Environment and mental health: the impact of new buildings on the programs and organization of a psychiatric hospital*

One of the implicit assumptions in ecosystems analysis is that the environment affects the behaviour of individuals, and modifications in the former are likely to bring about concurrent modifications in the latter (Schnore, 1961). It follows from this assumption that the introduction of a new environment can create significant changes in social organization. It is suggested here that this relationship is of a highly complex nature and that the chain of causality operates in both directions at the same time. Our study of the impact of a move to new treatment facilities on a large Canadian mental hospital demonstrates that a change in physical surroundings has a marked effect on treatment programs and on organizational procedures. The findings indicate, moreover, that this relationship is both intricate and dynamic.

The planning and design of built environments necessarily takes place within a societal context. Designers of mental hospitals, for example, are influenced by current conceptions about the nature of mental illness, the degree of optimism about its curability, and the prevailing theories about optimal treatment modalities.

Once completed, the new environment becomes a concrete embodiment of the treatment philosophies and policies which guided its planners. The new physical setting thus defines a set of opportunities and also imposes a series of limitations. Certain new treatment programs and organizational procedures are facilitated

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and even encouraged by the design of the new surroundings. The physically defined opportunities may result in the introduction of new programs and procedures which eventually become institutionalized. At the same time the new setting actually discourages consideration of alternative modes of social organization and treatment.

Both the new physical environment and the new approaches to treatment have a pronounced effect on staff members of the hospital. They serve to modify the professional self-conceptions of the staff and also the patterns of recruitment of new staff members. In addition, all these factors have an impact on patients. The appearance of the hospital, the facilities it offers, the treatment policies and philosophies which it embodies, its therapeutic programs and organizational procedures, and the morale of the staff all affect the patient's experience. In turn, the public image of the hospital, and indeed of mental illness itself, is influenced by all these considerations.

What should be clear from this analysis is the dynamic dimension of these relationships. Over time, architectural designs not only are affected by social policies but can also lead people to modify their policies. In the instance studied here, the new treatment environment symbolized and operationalized changed attitudes and treatment policies. Before the new structures were occupied, they served as a symbolic focus for fundamental reorientations in attitude; after the move, they provided tangible settings for the introduction of new and revised treatment modalities and organized procedures.

PREVIOUS RESEARCH

Analysis of social change within organizations has been undertaken by sociologists in two basic ways: the social-psychological approach selects individual members as the unit of analysis, and the formal organizations approach studies the organization sui generis. The social-psychological approach entails consideration of the sources and manifestations of motivation, morale, commitment, role performance and adaptation, and the interpersonal relationships of the individual actors within a social system as these factors pertain to change (or resistance to it) within a given organization. In contrast, the formal organization approach entails consideration of the internal structure of roles, objectives, decision-making processes, and so forth, as well as the environment within which the organization functions.

The relationship between the organization's environment and change within the organization has been studied most often from the viewpoint of the social (rather than physical) environment. Starbuck (1965:37–62), in a review of the literature on organizational change, regards the 'environment' as 'the climate in which the organization exists.' And Dill (1962:95–6), in a discussion of environment and organizational change, defines 'environment' as 'information which becomes available to the organization to which the organization, via search activity may get access.' Still others see environment in terms of technological and market conditions.

Hage and Aiken (1970:28) point out the importance of using a temporal perspective in any analysis of organizational change. Such a focus stresses changes in interrelationships over time, rather than merely looking at the arrangement of organizational parts at any given point. In this article we not only demonstrate that a whole range of changes within a specific organization are related to environmental change of a particular kind, viz., changes in the material, physical environment, but we also analyse the impact of the physical environment over a two-year period stretching from the planning stages to a year after the move, thereby permitting a temporal perspective.

The environment/organization relationship has been studied by Adams (1967). He reports that a move from relatively inconvenient, dark temporary quarters to a spacious, bright, new mental hospital was eagerly anticipated by staff and patients. Their expectations proved to have been unrealistic, however, and it was not until six months after the move that they began to develop the potential of the new environment. The findings from our own research, as will become evident, differ substantially from this experience.

Others in the psychiatric field, for example John and Elaine Cumming (1962), Baker (1959), Good (1965), Jones (1967), and Ricci (1972), have noted the role of the physical environment in both modifying and reflecting cultural attitudes towards mental illness and the philosophical and scientific approaches to its treatment. For most investigators, however, these relationships have been documented after a physical environment has been changed. In the study on which we report, we were able to
be present before, during, and after environmental changes took place at a major Canadian psychiatric hospital.

The research project on which this discussion is based was a two-year study of the effects on patients and staff of a move from obsolete deficient quarters to new and modern buildings on the same site. The opportunity to study this hospital became available when construction began on a series of new facilities for mental patients at the Queen Street Mental Hospital Centre, one of several government operated psychiatric hospitals in the province of Ontario.

METHODOLOGY

From the early planning for this study it became apparent that the best way to capture the rapidly shifting complexities of the changes which were to take place was to utilize the method of participant observation. The three-person research team entered the research field with no preformulated models or hypotheses except in the most general sense (for example, that changes, some quite unexpected, would occur). This open approach allowed the observers maximum flexibility. Specific hypotheses and theoretical perspectives were developed in time directly from the data.1

Our approach to participant observation entailed systematic observation of, and controlled participation in, the ongoing activities of Queen Street Mental Health Centre, particularly in one specific ward of the hospital designated here as Ward x.2 The aim was to discover and understand the substantive nature of the events in the daily life of the Queen Street mental hospital from various perspectives. Using this approach the investigators were able, so to speak, to make a movie rather than take a series of photographs.

The observation period was divided into three distinct phases: T1, the three-month period before Ward x moved: from 1 May to 26 July 1972; T2, the three-month period following this move: from 26 July to 31 October, 1972; T3, the three-month period one year later: from 1 May to 31 July, 1973.

DESCRIPTION OF RESEARCH SITE

Queen Street Mental Health Centre was erected over a century ago on 27 acres of wooded land situated on the outskirts of a large urban community. The city has long since engulfed this area which now consists mainly of secondary industry, unprepossessing retail outlets, and deteriorating housing.

The hospital complex itself is surrounded on three sides by a high brick wall and presents to the public the flat face of an administration building of uninspired design. Behind this building, erected in 1956, stood (until recently) a large, three-winged, five-storey structure capped by a striking dome. This hospital, occupied from 1850 on, was in its time believed to provide a therapeutic and humane environment for treating the insane. To a modern-day observer, however, the old buildings would likely have conjured up images of a walled fortress.

At the inception of this study most of the patients were housed in the 1850 building, in wards reached by narrow, steep, and ill-lit stairways. The wards were generally locked and were dominated by long, wide, high-ceilinged corridors with noisy wooden floors. The walls, which had been repainted countless times during the past 100 years, were done in drab institutional pastels. Only a few homemade posters and signs broke the monotony. Most of the patients congregated in the corridors, and with few draperies and no carpets to absorb the sound, the noise level made social interaction difficult and strained. Lining the main corridor were numerous doorways leading to patient dormitories, offices, and meeting rooms. Physical comforts were at a minimum, with an emphasis on utility rather than aesthetics. Patient privacy was also at a minimum; doors to patients' dormitories had long since been removed and toilets and baths were similarly exposed.

At the inception of the participant observation phase, Ward x was located in the 1850 building. It was a unit for acute patients and was organized on the model of a therapeutic community.3 An important goal of the ward – a

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1 For a detailed discussion of this strategy, see Becker, H. (1970).
2 At all times the investigators presented themselves as independent researchers, rather than attempting to pose as either staff members or patients.
3 In the therapeutic community, staff and patients assume joint responsibility for establishing an environment in which personal and ward problems are discussed and handled by the entire group. See Maxwell Jones (1953) and A.M. Kraft (1966).
goal which was both declared and operative (see Perrow, 1969:65–79) – was to restore the patients’ ability to function normally and to return them to the general community as soon as possible.

After the move, Ward x in its new setting assumed a different character. In contrast to the old ward, the new one was not locked and was colourfully carpeted, curtained, and painted. Comfortable chairs, pictures, magazines, and other amenities were plentiful. It was markedly quieter and more subdued and provided what appeared to be a less punitive environment for patients, staff, and visitors. The new Ward x looked very much like a college dormitory building with private rooms for each patient and spacious lounges and activity areas.

It is the impact of the change from the old to the new physical environment which this study examines. In this case, the research site is itself a crucial aspect of the problem being analysed.

FINDINGS: NEW TREATMENT PROGRAMS

One point stands out in bold relief: the effects of the physical environment are inextricably interwoven with the effects of the programs conducted in that environment. The reciprocal nature of this relationship makes it difficult to ascertain with any degree of exactness which factor is exerting the most influence. What is clear, however, is that a new environment can stimulate a total review of philosophies and policies and can facilitate the introduction of new approaches to treatment.

Crisis intervention unit

In this particular study, a specific example of the way that new architectural designs stimulated new treatment programs and organizational procedures was provided by the opening of crisis intervention unit. This program was inspired, in the words of the chief of service, by the desire to make ‘optimum utilization of the new architectural space for therapeutic programs.’

Before the move all patients coming to Queen Street were assessed in a central admitting office which served the entire hospital. From there new patients were assigned directly to wards throughout the hospital where they mingled with other patients, heterogeneous in terms of length of stay, diagnosis, and severity of illness. After the move, the crisis intervention unit was opened. Its policy stipulated that new patients be hospitalized there for a maximum of 72 hours before being either assigned to one of the wards or released. This policy’s success in developing alternatives to in-patient care, particularly for those who would otherwise have required a relatively brief confinement, is reflected in two ways: (1) there was a significant decrease in the number of admissions to the wards, and (2) there was an increase in the average length of hospitalization on the wards. For example, in the three-month period preceding the move, 146 patients were admitted to Ward x, with a modal length of stay of less than one week. During the three-month period after the move, however, there were less than one-third the number of admissions (only 49) and the modal length of stay increased to three weeks. Bed capacity and staff on Ward x were basically the same but clinical arrangements had changed.

The crisis unit had a positive impact on the treatment program of Ward x as well. The staff were freed from the voluminous paper work associated with the admission of new patients and from the extra hours of attention that a new and acutely disturbed patient often requires. Thus, they had more time to devote to essential but nonemergency care. A typical comment was ‘it relieves the pressure’ (postmove interview, staff, 1972). The ward now received patients at more regulated intervals and at hours more convenient to their treatment program. Ward x staff began to confer with staff from the crisis unit and to interview the patient prior to his transfer to the ward. In this way, more information was obtained about each new patient than under the old system. Interviews with family members were now done routinely. Home visits were initiated.

Staff on Ward x were now able to give more attention to building a therapeutic community, a relatively new program for that ward. Since they no longer had to deal with the full spectrum of psychiatric problems, they were able to concentrate more on developing and practising their skills in therapy. Opportunities now existed for the staff to become familiar with the patient as ‘person’ rather than as ‘paranoid schizophrenic’ or as ‘suicide risk’ and this helped the ward move away from ‘watching’ and ‘precautions’ – familiar terminology of custodialism – towards more therapeutic activities. The regulated transfers of patients to Ward x also permitted new patients to be incorporated into the program with less disruption of ongoing
activities than formerly. Staff, although still desirous of returning patients to the community as soon as possible, began to work with patients in more depth, attempting to develop substantial ego strength and firmer family and community supports. It was not unusual after the move to hear a staff member ask at a ward conference: ‘What can we do to give this patient something that’s going to change his life?’ (field notes, August, 1972). Such an approach required more time, but the hope was that the ‘revolving door syndrome’ which characterized a high proportion of Queen Street patients could eventually be avoided. One year after the move, the crisis intervention unit had become firmly established as a fundamental component of patient care at Queen Street. Within this time period, the crisis unit had evolved from an idea inspired by the new physical environment to an institutionalized nexus of programs and procedures. The establishment of this special unit for short-term care had the effect of ruling out contact between long-stay patients and those who required only brief hospitalization.

**Open door**

The intricate, contrapuntal relationship between programs, social organization, and environment was also apparent in the introduction of an open door policy in the new building. The attempt to unlock the doors on Ward X had been made several times in the old setting but each time it had proved too difficult for staff to carry out and, after a short trial period, the plan had been abandoned. The architecture of the old building seemed to encourage an emphasis on custodialism and security; there were numerous exits and entrances in unexpected locations which made it impossible to keep track of all the comings and goings. All the entrances were kept locked, as were most of the offices and meetingroom doors.

Locking doors had become a habit with the staff and, while some of the more warped doors would not stay closed unless the lock was turned, it also seemed that certain doors were locked merely because the lock was there. As other observers have pointed out, for example, Loeb (1968: 107), the key is an extremely important symbol in a mental hospital since it controls all possibilities of ingress and egress. The key serves to differentiate between the persons who regularly return to the outside world and those who do not and between the persons who are defined as healthy and responsible and those who are not. At Queen Street, the symbol of the key was a constant reminder to patients that they were not trusted. Patients were often forced to wait an inordinately long time for staff members to unlock the doors for them. Staff resented having to unlock doors and disrupt what they regarded as more meaningful activity. ‘It was such a hassle, so unnecessary’ (postmove interview, staff, 1972). In addition, the staff recognized and disliked the implications of these gatekeeping duties which conflicted with current shifts in ideology and practice away from custodialism towards more therapeutic and humanistic role definitions.

An important aspect of the premove planning was the decision to establish an open door policy in the new environment; as one of the doctors said: ‘I think it’s important to have open doors. The time to try it is the day we move … it’s been tried here a thousand times and it has never worked. This old building doesn’t lend itself to open doors. But let’s try it from the start in the new building’ (field notes, June 1972). The new building was designed with an open door policy in mind and, as a result, there was only one means of entering and leaving the ward (except for locked fire doors), making surveillance much easier. Some staff members were dubious at first about the open door policy. They expected patients to ‘escape’ frequently from the new, less protected surroundings but their apprehensiveness lessened after the move.

With the establishment of the open door policy and the development of the therapeutic community, the necessity for surveillance and monitoring of patients seemed less urgent. Patients were permitted more latitude in going about their own business while being encouraged to assume more responsibility. Staff attitudes shifted from a focus on control to an emphasis on treatment. The feeling developed that ‘our role is no longer to police patients but to treat them’ (field notes, September, 1972). Although it was easy for a patient to walk off the ward and out of the hospital without being noticed, few patients availed themselves of this opportunity. On the few occasions when it did happen, staff no longer felt guilty since they

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4 In 1950 only 26 per cent of the admissions to Queen Street were readmissions, whereas by 1970, the proportion had risen to 67 per cent.
considered it the responsibility of each patient to remain at Queen Street until he was well enough to leave. For some patients this shift in attitude must have taken the fun out of trying to escape.

Freed from their preoccupation with security and control and the perceived necessity to maintain constant vigilance, staff had more energy available for therapeutic measures. Almost half of the staff interviewed after the move spontaneously listed the 'open door' as an advantage of the new building. 'It's more like a hospital, less like a jail.' 'It is less like being in a looney bin.' (Postmove interviews, staff, 1973).

A year after the move, the general issue of security had been relegated to a minor position. The ward was completely 'open' except for stairwells which unlocked automatically in the event of fire alarms (as well as by staff keys). Gone were all other hints of a locked ward: the desk by the elevator from which access to and from the unit could be controlled was never manned and the main ward door was never locked except late at night in accordance with hospital regulations designed to prevent thefts. The attitude of the staff was that patients were admitted to the ward of their own volition, and if they chose not to stay the choice was theirs.

It is interesting to note that before the move, patients on Ward X also displayed ambivalence about opening the doors and worried: 'I feel more secure behind a locked door; you don't have to be responsible for yourself.' 'We will have to look out for each other.' 'More people will go AWOL — there'll be a lot of sick people running around the streets.' (Premove interviews, patients, 1972).

Even after the move, several patients said that one of the things they did not like about the new building was that there was 'too much freedom.' 'You have to control yourself rather than staff controlling you.' (Postmove interview, patient, 1972).

There were several forces simultaneously at work behind the formulation of the open door policy. One major impetus for change was the architecture of the new building which reflected changed societal views about mental illness and its treatment. Most professionals now believe that mental patients are best treated in open and 'normal' settings. The locked door has gone the way of the straight jacket and the padded cell. In addition, the new quarters created an opportunity for a fresh look at the traditional locked door policy. Reassessment of existing programs and philosophies was a significant feature of the premove period. 'Why do we have it?' and 'What do the patients really require?' were questions frequently asked in the months just before the move. The moving date itself provided a symbolic target around which the changes could crystallize. In this instance, the new physical environment was a response to modifications in prevailing ideologies about treatment of mental illness. In turn, the design of the new buildings facilitated the introduction and establishment of changed approaches to security and patient responsibility. In the process, both staff and patients came to feel differently about themselves and their roles.

EFFECTS OF DECENTRALIZATION

The architecture of the new buildings at Queen Street clearly favoured dispersion rather than concentration. The massive old building which had housed all the hospital wards was replaced by four separate buildings, one for each administrative unit (called 'services' and based on geographic divisions of the hospital's catchment area). The offices of the administrative staff remained in a separate building, a five- to ten-minute walk from each of the new treatment towers which were spread out over the 27 acres of hospital grounds. Whereas before the move administrative staff were dealing with one large hospital, after the move the task became one of administering four virtual minihospitals, each with its distinctive programs and unique combinations of personalities.

The new spatial arrangements served to promote decentralization of hospital authority. Admitting procedures, for example, were modified at the time of the move to allow for assessment of potential patients by the service to which they might be admitted rather than by a central admitting office serving the entire hospital. Each service thus developed its own organizational structure for dealing with admissions and at the same time gained considerable freedom in deciding who would be eligible for treatment and, by inference, who would be labelled as 'mentally ill.' Similarly, when disputes arose between the staff members of a particular service the administration adopted a policy of noninterference in these intraservice conflicts. The highly centralized administrative structure which had characterized the premove Queen Street was sufficiently diffused to permit each unit to deal with its new personnel problems.

Another consequence of the move to four
separate treatment units was increased differentiation between each of the units. Geographical isolation encouraged a sense of autonomy which was reflected in greater formality in communications between services. Before the move many decisions were made informally in the halls or in the staff cafeteria. In the new setting where chance encounters between staff from different services were infrequent, these same kinds of decisions tended to be made by formal mechanisms such as memoranda and reports. It also seems likely that the new autonomy and the friendly rivalry which it promoted between services were partially responsible for the increased creativity and innovation in programs which occurred after the move.

The geographical separation served to reinforce group cohesion among the staff of each service to such an extent that loyalty to the service began to seriously compete with traditional loyalties to professional discipline. In the old building, under centralized authority, nurses looked to the director of nursing for leadership, doctors to the medical director, and so forth. Within a year after the move, it was apparent that the primary allegiance of most staff members had shifted to their service. Needless to say these realignments in the distribution of authority were not accomplished without strains and tension. Renegotiations of the organizational order were accompanied by staff conflicts and considerable anxiety, which at times seriously threatened working relationships within the hospital. Such conflicts were most apparent among the nursing staff. Policies of the nursing supervisors frequently were at loggerheads with policies being developed in the service. In particular, deployment of personnel was a recurring bone of contention. For example, nursing administrators were distressed by the amount of time that nursing staff were spending at program planning meetings. They felt that nurses' time would be better spent on direct care of patients, whereas the service sentiment was that careful planning would eventually result in improved patient care (field notes, May–June, 1973).

From the patients' point of view decentralization had some clear advantages. Numerous studies have concluded that highly centralized, organizational structures tend to foster routinized, impersonal patterns of care, while the more decentralized structures encourage individualized approaches to patient care (for example, Linn, 1970). In the new mini-hospital, it was possible to pay closer attention to patients' problems and aspirations. As a staff member put it: 'There is a lot more communication with patients in this building,' (postmove interview, June 1973). It seems clear that a less centralized physical environment had a positive impact on the quality of patient care.

The architectural emphasis on dispersion also had an impact on the social organization of individual wards in the new setting. Before the move, the offices of all ward staff, with the exception of the nurses, were located in the separate administration building. The proximity of offices encouraged interaction between staff members of the different services and also facilitated communication between administration and clinical staff. This spatial arrangement caused recurring problems, however, on the wards themselves. Nurses often felt abandoned, and the 10-minute walk from the office to the ward wasted time and discouraged impromptu visits from 'off-ward' staff.

In the new hospital all professional staff had offices located on the wards to which they were attached. This major change in physical environment had a significant influence on relationships among ward staff. Nursing staff no longer were left alone on the ward and informal interaction among all levels of staff increased markedly. The interdisciplinary team approach to treatment which had been a major goal of the clinical staff prior to the move was effectively enhanced by these new office arrangements. As informal interaction among ward staff increased, status and role differences were reduced. These developments facilitated the growth of team spirit among the various professional disciplines; as staff members saw more of each other, they shared more information and developed common perspectives. In turn, this change encouraged a more comprehensive and integrated approach to patients' problems.

In sum, we see that architectural design influenced organizational procedures, staff relationships, and patient care. The introduction of the new environment which was deliberately designed with a view to decentralization of authority and development of the team approach to treatment precipitated widespread changes in the social organization of the hospital. The division of authority and responsibility was altered, professional loyalties shifted, more intensive patient care was encouraged, and role differences among staff were reduced. All these changes were reflected in actual treatment practices and thus had an ultimate impact on patients themselves.
PUBLIC IMAGE OF THE HOSPITAL

Just as societal values mould the treatment philosophies and policies which guide the architectural design of mental hospitals, so too, the appearance of the finished buildings helps to influence community feeling about such institutions. The old Queen Street suffered not only from the elemental stigma associated with all mental hospitals but its public image was also damaged by two additional factors.

The first has to do with the composition of its patient population throughout its history: the poorest, the sickest, and the most hopeless cases have always ended up there. Because it is a provincial hospital, Queen Street has, until recently, been constrained to accept all patients brought to its doors and was regarded as a ‘dumping ground’ for the mentally ill in Toronto.

A second factor was the forbidding and massive appearance of this ‘bastion of insanity.’ The dark, fortress-like 1850 building was the focus of many local horror stories and for years children were threatened with incarceration at Queen Street if they misbehaved.

To expect that a new building, no matter how modern and attractive, can entirely dispel such fears is clearly unrealistic. Nevertheless, the hope was expressed by most of the staff and patients at Queen Street that the new environment, combined with the new programs it helped stimulate, would create a better public image for the hospital: ‘when we pull the old building down, we will pull down the old mythology for the mentally ill in Toronto.

The optimists predicted that the new buildings would improve public attitudes towards the mentally ill, attract a higher quality of staff, make it easier to initiate community based programs, and allow Queen Street to hold its own with other, more prestigious psychiatric institutions in the city.

Only a few remained pessimistic about the potential effects of the new building on Queen Street’s image. These dissenters believed that the prevailing impression of Queen Street was too deeply embedded in the minds of the public to be altered by the cosmetic effect of new buildings.

It was not only the public who saw Queen Street as an outmoded and ineffectual treatment facility. This negative image was shared by many other professionals as well. In recent years a concentrated effort had been made to attract new staff members aware of the latest trends in psychiatry to assume leadership roles. The promise of the new facilities seemed to serve as an important factor in attracting new people of top rank. In the words of one: ‘I would never have come to Queen Street without [the new buildings]. There was no way that I could have come to work in a setting that the old buildings reflected, because to my mind they in turn reflected a community attitude ... If the community felt that that was all they were willing to provide, I didn’t want to work with a community that didn’t think any more of services for the mentally ill’ (unstructured post-move interview, staff, 1972).

The impetus provided by more attractive, up-to-date buildings also had the effect of encouraging closer relationships between the hospital and the general community. Even before the move, there were clear expressions by staff members of the wish to involve the community in the treatment of patients and to involve the hospital in preventive work in the community. After the opening of the new treatment facilities, staff appeared to feel more confident about approaching community organizations and agencies. One explanation of this is that the new architecture served as a visible symbol to the staff of their increased professional status and competence. ‘The modern, professional atmosphere has tended to make our new approach more professional.’ ‘Here you feel you’re working in a hospital making people well; there it was archaic and institutional.’ (Postmove interviews, staff, 1973). As a consequence of their improved self-conceptions, staff members felt more confident about moving into the general community to develop additional services for the mentally ill. ‘Now [we’ll be able to] get people to see the fantastic things we’re doing.’ ‘Professionals are starting to see us as a place to refer people, not just as a dumping ground.’ (Postmove interviews, staff, 1973). After the move, a number of specific policies intended to involve the community were undertaken. Orientation meetings with police and other community agencies, workshops with invited members of the community, and an ‘open house’ for the public were organized.

A year later, the burst of enthusiasm which followed the move had settled down, but the increased sense of pride continued to provide a momentum for community based activities.
The community centre attracted a variety of ‘outsiders’ and several such groups used the gym and the swimming pool, sometimes inviting patients to join them. Staff and patients agreed that, after the move, most visitors felt much more comfortable about coming to see their friends and relatives in the new building than they had in the old. The emphasis of the staff shifted from inviting people in to see what the hospital was doing to going out into the community with new treatment programs. Several new programs were planned such as a storefront crisis-intervention unit and a boarding house run by after-care and self-care patients.

Referrals of patients to Queen Street were much more common in the new setting and were more in the nature of referrals to an appropriate treatment program than merely the unloading of a patient for whom nothing else had worked. Staff visits to and from other institutions to observe programs became fairly commonplace, and staff expressed gratification and pride when making comparison with other psychiatric institutions.

Thus, even within a year of the move, it was possible to discern considerable reduction in the traditional isolation of the hospital. The public had begun to use its facilities for recreation and education, and the hospital had gone out into the community with treatment programs and with a new openness to public involvement. The larger question of a significant change in the public image of Queen Street remains unanswered at this time. The process of breaking down stigma is a painfully slow one and probably cannot be accomplished merely by the erection of a new building. While it may be possible for some institutions to change their image with their architecture, mental hospitals and other institutions with highly symbolic meanings for society cannot so easily alter the way in which they are regarded by the public.

In Queen Street’s case, new policies about the care of the mentally ill led to a decision to erect a new, up-to-date hospital. Once the public became aware that the mentally ill were no longer housed in frightening, outmoded quarters, it seemed more possible that the mentally ill were receiving good care and also that mental illness itself might not be so terrifying. This process was far from simple or direct, however. It included changes in patterns of recruitment of staff members, professional self-conceptions of the staff, treatment modalities, organizational procedures, and relationships with the community.

Beyond the context of these specific changes which have recently taken place at Queen Street, more basic shifts in attitudes about preferred methods and locales for the treatment of mental illness are occurring in psychiatric circles today. Serious questions are being posed in the general society concerning the very nature of mental illness itself (Szasz, 1961). The changes in social organization described here must be viewed against this larger backdrop.

DISCUSSION: A BACKWARD LOOK TO UNDERSTAND THE FUTURE

Current changes in societal conceptions of mental illness and its treatment can be better understood by utilizing an historical perspective. When Queen Street officially opened in 1850, it was the first permanent facility for the mentally ill in the province and the culmination of the public and official pressure, which had been growing throughout the two preceding decades, for such an institution. Medical and legal officials, influenced by the examples of England and the eastern United States, saw in such a facility a much needed alternative to the prevailing patterns of unenlightened confinement in the home, roaming at large, and the incarceration under brutal conditions in the county gaols (Price, 1950).

The rationale behind the construction of the original Queen Street institution was based on the prevailing beliefs that: (1) it was necessary and desirable to confine the mentally ill under humane and sanitary conditions; (2) it was important to separate mental patients from imprisoned criminals as well as from the general public; and (3) it was possible to successfully treat at least some people afflicted with mental illness. These views represented a shift from earlier notions about the animalistic and essentially incurable nature of insanity. The new ethos, which was consistent with emerging liberal-democratic political values in Canada, spread northward from the United States through the effects of proximity and assimilation and from Great Britain through the effects of immigration and the time-honoured Canadian custom of emulating British institutions.

These new philosophical and clinical perspectives on mental illness were reinforced by the development of the ‘moral treatment’
The therapeutic principles of 'moral treatment,' which dates from the end of the eighteenth century, may be summarized from Deutsch (1949) and Rosen (1968) as follows:

Separate confinement of the mentally ill in a pastoral setting; separation from the home to alleviate 'the improper association of ideas'; humane vigilance under an all-powerful physician, with attendants to act as servants; punishment for disobedience or unruly behaviour by isolation or straight-jacket; exclusion of visitors except for suitable friends (to curtail the practice of public viewing and taunting of inmates); regularized daily routines; adequate diet; freedom of movement; exposure to books, music and conversation; the absence of beatings, chains, and other indignities; development of a family environment, with the patients treated as guests of the physician's family; emphasis on employment and exercise; minimization of mechanical restraints and medication; moral instruction, to implant insights on the meaning (or moral) of the patient's life; and education on academic, social and religious matters, to effect restoration of mental abilities and prepare for discharge.

How then did these societal values and the corresponding philosophies of treatment manifest themselves in tangible physical terms? Public and official pressure for a separate facility for the insane led to the appointment in 1835 of a commission of three physicians to submit recommendations. Following a tour of the leading American asylums, they recommended a plan similar in conception to a new state hospital in Worcester, Massachusetts, with a number of modifications thought to combine all the advantages of the best institutions in America. As a result of this report, a legislative act was passed in 1839 providing for the construction of Queen Street.

The cornerstone for the first building erected on the present site was laid in 1846. The hospital was built according to the principles later codified by Thomas Kirkbride (1854), whose model for psychiatric institutions was regarded as the most humane and advanced in North America at the time. Some of the basic beliefs reflected in the design of the building were: (1) that patients should have plenty of room in which to move about; (2) that patients should be segregated by sex and according to the nature and severity of their illness; (3) that wards be spacious and interconnected so as to encourage circulation of traffic and thus provide stimulation for patients; (4) that grounds and gardens be provided for recreational activities; (5) that furnishings be in the style of the day and include refinements such as carpets, drapes, and pictures.

The newly completed asylum has been described as follows: 'Engravings dated circa 1874 show it as an impressive structure of neo-classic style, with massive columns topped by a handsome cupola. A high brick wall separates the complex from the street in which fashionable ladies and gentlemen seemed to enjoy a walk or a ride. On January 26, 1850, the patients from the Old York Jail (which in 1841, with the removal of prisoners to new quarters, had become the temporary provincial lunatic asylum) were transferred to the new asylum' (Allodi and Kedward, 1973:7).

Although initially regarded as a prototype for progressive care of the mentally ill, the fledgling institution was plagued from the outset with the pressures of high admission rates combined with extended periods of confinement. The province responded by constructing additional facilities in the same style, at Amherstburg (1859), Orillia (1861), and London (1870, expanded 1873), along with annexes and new wings for Queen Street (1856 and 1878). Although expansions provided the hospital with space for a rated capacity of 500 inpatients, it was obliged to accommodate an average of 706 patients between the years of 1878 and 1905 (Price, 1950:46–66).

This drastic increase in the numbers of mentally ill treated in hospitals such as Queen Street resulted from profound changes in treatment philosophy. The belief that insanity could be readily cured if treated sufficiently early ('the cult of curability') fell into disrepute as people came to believe that the origins of mental illness were essentially organic and hereditary in nature. Consequently, efforts to cure the mentally ill
ill were seen as futile and the orientation of psychiatric institutions like Queen Street shifted from therapy to custodialism. An air of hopelessness pervaded the field. The constant pressure for additional admissions, combined with the low social and professional prestige accorded the whole enterprise, resulted in overcrowding and underbudgeting. Under these circumstances, domiciliary care was the only kind of treatment obtainable, and even that was sometimes perfunctory at best.

After the first world war, new technologies were developed for treating mental illness. At the same time the belief that mental illness was curable began to emerge once again (Caplan and Caplan, 1969). Accompanying and reinforcing the effect of these developments was the growth of the mental hygiene movement in North America during this era. Following the second world war, further advances in psychotherapeutic technology (such as anti-depressants and phenothiazines) and a growing emphasis on the medical model of treatment served to strengthen the conviction that mental illness could be effectively treated.

Throughout these latter-day changes in treatment philosophy, the old building at Queen Street retained its original physical characteristics, although the periodic addition of new wings and outbuildings provided some flexibility and room for expansion. As new technologies and clinical perspectives again inspired hope for favourable prognoses for the mentally ill, the inadequacy and inappropriateness of the old hospital buildings became overwhelmingly apparent. In addition, it was apparent that the appearance of the 1850 building unfavourably influenced the community’s notions about mental illness. Hence, in 1956 a new wing was added, equivalent in itself to the size of most nonmetropolitan community hospitals. The physical layout of this facility reflected the postwar shifts in ideology and technology by providing extensive clinical (as well as administrative) office space, medical laboratories and clinics, paramedical facilities such as occupational and industrial therapy workshops, a lecture theatre, and two additional wards similar in design to general hospital units.

In the next decade, the old building became less and less acceptable as a facility for treatment of the mentally ill. Planning for the new hospital thus began in 1962.

Even as the plans for the new facilities at Queen Street were on the architect’s drawing board, however, further changes in ideas about the treatment of the mentally ill were occurring. The community mental health movement, spreading to Canada from the United States, emphasized the importance of maintaining the mental patient in the community. It has come to be believed by many in the field that the most effective treatment takes place when the patient remains connected with his family, his friends, and his community. The doctrine of community psychiatry is encouraging the development of outpatient facilities housed in small, often informal structures scattered throughout local communities. Inpatient hospitalization tends to be relatively brief and is shifting to general hospitals and small clinic units. These most recent developments may sharply alter, once again, the kind of physical environment thought to be most appropriate for the treatment of psychiatric patients in the future.

**Conclusion**

This paper has illustrated some of the ways in which changed values and attitudes about mental illness are linked to modifications in physical settings for treatment. It has been demonstrated both historically and in one recent instance that ideas change buildings and buildings modify ideas. Beliefs about the nature of mental illness and corresponding attitudes towards the mentally ill have changed during the life span of Queen Street from highly optimistic views that mental illness could be cured to the opposite extreme of hopelessness and then back again to the relative optimism of today.

A major purpose of this study was to assess the impact on patients and staff of changes in the physical environment of a psychiatric hospital. The lack of data from a comparable organization that did not experience a change in physical environment places serious restrictions on the extent to which the findings of this study can be generalized to apply to other, similar situations. In this instance, however, the findings point to identifiable relationships between a change in physical surroundings, the implementation of new treatment programs, changes in the social organization of the institution, and changes in its external relationships. It all begins with the planning and design of the new facilities, when the planners, influenced by prevailing social values, attempt to envision the ideal matrix for treatment. This projective planning process encourages a reexamination
of existing assumptions about treatment modalities as well as consideration of new and experimental approaches. When ideas have crystallized, and new goals concerning the range and character of treatment modalities in the new facilities have been determined, the physical setting is designed accordingly.

As the new physical environment takes shape, it becomes a symbolic focus for further reconsideration. The objective is to make optimum utilization of its potential for fulfilling the organization's goals. Still later, the practical considerations arising from the actual move to the new facilities influence the specific manner in which conceptualized treatment approaches will be implemented. Immediately following the move, and for some time afterward, further adjustments to programs and social organization take place as a result of living experience in the new environment. Programs and procedures become progressively institutionalized and through them, as well as through the attraction of new facilities, the composition of the staff is modified. Roles and practices are redefined under the impact of all these factors and in turn the new definitions influence the behaviour and attitudes of patients.

As Goffman (1959) has so persuasively argued, all social relationships are influenced by the physical settings in which they occur. The findings from this research strongly suggest that studies which focus on changes in social organizations should look more closely at the complex relationships between organizational change and alterations in physical environment.

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