

Place, policy and practitioners: on rehabilitation, independence and the therapeutic landscape in the changing geography of care provision to older people in the United Kingdom

Graham P. Martin, Susan A. Nancarrow, Hilda Parker, Kay Phelps & Emma L. Regen

A growing body of literature in geography and other social sciences considers the role of place in the provision of healthcare. Authors have focused on various aspects of place and care, with particular interests emerging around the role of the psychological, social and cultural aspects of place in care provision. As healthcare stretches increasingly beyond the traditional four walls of the hospital, so questions of the role of place in practices of care become ever more pertinent. In this paper, we examine the relationship between place and practice in the care and rehabilitation of older people across a range of settings, using qualitative material obtained from interviews and focus groups with nursing, care and rehabilitation staff working in hospitals, clients' homes and other sites. By analysing their testimony on the characteristics of different settings, the aspects of place which facilitate or inhibit rehabilitation and the ways in which place mediates and is mediated by social interaction, we consider how various dimensions of place relate to the power-inscribed relationships between service users, informal carers and professionals as they negotiate the goals of the rehabilitation process. We seek to demonstrate how the physical, psychological and social meanings of place and the social processes engendered by the rehabilitation encounter interact to produce landscapes that are more or less therapeutic, considering in particular the structuring role of state policy and formal healthcare provision in this dynamic.

Published in:

***Social Science & Medicine* 61(9): 1893-1904**

<http://www.elsevier.com/locate/socscimed>

http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6VBF-4G7NT5T-2&_coverDate=11%2F30%2F2005&_alid=306028092&_rdoc=1&_fmt=&_orig=search&_qd=1&_cdi=5925&_sort=d&view=c&_acct=C000009959&_version=1&_urlVersion=0&_userid=121708&md5=592be11e0f9b158729b755d6f5c351fe

5=592be11e0f9b158729b755d6f5c351fe

doi:10.1016/j.socscimed.2005.04.001

Introduction

Geographers and other social scientists have in recent years devoted attention to the role of place in the provision of healthcare. A particular theme has emerged around questions of the role of the psychological, social and cultural aspects of place in care provision (e.g. Aronson, 2002; Geores & Gesler, 1999; Milligan, Gatrell & Bingley, 2004; Williams, 2002). In the United Kingdom and other economically developed countries, the home and other non-hospital environments now provide the setting for some forms of healthcare which would previously have been provided in institutions, particularly for older people, who in popular and policy discourses are seen as better cared for outside the acute ward—whether for clinical, social or financial reasons. Whilst such settings may possess certain therapeutic qualities which aid recuperation and avert the supposedly institutionalizing effects of conventional places of acute and post-acute healthcare delivery, some authors have noted the transformative effect that clinical interventions may have on the characteristics of alternative settings, and the ambiguities

inherent in discursive opposites such as 'home' and 'institution'.

In this paper, we consider the role of place in care and rehabilitation through the testimony of practitioners working in a new British model of health- and social-care delivery known as 'intermediate care', a policy aimed primarily at older people with a view to preventing unnecessary hospital admissions and facilitating earlier discharges. We consider how healthcare provision in a number of places—hospitals, care homes, day centres, patients' own homes—interacts with the emotive and social aspects of those settings, and how this creates environments which are more or less therapeutic for clients. What we describe here is a complex picture in which relationships of power between patients, professionals and informal carers, expectations regarding particular settings, and the influence of community care policy imperatives are all implicated. The therapeutic environment is not, we suggest, a straightforward notion, but crucially dependent on the social, symbolic and policy contexts of care provision, and the way these interact.

Home, hospital and the 'therapeutic landscape'

Though the symbolic and psychological aspects of place are well researched in humanistic and cultural geography, it is only really since the 1990s that health geography and related disciplines have begun to address the relationship between these dimensions, places and health. Gesler's (1991) notion of the 'therapeutic landscape' as an environment conducive to wellbeing has been widely used since by writers looking at the link between places and healthiness or recovery. Within this literature, a focus has emerged on the emotions and social practices associated with different places as healthcare settings—"the complex links between space, power relations, the body, and the constitution of identities" (Dyck, 1998: 103). The home and the hospital have been studied in detail in terms of the values they connote, the social practices they ensconce and the consequences for those concerned as people and patients.

Commonly in this literature, the home is constructed as a therapeutic environment (e.g. Abel & Kearns, 1991; Williams, 1999), often in implicit or explicit contrast to the hospital. Where the home is a place of emotional and ontological security (Gurney & Means, 1993), the hospital—and other institutional environments, such as residential homes or day centres—are often alien, alienating environments of clinical domination and personal uncertainty (Godkin, 1980; Milligan, 2003; Twigg, 2000). Geores and Gesler (1999: 100) write of how curative and restorative environments frequently "do not coincide. Home ... might provide a therapeutic environment, but relatively poor treatment, whereas a hospital might provide good treatment, but a poor environment." Recognition is growing, however, of the complications to this general view. The meanings and practices associated with the home, for example, vary on an individual level and more systematically according to dimensions of class, ethnicity and age (Gurney & Means, 1993), and particularly gender (Moss & Dyck, 1996). Research into the meaning of home to older people has paid increasing attention to the complexities of their attachment to the home space, both as a long-term living place and a short-term alternative to hospital. Oldman and Quilgars (1999) question the received wisdom that home is necessarily the preferred habitat of older people, examining the diversity of views among those living at home and in residential settings. Percival (2002) notes the importance of autonomy and control in the home to a sense of security and attachment among older people; Mowl, Pain and Talbot (2000: 194) find this especially crucial for women: "the home is more likely to be an important symbol both of a positive feminine identity and of resistance to negative old age identities than for men. For many, a tidy home indicates someone who is fit and has visitors." The therapeutic value of a particular environment is increasingly recognized by researchers to be context-dependent, and so the social and symbolic aspects of 'home', 'hospital' or any other abstracted categorization of place cannot be taken for granted.

Over the last 10 years, then, health geographers have pointed to the ambiguities inherent in the notion of home: over the same period in the domain of social policy, though, successive governments in the UK have placed an increasing emphasis on the home as the best place for older people. In line with policies on care in the community introduced from the early 1990s

onward, numerous consultation documents and policy papers produced by the UK government have placed an onus on 'promoting independence' by 'enabling' older people to remain at home. Alongside the financial imperatives behind such policies, community care was ostensibly based on the (as we have seen, partially evidenced) assumption that older people prefer to live at home—though as Oldman and Quilgars (1999: 364; their italics) acutely observe, in many policy documents, even a positive choice to cease living at home was conceived as failure:

A report, commissioned by the Department of Health (1994), was titled: *The F Factor: Reasons why some people choose residential care*. The study aimed to find out more about people on the margins of residential care, those at [sic] 'at risk' of giving up their homes. F stood for fear; the question being asked was 'why do some people manage to remain in the community but others have *failed* to do so?'

As we shall see, intermediate care represents a continuation of such policies, with its professed aim of promoting independence with a view to maintaining patients at home (Department of Health, 2001a).

Given this discursive association between living at home and successful ageing, both in the testimony of some older people and in state policy, health- and social-care interventions in the home assume an intriguingly ambiguous role. As Aronson (2002: 402) puts it, "formal providers' very presence in the home signals an intrusion of public into private. Home care carries the contradictory potential both to support and undermine what home signifies." The extension of clinical authority into the home space brings with it power relations and a medicalization which may remove or even reverse the positive notions of home for older people (McGarry, 2003; Percival, 2002; Twigg, 1997): for Parr (2003: 216-7) this represents a "problematic merging of domestic space with both formal and informal care as a result of care restructuring in ways which (especially for the elderly) mean a curious kind of 'institutionalization', actually within their own homes." Alongside this, there is a recognition in the literature that institutional environments are not necessarily institutionalizing. Some 25 years ago, Godkin (1980: 83) wrote about the adaptation of a palliative-care unit to make it more 'homelike', including a kitchen where family members could prepare meals, and where "physical barriers which were initially designed to delineate professional space from patient space [had] been removed." Others have pointed to the more positive aspects of life in communal settings such as care homes (Oldman & Quilgars, 1999; Rowles, Concotelli & High, 1996); further, an American study (of acute, rather than post-acute or long-term, care) indicates a preference among older people for hospital over home treatment (Fried, van Doorn, O'Leary, Tinetti & Drickamer, 2000).

To remain in the home space, then, is not, in itself, what older people always necessarily prefer in the long- or short-term, and what is evident from the above overview of the literature is that social practices can dramatically alter the meanings of places and people's relationships to them. Yet only recently have researchers begun to look at therapeutic landscapes as processes, created as much by the acts of those involved in routines of care as by the discourses associated with places or their immanent properties. Though the dynamic between social and symbolic landscapes has always been a theoretical concern in the therapeutic landscape literature (e.g. Gesler, 1992), its empirical implications have until lately to some extent been neglected; more research is needed on the ways in which the symbolic constructions of home and other settings interact with the practices which produce and reproduce places:

It can hardly be claimed that geographers in this field have as yet fully examined the multiple material and symbolic dimensions to the giving and receiving of care, or thoroughly explicated care as a concept while critically assessed [sic] caring practices, roles, relations and so on. (Parr, 2003: 213)

Environment is embedded in a socially constructed space that acts as a medium of social relations discursively shaping and reshaping both individuals and places. Conceptualising environment solely in discursive terms, however, does not recognise privileged positions of power nor the ability of individuals to resist processes

structuring space. (Moss & Dyck, 1996: 746)

In this paper, we attempt to address these research agendas by considering the symbolic dimensions of place in the context of the social practices engendered by a particular form of short-term care and rehabilitation in the UK, which takes place in a variety of different settings, from the home to the hospital: 'intermediate care', the origins and objectives of which we now briefly describe.

Policy background: shifting geographies of care

In the UK as in much of the world, the burden of care of chronically and terminally ill people has increasingly been shifted from the state to the family, and consequently the home, for some time now (Cartier, 2003; Milligan, 2000). Increasingly, medical provision too has been offered in settings other than the acute hospital. Technological advances have meant that patients can be treated for a growing number of conditions as safely and effectively—and often at lower cost to the system—in a non-hospital setting as in hospital (Fried *et al.*, 2000); there is evidence, too, for the efficacy of rehabilitation in the normal living environment of the patient (e.g. Wade, 2003). In the UK, one area of focus in this transition has been the care of older people, a group perceived as frequently admitted unnecessarily to hospital for want of an alternative (Department of Health, 2000), as particularly vulnerable to the risks associated with hospital admission (Young, 2001), and as commonly feeling a strong attachment to home (Gurney & Means, 1993). In 2001, the British government introduced its *National Service Framework* for older people, which included among its standards a new initiative: intermediate care, the declared aim of which was “to provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living,” either “at home or in designated care settings” (Department of Health, 2001a: 41).

Provision for support, rehabilitation and care outside the hospital was not new, but this initiative did provide funding for three years to support development, with guidance and targets, as well as affirming certain principles of care: notably needs assessment and cross-professional and inter-organizational working to make services more ‘joined up’ for clients (Department of Health, 2001b). Of particular note in the context of this paper was the emphasis on treating the whole patient on the basis of her or his particular needs: intermediate care was to include “a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery” (Department of Health, 2001b: 6). More controversially, episodes of intermediate care—and the benefits of free social care and (if applicable) ‘hotel costs’ under the banner of a NHS service—were to be limited to a maximum of around six weeks’ duration. This serves to distinguish it from longer-term rehabilitation services already available through health- and social-services provision in the UK, and underlines the particular intended place of intermediate care within the British health- and social-care system: as a short-term episode of care or rehabilitation which avoids or reduces hospitalization and maximizes the capacity for independent living at home. Of course, both of these objectives are double-edged swords: avoiding unnecessary hospital admission and promoting timely discharge are seen as best for the patient’s wellbeing, and may also improve the efficiency of the health service; as outlined above, promoting independent living is generally viewed as what older people want, and may also reduce the cost to the state in terms of home-care provision and care-home placements.¹ As we have seen from the literature, however, and as we shall see in the presentation of data in this paper, it cannot always be assumed that the goals of patients are as neatly aligned with those of the system as policymakers might hope.

Intermediate care as put into practice has involved provision in various settings: from the client’s home to care homes, day centres, sheltered housing and even hospital wards. What we

¹Unsurprisingly, much debate has centred around which of these forms the main motive in the government’s promotion of intermediate care, as with other welfare state reforms: see, for example, Pollock (2000).

wish to look at in this paper is how the kinds of social relationships and interventions involved in intermediate care interact with the social and psychological aspects of these places to fashion more or less therapeutic landscapes, and with what effects on the actors involved.

Methods

This paper uses qualitative data produced in the course of two studies. One, a National Evaluation of Intermediate Care funded by the UK Department of Health and the Medical Research Council, was a multi-method inquiry into the costs and outcomes of intermediate care, which involved, *inter alia*, quantitative and qualitative work in five case study sites across England. The qualitative component consisted of in-depth interviews and focus groups with staff involved in the planning and delivery of intermediate care in various settings. The other study was a smaller-scale evaluation of an intermediate-care ward in an acute hospital funded by the local hospital trust, again including in-depth interviews and focus groups with staff. The role of place in respondents' work was not the main focus of the qualitative work in either study, but frequently arose 'organically' as an issue in the course of conversations. That place of care was not the main focus of these interviews might be seen as a weakness or a strength: though some issues might not have been covered as comprehensively as may have been the case in interviews 'about place', the material elicited was tangible, concrete, central to practice: not the result of the artificial pursuit of potentially quite abstract concepts by the interviewers.

In total, 92 interviews and focus groups were conducted in the course of the two studies, of which 45 produced material relevant to this paper, used in the construction of the themes considered below. Table 1 shows the professional designations and work environments of the respondents, together with codes used to identify them in transcript excerpts. Interviews and focus groups were tape-recorded and transcribed in full, and (due to the volume of material) keyword searches were used to identify passages of material relevant to the role of setting in care provision.² This material was then thematically coded and analysed in terms of themes identified across respondents and issues specific to individual services and settings (cf. Ritchie & Spencer, 1994).

We now turn to consider those themes in the following four sections on our results. In the first two, we look at respondents' views on the different settings in which intermediate care was provided, and begin to consider the role of the social context (for example, the relationship between those involved, or the therapeutic objective of the intervention) in defining 'homely' environments, and in determining which settings were seen as most physically or psychologically beneficial. From this examination of how social context mediates place, in the third section our focus moves to one way in which place mediates social interaction, as we highlight how the physical, social and psychological associations of different places influence the relationship between staff and clients in the rehabilitation process. Having sought to illustrate this dialectic between place and process, and between staff and clients, in the fourth section we emphasise the crucial structuring influence of state policy in these dynamics and in the kinds of therapeutic landscapes they produce.

The rehabilitation environment: 'homely' and 'institutional' settings

Respondents' testimonies about the settings in which they worked (or of which they otherwise had experience) often accorded with common perceptions of the home and institutions as places of care. Staff who worked with patients in their home environments were quick to highlight the merits of provision at home, referring to the direct benefit in occupational-therapy terms of improving function within place, and contrasting the home as a place of recovery with the hospital ward. Where service users became institutionalized in hospitals, according to many of these respondents, at home "people become themselves" (A-F3), or "naturally take more

²The keywords used were 'commun*' (to find community, communal etc.), 'environment', 'home', 'rehab*', 'setting' and 'ward'.

Code	Discipline(s)	Number	Setting
<u>National Evaluation: case study site 1</u>			
A-F1	Doctor, therapists, nurse, admin	7	H
A-F2	Therapists, assistants, nurse	6	H
A-F3	Therapists, assistant, CPN	4	RH
A-F4	Therapists, nurses, assistants	8	W
A-F5	Admins, assistants	5	SH
A-F6	Admins, nurses, assistants	6	H
A-F7	Therapists, nurse, admin., SW	6	H
A-F8	Nurses	2	H
A-I1	Manager (nurse)	1	W
A-I2	Manager	1	H
A-I3	Manager (OT)	1	RH
A-I4	Manager (nurse)	1	H
A-I5	Manager (OT)	1	H
A-I6	Manager (physio)	1	H
<u>National Evaluation: case study site 2</u>			
B-F1	Nurses, therapists, admin.	5	DH, H
B-F2	Therapists, assistants, nurse, SW	7	DH, H
<u>National Evaluation: case study site 3</u>			
C-F1	Therapists, admin.	4	H
C-F2	Therapist, admin., assistant	3	DC
C-F3	Therapists, admins	7	H
C-F4	Nurse, admin, assistant, therapist	4	H, W
C-F5	Therapists, admin.	6	H
C-F6	Managers (OT and admin)	2	RH
C-F6	Therapists, nurse, admin.	4	RH
C-I1	Matron	1	W
C-I2	Manager (physio)	1	H
C-I3	Manager (physio)	1	H, W
C-I4	Intermediate Care Co-ordinator (OT)	1	n/a
<u>National Evaluation: case study site 4</u>			
D-F1	Therapist, assistants	3	H
D-I1	Senior OT	1	H
D-I2	OT	1	SH, H
D-I3	Physiotherapist	1	H
D-I4	OT	1	H
D-I5	Intermediate Care Co-ordinator	1	n/a
<u>National Evaluation: case study site 5</u>			
E-F1	Assistants	5	RH, H
E-F2	Nurses, therapist	4	H
E-F3	Assistants	2	H
E-I1	Manager	1	RH
E-I2	OT	1	RH, H
E-I3	Manager	1	RH, DC
E-I4	Modern matron	1	NH
<u>Evaluation of an intermediate care ward</u>			
F-F1	Therapists	3	W
F-F2	Nurses, therapists	4	W
F-F3	Assistants	5	W
F-I1	Ward sister	1	W
F-I2	Consultant nurse	1	W

Table 1: breakdown of interviews and focus groups from which material was used in qualitative analysis for this paper. 'Assistants' are rehabilitation assistants, care assistants or nursing auxiliaries. H=home, RH=residential home, W=hospital ward, SH=sheltered housing, DH=day hospital, DC=day centre, NH=nursing home.

control" (C-F5). The hospital, in contrast, was a space of disempowerment:

You find somebody who's been in hospital for six weeks: just think, six weeks

they've never made themselves a cup of tea, they haven't done themselves a sandwich, a cooked meal or anything. (E-F3)

It's often their first admission into hospital which is quite traumatic, and you could see how institutionalized they became very quickly and their confidence, their anxiety levels really, of were they ever going to get home, you know, it was unnatural surroundings. So to be able to maintain someone in their own home, how much more benefit is that? Really, really good. (D-I4)

Respondents who worked in institutional environments other than the hospital (for example, residential homes) often made a similar distinction between the disabling environment of the ward and the 'homely environment'—a phrase used by many—of their own intermediate-care provision. One saw her residential home as "quite a homely environment: it is not home but it is the next step from hospital" (A-F3). An occupational therapist at another care home described how "we want it to be a home environment, because that's what people will be doing in their own homes. If they want a cup of tea when they get home they get up and make themselves a hot drink, so here we just try and keep it informal" (E-I2). The emphasis from these respondents, too, was on avoiding the institutionalizing effect (and affect) of the institution, and promoting the functional independence associated with life at home. Even those respondents who provided intermediate care in hospital settings stressed what distinguished their service from a 'conventional' hospital ward. Again, notions of homeliness and functional independence were closely linked: "It's more like home for them, it's do-it-yourself" (F-F3).

The home, then, was seen by many respondents as the ideal environment for care and rehabilitation: for those providing intermediate care in settings other than the home, the aim was often to make the environment as much like home as possible. Most frequently, as one might expect given the emphasis of intermediate-care policy on independence, this was expressed in terms of service users' improved capacity for *functional improvement* and *autonomy* in their home environment (the physical and social attributes of the home as a therapeutic landscape), although there were other aspects to this too, such as users' perceived emotional attachment to their homes (the symbolic attributes of the home). These, though, were relatively abstracted conceptualizations of places: as we shall see, when respondents started to speak in terms of more specific, concrete examples, the complications to such generalizations emerged, as they examined the interaction of symbolic and social dimensions of places as settings for rehabilitation.

Rehabilitation outside the domestic space

The home was not seen by all respondents as necessarily the best place for intermediate care. In the absence of physical adaptations to the home environment, for example, physiotherapy and occupational therapy were sometimes best achieved in more specialized settings. There were other aspects of rehabilitation which were best accomplished outside the home. One nurse working in a day hospital explained how her team promoted outdoor confidence:

Our little garden, I call it a rehab garden because some people are immobilized and they're confident in their own little world at home, but bring them out of their world [...] and taking them not only here in the hospital but taking them just outside in the garden or round the grounds of the hospital, where you've got the fresh air on your skin, you've got steps down, you've got slopes up, you've got uneven pavements, that's what they're frightened of often, of going to the post office or going to the shops themselves. (C-F4)

This respondent suggests that the home acts to restrict the aspirations of her clients: a limiting environment detrimental to the wider aspects of rehabilitation (cf. Moss & Dyck, 1996; Mowl *et al.*, 2000). An occupational therapist who worked in intermediate care in a residential home and in the community described a similar pattern:

A lot of them would have gone home and sat and given up, whereas at least having

come through intermediate care, whether it's here or if it's in the community, they've got the confidence to go and do something else: for a lot of them it's the confidence of getting back outside the front door and going back to church and other things like that, which they can do from here. (C-F6)

Another respondent, who worked in intermediate care in sheltered housing, described how, upon moving into the new setting, some service users "might very quickly improve without any other kind of input *et cetera*—the change of environment. The kind of change to the inertia that is set in to somebody's situation at home" (D-I2).

Other respondents drew attention to the benefits of the communal nature of institutions. A rehabilitation assistant working in intermediate care in a day centre pointed out the benefits of social interaction for her clients' rehabilitation:

The group activities, you will suddenly see that one of them is using what has been an affected hand really well because they are not actually thinking about it but they are joining in, copying and it is the social bit. You can say, 'I have watched you and you have been doing that for 10 minutes,' or they have been tapping their feet to music. Had you said, 'I would like you to tap your foot', they would not do it, or it would be laboured, struggle, 'Oh I cannot do this any more.' Get them in a social atmosphere, make it part of an activity, with a beat of music, and before you know it they are away. [...] If you have a group of people they are quite competitive and they do bait one another and that is the bit that works so well. It motivates and stimulates them to sort of do that little bit more. (C-F2)

Thus the interaction among service users within communal intermediate care settings could have a significant impact on the rehabilitation process, supplementing the more planned care drawn up by professionals. A nurse who worked in an intermediate-care ward made a similar point:

A lot of clients are living alone and they make friends here and communicate with each other and have overall a positive and quite social experience here and you are often dealing with people recently bereaved here. They lose their motivation, naturally, they go off legs and somehow end up on Intermediate Care Ward 4. [...] For them it is vital social contact on here so alongside the motor function and mechanical improvement that we hope to gain, one of the things I value about this ward is that we have a kind of socio-emotional input as well. (F-F2)

These respondents, then, describe the limits of the home as a site for rehabilitation, and of the discourse of the home as a site of independence and self-determination. What emerges is the context-dependency of function and independence: sometimes the social environment of the day centre might provide the most therapeutic landscape; at other times it is the escape from the four walls of the house. In the process, the respondents call into question the straightforward equation of 'independence' with 'living at home with maximized functional ability' (cf. Aronson 2002), drawing attention to clients' needs for the social and psychological aspects of rehabilitation (cf. Milligan *et al.*, 2004). In practice, the therapeutic landscape cannot easily be reduced to the straightforward physical, social or symbolic properties of place by themselves: rather it is the interaction of these in the particular context of the rehabilitation process which renders places more or less therapeutic.

Setting, interaction and behaviour

Closely related to this question of what social and spatial factors create a beneficial environment for rehabilitation was the role of place in structuring the relationship between service users and staff. A number of respondents illustrated how assessing and serving patients in less institutional settings made the relationship less hierarchical and more client-centred, and enabled them to view the needs of the client holistically and in context (cf. McGarry, 2003; Twigg, 2000; Williams, 1999):

- R1: I find it easier to understand people in this environment than I do in hospital because I think in hospital people can get into the sick role ...
- R2: Quite institutionalized.
- R1: Institutionalized. Whereas here they see it maybe as a, I mean I talk to people here and they don't like hospital but they like here, or Blossom Hill or Fairview [residential homes where intermediate care is provided]. If you can work with people in those environments it is a lot easier, and they are more co-operative, they don't see you as an authoritarian figure, they see you as a friend that they can work with. (A-F3)

Other respondents, though, felt that a more formal relationship between staff and clients was preferable, as connoted by the physical environment and other signifiers, such as staff wearing uniforms: one rehabilitation assistant compared her previous experience working in users' own homes to her role now in a day centre:

Before I wore uniform, I went in for a chat and had a nice cup of tea with them as opposed to physio, who would go in in uniform and they would be up and doing everything. So OK, that is it, back in uniform. Completely different. It just sets the boundaries, bringing someone into this environment, they expect to work or they expect to go home better, because you are not working on things they would do on a normal day at the house. (C-F2)

The manner in which setting fixes the norms for the behaviour and interaction of client and staff member was complicated by the role of family members, often informal carers of long standing, in the rehabilitation process:

Having another person in the house can affect what you can do with that individual. You can't say, 'Excuse me, can you leave the room while I do this?', because you are in their home. Particularly elderly couples, the dialogue between husband and wife has not been good for 30 years. You go in to perhaps change things in their environment. If you have an irritable partner the other side of the room giving negative feedback to the person you are working with, it is difficult. (C-F2)

Her sister said, 'I don't think she's going to manage coming home, she can't get up that step.' I said, 'Come on Patricia, you can get up that step, you do group exercises, you lift your leg up as high as I can!' [Her sister said,] 'She can't get up that step, she can't.' [...] As soon as [her family] come in, she would just go to pieces because they would tell her, 'You can't do that.' (E-F1)

The power relationship between individuals and their carers, then, sometimes worked to render the home environment a stifling one, quite inappropriate to rehabilitation. Whether through carers' overbearing love or their fear of the burden created by their relative's return home, the social relations and behavioural norms of the home environment were not always conducive to the kinds of functional independence that practitioners were trying to consolidate in their clients.

Equally, however, respondents often reported that clients themselves had an ambivalent attitude towards the rehabilitation process. Some patients were unwilling to engage in the active rehabilitation required by their intermediate-care programme. Others became, in the words of the respondents, too 'attached' to the social contact entailed by intermediate care:

Once they've built up this wonderful rapport with the carers and everything, they don't want you to go, that's the down side of it, you know, that they've got used to the carers coming in and this is rather lovely and this is nice, you know, so I think that is the other side, where you've got to be very careful when you're assessing all the time. Once you've set up the care package and you're having to go back at regular intervals monitoring that patient's progress of having to pull out the care at certain intervals because you're trying to make that person independent, keep stressing that,

and then I come along, this big bad wolf and pull it out altogether and they say, 'Oh,' that's a hard thing, it is sometimes. (D-I4)

As one might imagine, this was perceived as a particular problem by those working in communal settings—even those supposedly dreaded hospital wards:

- R1: The transition between being on the ward and going home seems to get extended and extended, and it's something we just haven't struck a balance on yet. People come and yes, it's a nice environment, it's nice staff and all the rest of it. Consequently you've got to start prising them out because ...
- R2: They don't want to go.
- R3: They actually stick up their own barriers.
- R1: It's human nature. If you give somebody all this kindness and comfort they're not going to want to go, but we haven't found the happy medium yet as to when that point should be forced. (A-F4)

They've been so lonely in their own home, they come here and meet people, they don't want to go home. (E-F1)

The social environment of the communal intermediate-care setting, or the welcome intrusion of rehabilitation assistants into a sometimes lonely home environment, often, then, has implications for the relationship between practitioners, patients and informal carers in putting into practice the rehabilitation programme.

Place, independence and the limits of 'patient-centred' care

We see in the previous section examples of the disputes between patients, staff and carers over the aims, means and boundaries of intermediate-care interventions in the home and institutional settings (cf. Milligan, 2003). What emerges from this are the limits of some of the wider benefits of our respondents' practice, those which extend beyond functional rehabilitation. There is a conflict, for example, between the 'social rehabilitation' which many respondents saw fostered by a communal environment, and the need they felt to ease their clients away from those environments before they became too dependent on them, sometimes against the clients' wishes. The incongruence between different actors' goals in the rehabilitation process indicates the ambiguity of the concept of the therapeutic landscape; the differential power of those actors was crucial in determining whose priorities it was that tended to dominate. Ultimately, the services provided were a means to an end, and that end was reducing functional dependency: if there were social benefits for older people, then this was a welcome bonus, unless it started to undermine that primary aim. The following excerpt from an interview with care-home co-managers is illustrative:

It's very much like being at home, it's really a practice run within a very supportive goal-set environment really. We've stayed away from the social activities and groups for things, we did it for a long, long time. [...] When we were still doing quite a lot of it and every day was structured, people were going home and not coping because the structure of their day had gone, they were lonelier and they weren't feeling as good about themselves, and then everything else was becoming more difficult. [...] It's not a busy, dynamic unit: as I said, we tried busy-dynamic and it worked while they were here but it backfired. (C-F6)

Another respondent stated that the six-week limit to intermediate-care interventions was useful, because "if it tends then to be dragged out, [it's] because they want you there, not because you've been of any use to them" (E-F3)—'use' in this context evidently defined as the technical instruction of functional rehabilitation rather than the value placed by service users on company. And as another respondent stressed:

With some of this particular client group, they do love to have somebody coming in

to see them because they have been lonely for a long time. It is important that we very quickly establish goals, [...] let them know that we are only around for a short time, yes, they can make the most of it. (D-I1)

Whilst, as many respondents stressed, the majority of clients accepted these ground rules for the interventions, conflicts emerged where patients or carers had different priorities to those of the services.³ In an intermediate-care ward, another respondent described her efforts to create a rehabilitative space that might mitigate the disabling effect of the hospital environment:

You do get the odd one or two that will think, 'I'm in hospital: you're here to do it for me'—they take on a sick role. We do try and encourage patients to wear their own clothes, we try and encourage patients not to have bedside tables. [...] We put the patients in groups at the end of the bay to sit and chat with each other, and the interesting thing was it wasn't the patients at that stage that wanted to go back by the beds, it was the relatives that had come in and taken them back to the beds, whether they felt they wanted to talk to them personally or quietly. [...] That is one thing I would like to change definitely from the beginning, is not have the chairs by the beds because the patients now won't allow us to remove the chairs. (F-I1)

It was in these conflicts between staff, carers and service users that the limits of the kinds of non-hierarchical, user-centred care to which many respondents alluded began to emerge.

Discussion

The themes considered above indicate the multifarious nature of the rehabilitation practised by the respondents, and the context-dependency of the different kinds of independence they work to promote. While in some circumstances the emotional significance and the physical familiarity of the home setting were seen as most conducive to patients' psychological and functional rehabilitation, at other times it was escaping the confining walls of the house or enjoying the conviviality of the residential home or day centre which benefited older people. What emerges is the centrality of social and symbolic context in determining the therapeutic qualities of these different settings of intermediate care, and in particular the sometimes-conflicting goals of the actors involved. The role of conflict and power, and the diversity of symbolisms held by these environments for different people, call into question the reification of particular landscapes, such as the home, as necessarily 'therapeutic', as is often the case in policy discourse, and which occasionally informs academic assumptions too. The therapeutic landscapes is better conceptualised as the product of dialectic processes: those studying the role of place in healthcare must remain mindful of Gesler's (1992: 743) assertion that it is "dynamic, a constantly evolving process, molded by the interplay, the negotiation between, physical, individual, and social factors. Thus therapeutic landscape becomes a geographic metaphor for aiding in the understanding of how the healing process works itself out in places." Recent expositions of, for example, the home as a simultaneously liberating and confining environment (Mowl *et al.*, 2000), or the nursing home as a potentially integrated element of local community life (Rowles *et al.*, 1996), provide important reminders of the fact that social and symbolic generalizations about place must be questioned through grounded empirical research.

In the material presented in this paper, the structuring role of intermediate care policy was particularly relevant, with its key objective of improving the functional independence of service

³Some respondents were acutely aware of such conflicts. As one physiotherapist lamented, "The word 'rehabilitation' is grossly overused these days. Everybody has got to be rehabilitated and everybody can do rehabilitation and everybody, if they are not up and running around, ought to be rehabilitated, apparently. There are people who don't want to do that but it keeps them happy going to a day centre, sit quietly in the corner, see other people moving about, chatting, doing things and being given lunch and a cup of coffee, watching the TV somewhere else, just getting out of their own four walls" (D-I3).

users. Although certain forms of provision, particularly in the voluntary sector (Manthorpe, Andrews, Agelink, Zegers, Cornes, Smith *et al.*, 2003), have focused on more 'social' rehabilitation (Martin, Peet, Hewitt & Parker, 2004), the central aim of intermediate care is prevention of unnecessary hospital stays and avoidance of residential long-term care admissions, as the Department of Health (2001b: 5) made clear in its original guidance on the development of the policy:

In conjunction with improvements to community equipment services, home care support and related services it will enable increased numbers of older people to maintain independent lives at home. The expansion of intermediate care is also important to the efficiency and effectiveness of the health and social care system as a whole. It will enable more effective use of acute capacity, supporting targets on waiting times and enabling the NHS to respond more effectively to emergency pressures (particularly in winter). It will also help enable more effective use of capacity in continuing health care and long term care as part of a wider set of measures to reduce dependency and institutionalisation.

To this extent, intermediate care maintains the overwhelming emphasis on functional and social independence among older people of community care and associated policies: the rationale for care closer to home is the functional independence afforded by the home environment. While this may well be what many older people want, it constructs a narrow definition of what constitutes 'success' (independent living at home with as little formal help as possible) and 'failure' (increased dependency on community support services, or admission to long-term care) (cf. Oldman & Quilgars, 1999). As Aronson (2002: 400) puts it in relation to the not dissimilar Canadian policy context, "dependence' is demonised and the interdependencies inherent in human experience obscured. [...] This individualising ethos is compounded for older people by a dominant imagery of successful or positive ageing that enjoins them to age actively and self-sufficiently."

Consequently, as others have found in various contexts, the emotional or 'psychosocial' aspects of the home are rendered marginal in healthcare interventions, or even annulled by an extension of medical practice into the home environment (Allen, 2001; McGarry, 2003; Milligan, 2003; Twigg, 1997). In the process, as we have seen, holistic, non-medical notions of patient wellbeing become somewhat sidelined, as the mantra of functional independence dictates the ultimate aim and means of the intervention. Perhaps inevitably, the policy and its implementation are based on the evidence for the best place for rehabilitation for functional improvement, the (partially evidenced) assumed preferences of older people in general, and the exigencies of the wider health- and social-care system: consequently, the priorities and preferences of individual service users can become sidelined. Allen (2001: 90) makes a similar point in relation to the discharge of older hospital patients:

Community care debates have limited the significance of housing need factors to the physical (e.g. access and utility) aspects of the home. The more oblique aspects of housing need, such as emotional attachment, are seen to possess little or no significance in social policy research, which remains locked in a positivist paradigm where *only* 'hard' facts that can be visibly observed and empirically verified (for example, 'X% of tenants have difficulty with stairs') tend to count as 'rational' knowledge. Furthermore, 'emotional' aspects are seen to have no place in the public sphere of housing practice where hard and rational decisions have to be made about housing need.

Gesler, Bell, Curtis, Hubbard and Francis (2004) paint a strikingly similar picture of policy concerns in hospital design, where NHS priorities centre around the physical dimensions of place, with little attention paid to social or symbolic aspects.

There is an interesting contrast, here, with Wilson's (1991) influential argument that policymakers' 'assumptive worlds' regarding dependency in old age themselves act to enforce

dependency on older people. Certain developments since her paper, such as the increased emphasis on 'enabling independence' through assessment, rehabilitation and support at home, are certainly to be welcomed, but there is a sense that an alternative 'assumptive world' has emerged where the creed of 'independence' risks imposing its own structure on older people who lack the will or means to evade it, whether they conform to the assumptions or not. We also see the limits to the value of potentially therapeutic landscapes other than the home, such as the care home, in a policy context which so emphasises the goal of independent living. Though respondents were aware of the importance to many older people of the social dimension to their programme of rehabilitation, they were eager to prevent their clients becoming too 'dependent' on them or 'attached' to the social environment where this threatened to contradict the central aims of their service (cf. Martin, Phelps & Katbamna, 2004). Grimley Evans' (1997) distinction between governments' focus on *independence* and older people's own aspirations for *autonomy*, which in some cases might only be achievable through a degree of dependency, is pertinent here.⁴ Evident also, though, are the limits to the *policy-enshrined* ideal of client-centred care, where the needs and wishes of the patient are supposedly central: this is all very well and good where the client's aims are aligned with those of the policy and practitioners (as in many cases they were, according to our respondents), but it can become elusive where older people do not see functional independence as their panacea. Reconciling these aims is not an easy prospect, especially given the increasingly narrow remit of personal social services in the UK, but what it clearly does require is a more genuinely client-centred approach, which takes into account the needs and preferences of service users on an individual basis rather than as a collective ('older people' in general). In this way, a genuinely 'holistic' approach to service provision, taking on board the psychosocial dimensions of the client's day-to-day life as well as the more purely functional objectives that tend to be prioritized, might be achieved, though as ever, such aspirations are limited by finite resources, especially in social care.

Conclusion

As others have begun to discover in various settings, the notion of the 'therapeutic landscape' is one that is not easily defined or delineated: rather it is context-dependent, contingent on normative structures of power and social relations and on discourses about the body and place, as well as on the physical properties of the environment as an enabling place (cf. Dyck & O'Brien, 2003; Milligan *et al.*, 2004; Twigg, 2000). In this paper, we have sought to explain how a number of factors come together in constituting therapeutic landscapes in various settings, in the specific context of a British policy initiative which brings its own structuring influence to the way in which care and rehabilitation are conducted. The physical and psychological aspects of alternative settings are important in this, but evident too is the way in which social processes—the ambiguous role of patients' families, for example, or the medicalizing influence of health- and social-care staff—can reinforce or contravene the conventional discourses associated with particular settings, such as assumptions about their 'homely' or 'institutionalizing' properties, to render places more or less therapeutic. Acknowledgement of the malleability of the therapeutic landscape is especially important given the tendency of popular, academic and policy discourse to reify the therapeutic properties of places, or even to focus on the physical aspects of place without recognizing the importance of social and symbolic factors (Gesler *et al.*, 2004).

Our analysis rests on interviews with professionals and other practitioners: the testimony of older people themselves as 'recipients' of care (or, more accurately, as co-actors in care practices

⁴Our findings perhaps also indicate the boundaries of Conradson's (2003) critique of Foucaultian analyses of care and power: in contrast to the spaces of care in Conradson's study (where practices were informed by faith-based notions of unconditional empathy and support), here the structuring power of state policy (and individual practitioners) was evident in the form and function of care and rehabilitation—though as respondents indicated, the service users, as subjects of this power, were often willing to contest its discourses and practices.

and in the production and reproduction of therapeutic environments) was beyond the scope of this research. Whilst there is always a need to learn more from service users themselves, however, the accounts of practitioners provide a revealing perspective on the social and psychological attributes of the intermediate-care environments considered, and in particular on the roles of professional power and policy priorities in defining the limits to these places as therapeutic landscapes for the older people involved.

Acknowledgements

This paper stems from data collected in the course of two studies: a National Evaluation of Intermediate Care, funded by the Department of Health and the Medical Research Council, and an evaluation of an intermediate-care ward funded by a hospital trust. We would like to thank the funders and our colleagues on these studies, and Carol Jagger, Nicky Spiers and two anonymous referees, who read earlier drafts and provided helpful comments. The views expressed in this paper are those of the authors.

References

- Abel, S., & Kearns, R. (1991). Birth places: a geographical perspective on planned home birth in New Zealand. *Social Science & Medicine*, 33(7), 825-834.
- Allen, C. (2001). Back to the old house? 'Sick role' and biographical narratives of the housing needs of short-stay hospital patients. *Health & Place*, 7(2), 81-92.
- Aronson, J. (2002). Elderly people's accounts of home care rationing: missing voices in long-term care policy debates. *Ageing and Society*, 22(4), 399-418.
- Cartier, C. (2003). From home to hospital and back again: economic restructuring, end of life, and the gendered problems of place-switching health services. *Social Science & Medicine*, 56(11), 2289-2301.
- Conradson, D. (2003). Spaces of care in the city: the place of a community drop-in centre. *Social & Cultural Geography*, 4(4), 507-524.
- Department of Health (2000). *Shaping the Future NHS: Long-term Planning for Hospitals and Related Services*. London: Department of Health.
- Department of Health (2001a). *National Service Framework: Older People*. London: Department of Health.
- Department of Health (2001b). Intermediate care. HSC2001/01 / LAC(2001)1. London: Department of Health.
- Dyck, I. (1998). Women with disabilities and everyday geographies: home space and the contested body. In R.A. Kearns & W.M. Gesler (Eds), *Putting Health into Place: Landscape, Identity and Well-being* (pp.102-119). Syracuse: Syracuse University Press.
- Dyck, I., & O'Brien, P. (2003). Thinking about environment: incorporating geographies of disability into rehabilitation science. *Canadian Geographer*, 47(4), 400-413.
- Fried, T.R., van Doorn, C., O'Leary, J.R., Tinetti M.E., & Drickamer, M.A. (2000). Older persons' preferences for home vs hospital care in the treatment of acute illness. *Archives of Internal Medicine*, 160(10), 1501-1506.
- Geores, M., & Gesler, W. (1999). Compromised spaces: contests over the provision of a therapeutic environment for people with mental illness. In A. Williams (Ed.), *Therapeutic Landscapes: the Dynamic between Place and Wellness* (pp.99-121). Oxford: University Press of America.
- Gesler, W.M. (1991). *The Cultural Geography of Health Care*. Pittsburgh: University of Pittsburgh Press.
- Gesler, W.M. (1992). Therapeutic landscapes: medical issues in light of the new cultural geography. *Social Science & Medicine*, 34(7), 735-746.
- Gesler, W., Bell, M., Curtis, S., Hubbard, P., & Francis, S. (2004). Therapy by design: evaluating the UK hospital building program. *Health & Place*, 10(2), 117-128.

- Godkin, M.A. (1980). Identity and place: clinical applications based on notions of rootedness and uprootedness. In A. Buttimer & D. Seamon (Eds), *The Human Experience of Space and Place* (pp.73-85). London: Croom Helm.
- Grimley Evans, J. (1997). Implications for health services. *Philosophical Transactions: Biological Sciences*, 352, 1887-1893.
- Gurney, C., & Means, R. (1993). The meaning of home in later life. In S. Arber & M. Evandrou (Eds), *Ageing, Independence and the Life Course* (pp.119-131). London: Kingsley.
- Manthorpe, J., Andrews, J., Agelink, M., Zegers, S., Cornes, M., Smith, M., & Watson, R. (2003). Volunteers in intermediate care: flexible friends? *Journal of Integrated Care*, 11(6), 31-39.
- Martin, G.P., Peet, S.M., Hewitt, G.J., & Parker, H. (2004). Diversity in intermediate care. *Health & Social Care in the Community*, 12(2), 150-154.
- Martin, G.P., Phelps, K., & Katbamna, S. (2004). Human motivation and professional practice: of knights, knaves and social workers. *Social Policy & Administration*, 38(5), 470-487.
- McGarry, J. (2003). The essence of 'community' within community nursing: a district nursing perspective. *Health & Social Care in the Community*, 11(5): 423-430.
- Milligan, C. (2000). 'Bearing the burden': towards a restructured geography of caring. *Area*, 32(1), 19-58.
- Milligan, C. (2003). Location or dis-location? Towards a conceptualization of people and place in the care-giving experience. *Social & Cultural Geography*, 4(4), 455-470.
- Milligan, C., Gatrell, A., & Bingley, A. (2004). 'Cultivating health': therapeutic landscapes and older people in northern England. *Social Science & Medicine*, 58(9), 1781-1793.
- Moss, P., & Dyck, I. (1996). Inquiry into environment and body: women, work and chronic illness. *Environment and Planning D: Society & Space*, 14(6), 737-753.
- Mowl, G., Pain, R., & Talbot, C. (2000). The ageing body and the homespace. *Area*, 32(2), 189-197.
- Oldman, C., & Quilgars, D. (1999). The last resort? Revisiting ideas about older people's living arrangements. *Ageing and Society*, 19(3), 363-384.
- Parr, H. (2003). Medical geography: care and caring. *Progress in Human Geography*, 27(2), 212-221.
- Percival, J. (2002). Domestic spaces: uses and meanings in the daily lives of older people. *Ageing and Society*, 22(6), 729-749.
- Pollock, A.M. (2000). Will intermediate care be the undoing of the NHS? *British Medical Journal*, 321, 393-394.
- Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman & R.G. Burgess (Eds), *Analyzing Qualitative Data* (pp.173-194). London: Routledge.
- Rowles, G.D., Concotelli, J.A., & High, D.M. (1996). Community integration of a rural nursing home. *Journal of Applied Gerontology*, 15(2), 188-201.
- Twigg, J. (1997). Deconstructing the 'social bath': help with bathing at home for older and disabled people. *Journal of Social Policy*, 26(2), 211-232.
- Twigg, J. (2000). *Bathing – the Body and Community Care*. London: Routledge.
- Wade, D.T. (2003). Community rehabilitation, or rehabilitation in the community? *Disability and Rehabilitation*, 25(15), 875-881.
- Williams, A. (1999). Place, identity and therapeutic landscapes: the case of home care workers in a medically underserved area. In A. Williams (Ed.), *Therapeutic Landscapes: the Dynamic between Place and Wellness* (pp.71-96). Oxford: University Press of America.
- Williams, A. (2002). Changing geographies of care: employing the concept of therapeutic landscapes as a framework in examining home space. *Social Science & Medicine*, 55(1), 141-154.
- Wilson, G. (1991). Models of ageing and their relation to policy formation and service provision. *Policy & Politics* 19(1), 37-47.
- Young, J. (2001). My place or yours—what is the best place for early stroke care? *Age and Ageing*, 30(3), 185-186.