Title: Children's spaces of mental health: The built environment as places of meaning

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Abstract

This chapter will look at the role of the built environment and space in children and young people's mental health settings. In particular, the chapter will focus on the internal and external space of the Child and Adolescent Mental Health Service (CAMHS) outpatients setting. Since work on the built environment and space in children's mental health settings is so sparse, the chapter draws on commentaries from psychological and sociological studies on children's space and place, adult mental health settings and research examining the internal and external spaces of children's hospitals. As well as providing some context-setting for why the child and adolescent mental health services offers an informative site for studying spaces of mental health, this chapter attempts to theorise how different meanings around 'childhood' and the 'child' are enacted through the built environment. In essence, there will be an examination of what meanings are developed through children and young people's interactions with CAMHS. Notably, how specific features of the built environment, symbolic associations with other types of buildings and past memories, serve as the frame of reference for understanding the role of place. Discussions about the construction of the 'normal' childhood will show how features of the built environment in children's mental health settings positions the child as 'dangerous'. The building façade of children's mental health settings are so discreet they perpetuate the stigma associated with children's mental health. CAMHS therefore becomes a 'hidden' service, rather than a service developed *for* children, *by* children. The chapter will conclude by using some empirical data from a study of the CAMHS built environment, collated with parents and children and young people, to act as exemplars for the phenomena discussed.

Introduction

Colin Ward's (1988) seminal book on children in the country has been credited with bringing to the fore, the experiences of 'other' groups of young people (Philo, 1992). In some instances, Ward (1988) details the lives of previously 'invisible' groups of children, or at least, those who have had the least attention in the academic literature and wider public consciousness (Valentine, Skelton & Chambers, 1998). The focus of attention in this chapter, namely children and young people with mental health difficulties, certainly fits into this 'invisible' group. This chapter aims to address a particular mental health space used by some children and young people, namely the built environment. When children and young people have emotional or mental health difficulties in England they may get referred to the Child and Adolescent Mental Health Service (CAMHS). Some of the children will be out-patients, visiting a clinic for appointments only and more serious cases may warrant an in-patient stay in a more formal hospital facility. This chapter will focus on the issues associated with the built environment of the former and aims to examine what impact the built

environment might have on a child or young person coming for outpatient treatment for mental health difficulties.

Whilst there have been notable examples detailing the role of the built environment and space in adult mental health settings, such as asylums (e.g. Philo & Pickstone, 2009; Parr, 2008), community mental health spaces (Parr, 2000; Smith, 2012), and home spaces of mental health service users (Tucker & Smith, 2014), children's mental health services as a context for examining 'space' and 'place' have been sparse. Halpern (1995) suggests that "the built environment includes, but is not limited to physical form of specific dwellings..." (p. 1). By space we refer to they types of settings for interaction and place refers to the specific meanings associated with those spaces (Philo, 2000).

The research on the built environment, space and place relating to children has looked at hospital settings (Birch, Curtis & James, 2007), schools (Gislason, 2010; Kraftl, 2006), nurseries (Clarke, 2010), or the outdoors, such as neighbourhood spaces (Valentine, 2004). There is a significant need to explore in more depth mental health spaces for children and young people more generally. This also applies specifically to the built environment. The lack of empirical evidence regarding children's mental health spaces and the built environment is akin to the shortcomings that was evident in research on children's hospitals. When Birch, Curtis and James (2007) embarked on their children's hospital study 'Space to Care' they remarked that relatively little was known about children's perspectives on internal spaces. The same is true of children's mental health space though it is both the internal and external built environment that is discussed in this chapter. Furthermore, throughout the chapter the authors will argue that aspects of the built environment for mental health are inextricably linked with, and contradict, constructions of the 'normal' childhood.

Some background to the provision child and adolescent mental health

There is now clear evidence that the mental health needs of children and adolescents are at a substantial level, although the figures only reflect those who go through the treatment system. A survey of the mental health of children and young people in Britain (Green et al. 2004) suggested that ten per cent of 5-15 year olds have been diagnosed with a mental health disorder and of those, a possible 45,000 have a severe mental health issue. One in ten children under the age of 16 have been clinically diagnosed with a mental health disorder (Board of Science, 2006).

Support for children and young people with mental health and emotional problems can come from a variety of sources. In 1995, the review *Together we stand* (HAS, 1995) laid the basis for what is now a four-tier model for Child and Adolescent Mental Health Services (Cottrell & Karaam, 2005). Tier 1 staff tend to be those whom families seek help from first, such as teachers or social workers. If additional help is needed, these staff can refer families to Tier 2 professionals, who have specialist training but are usually based within the community. Tier 3 staff comprise specialist teams who deliver complex packages or interventions of care help. Tier 4 provides very specialist services to a small number, usually in in-patient and residential settings. It is clear that spaces of mental health cover a broad and complex range of contexts. However, this chapter will focus on the Tier 3 context, of which the specialist CAMHS outpatient clinics can be counted. This space of mental health is interesting because the built environments of CAMHS out-patient clinics vary considerably and therefore act as an interesting focus to look at the social relations and meanings identified

with these different places. Later on in the chapter there will be examples of how the built environment are embedded with meaning for those attending a CAMHS out-patient clinic.

Linking the built environment with the psychology of mental health

The body of work that explores the links between the physical form of the built environment and the impact on psychological aspects of our well-being has grown considerably. Material elements, such as light, noise and décor, connect with our emotional experiences or 'place feelings' (Hart, 1979). Much of the work in this area has focused on either hospital settings and to a lesser extent, adult mental health. Earlier work, with a more sociological focus, looked at the impact of particular neighbourhoods on mental health and wellbeing. One well-known study by Faris and Dunham (1939) for example, found a higher number of admission rates to psychiatric hospitals from those living in disadvantaged neighbourhoods in Chicago, (see Silver, Mulvey & Swanson, 2002). There has since been a rise in the number of studies looking at the relationship between the built environment and mental health (see Evans, 2003). For example, studies looking at the direct effects of the physical environment on mental health have addressed things like housing quality (e.g. Evans, Wells & Moch, 2003), the neighbourhood (e.g. Leventhal & Brooks-Gunn, 2000), privacy (Hutton, 2002), population density (Baum & Paulus, 1987), and noise and light (e.g. Lawson & Phiri, 2003; Ulrich et al. 2004). Evidence has shown that bright light, whether artificial or natural can improve health outcomes such as depression (Ulrich et al. 2004).

There are other aspects of the built environment and its physical form that have a bearing on issues linked to mental health that might apply to any form patient care. Lawson and Phiri's (2003), work in adult wards in hospitals found that regardless of whether accommodation was old or new, patients were sensitive to their environment. A particular dislike was the lack of control for noise, temperature and light levels. These issues also apply to the internal spaces in children's hospitals (Birch, Curtis & James (2007). The lack of control over the spatial environment in health settings was raised in a study in children's hospitals. In interviews with children, James and Curtis (2012) found that bedtime and lights out were a cause for complaint. Whether the health setting is an in-patients or out-patients, or whether it is related to mental health or physical health, children have very little control over what the built environments looks like.

Colour also represents an interesting point of contention for mental health spaces. Children's spaces are usually represented by bright colours and it seems that this is something desirable from the children's perspective. In a children's hospital study, Lambert, Coad, Hicks & Glacken (2013) asked children to draw their ideal hospital room. Interestingly, the children chose colourful but gender-neutral colours alongside artwork. This finding is echoed by another study of children's hospitals where they reported a general desire for spaces to be colourful and bright (Birch, Curtis & James (2007). However, children's mental health spaces differ significantly from children's hospitals on the subject of colour because for therapeutic reasons, neutral colours allow the room to act as a blank canvas for the mind. Child and Adolescent Mental Health Services clinics are deliberately decorated in very neutral colours and tend to have very little by way of pictures on the walls. While this may be good for therapeutic purposes, the built environment does not signify that this is a children's service *for* children.

Location and the imagined benefits of nature as a therapeutic landscape.

There has been growing evidence within the last decade that local area, or community factors, can have an impact on mental health (O'Campo, Salmon & Burke, 2009). In many instances, studies in these areas have focused on the links between physical disorder (such as run down neighbourhoods) and distress, which then negatively impacts on mental health (Ross, Reynolds & Geis, 2000). In the O'Campo, Salmon and Burke (2009) study, green areas and natural environments were highly related to good mental well-being by adult participants. Noise and bad smells were moderately related to poor mental well-being. Equally, gardens and nature have become increasingly associated with physical and emotional well-being (Wake, 2007). Whilst noises from cars, sirens and loud voices are intuitively associated with stress and negative emotions, green spaces become associated with peace and calm (Marcus & Sachs, 2013). In fact, Chawla, Keena, Pevec & Stanley (2014) report that studies with young people about the impact of green spaces on their psychological well-being mirror those from adults. Namely, that they improve attention, and improve coping with stress.

There is evidence in the literature that supports the assumption that green spaces play a restorative role, either by improving attention or by reducing stress (see Hartig, 2007; Ulrich, 1991). This idea has been applied to the context of children's hospitals where some have created garden spaces, believing they have restorative powers. However, it was the parents of sick children who used the garden to relive stress and worry, rather than the children themselves (Marcus & Sachs, 2013). It is worth examining, therefore, what any particular green space might be used for in a children's mental health context. Parr (2008) took a more critical look at the restorative ideal of green spaces whilst tracing the history of nature therapy in adult mental asylum contexts. Both historically, and now, such 'nature work' has been in the form of labour, often resulting in the commercialising of produce. Another assumption has been that nature allows the patient to 'master their madness' or become more 'rational' outside.

Whether or not one takes seriously the role of green spaces, there is no evidence to suggest that CAMHS clinics offer anything similar to children's hospital gardens, despite being a service geared towards improving mental health for children. In fact the National Service Framework for Children and Young People highlighted in a report on mental health and psychological well-being, that CAMHS community services (such as out-patient care) were often "poorly housed with insufficient space" (Department for Education and Skills, 2004, p.38). The report found that some services had very poor access, particularly for families who needed to use public transport. In addition, some CAMHS were located near adult services (e.g. drug and alcohol services) thereby putting the children at risk of harm. In the years since this report little seems to have been done to tackle the built environment of community services like CAMHS.

Mental health spaces as a places of meaning

Even when looking solely at the material features of the built environment it is impossible to ignore how particular meanings are developed through the spatial structures that shape the children's experiences of it (Curtis, 2007; Johnston et al. 2000). Many have argued that space plays an active role in the construction of social identities. That is, the way we see ourselves is shaped both by the people around us and by the spaces we occupy (Valentine, 2001). Different spaces hold particular meanings for us, so that school is a space designed for learning but entering a school building can evoke visceral physiological and emotional

feelings for us that may be linked to past experience or personal or collective memories (Taylor, 2010; Radley, 1997). In turn, the school building becomes symbolic of our feelings about being in that space. Once again, the literature on mental health spaces as places of meaning has largely focused on adults but this work can provide insights that can be taken forward to children's settings. In her seminal book about mental health and social space, Hester Parr (2008) writes a personal story about the uncertainty she felt in attending counselling in an adolescent psychology department located in a hospital asylum. In particular, she writes about the stigma and anxiety attached to simply walking into the building. In some respects, the built environment informs what we do in those buildings and the practices we undertake. In turn, these practices or activities, shape our identities and our sense-making (Wenger, 1998).

While it is worth bearing in mind that adult asylums are very different mental spaces than a CAMHS outpatients, they do provide a powerful indication of the highly symbolic and emotional meanings invested in such buildings (Parr, Philo & Burns, 2003). These kinds of studies also give some insight to the role of internal spaces of mental health, particularly in the way that corridors, doors and locks add to the 'impersonalness' of institutions (Parr, Philo & Burns, 2003). In terms of children's spaces, there has been less work looking at their perspectives of internal built environments. One notable exception to this was a study by Birch, Curtis and James (2007), mentioned above, who looked at children and young people's views about internal hospital spaces. These authors describe a push within healthcare policy to make hospitals more 'child-centred' and friendly, including mental health environments (NHS, 2003). However, the degree to which this has extended to children and young people's mental health has been arguably more limited. At the time of writing this chapter, it is satisfying that a CAMHS unit in Prestwich was recently nominated for Design Project of the Year (see http://www.buildingbetterhealthcare.co.uk). Nevertheless, where there is a push to improve built environment and space in children's mental health services, the focus is generally, and perhaps understandably, on inpatient settings.

Children's mental health spaces as 'dangerous'

A number of commentators have discussed the often complex and contradictory ways that children are positioned in relation to how we construct childhoods (Burman, 2008) and what this means for children's use public spaces (Valentine, 2004). Valentine argues that on the one hand we seek to protect children from the dangers of outdoor life but on the other hand, children are viewed as being contributors to the outdoor dangers. What ensues are 'moral panics' that partly revolve around places (Aitkin, 2001, p.25). Such debates about how childhood is constructed through place have centred on outdoor spaces such as local neighbourhoods. This is exemplified by the work of Lucas (1998) who discussed the moral panic around youth gangs in Santa Cruz, California.

However, children's mental health settings and the children who use those services are positioned in even further contradictory ways. Children and young people attend mental health services because they are vulnerable and in need of care, but on arrival in the building, the environment in a number of CAMHS signifies that they are potentially dangerous. The receptionist usually sits behind a glass window, each corridor has door locks

that are controlled by the adults in the building, cameras are in place in the corridors (and sometimes the therapy rooms[1]) and some rooms have one-way mirrors built into the rooms.

Children's mental health spaces can be therefore be considered what Jones (2000) calls, 'othereable spaces', where the connotations and constructions of those spaces are defiled. Perhaps this goes in some way to explain why there has been a surge of work looking at everyday spaces like home, school and the urban environment (see James et al. 1998). However, spaces of mental health have had less attention in the academic literature.

Commentaries about risk are also interesting in the wider context of the study of childhood and have some pertinence here. On the one had children are seen as being in need of protection from dangers in the external world, particularly with respect to the risks posed by strangers and traffic in wider neighbourhoods (Knight, 2013; O'Brien et al. 2000). In studies looking at risk in the neighbourhood, for example, whilst travelling to school, other young 'dangerous' people also present a risk (Knight, 2013). In the child mental health setting, the built environment sets the child up as 'the risk' by virtue of having a mental health difficulty.

Children's mental health spaces are 'hidden' spaces

The 'othereableness' of the external space for outpatient child mental health settings are an interesting a site for discussion. Unlike children's hospitals, outpatient mental health services like CAMHS are not always obviously or visibly spaces that are a children's service. In many instances, the signage on the outside of the building is very small and looks similar to any other adult health hospital facility. Research in urban environments have shown how children appropriate spaces for themselves, often naming favourite spaces (Hart, 1979), but most 'official' spaces, and this particularly applies to CAMHS outpatients, are designed by adults so this is not possible. Children have little power to affect the built environment and space they inhabit.

There are very legitimate reasons for making the signage for CAMHS small and discreet. Such an approach seeks to protect children from the stigma attached to entering a building geared towards mental health issues. However, in many ways this could also serve to perpetuate the negativity associated with mental health. Returning to the arguments put forward by scholars such as Valentine (2004) and Burman (2008) about constructing the 'normal' childhood, mental health difficulties in children positions them as 'different' or 'damaged'. O'Dell (2008) makes a similar point about children who have been abused, in that they "stand as iconic referents to how child is, should be and has been destroyed" (p. 383). In the paper she discusses how the portrayal of abused children in advertisements, such as those displayed by charity advertising campaigns, reinforce our ideas that childhood should be a time of innocence. Children with mental health difficulties present a similar challenge to the 'ideal' childhood experience. The 'hidden' quality of CAMHS perpetuates this invisibility and thus reinforces the stigma associated with children's mental health.

The context of the Child and Adolescent Mental Health Service

To supplement these discussions, this chapter will now present some examples from an empirical study undertaken in 2008/2009, which aimed to explore how staff, parents and

[1] In some instances encountered in a project discussed in this chapter the cameras in therapy rooms had been disconnected though the camera remained in the corner near the ceiling

children and young people felt about their CAMHS built environment (See Crafter, Prokopiou & Stein, 2010). The study took place in two outpatient clinics in different towns within the same NHS primary care trust. Clinic A had been occupied by CAMHS for a number of years and was placed in a building with other health services (doctors and dentists). It was fairly small in size and this was particularly the case for the waiting room, which at most could sit five people. The CAMHS team occupied the second floor where, as well as the waiting room, there was a reception (with office staff), 8 therapy rooms and a small kitchen. The clinic was located in the centre of town near the central pedestrian area with shops at the front and parkland at the back[2].

Clinic B occupied its own building which was fairly old but which had been specially redesigned and decorated for its purpose. It was located a little out of the centre of the town, requiring about a fifteen minute from central transport. There was a busy duel carriageway on one side and a housing area on the other. There was little in the way of parking facilities available nearby. Clinic B was quite a bit larger than clinic A with a comfortably large waiting room, reception for office staff, and three floors. The first two floors had 12 therapy rooms and the top floor was used as office space for the clinical staff.

It is worth noting that CAMHS buildings vary considerably across the country. There is a sense of uniformity to the treatment rooms but not the style or type of building they occupy. These two clinics are a good example of how different the built style can be. Below are pictures of the outside of the two clinics in question.

Figure 1. The outside of the two clinics – Clinic A on the left and Clinic B on the right

The staff (N=27), parents (N=30) and children and young people (N=13, between 11-18 years old) were interviewed and additionally, some of the young people created drawings of their 'ideal' CAMHS clinic. They were asked to draw and comment on the surrounding location of the clinic, the building façade and the internal space. The interview questions focused on how respondents felt about the internal and external built environment and how it made them feel, what they liked most/least, what their ideal CAMHS building would look like and how they thought the built environment affected their treatment.

[2] Since this study Clinic A has moved to a different location

The authors have taken extracts from the interviews with parents and children that stand as exemplars of the kinds of issues raised here. A more systematic analysis of the data can be found in Crafter, Prokopiou & Stein (2010).

The external built environment, outside location and the perception of the value of green space

You will recall Hester Parr's description of her own anxieties and concerns the first time she entered an adult asylum when she was a teenager. Some of the children spoke of similar feelings when they first attended the outpatient CAMHS clinic. They reported feeling scared and the built environment was a contributor to some of those feelings, particularly when visiting CAMHS for the first time. These quotes are indicative examples of some of the comments:

> *I: what do you like least about the building?*
> *C: It's scary (laughs)*
> *I: It's scary huh? It looks scary…*
> *C: Yeah it looks like a church and I don't like churches (Child, Clinic B)*

> *It's like [the building] um, a bit like um, it reminds me a bit like a hospital um, I don't know, when you're sitting there and I'm a bit nervous sometimes (Child, Clinic B)*

One parent, when asked how they would feel if they were a parent or child coming to Clinic B for the first time said:

> *Oh well it's not much of a view, you've got a brick wall there, and with the barbed wire there, I'd feel a bit scared really, there's nothing nice you know, it looks almost like you're in a prison (laughs) you know with the brick wall, barbed wire, you know, and somebody who may be, you know, who could be claustrophobic, that could be quite scary couldn't it, you know (Parent, Clinic B)*

As well as associations between churches, hospitals and prisons a number of people mentioned feeling like that were going to the dentist. If fact, Clinic B had, at one point, been the local school dentist and the negative memory of visits to the building persisted for one parent:

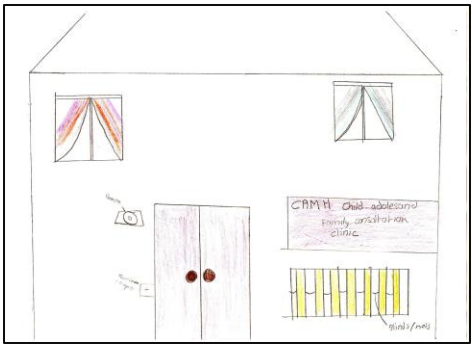
> *I: What did you think when your first came into this place?*
>
> *P: (laughs) well my memories of when I was a child, cause' this used to be a school and it also it was the um, the dentist was here, the school dentist and um I remember having a bad experience here as a child actually and I had to have a tooth extracted and I had to have gas and they put the mask over your face so um, I thought 'oh no' so um well um, I don't like this place cause' it's not a nice, not a nice...but it's, it's quite old really and it's a bit run down, shabby you know it's very, it's not, it's not very welcoming really (Parent, Clinic B)*

This quote speaks to the power the built environment and place has for evoking remembering and the past. Like the children in the 'Space to Care' study of children's hospitals (Curtis, 2007), the children were asked to imagine an 'ideal' space. Most of the children, rather than creating discrete or 'hidden' spaces, wanted the building to be more obvious as a place where children can go to get help. The majority of the children created an

'ideal' building façade that was bright, colourful and designed to make the building 'cheerier'. As one child put it:

> *I've done like um, um pictures on the windows and to show that it's like a child's place and cos' here's no indication outside that um children come here and um I've put like a phone number on the front (Child, Clinic A)*

Figure 2. Two of the children's drawings depicting an 'ideal' building façade



This is not to say that the children were not concerned about the stigma of attending a CAMHS clinic. Rather, they wanted to recast the building as a service attended *by* children *for* children. Such a building would signal that this was a place where one went to get help.

When asked for their views on what the outside location of an ideal CAMHS clinic might look like, it is not surprising many of the young people in both clinics imagined somewhere greener and quieter:

> *I'd just like a tree or a plant to show um that; I think that it's too busy here, there's too much traffic and I think it should be somewhere where there's a lot more green. There is the park just across the road but I think the area itself is just really busy (Child from Clinic A)*

> *I think it should be, I think its good but I think it should be in a bit of a quieter estate because if the windows are open there's always sirens or cars or people shouting (Child from Clinic B)*

The notion of green space as a therapeutic healing landscape appeared to e quite powerful in the minds of parents and children in this study. However, it is worth noting that the children and parents also valued the convenience of having clinics close to town centres:

> *The landscape could be nice, more welcoming, more peaceful, because I think this type of environment is nerve-racking and I think that, that the element of green and colours and they could make a big difference in the way you feel (Parent from Clinic A)*

I think for people with mental health problems it's just anything that looks beautiful, calm, friendly and welcoming it's good for mental health problems (Parent from Clinic B)

For both of these parents, there was an assumption that green spaces offer some psychological comfort that would be particularly beneficial to people with mental health problems. Moreover, the power of nature and greenery to make one feel happier, was strongly represented in the CAMHS build and space study by both parents and the children and young people. As noted above, the research evidence for these assumptions is more mixed.

Internal build environment spaces: tensions between the desire for 'homeliness' and the therapeutic 'blank canvas'

Issues like those discussed earlier in the chapter, such as light, noise and colour, were all raised as concerns for respondents in this study. For example, parts of the building, particularly in Clinic B were described as being dark. As one parent from Clinic B said "*I think it's quite dark, the waiting area's very confined…its very claustrophobic*." Another parent described how more light in the clinic would be *"less depressing."*

However, it was the role of colour and the general décor that was discussed by parents and children to the largest extent. For some therapeutic approaches the room itself acts as a blank canvas so the focus of the therapy is entirely on the child. However, for the children and parents visiting the clinics, this gave the impression of a service that was not 'child-centred' or 'friendly'. In the clinic of the children's (and parents) imagination, the ideal décor would be bright, colourful and linked to positive emotions. The only exception to this was a boy in his mid-teens who stated he preferred neutral colours. The following quote exemplifies the role that colour might make to an indoor mental health spaces.

Cause' like a bright colour could also help how you're feeling so if you're like talking about something that's like bad and hard, if you just look at the bright colours, it can sort of like help you to calm and settle down a bit easier (Child from Clinic A)

Curiously, even the waiting rooms tended to be very neutral and even if they contained posters on the wall they were a token effort at child friendliness. When the children and young people were asked to imagine an ideal clinic setting they attempted, both through their interviews and their drawings, to reconstruct new meanings by describing spaces with a sense of 'homeliness'. CAMHS, as an outpatient clinic, offers very little possibilities by way of establishing some kind of personalised or private space, which might facilitate an identification with the place. Even the kinds of boundary crossings and transgressions described by Parr (2000) in her study of an adult mental health 'drop-in', are minimalized and the young people have little, if no control, of the built environment. Visits are tightly timed, and not long in duration; a temporary fleeting in-and-out of the environment.

When the children described or drew their 'ideal' clinic, they tended to create symbolic features of 'homeliness' such as rugs, sofas, curtains, and pictures. The actual therapy rooms contained both practical materials, such as a table and chairs, a familiar feature of the therapeutic room, with spatial features that was very much like a bedroom. Here are two indicative examples:

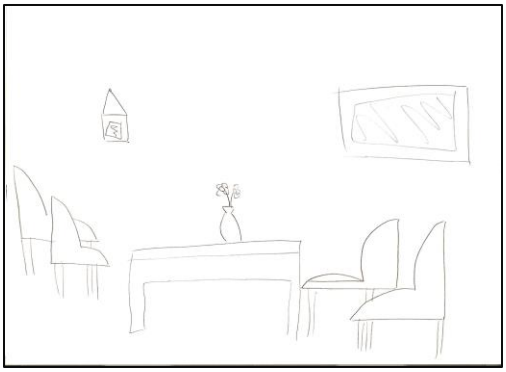
It would be, it would be nice to have the walls just painted; thinking it could be like

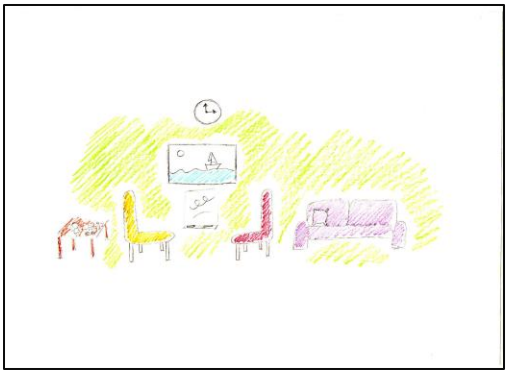
one colour or two; the two colours like split in half and a border around it but pictures you get some people come to clinic like most, some of the young kids draw pictures to put on the walls or like me and use stencils so you can draw them straight onto the walls (Child, Clinic B)

I would like it [the therapy room] to have more of a homely feel and some couches (Child, Clinic B)

The drawings below provide two indicative examples of the kinds of therapy rooms drawn by the children. Whilst the rooms recognise the functionality required for a therapeutic setting, extra 'homely' features such as pictures, a sofa, and flowers are included. To provide a comparison, there are photographs of the therapy rooms from clinic A and clinic B.

Figure 3. Examples of 'ideal' therapy rooms drawn by the children and pictures of the real therapy rooms





The emphasis for the children may be quite at odds with the requirements of different therapeutic styles or needs. A psychoanalyst may prefer plain walls with no pictures, so that the room is almost like a blank canvas. Art therapists often prefer colour and pictures, and family therapists need rooms large enough to comfortably fit the whole family. CAMHS is an excellent example of the tensions exemplified in mental health spaces that may not be so apparent in schools or children's hospitals research. There is also another 'double-bind'

because in a context where children are treated for difficulties following child sexual abuse, it is easy to question whether a therapy room that is like a 'bedroom' is appropriate. However, this chapter and the data it draws on, is about representational spaces, so more critical thinking is needed about how to create a space that symbolises 'homeliness' without crossing inappropriate boundaries of home and institution.

Children as dangerous – symbolic meanings associated with the built environment

In both the CAMHS clinics discussed in this chapter, when children and young people and their parents arrived to the clinic they would check-in for their appointment; much as one does in a doctor's surgery. In both CAMHS clinics there was a glass 'hatch' with sliding glass doors (see Fig. 4) rather than an open registration desk which is more common in children's hospital wards. The glass 'hatch' was mentioned by some of the staff and quite a number of the parents in the study sample. The pictures below show what the hatch in both clinics looked like:

Figures 4. The 'hatch' in the waiting area – Clinic A on the left and Clinic B on the right

This quote illuminates how a feature of the built environment can mediate negative symbolic associations:

> *You wonder what it's gonna be like because I mean, what's it's name, "mental health" so you don't know quite what to expect and it's a bit like, behind glass doors you know it reminds me of a benefit office or somewhere where they expect you to be violent people so, I don't know, maybe they are (laughs)...yeah um, it's a Government run State thingy that you're…um yeah it implies you're, it's almost, it's got that atmosphere of um, you're coming for a service that we need to protect ourselves from you (laughs) yeah?* (*Parent, Clinic B*)

None of the secretarial or therapy staff mentioned feeling under threat from any child, adolescent or parent. As another member of staff put it "it's not patient friendly". This raises questions about the need for the hatch and the sliding glass and the symbolic representations it creates. The views of the parent quoted above were shared by other parents, although his views were the strongest. For them, these features do not send a positive, client-friendly message to the patients, but rather they create a symbolic association with fairly simplistic understandings of young mental health patients as dangerous. The glass was not able to act as a barrier to confidential conversations or phone calls made by reception staff. The parent quoted above also mentioned that his child liked to

check himself in to the clinic, but the hatch was so high it made it difficult for him to perform this small act of agency within the setting.

The children and young people had different concerns that tapped into similar symbolic associations with the built environment and the 'dangerous' child. In both clinics, access to the therapy rooms was only available to either clinic staff or reception staff through a coded lock. In this next quote, one of the children from Clinic A describes how the lack of access is his least favourite feature of the internal building:

> *I: what you like least about the building?*
> *C: The door leading to the stairs I always walk into it*
> *I: Which door?*
> *C: The one downstairs. It has to be unlocked by reception*
> *I: What would you like instead of that, how you would imagine…*
> *C: Just something so you can get up the stairs easier so I don't have to walk into the door or*
> *I; I see, easier access*
> *C: Yeah and go to reception to get it unlocked*

In some ways this child's reasons for wanting easier access to the therapy rooms seems quite benign; they just want it to be easier. However, it can also be argued that, like the hatch, the locked door is there to put in place boundaries that are both physical and symbolic. Issues of surveillance, particularly concerning the use of one-way mirrors and cameras also led to feelings of uncertainty for some of the children:

> *C: Um well that mirror always makes it feel a little uncomfortable it seems that there's somebody moving behind it*
> *I: A mirror you said OK*
> *C: A one-way mirror*
> *I: Mmm, mmm so you would like that not to be*
> *C: A bit more discreet (Child, Clinic A)*

> *I was in a bit of a mood when I first came but it didn't really make me happy when I came in here, and the doors were opened and the mirror up, and I could see people behind the mirror and the camera was on and they were watching us and I didn't, I was worried about that, and it made me angry...so it made me think that the clinic; it isn't all as they say it is, because of the danger (Child, Clinic A)*

From an adult perspective the mirror is used for therapeutic and training purposes. However it made these two children uncomfortable in ways that might not be foreseen by adults. In the first quote the child perceives there is danger behind the mirror because they sense people moving about. In the second quote, the one-way mirror and the camera in the therapy room angered him during his first visit. He felt deceived by the clinic, not because people were watching him, but because the safety he felt on entering the clinic seemed false.

Conclusion

This chapter has discussed a largely untapped area of research, namely the built environment and place meanings of children's and young people's mental health. In particular, it has focused on the internal space of two CAMHS outpatient clinics. The discussions in this chapter have resonance with research in adult mental health spaces, both with respect to asylum and drop-in centres. For example, the material or physical features link powerfully to users emotions. Light, noise, décor, the locked door and corridors were all mentioned. The children's mutual feelings of uncertainty in attending clinics for the first time and how the building façade could feature as part of the insecurity (in looking like a church for example) were evident. There are clear limitations to the data presented in this chapter because it involved the comparison of only two clinics. CAMHS outpatients occupies a wide range of settings across the UK and there is more work to do in looking at how these associations play out across contexts.

More than this, elements of the place were tied up with constructions of the 'normal' childhood and the 'dangerous' child in ways that echoes commentaries from children in the neighbourhood. 'The hatch' was used as an indicative example of how parents took aspects of the built environment as a symbolic representation of the dangerous child. The hatch suggests that it is the staff inside the building who are in need of protection from the children and young people. There was no evidence in these two particular CAMHS clinics that this was necessary. Similarly, locked doors and one-way mirrors led to feelings of discomfort in the children. The children seemed to struggle to articulate the nature of the discomfort, but it bears some resemblance to the parents' concerns about the 'hatch. The locks and surveillance from Hester Parr's reminisce about the uncertainty in entering mental health spaces.

Gathering children and young people's representations of an 'ideal' or 'imagined' CAMHS space has raised some questions about the visibility of CAMHS as a children's service. The young participants were conscious of the stigma attached to mental health, but seemingly far less concerned than the adults around them. Should an 'imagined' service that is publically colourful and openly geared towards helping children, be taken seriously? Or have the children only articulated this ideal space because the research methodology, by asking for something 'ideal', allowed them to remove themselves from the reality of stigma? Moreover, in making the service 'hidden', is this perpetuating the stigma associated with children and young people's mental health? More research is needed in a range of children's mental health spaces like CAMHS to wrestle with the tension visibility and stigma.

Parr (2008) writes about re-imaging adult mental health by creating different narratives that represent the complexity of the experience. In doing so, representations become sites of active resistance with active agents. It is even harder to do this in a childhood mental health setting because there has been relatively little work from a built environment and space perspective and 'empowering' children and young people offers an additional challenge within formal institutions. Children and young people attending CAMHS could be said to have multiple barriers to 'individual and collective resistances to psychiatric power and control' (Parr, 2008, p.23 quoting Crossley, 2006).

The focus on the children's 'ideal' CAMHS space served a very useful purpose for the original aims of the study, which was to gain an understanding of the users experiences, and an understanding of the CAMHS of their imagination (through children's drawings and

interviews). What the majority of children sought were feelings of tranquillity through the use of green spaces, warm colours and less institutional-looking furniture. Overall what they conveyed was a sense of 'homeliness', often with features of a bedroom space. However, these findings raise critical questions about the boundary crossing between formal/institution and informal/home settings that require further explanation. How can CAMHS be a service that *looks* like it is designed *for* children *by* children whilst managing the complex needs of the people who use it?

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