. Every effort will be made to ensure that the participants are comfortable during their interviews. The interview times will vary by participant but it is estimated that between 5 and 45 minutes of the participants time will be taken.

18. How will you make it clear to participants that they may withdraw consent to participate at any point during the research without penalty?

This will be made clear on the information sheet and participants will be reminded about this before the interview starts.

19. Detail any possible distress, discomfort, inconvenience or other adverse effects the participants may experience, including after the study, and you will deal with this.

N/A

20. How will you maintain participant anonymity and confidentiality in collecting, analysing and writing up your data?

Unlinked anonymity will be maintained by making the interviewees and the sites themselves anonymous. The sites and towns which the interviewees reside in will be given pseudonyms.

Respondents will be given the right to deem their responses confidential if they so wish.

21. How will you store your data securely during and after the study?

The University of Southampton has a Research Data Management Policy, including for data retention. The Policy can be consulted at http://www.calendar.soton.ac.uk/sectionIV/research-data-management.html

Survey responses will be stored on a password-protected personal computer and on the password-protected university network.

22. Describe any plans you have for feeding back the findings of the study to participants.

Participants will be given the opportunity to provide contact details via the survey. This will allow me to contact them about research results if they so wish. Respondent will also be pointed to a web address where summary results of the survey will be posted.

23. What are the main ethical issues raised by your research and how do you intend to manage these?

I do not believe any ethical issues will be raised. At most time will be taken out of NHS staffs busy schedules.

24. Please outline any other information you feel may be relevant to this submission.

Interview Schedule

a. What factors do you believe have contributed to the retention of health care on the <> Hospital Site?

b. What are the challenges posed by the retention of the <> Hospital site (with regards to both healthcare and administrative uses)?

c. Is it important to have a site such as <> as a core from which mental health care can be provided? Are sites such as these still important to mental health care today?

d. Does the current government have a general stance on the retention of these sites within the NHS?

e. Have you had any personal experience of the <> Hospital site (not necessarily for medical reasons)?

f. What is your opinion on the retention of the <> Hospital site within the NHS (both as a site of healthcare and healthcare administration)?

g. What is your opinion of the <> Hospital facilities (i.e. the buildings currently/recently in use on the site)?

h. What is your opinion regarding the original facilities on the site (i.e. the original asylum buildings e.g. the main building)?

i. Have any of your constituents ever approached you with regards to the <> Hospital site- be that regarding healthcare/site development or any other reasons?

j. Have the opinions of the general public affected the ways in which <> Hospital has continued to be used (or not used)?

k. Do the local community make use of the hospital site in any way for non-medical purposes?

l. What are the opinions of the local communities surrounding <> regarding the site?

m. So would you say that the hospital suffers from any form of stigmatisation due to its history?

n. Has the main building's listed status affected the retention or the decision to move services off the site in the near future?

o. Have the Tree Preservation Orders affected the site's day to day running?

p. Is there any additional information you would like to add?

Example Interview Transcript

Interview A4

M: Has the decision to retain health care on the Cefn Coed site been made at a local level, a regional level, or a national level?

A4: It'll have been made at a local level, with the local health board, the Abertawe Bro Morgannwg Health Board

M: And what factors do you believe have contributed to the retention of the health care on the Cefn Coed site?

A4: Well I think for the Cefn Coed site there were some issues that arose and in December 2010 I know that the health care inspector of Wales has issues around patient safety at the Hospital in fact, and a report by the inspector found that the hospital built 80 years ago and to put it bluntly it was way beyond its sell-by date. And then there were some allegations of abuse by staff and what have you so it was time to have a really good look at the premises, whether they were fit for purpose and met today's demands.

M: What do you think the challenges are posed by the retention of Cefn Coed? So with relation to health care and treating patients?

A4: The challenges? Well it's like anything these days it's resourcing. But the hospital has to, it is still designed to meet demands of older people with health care issues, there is a growing population here in Wales, it is a growing problem Alzheimer's that sort of thing, so those are the real challenges it has to meet.

M: Do you think it is important to have a site such as Cefn Coed as a core from which mental health care can be provided?

A4: Yes I'm a great believer in having local services for local people; I'm a great believer that where you have an issue such as this there should be a facility where people particularly where the elderly are concerned, where their families and whether it's their partners, husbands, wives whatever can visit them. We're not blessed with, in some of our rural areas, the best of bus services, so it needs to be local so yes.

M: Does the current government have a general stance on the retention of these sites within the NHS?

A4: In relation to mental health issues? I'm not fully aware of any great policy that the Welsh government may have on this.

M: what is your opinion on the retention of Cefn Coed?

A4: I, as I perhaps back to my other question, my opinion of Cefn Coed now in its refurbished state is a very positive move for the local people. I want to, in fact I'd like to see more beds available there but we can only operate within the resources we have and I'm happy that we have what we have in Cefn Coed on site for the people of the locality.

M: Do you think that the opinions of the general public have affected the ways in which Cefn Coed has continued to be used?

A4: That's a very good question that actually. Cefn Coed, there is no doubt about it, Cefn Coed was known as and I use the term, you know, sort of, as the, where all the, all the sort of local mental people went to, and it was always known as oh, and the jokes people would say you know 'if you're not careful you'll end up in Cefn Coed' that sort of thing. So Cefn Coed's had a stigma about it unfortunately, but I think with it's kind of relaunch and its current form, it's recognised as being a place which is far more suitable for people in, and meets modern day demands. So yes it was stigmatised but now I think, with its relaunch it's far more accepted by people for being a modern hospital.

M: Do you know if the community make use of the hospital site in any way, for non-medical means?

A4: I'm not aware I can't help you with that I'm sorry.

M: What are the opinions of the local community surrounding Cefn Coed regarding the care it provides? So the people who live in and around the area?

A4: Well I have to measure it by, and I get lots of people coming to me as a representative with massive issues concerning Hospital treatment here in Wales, in sorry in my area, the Abertawe Bro Morgannwg area, and erm the way the heath service deals with them, the waiting lists etcetera etcetera. I've never had a complaint or issue come to me regarding the current Cefn Coed set up, so on that basis I have to assume that people are very satisfied with it.

M: So, I think you mentioned this, but would you say the Cefn Coed site suffers from any form of Stigmatisation now due to its history?

A4: Not now, not now. I think certainly it did. But now I think people accept it as a modern hospital offering treatment which is you know commensurate with modern day treatments.

M: Do you think that the recent-ish newspaper articles, between say 2010 and 2012. Do you think that they had an effect on the site? Or on opinions of the site?

A4: I think it brought it, well those that, those that were associated with the hospital were aware of what was going on perhaps and didn't want it to surface. I think now it's surfaced, now it's been dealt with, now that the hospital has been revamped if you like it's had a new relaunch and people accept it for what it is today. So I don't think it's carried on the traditional kind of stigma that it's had in the past. No I don't.

M: Are you aware of any issues relating to the new developments, the new building on the east, east of the site/ or west of the site?

A4: I'm trying to think which way is north now.

M: I think I was looking at it upside down but I'm not entirely sure. The new developments on the edge of the Sketty ward?

A4: Yes yes that would be the West side of it yes. Am I aware of?

M: Any issues from the community in relation to those block going in so close to the residential housing?

A4: Nobody has approached me regarding them. I can only measure it by people coming to me for advice or asking me to do something about it, and I've not had anybody come to me no. But it, I think that it's going to be, there's ongoing work going on until 2015 isn't it so that's not to say that people could be coming to me?

M: Are you aware of the recent planning permission that I think has gone in for the 400 houses to be built on the site?

A4: No, not heard anything about that at all.

M: Would you have any opinions on that as a policy?

A4: As a matter of policy, we're short of housing here in the Swansea area, and if the sites available for that it's a very nice residential area, it would make a very nice residential area, we have to be realistic, we have to build houses somewhere, I would guess that that would be a prime site, yes, and I'd support it probably.

M: One last question, if in an ideal world, where would you want the mental health care in Swansea to be based.

A4: I think the idea of putting people into a kind of isolated areas is not right, people have mental health, it's not their fault that they have this, they, a lot of people are, a lot of people get some rehabilitation out of it actually, associating with people in the community.

<Interruption – phone call>

… patients really need to be integrated really with their families, with other people in the community and I think that's been proven over the years to help people with their recovery of course with elderly people it's perhaps not so much the case, but I've absolutely no problem with it being situated where it is and with these places being within communities I think that's the right way forward to. I can remember, my background by the way is, funnily enough, in policing, and I can remember when I was a young policeman in London going to places, Shennley, Knapsbury, Harperbury, outside of London these great Victorian building where there were rows and rows and rows of beds and wards of people with mental illness, and it was just awful. And there they stayed, institutionalised for many years, and I actually never want to see the return to that so I think they should be in these sorts of areas, yea. That's my view right?

<Chatter>

Cefn Coed when I was a young boy was erm, it was where all the nutters went and I used to, dislike that, I've been to these places and had a lot to do with them over the years in my previous work and I don't like that, <best bet?> getting them back integrated?

M: Did you, when you were working what kind of association did you have with these sites?

A4: Well, in the main there were people when I was a young constable I found that you know you had many people with mental illnesses. You knew them in the community you know they'd go in they'd be sectioned, and then they'd go in and for a certain amount of time and then they'd be back again. They just go loose again in the family, assaulting members of the family, going berserk and what have you, you'd go along there to try and sort the situation out and they'd start assaulting policemen and throwing things around. And the only thing that you could do was to get a doctor to section them again and off they went to the institutions and very often you took them in police transport a police van or something you know. And they were violent some of them, very violent, so that's my kind of, that's my sort of interaction with them. But I can remember going into this one very famous hospital, Knapsbury hospital, it's gone now I'm pleased to say, well they're all gone really. In south Hertfordshire, and I can

remember going there at night one night at about 2'o'clock in the morning taking someone back in there and it was horrendous, it was very Victorian, very Victorian, this guy was mad, he was absolutely raving, and we had him wrapped up, the only way we could transport him, he was that violent, was to wrap him up in a, you know a roller towel that you like behind a, to wrap him up in one, mummify him almost. And take him back, and erm, we put him into a particular cell that they had there for him. And as a young man, probably not much older than you, I was 19 or whatever I was, and erm, I just, it has an effect on you and you think, crikey is this how we deal with human beings. So I never want to see that. That probably doesn't make that much sense to you.

<End chatter>.