17. Prisoners with severe mental illnesses and everyday prison interior (re)design

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Introduction

Designing an institution involves a complex array of processes and practices, which are not bound up solely in the period from the original commissioning to opening, but also often both pre-date the formal commissioning process and extend beyond the opening of a new facility. Much of the custodial estate in England and Wales today is the result of re-commissioning, re-designing and adapting current architecture and its interiors to meet the diverse and changing needs of the prison population. Frequently, these adaptations have emerged to meet physical, mental and social care needs and range in scale from the building of specialist units such as those for prisoners with dangerous and severe personality disorders (DSPD) (Saradjian et al 2013) to the renovation of existing wings and creation of day care centres for older prisoners (Moll 2013, Turner et al 2018). Indeed, given the complex array of public-private service provision within the prison estate, commissioners are also not solely limited to prison authorities.

The prison design literature has highlighted the difficulties of accommodating the differentiated needs of prisoners (McConville 2000). In particular, attention has focused on design solutions to the mental and physical harms prison buildings and interiors cause to prisoners (Jewkes et al 2019, Jewkes et al 2020, Söderlund and Newman 2017, Grant and Jewkes 2015). Although the increasing range, severity and complexity of mental health needs in prisons is widely recognized (Bebbington et al 2017, Crichton and Nathan 2015), the focus

of literature on prison design in relation to mental health tends to be on general wellbeing rather than the treatment of acute illnesses (Moran 2019, Jewkes 2018, Söderlund and Newman 2017).[1] Meeting the needs of prisoners with serious mental illnesses forms an increasingly important part of decision-making regarding in contemporary prison (re)design and adaptation (Cassidy et al 2020).

In this chapter, we analyse the creation of a specialist unit commissioned by the National Health Service (NHS) for England in a large reception prison in the North of England. We follow the adaptation of a small wing to create the Unit and highlight three elements of the design process: firstly, we attend to adaptation to understand the complexities of re-designing existing interior spaces within the custodial estate to meet the needs of specific groups; secondly, we explore the opportunities presented by *indeterminacy*, as the Unit began operating when so many elements of its design, usage and regime were still unknown; finally, we elucidate the centrality of forms of *accommodation* in the re-design of the Unit, involving compromise and negotiation Attuning analysis of prison design to the everyday processes and practices that shape much of the custodial estate enables insights to improve the re-design and adaptations of existing prisons.

Prison Interior Design

Rather than as a one-off event with a delineated start and finish, custodial design, even on individuated sites, is better understood as an ongoing set of processes and practices that shape the environment in which a prisoner may find themselves. Initial designs often emerge not

[1] 'Severe mental illness (SMI) refers to people with psychological problems that are often so debilitating that their ability to engage in functional and occupational activities is severely impaired' (Public Health England, 2018).

from the vision of one commissioner or architect, or even as the process of one negotiation (or tender), but through a series of ongoing conversations, dialogues, shifts and changes over time (Grant and Jewkes 2015). This processual approach applies not only to contemporary custodial design but also to the many historic buildings that comprise the penal estate in England.

In this chapter, we are specifically concerned with interior design. This field of research and practice is often expansive and relates to all elements of the design of spaces interior to buildings (Brooker and Weinthal 2013), overlapping with architecture and cognate disciplines (Dodsworth and Anderson 2019). Practice and theory encompass everything from the total re-design of an interior space, including changes to the interior architecture, to interior redecoration, which does not involve structural adaptations (Dodsworth and Anderson 2019). The case study analysed in this chapter did not involve major structural changes, as we shall see, but extensive re-decoration and re-purposing of an interior within an existing prison wing, which extended beyond interior re-decoration. Whatever the scale of the design, however, it is clear that it involves much more than simply changing the aesthetic of the space. Analysis of interior design reveals the ways in which those involved might be seeking to question or challenge the current status quo by offering different possibilities and ideas for the way in which people are able to inhabit a space (Dodsworth and Anderson 2019).

If the 'design of a prison reflects the penal philosophy of the prevailing social system' (Moran et al 2016: 114-115), then the additions, adaptations and changes to an original design (particularly interior) within existing prisons evidence not only how penal philosophy has changed, but also commitment to and prioritisation of any shifts by different authorities

involved in making changes to the prison estate. As has been noted by a number of commentators (McConville 2020, Moran et al 2016), the main aims of contemporary incarceration in the UK are to provide security for the wider public, punish and rehabilitate. However, what constitutes punishment differs between countries (Moran et al 2016) and impacts upon the conditions and, consequently, design *within* prisons, in particular. Designs should be developed that recognise these differing contexts (Grant and Jewkes 2015).

However, the coherence of any penal philosophy in practice has been questioned (McConville 2000) with clear gaps existing between wider public and political discourses and experiences within prisons. '[T]he actual connection between policy and design is often tenuous and […] difficult to establish' (Dunbar and Fairweather 2000, p. 46). The divergence can, to some extent, be explained by the lack of funding that would enable prison buildings to keep pace with the changes in penal philosophy (Dunbar and Fairweather 2000). However, even when there is support for and intention to implement a particular idea or principle, practical difficulties frequently arise particularly in relation to design. Any penal reform agenda can be 'thwarted if it is not accompanied by a reform to the way that prison buildings are commissioned, designed, maintained and upgraded (Karthaus et al 2019, p. 196).

For example, the principle of 'equivalence' in the delivery of healthcare in prisons, i.e. that prisoners are expected to receive the same level of care as they could access in a community setting (Shaw and Elger 2015), ignores the extent of the adaptations necessary to provide the same level of care within a custodial setting (Niveau 2007). Consequently, whilst such policy initiatives make demands that necessitate adaptations to the custodial estate, they are frequently not supported by budgeting or direct guidance to institutional management or healthcare providers to support implementation. Therefore, whilst custodial design is shaped

by top-down policy-making, it is important to also consider 'grass-roots innovation […] led by innovative Governors, officers and ex-prisoners, in some cases supported by philanthropic organisations, charities and social enterprises' (Karthaus et al, 2019, p. 198-9).

The need for *differentiation* between prison populations is not easily accommodated by the uniformity of prisons in England and Wales (Dunbar and Fairweather 2000). Prisoners' safety needs differ (McConville 2000). Prison policy and management, therefore, is often focused on the practicalities of classification and separation (McConville 2000) in order to meet these needs. Yet, prisons designed to enable subdivision into more manageable group sizes and with in-built regime facilities did not begin to emerge in England and Wales until after 1945 and are limited in number across the prison estate as a whole (Dunbar and Fairweather 2000).

Over-design of spaces within the custodial estate, i.e. designs pre-determining and consequently limiting the use of interiors, has the potential to lead to costly mistakes that may need to be corrected in the future if a space proves impractical (McConville 2000). Therefore, there has been an overall shift in prison design in England and Wales towards under-designed, flexible and multi-use spaces (Dunbar and Fairweather 2000), creating opportunities for differentiation through interior design. The role of interior design is somewhat marginalised within the prison design literature, although its importance is well-established in research in social psychology, criminology and cognate fields (cf. Sommer 1971). Nonetheless, as we shall see in this chapter, the re-design of interior spaces is also marginalised in practices by prison authorities and commissioners. 'The object of interior design is to make the prison more attractive, brighter, more cheerful and personalised – in general less institutional' (Fairweather 2000, p. 74). Paying attention to interior (re)design is

particularly important when considering adaptations to existing interiors within the prison estate. The academic literature is increasingly concerned with learning from healthcare settings (Jewkes 2018), as well as exploring certain types of interventions such as nature/'green design' (Moran 2018, Söderlund and Newman 2017) and water/'blue design' (Jewkes et al 2020). In this chapter, we seek to contribute to this growing literature by analysing the interior re-design of a wing to accommodate prisoners with acute mental healthcare needs.

Prison Interior Re-Design and Mental Health Care

Changes and adaptations to existing prisons are influenced by a range of external processes and pressures. Re-design may reflect shifts in standards and conditions of living (Dunbar and Fairweather 2000), as well as a more generalised alteration in wider societal understandings of the composition and needs of prison populations (Cassidy et al 2020). In the UK, the announcement of a 'rehabilitative revolution' by the then Justice Secretary in 2010 has shifted prison regimes away from an overall emphasis on punishment and surveillance to more subtle controls and 'learning'. Yet, as Henley (2003, p.13) has highlighted, such shifts have been difficult to accommodate within the confines of the existing built custodial estate. Although some have argued that prison environments have become less repressive mentally and emotionally (Jewkes and Johnston, 2012), Ben Crewe (2011) has suggested that we need to be cautious in surmising that seemingly more efficient regimes of discipline and regulation are, in fact, less damaging for individual prisoners.

The impacts of imprisonment can often be most acutely felt by those who enter a penal environment with existing illnesses and conditions; not all prisoners are equally vulnerable to prison regimes and environments. Poor mental health, and importantly, complex and severe

mental illness is a growing problem in penal settings in England and Wales (Bebbington et al 2017, Cassidy et al 2020). One study (Bebbington et al, 2017) found that in the year before imprisonment, 25.3% of respondents had used mental health services. In 2018, the Prison Reform Trust noted that over 16% of men said they had received treatment for a mental health problem in the year before custody, and 15% of men in prison reported symptoms indicative of psychosis (compared with 4% in the general public). In 2017, the House of Commons Committee of Public Accounts identified record numbers of suicides and incidents of self-harm in English prisons. Mental health problems in prisons are also often compounded by related issues such as substance misuse and/or personality problems, as well as family and social difficulties (Crichton and Nathan 2015).

Meeting these complex needs generally falls upon in-reach mental health teams,[2] contracted by the prison with a mixture of NHS and private providers across the country. These teams, comprised of mental health clinicians, deal with a very high numbers of referrals and are often too small to meet the demands and health needs of all prisoners (Jordan 2011). The situation is compounded by external constraints, including a shortage of both high and medium security beds within the NHS (Sloan and Allison 2014). Consequently, prisons increasingly use separation and isolation to manage the behaviour of some of their most mentally unwell prisoners, who are awaiting transfer to hospital (Dyer et al 2020).

[2] Mental health in-reach teams provide support and treatment to prisoners within the mainstream prison environment. They emerged after 2006, when following a Department of Health strategy to improve mental health in prisons (published in 2001), the NHS took over providing mental health care in prisons (Brooker and Webster 2018). Similar to Community Mental Health Teams (CMHTs) outside prisons, they carry out assessments on prisoners referred to them both on admission to the prison and during their time there, develop treatment plans and monitor prisoners, as well as make referrals on to specialist services and liaise with community-based teams prior to a prisoner's release.

A New Prison Mental Health Unit

Setting

The research presented here took place in a reception prison[3] in the North of England. Located close to the centre of a city, the prison was originally built and opened in the early 19th century. Started and re-started by two different architects, the building was finally finished by a third, who (according to local records) completed the work without much of the ornament envisaged by his predecessors. However, like many prisons built during this period, it has been adapted over the last two centuries; significant additions include the building of a maximum-security wing, a new gatehouse and reception centre in the 1960s, as well as a new healthcare wing that opened in 2017. Alongside these new additions, the internal design of the building has also been extensively modified. Some of these changes intentionally sought to hide the origins of the jail according to a local newspaper report from the early 2000s, 'millions of pounds have been spent refurbishing the wing to stop it looking like a Victorian[4] jail. Each cell has en-suite facilities, curtains adorn the bars on the windows and TV is allowed'.

This chapter is based upon research undertaken in a new mental health unit, which represents a unique development across the prison system in England and Wales (Dyer et al 2020). The Unit occupies a small wing built in the 1990s and has the capacity to take 11 patient-prisoners (single cell), plus two prisoner peer workers (sharing a cell). The Unit provides a service for male remand and sentenced prisoners (adult and young offenders) with serious or

[3] The prison serves the court services of North East England and parts of the North West. It is where prisoners are transferred to if they are remanded into custody awaiting trial or following conviction and a custodial sentence. For those, who have been sentenced already, they are then, most often, transferred on to another regional prison. Those awaiting trial might stay in the reception prison until they appear in court, depending on how long they may have to wait for their trial date and on the severity of the possible punishment for their alleged crime (the prison does not hold high security or category A prisoners).

[4] The prison was actually opened in the late Georgian period, however the reference to a Victorian prison in the media is not related to the period as such, but more to evoke the austere aesthetic of some of England's older prisons.

severe mental illness (SMIs) across the region (excluding high security prisoners based upon level of security). Mental health staff are on the wing Monday-Friday 8am-8pm and Saturday-Sunday 8am-4pm. Prison officers staff the Unit 24 hours a day, seven days a week. The development is funded by the regional offender health commissioner, NHS England, and the Unit opened in October 2017.

The creation of the Unit was driven by the growing number of prisoners within the region awaiting transfer to a secure mental health facility for treatment (Dyer et al 2020). It was also underpinned by a logic of economic efficiencies due to the costs of keeping such prisoners either in the segregation unit or hospital wing for long periods of time (Cassidy et al 2020). The managers of the local NHS trust contracted with in-reach mental health provision and the prison governors hoped that in addition to acting as a safe place for those awaiting transfer, that treatment within the Unit would reduce referrals to secure facilities by enabling more prisoners to be returned to mainstream prison locations.

Methodological Approach

The methodology sought to develop a deep understanding of the Unit and the contexts within which it began to operate. The project was informed by critical realism, recognising that the mechanism for change that is introduced (in this case the creation of a new mental health unit) can only be understood when analysed within the existing context, which includes both existing mechanisms and structures for mental health care, as well as wider, pre-existing economic, political, social and cultural conditions (Kazi 2003). The research was planned in two phases, the first of which followed and proactively supported (see also Karthaus et al 2019) the development of the Unit. Data collection was completed for this phase by the end

of 2018. Phase two seeks to understand the context, mechanisms and outcomes produced by the Unit and began in October 2019.[5]

One member of the research team was embedded in conversations surrounding the development of the Unit from early on as a member of the steering group. This meant that the research team undertook participant observation at monthly Steering Group meetings from November 2016 to November 2018, which was supplemented by analysis of relevant background documents, including minutes of meetings between stakeholders. As participant-observers, members of the research team were in attendance at initial meetings and able to ask questions and provide feedback on the development of the research design. Therefore, participation focused primarily on collecting data for use in the process analysis, which was a key part of the first phase of the research, as well as briefing the Unit manager (after appointment) on the practical implications for staff of the research, rather than on contributing directly to the design of the Unit. The findings from this phase of the research were not presented (both in written and oral format) to the steering group and staff on the Unit until Spring 2018. However, during the pre-opening phase, participant observation did extend to providing a summary of information that emerged in the literature review to the custodial manager on colour schemes for the interior decoration of spaces used for the detention of people with serious mental illnesses.

Once the Unit opened in October 2017, members of the research team were also able to undertake non-participant observation on the Unit until October 2018. This usually involved spending a few hours on the Unit, speaking primarily to the staff and prisoner-cleaners and

[5] Phase two of the project has been delayed as access to the prison has been restricted since the onset of the Covid-19 pandemic.

observing activities in the communal, open areas of the Unit both when the patients and prisoners were unlocked and also when they were confined to their cells. In addition, a minimum dataset (MDS), recording information pertaining to referrals, activities and outcomes, was created by the research team and populated by healthcare staff working in the Unit. Semi-structured interviews with 16 key stakeholders were also undertaken between January and May 2018. A number of informal discussions with mental health team managers in the region's prisons were undertaken as part of phase two of the project towards the end of 2019 and in early 2020. These sought to gain differing perspectives on how the Unit was operating.

Adaptation

As Brooker and Stone (2019, 1) have described, buildings can accommodate change; they evolve and are adapted 'as the needs and priorities of those who occupy them become different'. Attention has shifted over the last two decades or so to accommodating the needs of older prisoners (Moll 2013, Turner et al 2018), as well as improving specialist mental healthcare (Karadjian et al, 2013). In the 21st century, architects, designers, planners and other professionals engaged in shaping built environments, have become more readily engaged in a *tabula plena* approach (Brooker and Stone 2019; Roberts 2016), which involves the adaptation of existing buildings, rather than their removal and replacement. For many practitioners and theorists in these inter-related fields, the sustainability agenda has been key to this shift and interest in the transformative potential of adaptation (Ellin 2012). In this section, we explore how the interior of an existing wing was adapted to create the Unit's interior environment. We argue that whilst there was an initial adaptation to the interior design of the Unit prior to opening, that this process was incomplete and, therefore, ongoing

after the Unit became operational. Consequently, possibilities for adaptive co-design with patients as they moved onto the wing emerged.

Initial Adaptation

The wing allocated for the new Unit was itself the result of a previous, more extensive adaptation of the prison, which included the expansion of the current built environment through the addition of the wing in the 1990s. Although much smaller than the existing prison wings, the wing reflected some of the ideas dominant in prison architecture at the time (Dunbar and Fairweather 2000). It had just two floors housing a small number of cells and there was also some open, multi-purpose space on both floors. The ground floor held the custodial staff's office and there was a group therapy room with little external light and part of which was cave-like in its appearance due to its proximity to the outer wall of the prison site. A number of smaller rooms used for one-to-one meetings and storage completed the ground floor. Up on the first-floor landing, in addition to the remaining cells there were showers and then through a locked internal door, there was a large light-filled group room, as well as an office and common room with kitchen facilities that had been used by staff from the regional drug and alcohol recovery team (DART), who were the previous occupants of the wing.

In the weeks before opening, there were still considerable uncertainties over funding and the supply of materials, which would enable the interior re-design to be completed. Without any input from external specialists, local-level managers took decisions about how to re-design the space. The process was fragmented and population pressures meant that the space continued to be occupied by vulnerable prisoners whilst the re-design was being undertaken. During this time, the custodial manager was given a small budget for interior re-decoration

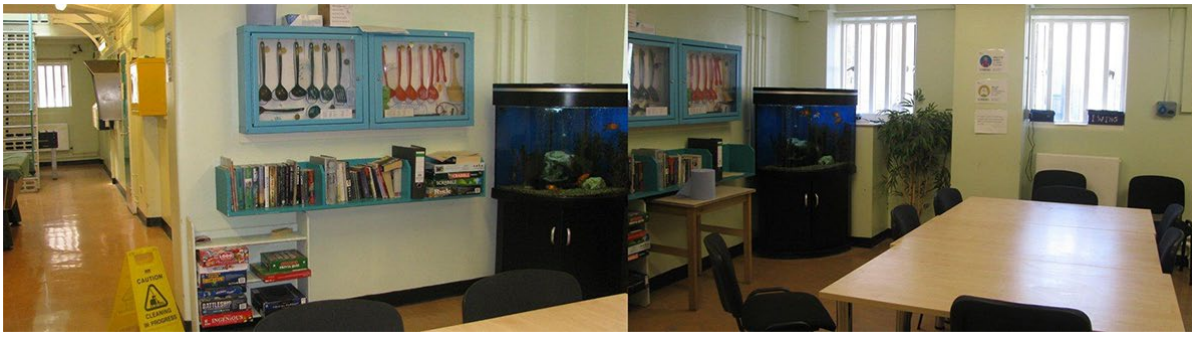
and this work was undertaken by prisoners on his instruction. Furniture had to be ordered from another prison within the region where there were long delays in fulfilling orders. At the same time, once key healthcare staff had been appointed, they were engaged in reconfiguring and re-designating the different rooms within the wing. The wing had previously operated in a similar way to community-based residential rehabilitation facilities and was configured and designed to meet their needs, with a focus on group therapy rooms, the walls of which were emblazoned with slogans familiar to recovery settings. The very different therapeutic regime from that operated by DART necessitated the creation of new facilities, as well as changes to the existing interior decoration, furniture and layout. For example, a ground-floor one-to-one meeting room had to be renovated to act as a dispensary with secure storage for medicines, washing facilities and healthcare supplies.

There were also changes to the staff work spaces. The separation of custodial and therapeutic staff, which had previously existed on the wing, was no longer feasible. The main reason for this was that the Unit was to offer enhanced observation to enable better diagnosis and treatment of mental health conditions. 'Any designated area within the prison will require necessary adjustments to ensure cell accommodation is suitable to conduct *constant supervision* and high levels of observation' (Project Proposal 2017). Observation had to be led by healthcare staff with support from their custodial colleagues, but the idea that this would involve adaptations to cell accommodation changed when it was decided that the Unit would operate a regime with prisoners unlocked from their cells during the day except for an hour after lunch. When healthcare staff were on the Unit, prisoners were often not in their cells, consequently healthcare staff could not be locked away from prisoners outside of formal sessions like their DART colleagues had been. Custodial colleagues made space for healthcare workers in the observation office on the ground floor. The upstairs group therapy

room, office and kitchen were surplus to requirements and became occupied by the in-reach mental health team with whom staff on the Unit worked closely.

Ongoing Adaptation

The Unit opened with many of the planned interior adaptations incomplete. For example, the showers on the first floor had not yet been made safe and usable for the vulnerable occupants of the wing and the ordered furniture had not arrived. However, aside from these planned changes, the initial adaptation had also not touched some areas of the Unit. In this section, we analyse how this led to ongoing adaptation of the interior space of the wing once the new occupants started to arrive.



<INSERT FIGURE 17.1 HERE>

Figure 17.1: The downstairs communal area on the Unit

The ground-floor communal area was not given a particular use during the initial adaptation of the Unit. It was situated immediately in front of the locked entrance corridor separating the Unit from the nearby prison wing. The wing's administrative office overlooked it on one side and to the rear was the exit to the outside space. The administrative office was the primary location in which to find staff during the day and also the key area in which healthcare staff

and prison officers mixed without the prisoners and undertook observations of the prisoners when they were unlocked.

The adapted interior design of the communal area emerged as the result of the healthcare staff trying to manage the behaviour of one patient, who was using food to block the pipes in his cell. They, therefore, obtained a small table and chair and situated them in the area in front of the office, to enable them to watch him whilst he ate. The lead nurse explained that after a few days, another patient sat down at the small table with this patient to eat with him and that this attracted other patients and prisoners and they brought in more tables and chairs from the large upstairs group room to accommodate them. There had not been any designated, freely accessible common space on the wing in which the patients and prisoners could interact with staff until this time. Meal times involved the prisoners eating in their cells. So, even though they were unlocked, the interior design of the wing inhibited the formation of relationships.

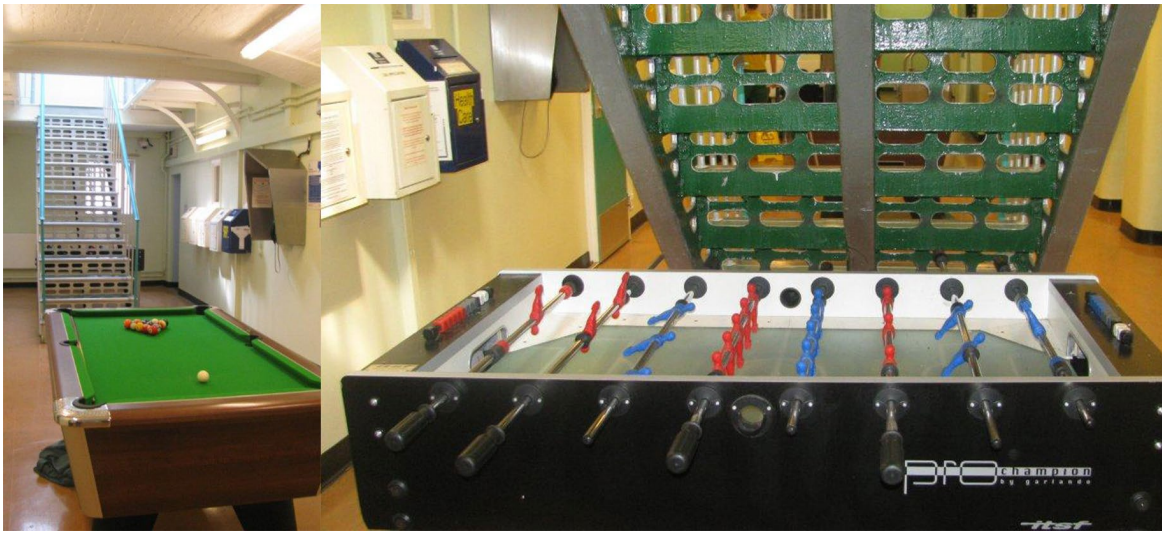
The tables were only part of what became the emerging materiality and ongoing adaptation of this centralised space on the wing. Analysis of this space can help us to better understand the competing priorities and constraints shaping custodial interior re-design, particularly within small units. Firstly, the cabinets with the locked utensils on the wall and the roll of institutional-size paper towel draw attention to the Unit as an institutional space, and not only that but an institution with a high level of control over the mundane aspects of the lives of those dwelling within it. In locking away the utensils in such a visible, but also practical, space, those using the communal area are reminded of the very intense and specific forms of control in operation on the Unit. In addition, these items also highlight two people, whose position was relatively marginalised in the planning and discussion of the operations of the Unit, but who in the context of everyday life are very visible in the material spaces of the

Unit itself – the two prisoner-cleaners. The *work* being undertaken on the Unit is not solely that of the prison guards and healthcare staff, but also the prisoners themselves. During the initial phase of re-designing this space, the needs of the prisoner-workers had been neglected, as the NHS England manager also noted in the previous section.

The next two items of note are clustered in the corner of the communal area – the fish tank and the plant. These items were placed in this area prior to the Unit opening and signify efforts on the part of the healthcare staff to introduce design elements found in other therapeutic spaces. In particular, the use of these items demonstrates an attunement to interior re-design that is beneficial to the mental health and wellbeing of the patients through 'green' (Moran 2019, Söderlund and Newman 2017) and 'blue' (Jewkes et al 2020) design. However, once the communal area began to develop, they became somewhat marginalised, as the specific care needs of the prisoners were determined and they were able to assert their own preferences in relation to the organisation of space and material objects.

A closer look at the wall upon which the utensils are hanging also highlights the increasing recreational use of the communal area after occupancy. The original shelf filled up with books and games and an additional small white unit of shelving had to be added to accommodate these materials. The growth of the communal area for recreational purposes was indicative of the *differential spatial* regime on the Unit, i.e. that the space of the wing was used and occupied differently than by prisoners elsewhere in the prison. This differentiation was primarily due to the patients and prisoners spending most of the day out of their cells, which as we have argued elsewhere (Cassidy et al, 2020) should not be interpreted as them being subject to less control than elsewhere in the prison.

Yet, the interior re-design of the communal spaces did not end with the area in figure 1, but began to shape neighbouring spaces on the ground floor. The unlocking of prisoners during the day shifted relationships between them and the prison officers (Cassidy et al, 2020). The ground-floor area became insufficient to accommodate the recreational activities integral to these relationships. The Unit went from having a handful of board games to a pool table and also table football (see figure 2), reproducing the recreational materiality often found elsewhere in prisons.



<INSERT FIGURE 17.2 HERE>

Figure 17.2: Pool table and table football on the ground floor of the Unit

Although small, the original design and layout of the wing had left open, flexible, multi-use space that could be developed through interior re-design.

Adaptive Co-Design

Approaches to custodial design within architecture tend to understand co-design as part of a more formal engagement with service users during the commissioning and planning of a building (Karthaus et al 2019). However, as noted in the section on the initial adaptation of

the wing, the re-design had to take place relatively rapidly and whilst other prisoners were living there. Consequently, engagement with users – both patients and the prisoner-workers - developed after the Unit had opened. In part, each of the prisoners that came to the Unit for assessment and treatment informed and shaped the unfolding design in smaller but also sometimes quite significant ways, as the example of the downstairs communal area illustrates.

> The quiet room has been used by two poorly lads for time-out rather than going back to their cells. However, the usage is variable and depends on who is on the unit. The current lads have decided to move the 'comfy' furniture down to the big room for acupuncture […]. The prisoners on the unit decide themselves how to use the space and furniture (lead nurse, October 2019).

This was enabled both by the original design of the wing, which had some flexible, multi-use spaces, as well as spaces left incomplete during its adaptation that provided prisoners and staff with opportunities to meet individual needs as they emerged. Such elements were not just ad-hoc but came to form a key part of the re-design of the interior space and its usage. We would argue, therefore, that this approach to co-design be understood as *adaptive co-design* developed through the ongoing nature of the adaptation process on the wing. In the following section, we explore how this adaptation was facilitated by an underpinning indeterminacy in relation to the interior re-design of the wing.

Indeterminacy

> [T]he notion of indeterminacy within architecture and the city not only halted the project of Modernism but also spawned several trajectories of design that embraced flexible, soft, dynamic and transforming systems to respond to the new needs of the expanding city and its pluralistic inhabitants (Kol and Zarco Sanz 2014, p.193).

In their analysis of Rem Koolhaas' work, Kol and Zarco Sanz (2014) argue that for architects, underpinning projects with indeterminacy involves the development of strategic tools that forces designers to think through how to make space for user improvisation and ongoing cultural mutations. Such an approach in architectural practice involves recognition of users as not simply passive or reactive, but as creative in their interactions with a space (Hill 2003). In this section, we explore how indeterminacy develops within a differing context, i.e. through experimental commissioning to address mental healthcare needs within prisons. Here, indeterminacy is less part of architectural practice and individual approaches to design and more the result of a confluence of the different actors involved in the commissioning and operationalising of the Unit.

The under-design that emerged from the initial adaptation phase and created potentiality for further adaptation of the wing was shaped by indeterminacy in the commissioning of the Unit. For us, the indeterminate approach can be viewed as a successful and replicable element of the Unit's interior design.

> There were two potential models but then we were offered one wing in [prison] because it is a remand prison. If there was unlimited funds, I would build a new wing. A designated hospital within the prison is the way it is going. The advantage is the

> process of moving people with acute need would be smoother and it would be dedicated for prison transfer (service manager, NHS Trust, April 2018).

The service manager suggested that there were two potential models developed for the Unit, one of which was to commission and build a new wing within a regional prison. However, it was clear that the key manager within the commissioning body had some reservations, which meant that the development of this model was not supported.

> At first, I did not like the idea. I was worried it would become a mini-hospital […] and that it and the prisoners would be stigmatised. However, I agreed to a trial and in hindsight it has worked well (manager, NHS England, April 2018).

Consequently, the project proposal focuses on identifying a space within the local remand prison that could be used for the Unit. The nature of the re-design and how that might specifically meet the needs of the prisoners were not defined in the proposal itself. The indeterminacy shaping the interior design of the Unit emerged not so much as part of a strategic approach by a designer (Kol and Zarco Sanz 2014) but as a strategy driven by the healthcare provider.

> The first step in this project will be to identify a specific area within [prison] that could potentially be used to care for and manage those prisoners with acute mental health needs, including those prisoners where an 'Access Assessment' may be required for transfer to secure hospitals. It is anticipated that this area/environment may require some changes/alterations to provide and promote specialist assessment, care and treatment (Project Proposal 2017).

This indeterminacy in terms of the re-design was due, in part, to no specific area having been identified prior to the development of the proposal. However, it was also the result of an approach that was based upon highlighting and identifying problems and gaps in current prison environment for assessing and treating prisoners with SMIs, rather than one which focused on clearly defining alternatives.

> Currently, there are no evidence-based guidelines to assist healthcare professionals and prison staff in making decisions about where a prisoner with often unmet mental health needs is managed within the prison, nor is there a designated area within the prison to offer enhanced therapeutic mental health care and observation, including specialist assessment, care and treatment. The healthcare unit in [prison name] has not been designed to manage prisoners with an acute mental illness and associated risks. Equally, the SACU/Segregation Unit is not a suitable environment to manage prisoners with an acute mental illness or on an open ACCT Plan (at risk of self-harm/suicide), and often placing patients there can exacerbate their problems and increase risk (Project Proposal 2017).

The project proposal refers specifically to the ways in which the healthcare unit's design excluded healthcare for SMIs. In contrast, the environment of the SACU is described as being harmful to these prisoners. Consequently, the focus for the proposers from the NHS Trust and the prison seemed to be upon securing space and funding for the Unit, leaving the re-design of any space to be determined at a later date. Nonetheless, the proposal does explicitly acknowledge that adaptation will be necessary. This is reflective of interior design

practice, as there is a need to know and work with the existing interior design and architecture in order to identify and prioritise changes for the re-design of the space.

As Tsing (2015, p. 47) has argued, '[o]ur daily habits are repetitive, but they are also open-ended, responding to opportunity and encounter'. In order for design to respond to the opportunities presented in everyday encounters, there has to be recognition of a level of indeterminacy embedded within the process, as Kol and Zarco Sanz (2014) explain. This is particularly the case in small units within prisons, which attempt to adopt an experimental approach (McGeachan 2019), and offer the potential to develop strategic tools for interior design that address diverse needs *in situ*.

> Generally the environment is more comfortable, less chaotic. There is more access to trained nursing staff and increased levels of observation. […] The key aim is to alleviate mental distress. […] It has an assessment function, to make a more thorough assessment and therefore a more reasoned identification of need (Unit consultant psychiatrist, April 2018).

As the psychiatrist explains, the determination of need is based upon the individual, rather than existing, top-down, generalised understanding that has informed some elements of prison architecture (Moran 2019, Jewkes 2018, Söderlund and Newman 2017). This is very important when we consider moving custodial design away from generalised ideas of health and well-being for the wider population to thinking about those with SMIs. Even amongst the 11 prisoners receiving care on the Unit,[6] there is considerable variation in terms of their

[6] After opening, the cells quickly became occupied. The Unit ran at full occupancy for most of the time due both to demand for the specialist services but also because of wider pressures and over-crowding in the region's prisons as a whole.

specific symptoms, diagnoses and treatment needs. The interior re-design of the Unit needed to enable this determination: a determination, whose complexity could not be within the purview of a custodial manager charged with interior re-decoration or even healthcare clinicians with experience of secure mental health care. For the psychiatrist, the Unit should offer comfort, quiet, calm, access to staff and opportunities for observation. The key impact is to alleviate distress that makes determining needs difficult in the wider prison. Indeterminacy in this context, therefore, created space in which diagnoses and treatment could become determined through intensive observation and assessment, as well as creating possibilities for prisoners to co-design the Unit alongside the staff. Nonetheless, there were still gaps in the interior design, which made it difficult to meet the needs of prisoners with SMIs.

Accommodation

The Unit was re-designed upon a foundation of *accommodation*, as it sought to create a safer space within the prison for those who were awaiting transfer to secure mental health units within the NHS. Our understanding of accommodation here draws together not only the creation of a physical space for prisoners with SMIs to reside within the prison, but also an acknowledgement that the Unit itself represented an arrangement that was not seen to be optimal by any of the actors involved. The optimal solution for these prisoners was that which was inaccessible to them – transfer to a secure hospital setting. This reflects an over-arching theme in literature on prison design, in which architects highlight that they cannot conceive of a 'good prison', but seek instead to offer design alternatives that are better than those currently on offer (Karthaus et al 2019). The positioning of the Unit as *between* prison and hospital had a significant influence over subsequent decisions on how the wing was re-designed and which elements of both types of institutions and regimes were incorporated.

We, therefore, draw upon sociological conceptualisations, which analyse accommodation as the processes and practices of relational adaptation that take place in a new context or setting. The Unit is like a bail hostel or a halfway house – a stepping stone halfway between prison and hospital' (mental health in-reach team manager, another regional prison, May 2018). The term halfway house was used to describe the Unit by a number of different actors. The implication was that the Unit occupied a position between a prison and a secure mental health unit, meaning that it possessed some, but not all, the design elements of each. During the process of designing the space for the Unit, managers were forced to make decisions surrounding which features of each setting were to be prioritised. In some cases, this meant having less of a particular design feature. 'We've only got two safer custody cells.[7] And I think, in an ideal world […] everyone would be a safer custody cell […] but whether they have the funds to do it, I don't know (manager, NHS England, April 2018).

This decision to include only a small number of safer custody cells reflects the approach we have seen elsewhere in the prison estate in England and Wales, when seeking to *accommodate* prisoners with severe disorders (Saradjian et al 2013). Here, a manager from the commissioner, NHS England, recognises that the Unit does not have all the features that would be expected in a secure unit. The manager's supposition that this was due to funding is confirmed in a conversation with a colleague from the NHS trust tasked with provided the service on the Unit.

> We are aware that the Unit does not meet [NHS] standards but that would be impossible without millions of pounds to bring it up to date. The point is that the

[7] Safer custody cells are designed to make suicide or self-harm more difficult, for example through the removal of any ligature points. On the Unit these cells were also fitted with smart glass to enable constant watch/observation.

> environment is not any worse than anywhere else in the prison estate (service manager, NHS Trust, January 2018).

> There are still ligature points in the cells, like pipes that are not boxed in. The prison is arguing these are 'known and manageable risks'. These are the functioning prison cells in an old Victorian prison, and the prison is limited by contracts. We were quoted approximately two thousand pounds per cell just to box the pipes in (lead nurse, October 2019).

Therefore, in accommodating the Unit on the wing, managers also required nursing staff to *accommodate* the absence of features that were considered foundational within secure units, thus shifting their professional practice, and also recognising wider constraints on re-design caused by the prison's contractual arrangements with service providers. The Unit did not offer a suitable alternative to a hospital setting for those patients at risk of suicide due to the existence of ligature points in the majority of the cells.

> We do this through offering a unique approach within the prison. We run a regime that has been developed to provide a therapeutic "ward-type" atmosphere whilst maintaining some of the prison routines to help people both get the support they need but also continue to have some of the routines needed to manage in prison (Service Operational Policy, 2019).

The official documents relating to the Unit also highlight that it does not offer all of the services found in a hospital setting. The operation policy describes a 'ward-type' atmosphere, i.e. something which is, in part, intangible.

The Unit not only lacked elements of secure unit design, but also some of those found in the wider prison. Whilst we might assume that departures from the design of the prison would be welcome, this was not always the case, as the manager from NHS England explained when asked about changes s/he would like to see to the Unit.

> I would say, probably, a more suitable environment for them to do the servery. They struggle to […] do the dishes and wash the things that they use on a daily basis. They've got to go through [neighbouring] wing, where it would be so much easier for the lads if they had, maybe, a sluice room, and then another area where they could do… not pots and pans, but you know, the… the dishes and stuff like that.

The size of the Unit (Cassidy et al 2020) meant that it remained dependent on the wider prison and made it difficult for the Unit's two prisoner-cleaners to carry out their duties effectively. They, like the healthcare staff, were also expected to *accommodate* these absences and resolve them through changes to their working patterns. These *accommodations*, in turn, shaped the physical environment of the Unit. The servery had to be stored under the stairs when it was not in use and was moved into the main communal area on the ground floor at meal times. Cleaning products and equipment often over-flowed into other areas of the Unit. Issues relating to the (re)design of the Unit were also evident outside.

> And possibly a bigger, more functional exercise yard. We've got a little, sort of, triangle out the back there. Whereas the other ones have got a big area with different machines and whatever on. And we've got a little triangle (manager, NHS England, April 2018).

Being situated *between* prison and hospital as a *transitional* space, it became apparent that the Unit lacked both some of the utilities of the wider prison, which limited its functionality, as well as the security of a hospital. Thus, in accommodating its in-between positioning, the commissioners and managers responsible for making decisions about the re-design of the Unit also imposed certain accommodations on the practices of staff and prisoners.

Custodial and healthcare staff working on the Unit found it difficult to accept these accommodations. They spoke frequently of alternative models for prisoners with specific care needs that they felt not only represented more radical re-designs of the custodial estate, but demonstrated a clearer understanding of the scale of the issues they were being faced with. As the manager of the custodial staff on the Unit stated, 'It needs to be bigger. I would have liked to see a brand-new unit like DSPD [Dangerous and Severe Personality Disorder]'.

Yet lead clinicians did not see the solution as lying within the custodial estate. For them, this was not solely a compromise in design emerging from economic constraints, but one that sought to navigate legal and ethical issues as well.

> In order to maintain a therapeutic atmosphere, we are limited. We are not a hospital, not a medium secure unit for legal and ethical reasons. [...]There has to be throughput. We have to move people. It's not a standalone unit (Unit consultant psychiatrist, April 2018).

Referring once more to the therapeutic atmosphere, the lead psychiatrist also describes a need for throughput; the design of the Unit needed to reflect that it is not, in fact, a hospital setting,

but part of the prison estate. In the psychiatrist's analysis, the Unit could prevent some of the trauma of moving between these two very different design settings by incorporating elements of both.

> The [Unit] provides a 'halfway house' between main location and specialist NHS locations […] This makes transfer to and from [the Unit] less stressful for prisoners (especially discharge back to prison) as the environments are not too different […] The switch between NHS and prison regimes can be traumatic for prisoners. [The Unit] can reduce this trauma (Unit consultant psychiatrist, December 2019).

However, the psychiatrist also spent just half a day every week on the Unit, speaking to patients and staff. S/he had little exposure to the everyday difficulties arising from the accommodations made in re-designing the Unit. It was apparent that the Unit itself represented a compromise, an accommodation, which led in turn to other accommodations that clearly unsettled some of the staff and did not offer the best options – design or otherwise – for seriously unwell prisoners. Nonetheless, the Unit offered significant improvement on the existing arrangements for accommodating these prisoners (Dyer et al 2020). The accommodations embedded in the Unit could only be realised through under-design (Dunbar and Fairweather 2000), which was supported by the wing's layout from its construction in the 1990s. In the next section we explore further how this under-design was able to emerge.

Conclusions

In this chapter, in response to the question of what works in custodial design, we have argued for a processual approach that is inclusive of re-design and adaptation of the existing prison

estate and analysis of everyday processes and practices shaping prison interiors. Whilst larger developments might offer the most transformative potential, within England and Wales, such smaller re-designs and adaptations also offer potentiality for changes that can significantly improve the custodial experiences of certain groups of prisoners. Re-design can create collaborative solutions that support minoritized groups for whom prison is particularly harmful, i.e. prisoners with severe mental illnesses. The potential of smaller adaptations does not match that of wholesale re-designs and new buildings, which can greatly improve the general health and well-being of the prison population. However, given the lengthy processes involved in such larger-scale changes (Karthaus et al 2019) within England and Wales, it is particularly important for those for whom existing environments are harmful – even fatal – that we remain open to the possibility of significant improvements to their safety through smaller, everyday interior re-design.

Our analysis highlights the potentiality for adaptive co-design within the re-design of interior spaces for mental healthcare within the prison estate. However, we have also suggested that the Unit within which the research was conducted was successful because of indeterminacy, which offered created scope for these ongoing practices of co-design of the wing's interior to emerge once it was operational, offering enhanced opportunities to meet the needs of specific prisoners and help them move on from acute mental health crises. Nonetheless, we have also acknowledged that everyday interior re-design is embedded in multi-layered processes and practices of accommodation. These accommodations involve not only making space for prisoners with SMIs within the existing prison estate (Cassidy et al 2020) but also sub-optimal arrangements from a healthcare and custodial perspective that changed professionals' practices.

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