Title:

Creating 'therapeutic landscapes' for mental health carers in inpatient settings: a dynamic perspective on permeability and inclusivity.

Authors and affiliations:

Dr Victoria J Wood [a]

Professor Sarah E Curtis [a]

Emeritus Professor Wil Gesler [b]

Dr Ian H Spencer [a]

Dr Helen J Close [a]

Professor James Mason [a]

Professor Joe G Reilly [a]

[a] Durham University, UK

[b] University of North Carolina, US

Corresponding author:

V J Wood, Durham University, Wolfson Research Institute, Durham University, Queens Campus, Stockton-on-Tees, UK. DH17 6BH. v.j.wood@durham.ac.uk. 0191 3340370

Creating 'therapeutic landscapes' for mental health carers in inpatient settings: a dynamic perspective on permeability and inclusivity.

ABSTRACT: Although there has been a shift toward treatment in the home and the community, in the UK inpatient facilities are still important in modern mental health care. 'Informal carers', including family members, often play an essential role, not only in providing care in the community but also in care of patients during periods of hospitalisation. UK National Health Service policies increasingly consider the position of these carers as 'partners' in the care process, but relatively little attention has been paid to their position within the hospital settings where treatment is provided for inpatients. This paper contributes to geographical work on carers' experiences, by reporting how this issue emerged through a study focused on perceptions of a newly built hospital, compared with the inpatient facilities it replaced. We draw on qualitative research findings from discussion groups and interviews with informal carers. The material considered here focused especially on carers' views of aspects of the hospital environment that were important for wellbeing of carers and the people they look after. The carers' views were supplemented by relevant material drawn from other interviews from our wider study, which included service users and members of hospital staff. These accounts revealed how informal carers experienced the hospital environment; we interpret our findings through a conceptual framework that emphasises carers' experiences of a 'journey' along a 'caring pathway' to and through the hospital space. This perspective allows us to make a connection between three bodies of literature. The first relates to phenomenological interpretations of one's environmental perception, formed as one moves through the world. The second derives from the literature concerning 'permeability' of hospital institutions. Bringing these ideas together provides an innovative, dynamic perspective on a third strand of literature from health geography that examines hospitals as 'therapeutic landscapes'. The analysis helps to explore the extent to which carers in this study were positioned as 'outsiders' in the hospital space.

Introduction

Over the last few decades emphasis in the UK has shifted from long-term institutional care for people with mental health difficulties to care in the community, complemented by short term hospital care during periods of severe illness. From a geographical perspective these changes are reflected in a shift towards 'post-asylum' geographies, which focus on the ways that individuals interact with spaces and places of care in a range of settings, in the community as well as in institutions (Kearns and Joseph, 2000; Philo, 2000; Curtis, 2010).

This paper focuses particularly on the experiences of 'carers'; family and friends who provide 'informal care' to people with mental health conditions. Their perspective is important, not least because in health services generally, the landscape of care and caregiving has been restructured (Brown 2003), blurring the boundaries between the public and private spheres of care and redefining the roles and responsibilities of professionals working in the 'statutory care sector', and of family and friends providing 'informal' care (Milligan, 2001, 2003, 2005, 2009; Milligan et al., 2007; Wiles, 2003). In the UK, recognition of the rights of informal carers and how their caring role may impact on their own needs and wellbeing has also been acknowledged, with the development of national carers strategies emphasizing how carers need to be '*supported and viewed as partners in the care of their family member*' (Milligan, 2003, p. 456).

British (NHS) strategies to support carers have been set out in government policy documents (Department of Health, 1999 & 2010). These acknowledge that supporting carers has benefits for society and the wider economy and that carers '*are key players in their local communities in terms of their knowledge and experience*' (Department of Health, 2010, pp. 46-47; p.34). In the case of carers who look after people with mental illness, the NHS invokes the idea of a '*Triangle of Care*,' acknowledging the important role that they play and highlighting that '*they can be essential partners in the treatment and recovery process*' (Worthington & Rooney, 2010, p. 2). This guidance encourages better '*collaboration and partnership*' between service users, carers and professionals to address '*failures in communication*'; to include carers more effectively in NHS care processes; and to respond more effectively to requests for advice and information (Worthington & Rooney, 2010, p. 6). The 'triangle of care' is deemed to represent '*a therapeutic alliance between service user, staff and carer that promotes safety, supports recovery and sustains wellbeing*' (Worthington & Rooney, 2010, p. 3).

Since inpatient facilities continue to play an important role in the treatment and recovery of service users (e.g. Priebe et al., 2005 & 2008; Turner 2005), the inclusion of

carers in the treatment and recovery process (while the patient is in hospital) is as important as supporting carers in the community. Historically, psychiatric inpatient settings have been described by Goffman (1968) as 'total institutions' intended to separate the patient from the outside world. This idea resonates with the discussion by Moon et al (2006, p. 132) of care models that have '*sought to promote the recovery of mental health by the removal of the 'client' from the stresses of everyday life through confinement in an ordered, harmonious and calming place of sanctuary'*. Though this may be therapeutic in some respects, it leaves little scope for involvement of family and friends as carers.

In contrast, psychiatric hospitals can also be considered as 'spaces of transition', intended to prepare the 'service user' to return to life in the community, by encouraging a degree of connection between the community setting and the clinical environment (e.g. Quirk et al., 2006; Curtis et al., 2008). Nevertheless, movement across the interface between inside and outside the hospital is still carefully controlled by medical staff and has been described by Curtis et al. (2008, p. 344) as a condition of 'managed permeability', positioning informal carers as 'outsiders', and locating power and control with the medical staff working in the hospital. In this paper we examine the extent to which carers experienced the hospital space as offering a setting which is permeable to carers. Schweitzer et al., (2004, pp. 72-73) suggest that '*poor design contributes to restrictive family access'* while '*buildings can be designed to encourage social connectedness by providing opportunities for social contact and engagement'*.

These notions of accessibility and permeability for carers were evident in the findings we report below. Also emerging from our findings were strong impressions of carers' perceptions of moving through the community and the hospital to exercise their role, emphasising the ways that the hospital environment facilitated or impeded their journey along a 'pathway of caring', and how this related to their overall assessment of the hospital setting. This is interesting to consider in light of phenomenological interpretations of the ways that human perceptions of the environment are formed, through the dynamic experience of '*being in the world'* (Merleau-Ponty, 2001) and of moving through spaces over time. We have therefore adopted the metaphorical and literal idea of a carer's 'journey' to and through the hospital space as a way to structure our findings about the ways that carers experienced the hospital setting and the extent to which it supported their caring role.

We consider how this dynamic perspective contributes to ideas about psychiatric hospitals as 'therapeutic landscapes' (Gesler et al., 2004; Campling et al., 2004; Curtis et al., 2007; Karlin & Zeiss, 2006; Ruane, 2004; Schweitzer et al., 2004), which are not only

'clinically efficient' but also offer physical, social and symbolic features that are beneficial for one's sense of wellbeing and therefore help to promote healing in a more holistic sense. Brown (2003, p. 490) suggests that 'health care facilities hold a position of symbolic significance within their localities' and that 'the sense of ownership' by the community is important for the way they are perceived. For informal carers to achieve a 'therapeutic alliance' and be equal 'partners' in the treatment and recovery process, it is important to consider their views on hospital design and to examine whether it offers a therapeutic landscape, beneficial to the wellbeing of carers as well as patients and medical staff.

This paper therefore aims to use the analytical device of the carer's 'journey' to explore the extent to which carers seem to be positioned as 'outsiders' in the hospital space, the degree to which they experience the hospital space as 'permeable' and their individually variable and contingent sense of whether the hospital provides a 'therapeutic landscape'. While we focus on a specific case study, this approach makes an original contribution to the wider literature on hospital design and therapeutic landscapes by virtue of its specific focus on the carer's experience and the dynamic, individually variable sense of place reflected in our findings.

Context and methods

This research was part of a wider university research project, funded by the UK National Institute for Health Research, to evaluate a significant hospital building project. The research in this study took place between March 2010 and February 2011 and was located in a mid-sized industrial town in Northern England in an area with high average levels of socio-economic deprivation where the average health of the population is relatively poor. The research protocol was approved by a Research Ethics Committee under the UK NHS research governance process, and by the relevant research ethics committees in the University Institution hosting the research team. In accordance with their requirements, we have masked the locational details of the hospital.

At the start of the study period, psychiatric inpatient services in the study area were provided in what we refer to here as the 'Old Hospital', which was built in the late 1800s, with an original design typical of 19th Century asylums. While our research was progressing, construction of a new acute facility was completed on a site adjacent to the Old Hospital. We refer to this building as the 'New Hospital' and in the period covered by this study services were transferred to this new building. In addition, at the start of the study period, there were two acute mental health wards at a general hospital on another site about five miles distant

from the 'New Hospital', referred to here as the 'General Hospital'. These wards at the 'General Hospital' were also closed and services transferred to the 'New Hospital'.

Since, in practice, many mental health service users spend extended periods of time in inpatient care, experiencing repeat admissions, these changes meant that many patients and their carers had experienced the environment at the Old or General Hospital, and at the New Hospital. The aim of the study overall was to understand how service users, carers and hospital staff felt about this move, and in particular which aspects of the building design and hospital environment were considered to be important for their sense of wellbeing.

The approach used to conduct the research was based on similar techniques that had been trialled previously (Curtis et al., 2007 & 2008) in a different location, and is broadly consistent with what Gatrell (2002) identified as a social interactionist methodology. The methods used to collect the data were interviews and discussion groups in which we asked participants to give us their views on what aspects of the New Hospital (and of the Old Hospital or the General Hospital) were good or bad for the wellbeing of people using the facilities. We were able to talk to some informants twice; once *before* and once *after* psychiatric services were moved to the New Hospital.

Purposive sampling was used to recruit participants to the study. In the wider research project we included informants who were service users and staff in the different parts of the inpatient services, as well as carers of service users. The purposive sample was obtained through key contacts previously made at the hospital, and also with the assistance of the Patient Advice Liaison Service (PALS) and other organisations that provide services to patients and carers at the hospital and in their local community. Altogether, nine carers took part in the discussions; this paper identifies individuals or groups using pseudonyms. Before the move to the New Hospital, seven carers from 'The Bridge' carer group took part in discussion, focusing on their experiences of the acute wards at the General Hospital. We also report on two interviews with carers 'Susan' and 'Amy', both of whom had relatives using acute inpatient services and had previous experience of the Old Hospital. Initial discussions with carers spanned the period of time before and during the move to the new psychiatric inpatient facility. Later, after services had been completely transferred to the New Hospital, Amy and two other carers from 'The Bridge' took part in a second interview. We also interviewed 'Jan', a Senior Carer's Support Worker from a local charitable organisation that provides information and advice to mental health service users and carers. In addition, some of the staff and patients who were included in the wider study spontaneously raised issues relating to carers in their discussions about the hospital design. These are interesting

to consider in relation to comments from carers themselves. We draw on material from three main sources: first, two group discussions with hospital staff from the General Hospital, the first of these discussions taking place before the move and the second discussion (with different members of staff) after the move, with staff who had relocated from the General Hospital to the New Hospital; second an interview with 'Lisa', a member of the hospital staff who had previous experience of working at the General, the Old and the New Hospital; and third an interview with 'Stan' a recently discharged service user with experience of both the General Hospital and the New Hospital. Information on the informants is summarised for ease of reference in Appendix Table 1 [*insert link to Electronic Appendix 1: Summary of respondent characteristics*].

Although the term 'carers' is used here to refer to family and friends providing care to a mental health service user, it should be recognised that the term is not without complication, as not all individuals who adopt a caring role will identify themselves as such (see Milligan 2000, 2001), and some may have limited contact with support organisations or statutory services (Milligan 2001). However, all the carers in this study did define themselves as having a 'carer' role, had direct or indirect contact or links to services, and were caring for immediate family members.

The local context may have influenced the response by carers to our research. Some areas where our respondents were living were characterised by severe deprivation, with high levels of 'illness and disability, poverty, worklessness and social exclusion', which are noted as 'putting particular pressure on carers' who often have relatively poor health themselves (Buckner et al., 2010: p3 & p10). Local agencies provide support for carers (including providing respite care, information and advice) and have set up local 'Carer Strategy Steering Groups'. However, the carers that we spoke to described how they often had difficulties in attending these sorts of meetings:

They expect us to go to meetings all over the place, but we don't get our transport paid, so we will only go to meetings now when they pay our transport [...] most of us haven't got a voice anymore, so it is a handful of people making decisions for all of us [The Bridge, before the move]

Some of these issues may explain why we found it relatively difficult to recruit carers to this study, in spite of special efforts to include them, provision to cover their costs for participation, and additional contacts made with carers' organizations in the local community. It also accounts for the fact that we did not use a standard research format for all

participants, but to accommodate their needs we conducted either discussion groups or individual interviews.

Discussion groups and interviews were recorded and transcribed. Based on recommendations of authors such as Ryan and Bernard (2003), we sought to ensure 'inter-coder reliability', a process through which the raw transcripts were first considered independently by three members of the research team who made a thematic analysis of the aspects of the hospital design mentioned by respondents as important for wellbeing. A therapeutic landscapes framework was used to categorise these themes into physical, social and symbolic dimensions. Researchers then met to compare their analyses and agree on a consistent interpretation. Our interpretation of the key themes was summarised and fed back to all the participants and further information about the comments from carers was also presented at an event held by 'The Bridge' carer group and at policy and practice seminars organized through the NHS, at which local carers and service users were present.

Findings: Carer experiences: 'outsiders' in the inpatient space?

We present our findings concerning the position of carers in relation to the hospital space and their perceptions of the hospital. As noted in the introduction, many aspects of carers' accounts reflected their experience of moving from home, where they also use services provided in the community, to and through the spaces within the hospital environment that are important for them. We have therefore ordered material below in a way that reflects this 'journey' undertaken by carers along a 'caring pathway' into the hospital. The idea of a journey, in the sense that we are using it here, is both literal and metaphorical (as discussed by Kearns, 1997). It conveys a sense of the dynamic processes of care that carers provide, for which they require a hospital setting, and which is permeable and comfortably accommodating for their caring role.

Starting from 'home base'

Some carers in our study, whose family members had been inpatients at the General Hospital, emphasised the paramount importance for them of services provided *outside* the hospital. It was suggested that, for them, a priority was "*the community services in place, assessment* [of health care needs] *being done properly, [and] community and hospital staff working together*". The idea of "*prevention in the community*" was seen to be particularly important, but they suggested that "*...they* [NHS staff] *rely too heavily on families to get on with it, without giving them the support they need to do that*," and that "*you get took for granted, don't you, as carers*" [The Bridge group before the move].

This group of carers also questioned whether a new hospital, at what was for them a more distant location, was a cost effective solution: *"I don't see why they are closing [General Hospital Wards] down; it's just as good as any other hospital; they have just paid for all new stuff for it"* [The Bridge group before the move]. They also told us that when they were initially asked how they wanted their "*new modern health service to look*":

what we said was, in all earnest, having an acute inward [i.e. inpatient ward] *but also having the staff in the community working together with acute inwards – what they decided to do was totally ignore what we wanted* [The Bridge group before the move]

Susan also described the lack of "*secondary care provision*" in the community, previously served by the Old Hospital, saying that "*there [aren't] the resources there*", citing delays in provision of community based treatment and suggesting that "*if there was more available for people [...] it would maybe minimise the inpatient stay even further*".

Another issue for some carers, for whom the hospital service was relocating from the General Hospital, was the distance that they would now have to travel to make visits to family members who were hospitalised. They suggested that the number of visits they could make would be reduced due to the time and cost of the longer journey time to the new site:

I mean the biggest worry among our carers and service users, is how are we going get there ...at the [General Hospital]... instead of going every other day, or once every two or three days we can go every day ... Why do we have to travel over there? [to the New Hospital*]...it is about five minutes from my house to the [General] hospital* [The Bridge before the move]

The more complicated public transport route, using more buses, the extra cost of the travelling, and the fact that "*sometimes your benefits get reduced after you have been in* [the hospital] *for so long*" were all issues relating to the location of the hospital, which was felt to prohibit regular visiting and *"put a burden on us."* [The Bridge before the move]

The first ward staff discussion group (General Hospital acute ward staff) also discussed some of the difficulties with visiting. They explained that patients were concerned about receiving fewer visitors when their care had been transferred to the New Hospital. Some patients hospitalised under legally compulsory admission procedures were allowed limited periods of 'leave' from the ward for part of a day. However, once they had moved to the New Hospital the longer travel distance would make it difficult for them to spend this leave at home to maintain links with their family.

One patient, who had recently been discharged, also described the difficulties that his wife faced in visiting him during his stay in an acute ward at the New Hospital because of the location:

I think my wife only came about two or three times because it was such a journey [...] she doesn't drive so it took her three buses to get to the New Hospital, and then she had a problem finding out where the New Hospital was [Stan]

Thus, for carers, the physical connection between the hospital and their community is important for the ease with which they can maintain close contact with the person they care for. For some carers, concentration of services in one location increased the distance they had to travel, making the hospital space harder to access, especially given their reliance on public transport systems and their limited incomes. For these carers, a hospital needs to be designed as an integrated part of a wider space of care, centred in domestic settings, outside the hospital, where they performed much of their caring role.

Arriving at the hospital

Some carers accessed the New Hospital by car, and placed importance on the hospital car park. One carer suggested that "*it's quite a walk from the car park to the entrance"* that "*is going to cause major problems for people who are disabled*". Another carer in the same discussion group remarked that access to the New Hospital site for taxis was "*too far away for dropping off...it's not very carer friendly*" [The Bridge before the move].

On arrival at the New Hospital, carers are greeted by the external appearance of the building. The new building was often described in positive terms by carers from both the Old and General hospitals. Carers from the General Hospital described the new building as "*beautiful*" and "*a good future design*" [The Bridge after the move] while Amy suggested that it was like "*a breath of fresh air in comparison* [with the Old Hospital]...*much more inviting*".

While carers from the General Hospital had been quite happy with the appearance of the buildings there, the Old Hospital was described in comparatively negative terms, as being "*like something out of Dracula's time*" and "*overpowering and just looming there, not inviting*" [Amy]. Amy described her husband's fear of the names he would be called, such as "*loony*" and "*a head case*" if people were to find out that he had been an inpatient at the Old Hospital. Susan said she would be "*glad to see the place [Old Hospital] knocked down*" because it "*reinforces the whole stigma attached to mental health*". The words that carers used in their descriptions of the Old Hospital reflect the high degree of stigma attached to the 19th century asylum building, which reinforced the social stigma suffered by those using

mental health care. In a study in Scotland, Parr et al (2003) similarly highlighted the way that an old asylum institution can evoke emotions of fear, and how patients using these buildings suffered associated stigma and loss of community connections.

Although the New Hospital building was more often described in positive terms, some carers drew attention to the way in which it was now being described as resembling a hotel. "...*there seems to be shame in calling it a mental institute...they think it's a hotel now*". Another carer made a similar point that by obscuring the mental health care function of the New Hospital, stigmatising social attitudes were not being effectively addressed:

If you're not ashamed of something you call a spade a spade... I'm thinking what about all this positive work that we are supposed to do to change people's views on mental health, and we aren't hiding it away [The Bridge group after the move].

The carers' comments above underline the contested ideas about the role of a psychiatric hospital building. The symbolism of a 'hotel' may help to 'destigmatize' mental health care by representing it as consistent with other aspects of consumption in modern society. This may correspond to a more general trend to reinterpret hospitals as spaces of commercialised consumption (Kearns & Joseph, 2000; Kearns & Barnett, 2000; Kearns, Barnett & Newman, 2003; Gesler et al., 2004). However, the interests of patients and carers may be better promoted through a more explicit symbolism, acknowledging mental health care in terms of more profound moral principles of respect and dignity.

Entering the hospital

The reception and entrance area is the first point of contact when carers enter the hospital space. In contrast to the Old Hospital, Jan, the Senior Carer's Support Worker related that some carers found the entrance space at the New Hospital to be "*a much better place to be, they've said they feel more comfortable walking into the building*" [Jan]. However, she noted that there was not always a receptionist on the desk at the New Hospital to "*meet and greet*" the carers when they arrived for their visit, which she felt was difficult for those families who had never been there before and who may be "*in distress because their family member has been admitted to hospital*". Although there was a map giving directions to each of the wards, it was suggested that carers visiting a hospital would feel more reliant on personal guidance through the hospital space:

...people are not going to use a map, they are not. When you are coming into that situation ... people just won't think about looking for a map. They will just look for a

person to direct them, they will be looking for somebody to help them. You know it's not like going to a shopping mall. [Jan]

Again, this comment challenges the 'consumerist' notion of mental health care, while also expressing the need to make hospitals really permeable for carers. This example suggests that consideration should be given to the situational dynamics for those coming to the hospital, and that helpful social interaction is equally important in providing a welcoming environment as a good design with ample signposting.

Interactions in the ward space

The next part of the carer's journey through the hospital space would involve gaining entry to the wards. While some modern acute inpatient units for mental health care, now have unlocked wards, visitors coming into a ward are generally still screened by staff (see Curtis et al., 2008). In all the hospitals considered here, wards were permanently locked, and nursing staff were the gatekeepers to ward entry and exit for all patients and visitors. While this is a measure intended to protect patients, it also reflects the subordinated position of carers and patients in the hospital space.

Despite this, the hospital did seem to be moving towards greater support for carers, by providing them with more information, and by fostering stronger and better relationships between carers and members of staff. For instance the hospital was running special events for carers and conducting short surveys and questionnaires about their experiences. 'Carer champions' were identified on each of the wards; these were members of staff, trained to provide information to carers and look after them when they came in to visit a patient. The Carer's Support Worker, Jan, also told us that:

They [the hospital] have done quite a lot of work on looking to see how they can support carers better, they have produced an A4 [sized] *sheet of information: when visiting time is; do's and don'ts on the ward; and where to get support for themselves.*

Information for carers was also placed on notice boards around the hospital and just outside the wards "*informing them [carers] of a range of different things from involvement opportunities*" to information on "*where people can go for support...*" While these efforts were clearly appreciated by carers, some of this advice seems to have been targeted at 'socialising' carers to adjust to the regime on the ward, rather than adapting it to their needs, and on redirecting carers to alternative sources of support, rather than offering support directly.

The quality of the relationship between staff and patients was important for carers. For instance, Amy was distressed that her husband would sometimes get "*very upset going back to the [Old] hospital*" after she had accompanied him outside the hospital on "*leave*"; he would go "*straight up to his bedroom and cry*". In contrast, if a member of staff took the time to talk to her husband, to welcome him back and ask him how his leave time went, and whether he wanted to talk about it over a cup of tea, then she said that her "*husband would go in bouncy instead of going up to his room and crying, and that made a huge difference*". Amy's account emphasises the importance of the social, as well as the physical environment on the ward, and how it is influenced by encounters between staff and patients. Gesler (2003, pp. 14-15) also comments that healing can be considered as a social, as well as a medical process, and therefore the quality of social relationships contributes importantly to a therapeutic setting. Here we see that a good relationship between patients and hospital staff is not only therapeutic for the service user but also relieves some of the distress and burden felt by the carer. Underlining this point, Susan told us that:

> *...staff make a massive difference to the whole environment, they really do, and you know there are some really good staff... when you go on to the ward they will meet and greet you, you know, they will spend time with you, if you want to go and talk to them.*

Susan also emphasised that the triangular relationship between service users, medical staff and informal carers depends on other hospital practices. She suggested that including carers in the treatment of the service user was important because "*[it] helps to bring the service user and carer together.*" A closer involvement of carers in the medical process was something that the hospital was more actively trying to foster. Lisa, a member of staff told us "*we try and include them, the relatives, and try and talk to them as much as we can, just so they feel part of the system, part of the care*". Susan described to us how this differed from previous approaches in which the patient and carer were seen separately:

> *What used to happen is that you would be seen in isolation so, you know, staff would talk to the service user and maybe would talk to the carer quite separately, but not thinking that it is something that's affecting everybody.*

However, Susan said this practice was still seen as a bit "*hit and miss*" and often depended on whether the patient's "*named nurse*" (identified as responsible for liaison with the patient and their carers) used this approach effectively.

Carers of patients at the General Hospital also suggested that some continuity in the relationships that they had already developed with staff was important to them as part of the process of making the transition to the new hospital building. They were reassured because these familiar nurses were also transferring to the New Hospital; *"...the only reason that most of us feel comfortable about going to the new hospital is because they're going to be looking after us when we go in there. We won't have new staff we don't know...*" [The Bridge, before the move]. The same group of carers also described their relationship with staff as "*good*" because they felt they could talk to staff and that "*if there is a problem we can get it nipped in the bud*" without "*going to complaint*" [The Bridge, after the move]. Thus it is not only the relationship between carers and staff that is important, but also continuity in that relationship which can serve as an important source of support.

Spaces for family and community living within the hospital

The organisation of space in the hospital was important for the ways that it allowed opportunities for activities which replicated family life and social activity in the community. These included spaces provided for visiting. For carers, visiting enables them to keep contact with their family members while they are in hospital and is one of the main ways of maintaining a relationship during periods of hospitalisation. Since privacy is an important part of family relationships it is important to have comfortable, private rooms for visiting. As Susan suggested, "*it's nice to get some space away from other people because obviously you want to have the opportunity to talk in private*", while Amy suggested that at the New Hospital: "*there were little rooms where you could go and just sit and be quiet [...] if you were visiting somebody; it was light so that was good*". The need for private spaces for visiting was also recognised by the staff. On the acute wards of the New Hospital, however, there was no room specifically designated for private family visits, so these normally took place in one of the 'quiet rooms' or 'calm rooms' on the ward. These were also used for other purposes requiring a separate space from the shared lounge areas or patients' rooms, according to the second ward staff discussion group. This might reflect a flexible and efficient use of space on the ward, allowing alternative usage outside visiting times, but it is interesting that visiting space was not specifically identified or reserved on the wards, which may also seem to depreciate the value of the carer's role.

More generally, carers visiting service users at the hospital would sit in the lounge area on the wards. According to several participants in our study the acoustics in the New Hospital building produced a high level of ambient noise in the common areas. This was felt to create an uncomfortable environment for visiting. Amy commented on this and described

how she would try to go out into the enclosed garden area, to find a quieter, more "*relaxing*" space, during her visits with her brother at the New Hospital. Here it was possible to have the kind of conversation one might have in a domestic garden:

> ... *rather than sit inside, I would suggest: "Let's go and sit in the garden." Or my brother would say: "Oh I have been watering the tomatoes.", and we would go and look at them'....The grounds in the new hospital are beautiful, the gardens are all lovely, I don't think there was anything else you could do to make it more relaxed [...] the main colour was lavender and lavender is relaxing so they had everything on the lilac colour scheme, huge big pompoms and it's good, it is a nice place to be in.*

These enclosed courtyard spaces in the New Hospital seemed to be an enhancement of the hospital environment previously experienced at the Old Hospital, where the courtyard areas were described negatively by Susan as "*very oppressive.... it reminds me of a prison yard... because it has got a high wall [and it is] very small".*

These comments reflect the importance of grounds and gardens as features of the modern inpatient facilities, reflecting continuity in the emphasis historically placed on the therapeutic value for patients of attractive, 'restorative' outdoor settings as part of a 'healing landscape' in a psychiatric hospital (Rutherford 2005).

Overall, the comments about visiting spaces suggest that carers and family members need to have access to a variety of different settings within the hospital where they can spend time with a patient during their visit; private living rooms and garden spaces similar to those enjoyed in the domestic family home were important in this respect. However, as we have seen, several features of the ward space were restricted and limited in ways that did not replicate the home space. Furthermore, family members were not allowed near the bedrooms and there were separate spaces, away from the wards, for children to visit because according to staff the wards were considered unsuitable spaces for children. Access to wards for carers was also limited in terms of times as well as spaces for visits. Susan commented on the difficulties of visiting times which clashed with her work commitments. Such restrictions illustrate the degree to which the hospital spaces remain controlled by the medical institution, aiming for a degree of seclusion of patients from the outside world as part of their treatment and recovery. This seems to be in tension with the aim to move towards a greater degree of inclusivity and permeability for the carer in the hospital space.

Recreating the community within the hospital: spaces for recreation and social gathering

As well as 'homely' settings for more intimate or private family interactions, carers commented on those spaces which were located within the bounds of the hospital but outside the closely controlled environment of the ward and which offered opportunities for social gathering and spending time with the patient. These seemed to be valued because they provided the kinds of 'social venues' that one might find close to home in a community setting. For example, at the heart of the Old Hospital building, accessible from all the wards, there was a recreation hall. Carers valued this feature of the Old Hospital and missed it after the move to the New Hospital. Jan suggested that:

I have had a couple of people mention that [in the New Hospital] *there isn't a large recreational area for people, so I think that is something that was missed [...]there isn't that at the new hospital.*

Amy also suggested that she missed the old recreational hall, because it provided a space "*where everybody can congregate on an evening*", with activities that both carers and service users could take part in, such as "*table tennis, a pool table [and] a piano*" and "*bingo*". Amy further suggested that she felt this place was "*vital*" to service users because it enabled them to socialise, and told us that "*I have spent many a happy hour playing table tennis and pool*". Her comments suggest that this type of social space at the Old Hospital had been important to her, as well as for the service user she was visiting, which might reflect the potential for the hospital space to create supportive social connections for carers whose role may at times feel stressful and isolating. However, not everyone appreciated this space in the same way. Susan described the old recreation hall as "*...quite patronising*", commenting that: "*...you know, we are not children*". She illustrated this 'patronising' activity in terms of: "*...going to play bingo on an evening to win a [chocolate] bar*". Susan did, however, acknowledge that some of the other carers "*...enjoyed that, and obviously you can't cater for everybody*".

There was no similar type of space for public social use at the New Hospital, although there was a cafe that was publicly accessible, close to the main reception area. This was not open in the evening and did not run any social activities or events like those that had taken place in the recreation hall of the Old Hospital. While the old recreational hall cafe had been partly 'staffed' by patients, in the New Hospital the cafe was run as a commercial operation with employed waiting staff. Amy commented on the fact that this meant it was more expensive to use. One carer in a discussion group seemed to consider the cost prohibitive, as she suggested to us: "*if you go... weekend visiting... the cafe is not subsidised, so I'll be taking packed lunches over there*" [The Bridge before the move].

The only other type of space within the New Hospital which was publicly accessible for social activities was the 'Multi-Faith' space for religious observances. As Schweitzer et al (2004 p72) suggest '*[h]ealth care has a long history of being intertwined with spirituality...[y]et, most hospitals today are designed to meet the needs of technology more than spiritual needs of patients, families or staff'*. At the New Hospital the space provided for such spiritual needs was seen to be less than adequate by one of the carers involved in a discussion group. Although facilities required for some religious practices, such as washing facilities, were provided, the room was too small for family prayer gatherings and unsuitable for patients to pray together with their family, or to carry out different religious practices. As one carer suggested:

> **Carer:** *If four or five different people were all there at one time, from different faiths, [and] decided to ... pray at the same time, or whatever they do, it would be impossible.*
>
> **Researcher:** *What makes that impossible?*
>
> **Carer:** *The room is not big enough, and it is all one room and so, if I was praying, and another person was praying louder, I won't be able to pray .... There should have been separate rooms for each faith, not just one place ... because you come there and then two or three people in the family say; "We want to do it together!" So it won't work ....*
> [The Bridge after the move]

A space which allows carers and service users to practise their spiritual beliefs together may be important socially as well as spiritually, supporting connections with family members and others from their own community. The comments above reflect the difficulty of reproducing in a single, restricted hospital space the diverse settings for religious practices existing in the wider community. In the community, the spaces used by different religions are usually symbolically, as well as geographically, separate and this informant seemed uncomfortable with the idea that they could be physically and symbolically merged in one room.

Another part of the carers' discussion also reflected a desire for the hospital setting to be consistent with one's own neighbourhood 'sense of place'. One recalled participation in meetings with the hospital management at an early stage of planning the New Hospital design. She had helped to choose some of the soft furnishings and aesthetic features of the building, such as the decoration of the window glass in part of the building. This was seen to have been "*done very fairly*". One option which designers proposed for the window decoration would have made references to the immediate local area in which the New Hospital would be situated. This informant, who was living in a different area, voiced an

objection: *"we said: Hang on a minute, this is not a [local area] service, it is a service for everybody"*. As a result, *"…they ...listened to us… we just got a nice piece of flowery stuff on the windows that didn't put anybody to any grief"* [The Bridge before the move]. It seemed important for this carer to choose a neutral design, symbolically inclusive for members of all the different communities using the hospital.

These comments emphasise carers' expressed desire for the hospital space to be reflective of the wider community where they live with the service users and to allow community practices to permeate the hospital space.

Discussion: How carers may become 'insiders' in the hospital space

Clearly the findings reported here cannot be generalised. They are based on a small sample from a study focussed on a single hospital in the UK NHS system. A more extensive study, dedicated solely to exploring the views of a wider spectrum of carers, might extend the diversity of carers' voices. However, post-occupation evaluation of new hospital buildings is relatively rare, and this study makes an original contribution to knowledge about designing hospitals to promote wellbeing. Our findings are suggestive of a broader agenda to be addressed both from a policy perspective and in terms of the development of theories of therapeutic landscapes.

If carers are to be seen as equal partners in the treatment and recovery of mental health service users, then as well as being aesthetically pleasing, safe and secure, it is important that the hospital environment be experienced as 'permeable' for them in their caring role. A permeable institution in this sense would be one that ensures for carers:

- accessibility to the site;

- free movement across the interface between 'inside' and 'outside' the hospital;

- an inclusive, 'homely' hospital setting, fostered though good relationships between the hospital staff and carers, and peace and privacy to reproduce domestic practices;

- good links to the community and spaces within the hospital that partly substitute for social and faith-based venues in their home communities and help to maintain kinship and friendship bonds.

It seemed the newly built inpatient facility for mental health care considered here offered these features to some extent. Some of our informants especially valued the efforts by staff at the hospital to include carers more fully, not only in the treatment and recovery of

service users but also in plans and strategies to improve the hospital environment. One of our informants had been included in the design process; and there seemed to be a concerted effort through the hospital and other organisations to provide information and support for carers. The construction of a new, attractive looking building that departed from the appearance of the stigmatised, 19th Century building housing the Old Hospital facility was seen as a helpful development. However, our findings also suggest that carers are still experiencing the hospital space as 'outsiders' and more could be done to ensure accessibility, permeability and inclusiveness for carers in the hospital space. Some of the efforts to engage with carers and acknowledge their key position in the 'Triangle of Care' seemed sporadic and inconsistent. The New Hospital could potentially have been made more permeable for carers by paying more attention to the interrelated material, social and symbolic aspects of the inpatient setting from a carer's point of view. The information provided by the carers participating in this study suggested that it would have been helpful if the hospital design and model of care were based on a stronger understanding of the ways in which carers experience the hospital setting, through dynamic engagement with the space, linked to their caring roles.

Our findings therefore raise challenging questions as to whether it is really possible to accommodate the diverse needs and preferences of all carers and users in an inpatient setting. One might even question the wisdom of recreating too faithfully a 'homely', personalised environment in a hospital, when the aim of hospital care is to help patients to recover and return to community settings. Furthermore, the transfer of features from the hospital space into the home space and vice versa may be experienced as disempowering and excluding for some carers and service users, as argued by DeVerteuil and Wilton (2009) in their study of addiction services. Some hospital patients may also prefer to retreat, at least temporarily, from their home or the community, so that greater permeability may not always be conducive to their wellbeing. Nevertheless, for many mental health service users and family carers, the hospital is the setting for extended or repeated periods of care, so it seems essential to explore how to enhance the permeability and therapeutic quality of the hospital setting from their point of view.

This paper also contributes to geographies of health concerned with the interpretation of 'healing landscapes'. Our findings reinforce arguments from authors such as Conradson (2005) that perception of therapeutic landscapes is contingent on individual characteristics and experience. We have stressed the need for a *dynamic* perspective, reflecting individuals' phenomenological experiences of 'being in' place and space and moving along 'caring pathways' in their routine practices of care.

References

Brown, T. (2003). Towards an understanding of local protest: hospital closure and community resistance in *Social and Cultural Geography*, 4(4), 489-506.

Buckner, L., Fry, G., & Yeandle, S. (2010). *Carers in the Region: A profile of the North East*. Commissioned by the Department of Health and Conducted by Centre For International Research on Care Labour & Equalities, University of Leeds.

Campling, P., Davies, S., & Farquharson, D. (2004). *From Toxic Institutions to Therapeutic Environments: Residential Settings in Mental Health Services*. Gaskell, London.

Conradson, D. (2005). Landscape, care and the relational self: Therapeutic encounters in rural England. *Health and Place,* 11, 337-348.

Curtis, S. (2010). *Space, Place and Mental Health.* England. Ashgate, Geographies of Health Series.

Curtis, S., Gesler, W., Priebe, S., Francis, S. (2008). New spaces of inpatient care for people with mental illness: A complex rebirth of the clinic in *Health and Place.* 15 (1). 340-348.

Curtis, S., Gesler, W., Fabian, K., Francis, S., Priebe, S. (2007). Therapeutic landscapes in hospital design: a qualitative assessment by staff and service users of the design of a new mental health inpatient unit. *Environment and Planning C: Government and Policy,* 25, 591-610.

Department of Health (1999). *Caring about Carers: a national strategy for carers*: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAnd Guidance/DH_4006522

Department of Health (2010). *Recognised, valued and supported: Next steps for the Carers Strategy:http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsP olicyAndGuidance/DH_122077*

Conradson, D. (2005). Landscape, care and the relational self: therapeutic encounters in rural England. *Health & Place,* 11(4), 337-348.

DeVerteuil, G., & Wilton, R. (2009). Spaces of abeyance, care and survival: The addiction treatment system as a site of 'regulatory richness' in *Political Geography* 28, 463 – 472.

Gatrell, A. (2002). Geographies of Health: An introduction. Oxford, Blackwells.

Gesler, W. (2003). *Healing Places.* Oxford UK. Rowman & Littlefield Publishers.

Gesler, W., Bell, M., Curtis, S., Hubbard, P., Francis, S. (2004). Therapy by design: Evaluating the UK hospital building programme in *Health and Place* 10 (2005) 117-118

Goffman, E. (1968). Asylums: essays on the social situation of mental patients and other inmates. Harmondsworth: Penguin.

Karlin, B, E., & Zeiss, R, A. (2006). Environmental and Therapeutic Issues in Psychiatric Hospital Design: Towards Best Practices in *Psychiatric Services,*57,(10), 1376-1378.

Kearns, R, A. (1997). Narrative and metaphor in health geographies in *Progress in Human Geography* 21, 2, 269 – 277.

Kearns, R, A., & Joseph, A, E. (2000). Contracting opportunities: interpreting post-asylum geographies of mental health care in Auckland New Zealand. *Health & Place* 6, 159-169.

Kearns, R, A. & Barnett, J, R. (2000). "Happy Meals" in the Starship Enterprise: interpreting a moral geography of health care consumption in *Health and Place* 6, 81-93.

Kearns, R, A., Barnett, J, R., Newman, D. (2003). Placing private health care: reading Ascot hospital in the landscape of contemporary Auckland in *Social Science and Medicine* 56, 2303-2315.

Merleau-Ponty, M. (2001). Phenomenology of Perception. 2nd Edition, London, Routledge.

Milligan, C., Atkinson, S., Skinner, M., Wiles, J. (2007). Geographies of care: A commentary in *New Zealand Geographer,* 63, 135-140.

Milligan, C. (2000). 'Bearing the Burden': towards a restructured geography of caring, *Area,* 32: 1 49-58

Milligan, C. (2001). *Geographies of Care, space, place and the voluntary sector*. Ashgate. England.

Milligan, C. (2003). Location or dis-location? Towards a conceptualization of people and place in the care-giving experience in *Social and Cultural Geography*, 4, 455-470.

Milligan, C. (2005). Bearing the burden: towards a restructured geography of caring in *Area,* 32.1, 49-58.

Milligan, C. (2009). *There's No Place Like Home: Place and Care in an Ageing Society*. Ashgate. England.

Moon, G., Kearns, R., Joseph, A. (2006). Selling the private asylum: therapeutic landscapes and the (re)valorisation of confinement in the era of community care in *Transactions of the Institute of British Geographers,* Royal Geographic Society, 31 (2), 131-149.

Parr, H., Philo, C., & Burns, N., (2003). "'That awful place was home": Reflections on the Contested Meanings of Craig Dunain asylum. *Scottish Geographical Journal* 119: 4, 341-360.

Philo, C. (2000). Post-Asylum geographies: an introduction. *Health and Place* 6, 135-136.

Priebe, S., Badesconyi, A., Fioritti, A., Hansson, L., Kilian, R., Torres-Gonzales, F., Turner, T., Wiersma, D.,(2005). Re-institutionalisation in mental health care: comparison of data on service provision from six European Countries. *British Medical Journal* 330, 123-126.

Priebe, S., Frottier, P., Gaddini, A., Hansson, L., Kilian, R., Lauber, C., Martinez-Leal, R., Munk-Jorgensen, P., Walsh, D., Wright, D., (2008). Mental health care in nine European countries, 2002-2006. Psychiatric Services 59 (5), 570-573.

Quirk, A., Lelliott, P., Seale, C. (2006). The permeable institution: An ethnographic study of three acute psychiatric wards in London. *Science & Medicine 63,* 2105-2117.

Ruane, P. (2004). A carer's perceptions of the therapeutic value of in-patient settings. In

Campling, P., Davies, S., Farquharson, G. (Eds) *From Toxic Institutions to*

Therapeutic Environments: Residential Settings in Mental Health Services.London.

Gaskell. Ch. 16.

Rutherford, S. (2005). Landscapers for the Mind: English Asylum Designers, 1845-1914.

Garden History 33 (1), 61-86.

Ryan, G, W., & Bernard, H, R. (2003). Techniques to identify themes in *Field Methods*, 15,

85 - 108.

Schweitzer, M., Gilpin, L., Frampton, S. (2004). Healing Spaces: Elements of Environmental

Design that make an impact on health in *The Journal of Alternative and*

complementary medicine 10 (1), 71-83.

Turner, T. (2005) From Toxic Institutions to Therapeutic Environments: Residential Settings

in Mental Health Services in *Psychiatric Bulletin* 2005, 29: 318.

Wiles, J. (2003). Daily geographies of caregivers: mobility, routine, scale in *Social Science*

and Medicine 57, 1307 – 1325.

Worthington, A., & Rooney, P. (2010). *Triangle of Care, Carers Included: A Guide to Best*

Practice in Acute Mental Health Care. National Mental Health Development Unit.

Available at: http://its-services.org.uk/silo/files/triangle-of-care-carers-included.pdf