Chapter 1
Introduction

For the great majority of these establishments [psychiatric asylums] there is no appropriate future use, and I for my own part will resist any attempt to foist another purpose upon them unless it can be proved to me in each case that, such, or almost such, a building would have had to be erected in that, or some similar, place to serve the other purpose, if the mental hospital had never existed (Powell, 1961).

In his 1961 opening address to the National Association for Mental Health, the then UK Secretary of State for Health, Enoch Powell, gave voice to what was to become one of his more felicitous contributions to society. He spoke of the imminent programme to close the network of psychiatric asylums and move to community-based care for people with mental health problems. Powell’s speech, characteristically convoluted, is generally remembered, and indeed named, for its reference to the water towers that in the UK almost invariably signalled the presence of asylums within the landscape. Less noted is the above quote, with its assertion that there is no appropriate future use for asylums. In this book, we draw upon 20 years of collective collaborative research to assess Powell’s bleak prognostication – primarily for psychiatric asylum sites but also for the idea of asylum – and to develop an understanding of the interrelated processes, operating at local and higher scales, that have acted to shape the fate of this treatment modality and the sites of its delivery. In so doing, we also wish to develop an appreciation of the traces of this once-dominant form of care in contemporary physical and cultural landscapes and of consequent implications for the remembrance of the psychiatric asylum.

Our subject matter demands an early statement about language. Mental health care is a fraught area in this regard, with linguistic preferences shifting and changing over time and place and also with respect to meaning. The facilities that are our central concern have been variously retreats, asylums, hospitals and homes. They have served lunatics, the insane, mad people, people with mental health problems and the mentally ill. More pejorative terms pervade popular discourse. We are acutely aware of the labelling and stereotyping that follows from this changing and contested terminology. In this book we use the term ‘psychiatric asylum’, which we contend to be neutral but meaningful. It conveys the focus of the institutions (psychiatric) and their underlying philosophy (asylum). For preference, we refer to people with mental health problems as the users of these facilities.

During an era of closure spanning the decades since the 1960s, with temporal epicentres varying by country, the psychiatric asylum was, at once, characterised as outmoded and ill-suited to the needs of contemporary health
care and stigmatised as a site of patient abuse. This made it all too easy to forget that at its inception more than 150 years earlier the psychiatric asylum was itself an innovation of considerable significance. In the early nineteenth century, the options for families who could no longer care, or arrange care, for people with mental health problems at home were limited. The psychiatric asylum represented a rejection of practises that had seen such people relegated to poor houses, private establishments or prisons, and sometimes exploited as spectacle or as a source of profit (Philo, 2004). The emergence of the idea of asylum epitomised a desire for order that diffused from Europe to the rest of the world. It manifested itself in a categorisation through which people with mental health problems were seen to be distinct and different from the likes of offenders, the indigent poor and other groups on the margins of ‘normal’ society (Foucault, 1967). In later years this ordering would be extended to differentiate further between mental health problems and learning disabilities and between the needs of children and adults.

Key characteristics of the idea of the psychiatric asylum included the notion of potential recovery in an ordered, secluded and generally rural environment away from the social stresses of an emerging industrial urbanised society. Coincidentally, this also catered to the sensitivities of families and society at large regarding mental illness by facilitating the removal of individuals whose behaviour was deemed in some way to be socially unacceptable. In addition to a calming, therapeutic landscape, recovery in asylum settings was also held to require opportunities for structured work. Early proponents of this approach, such as Tuke at the York (UK) Retreat, were instrumental in establishing the positive case for asylum. By the middle of the nineteenth century the case was widely and internationally accepted, being adopted by the state as a response to the growing mental health care needs of burgeoning urban populations that could neither be accommodated in the erstwhile private asylums nor afford their fees.

State involvement in psychiatric care involved an inevitable scaling up of the ‘private retreat’ in order to accommodate larger numbers and to do so at a lower cost. The institutions created were large and visually impressive, with leading architects of the time being employed in their design. They were built within extensively landscaped estates in locations removed, but not always isolated, from cities and other major centres of population (see Chapter 4). England provides some idea of the eventual extent of the network of state-provided psychiatric asylums and the scale of constituent institutions. By 1914 there were over 100 asylums. The great majority of these were ‘county asylums’, with most of the then 39 traditional counties and many of the 39 county boroughs having at least one facility. A small minority of asylums continued as private or ‘subscription’ facilities. London was served by some 16 asylums. Notable among these was the ‘Epsom colony’, a cluster of five facilities occupying a 405 hectare site to the south-west of London. Single site facilities were no less extensive. The former Colney Hatch Hospital featured monolithic Italianate buildings in 13 hectares on the outskirts of London. Sites of 80–160 hectares were not uncommon. Asylum
buildings were intended to impress and to stand out in their park-like grounds, and few failed in this regard. The upkeep of buildings and grounds and the care of patients provided considerable employment for those in nearby towns and cities and in the case of the more isolated asylums gave rise to single-purpose communities dedicated to the housing of asylum workers (Philo, 2004).

Across the world, the psychiatric asylum, made real in bricks and mortar, epitomised the delivery of mental health care well into the second half of the twentieth century, with many institutions surviving to celebrate their centenaries. It is these facilities that are the key focus of this book. The seeds of their fall from favour were evident early. Though built with the best of intentions to meet mental health needs, population growth was such that demand outstripped capacity within a few decades of their construction. Moreover, there was a realisation that for all its positive aspects, asylum did not necessarily result in cure for a significant subset of patients, with consequences for the throughput of resident numbers. Overcrowding emerged as a serious problem and was marked by the middle of the twentieth century. Yet the idea of asylum persisted – seclusion and separation remained a hallmark of mental health care. Although the monolithic asylum buildings in their isolated (and isolating) estates were supplemented by ‘villa developments’ intended to humanise the scale of provision but retain its key elements, the asylum nonetheless remained a key presence in the physical and cultural landscape into the latter half of the twentieth century.

While overcrowding and emergent evidence for ineffectiveness may have presaged the demise of the asylum, their well-documented final fall from favour resulted from further factors. The fine buildings of the nineteenth century were showing their age following years of heavy use by larger populations than were ever intended; repair costs were escalating. At the same time, earlier evidence for ineffectiveness was put into stark relief by the emerging availability of alternative treatments, notably those employing new drugs that enabled people to be treated outside institutional settings. Moreover, the institutional nature of the asylum was increasingly recognised as problematic. While isolation and seclusion may have initially been seen as components of effective care, they could also foster mistreatment and abuse. High profile scandals were allied to a recognition that overcrowded facilities often resulted in routinised and uncaring treatment that fostered a stigmatisation of mental ill-health (Goffman, 1961). The result of these diverse pressures was the decline and fall of the psychiatric asylum. This generated considerable challenges for governments and interest among academics. Geographers showed particular interest in the opening up of new spaces of care in the community for the treatment of the mentally ill, the process commonly referred to as deinstitutionalisation (e.g., Dear, 1978; Joseph and Boeckh, 1981; Smith and Hannam, 1981; Giggs, 1986; Moon, 1988; Kearns and Smith, 1993; Philo, 1997).
Closing Places and Opening Spaces

Thus far, we have traversed familiar and well-researched territory. There has been extensive scholarship on the history of the psychiatric asylum, asylum closure and the unfolding of the process of deinstitutionalisation. In contrast, our interest in this book lies in the under-explored territory of the post-closure fate of the asylum in the era of community care. We are interested both in the survival and re-framing of the idea of asylum and in the fate of asylum buildings and grounds. Our interest in this gap in knowledge emerged from our different but converging research concerns with deinstitutionalisation – work on the policy and human dimensions of asylum closure (e.g., Joseph and Kearns, 1996) and calls for the rehabilitation for the idea of asylum (e.g., Moon, 2000). These twin threads of interest were brought together by an opportunistic encounter with a surviving private-sector asylum in Canada (Joseph and Moon, 2002).

We see deinstitutionalisation as the basis for two challenges to the asylum: how to set up networks of community care and housing for former asylum residents; and what to do with large institutions, often with architecturally significant buildings on extensive, landscaped estates now deemed surplus. The former, patient-focussed challenge almost totally eclipsed the latter, institution-focussed challenge, both in terms of policy response and academic commentary. Notwithstanding the generally-accepted merits of moving to a community-based modality of care, contemporary accounts of deinstitutionalisation across various jurisdictions painted a picture that was anything but pretty (e.g., see Dear and Taylor 1982, Dear and Wolch, 1987). It proved easier to empty asylum wards and villas than to develop networks of community-based housing and care. The scale of the challenge comes into sharp focus when one thinks in terms of the ‘reverse economies of scale’ that were being encountered. Consider, for instance, the challenge of coping with the displacement of patients from even a relatively small psychiatric asylum, one with say 500 patients. A sub-set of patients, perhaps even a sizable one, would be deemed unsuitable for community care because of the severity of their illness. Places for these patients would need to be found in (expanded or newly created) psychiatric wards in general hospitals and provision made in budgets for their care and treatment. Assuming that one-fifth of patients fall into this category, there would remain 400 to be housed and cared for in the community. With say 10 residents as an ideal size for a group home, municipal planners would be tasked with finding 40 ‘suitable homes’ in ‘suitable neighbourhoods’ (Smith and Hannam, 1981; Moon, 1988).

With respect to the residential dimension of care, the well-documented Toronto situation in the 1970s and early 1980s was probably typical (Dear and Taylor, 1982). Municipal officials and advocates of community care tasked with setting up group homes found neighbourhood residents to be less than welcoming, as reflected in the catch cries ‘not on our street’ and ‘not in my back yard’, with the stigma of mental illness following affected individuals from the asylum into the community (Dear and Taylor, 1982). Planning frameworks were found to be
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glaringly inadequate for the challenge posed by deinstitutionalisation (Joseph and Hall, 1985). The result in Toronto, as it was in many other cities in North America and elsewhere, was the concentration of residential facilities in deprived, largely inner-city neighbourhoods permissive of ‘boarding house-type functions’ but arguably bereft of the supportive therapeutic environment imagined as ideal by advocates of community care. The aftermath of these planning conflicts were imprinted deeply in the lives of former asylum residents relegated to ‘landscapes of despair’ or ‘service-dependent ghettos’ (e.g., see Dear et al., 1980; Kearns et al., 1987; Kearns, 1990; Laws and Dear, 1988).

Our own collective engagement with this theme sought to re-incorporate the asylum into the critique of community care. Joseph and Kearns (1996) examined the then impending closure of Tokanui (Psychiatric) Hospital in the Waikato Region of New Zealand’s North Island. They considered the social and cultural costs associated with the closure of a psychiatric asylum – the ‘loss’ of symbolic identity as well as employment and the abandonment of asylum-based innovations in the culturally-sensitive treatment of mental illness among Māori. In a subsequent paper (Joseph and Kearns, 1999), they provided evidence for the re-criminalisation of mental illness. A similar theme was pursued by Moon (2000). Drawing on a discourse analysis of former contemporary mental health care policy in the UK, he was able to demonstrate that popular understandings of mental health and well-publicised failures of community care contributed to a revalorisation of the asylum. In this framing, it was regarded as a place where people with mental health problems could be treated safely and separately, away from a public increasingly concerned with the risks and dangers posed by the delivery of care in the community.

Despite these small incursions pointing to the continued relevance of asylum facilities and the idea of asylum in the era of community care, there remains little work on the fate of asylums. Discourse on mental health care has referred often to notions of survival (Parr, 2008; Pinfold, 2000): patients survive their illnesses and patients and those charged with their care survive the (often chaotic) processes of deinstitutionalisation. But what of the institutions? What was their fate? Was there a ‘life’ for them beyond closure? And what happened to the notion of asylum that had so dominated thinking about the treatment of mental illness for more than a century?

Developing an Approach

The very sparse international literature on the uses to which former asylums have been put is of two general types, the first presenting a snapshot of re-use in particular jurisdictions (or parts thereof) at particular times (Dolan, 1987; Lowin et al., 1998; Chaplin and Peters, 2003) and the second presenting case examples of re-use (Franklin, 2002; Maachi, 2003; Joseph et al., 2009; Kearns et al., 2010; Bowden, 2012; Kearns et al., 2012; Joseph et al., 2013). This relative lack of prior
attention to the subject matter of this book underlines the gap in knowledge that we seek to fill.

Notwithstanding the sparse prior literature, we found the three survey papers to be particularly useful in shaping our research strategy. In a US survey, Dolan (1987) sent questionnaires to 258 state hospitals, asking about changes to the size of grounds and buildings, 1970–1985. He found that 32 per cent of hospitals had undertaken property transfers involving 370 buildings and nearly 10,000 hectares of land. Of the new uses, 26 per cent were related to mental health care and 11 per cent involved correctional activities (e.g., prisons and juvenile detention facilities). Most of the other cases of re-use (53 per cent) involved activities such as recreation, education and housing. A decade later, and speaking to the results of a comprehensive survey conducted in 1996 of 206 large (> 100 bed) UK psychiatric and learning disability hospitals, Lowin et al. (1998, p. 129) reported that more than half of the sites made available through hospital closure were vacant and that “re-used land was most commonly deployed for agricultural, residential, education, leisure, business and other NHS activities”. A few years later, the emergence of residential development as a favoured re-use of former psychiatric hospital in the UK was coming into focus. Chaplin and Peters (2003) surveyed 71 hospitals in six areas of England to determine the proportion of hospitals still open and the fate of those that had closed. Preserved buildings were found on more than a third of the sites, often as part of ‘luxury’ housing developments. Indeed, the authors reported that six developments were “entirely private with no public access, often guarded by security guards” (Chaplin and Peters, 2003, p. 227).

Based on these surveys of the ‘fates’ of former psychiatric asylum sites, we posit a four-fold heuristic framework for our study. The fates within this framework are not exclusive categories; they can overlap and recur. Despite the ostensible demise of the asylum modality, the first fate is retention. Mental health care uses such as outpatient clinics or small residential facilities may remain on site; health care administrative functions may also persist or indeed shift to a former asylum site in tacit recognition of its locational advantage, ownership and historical associations. In direct opposition to retention lies dereliction, a second fate wherein sites and buildings constitute an unrealised asset, abandoned upon closure, with the ravages of time, weather, vandalism, neglect and infestation by animals and plants becoming increasingly evident. Short-term dereliction may precede two further fates. Some former asylum sites may be transinstitutionalised: there may be a recognition of the amenity value of the grounds and of site accessibility such that the architectural shell and the site of the closed asylum (especially in urban locations) is converted into another institutional use such a prison or a tertiary education campus. With this fate we borrow and reformulate a concept generally used to refer to the cycling of clients through community care providers in both the health and criminal justice sectors (Prins, 2011). In other cases, sites and buildings may be converted to residential uses through housing developments in converted asylum buildings or through new build on what otherwise amounts to a ‘brown field’ site. In some of these cases, the bounded character of the asylum lends itself
to the development of ‘gated communities’ where intruders are kept out where, formerly, patients were kept in. Both the transinstitutional and the residential fates may entail complete or partial demolition of asylum buildings as a precursor to redevelopment after a period of dereliction.

Turning to the fate of the idea of the asylum, our argument is two-fold. First, and in a direct way, the private sector in health care has continued to offer asylum to those who can afford its services. While in a sense complementary to the community care model pursued in the public sector, the persistence of a residually-based modality in the private sector has served as a reminder of the enduring public support for notions of psychiatric asylum. Second, the original links between asylum, therapeutic landscapes and seclusion have a powerful contemporary resonance. They have been deployed both as a tool for the ongoing marketing of care in the private sector and as a selling point underpinning the re-cycling of former sites, notably for housing purposes.

We use a suite of case studies to anchor the development and illustration of our conceptual framework and key arguments (Yin, 1989). Our case study approach allows us to consider process without separation from context and provides a lens through which to identify key cause and effect relationships as well as to distinguish the exceptional from the normative. It also allows us to build on and enhance the limited existing literature cited above. We draw our examples primarily from three countries – Canada, New Zealand and the United Kingdom. For the most part, these countries have been on convergent paths in terms of the evolution of attitudes toward mental illness and treatment modalities. The evolution of mental health care in New Zealand was, for instance, heavily influenced by approaches in Scotland (Brunton, 2011). In Canada, developments combined the thinking from the United Kingdom with innovations, especially in the design of asylum buildings, from the United States (Paine, 1997).

Against this backdrop of considerable shared experience, we note significant dimensions of divergence that insert important aspects of difference into the case studies. One of these is the presence of (Māori-European) bi-culturalism in New Zealand, which pervades all aspects of health care delivery in that country (Durie, 1999). Another, and perhaps an even more defining attribute of the New Zealand context, is that deinstitutionalisation – the closing of places (of asylum) and the opening of spaces (of care in the community) – was considerably delayed (Brunton, 2003). In New Zealand the process occurred some 25 years later than in either the United Kingdom or Canada. The fact that this transition did not occur earlier, in the 1980s or even the 1970s, is attributable to the piecemeal approach of the New Zealand government to mental health care. Indeed, Hall and Joseph (1988) go as far as to label the government stance on mental health care in those decades as ‘non-policy’; the lack of even a weak policy framework for deinstitutionalisation guaranteed an ad hoc approach to community care and the survival of asylums as the dominant modality of care into the 1990s. Delays in pursuing deinstitutionalisation meant that the policy debate on the closure of psychiatric hospitals and the opening of new spaces of care in the community was
overtaken and engulfed in New Zealand by the ideologically-driven restructuring of the welfare state (Joseph and Kearns, 1996). There was no such conflation of policy directions in the United Kingdom, where successive waves of closure proceeded in the 1970s and beyond, notwithstanding local opposition focussed on the loss of employment opportunities and suspicion of the community care option (Jones, 1993).

A second important point of divergence relates to the dramatic shift in the role of the state in the provision of all aspects of health care in Canada in the 1960s. In that country, a growing and increasingly radical critique of asylum-based care (Dear and Taylor, 1982) coincided with a groundswell of support for the introduction of socialised medicine (Vayda and Deber, 1992). In contrast, in the UK and New Zealand there was little challenge to the persistence of well-established mixed public-private health care provisioning in the 1960s. Thus, in Canada thinking about the future role of asylum-based care in that decade and beyond was coloured by issues of hospital ownership and access to the new stream of government funding for all types of health care. Similar debates about the role of the public and private sectors characterised the United Kingdom following the election of a reform-minded Conservative government in 1979. In this case, the situation was one in which the dominant socialised model of health care was challenged by both the rehabilitation of the private sector generally and the introduction of fiscal measures enabling the growth and success of private care providers, most significantly in the care of the elderly but also in mental health care (Pilgrim and Rogers, 2001).

Other salient aspects of national context will be drawn out later in connection with specific analytical themes, but one final general attribute is worthy of immediate comment. New Zealand, with a population of a little over 4.5 million is by far the least populous of the countries from which we draw our case studies, with obvious implications for the scale and number of health care facilities. Consequently, by including New Zealand case studies in the examination of virtually every theme addressed, we ‘over-sample’ from that country. However, this brings with it the benefit of being able to generalise more definitively about the New Zealand situation than that in the other two countries, Canada and the United Kingdom, from which we draw the majority of our case studies.

In choosing case study institutions we had to draw boundaries without sacrificing the possibility of learning from parallel situations in which ideas that underpinned institutions and the physical fabric of those institutions were recycled. We have set aside from consideration more ephemeral treatment facilities. In all three of the countries introduced above there were, for example, residential institutions set up during each of the two world wars of the twentieth century to deal with service personnel with various physical and mental health problems. Such facilities were short-lived and small in scale compared to the major psychiatric asylums and did not have a comparable presence in the cultural landscape. Our focus has been on major established and long-lived facilities that
were, and in some cases still are, fully integrated into the landscape of mental health care provision in the respective countries.

It is their visual presence and strong, almost visceral, cultural identity that makes these facilities such a distinctive example of the nineteenth century proclivity to establish networks of institutions to deal with health and social issues. The list of contemporaneous institution-building initiatives is both impressive and daunting – sanatoria, homes for the physically disabled and for the intellectually disabled, workhouses (although these pre-date the period under discussion here), industrial schools, facilities for the assimilation of particular ethnic groups, isolation hospitals and orphanages – to name but a few. However, it was only the asylum that combined three important sets of characteristics salient to our study. First, and as mentioned earlier, the asylums were large in number, built on an impressive scale and sited in large, often park-like estates. Second, they were long-lived and developed strong linkages with their local communities, through employment as well as service provision. Third, and arguably of greatest significance, the stigma attached to mental illness and to the sites of its treatment was (and still is) of a nature and intensity arguably matched only by prisons. This stigma seems resolutely to transcend time and place, in part because of the prominence of gothic horror images of the asylum in popular culture (see Chapter 7). We will acknowledge (and unpack) the various and several impacts of this stigma on the memorialisation, remembrance and re-use of individual institutions and on the re-deployment of the concept of asylum.

Notwithstanding our focus on the psychiatric asylum and on related developments in mental health care policy and delivery, we selectively draw insights from studies of the re-use of other types of institution, such as those noted above, and from scholarship which probes the interconnection and inter-penetration of the built and cultural landscape. By inter-penetration we refer to the processes by which aspects of the built landscape are given shape and meaning culturally, but which then, by their very existence (or persistence), transform the cultural landscape. This stance leads us to different literatures and constituent concepts, covering a diverse range of topics such as the re-use of contaminated brown-field sites, the adoption of ‘asylum-related’ imagery in the marketing of gated communities, and urban exploration. We hope that, in turn, our insights into the re-use of the former psychiatric asylum will inform theorisation in those fields of inquiry.

**Structure of the Book**

The remainder of the book is organised in seven chapters. Chapter 2 sets out the major ideas upon which our understanding of the recycling of the psychiatric asylum is built, noting first the overarching importance of policy. We then observe the difficulties associated with defining ‘closure’ for particular institutions (and associated challenges of developing closure narratives) and the complex ways in
which the asylum and the layers of stigma associated with it can be deconstructed. We also point to the importance of landscape, both as metaphor and as the medium in which traces of the psychiatric asylum are preserved through heritage conservation. Specifically, we introduce critical ideas associated with memory, focussing initially on the concepts of memorialisation and remembrance. We then go on to introduce two further ideas that we have developed in association with our investigation of the recycling of the psychiatric asylum – strategic forgetting and selective remembrance. Following a discussion of the interplay of time and space in the recycling of the idea of asylum buildings and sites, the chapter concludes with a short discussion of the methods employed in our research, both generally in relation to our chosen strategy of case study research and in connection with particular lines of inquiry.

Chapters 3 and 4 deal with two aspects of survival. In Chapter 3 we consider the persistence of the idea of asylum in an era of community care and highlight the role of the private sector in its contemporary re-formulation. Case studies of the Homewood Health Centre (Canada), Ashburn Hall (New Zealand) and the Priory group (United Kingdom) are used to illustrate survival and business strategies. Particular attention is paid to the importance of marketing generally and to the specific use of ‘imagining’ to re-work, revitalise and re-deploy notions like therapeutic landscape to sell the concept of asylum. We note that such strategies blur the boundaries between sites of mental health care delivery and facilities such as health spas and sanatoria, both in terms of the business strategies employed and the celebrity culture sometimes invoked. Chapter 4 considers the persistence of mental health care activities on former asylum sites retained within the public sector. We consider the retention of specific aspects of care and the balance between full and partial retention. Where core (residential as well as out-patient) psychiatric services continue to be delivered on former asylum sites, efforts to escape the long shadow of the past are noted in initiatives to re-name and to obliterate iconic buildings or other reminders of the past. Case studies consider the journey to retention in the UK, using the example of St James’ Hospital, Portsmouth. This example is complemented by a consideration of the re-emergence of residential care as a treatment modality in Ontario and the persistence of ‘forensic care’ in all three of our case study countries. Forensic care caters to people at the interface between the health and criminal justice systems and is generally highly stigmatised. As a novel twist and coda to Chapter 4, we touch on the commemoration of the asylum era through on-site museums, with Porirua (New Zealand) and Glenside (United Kingdom) offered as examples. We connect this psychiatric museology back to the theme of survival by noting that the continuation of mental health services on former asylum sites itself constitutes a living memorial to the heritage of asylum care.

Chapters 5 and 6 present case studies of the recycling of asylum sites into other institutional uses and residential uses respectively. Tertiary-level education is used to illustrate the mechanisms involved in the asylum fate we term transinstitutionalisation. Two case studies, Lakeshore Hospital/Humber College
(Canada) and Carrington Hospital/Unitec (New Zealand) are considered in detail, with additional insights drawn from Challinor/University of Queensland (Australia) and Kalamazoo/Western Michigan University (USA). Strategies to ‘purify’ space and mask the former asylum use – which we refer to as strategic forgetting – are examined. Examples of deliberate memorialisation are set against the dominant trope of distancing from the past. In Chapter 6, in the examination of the recycling of asylum sites and (sometimes) buildings for the residential fate, we extend the consideration of strategic forgetting through illustration of complementary practises of selective remembrance associated with re-naming and re-imagining in marketing. Drawing primarily on three examples – Graylingwell and Knowle (both in the United Kingdom) and Sunnyside (New Zealand) – we examine adherence to heritage designations and land-use controls as a key tension. We describe how the peripheral (and attractively landscaped) sites of many asylums have led to their appeal for housing and transformation into (paradoxically) gated communities. We round out this consideration of what is emerging as a dominant re-use of asylum sites by considering parallels and contrasts with the re-use of military and industrial sites and infrastructure.

Chapter 7 deals with the significant number of former asylum sites that remain in a state of dereliction, our remaining fate. We consider the literal and metaphorical isolation of these abandoned sites and reflect on their presence in a postmodern landscape as spectral reminders that evoke memories and images of what was once mainstream and is now ‘other’. We note the perverse attraction evoked by dereliction, enhanced sometimes by the conversion of former asylum buildings into ‘horror attractions’ but almost always underlain by a fascination with the imagining of the gothic asylum. Recent scholarship on haunting and spectral geographies is used to frame an interrogation of discourses on the derelict psychiatric asylum evident in the ‘blogs’ of individuals committed to the exploration of abandoned buildings and landscapes. Analysis of ‘bloggings’ for a number of former psychiatric asylums, including some of those used as exemplars in earlier chapters, reveals the identification of derelict sites as not only places of danger and discovery, but also as places where particular images of the psychiatric asylum are recovered and remembrances created.

Chapter 8 offers a series of conclusions concerning the fate of the idea of asylum and of its former sites. We see in the creeping distrust of the state-promoted panacea of community care an opportunity for at least the idea of asylum to be rehabilitated. However, we wonder whether such distrust is sufficient to transcend the stigma that still weighs down the memory of the psychiatric asylum. In terms of the re-use of former asylum sites and buildings, we reflect on the importance of location within the context of an urbanism that increasingly values brown-field sites and has exhibited a willingness to manipulate, if not accept, a challenging history of institutional use. We note that recent successes in combining heritage conservation with (profitable) housing re-development suggest that a number of former sites currently derelict may soon be swept up by eager developers and that intensification and/or diversification may occur on sites redeveloped in earlier
decades. We also suggest that the overarching reality is one of mixed re-use in which paradoxically the re-appearance of residential mental health care will play a part. Where such mixed re-use does not occur, we believe that the on-going re-development of sites and buildings will make it ever more difficult to discern the traces of the asylum in the physical landscape, such that popular culture, with its interest in imaginings as much as memory, may be more important as a source of long-term remembrance of this previously-dominant mode of mental health care delivery than any physical traces in the landscape.