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Document Version
Accepted author manuscript

Published in:
Sociology of Health and Illness

DOI:
10.1111/1467-9566.13011

Publication date:
2020

License
Unspecified

Citation for published version (APA):
Simonsen, T. P., & Duff, C. (2020). Healing Architecture and Psychiatric Practice: (Re)ordering Work and Space in an In-patient Ward in Denmark. *Sociology of Health and Illness*, *42*(2), 379-392. https://doi.org/10.1111/1467-9566.13011

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Journal article (Accepted manuscript*)

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Abstract

Healing architecture is a defining feature of contemporary hospital design in many parts of the world, with psychiatric inpatient facilities in Denmark at the forefront of this innovation. The approach rests on the contention that designed clinical spaces, and the particular dispositions they express may promote patient recovery. Although the idea that health may be spatially mediated is well established, the means of this mediation are far from settled. This paper contributes to this debate by analysing medical encounters in the context of a new purpose-built psychiatric hospital opened in Slagelse, Denmark in late 2015 as an example of healing architecture for the region. Grounded in qualitative research conducted in two wards between 2016 and 2017, we explore the key material and social effects of the hospital's healing architecture, and the spaces and practices it enacts. Following the work of Michael Lynch, we consider both the designed 'spatial order' of the inpatient wards, and the 'spatial orderings' unfolding therein, with a particular interest in how order is accomplished in psychiatric work. With much of the existing discussion of healing architectures focusing on their impacts on patient wellbeing, we consider how healing architectures may also be transforming psychiatric work.

Keywords: Healing architecture; spatial ordering; psychiatric work; mental health; medical encounters; Denmark

Introduction

Psychiatric spaces in many parts of the world are slowly being transformed with the emergence of healing architectures (Frandsen *et al.* 2012; Nickl-Weller and Nickl 2013), a model that contends that particular features of the built environment, such as lighting and ambience, access to and/or views overlooking green spaces, accessibility and openness, have a positive impact on patient experience, wellbeing and recovery (Connellan *et al.* 2013; Curtis *et al.* 2007; Lawson 2010; Reavey *et al.* 2017). Debates about these impacts have been widely discussed in medical and health geography (e.g. Andrews 2004; Cummins *et al.* 2007; Duff 2011; Kearns and Moon 2002), medical anthropology (e.g. Dyck and Fletcher 2015; Long *et al.* 2008) and the sociology of health and illness (e.g. Buse *et al.* 2018; Martin *et al.* 2015), with each field offering unique conceptual and empirical elaborations of the designed, material features of health care settings and their impacts on the health and wellbeing of patients and staff. This paper considers these debates in the context of a new purpose-built psychiatric hospital opened in Slagelse, Denmark in late 2015 as an example of healing architecture for the region (Region Sjælland 2012). Grounded in qualitative research conducted in two acute inpatient wards between 2016 and 2017, we examine some of the key material, social and organisational effects of the hospital's healing architecture, and the spaces and practices it enacts.

We are guided in this analysis by Martin and colleagues' (2015: 1015) recent articulation of a novel "sociology of healthcare architecture" capable of elaborating the ways space mediates "forms of interpersonal interactions, medical encounters, and socio-technical practices" in clinical settings. Ongoing discussions of the methods appropriate to this sociology have also informed our analysis (Buse *et al.* 2018; Ivanova *et al.* 2016; Latimer 2018; VanHeuvelen 2019). Questions of method are critical in our view inasmuch as the notion of healing architecture inevitably introduces a relation

between recovery and space, between health and design that defies easy explanation. Although the idea that health may be mediated by aspects of place and space is well established, the means of this causal relationship are far from settled and continue to generate robust debate (e.g. Bell *et al.* 2018; Cummins *et al.* 2007). With respect to the question of healing architectures more directly, this problem becomes even more acute insofar as a direct causal relation is imputed to the designed spatial order of the site. Indeed, it is the design itself that is regarded as therapeutic, as capable of generating 'healing' effects. This is the issue that this paper grapples with, as we explore the material, social and organisational effects of Slagelse's healing architecture. We hasten to add that we are not interested in somehow measuring the extent to which the design of the hospital at Slagelse might have promoted the health and wellbeing of either patients or staff. Our interests are more general as we wish to start with a broader consideration of the material, social and organisational effects of Slagelse's healing architecture. Understanding these general effects is fundamental, in our view, to the elaboration of more refined methods for evaluating the distinctively therapeutic effects of this architecture. Following the work of Michael Lynch (1991), we treat these effects as a matter of 'spatial ordering'. We consider both the designed 'spatial order' of the inpatient wards at Slagelse, and the 'spatial orderings' unfolding therein, with a particular interest in how order is accomplished in and through psychiatric work. Such work might fruitfully be thought of in terms of a continuous 'tinkering' (Mol *et al.* 2010) by which everyday encounters between patients, staff, and spaces are mediated, transformed or disrupted. More broadly, our interests in this paper run parallel with recent discussions of "Caring Architecture", where Nord and Högström (2017: 10), for example, examine "how architectural space in institutions is involved in processes of complex ordering".

The idea of spatial order(ing) suggests that the spatial layout of a ward organizes and frames psychiatric practices, distributing individuals and allocating functions, shaping *where* certain activities

take place and *how* these activities are rendered appropriate in relation to the spaces they take place in. This notion offers a way of exploring how healing architectures mediate experiences, practices, activities, and encounters in situ, and how these mediations re-order such spaces, creating new, albeit transient, "geographies of care" (Conradson 2003). We will argue that these geographies should be understood as performative effects of the spatial orderings enacted by staff, as much as they are mediated by the specific architecture of the site. More directly, our findings reveal how the open and transparent spaces of the wards at Slagelse often require staff to enact spatial orderings of safety and control in the everyday management of patients. These orderings, although enacted, are no less objective or real in their effects (Lynch 1991). Our findings indicate how healing architecture mediates the practices and organisation of psychiatric work, as it mediates the spaces, management, and delivery of psychiatric treatment. Before we turn to this argument, we will briefly review recent discussions of spatial orderings and their relevance to our study of Slagelse's healing architecture.

Spatial Ordering

Hetherington (1997: 35) argues that "ordering is not just simply something we do; more significantly, it is something we are in". Social order, in this respect, may be understood as a dialectical function of space and action, and their various convergences and tensions. These insights draw attention to the importance of physical space, and the ways it fashions the settings and contexts in which people live, interact and work, mediating particular social orderings (Söderström 2017: 57). Hetherington is particularly interested in how spaces emerge in particular technologies of governance, in the ways space is formed in action (see also Lynch 1991; Woolgar and Neyland 2013). Space, then, not only constitutes a container *for* action but may also be understood as an effect *of* action (Mol and Law 1994). Action, therefore, creates space, as much as space may be said to mediate or inflect action. Shifting our attention to diverse 'modes of ordering' (Law 1994) clears

the way for novel investigations of what architecture *does* in different instances and how it is enacted as part of ongoing efforts to accomplish order in psychiatric practice. Following Lynch (1991), we approach these accomplishments as 'spatial orderings' that affect and re-order the spaces of the inpatient wards, challenging their designed order. This approach will also enable us to offer renewed insights into the more specific orderings that may affect the work of treatment in clinical settings.

Lynch (1991: 51) argues that physical places of work may be defined and understood in terms of what he calls "locally organized topical contextures", where the place of work is comprised by a complex of materials and action, of spatial orders produced in, and informed by, the knowledge practices of members in that setting (see also Suchman 1996: 35). Places of work are organized in contextures of activity and enacted through complexes of action, which are each contingent upon the disciplinary practices of *that* particular setting. Order, then, emerges as a distributed, local property of social practice (Preda 2000: 279). It is equally true that situated, local actions may also make use of the structures that the enactment of particular spatial orders provides (Lynch 1991: 53). Following this line of argument points to the ways particular spatial orderings are topically tied to spatial and material practices of psychiatric work. How, in other words, do complexes of materiality and human action mediate the spatial order of a ward and its impact on different psychiatric work practices, like ensuring safety, administering medication and delivering care? Psychiatric work, in these respects, may be understood as a specific disciplinary practice, a certain 'mode of ordering' (Law 1994) in which architecture, materials, and social relations are enacted (or have effects) as they are organized. Lynch's (1991: 53) focus on the 'spatial orderings' of practice suggests a means of interrogating how the orderings of space and practice mediate the delivery of care in psychiatric settings, along with the effects of these orderings. Psychiatric practice may, in these terms, no longer be understood as concerned exclusively with the cognitive, neurobiological or social aspects of

patient care, since it *takes place* in particular material settings while simultaneously constituting and (re)constructing those environments. The work of 'spatial ordering' alerts us to the relationship between psychiatric practice and the spatial configuration of a psychiatric ward, drawing attention to the way psychiatric work is spatially and materially organised.

With these arguments in mind, the goal of the present paper is to offer a *re*specification (Suchman 1996: 35) of the spaces and orderings of the psychiatric ward in general, and the separate rooms of Slagelse in particular, in relation to the work of delivering psychiatric care for patients. We will treat each aspect as a function of the continuous (re)ordering of spaces by patients and staff alike. We are interested in the work of ordering space for the insights it may offer into the mediating force of healing architecture. Spaces, then, are not so much a *locale* within which the work of psychiatric care simply takes place, but, following Lynch (1991), must be reimagined as a complex habitual field of materiality and action, involving intimate relations of architecture and practice, embodiment, place, and activity. In the following, we consider some of the methodological implications of the ways we have drawn these interests together and specify how fieldwork for the study was conducted.

Methodology

The study drew from the ethnomethodological tradition to investigate diverse ordering practices and situated actions according to actors' own (ethno)methods (Delamont 2011). Ethnomethodology, as articulated in the work of Garfinkel (1967) and Lynch (1993), involves a strict commitment to members' methods for making sense of the world. Following this lead, and the specific suggestions offered by Pollner and Emerson (2001: 118), we treat ethnomethodology as a way to "selectively heighten sensitivity" to the spatial arrangements of inpatient treatment and their impact on ordering practices in psychiatric wards. This approach afforded insights into how these orderings regulate,

support and/or enable certain health trajectories, practices and relations while disabling others (Moser, 2017). Our empirical investigation was directed towards the iterative and contingent, but always observable, (spatial) orderings of psychiatric work. Given these interests, we have elected to focus on the orderings that shape a specific event – the administration of patient medication – and the spaces through which these orderings pass. We focus on medication because of its centrality to the observed work of psychiatric treatment. This focus will enable us to tease out relations between the spatial order of the ward as it was designed, and the spatial orderings emergent therein. Rather than offering a post hoc account (Suchman 1996) of the instances of interest here, we will follow the course of events as they emerged in situated actions, in particular spaces within an inpatient ward.

The empirical material from which this analysis is drawn was collected as part of a broader research project on healing architecture and psychiatric practice in inpatient wards in Denmark. Data collection consisted of shadowing intervals (Czarniawska 2007) in which nursing staff were followed during either day or evening shifts, and participant observations (Delamont 2011) of interactions between staff and patients, with particular focus on the spatial arrangements within which these interactions took place. Approximately 200 hours of fieldwork was conducted by the first author at two psychiatric inpatient wards at Slagelse throughout 2016 and 2017. Before fieldwork commenced, information on the research project, its aims, and methods, was circulated among staff, who then informed patients about the project and introduced the first author. Consent to approach staff for interviews was obtained from senior hospital management and then confirmed with individual staff members prior to the commencement of fieldwork. While no formal ethical clearances were required at the site, the first author completed a confidentiality agreement and obtained verbal consent from patients to take notes when in direct conversation. Participant names have been anonymised to protect the confidentiality of patients and staff. Documentary materials were sourced

from the lead architect at Karlsson Architects, who also provided permission to reproduce the images presented below. All study data have been stored in accordance with data protection rules at the first author's home university.

Field Setting

In the fall of 2015, approximately 650 employees from five psychiatric facilities in Region Zealand were relocated to the new hospital at Slagelse. Fieldwork commenced shortly after the hospital opened. The new building reflects current trends in health care design, including access to and oversight of green spaces, proximity to the local community, and the use of an advanced lighting system to complement the circadian rhythm. More particularly though, Karlsson Architects and Vilhelm Lauritzen Architects who spearheaded the design of the hospital developed four guiding principles during initial phases of development, which then informed all phases of the construction. The design-principles guiding the development were: 1. Healing architecture and the principle of recovery; 2. Transparency and proximity between people and functions; 3. Generality and flexibility in rooms and sites; and 4. Hierarchy of spaces and stimuli (Karlsson Arkitekter n.d.). These principles are made manifest through a series of deliberate design interventions, including the widespread use of glass and open spaces. By seeking to promote social interaction and afford freedom of mobility, the design seeks to mirror key assumptions about recovery from mental health problems and the modes of care that may facilitate it. The hospital contains 194 beds across six psychiatric inpatient wards, six forensic units, an emergency reception, outpatient treatment, and facilities for research and education. It is organized for quick patient turnover, with the spatial structure reflecting the site's key psychiatric functions: forensic psychiatry, child and adolescent psychiatry and research.

It is particularly important that we highlight the patient Environment, which was explicitly designed as a ward's most social space, encouraging interaction and affording easy access to staff, who are situated in the adjacent and transparent office space, the Dovecote (See. Fig. 1). Key to this design is the attempt to devise an architectural solution to the sometimes incompatible clinical goals of encouraging social interactions and reducing perceived staff/patient hierarchies, whilst promoting at the same time a high degree of patient visibility. These spaces feature heavily in the analysis to come.

Fig. 1. Inpatient ward – © Karlsson Architects/VLA, Photograph by Jens Linde

Ward staff include physicians, nurses, educators, social workers, and auxiliary nurses, who are managed by a chief physician and a head-nurse. Ward management is locally organized and wards are staffed continuously with shifts at 8-hour intervals.

Findings

The analysis presented below will focus on one specific instance taken from the wider material, illustrating an important aspect of how 'spatial orderings' variously enable and constrain courses of action fundamental to the work of administering psychiatric medications. The instance was observed during a shadowing interval where the first author followed an auxiliary nurse. The instance might be understood as 'routine trouble' (Suchman 1996: 36), in that it represents the kind of contingency to which the normal order of a ward is perpetually subject. Analysing this instance will also provide an opportunity for broader reflections on the spatial ordering of healing architecture.

Managing patient behaviours through spatial orderings

> Staff are discussing how to isolate A from the other patients, when the chief physician intervenes and says: "He isn't supposed to run around like a madman out there", to which the head-nurse responds; "He uses a lot of square meters" (Fieldnote, 16 August 2017).

These statements were made at a routine coordinating meeting in the Dovecote prior to the head physician's morning rounds. Staff were gathered around the long table at the centre of the room, with the chief physician leading a discussion about whether or not to move A to the Seclusion room. Both the chief physician's and the head nurse's remarks were uttered with some urgency, indicating their frustration at A's misconduct. When the chief physician says *'he isn't supposed to run around like a madman out there'* (ironic, if not insensitive, given A's formal designation as a psychiatric in-patient), she was presumably referring to the disorder in A's behaviour, with the conviction that it should not be tolerated. For this reason, staff discuss the prospect of moving A to the Seclusion room, even though it is currently occupied by two other patients. Staff explore the possibility of moving these patients to regular rooms, though quickly conclude that this option is not viable, and so the chief

physician suggests that they might have to isolate A in his room. An hour later, the issue remains unresolved, and the two nurses return to the issue of the Seclusion room being occupied. The following fieldnote highlights the spatial orderings at work in this incident, how they are connected to staff knowledge of prior patient behaviour, along with the tensions between the different spatial orders enacted (or attempted to be enacted) by the staff involved in this discussion:

> "It's completely insane" says one of the nurses, referring to the fact that in practice only one patient can occupy the Seclusion room. I ask about the Seclusion room and its function. They explain that two patients in an ill state cannot simultaneously occupy the room, essentially making it "a two-bedroom apartment for one" as the other nurse sarcastically states. They discuss options for moving M, one of the patients currently in the Seclusion room. M could change rooms with A, but then she would be too close to the exit, which is a problem in that she has tried to escape on multiple occasions, as they briefly discuss. Another room is empty at the bottom of the ward, but they also reject that option because then M would not be visible to staff, which is necessary as she was reportedly having suicidal thoughts. As they are talking, A suddenly passes, wearing only a jacket and a towel around his waist. He has just showered and has come out into the Environment without underwear. He goes out to smoke. One of the nurses follows him and they both walk through the courtyard, where she enquires about the clothes he has left to dry on the outside furniture. The nurse instructs him to go back to his room and put on some clothes. They agree that the nurse will wash his clothes and A returns to his room without incident.

Space is critical to the varying clinical, logistical and organisational tensions evinced in this passage. First, A has disrupted the (spatial) order of the ward (behaving apparently "like a madman"), leaving

his clothes in the 'wrong' place, moving about the ward in the wrong ways, disrupting ward orderliness and the orderly conduct of other patients. Staff responses are equally spatial in orientation, first as they consider relocating A to the Seclusion room with all the affordances it offers for surveillance and the ordering of A's conduct, and then, as they realise that this option is not viable, they briefly consider moving other patients, but decide not to due to their knowledge of these patients' mental states. The chief physician's characterisation of A's conduct *as mad* ostensibly derives from her assessment that A's conduct has failed to accord to the proper spatial ordering necessary for the management of patients on the ward, insofar as A is failing to conduct himself in the right ways, in the right places. These failures are the explicit focus of the meeting described above; failures that staff usually manage by restricting access to particular spaces, thereby limiting patient mobility around the ward. Key to this tension, and its broader implications for the spatialisation of psychiatric treatment across the wards, is the fact that the designed order of these particular wards enables individual patients to enact their own spatial orderings, which often clash with both the designed spatial order of the ward, and the spatial orderings favoured by staff in relation to how patients are expected to conduct themselves in and around the space. In this case, the spatial orderings to which M and A are subjected are in tension, limiting staff responses to A's actions. This tension is the implicit focus of A's subsequent meeting with the chief physician:

> The chief physician is already in the conference room. She has her computer and the medication she intends to give A, which he apparently did not take the previous day. Two nurses collect A for his meeting with the physician. He follows them down the hallway to the end of the ward and they all enter the conference room. The physician is sitting down nearest the Dovecote, but gets up when we enter. She informs A that they need to talk and that he needs to take his medication. We all sit down, except A, who refuses. He does not

> want his medication. He becomes agitated. The physician tries, in a calm voice, to inform A that he needs to take his medication, and that calling her 'an ugly bitch' is uncalled for. He continues to use foul language but then decides to leave the room. We have been in the room for approximately 2 minutes. The staff look at each other with the physician saying that 'It's hard to talk to a patient if they don't want to talk'. While they are talking A suddenly returns in a more conciliatory manner. He apologizes, and the conversation continues. But before long he is agitated once more as the physician insists that he take his medication. "*I DON'T WANT THAT MEDICATION*" he shouts, once again leaving the room. Staff start planning how to give him the medication, when, once again, A returns and apologizes for his behaviour. He recognizes one of the two pills they are asking him to take and agrees to take *that* one. He then leaves the room, this time without returning.

A complex of actions unfolds in this passage according to the different spatial and clinical orderings enacted. Staff enter the conference room and position themselves in a rehearsed manner in order to enable safe passage into the Dovecote and out of the conference room in the event A becomes disruptive. They simultaneously ensure that A is positioned near the side-door affording him easy access to the adjacent hallway and unhindered passage out of the room. By being in the conference room, consulting the patient record on the computer, displaying the medication for A to see, and articulating their intentions, staff enact a particular spatial and clinical order; a locally organized topical contexture informed by their knowledge of A's failure to take his medication the day before, and actualized in accordance with their intentions to make A comply with their preferred spatial and clinical orderings at this particular time. The material properties of the room, together with the medication and the staff's utterances, co-constitute the room as a space of treatment, simultaneously offering a trajectory of care and enacting an element of control. Staff assess that A needs his

medication because he didn't take it the day before. The actions that follow accord with this goal, even as they entail a series of spatial interventions aimed at securing A's compliance according to the spatial order of the ward. The aim is to maintain a safe ward environment for staff and patients by maintaining a spatial ordering that regulates movement around, and conduct within, the ward site.

Securing the ward

As such, the spatial ordering of the site and the material layout and design of the ward, introduces unique affordances for patient activity, movement and interaction, some of which, reportedly make the work of providing clinical care and maintaining ward security more straight-forward given, for example, the high degrees of visibility the space affords, and some of which make this work more difficult for staff, such as the possibility for patients to freely move around and between the different ward spaces. With respect to the 'problem' of A's conduct and the ways it affects other patients on the ward, the central issue concerns the spatial interferences between A's conduct and other patients, and the most effective strategies for spatially isolating A from others.

> The staff walk into the Dovecote, calling on the aid of their colleagues. "We have a situation" says one of the nurses, informing other staff of what is about to happen with A. The door connecting the Dovecote with the Environment is closed. "I want the other patients to go to their rooms", says the nurse and looks over at the auxiliary-nurse-student – "or else there will be a spectacle". "I want you to go into the Environment – no drama – just go to your room" she says, rehearsing the command she wants to be given to patients. The student and another staff-member walk into the Environment and start moving patients to their rooms.

This fieldnote might be taken to describe a situation of high drama, which in a sense it is, but it also captures a routine aspect of the work staff undertake to enact the specific treatment and recovery plans prepared for each patient. Staff are mobilized into a 'state of readiness' (Suchman 1996: 43) when assembling inside the Dovecote, preparing and planning what to do next. In order to act in concert, staff require a shared understanding of what is going on. Without much elaboration, the commands uttered by the nurse are followed without question, indicating a shared understanding of the situation, its mutual intelligibility (Garfinkel 1967). The key for us, though, is how much of this work involves a spatial ordering of mobility and activity, particularly in instances where patients fail to comply with staff directives. In an effort to avoid 'spectacle', patients are moved to their private rooms and confined there for a time to enable staff to focus on the needs of an individual patient. In this respect, spatial confinement enables an ordering of focus and compliance; it is a crucial means of ensuring that A takes his medication. In order to achieve this goal staff enact a specific spatial order. This order is achieved materially and spatially as staff gather inside the Dovecote, closing the door so no patients can hear what is going on. The open and transparent character of the ward design must in this instance be countered directly. Crucially, moving patients to their rooms enables the simultaneous coordination of clinical activity *and* patient surveillance as staff continue to observe the ward as they speak, periodically peering through the space's transparent glass walls which look out over the patient area. This ordering is then translated into further action as patients are moved to a particular place, determined in advance, and staff coordinate how to move through the ward in order to isolate and secure A in his own room for the purpose of administering his medication. The next excerpt further illustrates this relay between space and action in the work of spatial ordering:

> One of the nurses goes down to get A, who incidentally, has entered another patient's room. He has locked the door. "I'm unlocking it", says the nurse and opens the door, admonishing

A for being in the wrong place and for locking the door. A follows the nurse out of the room. As they are walking, A starts talking about an earlier situation in which he also did not want to take his medication – "you came with a hundred men – I don't want that" he says and follows the nurse to his own room. The nurse returns to her colleagues who are still inside the Dovecote, where they are coordinating how to give A his medication. The nurse in charge explains that if the plan doesn't work they will return to the Dovecote to discuss what will be "a new situation", as she says. They all seem clear on what is going to happen next and walk over to A's room. They place themselves in a semicircle around the wide door opening, with A beside his bed. "Now it's serious!" says the physician and shows him that she has the medication. A seems calm. The physician informs him what kind of medication they are giving him and how much. She then hands over the medication, which A promptly takes, with the physician asking A to stick out his tongue to confirm that he has swallowed it. "Should I register that it was by coercion?" asks the physician, to which A replies "Well, that's for you to worry about". Everyone leaves the area around A's room. Inside the Dovecote the physician starts filling out a document on the coercive administration of medication.

Understanding this entire incident as being fundamentally a matter of spatial orderings draws attention to the tensions and negotiations triggered by A's refusal to take his medication. This refusal provokes a set of spatial responses. It starts with a conversation between the chief physician, A, and two nurses in the conference room. The adjacent hallway, accessible through an open door, offers an escape route for A as he paces back and forth, returning multiple times to the conversation, while simultaneously becoming an element of disorder in the rest of the ward. The designed order of the ward makes it possible for A to contemplate whether or not he wishes to participate in the

conversation, just as it facilitates a kind of spatial disordering as A's frequent retreats from the discussion disrupt other spatial orderings across the ward. It also creates a situation in which the physician must wait, inducing an element of frustration on her part: "we can't talk to someone who doesn't want to be spoken to" as she put it. The Dovecote may also be seen to function as a safe space for staff in that they can unobtrusively surveil the entire ward while simultaneously planning and coordinating their response to A's refusal to take his medication. The Environment also changes from being a social space for patients into a potentially dangerous place, for it's not yet clear what the forcible administration of A's medication might entail. Other patients must be removed from the Environment in order to minimise any risk. Once all patients have been sequestered in this way, A is taken to his room, designed as a private space in which A can conduct himself as he chooses, but in this instance, the room is transformed into a space of coercion, a medicalized space, a secure space for psychiatric work. The room's double doors, designed to create more space at the entrance to a patient's room, are opened wide and the staff (seven in total) fan out in a semi-circle around the chief physician, closing off A's mobility and enacting a spatial order of control, security, and compliance. This spatial organisation will enable the forcible administration of A's medication should he continue to refuse to comply. Perhaps in acknowledgement of this spatial ordering, A takes his medication and order is restored according to the ordering of psychiatric work.

Patients are well aware of this spatial ordering and typically comply with staff commands to return to their rooms in such moments. While compliant, patients are not necessarily happy with this spatial directive. Indeed, one patient stated that she didn't feel safe being alone in moments like this, because of a history of self-harm and suicidal ideation. Another patient stated that she felt 'forgotten' during these episodes, with no idea when she might be allowed to leave her room. For these reasons, it is important to stress that the spatial orderings enacted during these episodes

transform the patient rooms from a personal space, somewhere thought to be private, into a holding place, a temporary cell, a space of control subject to strict staff direction and oversight. Moving patients to their rooms also transforms the general order of the ward, from a place of activity, sociality, and repose, into a place that is literally off-limits. In these respects, A's seemingly disordered conduct provokes rapid shifts in the spatial orderings enacted and enforced by staff across the entire ward.

Discussion

The 'routine trouble' of administering medication reveals many of the spatial orderings involved in managing 'disorderly' patients in psychiatric settings. It also points to emergent tensions, in this particular setting, between the designed spatial order enacted in the very architecture of the wards at Slagelse, and the spatial orderings conceived by staff, sometimes in direct response to the effects of this designed order. The concrete practice of ordering thus provides analytical insights into the spatial relations of healing architecture, of the ways designed order and situated orderings may affect the delivery of care in psychiatric settings like Slagelse. The layout of the ward is central to this work, enabling specific patient-mediated orderings, practices, and movements, just as staff seek to enact their own orderings in the work of organising and delivering care. Tensions between these divergent orderings are at the heart of our findings. Partially, tensions derive from the spatial design of the ward. For instance, the openness of the Environment, the transparent nature of the ward's general layout, and the broad hallways all enable spatial orderings that sometimes make the work of providing psychiatric care more difficult, even as they undoubtedly afford greater patient mobility and freedom. Staff respond with their own attempted orderings: patients are returned to their rooms; staff position themselves in space so as to close off options for patient movement; patients are prevented from entering common rooms so as to permit more effective staff surveillance and

control. What our analysis of the complexes of actions rendered here demonstrates, then, is that spaces are an effect of local orderings of disciplinary practice that sometimes sit uneasily with the designed spatial orders of the ward. As the analysis above has shown, staff utilize and evoke particular spatial orderings when managing patient conduct. Convening in the dovecote, moving the patients to their rooms while isolating the patient in need of medication describe spatial 'complexes of actions'. These complexes involve situated actions that draw on spatial orders expressed in the designed ward, especially distinctions between inside/outside, close to/separate from, private/social, enabling staff to work in concert in the delivery of psychiatric care.

In these respects, spatial order is not simply determined by the design of a ward and its architectural layout but *becomes ordered* in particular ways through collaborative efforts involving the continuous performance and transformation of a variety of spaces; personal spaces, coercive spaces, safe spaces. These complexes of actions *together with* the designed spatial order of the ward indicate how competing requirements of care and coercion, of safety and security, of the scrutiny of individual patients and entire ward populations rub against one another in a discontinuous ordering of differentiated spaces. Through interactions with other staff, patients and the ward environment, staff attempt to enact safe and caring spaces, even if, in the process, they also often enact coercive, isolating and medicalized spaces, re-ordering the wider ward environment. Here then is the work of architecture as it is ordered in the experiences of ward life for staff and patients alike. The extent to which this architecture may or may not be healing requires attention to the complex tensions between orders and orderings as they unfold in practice, in place. Gavin Andrews (2004, 2006) has made similar points in relation to nurses' spatial practices and their role in managing ward life (also Andrews and Shaw 2008). In the particular instances analysed above, the spatial orderings enacted by staff are as concerned with the maintenance of patient order on the ward, as they are with

specific therapeutic outcomes. It is for this reason that we would conclude that healing architectures have a profound effect on the work of psychiatric care, even if their specific therapeutic effects and properties are more difficult to determine, as they are shaped by particular ordering practices.

Our analysis suggests that the 'healing' properties of the architecture – the extent which the spatial order of the ward may indeed promote recovery – are contingent upon specific spatial orderings that must be continually laboured over. The spaces of the ward cannot, then, be treated as singular places, with clear functional effects. Rather, they should be thought of as effects of particular complexes of activities, of spatial orderings enacted through situated actions. By focusing on the activity observable in the administration of medication to A, we have been able to uncover some of the work involved in ordering ward spaces in this way. As we have noted, the ordering practices engaged in by staff seek a balance between care and control, safety and recovery, which are expressed in specific spatial orderings that are themselves subject to routine negotiation. Sometimes this negotiation involves conflict between incompatible staff and patient orderings, though more nuanced tensions between these orderings are just as common as staff and patients seek to resolve tensions through enduring negotiation, a kind of spatial agonism. In this respect, we echo Philo's (2017:30) conclusion that "instances of institution-based care are less likely to arrive from pre-programmed care plans (and care spaces) than from more ad hoc 'tinkering' in the lived grain of the spaces involved".

This 'tinkering' (Mol *et al.* 2010) permeates the clinical management of psychiatric patients, just as it transforms individual recovery trajectories. Perhaps the key focus of this tinkering concerns the extent and autonomy of patient mobility in and around the ward. The wards at Slagelse ostensibly afford more freedom of movement than other psychiatric facilities, even though these affordances

are routinely complicated by staff ordering practices aimed at limiting patient mobility in the interests of safety and control. These orderings reveal a potent site of tension between the designed spatial order of the ward (and the healing architecture it expresses) and the clinical work by which patient recovery is partially realised. In certain moments, like those analysed above, the spatial affordances of the ward potentially make the work of managing patient conduct more difficult, and so staff work to enact spatial orderings by which this control might be more reliably sustained.

Our findings further resonate with those offered by Reavey and colleagues (2019: 274), who contend that patient experiences in psychiatric settings are deeply shaped both by relationships with staff and other patients and by the very socio-material environment of care itself. These findings offer some interesting reflections on the nature and impact of 'therapeutic landscapes' (e.g. Curtis *et al.* 2007), and the ways such landscapes manifest in formal clinical settings like Slagelse. However, with Frandsen et., al (2012: 1062), we note that this work sometimes adopts a "passive view of the way clinical practice is shaped by space" as if architecture might itself be understood as a therapeutic agent. Clearly space and design matter for health, but how they matter, and the specific ways, means, and relations by which spaces shape psychiatric experiences of care remain far from certain. While healing architecture constitutes a design concept that deals with the relations between space and practice, it does so from a largely functionalist perspective. As a potential alternative, Frandsen and colleagues (2012) argue for a theoretical perspective sensitive to "the connections between the spatial configuration of healthcare infrastructure and practice beyond space as distance, to consider how infrastructure reproduces specific practices and engages with its users in multiple ways". We endorse this alternative view and argue for studies of the relationship between space and healing in psychiatric settings that consider both situated actions and spatial orderings.

Conclusion

The notion of healing architecture has only very recently become part of the design of psychiatric facilities, drastically altering the spatialities of psychiatric inpatient care. Our study has explored these spatialities by way of the routine example of the administration of patient medication and its role in everyday psychiatric work. By analysing instances of the administration of medication, we have demonstrated how space, and the ordering of space, are central to the control so often required of psychiatric work, highlighting an occasional tension between the spatial affordances of the site, and the spatial orderings preferred by staff. Our paper should, therefore, be read in relation to other studies of psychiatric inpatient care (Bowers *et al.* 2009; Quirk *et al.* 2006; Salzmann-Erikson 2015), and the unique spatial and relational character of inpatient settings (Brown and Reavey 2016; Curtis *et al.* 2013; Reavey *et al.* 2019). Together with these scholars, we argue for analyses of healing architecture as alert to the complexes of action and socio-material practice as they are to the physical orderings of design. To the extent that any given architecture may be regarded as healing per se, our work suggests that this therapeutic effect will be more a function of spatial orderings than any simple material causation. Finally, our analysis suggests that healing architectures might have at least as great an impact on the character and organisation of psychiatric work, as they do on patient experience, wellbeing, and recovery. Indeed, understanding their effects on the work of psychiatric care may prove critical to uncovering the impact of healing architectures for recovery.

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