4

'The general atmosphere of this admission unit is reassuring and optimistic': modernism, architectural research and evolving psychiatric reforms in post-war England

Christina Malathouni

The thirty years following World War II have been characterised 'as the age of reform in psychiatry' in Western countries (Henckes, 2011: 164). In the British context, major changes were manifested in a series of related legislation, policies and guidance, such as the launch of the National Health Service in 1948, the passing of the Mental Health Act in 1959 and the publication of 'The Hospital Plan for England and Wales' in 1962. The examples listed here suggest a bias towards approaches that relate to hospitals, and more broadly to overlaps with physical healthcare. These are indeed two key points of the discussion below, yet the primary focus of this chapter is the contribution, whether real or aspired, that architecture made to psychiatric reforms in post-war England.

The discussion below borrows Nicolas Henckes's (2011) proposition for a framework of analysis for reforms in psychiatric institutions in the mid-twentieth century that '[put] reform practices themselves at the centre of the analysis' (Henckes, 2011: 164). Within this context, Greg Eghigian (2011) highlights the expanding pool of new expertise that became directly relevant to the history of mental healthcare during the second half of the twentieth century. He points out 'the growing importance of psychologists, social workers, neuroscientists, drug manufacturers, nurses, pedagogues, self-help groups, counsellors, legislators, accountants and consumers since 1950' and the need to consider psychiatry 'as working within a complex ecology of sciences, technologies, policies and actors' (Eghigian, 2011: 205).

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Both Eghigian and Henckes stress the multiplicity and diversification of actors in the post-war period and their critical role in reforms.

Despite this significant expansion of professionals associated with mental healthcare in the post-war period, architects are a professional group that is not automatically included in historiographic studies of post-war psychiatry. However, although an exclusive, or even 'proprietary', connection between architects and space has rightly been challenged by theorists such as Henri Lefebvre (1991, originally published in 1974), architectural practices can still influence spatial practices. Existing studies of mental healthcare spaces have firmly established the significance of asylum architecture (and more broadly of spatial arrangements) in the development of psychiatry and the social history of madness (see, for example, Scull, 1979; Topp, 2007), and the large scale and expansion of asylums in the nineteenth century have attracted extensive scholarship from an architectural history perspective (see, for example, Taylor, 1991; Richardson, 1998). However, scholarship on mental healthcare architecture in the twentieth century, although growing, remains largely fragmentary (see, for example, Soanes, 2011; Topp, 2017).

This chapter discusses how the architectural profession joined a larger pool of reformist actors in post-war psychiatry in England in the 1950s and to what extent architectural practices became, or envisioned becoming, reformist psychiatric practices in themselves.[1] It focuses on the admission and treatment unit for an existing psychiatric hospital for the mentally ill, Fair Mile Hospital[2] in Cholsey, near Wallingford, Berkshire (now Oxfordshire), England, commissioned before July 1954 and built by April 1956.[3] It explores a range of practices by its architects Philip Powell and Hidalgo Moya, from their design proposals and the building itself to their collaboration with specialist consultants and engagement with architectural research.

The full description of the building was 'Admission and Treatment Unit' and its cruciform plan comprised four wings on a single level: two separate male and female wings with thirty beds for women and twenty-three beds for men, a mixed-sex common room used for games and occupational therapy (*Architects' Journal*, 1956: 388), and a treatment wing for insulin and electroconvulsive therapy (ECT) that was to be open to inpatients as well as 'the ever-increasing number of outpatients requiring treatment' (*Architects' Journal*, 1956: 394).[4] The unit was to accommodate all new admissions,

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Figure 4.1 Admission and treatment unit, Fair Mile Hospital. Exterior (Common Room), 1956. Source: RIBA Architecture Image Library, RIBApix Ref. No. RIBA56469.

which were expected to stay for an average of seven weeks (*Architects' Journal*, 1956: 385).

Published in the *Architects' Journal* on 19 April 1956, an article on the newly completed building reveals the aspirations of the architectural profession to make its own mark in the field of mental healthcare. The building is hailed within as a most welcome architectural intervention as it embraces a departure from an 'institutional atmosphere', which is further linked to a positive perception of post-war mental healthcare as 'advancing', 'modern' and associated with (health and) illness, medicine and cure:

> The general atmosphere of this admission unit is reassuring and optimistic, to be in line with the modern conception of much mental illness as a curable condition. … It is fortunate that a building of this quality, without an institutional atmosphere, has been erected so early in the post-war mental health building programme; while medical work in this field has advanced greatly, architectural expression has not generally been of a very high order, and this building is therefore of particular significance (*Architects' Journal*, 1956: 385).

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In line with the above, this chapter argues that the psychiatric reforms to which the architects of this 1950s unit envisioned giving expression were twofold. Firstly, they included the notion of deinstitutionalisation, by giving mental healthcare buildings a non-institutional character rather than by the actual abolition of institutional care; that is, closer to an early version of the movement's various and nuanced readings (Topp *et al.*, 2007; Eghigian, 2011; Henckes, 2011) and 'the ethos of deinstitutionalization' (Long, 2017: 125). Secondly, such reforms also included the medical model of mental health (Jones, 1993): both the overarching shift towards treatment (Hess and Majerus, 2011), and specifically the adoption of physical treatments and the aspiration to align mental and physical healthcare provision.

Architectural practices towards these two ends are also grouped into two areas. Firstly, through their principal architectural practice – that is, their active interpretation of a building programme into a material and spatial structure. The architects employed design principles of architectural modernism so as to give their buildings a non-institutional character.[5] Secondly, their practices expanded to embrace interdisciplinary research on hospital architecture so as to match the perception of mental health as a medical, curable condition, and to align it with physical healthcare provision. Overall, this chapter argues that the engagement with post-war psychiatry that envisioned new practices towards psychiatric reform came both from outside psychiatry, as discussed here with a snapshot of mid-1950s England, and from inside the mental health field.[6]

National policy context

The historical context of the British National Health Service (NHS), launched in 1948, is directly relevant to all post-war healthcare provision in England, including psychiatry. During its first administrative period (1948–73) its principal focus was the hospital, both as an organisational and as a spatial entity (Rivett, 2014). Under the NHS Act of 1946, the minister of health became the central authority for all health services and all hospitals were transferred to fourteen (later fifteen) new Regional Hospital Boards (Jones, 1993: 146). Under the boards' overview, Hospital Management Committees were

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'the agents of the Boards' and mainly responsible for running their respective hospitals. Most power sat with the Regional Hospital Boards, as their regional functions included hospital capital works and the management of financial allocations to Hospital Management Committees (Rivett, 2014).

Whether mental hospitals should be 'included in the centralized NHS scheme, or left with the county authorities' had been questioned during the planning process of the National Health Service (Jones, 1993: 143–4). Eventually, mental hospitals were included within the NHS under their local Regional Hospital Boards, but under special conditions, as legislation at this point still kept mental health separate from physical health (RHB(47)1: §1). This absorption remained partial in other ways too, as mental hospitals were grouped separately under their own Hospital Management Committees (Rivett, 2014) and boards' medical officers for mental health were required to be psychiatrists (RHB(48)1: §62).

It would be more than a full decade before mental healthcare was fully integrated with the rest of the healthcare provided by the NHS – that is, following the appointment of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency in 1954, chaired by Lord Percy and completed in 1957, and the introduction of the Mental Health Act in July 1959. The Act brought about a complete overhaul of mental health services by 'replac[ing] much of the existing legislation on the provision of mental health services in England [and] bringing the provision of mental health services within the general administrative machinery of the NHS for the first time' (Rivett, 2014).

NHS hospital aspirations and constraints

The hospitals that the NHS inherited had previously been commissioned and administered under multiple separate systems, such as charitable, voluntary and municipal bodies (Rivett, 2014). In addition to the need to co-ordinate existing provision, there were also significant infrastructural shortcomings, both because of the advanced age of most hospital buildings, which were in need of maintenance and modernisation, and in terms of bed shortages that dictated the commission of new hospitals.

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Despite these pressing needs, budgetary constraints and competing priorities meant it was not until the early 1960s that a commitment to substantial hospital rebuilding was actually undertaken. Nonetheless, limited activity was initiated in the 1950s. For the design of new buildings, tuberculosis initially came as first priority, but soon became less relevant, and mental healthcare came second (Harwood, 2015: 283). In 1950, Minister of Health Aneurin Bevan included mental hospitals among the top priorities set for hospitals (Jones, 1993: 143–4). However, as the enormous scale of the endeavour and state funding limitations were recognised, capital expenditure in 1954 worked out to be four hundred and thirty million pounds for housing, fifty-seven million for schools and only ten million for hospitals (Hughes, 1996: 39). Such delays in healthcare investment soon became alarming: by the mid-1950s there were fourteen new towns built but not one new hospital. A recommendation for a seven-year programme of capital investment followed (Hughes, 1996: 40–1). Most importantly for the discussion here, Minister of Health Iain Macleod allocated some 'meagre' funding for additional psychiatric facilities in 1954 and 1955: the so-called 'mental million' (Hughes, 1996: 41). To date there is no comprehensive survey of this period and it is not known how many buildings were commissioned under this scheme, nor how many were actually realised or survive at the date of this publication. However, preliminary research undertaken by the author suggests a number of admission and treatment units were commissioned in the mid-1950s as part of this scheme (see also *RIBA Journal*, 1957: 268). They were scattered across England and were, in fact, the effective continuation of a similar building programme started in the inter-war period.[7]

Fair Mile Hospital

Initially introduced in the architectural press as 'Berkshire, Reading, and Newbury Lunatic Asylum' (*Builder*, 1870), Fair Mile has been known under several different names during its lifetime. These mainly comprised variations on the following: 'Moulsford Asylum' (1870–97), 'Berkshire Lunatic Asylum' (1897–*c*.1915), 'Berkshire Mental Hospital' (*c*.1915–48) and 'Fair Mile Hospital' (1948–2010).[8] The original building for Fair Mile was purpose-designed and built as

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a 'lunatic asylum' in 1870, and further extended in 1878 by Charles Henry Howell, one of the 'key contributors to the design of asylums' during the 1870s (Taylor, 1991: 153).

The size of the institution varied significantly during its lifetime. Initially, it accommodated 133 male and 152 female patients (Wheeler, 2015: 13), but these numbers were far exceeded in subsequent decades. During World War II the hospital reached its greatest size, accommodating over 1,400 patients.[9] Overcrowding remained a problem following the war, with 1,202 beds recorded in 1947[10] and around one thousand beds in 1951 and 1959.[11] From the 1960s onwards, in line with new deinstitutionalisation policies, the hospital decreased in size, and by the end of the century it accommodated only 200 patients.[12] Following the regional administrative organisation of hospitals under the NHS, Fair Mile fell under the remit of the Oxford Regional Hospital Board and more specifically the Berkshire Mental Hospitals Management Committee, renamed 'St Birinus Group Hospital Management Committee' in 1957.

The new admission and treatment unit

The new admission unit was part of 'the first group of units to be sanctioned since the war by the Ministry of Health' (*RIBA Journal*, 1957: 268).[13] In local administrative documentation, the new admission unit was first reported in July 1954, found within the Hospital Inspectors' Reports, and was anticipated to 'assist in the better classification of patients, and … provide good facilities for the clinical teaching of Student Nurses'.[14]

As was common practice in post-war England, under the oversight of the Oxford Regional Hospital Board and in collaboration with W. J. Jobson of its Architects' Department, the project was commissioned to a private architectural practice: Philip Powell and Hidalgo Moya, one of the most important post-war architectural firms in England. Such a commission for the new admission unit was particularly significant. Incremental building activity was carried out continuously in existing mental hospitals, whenever funds allowed it, yet this usually resulted in nondescript structures with no particular architectural merit. By contrast, upon its completion, the Admission Unit at Fair Mile was welcomed by the Commissioners of the Board

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of Control as a significant development in the history of the hospital and noted as original in design and appearing to be 'admirably suited to its purpose'.[15] The building was also widely published in the architectural press from January 1956 to May 1957, with dedicated reports appearing in the *Architect and Building News* (1956), *Architects' Journal* (1956), *The Builder* (1956) and *RIBA Journal* (1957), as well as a specialist journal, the *Hospital* (1956). In 1957 it was also awarded a Royal Institute of British Architects Bronze Medal.[16]

The above articles provide most of the factual information available about the admission unit as a built structure. The architectural vision and areas of interest are clearly highlighted, including detailed constructional information, as is common in similar publications for any type of building. In fact, the text across these articles is largely repetitive and one can assume a summary was provided by the architects themselves which closely reflected their priorities for the commissioned project. This is most noticeable in the article published in *The Hospital*, which is very similar to the rest, despite the journal otherwise having a more specialist character (*Hospital*, 1956).

Various individual design components are described and partly interpreted in the journal articles. First of all, good connections to external spaces and natural lighting dominate all accounts of the new building in the professional press. In addition, the cruciform plan is seen as serving to minimise the perceived size of the building and thus any institutional associations (*RIBA Journal*, 1957: 269), as well as allowing the creation of separate gardens for the male and female wings. Internally, the cruciform plan further created good connections between all four wings and allowed for efficient yet discreet supervision. The single-level design further minimised the perceived size of the unit and it was only the common room that stood out as a special space with its inverted 'butterfly' roof and extensive use of glazing (see Figure 4.1). In the rest of the building, the use of glass was also increased, as allowed by recently relaxed design requirements, and it is specifically noted that no windows had bars installed (*Architects' Journal*, 1956: 386). The single-storey design, we are told, was also enhanced by varying roof levels, clerestories and roof lights, which allowed for compact planning with short corridors (*Architects' Journal*, 1956: 388; *Builder*, 1956: 387).

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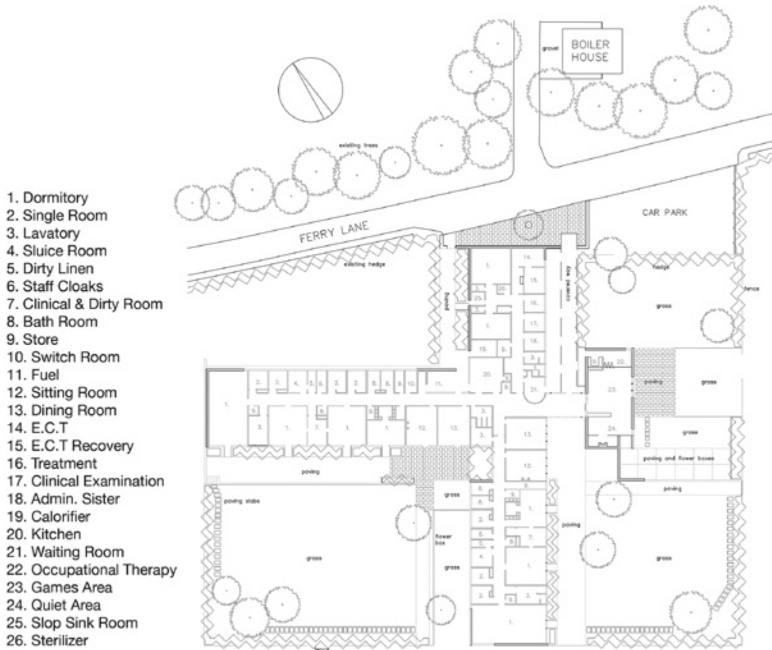

Figure 4.2 Admission and treatment unit, Fair Mile Hospital. Floor plan (drawn by Alex Wood).

Even when not explicitly stated, these articles provide insights into some of the psychiatric reforms that its designers envisioned enacting or supporting through design: their principal architectural practice. Specifically, their application of modernist design principles is argued here to have aimed to materialise the pleasant atmosphere and non-institutional character mentioned in the quote from the *Architects' Journal* above. Such modernist design principles included: a functionalist design (that is, a design where 'form follows function'), an unadorned appearance, extensive openings and emphasis on the building's overall structure and mass composition. The functionalist interpretation of the wards, common room and treatment wing further aimed to give expression to the advances towards the treatment, or even cure, of mental illness – yet with a material outcome as complicated as the evolving psychiatric practices themselves, as will be discussed below. Other specific design elements of the building,

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such as its four- and six-bed wards, highlight the new architectural practices brought into the field in the post-war period – namely, the new practices of interdisciplinary research and collaborative practices between designers and researchers, also discussed below.

Along with the main text of those articles, the accompanying photographs and drawings allow for further insights. The impression that the unit is a separate, independent facility comes across very strongly and seems intentional. Although the addition of detached buildings within mental hospital grounds at that point already had a long history (see, for example, Richardson, 1998: 15, 177), several other features of the unit make the effort to hide its connections to the main hospital quite distinct. Telling in this respect is the placement of the new building, situated across a public road by the southern boundary of the hospital grounds, with trees screening the existing hospital from view, while the gentle slope from north-west to south-east and open views to the east, south and west further strengthen this visual separation (*RIBA Journal*, 1957: 268). Illustrations in all publicity material also omitted any images of the main hospital (*Architects' Journal*, 1956: 386, 394; *Architect and Building News*, 1956: 11).

However, this implied independence from the main asylum is contradicted by a key function that was omitted from the new unit: food service. Each ward wing had a day room and a dining room, but it is unlikely that the small kitchen near the junction of the four wings actually catered for these two dining rooms (see Figure 4.2). Its small size, as well as common practice in similar buildings,[17] suggest this was merely a distribution kitchen that was dependent on the central kitchen of the main hospital. Conversely, the inclusion of an area for occupational therapy in the common room strengthened the independence of the unit, but there is insufficient information as to what degree this was the case for other patient activities within the hospital grounds, or for extramural events.

A rare photograph showing the common room occupied was included in a nurse recruitment booklet published in 1959 (Figure 4.3).[18] Although this may have been staged, with staff posing as patients, the photograph supports the designers' intention for a non-institutional, almost domestic, character. Such an intention is further reflected in the unit's two sitting rooms, one in each single-sex

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Figure 4.3 Admission and treatment unit, Fair Mile Hospital. Common room. Source: BRO, P/HA2/5/1, Fair Mile Hospital, 'Into the Light', staff recruitment booklet, 1959.

wing (see Figure 4.2), and can be traced back to the mid-nineteenth century.[19]

In this 1959 photograph, three pairs of people (two single-sex and one mixed-sex) are sitting in the games area of the common room, which is flooded with sunlight. One man and one woman, in each one of the two single-sex pairs seated around small tables, are reading newspapers. Well looked-after potted plants are noticeable throughout the otherwise scarcely decorated room, with one pot on each one of the room's tables as well as on the counter separating the games area from the 'quiet corner'. Three more pots can be seen on two console tables: one inside the common room and two on a second console table in the adjacent entrance hall, which can be seen through the open door. The room is tidy, clean and in good

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condition. The range of materials, including extensive use of timber and glazing, and exposed brick at the fireplace, make the space feel both warm and fresh. Apart from two books on two of the tables, however, the lack of other objects is striking. Whether a depiction of real patients or a staged photograph, the image reminds the viewer more of a hotel foyer or other type of communal living space, rather than a family home. The uniformity of some of the furniture further reinforces this impression, and so does the appearance of its occupants: neatly groomed, fully dressed and wearing shoes, they convey a message of care, but also diminish to a degree the implied domestic character of the space.

The open door of the room and the absence of staff are also interesting. Although not explicitly stated in any of the documentation identified so far, it is likely that an open-door policy was adopted in the unit. Not only had this become widespread practice in Britain in the 1950s (Hide, 2018), but moreover the floor plan of the unit and photographs also support such a conjecture: the entrance hall to the inpatient part of the building has no nurse station or reception controlling access (see Figure 4.2). In the external spaces, although the two yards outside the wards are fenced, those fences are transparent and suggest no intention to enforce confinement (*Architect and Building News*, 1956: 13).

The suggestion of a non-institutional character of the building as a whole and the implicit domestic character of the common room in particular are, however, challenged by various strongly clinical elements. Neither the intention for a domestic character nor the hybrid nature ('clinical, domestic, institutional, and in some respects carceral', as Hide (2020: 190) sums this up) of the building was a novelty. However, the conflict seems to be intensified in the admission unit, partly because of its condensed size, and therefore closer proximity between conflicting aspects, and partly because of certain additions of a clinical character: not only was one of the four wings devoted to a purely clinical purpose, it was also open to outpatients and bore the stamp of a highly technological nature in the form of ECT facilities. Moreover, the wards of the unit, in contrast to the common room, also have a strongly clinical atmosphere, rather than a domestic one.[20]

A number of photographs and drawings provide information on the wards. The plan demonstrates that these comprised single rooms,

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in addition to four-, six- and ten-bed wards (see Figure 4.2), while photographs demonstrate that due consideration was given to both natural and artificial lighting. The rooms are flooded with daylight through the extensive external glazing, including clerestories, and the individual wall-mounted light fittings at bedheads provide one opportunity for patient control over their personal space. However, the strongly clinical, even sterilised, character of these spaces is also conveyed in all images. This is the case in both a literal and a metaphorical sense: the spaces are unoccupied, with neither people nor personal belongings. There is no evidence of individual wardrobes, although a small side table or cabinet can be discerned next to each bed. Most strikingly, the beds, and the privacy curtains around them, strongly convey the character of a clinical environment. They have a similar but reverse effect to what Benoît Majerus has pointed out about the function of a bed changing when transposed from a standard room into an institutional setting (Majerus, 2017: 268): any domestic character is nullified and the hospital atmosphere becomes dominant.

Interestingly, no illustration of the actual treatment spaces features in any of the architectural articles. Only one photograph shows an insulin therapy dormitory, which looks like a starker version of the main wards (*Architect and Building News*, 1956: 16). Another photograph showing ECT treatment at Fair Mile was included in the 1959 nurse recruitment booklet 'Into the Light' (see Figure 4.4). The clerestory windows and wall-mounted light fittings indicate that this was taking place in the new admission unit. The room is sparsely furnished with a hospital bed and the necessary support for the technical equipment. A doctor in a white coat and a nurse in uniform strongly underline the clinical nature of the setting and the experience for the patient, while the presumably white[21] walls and sheets covering the patient further reinforce this tone.

The stark architectural space here seems to complement what Gawlich (2020) calls 'the concept of pushbutton psychiatry … the uniform, disciplined, and disinterested treatment regimen, which therapeutically "shocked away" disorders as well as affective failures' (Gawlich, 2020: 215). The creation of a dedicated space further supported the development of 'concrete therapeutic action' through the push of a button by offering a second component: 'the availability

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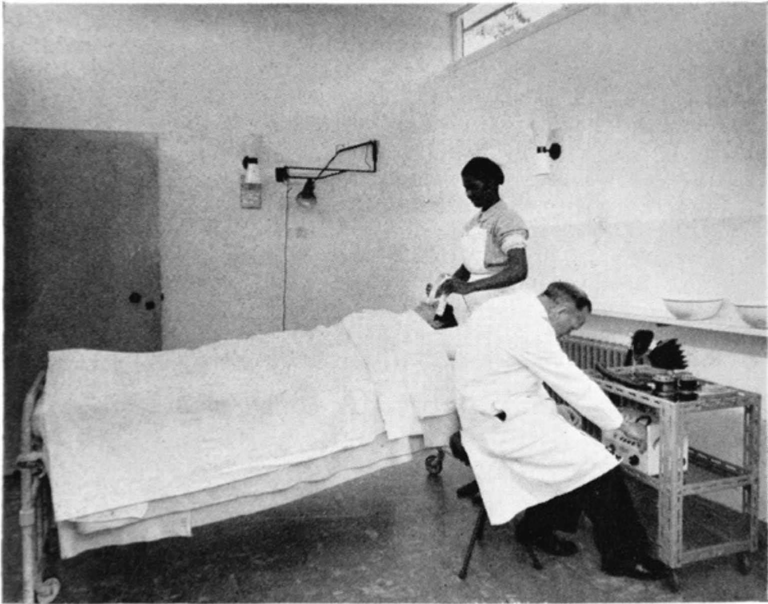

Treatment — Fair Mile Hospital.

Figure 4.4 ECT treatment at Fair Mile Hospital, *c.*1959. Source: BRO, P/HA2/5/1, Fair Mile Hospital, 'Into the Light', staff recruitment booklet, 1959.

of electroconvulsive therapy embedded into the room' (Gawlich, 2020: 217).

However, the omission of technological aspects of both the clinical and 'domestic' sides of the building in the published articles is intriguing. One wonders if this was perceived by the architects as threatening their imagined 'control' over their creation in adhering to the use of architectural symbols of domesticity. In the common room, one can notice the absence of a television set (see Figure 4.3), despite the device's increasing popularity both in mental hospitals and in domestic family life in the 1950s (Hide, 2020). Instead, 'patient' pairs pictured here at individual tables seem to suggest the intended encouragement of social interaction, even if no such interaction is actually captured in this instance. By contrast, a more traditional symbol of domesticity was emphatically introduced as part

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of the building design, namely fireplaces. These were included in the two sitting rooms and the 'quiet corner' of the common room. Notably, however, staff in a similar unit were reported to have expressed doubts as to whether the fireplaces would ever be used, 'as the heating system should be adequate, but these were regarded as contributing to the domestic character of the room' (*Architects' Journal*, 1959: 361).

Architectural practices in support of psychiatric reforms

Modernist architecture

Although rather late compared to certain other geographical regions,[22] the adoption of modernist design principles was relatively novel in post-war England. The Modern Movement barely took hold before the 1930s, and it was the Festival of Britain in 1951 that 'gave Britain modernist precincts at last' (Harwood, 2015: xii, xxv). Within this context, British modernist architecture was interlaced with post-war optimism and the welfare state. Powell and Moya were very much part of this important shift (Harwood, 2015: xii, xxv; Powell, 2009), and their admission unit at Fair Mile reflects this: entrenched in their roles as designers, Powell and Moya appear to have maintained a certain professional insularity as architects subscribing to the utopian and often limiting, even controlling, aspects of modernism. Nonetheless, through their associated design practices they managed to give the new unit a refreshing and uplifting appearance, which was perceived in the local community as 'ultra-modern' (Wheeler, 2015: 74). Leaving behind historical styles, monumental symmetrical elevations, masonry construction and pitched roofs, their design embraces a range of modern architectural features: an asymmetrical composition, large openings and extensive glazing, as well as both flat and 'butterfly' roofs, which matched the non-institutional aspirations of the evolving mental health field, despite the budgetary and building material supply constraints of the 1950s.

However, the functionalist side of the design leaves more to be desired: the 'hybrid' nature of the functions accommodated, both 'domestic' and medical, appears to remain unresolved. It is here that an expansion of architectural practices came into the picture

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as manifested by the introduction of the complementary role of architectural researchers, in parallel with the customary role of architectural designers. This expansion supported the evolving medical model of mental health, but also appears to have contributed to some of the unresolved issues with the dual atmosphere intended to be conveyed internally: both non-institutional and 'scientific'.

Research in hospital architecture

The increasing significance of research in hospital architecture during the period is strongly reflected in a study by the Nuffield Provincial Hospitals Trust (NPHT, 1955). It is argued here that this study had a direct influence on the new unit at Fair Mile. The Nuffield Provincial Hospitals Trust was founded in 1939 by Lord Nuffield, aiming to promote the co-ordination of hospital and ancillary services in the provinces, as a provincial equivalent of King Edward's Hospital Fund for London (McLachlan, 1992: 9). In 1949, the trust, with the co-operation of the University of Bristol, launched an investigation into the functions and design of hospitals (NPHT, 1955: xix). This was conducted by its Division for Architectural Studies under the direction of Richard Llewelyn Davies and a multidisciplinary team. In addition to architects and research and administrative assistants, other specialisms included: a statistician, a historian, a physician, a nurse and an accountant (NPHT, 1955: vi). Aside from the investigation, through co-operation with hospital authorities, two experimental hospital buildings were also built: a sixty-four bed medical ward unit added to Larkfield Hospital, Greenock, Scotland, and an eighty-bed surgical unit for Musgrave Park Hospital, Belfast, Northern Ireland (NPHT, 1955: xix).

Although there is no definitive evidence that Llewelyn Davies or his partner John Weeks had been directly involved at Fair Mile,[23] they had recommended Powell and Moya to the Oxford Regional Hospital Board in 1951 as 'the best young firm in the land' (Harwood, 2015: 285). What is more, the two men were consultants for other major hospitals designed by Powell and Moya, including the Princess Margaret Hospital at Swindon, Wiltshire, which was being designed in parallel with Fair Mile (Harwood, 2015: 285). Powell and Moya's involvement at Swindon began as early as 1951 (Powell, 2009: 87)

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and the hospital's eight forty-bed wards were based on the Nuffield layout developed at Musgrave Park (Hughes, 1996: 104).

Although the Nuffield study was limited to acute general hospitals, with mental hospitals specifically excluded, there are numerous design elements applied at Fair Mile that carry the stamp of that study. Two of these elements are briefly discussed below: the design of four- and six-bed wards, as applied at Musgrave Park, and the particular consideration given to both natural and artificial lighting.

The Nuffield report stresses the novelty of the wards' design, which would become widely influential:

> The arrangement of beds 3-deep parallel to the window-wall [as used in the 6-bed wards] is common on the Continent, and architecturally is valuable because it allows greater compactness in the building. This arrangement has yet to be fully accepted in Britain, but the Musgrave Park experimental ward units offer propitious conditions for testing the reactions of patients and staff to it (NPHT, 1955: 30).

As regards lighting, aiming simultaneously for maximum light and minimum glare made the design of hospital windows particularly challenging. Various possibilities were explored during the Nuffield studies and tested in the two experimental hospitals designed by Llewelyn Davies's team (NPHT, 1955: 91–9, figures 12, 76, 79–81, 83). These included what can be also seen applied in the wards at Fair Mile, namely the inclusion of 'a horizontal baffle to limit the view of the sky for patients in the beds nearest to the windows and thus reduce discomfort from glare' (NPHT, 1955: 99). Artificial lighting was also studied, again aiming at avoiding glare, and proposals for 'separately controlled local lighting at bed-head' bear close similarities to the fittings applied at Fair Mile (NPHT, 1955: 101–7, figure 88). Sun and daylight were also encouraged throughout hospitals for the benefit of patients as well as staff (NPHT, 1955: 148).[24]

Research in mental healthcare architecture: researchers and designers

Despite their exclusion from the 1955 Nuffield study, pleas for further studies that dealt with psychiatric hospitals were voiced by architects involved in designing similar admission units, as exemplified

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in an article appearing in the *Architects' Journal* in 1959 which discussed another admission unit, at St John's Hospital in Stone, Aylesbury, Buckinghamshire. Building of the facility began in November 1956 and was completed in April 1959. It was designed by Gollins, Melvin, Ward and Partners but, despite the different design teams, certain contributors took part in both the Fair Mile and St John's projects: both buildings were under the administrative remit of the Oxford Regional Hospital Board and as such the architect to the board, W. J. Jobson, was involved in both projects (*Architect & Building News*, 1957b: 761); moreover the work of the Nuffield study can be safely presumed to have influenced both projects.[25] In addition, there are some design similarities which make two points from the 1959 article on the St John's unit relevant to Fair Mile.

Firstly, the 1959 article comments on the distinct environmental needs that different mental health conditions may have, suggesting emerging knowledge in the field: 'With mental patients of certain types, awareness of certain aspects of the environment may be heightened, so the surroundings become more important than usual' (*Architects' Journal*, 1959: 360). Secondly, the article concludes by openly addressing the need for research into this particular area of hospital building and for such research to match advancements in treatment: 'So little building has been done in this field since new ideas of treatment for mentally sick developed that it will clearly be the job of the health authorities to establish research teams in mental hospital building similar to the Ministry of Education's' (*Architects' Journal*, 1959: 362).[26] Interestingly, a key such study appeared that same year in the form of a report for the World Health Organisation, led by Llewelyn Davies in collaboration with two psychiatrists, the French Paul Sivadon and the British Alex Baker, and titled *Architecture and Psychiatric Services* (Baker *et al.*, 1959).[27]

David Theodore's (2019) analysis of the connections between the work conducted at Nuffield and Llewelyn Davies's keen interest in architectural research is particularly enlightening here as it offers insights into two parallel architectural roles envisaged in the field: one for specialised research bodies and one for practising architects. Theodore points out that in 1960, as Llewelyn Davies was moving from his role at Nuffield to an academic job at the Bartlett School of Architecture at University College London, he organised a 'Hospitals

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Course' at the Royal Institute of British Architects which demonstrated how he envisaged the interdisciplinary research on hospital design 'as a model for integrating specialist knowledge with design' (Theodore, 2019: 989). Notably, however, Llewelyn Davies also insisted that architects must remain architects, both when participating in multidisciplinary research teams and when practising architecture. The goal was the pursuit of '*specialist knowledge*, freely available, not *specialised men*' (emphasis in the original).[28]

Theodore's analysis throws light on the new division of labour applied in the admission units for the Oxford Regional Hospital Board as matching Llewelyn Davies's vision of 'a few specialist architects, engaged in research, and the majority of architects, engaged in practice' (Theodore, 2019: 991). Although prolific as architectural designers, neither Powell and Moya, nor Gollins, Melvin, Ward and Partners, ever became exclusively hospital architects, let alone dedicated to psychiatric buildings. In this respect, both the presumed role of the Nuffield study and the architects' pleas for further research in the area of mental healthcare architecture support the position put forward here that a new layer of research practices was introduced in the interface between architecture and psychiatry in post-war England.[29] This research element was added to design as the principal architectural practice, but also to known precedents in general hospital and asylum architecture, where architects specialised in such architecture and doctors or medical superintendents became experts in architectural design (see, for example: Adams, 2008: chapter 4; and discussion of G. T. Hine and Dr John Conolly in Taylor, 1991: 21–2, 25, 48, 135, 146).

Conclusion

The study here presents a snapshot of some of the architectural activity in 1950s England in relation to mental healthcare provision. The full scope of this activity remains to be established, yet evidence suggests this was widespread, varied, and had a degree of continuity with the inter-war period. The placement of importance on admission units in particular is not a novelty of the post-war period nor of the English context (see, for example, Topp, 2017). However, their inclusion in the restricted 'mental million' programme and the

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commissioning of distinguished private architectural practices further underline the role of the architectural profession as an actor in post-war psychiatric reforms.

At Fair Mile, the architects worked within the context of a former asylum, rebranded in the first half of the twentieth century as a mental hospital and in the post-war period simply as a hospital. The discussion above highlights how they aimed to give material and spatial expression to an early version of the notion of deinstitutionalisation. This related to a change in perceptions of institutions for long-term care, rather than a desire for their abolition, and was supported by an increase in voluntary admissions and outpatients. This type of deinstitutionalisation had already been implemented in the first half of the twentieth century both with attempts 'for lighter, more domestic designs', including looser planning and providing more accommodation in 'detached villas' (Taylor, 1991: 45), as well as with new spatial models of mental healthcare institutions (see, for example, Topp *et al.*, 2007). However, within the post-war British context, architects used their principal architectural practice, that is, design, to facilitate the expression of a non-institutional character, by engaging with principles of modernism, but also hospital design considerations, such as those included in the Nuffield study. Although research on other units of this period remains a work in progress, the building for Fair Mile stands out as an early example of this notion, designed by a notable modernist architectural practice and embracing several of the new trends put forward by the Nuffield study.[30]

In addition, the particular inclusion of a treatment hospital further stressed the shift towards the medical model of mental health, in line with the overarching reform of twentieth-century psychiatry towards treatment (Hess and Majerus, 2011). This was expressed at Fair Mile in a twofold manner: firstly, by the adoption and intensification of physical treatments in the treatment wing, and secondly by the implicit ambition to align mental and physical healthcare provision. Given the exclusion of mental hospitals from the Nuffield study, it is argued here that ongoing policy work towards the merging of mental and physical health services was seen as permissive towards, and even encouraging of, some permeability in architectural solutions between the two fields. Although the unit predated any political declarations of the abolition of mental

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hospitals as found in the Percy Report in 1957, the Mental Health Act in 1959 and 'The Hospital Plan for England and Wales' in 1962, the merging of physical and mental healthcare provision and psychiatry's 'parity of esteem with other medical specialisms' were being discussed for decades prior. Notable landmarks include the White Paper of 1944, which quoted the Macmillan Commission of 1924–26[31] on the interaction of mind and body, and an article published in the *British Medical Journal* in June 1945 (*British Medical Journal*, 1945; also cited in Jones, 1993: 143). During the 1950s the merging of psychiatric and physical health services was suggested by various publications, opining that the mentally ill would probably be accommodated in psychiatric units at general hospitals in future,[32] as well as more comprehensive propositions for the reorganisation of hospital services.[33] In this context, the engagement with Nuffield's research practices should not be seen as random, or even compromising. Instead, insider knowledge, probably through Regional Hospital Board officials and the Nuffield team, is most likely to have encouraged some reformist expansion of architectural practices by the architects involved, either in the form of design or research.

Notes

1 More broadly within this volume, questions relating to spatial and material aspects of psychiatric practices appear in several chapters, as Chapters 10, 11 and 12.
2 The name 'Fair Mile', rather than 'Fairmile', will be used here, as this version appears in most official records. 'Fairmile' will be used only in any exact quotes or titles where it appears in this form.
3 Following the hospital's decommissioning and closure in 2003, the admission and treatment unit was demolished. The Victorian asylum became a Grade II listed building in 1986 and has since been converted to housing.
4 The introduction of these treatments to Fair Mile predated the new unit. Electroconvulsive therapy was introduced by 1951 (The National Archives, Kew, General Nursing Council for England and Wales: Education, Hospital Inspectors' Reports and Papers, DT 33 (hereafter TNA, DT 33), file number DT 33/1243, 8 March 1951, p. 4) and insulin coma therapy by 1954 (TNA, DT 33/1243, 8 July 1954, p. 5).

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5 This association with modern architecture is much more complex than what is briefly presented here. Leslie Topp (2017) has identified examples as early as the late nineteenth century, in Germany and Austria, in which the symbolic and representational role of architecture was used in the struggle for psychiatric legitimacy in order to improve the image of asylums. A comparison to the experimental work of the architect Kiyoshi (Joe) Izumi in Saskatchewan, Canada (also in the 1950s and whilst existing institutions were not being abolished) is equally fascinating (Dyck, 2010).
6 As discussed by Despo Kritsotaki, Marica Setaro and Gundula Gahlen in Chapters 1, 2 and 3.
7 A scoping exercise was started in early 2020 but interrupted by the Covid-19 pandemic. Although a full comparison with the inter-war period requires in-depth analysis, one immediately noticeable difference is the post-war shift towards architectural modernism.
8 Berkshire Record Office, Reading (hereafter BRO), Records of Fair Mile Hospital, Administrative History, D/H10 (hereafter BRO, Admin. Hist., D/H10), http://ww2.berkshirenclosure.org.uk/CalmView/TreeBrowse.aspx?src=CalmView.Catalog&field=RefNo&key=DH10 (accessed 6 July 2018). See also Wheeler, 2015: 18.
9 BRO, Admin. Hist., D/H10.
10 TNA, DT 33/1243, 13 November 1947, pp. 1, 3; 12 April 1962, p. 1.
11 BRO, St Birinus Hospital Group Management Committee (previously Berkshire County Mental Hospital Management Committee), P/HA2 (hereafter BRO, P/HA2), file number P/HA2/5/1, Fair Mile Hospital, 'Into the Light': 3; TNA, DT 33/1243, 8 March 1951, p. 6.
12 BRO, Admin. Hist., D/H10.
13 The unit is noted here as 'the second to be completed', which conflicts with later scholars naming this as the first NHS hospital to be completed in England. I mistakenly repeated this claim in an earlier article (Malathouni, 2020: 458).
14 TNA, DT 33/1243, 8 July 1954, p. 6.
15 TNA, General Nursing Council for England and Wales: Education, Nurse Training Schools, Correspondence and Papers, Parts I and II, DT 35 (hereafter TNA, DT 35), file number DT 35/194, Copy of the Report by the Commissioners of the Board of Control at their visit to Fair Mile and Hungerford Hospitals on the 12th and 13th of April, 1956.
16 BRO, P/HA2/1/1/3, 9 May 1957, p. 1160.
17 For example, this is known to be the case for an admission unit at Herrison Hospital, Dorset (*Architect & Building News*, 1957a: 764).
18 Also reproduced in Wheeler (2015: 76).
19 Hamlett (2015), as cited in Hide (2020: 190).

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20 The discussion here regarding the domestic character of parts of the building naturally relates to newly admitted patients who stayed in the ward and not to patients of the main hospital or outpatients who only came for day treatment.
21 The colour scheme throughout the building cannot be seen in the photographs, as these are all printed in black and white. However, colour is mentioned in some detail in two articles (*Architect and Building News*, 1956: 16; *RIBA Journal*, 1957: 270).
22 International examples of mental healthcare facilities reflect a different timeline as regards stylistic evolution. See for example the very interesting analysis in Topp (2017).
23 Powell and Moya's professional papers survive only in part and are very limited in scope (Victoria and Albert Museum, London, RIBA British Architectural Library Drawings and Archives Collections, Sir Philip Powell's notebooks, illustrated lecture notes, and design feasibility reports for Powell & Moya, 1964–2000, PoP). Llewelyn Davies's papers, meanwhile, are considered lost.
24 For a much more nuanced and multilayered discussion on the role of light, see Sammet (2020). Sammet's article suggests further investigation into the origins and meaning of the title 'Into the Light', as used by Fair Mile for its 1959 staff recruitment booklet, may be a worthwhile future exercise.
25 Like Powell and Moya, Gollins, Melvin, Ward and Partners were also involved in further major hospital commissions, so their knowledge of the Nuffield work should likewise be assumed (Aldous, 1974).
26 This burgeoning realisation that there could be a correlation between distinctive characteristics of mental illness and associated care facilities was also strongly reflected in a 1961 memorandum of the Scottish Home and Health Department (Long, 2017: 118).
27 Notably, this report recommended that 'special admission units should be avoided' (Baker *et al.*, 1959: 50), yet the advantages of the number six (and to a lesser degree four) for the bed layouts of wards and other patient groupings was repeatedly recommended here too (Baker *et al.*, 1959: 25, 36, 42, 52, and figures 4–6).
28 Llewelyn Davies (1957: 189), as quoted in Theodore (2019: 990).
29 Close collaboration between mental health professionals and architects in the post-war period has been evidenced and discussed in other geographical settings too, both in terms of direct collaboration within individual projects and in terms of broader research in the field. Published scholarship to date includes studies in relation to 1950s and 1960s work in Saskatchewan, Canada (Dyck, 2010), in 1960s France, in relation to Nicole Sonolet's work as well as the research collective CERFI (Centre

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d'etudes, de recherches et de formations institutionelles, or Centre for Institutional Studies, Research and Training) (TenHoor, 2019), and in the 1960s US, in relation to Community Mental Health Centers (Knoblauch, 2020: Chapter 2).

30 Articles concerning a small number of similar admission units have been published in the architectural press (for example, *Architect & Building News*, 1957a, 1957b; *Architects' Journal*, 1959). Several more units have been identified in the archival material of an English hospital historical survey conducted in the late 1990s (Richardson, 1998), held at the Historic England Archive in Swindon, Wiltshire.

31 The Macmillan Commission of 1924–26 had recommended the adoption of medical terminology ('hospital', 'nurse', 'patient' and so on) and voluntary treatment, and effectively led to the Mental Treatment Act 1930.

32 Godber (1958), as cited in Rivett (2014).

33 McKeown (1958), as cited in Rivett (2014).

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