Social Science and Medicine manuscript #: SSM-D-13-00286

Title:

Spaces for smoking in a psychiatric hospital: social capital, resistance to control, and significance for 'therapeutic landscapes'

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Acknowledgements:

The research reported here forms part of a larger project, funded by the National Institute for Health Research, UK: *Evaluating the implementation of a new psychiatric inpatient facility, a mixed methods approach.* The research ethics protocol for this project was approved by Sunderland NHS Research Ethics committee and the School of Medicine and Health Research Ethics Advisory committee, Durham University. The views expressed here are those of the authors and not necessarily the funding body.

Abstract:

This paper reports on research framed by theories of therapeutic landscapes and the ways that the social, physical and symbolic dimensions of landscapes relate to wellbeing and healing. We focus especially on the question of how attributes of therapeutic landscapes are constructed in different ways according to the variable perspectives of individuals and groups. Through an ethnographic case study in a psychiatric hospital in the North of England we explore the perceived significance for wellbeing of 'smoking spaces' (where tobacco smoking is practiced in ways that may, or may not be officially sanctioned). We interpret our findings in light of literature on how smoking spaces are linked to the socio-geographical power relations that determine how smoking is organized within the hospital and how this is understood by different groups using the hospital building. We draw on qualitative research findings from discussion groups, observations, and interviews with patients, carers and staff. These focused on their views about the building design and setting of the new psychiatric hospital in relation to their wellbeing, and issues relating to smoking spaces emerged as important for many participants. Creating and managing smoking spaces as a public health measure in psychiatric hospitals is shown to be a controversial issue involving conflicting aims for health and wellbeing of patients and staff. Our findings indicate that although from a physical health perspective, smoking is detrimental, the spaces in which patients and staff smoke have social and psychological significance, providing a forum for the creation of social capital and resistance to institutional control. While the findings relate to one case study setting, the paper illustrates issues of wider relevance and contributes to an international literature concerning the tensions between perceived psychological and psychosocial benefits of smoking vs. physical harm that smoking is likely to cause. We consider the implications for hospital design and the model of care.

Key Words: North East England, UK, smoking spaces, psychiatric hospital design, power and place, social capital, resistance to control, therapeutic landscapes

Introduction:

This paper reports on research framed by theories of therapeutic landscapes and the ways that the social, physical and symbolic dimensions of landscapes relate to wellbeing and healing. We focus especially on the question of how attributes of therapeutic landscapes are constructed in different ways according to the variable perspectives of individuals and groups. Through an ethnographic case study in a psychiatric hospital in the North of England we explore the perceived significance for wellbeing of 'smoking spaces' (spaces in and around the hospital where tobacco smoking is practiced in ways that may, or may not be officially sanctioned).

Spaces for smoking in hospitals are controversial, since there are clinical arguments for preventing smoking to protect physical health. However, as we discuss below, smoking spaces are also perceived to be significant for the psycho-social wellbeing of patients and staff and, for those who smoke, are seen to contribute to the 'therapeutic landscape' of the hospital. As we discuss below this raises interesting questions about the social and symbolic construction of what constitutes a 'therapeutic landscape'.

The theoretical basis for this study draws substantially on the therapeutic landscape literature developed within the field of health geography and beyond (e.g., the anthropology of health) over the past two decades (Gesler, 1992, 2003; Curtis, 2010; Williams, 1999, 2007). Briefly put, the therapeutic landscape concept proposes that health situations in places can be considered as consisting of three interconnected environments: (a) natural and built physical environments; (b) social environments, including social relationships; and (c) symbolic environments, which emphasize the importance of meaning (Curtis, 2010). Studies of hospital design have a decades-old history of a focus on how to make physical environments therapeutic (e.g., Canter & Canter 1979; Ulrich, 1984; Philo, 2004). However, a study of an inpatient mental health unit in East London (Gesler, Bell, Curtis, Hubbard & Francis, 2004; Curtis, Gesler, Fabian, Francis & Priebe, 2007; Curtis, Gesler, Priebe &

Francis, 2008) found that contemporary assessments of the designs of health care buildings by the UK National Health Service (NHS), and studies of hospital design in general, tended to neglect social and symbolic landscapes. Of particular importance to this study are the ideas that social dimensions of therapeutic landscapes may include the formation of social capital within health care settings and symbolic dimensions may include the development of opposing feelings of stigma and empowerment.

As work on therapeutic landscapes evolved, the field of study widened and deepened, and it was soon recognized that therapeutic landscapes are complex and contested (Geores & Gesler, 1999). Indeed, not only do different features of physical, social, and symbolic environments have either positive or negative impacts on different participants in health care settings (Wakefield & McMullan, 2005), but human interactions and 'relational dynamics' within potentially therapeutic spaces (Conradson, 2005; 2007). The enactments and performances that are carried out 'in and with place', such as socialising behaviours or exclusions of certain groups (Foley, 2011, p. 476-477), may influence and shape therapeutic outcomes. Collins and Kearns (2007) focused on the tensions between enjoyable sunbathing and risks from ultraviolet radiation, highlighting how the New Public Health Agenda and related health promotion discourses emphasise the health risks associated with activities that may also be deemed to be pleasurable. These discourses may be effective as a means of influencing behavioural change, but may inadvertently lead to a disrupted sense of wellbeing.

In terms of our study on smoking spaces within the psychiatric inpatient facility the initial landmark, which has served to shape smoking within the context of institutions was the 2006 Health Act. In 2006 the Health Act in Britain (GB Parliament, 2006) specified that almost all enclosed public spaces, including vehicles and work spaces, were to be 'smoke free', though exemptions were made for *'any premises where a person has his home, or is living whether permanently or temporarily (including hotels, care homes, and prisons and*

other places where a person may be detained)' (Health Act 2006 chapter 28). Mental health facilities were only granted temporary exemption for a year, after which time all indoor smoking areas were to be 'removed' (Ratschen, Britton & McNeill, 2008). Some of the high-security forensic psychiatric inpatient facilities in England (e.g. Rampton Hospital in Nottinghamshire), responded by banning smoking altogether (Cormac, Creasey, McNeill, Ferriter, Huckstep & D'Silva, 2010). However, implementation of such complete smoking bans and smoke-free policies in psychiatric facilities are acknowledged to be challenging, and open to debate (Ratschen, Britton & McNeill, 2009; see also Haller, McNeill & Binder, 1996; Lawn & Pols, 2005; Wye, Bowman, Wiggers, Baker, Knight, Carr, Terry & Clancy, 2010). Some psychiatric hospitals, such as the one where we conducted our research, have chosen, rather than instigating a complete ban on smoking, to regulate smoking among patients and only allow it in certain outdoor spaces, while staff members are required not to smoke at work. In this paper we explore some of the reasons for such a compromise and the implications for the design and use of the hospital as a therapeutic landscape.

Rates of smoking among people with mental illness are often higher than those found in the general population (Ballbe, Neiva, Mondon, Pinett, Bruguera, Salto, Fernandez & Gual, 2011; Esterberg & Compton, 2005; Goff, Henderson & Amico, 1992; Lawn, Pols & Barber, 2002; Olivier, Lubman & Frazer, 2007; see also HDA 2004). This may be partly because smoking has certain perceived social and psychological benefits, seen by those who smoke to outweigh the physical health risks (Hirshbein, 2010). For example, smoking may be used as a form of relaxation which alleviates stress. It may be seen as a psychological support and facilitator for social interaction with other smokers, helping to alleviate the isolation that often accompanies mental illness. Exercising the choice to smoke may seem to provide sense of empowerment in an aspect of one's life, which may be important for relatively disempowered groups (Kagan, Kigli-Shemesh, Tabak, Abramowitz & Margolin, 2004; Lawn et al., 2002). Thus, according to Ritchie, Amos and Martin, (2010, p. 461) "*[c]ultural and social contexts are important in shaping smoking behaviours*." It has

also been suggested that nicotine is seen as a form of self-medication, which may "alleviate some side effects associated with anti-psychotic medication" (HDA 2004, p. 5). There may also be a lack of advice and support given to people with mental health problems who may want to give up smoking (Department of Health 2011, p. 20), and there is some discussion as to whether smoking may in itself be one of the possible trigger factors of psychological ill health (Boden, Fergusson & Horwood, 2010; Pasco, Williams, Jacka, Henry, Nicholson, Kotowicz & Berk, 2008). Even though the practice of cigarette smoking may in fact be unhelpful for their psychological as well as physical state, smoking cessation may therefore be more difficult for some of those experiencing mental health problems.

In a psychiatric hospital setting, smoking may 'play a central role in social interactions on the ward', and staff may seek to control patient's access to smoking as a mechanism of social control as well as a health protection measure (Oliver et al., 2007, p. 572; Skorpen, Anderssen, Oye & Bjelland, 2008). In a study undertaken in a psychiatric setting in Norway, Skorpen et al., (2008) describe the smoking room 'as [the] 'patients' sanctuary' and 'a place for resistance', which enables patients to retain a certain amount of control over their identity and their dignity in what would otherwise be a powerless situation.

These arguments are also supported by socio-geographical literature which shows how smoking behaviour is related to social geographies of power, resistance and social capital, which we elaborate on in the following sections of this paper before moving on to discuss our methods and findings.

Spaces of power and control: regulation of smoking spaces

There are a number of ways in which power and control operate through the regulation of smoking spaces. One of these is through the visible signs and floor markings, which are used to territorially demarcate the areas of public space in which smoking is either allowed or prohibited (Poland, 2000, 2006; Colgrove, Bayer & Bachynski, 2011). In places

where there is no such demarcation, the situation can be ambiguous, and under these circumstances, smokers are required to determine and monitor the applicability of smoking regulations (Poland, 1998, p. 216), an act which requires a clear understanding of the socio-geographical context. For example, in England smoking is now no longer allowed in enclosed public spaces or public transport. The formal legal sanctions which enforce compliance to the regulations may include fines for smoking in a space that has been designated as 'smoke-free' (see: Health Act 2006, chapter 28).

Emphasis is also continually placed on the benefits of smoke-free environments (Bell, Salmon, Bowers, Bell & McCullough, 2010; Colgrove et al., 2011), and social sanctions may consist of negative public reaction and embarrassment that the smokers may experience if they are found smoking in places where it is forbidden (Poland, 1998, 2000). Sanctions such as this can be seen to be part of the process of 'denormalisation' and stigmatisation that smokers increasingly experience. As a way of dealing with the stigma, smokers may withdraw from socialising with non-smokers, and they may adopt strategies of secrecy to hide their smoking status (Stuber, Galea, & LInk, 2009). For people with mental health problems, anti-smoking policies and institutional practices designed to protect their physical health may actually be experienced as coercive, inducing a 'double' sense of stigma, associated with their status both as smokers and as people with mental illnesses, and leading to an erosion of their quality of life (Link, Castille & Stuber, 2008).

Spaces of resistance: smoking as subversive or assertive behaviour

One way of avoiding the stigma attached to smoking is through self-regulation, which varies according to the setting one is in. For instance, some people practice secret smoking in some places and with some social groups, while avoiding it in other public spaces, effectively oscillating between a 'smoking' identity and a 'non-smoking' identity, depending on the social context (Stuber et al., 2009; Thompson, Pearce & Barnett, 2009). The way in which some people practice secret smoking can be seen to relate to Foucault's notion of

'governmentality', described as 'a subtle balance between technologies of power and technologies of the self which operate to produce apparently self-governing subjects' (Thompson et al., 2009, p. 567). Especially relevant for this paper is the idea of 'hidden spaces' for smoking, in which people contrive to smoke 'subversively' although they are outwardly compliant with smoking restrictions in public places. As explained below, asserting one's choice to smoke, even in a clandestine way, may also be experienced as a form of self-empowerment.

Geographies of social capital: smoking spaces as access to social networks and resources

Access to smoking spaces may also have social and psychological benefits for the wellbeing of patients and staff, by enabling them to gain access to social capital in terms of access to resources and to build up stronger social relationships and networks. Within the literature on social capital there are two main theoretical perspectives (Fulkerston & Thompson, 2008). The first of these is concerned with *normative* arguments about social capital, focused on the idea of shared social values in society as a whole, associated with high levels of trust and social cohesion in communities with strong social capital. It is acknowledged that normative social capital may facilitate 'collective action' (see: Fulkerson & Thompson, 2008, p. 554) and can help to promote healthy behaviour, for example, by discouraging smoking. A second theoretical perspective interprets social capital in terms of *access to resources* whereby certain behaviours and practices are used to express membership of social groups and may provide a means to gain access to benefits and resources associated with group membership (see: Bourdieu, 1983, 1984; Portes, 2000). Although general social condemnation of smoking may disempower smokers (Poland, 2000), this may be offset by the sense of collective identity and support that individuals feel when they are part of a group of smokers. To some extent both aspects of social capital may be operating in the case study we present here.

In this paper we explore these arguments through a case study regarding the design and use of a psychiatric hospital. We focus on the perceived significance of spaces used for smoking, and their importance for wellbeing of patients, staff and others using the hospital buildings. We discuss how this is associated with the socio-geographical power relations that influence smoking behaviour and how our findings contribute to theorisation and practical application of ideas about therapeutic landscapes.

Context and methods:

We report below on qualitative research findings which were part of a larger University research project, funded by the UK National institute of Health Research to evaluate the transfer of services from an old to a new psychiatric hospital building. The case study was located in North East England and took place over a period from just before the move to newly built premises (referred to as the 'New Hospital') until about six months after the move. Informants discussed how this 'New Hospital' compared with the older facilities it replaced. The replaced facilities consisted of the 'Old Hospital' buildings, that originated as a 19th Century asylum, located on an adjacent site, and a 'General Hospital' where psychiatric wards had been provided as part of a general inpatient facility (located a few miles away).

The research reported here drew upon mixed-methods, ethnographic approach involving participant observation, non-participant observation and conversations with participants in interviews and discussion groups. A diverse set of methods were used since one method alone would have limited the scope of engagement with the range of informants and settings of interest. For example, patients who were seriously ill could not, for ethical and practical reasons, be involved actively in methods such as interviews or discussions, but their experiences might be observed while observational techniques alone would not have provided the same degree of information on the perceptions of groups of people involved. Also 'triangulation' of findings derived from different methods helped us to validate our interpretation of findings from each source.

Participant observation was carried out by two of the authors, who took part in what has been referred to as a 'habitation exercise' carried out in April 2010 just before the new hospital was opened for patients. NHS staff and other related professionals were invited to be 'volunteer patients' for a 24 hour period, during which they were resident at the institution, staying overnight in the forensic wing of the hospital. The exercise was aimed at enabling the forensic medical team to test their operational and security procedures. Volunteers were given an insight into aspects of the patient experience. For instance, the volunteers were searched at the beginning of the exercise before being allowed to enter the hospital premises, and various items that were deemed to be contraband or 'risky', such as lighters, lip balm, body spray and a metal spiral bound note book, were confiscated. Volunteers were then provided with a list of timed activities to attend and details about mealtimes and other aspects of the regime such as medication. Volunteers were also continually supervised by staff, who ensured that the volunteers followed the ward rules and procedures. Taking part in this exercise as volunteers provided the researchers with an opportunity to experience the setting and ward environment. The rules and restrictions on smoking were a reoccurring feature in the notes of one of the researchers [VJW], who was a smoker. Following the 'habitation exercise' twelve out of twenty-seven habitation participants also took part in three 'habitation discussion' groups, aimed at capturing their views and experiences on their stay (see below). The topic of smoking was an issue which was raised in all three of these discussions (unprompted by the discussion group facilitators).

A series of ethnographic observations were also made by one of the authors [IHS], at the 'Old Hospital' and the 'New Hospital' prior to opening and once it was operational. The observations included spending time on both the forensic and acute psychiatric wards and talking to both staff and patients. The researcher also attended some of the ward meetings. Observations were aimed at collecting detailed information on the issues that were the focus of the research (Hammersley & Atkinson, 1995), such as life on the ward and in particular the ward environment and how this influenced and was influenced by interactions between

staff as well as between patients and staff. The researcher who undertook the observation was a qualified, registered mental health nurse who already had a substantial amount of previous experience of working in other mental health inpatient settings. The presence of the researcher and the purpose of his observations were announced to ward staff and patients before observations took place. Field notes were recorded overtly, close to the time of the observation taking place. Some references to smoking were made in the researcher's field notes and are reported in the findings below.

The other main methods of data collection used were discussion groups and interviews with patients, staff (including senior members of staff and clinicians) and carers. Participants had the option of participating in either a discussion group or an interview in order to accommodate their own preferences and work schedule. The aim was to include participants from the different groups of people using the hospital, who would be likely to have varying perceptions of the hospital setting and environment, and who would therefore be able to reflect and comment on the building and environment from their different positions. Recruitment was by means of voluntary response to advertisement through the hospital wards and carer and patient groups in the community. In all, the study included 114 participants. In brief, these included 5 individual interviews and 11 discussion groups, with 17 patients, 25 staff and 1 family carer of an acute inpatient, and 12 volunteers from the habitation exercise described above. Further details of participants are summarised in Electronic Appendix table 1 [Link to Electronic Appendix] although for ethical reasons we were not able to collect full personal details.

The discussions and interviews that we draw on for this part the research took place between April 2010 and March 2011, and encompassed three phases: in the weeks just before the move (during March and April 2010), immediately following (May to September 2010) and a few months after the move to the new hospital (December 2010 to March 2011). The aim was to explore perceptions of the hospital as a therapeutic landscape and

discussions and interviews were open ended and framed around a central question: ‘which aspects of the old or the new building are good or not good for the wellbeing of patients, carers and staff using the hospital’. The question was designed to allow participants to express their views on the different aspects of the hospital building that were perceived to be most important for the wellbeing of different groups of people using the hospital. The approach used to conduct this part of the research was based on similar techniques that were used by two of the authors in a previous study in a different location (Curtis et al., 2007, 2008).

All of the discussions and interviews were digitally recorded and transcribed verbatim. Following the first two phases of the research a thematic analysis of the data was then conducted independently by three of the researchers working on the project. Following this the researchers met to discuss the main themes that seemed to be emerging and which participants considered to be important. This process of ‘intercoder reliability’ is often used in data analysis to validate the findings and prevent researcher bias (Ryan & Bernard, 2003). Our preliminary findings were then fed back to the research participants in face-to-face meetings, to help the researchers establish whether their interpretations of the data were reasonable, and accurate.

Following this a final round of discussions and interviews were conducted. In these later discussions participants were also prompted to comment on some of the themes from the first two phases of the research. An emerging ‘theme’ was the topic of smoking and smoking spaces. (The question of spaces for smoking was not the only issue to emerge; some of the other dominant themes included issues of risk governance and the experiences of carers using the hospital, and these are discussed in other publications (Curtis, Gesler, Wood, Spencer, Mason, Close & Reilly, 2013; Wood, Curtis, Gesler, Spencer, Close, Mason & Reilly, 2013).

Finally, following the collection of data from the discussion groups, interviews and observations, and because of the emphasis that participants seemed to be placing on spaces for smoking, one of the researchers (first author) returned to the hospital to conduct an observational tour of the smoking spaces in forensic wards, similar in technique to that which Carpiano (2009) describes as the "Go-Along" interview. The tour was led by a senior member of staff, who discussed the importance of spaces for patients and staff, and policy issues in more detail. The researcher was also given the opportunity to talk to some of the patients on the wards. Field notes were recorded immediately afterwards, and further notes were recorded on the researcher's observations around the hospital grounds and of the informal discussions with staff members at the unofficial smoking spaces. We refer to these observations as: 'site tour field notes'.

Our findings about the importance of smoking spaces were subsequently presented at a number of policy and practice seminars, organised through the NHS, where staff and patients were present.

Findings:

The practice of smoking and access to smoking spaces at the psychiatric hospital were commented on by many of the different groups of participants. As explained below the comments were framed in ways that reflected the themes introduced above concerning the importance of smoking behaviours as processes of social control, resistance and subversive behaviour, and practices promoting social capital outlined in the introduction.

Institutional regulation of smoking spaces and differentiation of groups of smokers

Consistent with the wider literature, a large proportion of patients, especially on the forensic wards, were reported to be smokers and therefore restricted by smoking regulations. For instance, in a discussion with a group of female patients on one of the forensic wards, the researcher was told that out of the 13 patients on the ward at that time

11 were smokers. A senior staff member also estimated that about 70 to 80 percent of the patients on each of the forensic wards were smokers [Site tour field notes].

A senior member of staff described hospital smoking regulation as follows: **"***We allow smoking but don't encourage it*" [Site tour field notes]. Another senior staff member also explained how the institutional stance on spaces where smoking was permitted had developed and become more restrictive over time, to the point where smoking was restricted to outdoor spaces such as courtyards within the hospital perimeter.

> *there has been a gradual step change ...from the days where everywhere was regarded as a smoking area.... Then we created dedicated smoking rooms that... started off maybe about this [whole room] size then gradually reduced ...to the size of telephone boxes in order to encourage patients not to hang around in there, just go in for a cigarette and come out again, to not having any internal spaces at all [so that]...they would smoke in the courtyards* [Senior staff 1]

When smoking spaces were factored into the design brief of the new hospital, in keeping with the ethos of allowing but not encouraging smoking, outdoor shelters for use by smokers were installed in the courtyards, and were designed to be quite small, in order to discourage patients from lingering in the smoking area. As a patient on one of the forensic wards told us: "*you can only sit two maybe three in the shelter, everyone else is standing around and obviously the weather being the way it has been...I was getting drenched"* [Forensic ward Inpatient1].

Regulation was seen by a senior member of staff, to be preferable to an outright ban on smoking. He described complete prohibition as reflecting outmoded attitudes toward patients ("*from the stone age")*, saying it would "*make patients agitated"* [Site tour field notes]. He cited the example of the riots at a high security psychiatric facility in North West England, which were provoked by a smoking ban. He commented that at the hospital we

were studying, with many long term patients, *'we don't want to ban smoking because at the end of the day these [wards] are patients' homes*' [Site tour field notes]. It was deemed preferable to regulate smoking by providing timed smoke breaks in the outdoor spaces. This policy seemed to afford patients as a group a certain degree of privileged choice in use of the hospital space for smoking, since smoking in the courtyards was forbidden to other groups such as staff. However, the same member of staff also emphasised that allowing patients to smoke provided the hospital with a degree of '*leverage*', in that patients were always aware that the hospital still had the power to ban smoking if it found the regulations were contravened. Smoking in this context was therefore a privilege that was used as a means of social control.

Members of staff were required to leave the grounds of the hospital when they wanted to smoke. Previously, at the Old Hospital, they had found it possible to smoke unobtrusively within the hospital grounds, when "[staff] *used to go in the pigeon hut [in the hospital grounds] where it was out of sight, no public could see you, no patients could see you, but you would go in the pigeon hut...have a cigarette and feel happy enough to go back to work...".* [Habitation 1]

At the 'New Hospital' staff were now required to go "off site" to smoke. Smokers tended to gather at the end of the approach road to the Hospital. As one staff member suggested, "*staff are getting taught that you have to go to the bottom of the road to have your cigarette."* [Habitation 1]. Institutional restrictions were extended beyond the hospital site, into the proximate area around the hospital, as staff had been reprimanded for smoking just outside the hospital entrance: *"there has been an issue where I think a lot of domestics got told off for standing... together, for smoking...."* [Habitation 1] Some staff resented the fact that although they were no longer allowed to smoke in the hospital they were nevertheless required to supervise patients' smoking activities: "*because the patients do*

smoke [and] we are still in a smoky environment [...] the staff rights have been taken away" [Forensic ward Staff 2].

The varying rules determining where staff and patients are allowed to smoke, illustrated how institutional social control was exercised differentially according to the individual's position in the institution and the socially defined ways that they occupied the hospital space. This served to emphasise social distinctions between different users of the hospital buildings.

The impact of smoking regulations on ward regimes:

The smoking regimes and the supervision of smoking on the acute and the forensic wards were different. On the acute wards the attitude towards smoking seemed fairly relaxed. Although patients were "*not allowed to keep their own lighters, for fire prevention*" [Acute ward Staff 1] they were allowed to smoke unsupervised in the enclosed outdoor courtyards, whenever they wanted, "*because it is part of the ward"*. Some staff who had transferred from the General Hospital suggested that this was a relaxed regime for smoking at the New Hospital, and was better for patients:

> *the big issue at the [General Hospital] with patients was being escorted off the wards to go for a cigarette, so anyone who wanted a smoke had to ask to go for a cigarette, whereas here they just ask for a light and then go outside [to the enclosed courtyard], they don't have to be escorted, and it is not time constrained, and it is not [limited to] when we can fit it in, and the difference; straight away you could just see it in the patients* [Acute ward Staff 2]

Staff also described the process of escorting patients off the ward for a smoke break at the General hospital as '*a bit scary at times'* because it meant using the lift to access the outside and being in a '*confined space with patients'* [Acute ward staff 3]. Thus the physical design of the new hospital building, with courtyards in which patients were able to smoke

without having to be escorted off the wards, contributed to a more therapeutic landscape, facilitating a more relaxed regime that gave patients an enhanced sense of personal freedom, with benefits for their psychological wellbeing, if not their physical health and the wellbeing of staff.

However, there were limits to the amenities available to smokers. One of the family carers that we spoke to highlighted how patients at other psychiatric inpatient facilities were able to use a built-in wall lighter to light their own cigarettes rather than having to rely on a member of staff, which she thought was '*... fairly safe*' and it '*gives the patients independence*' [Family Carer]. Again, this highlights the therapeutic value for patients of a sense of personal autonomy supported by their environment.

On forensic wards, where constant observation of patients is often required for purposes of risk governance, regimentation and supervision of patient smoking had become part of the ward regime, through which staff exercised control over individual patients. Although the wards on the forensic site have enclosed and secure courtyards, similar to those on the acute wards, the patients are not allowed to smoke when they want to, but instead smoking activities are regulated as part of the ward routines. Patients are allowed a smoking break for about 10 minutes every hour and they get about 12 'smoke breaks' a day between 7.30am and 7.30pm. The time for smoking varies by ward, and a list of times is posted on a notice board on each of the wards indicating to patients when they can smoke. One patient described the smoking routines as "*beyond a joke*" and went on to describe how:

> *I get stressed out sometimes... I go to bed at 11.00 o'clock on a night or 12.00 ...and... smoking is finished by half seven, and... it takes me three or four hours to get to sleep..*
> [Forensic ward Inpatient 2]

One of the effects of the smoking routine was a preoccupation with smoking. For instance, one of the 'volunteer patients' on the habitation exercise suggested that the restrictions on smoking meant that "*it just made [smoking] more of a focus of the day"* [Habitation 3], and in another discussion smoking was described as *"one of the main events of the day"* [Forensic ward Staff 3]. In some cases the smoking routine seemed to lead to an unintended increase in consumption as patients were loath to miss any opportunities to smoke:

> *One person said that they do smoke but they've never smoked so many cigarettes in a day... thinking 'oh I don't really want one'.... 'but if I don't have this one and I miss the next one'...* [Habitation 3]

This observation concurred with the observations by a researcher taking part in the habitation exercise who noted that her "*thoughts were continuously preoccupied with cigarettes to the point where you feel like you are living from cigarette to cigarette"* [VJW], and in a group discussion the same researcher similarly described how the '*obsession*' with smoking "*just sort of took over'* which '*I don't think is very healthy*" [Habitation 2].

The way that smoking routines can serve to increase this type of dependency was also described by the manager of the ward:

> *We know that it [smoking] is important. The unfortunate side effect [of the ward routine] is that it increases dependency; you are looking for the next smoke time. That is all you're basically counting... I'm getting another smoke in an hour, right, what am I going to do for another fifty-six minutes? And that's how it turns into the cycle, which I know from a lot of people that do smoke gets turned into that regime of organising your time around your smokes, which is an unfortunate side effect [...] that's what a lot of patients experience* [Habitation 2]

On the other hand, less restrictive smoking regimes would not be very healthy for patients. For example, one participant in our study pointed out that in the Old Hospital, before the current restrictions were introduced '*the whole day* [for the patient would often be] *dominated around smoking and looking for tobacco"* [Habitation 3], and "*when smoking was allowed on wards many patients chain smoked*' [IHS]. However, the imposition of partial restrictions on smoking has not significantly alleviated these issues, raising interesting issues over whether a complete ban or partial restriction of smoking in psychiatric hospitals is the best overall option for psychiatric inpatient facilities.

Our findings suggested that factors that help to explain why smoking is important for patients in the New Hospital, apart from nicotine dependency, include boredom, a sense of disempowerment, and the attraction of smoking spaces that are deemed to be more relaxing than the ward. For instance, one habitation participant described spending his time on the ward as a patient as difficult, because there was '*nothing to do*' and he '*felt oppressed'* by his status. '[*A]ny time off the ward became incredibly valuable*' and as a result, even though he was not a smoker, he told us '*it crossed my mind to have a cigarette just so I could go out'* [Habitation 2]. In a group discussion conducted before the move, a patient also told us how he was hoping that when they moved into the new hospital there would be "*a nice relaxing courtyard where you can have a nice smoke*" [Forensic ward Inpatient 3]. The relaxing effects of the courtyard may relate to Conradson's (2007, p. 33) ideas about stillness, and the way in which some people find that certain places engender an embodied experience, which manifests in a sense of calmness, brought about by 'a slower rhythm of activity and the distance afforded from everyday routines'.

Spaces of resistance:

As a way of dealing with the smoking routines and the restrictions imposed on the spaces and places in which patients and staff could smoke, it seemed that some had adopted the strategy of seeking out what may be referred to as spaces of clandestine

resistance. For instance, according to one staff discussion patients were now more likely to try to smoke in their bedrooms because of the smoking restrictions [Forensic ward Staff 1]. In one case this had led to a fire when one of the patients tried to light his cigarette with "*a chargeable battery and a bit of wire"* [Forensic ward Inpatient 2].

Similarly, staff had identified areas out-of-doors, which were *"out of sight of the [CCTV] camera, behind the line of trees"* where they could congregate to smoke, as well as gossip about the stresses on the ward, and they reported feeling '*much better for a 'fag'* [Site tour field notes]. Finding alternative and hidden spaces in which to smoke may be an example of self-regulation and governance, in which staff members attempt to avoid the disapproval and stigma which accompanies smoking; it may also serve as a mechanism used to challenge and resist institutional control.

Furthermore, the NHS Trust (agency managing the hospital) had begun to take note of this behaviour on the part of the staff. As we were told:

> *if you go round the back of [the ward] you can always see staff hanging around there smoking, so the Trust has taken the decision; it has acknowledged that problem and they have agreed that all of the main Trust sites should have a staff smoking shelter* [Senior staff 1]

Thus although the institution was striving to control smoking, imposing regulations on the spaces and places in which it is permissible to smoke, those who did smoke were employing their own mechanisms of resistance, in ways which the institution was eventually having to accommodate, being unable to prevent such behaviours.

Encroachment of permissive spaces into restricted space:

Some comments suggested that permissive spaces for patients who were smokers were provided at the cost of non-smokers on the wards. For instance, one patient recalled how the proximity of the ward day area to the smoking area in the courtyard meant that

when the door was left open the ward would 'reek' of smoke, telling us "*I don't think this is fair on people who don't smoke, it's absolutely disgusting*" [Forensic ward Inpatient1].

One of the non-smoking habitation participants suggested that the smokers were the only ones who got any fresh air because they "*shouted the most*" [Habitation 3]. On a tour of the smoking spaces on one of the forensic wards, patients were observed continually asking the staff: "*is it time for a smoke break'* and '*when's it time for a smoke break, I need a fag"*. Then at the designated time for a smoke break the patients lined up along the length of the windows leading into the courtyard to indicate that their smoke break was due; waiting and watching for one of the ward staff to go and get the lighter from the office where it was kept so that they could obtain a light for their cigarette [Site tour field notes]. Thus patients who smoke and those who choose to socialise with the smokers can be seen to 'appropriate' the outdoor spaces within the hospital and they may also impinge on the indoor areas.

This illustrates the contested nature of therapeutic landscape, and how certain acts which are performed in, and which make use of particular places may serve to shape therapeutic outcomes. For instance, smokers, and those who chose to socialise with them may be able to create social connections with each other, while excluding those who don't smoke, and they may achieve a sense of empowerment though their encroachment into a space in which smoking is formally restricted. On the other hand staff and non-smoking patients on the wards may be exposed to the dangers of 'second-hand' smoke and the disruptions to the ward environment may serve to increase any stress and anxiety that they experience.

The social advantages of smoking – social capital and cohesion:

Access to the spaces where smoking could be enjoyed as a shared social activity, not only a chance to consume tobacco, was seen as socially advantageous for patients and for staff. Smoking spaces may also be occupied by non-smokers who wish to take

advantage of the situation by socialising with smokers. In this context smoking and smoking spaces are conducive to social capital, enabling patients to talk to each other, and build up connections and friendships in what is perceived to be a 'safe' environment.

> *The outside garden area was good...you could go for a cigarette and sit outside and talk to the other patients. We all ended up as friends, most of the patients, but yeah it was really nice, you felt secure as well as safe* [Discharged patient (acute) 1]

One patient we spoke to, who did not smoke, also suggested that she would sometimes *"go out with the smokers, just for the social bit"* [Discharged patient (acute) 2]. In this sense, the interactions that take place within smoking spaces can be seen to enhance the therapeutic potential of the hospital landscape.

Staff also described the period of time when they were allowed to smoke with the patients as one where *"you would sort of be with them"*. One member of staff suggested that when patients and staff could smoke together "*the patient would actually sit and talk to you, they would see you on the same level then"*; in the same discussion, we were also told that '*in the past you always got a lot more information out of patients in the smoke room, having a cigarette, when you could sit with them*' [Forensic ward Staff 2]. Sociability and the intersubjective, or shared dimensions of smoking behaviours may be conducive to the levelling of social positioning between patients and staff. The requirement for staff and patients to smoke in different spaces may undermine the potential to build social capital in terms of access to shared information, and 'bridge' the distance between staff and patients by providing some sense of unity and cohesion.

Discussion and conclusion:

This paper reports on a single case study situated in one part of England, so the results are not necessarily applicable more widely. However, the issue of how to regulate

smoking behaviour in psychiatric inpatient settings is a topic likely to be relevant in similar institutions, in England, and in other countries.

The findings from the discussion above make an original contribution to the literature on therapeutic landscapes by demonstrating some characteristics of therapeutic landscapes which are important for our understanding of how socially constructed spaces contribute to wellbeing. First, the attributes of a therapeutic landscape were seen to be variably perceived and contested between different groups of users of the hospital space. What for smokers were relaxing and restorative spaces, seemed for non-smokers to generate a nuisance, and for the hospital administration constituted spaces that needed to be carefully restricted. Furthermore, accounts of smoking spaces by smokers showed that they were seen to have therapeutic properties partly because they were experienced as sites of resistance to institutional controls. These were spaces which could be appropriated by smokers in ways that made them feel more empowered. Also, there were seen to be advantages to smokers from sharing in the social space created in settings used for smoking. These underline the beneficial psycho-social dimensions of therapeutic landscapes such as senses of social inclusion and cohesion.

In addition to contributing to our understanding of how socially constructed spaces contribute towards wellbeing, our analysis of the organization of smoking shows that smoking spaces in the hospital symbolised and played a role in the constitution of power relations between different actors in the hospital system. Formally the institution treats the hospital as a public space where smoking behaviours and activities are regulated through the design of smoking spaces, and rules which govern where, when and under what circumstances different groups of the hospital population can smoke. Patients are afforded a certain degree of entitlement because for them the hospital space is not just a public place of work, but is also their ‘home’ during inpatient stays. Thus more permissive rules, relevant to the private setting of the home, also apply to a degree. However, for all patients, especially

on forensic wards, this autonomy of individual action is strongly curtailed, institutionally marginalised and treated as a privilege. This also applies to staff for which smoking was spatially marginalised further and further beyond the hospital perimeter. The allocation of spaces in which to smoke and the application of rules of access to these spaces therefore serves as a mechanism which affords the institution social control. The response to this is resistance by patients and staff who practice secretive smoking behaviours and encroachment into spaces in which smoking is not formally permitted. This demonstrates the tensions that exist between the hegemonic power of the institution and the subordinate power of patients and employees. In turn, these tensions highlight how smoking regulations which are intended to benefit health and are imposed through restrictions on smoking spaces, can be counterproductive.

For a new public health system in which the focus of model of care is not only about the control of disease but also one that strives towards empowerment, a better experience for patients and an increased focus on wellbeing, our research suggests that, if it is accepted that patients need smoking spaces and staff should also be able to smoke in restricted areas, the following points could be considered for hospital building design, to achieve a more even balance, so that the space is experienced as therapeutic by more participants using the hospital:

- Shared smoking spaces for patients and staff
- On site smoking spaces for staff
- Consideration of the position of the smoking spaces in relation to ward areas for non-smoking patients, to prevent smoke drifting back on to the ward
- Increased attention and awareness of the way in which the regulations are applied to smoking spaces and the implications of this for the social (social capital and social rapport) and symbolic (power dynamics) dimensions of the hospital environment

More generally this paper highlights the challenges of regulating smoking in an environment where patients being treated for mental health conditions perceive smoking spaces as an important part of their social and mental wellbeing. The issue is controversial since the immediate and longer term physical health benefits of limiting smoking may need to be balanced against the psychological benefits (at least in the short term) of smoking behaviour and the distress and discomfort caused for smokers who are deprived of complete freedom to smoke in the hospital. Furthermore, for hospital institutions the tensions around regulation of smoking can result in significant resistance to their authority. As shown here, the spatial organization of smoking clearly expresses these conflicting considerations, and the creation and management of these spaces are very important for the well-being of both patients and staff and should be very sensitively negotiated. Not only the hospital regulations, but also the physical fabric of the hospital, play a role in the way that smoking can be managed. This means that the issue is likely to continue as a significant consideration for the design of hospital buildings and that building design needs to provide spaces that can be flexibly adapted to changing policies with respect to smoking restrictions.

Our research on 'smoking spaces' in the psychiatric inpatient setting also contributes to theories informing international research on geographies of health, since this case study highlights the contingent nature of what can be defined as a 'therapeutic landscape'. The perception of how the physical, social and symbolic environment contributes to psychological as well as physical wellbeing is seen here to be highly dependent on: variations in social position; socially and culturally (as well as individually) constituted health related practices; and the varying ways that the use of space constitutes processes of social power and resistance and generation of normative and resource based social capital. Our research raises questions of whether more active strategies might be deployed in therapeutic settings to provide care models that offer in alternative ways the kinds of benefits that patients in long

term psychiatric care perceive in relation to smoking, including enhanced social capital, relaxation and empowerment.

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