Emerald Journal of Health Organization and Management

Medicine, madness and murderers: The context of English forensic psychiatric hospitals.

Journal:	*Journal of Health Organization and Management*
Manuscript ID	JHOM-10-2016-0202.R2
Manuscript Type:	Original Article
Keywords:	Organizational change, Professionals, Psychiatry, Qualitative research

Medicine, madness and murderers: The context of English forensic psychiatric hospitals.

Approach

We used qualitative data collection (interviews and focus groups with staff and site visits to English forensic psychiatry hospitals) and our analysis was informed by Lefebvre's writings on space.

Purpose

The purpose of this paper is to add to our understanding of context by shedding light on the relationship between context and organisational actors' abilities to resolve ongoing challenges.

Findings

Responses to ongoing challenges were both constrained and facilitated by the context, which was negotiated and co-produced by the actors involved. Various (i.e. societal and professional) dimensions of context interacted to create tensions, which resulted in changes in service configuration. These changes were reconciled, to some extent, via discourse. Despite some resolution, the co-production of context preserved contradictions which mean that ongoing challenges were modified, but not resolved entirely.

Value

The paper highlights the importance of viewing context as co-produced in a continuous manner. This helps us to delineate and understand its dynamic nature and its relationship with the everyday actions and beliefs of the organisational actors concerned.

Introduction

Increasingly in recent years scholars have highlighted the importance of exploring context in order to understand attitudes and behaviours (Griffin, 2007; Johns, 2006) in the workplace. Context has been defined as dynamic 'situational opportunities and constraints that affect the occurrence and meaning of organizational behaviour' (Johns 2006: 386) and is multi-level in nature (Johns 2006; Pettigrew et al. 1992). A number of studies have explored the link between specific contextual factors and impacts on individuals or organisations (e.g. Mathieu et al. 2007).Various scholars have investigated the aspects of context which are likely to lead to acceptance or resistance (McDermott and Keating 2012; Barratt-Pugh and Bahn 2015) of novel practices (i.e. change) introduced in a 'top down' fashion, as well as the ways in which the adaptation of such practices by local actors facilitates implementation (Ansari et al. 2010; McDermott et al. 2013). Less attention has been paid to the relationship of context to ongoing challenges in the workplace which are not neatly resolved by workarounds (Campbell 2012) or contextual adaptations. This paper focuses on this issue and in particular the impact of context on organisational actors' abilities to resolve such ongoing challenges.

Johns (2006) identifies three dimensions of context, i.e. task, social and physical and his categorisation has informed many subsequent studies. The dimensions provide sensitising concepts, but we need to understand more about the ways in which the various aspects of context interact in practice (Ashkanasy et al. 2014). Johns' (2006) task dimension includes uncertainty, autonomy, accountability and resources. The social dimension is concerned with social density, the location of others within the organisational space, as well as social structure (differentiation of others according to role, gender, tenure and so on). It also covers social influence, which includes issues of power. John's physical dimension comprises the built environment, but amongst the many authors who use Johns' framework, there is a tendency to underplay or omit entirely the physical aspect of organisational context (e.g. Dierdoff 2012). Johns devoted very little attention to this apart from noting that it was understudied. More recently, Ashkanasy and colleagues (2014) highlight the need for further explanation of the relationship between the physical aspects of context and behaviours and attitudes; 'we seem to lack understanding of the underlying processes whereby features of the office environment serve to determine employee behaviors and attitudes' (2014: 1176). However, the tendency to see the physical dimension of context as a given, objective entity which acts in a deterministic fashion on behaviour threatens to limit our understanding of the potentially complex, dynamic and multi-dimensional relationships between context and behaviour. The contribution of this paper is to add to our understanding of context by shedding light on the relationship between context and organisational actors' abilities to resolve ongoing challenges. It does so in a way which incorporates the physical dimension of context as a central, as opposed to peripheral, aspect of context. To do this, it draws on the writings of Henri Lefebvre to interpret data from a study of English forensic secure hospitals. These house mentally disordered patients who have committed

serious criminal offences. Lefebvre's ideas reflect a much more subjective orientation to space which overcomes some of the limitations of treating space as a given, objective entity as we explain below.

Lefevbre's views of space

Johns (2006) views the physical dimension of context as comprising the built environment, temperature, light, décor and so on. For Lefevbre the built environment is characterised by spaces and organisational space is both a thing and a set of processes and practices. This contradictory and ambiguous nature of social space represents a challenge to formal logic and means that it can only be understood dialectically. For Lefebvre, space cannot be viewed as an independent, pre-given, material reality. Instead, it is socially produced. Space can be described in terms of three dialectically interconnected processes: 'spatial practice', 'representations of space' and 'spaces of representation' respectively. These processes correspond to 'perceived', 'conceived' and 'lived' space.

Spatial practice structures daily life and is important for ensuring cohesion and continuity. This involves 'production and reproduction and the particular locations and spatial set characteristics of each social formation' (Lefebvre 1991: 33). 'Representations of space', or 'conceived space', refers to the space of professionals and technocrats and is the dominant space within a society. It is tied to the relations of production and to the order 'which those relations impose, and hence to knowledge, to signs, to codes, and to "frontal" relations' (1991:33). Because it is effectively the space of capital, conceived space has a 'substantial role and a specific influence in the production of space' (1991:42) whose 'objective expression' is in monuments, towers, factories and in the 'bureaucratic and political authoritarianism immanent to a repressive space' (1991:49). 'Spaces of representation' or lived space, refers to embodied experience of space as lived, which Lefevbre argues, is 'strangely different' from when it is thought about and perceived. Language is important in all of these processes. It acts as a basis for the social imaginary (i.e. a shared conception of the world and the place of citizens within it). However, language interferes with and distorts lived experience by limiting what can be said and how, thereby constraining action which might threaten existing spatial practice and representations of space (Lefebvre 1991).

Spatial practice is concerned with networks and interactions resting on a material or built environment. This spatial practice can be described linguistically ('a system of verbal (and therefore intellectually worked out) signs' Lefebvre 1991:39; Schmid 2008) and delimited as space, which constitutes a representation of space. This provides a frame of reference which facilitates spatial orientation. The lived space or order which 'overlays physical space' is 'the dominated- and hence passively experienced – space which the imagination seeks to change and appropriate' (Lefebvre 1991:39). This is the space of meaning and unlike representations of space, does not need to obey 'rules of consistency or cohesiveness' (Lefebvre 1991:41). Although three elements are identified as involved in the process of space production, Lefevbre's intention is not to suggest a fragmentation and

disconnection. Instead these three must be understood as inextricably implicated in the process of producing social space. Furthermore analyses of local contexts must be grounded in an understanding of macro level influences. For Lefevbre the state is an important actor involved in the co-production of space which is mediated through diverse strategic political projects associated with modern capitalism. The process is not simply one of the state acting on a given, malleable space. Instead the state is continually reconstituted. Paying attention to nation states reminds us that local spatial practices reproduce a spatial and political hierarchy.

For Lefevbre space and time cannot be reduced to a set of a priori concepts, but must be understood by studying social constellations, power relations, and conflicts relevant to specific settings. It is also important to understand the relation of these myriad local spatial practices to the 'whole'. The context of these organisations and the work that happens within them must include consideration of the modern state, therefore. Lefevbre's views here resonate with mainstream approaches which see contexts as dynamic and multi-level (Johns 2006). At the same time, his analysis which is informed by an assumption of ongoing contradictions provides a framework which adds to our conceptualisation of context. We return to this point our discussion after describing our context and methods and reporting on our empirical data.

Forensic psychiatric provision in secure settings

The empirical data are drawn from secure forensic psychiatric hospitals in England, which house offenders who are mentally disordered. These organisations embody inherent contradictions relating to the nature of the task (Johns 2006); residents are patients and at the same time offenders. The aim is to rehabilitate and 'cure' patients in a caring environment, but patients are detained against their will in a regime which applies pressure to comply with therapeutic interventions. A 'recovery' (Shepherd et al. 2008) based approach to rehabilitation in contrast to the traditional medical models of treating people with severe mental illness aims to empower patients. Yet these hospitals have at various times been the subject of public inquiries which suggest an emphasis on producing places of incarceration with staff engaged in excessive brutality and 'inflexible and over structured regimes' (Martin 1984: 55).

Changes have been made following successive inquiries into problems in these 'total institutions' (Goffman 1961), aimed at shifting the hospitals away from incarceration and containment to clinical care and treatment (Evans & Oyebode, 2000). There has also been some recognition of the need to lessen the isolation of high secure hospitals by pursuing closer integration with wider services and transferring patients to less secure services where possible (Bartlett, 1993; Evans & Oyebode, 2000). However, the Fallon Inquiry into security failures at one hospital resulted in changes which have been criticised for treating residents as groups to be provided with regimes, rather than as patients with individual needs (Exworthy and Gunn 2003). These reforms might be interpreted as exacerbating a

situation in which aspects of the physical and task dimensions of the context (Johns 2006) contribute to the naturalisation of the patient as a depersonalised unit.

Historically, the need to contain and segregate 'mad' individuals (Prior 1988) from the rest of society meant that asylums were set in large grounds, removed from major centres of population. Two of the three English high secure hospitals are housed in buildings dating from the late nineteenth and early twentieth century in what were formerly known as asylums. '[B]y structuring therapeutic settings, in both their architectural layout and the permissible use of space' the result for patients is that 'the everyday gets smaller as the professional gets larger' (Bartlett 1994: 172). The restrictions on patient freedoms are influenced by professional views and actions since in relation to the task dimensions of context doctors enjoy a high degree of autonomy. In addition mandatory obligations (Department of Health, 2008; 2010; 2011) require security standards to conform to those of Category B prisons devised by the National Offender Management Service (NOMS) (Department of Health, 2008, 2010). Best practice guidelines for medium secure settings contain extensive specifications for maintaining security, specifying aspects of the physical context such as the minimum height of the perimeter, the frequency of its inspections, the requirement for electronically controlled air locks and alarms, systems for key management, control of visitors, illicit items and so on (Royal College of Psychiatrists College Centre for Quality Improvement 2014). These can be seen as conveying to staff and patients that highly structured management and loss of agency is normal within these walls. In 2000 a commitment was made to expand medium secure provision and as part of the 'Accelerated Discharge Programme', around 400 patients were discharged to medium secure facilities (Department of Health 2000). Since the late 1990s there has been a growth in the number of forensic psychiatrists and the number and range of medium secure facilities. The latter are a mixture of purpose built and adapted facilities.

The recovery and rehabilitation model does not cater for the many patients who will never leave secure settings (Harty et al. 2004). In the Netherlands, for example, such patients reside in a space many miles away from the secure hospitals. They are not subject to medically intensive psychiatric treatment and are likely to enjoy a superior quality of life compared to patients in English high secure hospitals. They have greater freedoms than patients in secure hospitals and the purpose-built dwellings reflect a conception of space as a home, despite its carceral purpose.

Methods

The paper draws on a larger study aimed at providing a comprehensive description of long-stay patients in high and medium secure settings, to inform future service developments. The paper uses interviews with 22 doctors (Consultant forensic psychiatrists), all of which were digitally recorded and transcribed verbatim. Some of the interviews were conducted on a face to face basis, but most (n=18) were undertaken by telephone. We used a mixture of purposive and snowball sampling to

recruit participants across a broad geographical area. Initially we contacted psychiatrists who were members of an advisory group informing commissioning decisions because we wanted to speak to individuals who might have a broad, as well as local knowledge. Additionally, since our study was aimed at making recommendations for change, we hypothesised that these people would be well placed to comment on alternative models of service. All interviews were digitally recorded and transcribed verbatim. We also spent a day in each of three 'long stay' secure forensic facilities where we visited wards, met and talked with staff and patients. For two of these visits we made notes as soon as we left the facility as we were not allowed to take in recording equipment. At the other visits we held a focus group with staff (2 nurses, 2 psychiatrists and 1 psychologist) and digitally recorded this. We also held two focus groups at a forensic psychiatry conference each comprising 3 psychiatrists and 2 members of the research team. The interview questions and focus group discussions explored the ways in which service provision currently operated, as well as views on possible alternatives to current arrangements. Data also included notes relating to the layout and physical environment of the setting. Doctors from 20 different facilities were interviewed as our aim was to understand differences between facilities. In addition to these day long structured visits, we also visited 2 high secure NHS hospitals, 4 NHS medium secure units 4 independent sector medium secure units, spending between 90 minutes and 2 hours in each. We made notes about the nature of the facilities and the narratives that doctors provided about them.

Initially a small number of the interviews were coded thematically using NVivo software. Emerging themes were discussed amongst team members and disagreements resolved and queries clarified. This process continued during data collection and was used to modify the interview topic guide to incorporate new areas of investigation as the study progressed. This also informed the focus group discussions and site visits and related coding. There was no prior intention to use a particular theoretical framework for data analysis, although during the initial process of analysis we began to explore approaches to theorising our findings and Lefebvre's work provided a useful conceptual tool. We went beyond merely identifying common themes to examine how space was produced as well as exploring differences and reasons why these might occur. All quotes used are from interviews unless otherwise specified.

Findings

Spaces suffused with ideology

Spaces convey ideologies, ways of seeing the world which privilege some interpretations over others. Whilst individuals are involved in the production of space, there are limits on the ways they can engage in spatial production. They enter into spaces characterised by spatial practices and representations of space which exist prior to them. To understand the 'here and now' of space production, awareness of what went before and continues to exert an influence on what happens now

is essential. Doctors' accounts conveyed the influence on practice of the broader state regulatory regime within which hospitals operate. Some doctors described historical changes imposed by the state, which had diminished quality of life and access to spaces inside the hospital. These reinforced the isolated nature of the social space and reduced the number and diversity of participants who could contribute to its production. Boundaries between the hospital and the outside world had become less permeable as a result.

> 'Following things like Fallon and the kind of reviews of security. …..football teams from outside used to come and play the patients and things like that and the community used to come in a lot more …and we don't have any of that any more, nothing like that. It's very isolated really and a bit more contained now here and a lot more secure in terms of that. But I think the patients felt more integrated, part of the world rather than very far removed. I think that's certainly a quality of life issue' (ID 4).

At the same time, others pointed to the positive influence of the state in disrupting the old order and compelling staff to engage in a recovery focused approach, despite the fact that the old asylum buildings in which they worked were not initially intended for this. Praise was articulated for the government initiated accelerated discharge programme aimed at ensuring that patients required this level of security and were not languishing on wards with no clear aim in sight. The reason for this review was that for some patients, these hospitals had become places of containment, rather than a means to a rehabilitative end. Although doctors identified constraints arising from the nature of the buildings in which they worked, it was possible for changes to be made in these settings.

> 'we work with an estate that's 150 years old. … I don't know if the building would accommodate to changes… what we found in 2001… there were a lot of people before the accelerated discharge programme about who the kind of assumptions had been made and in practice it wasn't that hard to move many of them on'. (ID 8)

The State's emphasis on active treatment and rehabilitation and a move away from institutionalisation has helped to fuel the growth of forensic psychiatry as a profession. It has increased from '2 professors and 18 consultants confined to working in a few grim special hospitals' (Turner and Salter 2008) in 1970 to around 260 consultant doctors today. General psychiatrists have looked on enviously as the State, against a background of an increasing preoccupation with risk (Beck 1992), has diverted resources away from general mental health provision and towards forensic services (Turner and Salter 2008). The rationale for forensic psychiatry as a discipline is to provide specialist treatment and representations of space and spatial practices reinforce this. In addition to physical and procedural security (69 standards), professional guidance (Royal College of Psychiatrists College Centre for Quality Improvement 2014) sets out standards for relational security (7 standards) which includes staff training and access to an accredited psychotherapist at least once a month to support supervision

and reflective practice. These standards are shorter and much less concrete, referring to training and regular meetings compared with detailed specifications covering for example locks, furniture, lighting and the banning of shrubs close to the perimeter.

Linked to the 'softer' nature of relational security requirements, changes in the training of forensic psychiatrists was seen by some older psychiatrists as having a negative impact on the way the psychiatrists now worked. This had implications for the production of space in these settings.

> 'I'm probably the last generation of psychiatrists who worked in the old asylums and was exposed to some of that literature about community life and so forth. …but we've got a whole generation of psychiatrists who haven't got any idea I think..…also… psychiatrists are not very well skilled at thinking about ward dynamics. Even though it's in their relational security document…they're not trained any more, they don't do any psychological therapy training…and they hive off all the psychology work to psychologists. And I think that that's had a terrible negative effect'. (ID 17).

This suggests that there is a tension between the representations of space outlined in guidance and the lived experience of psychiatrists. Such tensions are understandable in a context where various stakeholders have expectations which prioritise risk management over patient freedoms. Medical professionals are powerful relative to their patients, but such professionals enter spaces which constrain professional actions and beliefs. Psychiatrists are aware of such constraints and these have implications for the production of space in these settings.

> 'there are a number of other stakeholders in a patient's trajectory through secure care which have a bearing on this so it's not just simply the consultant forensic psychiatrist making a decision about what happens, you have the Ministry of Justice, you have victim issues, you have a whole lot of factors like that…. And even if they are not explicit in playing a role it would at least be in the mind of the person who is looking after the patient …. I don't think that psychiatrists are that interested in the effectiveness really to be perfectly honest. I think what they're concerned about is risk…. Our treatments are fairly feeble actually in their efficacy'. (ID 22)

This also highlights that individuals are not empty vessels, but bring baggage when they enter the space. Doctors reported that patients who arrived at medium secure hospitals brought with them expectations about the use of space. Most of the medium secure facilities we visited, in contrast to the high secure hospitals, were located close to urban conurbations. Their location, close to population centres meant that doctors reported restrictions having to be imposed on patients. In high secure units with perimeter fences, patients may have access to grounds and outdoor areas in a way which is not possible in medium secure facilities.

> 'For those who come from [high secure hospital] sometimes we've had a bit of a difficulty because they have high expectations and they think they're just coming here and it's a year and going into the community. When they know they have to stay longer they become a bit disillusioned …. While they're roaming over the whole of [high secure hospital] it's OK because it has got a perimeter fence but we don't here. Our grounds are open…. They come from a lot of leave within the grounds and then they go to the workshops and things like that just limiting them to the building' (ID 21)

At the same time, doctors reported that patients did not always conform to expectations, with some, for example, refusing to 'step down' to lower levels of security because this would mean losing their *en suite* facilities. Doctors' comments suggested limits to the domination of space by what Lefebvre might conceptualise as the state and its agents. They also highlighted a mismatch between the service as conceived by planners and perceived by professionals on the one hand and the lived experience of patients on the other. As we describe in the following section, the patients are not the only people whose lived experience of space differs from space as conceived and perceived.

Reconfiguring space

The emphasis on recovery and rehabilitation has implications for spatial practice and representations of space. Doctors appeared to be heavily engaged in the production of therapeutic spaces, almost regardless of whether or not the patient would benefit from these therapeutic interventions. Talking about patient pathways, almost all doctors appeared to conceptualise the process in terms of an 'admission, treatment, rehabilitation, cure' trajectory, with little or no acceptance that not all patients would fit this model. The Mental Health Act (2007) requirement to offer 'appropriate treatment' is embedded in the concrete spaces of treatment rooms and embodied in the presence and practice of various health professionals whose rationale is to provide treatment. The result is that spaces are perceived in terms of treatment, with treatment becoming an end in itself. Spatial practices and structures appear to exercise constraints on what can be thought, in a context where the social imaginary does not include ideas about radically different spatial configurations. The absence of alternative provision for 'long stay' patients who are unlikely to leave means that doctors focus on existing spaces and spatial practices, however deficient. At the same time, many do not see these as deficient, since these are part of the 'taken for granted' within these spaces.

> 'We do offer appropriate treatment. So we have things like occupational therapy, integrated therapies, we offer adapted sex offender treatment programme, adapted fire setters programme…I think even if someone's been there for twenty years you should still be trying to do something ... Now I know you can get all sorts of interpretations of what offering appropriate

> treatment is but to my mind it has to be something a little bit more than just saying well there's 24 hour nursing care. I know there have been high court judgements that have said appropriateness in care, 24 hour nursing care, is appropriate treatment but I think that becomes just warehousing of people really'. (ID3)

The phrase 'warehousing' was used often by psychiatrists who raised objections to cessation of treatment. It resonates with the idea of 'anti-place', as a site which disempowers its inhabitants (Casey 1997). Successful legal appeals by patients to limit 'appropriate treatment' to nursing care are dismissed by this doctor as part of a process in which doctors' views carry more weight than those of patients. At the same time, the insistence on treatment also implies a consistent project to prevent patients contributing to the production of a sense of place beyond the planners' intended use. Yet since patients do not fit neatly into the spaces that planners and doctors have conceived for them, changes were being made to accommodate them. Doctors' lived experience of space was at odds with the concrete buildings, guidelines and practices which characterised their daily working life. Patients did not readily conform to expectations implied in representations of space as places of recovery.

> 'we still have sexual offenders who have predatory behaviour even on the ward. They need that kind of context of management and they need all the security. You can't take them anywhere. They don't engage in therapy. They don't realise anything is wrong with them. And basically they're just not changing'. (Focus Group 1 – ID1)

Additionally, in some sites, there was a growing recognition that mixing 'long stay' and other patients was problematic. This was leading to changes in the production of space as these doctors described.

> 'It's a smaller ward. It has accommodated the fact that it will have a group of higher profile and longer stay patients, there for an extended period of time. …we shouldn't have too many people coming in and moving off elsewhere... And not having the ward unsettled by too high a turnover I think is important…. a lot of the patients say they prefer it here, they feel there, there's less bullying there, they feel more relaxed there and their mental states have improved as a consequence of being there'. (ID8)

At one site we visited staff described how they had travelled to another facility catering for 'long stay' patients to learn from their experiences. There they noticed that despite the professionals saying that patients were not left to lie in their rooms all day, which was seen as part of the ethos of making the place more like home, various patients were sleeping on couches in the lounge during the day. They resolved not to buy three seater couches to prevent this from happening at their new facility. Here the emphasis was on quality of life and building a long term community. Though patients' views about what constitutes a normal quality of life might be disregarded if they involved daytime sleeping.

The extent to which patients in 'long stay' facilities could personalise their rooms differed across sites as did the range of activities and facilities available to patients. Some patients in medium secure facilities had access to Skype to enable them to keep in touch with relatives and access to pornographic material was made available based on an assessment of individual patients. The emphasis and espoused ethos was to provide patients with a good quality of life and an existence which was as normal possible, implicitly and occasionally explicitly as the quote below from a doctor one month after starting on a new 'long stay' ward illustrates.

> 'On the current ward I'm on, they're going to die there. I don't have the option. They'll only go to a care home. Well a hospital because I can't send them to a care home…which is kind of depressing. It's not a ward I've worked on before and I was looking forward to it but …' (Focus group 2 – ID3)

The espoused ethos was based on a mostly implicit recognition of the fact that rather than being temporary residents, this would be the patients' home for many years, if not forever. However, there were limits to such normality and sexual activity was not permitted. There is no national policy preventing this, but in the absence of such a policy staff are free to apply their own judgment. Staff attitudes in the settings we visited contrasted with those in other countries such as Germany and the Netherlands where sexual activity between patients or with an outside partner is permitted (Majid 2015). Doctors explained the need to protect vulnerable patients and highlighted the fact that many patients were sexual offenders, implying that they saw engaging in a sexual relationship as an obstacle to recovery (Brown et al. 2014). These responses may reflect the broader social and cultural context in which forensic units are situated, with less liberal views regarding sexual relationships in the UK than the Netherlands for example (Brown et al. 2014) and they imply clear constraints on 'normal' living and quality of life. Furthermore, whilst spaces which encouraged the development of a sense of community were seen in a positive light, the nature of the community's residents meant that tensions between allowing freedoms and enforcing constraints required a delicate balance. Patients were not merely passive recipients in a dominated space, or to the extent that they were, there was always potential for this to change.

> 'a few patients have used [the phrase]"the brotherhood" and they feel like it's 'us' against 'them' and we need to stand up together for our rights. I also am beginning to get the feeling that because they…are quite close to each other there might be an element of them not wanting to move off the ward because that comes with its own anxieties and they wouldn't know if they'll have the same friendships and groups that they have with us… .we have had incidents where they have grouped up in communal areas and we thought that was extremely dangerous for staff because it's quite possible to have fifteen people…who know each other very well and if they decide to cause trouble there's very little that anyone can do'. (ID19)

Knowing spaces

The doctors in our study appeared at times to be conflicted and this can be conceptualised as concerned with different ways of knowing space. At one level the received wisdom or knowledge ('savoir' Lefebvre 1991) is that patients must be helped to recover. Yet their embodied experience suggests to them that there are some patients for whom this will never be possible, at least in the sense of recovery being synonymous with cure and discharge. This meant that doctors described and in our visits took us around spaces for patients who were not progressing. They explained that the focus was on improved quality of life and reduced medical input since such patients were unlikely to respond to treatment and equally unlikely to leave. At the same time, at the level of language, they insisted that patients would move on.

> 'Size is something that probably wasn't determined scientifically but was a consequence of the ward that was available that was refurbished and the size is such that it is probably quite cheap to run... The therapeutic input has decreased a little in recent years….But you know at the end of the day, it's not just a secure warehouse and it can't be. It has to be an environment that enables people to move on' (ID9).

Lefebvre distinguishes between savoir and connaissance. The former is rationalist, instrumental, disciplinary and therefore state-dependent knowledge. The latter, in contrast, does not serve power, but 'is a form of knowing which refuses to accept power' (1991: 10). This is a more local, embodied form of knowing. For Lefebvre, lived space 'is dominated space—and hence passively experienced—space which the imagination seeks to change and appropriate' (1991: 39). Lefebvre's work on language is important here. Doctors were opposed to the use of the phrase 'Long Stay' to denote spaces for patients who stayed for a long time and perhaps would never leave, with its implications of failure. Such language challenges the conceived and perceived (by doctors) space, which is a place of rehabilitation and recovery. When we talked to psychiatrists and visited these facilities for patients who were not progressing we found that they were variously named 'slow stream rehabilitation', 'enhanced recovery' and 'continuing care'.

Medical input was reduced but at the level of language, there was a reluctance or refusal to accept that some of these patients would not be discharged. The use of particular forms of language, enabled doctors who were involved in planning the use of these spaces, to initiate a process of transforming them, whilst continuing to insist that these were spaces of transition and recovery. These labels helped convey to the outside world that the activities therein conformed to the representations of space. However, this did not appear to be a cynical device for warding off state regulatory attention. Instead these labels appeared to help doctors cope with the tensions manifest in these two ways of knowing about space for these patients.

Discussion and conclusions

The findings are helpful in illuminating the relationship between context and ongoing challenges in the workplace in a number of ways. We can think of the physical dimension of context (Johns 2006) as characterised by hospitals which constrain patients, reflecting relations of domination. This built environment also influences staff perceptions and attitudes and simultaneously contributes to the challenges related to the task faced by staff. The task dimension of the context (Johns 2006) involves exercising both a protection and a policing role for patients who are a 'risk to self and others' (Bean 1987). Psychiatrists are also influenced by professional norms and values and in terms of the social dimensions of context (Johns 2006) forensic psychiatry is a relatively small community nationally. However, drawing on Lefevbre's view of space as co-produced in a continuous manner helps us to delineate and understand the dynamic nature of this context and its relationships with the everyday actions and beliefs of the organisational actors concerned.

Lefevbre's emphasis on studying social constellations, power relations, and conflicts relevant to specific settings is also helpful in drawing our attention to the importance of examining power relationships in specific contexts. In terms of the ongoing challenges in this setting, psychiatrists are powerful relative to other staff and certainly patients have much less say in this process than other participants. At the same time, although doctors enjoy a great degree of autonomy, they are also highly accountable. Their concern with risk suggests that containing patients is important to them and their views carry significant weight in decisions about patients' futures. Their power does not extend to being able to cure patients for whom no effective treatment exists and this challenge is not amenable to easy resolution. Furthermore, doctors contribute to the production of space, but they enter into a process of space production which is already infused with prevailing values and ideologies which act to constrain what is possible and thinkable. For Lefevbre investigation and understanding of the spatial requires that we locate it in historical and social contexts. Rather than viewing challenge simply as created by the task, therefore, we need to understand the history of scandals and state responses to concerns which help to explain specific moments in the production of space, as well as their enduring influence. This adds to our understanding of why the task has changed over time, as well as the reasons why challenges cannot be easily resolved by 'simply' changing the task.

In addition, Lefevbre's emphasis on the role of the state in spatial production draws our attention to the multi-dimensional nature of contexts and the ways in which relationships and practices which are physically many miles away contribute to challenges in the local setting. For Lefebvre attention needs to be paid to the macro and micro, since the former 'weighs down on the lower or 'micro' level on the local and the localizable' (Lefebvre 1991: 366). The importance of doing this is reinforced in a setting where the modern state is an ensemble of coalitions and alliances incorporating forms of (medical) professional expertise (Johnson 1995). Whilst state legislation and regulation has implications for our

context, there are clear limits to the power of the state. Lefevbre emphasised the state's role in assisting and promoting capital accumulation, but in the modern age, space production involves struggles amongst a range of stakeholders (e.g. workers, capitalists, managers, politicians) so that space is not just the product of capital's requirements (Massey 1995). Secure hospitals serve a function of containing public fears and anxieties and stories in tabloid newspapers do little to encourage an emancipatory project. The social imaginary, which constructs the inhabitants of secure hospitals as particular kinds of dangerous people, and is concerned with containment and punishment, rather than rehabilitation, is difficult to challenge. The formal expressions of use and configuration of bricks and mortar reinforce this message, as does the absence of alternative spaces, such as those in the Netherlands, for 'long term' patients needing secure environments. At the same time, in the context of the recovery movement and the abhorrence of old style asylums which led to state sponsored closure, representations of space and spatial practices reinforce this view. State policy reflects a backlash against the old order, which oversaw large numbers of patients languishing in asylums where clinical neglect was rife (Pilgrim and Rogers 1999). States are not simply powerful actors; they are also attempting to reconcile competing demands from the various groups on whose support they rely. The state is a key part of our context, but the relationship is not simply a linear one therefore.

Another way in which the relationship between context and ongoing challenges in the workplace is illuminated by Lefebvre's approach concerns his emphasis on language and the importance of discursive and symbolic practice in helping to explain the production of space in specific settings. In our study the conceived space and space as initially perceived by doctors in some cases was at odds with their embodied experience. What was articulated was contrary to doctors' lived experiences. For Lefevbre language is alienating in the sense that it separates meaning from the body and everyday sensory experiences. Language is 'dangerous' since it 'allows meaning to escape the embrace of lived experience, to detach itself from the fleshly body' (1991: 203). Ways of talking about things, '"figures of speech" give birth to a form, that of coherent and articulate discourse, which is analogous to a logical form, and above all…they erect a mental and social architecture above spontaneous life' (1991: 140). The language used by our participants enables a coherent account to be given, which is consistent with the recovery discourse. Language can inhibit the process of emancipation since it acts as an interstice which filters and distorts the emotional and sensory responses of lived space. 'The salvation of knowledge (connaissance) depends entirely on a re-examination of its established forms (savoir)…Collusion between knowledge and power must be forcefully exposed' (1991: 414-5). In the case of these hospitals, alternatives for 'long stay' patients might be purpose built premises, far away from the hospital, aimed at improving quality of life for patients. This process has happened in the Netherlands but such alternatives do not appear to resonate with the individual or social imaginary. Most psychiatrists did not openly challenge accepted wisdom or question the basis on which official

'knowledge' was generated. At the same, however, language did not obstruct change. Instead although it did not enable doctors to verbalise radical thinking, it did appear to facilitate change, albeit of a less radical nature. Doctors' discursive practices involved avoidance of particular labels and related connotations and adoption of others as part of the process of creating spaces for patients who did not conform to the rehabilitation and recovery model. This allowed them to retain the language of rehabilitation, whilst modifying treatment regimes and spaces.

Not all psychiatrists were in agreement about the benefits of creating 'slow stream rehabilitation' spaces. Amongst those who were, there exist different models which are characterised by varying levels of medical input. There is a possibility, however, that over time, such spaces may increase in number, with some form of consensus about their nature at least at the level of conceived space. This would result in a more explicit acknowledgment of the nature of spatial production and one which is acceptable in local contexts and within the broader state regulatory regime within which hospitals operate. Whether the language used to describe such facilities changes over time remains to be seen.

Conclusion

This paper's contribution is to demonstrate the importance of viewing context as co-produced in a continuous manner. It also illustrates the powerful relationship between the dynamic and subjective nature of context and the ability of organisational actors to resolve ongoing challenges. The paper uses Lefevbre's framework to place the physical dimension of context at the centre, as opposed to the periphery, of analysis. A final point concerns the importance of dialectical thinking and Lefevbre's use of the concept of sublation (or *Aufhebung*). In contexts which embody contradictions, sublation implies both preservation and change (Kauffman 1966). In Lefebvre's dialetics, a contradiction when sublated does not reach a final state or resolution. Instead, although in one sense the contradiction is overcome or negated, it is also maintained and further developed. For the psychiatrists, the contradiction between containment and rehabilitation is overcome by the creation of specific spaces for housing 'long stay' patients. At the same time, these changes represent a development of the contradiction. It appears in a different form, involving new spatial practices and representations of space, but is preserved nevertheless. Of course this does not imply that this preservation should be seen as a fixed entity. Instead, by locating our analysis in Lefebvre's ideas about space as both a product and a process, we can identify moments in the spatial and temporal flow, which enable us to understand 'context' in greater detail and in particular, the processes underpinning the dynamic, multi-level and ongoing practices involved in its production and reproduction.

Funding Acknowledgement:

This project was funded by the National Institute for Health Research HS&DR programme (project number 11/1024/06)

Department of Health Disclaimer:

The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the HS&DR programme, NIHR, NHS or the Department of Health.

References

Ashkanasy, Neal M.; Ayoko, Oluremi B.; Jehn, Karen A. (2014) Understanding the physical environment of work and employee behavior: An affective events perspective. *Journal of Organizational Behavior* Volume: 35 ,8 , SI: 1169-1184

Ansari, S. M., P. C. Fiss and E. J. Zajac (2010). 'Made to fit: how practices vary as they diffuse', *Academy of Management Review*, 35, pp. 67–92.

Bartlett, A (1993) Rhetoric and Reality: What do we know about the English Special Hospitals? *International Journal of Law and Psychiatry*, 16, 27-51

Bartlett, A. (1994) Spatial order and psychiatric disorder in Parker Pearson, M. and Richards, C. eds. *Architecture and order: approaches to social space*, London: Routledge, 178-95.

Barratt-Pugh, Llandis and Bahn, Susanne (2015), HR strategy during culture change: Building change agency. *Journal of Management & Organization*, 21, 6, 741-754.

Bean, P. (1985) Social control and social theory in secure accommodation in (ed. Gostin L.) *Secure provision a review of special services for the mentally ill and mentally handicapped.* London: Tavistock, pp. 288-306.

Beck, U. (1992) *Risk Society: Towards a New Modernity*. London: SAGE Publications.

Brown, S. D., Reavey, P., Kanyeredzi, A., & Batty, R. (2014). Transformations of self and sexuality: Psychologically modified experiences in the context of forensic mental health. *Health*, 18(3), 240-260. doi: 10.1177/13634559313497606.

Campbell, D. (2012). 'Public managers in integrated services collaboratives: what works is workarounds', *Public Administration Review*, 72, pp. 721–730.

Casey, E. (1997) Smooth Space & Rough Edged Places *Review of Metaphysics* 51, 267-96.

Department of Health (2000) *The NHS Plan*, London: Department of Health.

Department of Health (2008) *A Framework for the Performance Management of High Security Hospitals*, London, Department of Health

Department of Health (2010) *High Secure Building Design Guide: Overarching Principles for Ashworth, Broadmoor and Rampton Hospitals*, London: Department of Health

Department of Health (2011) *Guidance on the High Security Psychiatric Services (Arrangements for Safety and Security at Ashworth, Broadmoor and Rampton Hospitals) Directions 2011*, London: Department of Health.

Dierdorff, E., Rubin, R. and Bachrach, D. (2012) Role Expectations as Antecedents of Citizenship and the Moderating Effects of Work Context *Journal of Management* , 38 ,2, 573-598.

Exworthy, T. and Gunn, J. (2003) Taking another Tilt at high secure hospitals, The Tilt Report and its consequences for secure psychiatric services. *British Journal of Psychiatry*. 182, 6, 469-471.

Evans, C & Oyebode, D. (2000) From Homicide Inquiries to High Secure Hospital Inquiries: A decade of social and political restrictive pressure on forensic psychiatry, *Epidemiologia e Psichiatria Sociale*, 9 (4) 234-240.

Goffman, E. (1961) *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates.* Doubleday Anchor, New York, 1961.

Griffin, M. (2007) Specifying organizational contexts: systematic links between contexts and processes in organizational behavior *Journal of Organizational Behavior* 28, 859-863.

Harty MA, Shaw J, Thomas S, Dolan M, Davies L, Thornicroft G, Carlisle J, Moreno M, Leese M, Appleby L, Jones P. (2004) The security, clinical and social needs of patients in high security psychiatric hospitals in England. *J Forens Psychiatry and Psychol.* 15: 208 – 221.

Johns, G. (2006). 'The essential impact of context on organizational behavior', *Academy of Management Review*, 31, ,396–408.

Johnson, T. (1995) Governmentality and the institutionalisation of expertise in Johnson, T., Larkin, G., and Saks, M. *Health Professions and the State in Europe*. London: Routledge.

Lefebvre, H. (1991) *The production of space.* Oxford: Basil Blackwell.

Kauffman, W. (1966) *Hegel A reinterpretation*. USA: Anchor.

Majid, S. (2015) Attitudes towards sexual expression in professionals in forensic psychiatry in different EU countries http://lfpc-cost.eu/attitudes-towards-sexual-expression-in-professionals-in-forensic-psychiatry-in-different-eu-countries/ accessed 21/10/15.

Martin, J.P. (1984) *Hospitals in Trouble*, Oxford: Basil Blackwell.

Massey, D. (1995). The conceptualization of place. In D. Massey, & P. Jess (Eds.), *A place in the world? Places, cultures and globalization* (pp. 45–85). New York: Oxford University Press.

Mathieu, J. E., & Taylor, S. R. (2007). A framework for testing meso-mediational relationships in Organizational Behavior. *Journal of Organizational Behavior*, 28, 141-172.

McDermott, A., Fitzgerald, L. and Buchanan, D. 2013. Beyond acceptance and resistance: entrepreneurial change agency in policy implementation. *British Journal of Management* 24 (S1), S93-S115.

McDermott, A. M. and M. Keating (2012). Making service improvement happen: the importance of social context, *Journal of Applied Behavioural Science*, 48, 62–92.

Pettigrew, A. M., E. Ferlie and L. McKee (1992). *Shaping Strategic Change: Making Change in Large Organizations: The Case of the National Health Service*. London: Sage.

Pilgrim, D. and Rogers, A. (1999) *A Sociology of Mental Health and Illness*. Milton Keynes: Open University Press.

Prior, L. (1988) The architecture of the hospital, A study of spatial organisation and medical knowledge, *British Journal of Sociology*, 39, 1, 86-113.

Royal College of Psychiatrists College Centre for Quality Improvement (2014) *Standards for Medium Secure Services* http://www.rcpsych.ac.uk/pdf/Standards%20for%20Medium%20Secure%20Services%20(QNFMHS)_2014%20Amended%20CI.pdf accessed 21/10/15.

Schmid. C. (2008) Henri Lefebvre's theory of the production of space: towards a three-dimensional dialectic in Goonewardena, K., Kipfer,S., Milgrom, R. and Schmid, C. (Eds.) *Space, Difference, Everyday Life: Reading Henri Lefebvre*, London: Routledge. Pp37-45.

Shepherd, J. Boardman, J., Slade, M. (2008) *Making Recovery a Reality.* London: The Sainsbury Centre for Mental Health.

Turner, T. and Salter, T. (2008) Forensic psychiatry and general psychiatry: reexamining the relationship. *British Psychological Bulletin*, 32, 2-6.