Broadmoor Hospital: Prison-like hospital or hospital-like prison? A study of a high security mental hospitals within the context of generic function

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Abstract

This study examines changes in the spatial structure of high security mental hospitals in light of changes in mental health treatment philosophy over the last 100 years. The case of Broadmoor Hospital is utilised, which embodies tensions between the spatial requirements of security and health care.

Four ward buildings were compared, dating from different time periods and perspectives on health and security. The first dates to Broadmoor’s opening in 1863, the second ten years later, and the remaining two to the 1980’s. It is shown how space is used to adapt to changes in health care needs and trends throughout the hospital’s life, and how a shift in health care philosophy can be seen in the spatial layout of each building.

The findings of this paper are discussed in the theoretical context of generic function, departing from the fact that the original brief for the construction of Broadmoor required the capability for conversion into a prison, school or governmental institution. It is argued that current mental health conditions are sophisticated and space functions more specific, and that Broadmoor functions as an institutional hybrid, split between concerns over health care and prison-like security.

1. Introduction

This paper is based on a recent MSc Thesis at University College London. The Thesis set out to analyse Broadmoor Hospital using Space Syntax theories and methodology. Broadmoor Hospital opened as a mental institution in May 1863, when the attitude towards mental health was rather different to what it is today. The Broadmoor “Criminal lunatic asylum”, as it was first called, was designed by Major General Joshua Jebb and opened with 95 female patients. A block for male patients followed a year later. The site covered 290 acres on the edge of Berkshire, 32 miles away from London.

The asylum was “intended for the reception, safe custody and treatment of persons who had committed crimes while actually insane or who became insane whilst undergoing sentence of punishment” (web 1, BBC News). Nowadays, it is one of three high secure hospitals in England, the other two being Ashworth and Rampton. The complex now houses 326 patients in 22 wards (web2, West London Mental Health Trust).

The latest CHI Report (Commission for Health Improvement) praised the primary healthcare centre but said, “The majority of ward areas at Broadmoor Hospital are unsuitable for their purpose and cannot be considered an appropriate, humane environment for modern mental healthcare delivery...” (Web3, Commission for Health Improvement, 2003).

Why have the older buildings in Broadmoor become obsolete as mental care facilities? It is argued that with mental health becoming more sophisticated and treatment driven,
the spatial configurations have had to adapt to allow for these new functions to take place. The buildings grew in size incorporating a number of areas designated for treatment and common spaces making life in Broadmoor more localized. This relates to the theory of “normalization” (Peatross, 1997) and will help address issues of interdependence, institutionalisation and the analysis of different kinds of social relations that can be found in Broadmoor.

Although the nineteenth-century buildings were from construction intended as a mental institution, they had to allow for conversion into other types of institution such as a school, government institution or a hospital. This relates directly to the concept of “generic function”, which is what buildings must have in common in order to be interchangeable (Hillier, 1996).

Four buildings were studied in terms of their composition; geometry and form to see how they have adapted to the current care needs of the institution and how they are affecting both the patients and the staff. The discussion is set forward by analysing the ward’s configurational properties and underlying spatial structure in the light of social relations leading to appreciate how the wards function differently in terms of interfaces between staff and patients.

The study ends with the conclusion that normalization and a hospital-like setting is given at the local level within the wards. Globally though, the compound does resemble a prison rather than a hospital and there is a conscious intention of making the system unintelligible for the sake of security. The old buildings have become obsolete in part because they were designed to function at a global level and are not as self-contained. They do not have room to incorporate the new spaces required for modern health care. Generic function suggests that the old ward buildings were interchangeable with other institutions at the time but cannot absorb a modern building of the same type.

1.1. Total Institutions

What follows is to understand the nature of the asylum and more specifically of a High Security Hospital such as Broadmoor within the background of total institutions and restrictive settings. The intention is to become familiar with other institutions and compare them to Broadmoor to see whether differences are mainly social, spatial or merely semantic.

Goffman describes the total institution as “a social hybrid, part residential community, part formal organization—they are the forcing houses for changing persons; each is a natural experiment on what can be done to the self” (Goffman, 1962, p.4). Goffman classifies total institutions into five groups. There are two that are of particular relevance to this study: one of them are places that care for persons “that are both incapable of looking after themselves and a threat to the community” and the other is organized to protect the community against intentional danger (Goffman, 1962, p. 4).

What is common to both types of institutions is that a person’s life is subjected to regulations and judgments by staff (Goffman, 1962, p.38). They are based on a restrictive setting model to achieve desired levels of surveillance, separation, isolation and control. This model uses space and the imposition of rules and regulations to limit, prevent or direct behaviours (Peatross, 1997,p.1).

Pevner highlights the similarities between hospitals and prisons by saying that “both cases have a number of people confined in one particular place, although they would prefer not to be, and in both cases constant supervision is necessary” (Pevner, 1976, p. 159).
Prisons and hospitals as total institutions and as building types have a number of similarities. In the 19th century, classification was the corner stone of institutions and the trend was to isolate the mentally ill and handicapped people from society. The shift in the 20th century has been towards normalization. What follows is a brief description of the Normalization Principle so that its effects on restrictive settings can later be discussed.

1.2. The Normalization Principle

Bengt Nirjee, credited with the first comprehensive definition of normalization, says “The application of the normalization principle will not make the subnormal normal but will make life conditions of the mentally subnormal normal as far as possible ...” (Nirje, 1970, from Web).

Wolfensberger, influenced by Nirjee, developed the “developmental model”, arguing that institutions should provide an atmosphere as similar as possible to that of a typical home (Wolfensberger, 1969, p. 115). As a result, traditional practice has shifted from being medically oriented and dominated by professionals to a more holistic approach were the whole person is taken into account, not just his handicaps.

Normalization has affected hospitals and other care institutions in the 20th century both socially and spatially. What is of particular interest to this study is the way in which restrictive settings, and Broadmoor Hospital in particular, have had to balance security issues against the requirements for a more normal life (Peatross, 1997, p.2).

1.3. Broadmoor Hospital

The act of 1863 with its innovating notion of separating criminal from non-criminal lunatics was what formed the basis for the construction of Broadmoor in Crowthorne, Berkshire. The Broadmoor “Criminal lunatic asylum” (Figure 61), as it was first called, was designed by Major General Joshua Jebb, a military engineer who had previously designed Pentonville Prison (Taylor, 1991, 160).

According to the Commissioners in Lunacy, the institution would be: A Lunatic Asylum, A Convict Prison for criminal lunatics, and a Hospital.

Broadmoor changed from institution to hospital after the 1948 Criminal Justice Act. And also in 1948 the staff’s titles changed from Attendant to Nurse. The locked up regime, where the patients were locked in their rooms from evening till morning, was abolished six years ago. Now they are under what is called a “twenty-four hour therapeutic care”, which means that patients have keys to their rooms and are free to move about in the ward. Giving more freedom to the patients implies that more staff is needed to do the controlling part. Patients spend most of their time in the common rooms within the wards and have access to toilets at all times. They are not allowed to go to other wards within the same block and are not permitted outside the house without permission or an escort.

The approach towards mental health has changed over the years and Broadmoor has had to adapt to those changes both architecturally and as an institution. To achieve a more relaxed attitude towards patients, it had to enhance security. This seems to be the core of Broadmoor’s complex character. In terms of this call for normalization within restrictive settings, how do the old wards react to the process in comparison to the newer buildings? The new wards house a series of functions inherent to what built with the criminally insane in mind, they could have served any other purpose.
1.4. Broadmoor as an interchangeable building

Of particular interest to this study is that the brief mentioned that the secure asylum to be built had to be capable of ready conversion as a barracks, a school, a hospital, or some other public establishment (Conversations with Mr. Heritage) What spatial characteristics then do these institutions have in common? It is important to introduce here the idea of “generic function”. Hillier defines “generic function” in Space is the Machine as properties of spatial arrangements which buildings have in common, because they arise not from specific functional requirements (programme) but from what makes it possible for a complex to support any form of occupation and patterns of movement (Hillier, 1996, p.313). When looking at the 19th century buildings in their original form (Figure 62), one finds it almost impossible to determine their function. They could be indeed easily mistaken for a hospital, school or any other type of 19th century institutional building.

It will be proposed that the conception of Broadmoor when it was first built is totally different from what it is today, and this is a result of a constant struggle for maintaining equilibrium between treatment in a normalized hospital environment and confinement within a secure institution.

2. Methodology

The study of a secure hospital such as Broadmoor presents one with a series of challenges and difficulties. Special permission was granted to have access to the hospital and work at their Estate Department offices, where the plans were made available on demand. The condition was that under no circumstances could the plans be taken out of the premises or reproduced and made public in the report. Permeability Graphs and Axial Graphs were
A sample of four ward buildings was chosen. Kent House dates from when Broadmoor first opened in 1863. Somerset House opened a few years later. The other two buildings, Oxford House and Bedford House are the newest ward buildings within the compound built in 1983.

Given all the limitations and restrictions that hinder a thorough syntactical study using all the tools and methodology available, what contributions can space syntax make to a place like Broadmoor? The study turned out to be a bit of an archeological study, where historical facts provided by literature and a fascinating conversation with Mr. John Heritage, the person in charge of Broadmoor’s archives, made the pieces of the puzzle begin to fall into place.

2.1. Broadmoor’s ward buildings

Kent House is a three storey high building comprising 3 identical wards, one on each floor. It is an “F” shaped block where the main corridor runs across the “L” facing the terraces (Figure 63). The first spaces one encounters are the ward manager and offices to the left, followed by side rooms. Halfway through the corridor on the right projecting onto the terrace, one finds the staff mess room and offices followed by the patients’ common areas where they spend most of their time.

The system patients experience is linear and restricted and basically movement is limited to corridors.

Changes in this building seem to be more socially driven, starting from the fact that patients are now allowed to walk freely in the ward, using staff as means of control rather
Figure 63: Permeability Graphs of the four ward buildings. Each node represents a space.
than locked doors. Within the ward, there is a call for normalization.

2.2. Somerset House

Somerset House is a three storey high building compromising three wards with an identical layout. They are constituted by an “L” shaped corridor with all spaces off to one side. The ward manager is strategically located right where the two wings pivot gaining visual control of the two corridors.

The portions of the corridors near the intersection point from where the two wings pivot have the highest local integration values (R3). This is interesting since it is a strategic surveillance point from where a member of staff can see both wings at the same time.

2.3. Bedford House

Bedford House was built together with Oxford House. It is a one storey high building, east of the main entrance and rather separated from the older buildings located in the middle of the site. Both Oxford House and Bedford House are near the boundary wall.

Bedford House compromises Luton ward and the psychology department. All patients at arrival to Broadmoor Hospital go to Luton ward, which is the assessment ward, the most secure ward in Broadmoor. They are then transferred to a different block. The area of the Psychology department also houses treatment areas such as the dental surgery, ECT area, podiatric clinic, X-ray rooms etc.

The fact that this building is only partly assigned to living areas makes it configurationally different to the other three buildings. The whole block is in its majority occupied by clinical staff. Patients do occasionally visit the psychology department, but these areas are not part of their daily living routine as are the ward facilities.

The axial plans (figure 64) show how unlike the older buildings, axial lines cross more than one space, especially in the common areas. The trend is still to have spaces off corridors, but these have been reduced in length and clustered around courtyards, making the system more fragmented and reducing visual integration. It is difficult to be aware of what goes on in other areas within the same building.

2.4. Oxford House

Oxford House is a two storey high building mostly assigned to living areas. There are two wards on each floor. Both wards are identical, with a corridor on each wing and siderooms off both sides. Even though Oxford House is mainly a building for living in, there are a large number of spaces assigned to clinical treatment.

Oxford House at ground floor level also functions as two different systems clearly constituted by the two wards, linked only by outside spaces. Staffs’ movement is less restricted than the patients’ but within the common areas patients also find choices of route making the overall experience more pleasant and less controlled.

2.5. Comparison

Table 14 summarized some architectural aspects of the buildings. In terms of their composition, the buildings have gone from three story high buildings to one or two stories at the most. By doing so, they have grown in area at ground floor level. An important issue relates to corridor length. “L” shaped, long corridors constitute both Kent House and
Figure 64: Axial Plans of the four ward buildings.
Table 14: Built Form

<table>
<thead>
<tr>
<th>Feature</th>
<th>Kent House</th>
<th>Somerset House</th>
<th>Bedford House</th>
<th>Oxford House</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year of construction</td>
<td>1863</td>
<td>1870</td>
<td>1980</td>
<td>1980</td>
</tr>
<tr>
<td>Number of floors</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Length of corridors</td>
<td>Long</td>
<td>Long</td>
<td>short</td>
<td>short</td>
</tr>
<tr>
<td>Layout</td>
<td>Clear</td>
<td>Clear</td>
<td>Broken up</td>
<td>Broken up</td>
</tr>
</tbody>
</table>

Table 15: Function

<table>
<thead>
<tr>
<th>Feature</th>
<th>Kent House</th>
<th>Somerset House</th>
<th>Bedford House</th>
<th>Oxford House</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functions</td>
<td>Mono</td>
<td>Mono</td>
<td>Multi</td>
<td>Multi</td>
</tr>
<tr>
<td>Number of side rooms</td>
<td>57</td>
<td>75</td>
<td>29</td>
<td>95</td>
</tr>
<tr>
<td>Average Number of treatment spaces in bldg</td>
<td>3</td>
<td>3</td>
<td>30</td>
<td>20</td>
</tr>
<tr>
<td>Average Number of treatment spaces per ward</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>New activities</td>
<td>-Handicrafts -Gym -Consulting room -Occupational -Therapy</td>
<td>-Handicrafts -Gym -Consulting room -Occupational -Therapy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Somerset House. The 20th century buildings on the other hand, present shorter corridors organized around patios. In the 19th century buildings, accessibility and visibility seem to overlap, since one can usually see the whole corridor space at once, although the layout seems to maximize travel distance. On the 20th century buildings, the layout is broken-up, meaning that one is not aware of the whole system from a given point.

In terms of functions, the new holistic approach to mental health, where the whole person is taken into account, creates a need to provide a new range of spaces. Table 15 shows how the 19th century buildings are constituted mainly of siderooms off long corridors. There are few spaces assigned for treatment and the common areas where patients spend most of their time are often limited to a dayroom, dinnig room and TV room. The 20th century buildings on the other hand, have become more multifunctional, incorporating a range of spaces assigned for treatment and everyday living. Since patients tend to spend most of their time in the wards, they now provide facilities such as gyms, handicrafts rooms etc. to make life in confinement more pleasant.

The buildings have also evolved in terms of their spatial configurations. In both Kent House and Somerset House, the number of convex spaces is rather similar to the number of axial lines within the system. This was expected since there is usually one line running across the main corridor and then one line per sideroom connecting to the main hall. Even thought the buildings are three stories high, the number of convex spaces is rather low. On the other hand, Bedford House presents similar number of convex spaces than the 19th century buildings but they are all distributed in one floor at ground floor level. The number of axial lines is lower than the number of convex spaces since lines tend to cross more than one or two spaces. Circulation spaces are not limited to corridors and one
Table 16: Syntactical data

<table>
<thead>
<tr>
<th>Feature</th>
<th>Kent House</th>
<th>Somerset House</th>
<th>Bedford House</th>
<th>Oxford House</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of convex spaces</td>
<td>147</td>
<td>190</td>
<td>183</td>
<td>302</td>
</tr>
<tr>
<td>Number axial lines</td>
<td>180</td>
<td>198</td>
<td>164</td>
<td>336</td>
</tr>
<tr>
<td>Mean Integration (RN)</td>
<td>1.071</td>
<td>0.907</td>
<td>1.162</td>
<td>1.159</td>
</tr>
<tr>
<td>Mean Integration (R3)</td>
<td>1.615</td>
<td>1.569</td>
<td>1.793</td>
<td>1.788</td>
</tr>
<tr>
<td>Intelligibility-Rsquare</td>
<td>0.1151</td>
<td>0.0403</td>
<td>0.4387</td>
<td>0.3266</td>
</tr>
<tr>
<td>Synergy -Rsquare</td>
<td>0.2320</td>
<td>0.0258</td>
<td>0.3849</td>
<td>0.5745</td>
</tr>
</tbody>
</table>

Table 17: Summary

<table>
<thead>
<tr>
<th>Features</th>
<th>19th Century Buildings</th>
<th>20th Century Buildings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functions</td>
<td>Mono</td>
<td>Multi</td>
</tr>
<tr>
<td>Length of corridors</td>
<td>Long</td>
<td>Short</td>
</tr>
<tr>
<td>Layout</td>
<td>Clear</td>
<td>Broken up</td>
</tr>
<tr>
<td>Sleeping arrangements</td>
<td>Some dormitories</td>
<td>All Single siderooms</td>
</tr>
<tr>
<td>Daytime</td>
<td>More rigid</td>
<td>More choice</td>
</tr>
<tr>
<td>Intelligibility</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Synergy</td>
<td>Low</td>
<td>High</td>
</tr>
</tbody>
</table>

finds common areas from where other spaces are articulated. The same happens in Oxford House, which has the larger number of convex spaces compared to the other three, but organized in only two floors.

Since Kent House and Somerset House are constituted almost entirely by a single corridor space, the corridors tend to have the highest integration values.

The RSquare is the indicator of how “understandable” the system is in the case of intelligibility and how well structured the relation part-whole is in the case of synergy. Synergy is a measure of correlation between global integration (Rn) and local integration (R3). On the scattegrams of both 19th century buildings, one finds a number of points located far from the regression line. These points represent the corridors. It was expected that the broken-up layout of the 20th century building would have lower intelligibility values, since one is usually never aware of the whole system, but they have higher RSquare values than the 19th century buildings. Corridor spaces are broken-up so the hierarchical participation of the corridor spaces found in the 19th century buildings is lost and all spaces share a similar relation to all others. This is seen in the scattegrams for Bedford House and Oxford House, where all spaces are near the regression line. The syntactical data can be seen in Table 16.

The two 19th-century buildings share a number of characteristics, which are not found in the 20th century buildings and vice versa. They are clear products of their times. Table 17 clusters Kent House and Somerset House under the 19th century buildings category and Bedford House and Oxford House under the 20th century buildings category.

The shift from institutionalisation to a more holistic and therapeutic approach has deeply affected the buildings’ morphology and spatial configurations. The buildings have changed in the 20th century to incorporate functions inherent to the novel idea of normalization. Making the spatial configurations less rigid by offering more choices of route
provides a more relaxed environment within confinement. Also, the integration of new activities within the ward buildings in a normalized environment, have reduced movement at the global level, therefore security is more easily controlled.

3. Discussion - From Global to Local

Before the final discussion on the ward buildings is set forward, there are some things that can be said about Broadmoor Hospital as a system. The way in which the expansion of the hospital has taken place, with the addition of blocks through time, has deeply affected the way in which the system is experienced and perceived. Changes have not only taken place at the local level, but also at the global level. The general public’s perception is that Broadmoor is a prison-like institution and some people are even unaware that there is a distinction. This misunderstanding is common to high security mental institutions. High walls, fencing and other means of security only enhance this perception.

It is important to somehow try to illustrate what the asylum must have been like when it first opened its doors. The hospital was mainly configured by Central Hall in the middle, and the two ward wings mirrored on both sides extended along the terrace. Central Hall housed the common areas, as it does today and was not internally connected to the ward buildings. That they were adjacent but not connected meant that movement took place at the global level. Both patients and staff had to go outside the buildings into the courtyard or terrace to access any other building. This probably meant that one would often meet patients and staff from other wards and, even though the hospital was divided in three main blocks, it worked as one whole system.

Nowadays the picture is rather different. The new wards now incorporate the common areas and spaces assigned for treatment within the same building, therefore patients remain most of the time within the block. One can argue then that while Broadmoor Hospital has grown in size and complexity, the place is now experienced mostly at the local level.

The division of the buildings into wards also allows staff to manage their wards more easily. The patients within a ward tend to live, dine and recreate themselves together and separate from other wards.

The older buildings are three storey high blocks, while Oxford House compromises two stories and Bedford House only one at ground floor level. With buildings becoming larger at ground level and lower, it can be argued that there is an intention to make the buildings look less institutional. A long corridor still basically composes the areas assigned to siderooms, with rooms off one or both sides. What has changed the most is the way in which the wings are articulated and the relation between the siderooms areas and the common areas. The older buildings present a rather restrictive and controlled setting, where movement is primarily linear with “L” shaped buildings pivoting from the nurses’ office, which have complete visual control over the environment. Although the patient is free to move about in the ward, there are not really many places to go to. The newer buildings on the other hand, present ringier structures especially in the common areas, meaning that the inhabitant is presented with various choices of routes, making the experience within the ward more pleasant.

The newer buildings present a larger number of spaces dedicated to circulation and lobby areas. Hanson describes how transitional spaces such as circulation areas permit unprogrammed activity, which does not directly support the organization but function as
permissive spaces where people are liberated from the roles they occupy (Hanson, 2003, p.286). This is clearly seen in the newer buildings where spatial configurations are not limited to one long corridor as in the older buildings.

The panopticon model of control is to some degree present in all four buildings, with the ward office manager strategically located where the wings pivot, providing maximum scope of visual surveillance. The effect seems more dramatic in Kent House and Somerset House because of the simplicity and linearity of the layout.

Peatross argues that there is no reason why direct surveillance from one control point cannot be consistent with normalized behaviors (Peatross, 1997, p.12). Normalization in Broadmoor’s wards is achieved in first instance by not locking up patients in their rooms. Giving patients freedom to move about implies from the caretakers’ point of view, that they must be strategically positioned within the ward to control the environment. On the other hand, sufficient ranges of normalized activities need to be provided to reduce tensions and boredom implicit in confinement (Peatross, 1997, p.12). Bedford and Oxford house seem to have taken this approach by the addition of new facilities. It can be then argued that a specific purpose built layout embraces normalization in an easier way than the 19th century ward buildings.

4. Normalization within the wards of a prison-like system

As a visitor, it takes time to get used to Broadmoor’s way of calling things. Broadmoor is a hospital, not an institution or a prison. Patients are not inmates and they sleep in siderooms, not in cells. Staffs are nurses and not attendants. Although there seems to be constant effort from the board to portray Broadmoor as the NHS hospital that it is, why is it then that it is still thought to be a prison by the general public? What concerns this study is not only the image Broadmoor portrays to the outside world but how it is seen and experienced by those within its walls.

Strangely, Broadmoor calls the area within the secure perimeter (where the wards buildings are located) the non-sterile zone, and the area outside the secure perimeter, where the offices and estates department are found, the sterile zone. It is known that in hospitals, the sterile zones are the areas where the patients are, such as the patients rooms, treatment areas, theatre etc. Special concern is invested in the care of patients by offering a sterile environment where contagion is prevented. Why is it then, that in Broadmoor Hospital, the area where the patients are is seen as the non-sterile zone? This leads us to believe, that despite the effort, the insane are still seen as polluted like in the old days.

Douglas describes the polluting person as one that is always in the wrong. He has crossed a line and this unleashes danger for others (Douglas, 1966, p.135).

The study has shown that the wards in Broadmoor Hospital present a normalized environment. Patients within the wards have freedom to move about and enjoy a relaxed regime. Although access to and from the wards is highly restricted, doors inside are kept unlocked and a hospital-like environment is provided within the wards with staff doing most of the controlling part. It seems that it is once the patients come out of the wards into the other areas within the secure perimeter that they become “polluted” and the risk of an incident becomes imminent.

In the course of this project, it was found that Somerset House will be demolished together with other three buildings with similar spatial layouts, since they are no longer
suited for today’s care delivery. Kent House will remain standing since it is a listed building. That Somerset House will be demolished shows that normalization is not only a social phenomenon. All wards have the same approach to patients so there must be something about the configurational aspects of the buildings that make them obsolete. It is not only the fact that there is no room to expand within the buildings to provide the new facilities found in Bedford House and Oxford House, but rather that the restrictiveness of the setting and the lack of choices of routes (rings), does not allow for a normalized environment. Movement in the older buildings is basically restricted to the main corridor; therefore the patients are in constant encounter with members of staff and under obvious surveillance. The new buildings on the other hand offer choices of routes and a wider ranges of spaces to occupy, therefore encounter seems to be subtler.

Once familiar with the nature of Broadmoor Hospital, it can be seen that a lot can be gathered by the way the place is perceived. Special consideration seems to be given to the image Broadmoor portrays to the outside world, but this image is sometimes jeopardized in an attempt to guard security, producing the general misconception that Broadmoor is a prison rather than a mental hospital. The conclusions will be set forward, suggesting that Broadmoor has become more localized through time, and to this objective it has incorporated more care facilities within the ward buildings. Normalization is given then within the wards, but globally Broadmoor Hospital much resembles a prison rather than a hospital.

5. Limitations

Although the study of the four ward buildings has given quite conclusive results and has answered most of the questions that were addressed, there is no doubt that to understand Broadmoor Hospital properly one would need to look at the whole system. The system as a whole is highly unintelligible and because of the way the buildings are organized and the direction they are facing, one is never aware of the overall configuration. This made the understanding of the hospital rather difficult since the general plans did not show things such as fencing or new additions to enhance security, hence while looking at the plans it was difficult to have a mental picture of what the system was like in reality.

Access to the wards was not allowed; therefore this thesis is based on the architectural drawings, literature review, and conversations with staff from the estates department and inevitably to some degree, to speculation.

6. Conclusions

A study of a place as complex in nature as Broadmoor Hospital makes it difficult to reach clean-cut conclusions. Broadmoor Hospital is first of all a global system, and as such it has grown through time by the addition of blocks into an unintelligible system. It is difficult to be aware of the system as a whole and this is partly because of the way in which the blocks are distributed on the site and because of security measures such as walls and fencing which obstruct visual integration. It is difficult to determine accessibility in relation to what one can see. Way finding is made even more difficult because unlike other hospitals, signage cannot be provided.

That Broadmoor Hospital is not merely a mental institution but a high security one, implies that it needs to be securely guarded to prevent any possible incident. Trying to
maintain this balance between delivering mental health care and making the place secure seems to be the core of Broadmoor’s complexity and its misconceived image.

Several issues have been discussed regarding the way in which the ward building have adapted or have failed to adapt to new trends in mental health care delivery. It has been suggested that one of the reasons why the old buildings are considered unsuited for today’s approach to mental health is that they do not allow for a normalized environment since surveillance and control is too obvious because of the disposition of the settings. The tree-like configurations imply that movement becomes restricted and to some degree boring, not offering enough facilities that would make life in confinement better. The original buildings were planed to function at a global level, with the outside spaces used to go from the wards buildings to the common areas, chapel etc. With Broadmoor being experienced now more at a local level, confinement within the old ward buildings, which do not have much to offer for everyday living, become inhumane. It has been discussed that although the old buildings could have been converted at the time they were built into other institutional buildings, parting from the notion of generic function in 19th century buildings, they could not absorb today’s facilities.

Normalization is then not only a social phenomena, but a spatial one. It is achieved by making the layout less restrictive and offering more choices of routes, by facilitating more activity areas where patients can spend their time and by dealing with the staff/patients interfaces in a way that staff can control and survey the environment in a casual way. It can be argued then that normalization is given within the ward buildings, and it is outside the buildings that the system becomes very prison like.

Broadmoor as a total institution is then a true hybrid, presenting two sides. The global prison-like side on one hand, and the local hospital-like sine on the other. Although often criticized, Broadmoor is a place that constantly changes to adapt to new currents of thought although it is at risk of mutating into an unintelligible animal for the sake of security.

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