Green Care in Agriculture: Interim Report

A visual ethnographic study exploring the wellbeing effects of care farming for adults with intellectual disabilities

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# 1.	Introduction

Background and policy context

People with intellectual disabilities (ID) comprise one of the most marginalised groups in the UK; are often subject to inappropriate or discriminatory health care provision; and typically experience poorer physical and mental health than the general population (Alborzm, McNally, & Glendinning, n.d.; Disability Rights Commision, 2006; Hall, 2007; Hatton & Emerson, 2014; Taylor & Knapp, 2013). Indeed, people with ID are 2.5 times more likely to have health problems (Disability Rights Commission, 2006) yet recent evidence suggests that people with ID have higher levels of unmet need and receive less effective treatment (Disability Rights Commision, 2006, 2007; Mencap, 2007; Michael, 2008). Health and social care provision for people with ID in the UK also presents an increasing challenge as demand for these services continues to grow. People with ID are living longer (Bittles, 2002; Emerson & Hatton, 2008; Holland, 2008) and the number of adults with ID is predicted to increase by 14 per cent between 2001 and 2021, resulting in more than a million people with ID by 2021 (Emerson and Hatton, 2008). All this comes at a time when local authorities are facing increased cuts in public spending. Given this, local authorities are seeking viable and cost effective interventions designed to meet the health needs of people with ID and which also give people greater choice with regards to their health and social care provision.

One recent development aimed at tackling some of the health inequalities faced by people with ID that is gaining popularity in the UK, is green care in agriculture or 'care farming'. Care Farming is defined as the use of commercial farms or agricultural landscapes to provide health (both physical and mental) social or educational benefits through farming (Hine, Peacock, & Pretty, 2008). In the UK, care farms are often formally tied to local social services and hospitals, where farmers are paid to provide a health service to clients (delivered in partnership with health and social care providers) alongside their commercial farming activities. All care farms therefore seek to offer a balance of 'farming' and 'care', where the latter is typically delivered through therapeutic contact with farm livestock, food growing and/or horticultural activities (Hine et al, 2008).

The development of care farming is, therefore, part of a growing recognition that land is multifunctional, and can provide a range of environmental, recreational and health goods and services (Hine et al, 2008). Indeed, agricultural practices have changed significantly in recent years as a result of growing financial pressures and it is now becoming increasingly common for agricultural landscapes to be used for a range of purposes that are not always solely focused on food production (Brandth & Haugen, 2011; Burton & Wilson, 2006; Cloke, Marsden, & Mooney, 2006; Dessein & Bock, 2010). Such developments have often been described as 'multifunctional agriculture' (Wilson, 2007) and denotes a growing movement whereby farmers seek to offer additional services alongside (or instead of) their commercial food production activities. Care farming is, therefore, quite uniquely situated in terms of its potential for combining commercial food production and more care orientated goods and services.

The notion that the outdoors (and outdoor based activities) can produce specific therapeutic benefits for vulnerable groups is not new. Throughout history, prisons, hospitals and even monasteries have advocated the use of outdoor spaces for health (Ellings, 2011). Prisons, for example, have historically maintained prison farms to provide meaningful work and physical exercise to inmates (Sempik & Aldridge, 2006). Similarly, hospital gardens dating back to the middle ages were perceived to provide an important 'outdoor therapeutic experience' to patients, with many hospitals and monasteries traditionally incorporating open courtyards and designed gardens to provide outdoor shelter and aesthetic enjoyment for their patients (Hine et al., 2008; J Sempik & Aldridge, 2006). Bloor et al (1988) locates the earliest 'green care programme' in Geel, Flanders dating back to the 13th century. Here 'mentally distressed pilgrims' stayed in a therapeutic village where they were cared for by residents. Being a rural agricultural setting, the main work activity for people was farming, where a range of structures and procedures were in place for taking care of individuals in the context of local families and wider village life (Relf, 2006; Wilcox, 2007). In the UK, the Victorian era was associated with the building of large new asylums for the mentally ill and disabled. Typical Victorian asylums often included outside open grounds for leisure and sometimes had a farm estate or market garden which produced food for the inhabitants and a surplus to sell (Ellings, 2011; Philo, 2012). Importantly, patients were expected to work on these estates as it was

considered that engaging patients in meaningful work provided an important source of physical and mental stimulation (Digby, 1984; Philo, 2004).

As approaches to the care and treatment of mental patients changed and the hospital system was restructured and modernised during the late 60's and 70's, hospital farms were gradually closed (Sempik, Hine, & Wilcox, 2010). Indeed, there were growing concerns that the previous system relied too much on the labour of their patients, and was in many cases exploitative rather than therapeutic (Sempik et al., 2010). In recent years however, interest in the relationship between green environments and human health has grown once more. Indeed the past 20 years have seen a burgeoning of green care initiatives which seek to offer a range of health and social care services to vulnerable populations through contact with nature. Care farming is therefore situated within the broader 'green care' movement, an umbrella term for activities which aim to provide vulnerable and/or socially excluded people access to outdoor environments for a range of physical, psychological and social benefits. Such interventions include, horticultural practices (social and therapeutic) animal assisted activities, eco-therapy, wilderness experiences, forest schools, facilitated green exercise programmes and care farming (Hine et al., 2008; Sempik et al., 2010).

Care farming: an overview

Whilst all green care programmes seek to offer some form of 'care' or therapeutic benefit, the mode of delivery and the form this takes varies considerably. Animal Assisted Therapy (AAT), for example, tends to use specific animals selected for particular behaviour traits (e.g. calmness) to achieve pre-defined goals for specific client groups (Nimer & Lundahl, 2007). By contrast, many care farms that utilise therapeutic contact with farm livestock seek to offer more general therapeutic benefits for people with a variety of needs and abilities. However some care farms do offer AAT in addition to the more generalised contact with farm animals. Similarly the role of the therapist in 'green care' varies depending on client needs and the setting in which the intervention takes place. For example, in horticultural therapy a trained therapist works very closely with the client to achieve clinically defined goals. These may include the development of particular motor functions, work skills or psychological wellbeing through the use of horticulture. By contrast, care farming is

a much more diverse activity and the role of the therapist is generally separate from that of the farm worker, although the therapist may, as part of the programme, be engaged in farming work alongside clients (Hassink, Zwartbol, Agricola, Elings, & Thissen, 2007; Sempik et al., 2010). Many care farms enable clients to participate in the growing of crops, salads or vegetables with an aim to improve wellbeing in a more generalised way whilst others may offer more structured horticultural therapy sessions in addition or instead (Hine et al., 2008; Leck, 2013; Sempik & Aldridge, 2006).

Green care on farms is relatively well established in many parts of Europe, where care farming appears to be most widely practiced in Norway, the Netherlands, Italy and the Flanders region of Belgium (Leck, 2013). Care farming services are also being offered in other parts of the world, for example, a care farm for young people with intellectual disabilities was recently established in Taiwan (Leck, 2013). Similarly, there are farms in parts of Eastern Europe that offer sheltered accommodation and work for vulnerable young people (Leck, 2013).

In the UK, the term 'care farming' gained official recognition in 2005 and is a direct translation of the phrase used to describe this activity in the Netherlands. In 2008 and 2012 Care Farming UK (formally known has the National Care Farming Initiative (NCFI)) commissioned a scoping study which was carried out by researchers at the University of Essex to ascertain the extent and characteristics of care farming in the UK. According to Hine et al (2008; 2012) there are 180 care farms currently in operation in the UK and Leck (2013) suggests that there as many as 206 additional prospective farms that have also registered an interest in developing care farming activities. The size of UK care farm settings ranges from 0.3 hectares (ha) to 650 (ha) with the average farm size being around 50 (ha) (Hine et al, 2008). Types of care farms vary from the traditional farm, to the smallholding or city farm where the majority of care farms generally have a variety of livestock with the most popular livestock types being sheep (80%), laying hens (68%) and pigs (65%) (Hine et al, 2008). A number of farms linked with institutions or charitable organisations have more unusual animals on their holdings including alpacas, llamas, marmosets, and emu (Hine et al, 2008). The services provided by care farms are varied but overall the most common are the development of basic skills and work skills, social skills, with some offering some form of accredited training or education. Other services

include, AAT, horticultural therapy, rehabilitation, sheltered work/supported employment (Hine, 2008).

Care farming services for people with ID

As with other green care initiatives, such as Social and Therapeutic Horticulture (STH) or eco-therapy, care farming is characterised by the belief that contact with nature is inherently good for you. This is supported by a growing body of evidence which suggests that care farming can confer numerous benefits to individuals, including improved physical health and self-esteem in people suffering from drug or alcohol addiction (Ellings, 2011); reduced signs of anti-social behaviour in young people with behavioural problems (Hassink, Elings, Zweekhorst, van den Nieuwenhuizen, & Smit, 2010; Hassink, de Meyer, Sman, & Veerman, 2011) and overall reductions in anxiety and depression in those suffering from psychological ill-health (Berget, Pedersen, Bjarne, & Sciences, 2011; Hassink et al., 2010; Hine et al., 2008).

However, there is very little research to date, which has offered an in-depth exploration of the health and wellbeing effects of care farming for people with ID. This poses a very specific problem. Indeed, care farming is increasingly being advocated as a viable alternative to more traditional forms of health and social care, yet the views and experiences of people with ID (the UK care farm industries main service user) have rarely been sought. This apparent gap in the current evidence base may partially be explained by the fact that the cognitive and verbal skills possessed by people with ID cannot always be accommodated by conventional research methods. Indeed it is suggested that the methods deployed in studies on the health and wellbeing benefits of care farming for a range of service users were not sufficiently adapted to meet the needs of ID participants and were therefore unlikely to provide sufficient insight into the lived experiences of people with IDs. This reflects a broader problem within health geography research, namely a dearth of studies which have adequately captured people with IDs lived and embodied experiences of place and the way in which these place experiences are perceived to benefit health and wellbeing.

2.   Theoretical framework(s)

Framing wellbeing: a relational approach

Research and policy approaches to wellbeing typically deal with this rather abstract and complex concept by breaking it down into constitutive dimensions, in what has been called a 'components' based approach (Atkinson and Joyce, 2011). Such approaches tend to focus on the constituent factors which determine wellbeing, identifying a mix of objective and/or subjective elements (Clark, n.d.; Nussbaum, 2000; Stiglitz, Sen, & Fitoussi, 2009), whilst others focus on the components of personal subjective wellbeing, typically differentiated by hedonic (Layard, 2005; Seligman, 2011) and eudemonic or 'human flourishing' principles (Ryff, 1989; Veenhoven, 2000). According to Atkinson (2013) these different ways of conceptualising wellbeing share a common assumption that wellbeing is a quality that inheres to the individual, conceived as a sort of commodity which may be individually acquired or achieved. This, in turn, has significant implications in terms of policy 'as it drives interventions in terms of what can be done to enhance individual-directed acquisition of the components of wellbeing' (Atkinson, 2013 p. 139).

By contrast, research within the field of health geography signifies a move away from a components based approach to wellbeing to a more nuanced approach which takes into account the range of social and spatial contexts within which positive (and negative) health and wellbeing outcomes are realised (Fleuret & Atkinson, 2007; Hall & Kearns, 2001). This burgeoning interest in socio-spatial contexts, individual experiences and non-medically centred notions of health has resulted in a wide range of studies which have focussed on relational and place based notions of wellbeing (Nussbaum 2000; Puttnam 2001; Wilkinson and Marmot 2003; Smyth 2005; Conradson, 2005). Yet place-based notions of wellbeing have rarely featured in government policy and practice and current approaches to health and health care have tended to focus on the individual and health related behaviours (Atkinson, 2013).

In the case of people with ID, this has resulted in a rather narrow conception of wellbeing, one which is centred on ill-health and pharmaceutical treatment (Hall, 2007). Indeed examinations of the wellbeing of people with ID have tended to focus

on the presence or absence of certain medically defined mental health conditions (e.g. anxiety, depression, phobias, obsessive disorder) that people with ID experience (Hall & Kearns, 2001). However as Dagnan (2008) highlights, many people with ID also experience poor emotional wellbeing (e.g. feelings of anger, distress, sensitivity, lack of attachment, low self-worth and self-confidence) which are rarely considered in the literature.

According to Hall (2007) the persistent and on-going health inequalities facing people with ID signify a failure of current biomedical and public health approaches to health and social care. This calls for a non-medicalized approach to wellbeing, one which fully accounts for the emotional lives of people with ID, their embodied experiences and relational capabilities. On this view, wellbeing is conceptualised as an embodied individual and collective position which can be realised within a variety of social and spatial contexts where 'emotional and material needs are satisfied, social relations are present, self-confidence and self-valuing are strengthened and skills and capabilities are realised' (Nussbaum, 1999).

Fleuret and Atkinson (2007) set out a model of 'spaces of wellbeing' that attempts to capture the complex configuration of socio-spatial positions and relations which constitute wellbeing. On their view, wellbeing does not comprise of a set of entities which may be individually acquired or achieved, but is conceptualised as a complex assemblage of relations, between people and places 'that are dependent on the mobilisation of resources within different social and spatial contexts' (Atkinson, 2013). This approach therefore conceives of wellbeing as being in a constant state of production and reproduction. At the same time, habituated practices and everyday routines tend to reproduce rather than destabilise individuals' embodied sense of self thus allowing wellbeing to become a stable and measurable outcome over the mid to long term (Atkinson, 2013).

Framing wellbeing as relational and emplaced therefore demands a move away from approaches which are concerned with enhancing resources for individual acquisition towards attending to the social, material and spatially situated relationships through which individual and collective wellbeing are effected (Atkinson, 2013; Robin Kearns & Moon, 2002). In an examination of the wellbeing

effects of care farming for people with ID, this requires us to examine the contexts and networks within which people with ID live and the way in which therapeutic interventions, like care farming, may facilitate the destabilisation or disruption of habituated practices and open up new relational assemblages to produce positive wellbeing outcomes over the longer term.

Therapeutic Landscapes

For this study, the therapeutic landscape concept shall be used as a theoretical framework within which to explore the wellbeing effects of care farming for people with ID. The term therapeutic landscape was first introduced by Gesler (1992) and denotes a growing recognition of the importance of place in promoting physical and psychological wellbeing. Central to this is a move away from viewing landscape as a purely physical entity to a more relational view in which landscape is conceived as both a social and cultural category. On this view, understanding the role of place (and the healthcare services that characterise them) in promoting the health of populations involves attending to the way in which various environmental, societal and individual factors work together in certain natural or built environments to produce positive social and psychological outcomes (Jones & Moon, 1993; Kearns, 1993).

Although Gesler's research has tended to focus on landscapes with a reputation for healing, the therapeutic landscape concept is being adapted in other ways to explain the therapeutic qualities of our everyday landscapes, such as the home (Williams, 2002) and more recently, the garden (Milligan, Bingley, & Gatrell, 2005) and local urban landscapes (Gastaldo, Andrews, & Khanlou, 2004). Indeed, according to Milligan et al (2005) whilst much of the literature points to the use of famous events or places (such as baths, spas or national parks) in the healing and recovery process, the therapeutic landscape concept can also be used to explain the more general health and wellbeing effects of our ordinary place experiences. It is from this perspective that the therapeutic landscape concept will be used to understand the wellbeing outcomes of care farming for people with ID.

Whilst the therapeutic landscape concept is to be commended for its contribution to the field of health geography, research within this frame has been subject to a

number of criticisms. One such criticism is a tendency within the literature to situate the therapeutic landscape experience as an effect of the landscape itself (Conradson, 2005; Doughty, 2013; Willis, 2009). On this view, particular socio-environmental settings possess intrinsically therapeutic properties with the capacity to enhance or restore wellbeing. And yet individuals clearly experience different environments in different ways. As Milligan et al (2004) observed in their study on the potential restorative impact of woodland on young adults, commonly held 'healthy' natural environments such as forests are not always experienced positively. This is not to deny that some landscapes have attributes that a significant number of individuals experience as therapeutic (as Gesler's broad range of examples demonstrate) but it does suggest that positive experiences are not in any sense pre-determined outcomes (Conradson, 2005).

As a partial response to this, it is suggested that post-phenomenological approaches, like non-representational theory, offer an alternative approach to human geographical research which can overcome some of the challenges levelled against the therapeutic landscape concept.   The term 'non-representational theory' is used to refer to a body of work within cultural geography which denotes a shift from studies of representations of landscape and the body to studies which focus on the more concrete or material engagements between people and place (Doughty, 2013; Macpherson, 2010). On this approach, landscapes do not possess inherent features with the capacity to enhance or restore wellbeing; rather therapeutic properties are relational properties that reside in people's interactions with features of their environment.

As Conradson (2005) highlights however, a comprehensive relational analysis of the therapeutic potential of a particular environmental setting must take into account not only the specific forms of engagement that take place within that setting but also the wider network of socio-environmental relations within which an individual is embedded (Conradson, 2005). This is because in order to gain an understanding of the potential significance of particular instances of self-landscape encounter it is necessary to obtain some sense of the wider context through which these types of engagement are made intelligible.

In support of this view, Willis (2009) argues that the assumption that there are inherent attributes of certain places that makes them therapeutic has tended to result in the conceptual (and often physical) separation of healing places from the ordinary places and spaces where we spend most of our time. The majority of studies in this field (care farming being no exception) have focused almost exclusively on the wellbeing benefits of specific 'health giving' sites, with very little attention being paid to what happens once participants return to their 'ordinary places' (Willis; 2009). As Willis (2009) highlights, this makes it very difficult to ascertain the longer term benefits of these kinds of interventions and calls into question the extent to which so-called therapeutic landscapes are truly therapeutic, thereby inferring a longer term impact on health and wellbeing; or merely palliative, implying an immediate but only temporary effect. An exploration of the longer term wellbeing benefits of interventions, like care farming, therefore requires the researcher to observe the broader set of place relations within which an individual is imbricated and to look at longer segments of people's lives than is usual in the field (Conradson, 2005; Willis, 2009)

3.   Research aims and objectives

Based on a review of the literature this study shall:

- Examine the experiences of people with ID engaged in care farming activities from the point of view of individuals as active and embodied participants;

- Ascertain the wellbeing effects of care farming over the longer term, through an exploration of the wider impact that this activity has on the everyday lives of people with ID;

- Consider the different services offered by UK care farms (and varying ways in which these services are delivered) and how this impacts on the therapeutic potential of care farming for people with ID;

- Adopt an innovative methodological approach, including the use of visual methodologies, both as a technique for witnessing and interpreting embodied practices, and as a means through which to more effectively engage people with ID in the research process.

4.   Methodology

Methodological approach

In attempting to achieve the aims set out here, this research adopted an in-depth qualitative ethnographic approach in order to access first-hand the views, experiences and actions of people with ID engaged in care farming activities. Data were collected longitudinally, over a period of 10 months, in order to understand the experiences of people with ID engaged in care farming activities over a sustained period of time. An ethnographic approach was chosen for the study, as this enabled me to provide a rich and holistic insight into participants' views and actions as well as the nature (that is, sights, sounds and smells) of the places they inhabit. This reflects my epistemological commitment to a post-positivist perspective that treats the object of study as holistic, contextual and reflexive (Boyle, 1994) and which 'attempts to account for the position and partial perspective of the researcher' (Kearns and Moon, 2002: p.613).

Research suggests that people with ID respond well to methods of visual communication that allow them to be involved as active contributors. Indeed, by allowing participants to document their own experiences through photographs or film it is argued that it may be possible to offer people with ID more control over how they choose to represent themselves and how they depict their situation, thereby shifting the balance of power from researcher to researched (Aldridge, 2007). This study therefore decided to incorporate the use of visual methods, specifically photographs and film, as a means through which to more effectively engage people with ID in the research process.

The care farms

For this study, 3 care farm organisations delivering services to people with ID were recruited to participate in the research. These settings were selected with an aim to reflect the different types of care farms currently in operation in the UK, from commercially orientated or 'real' farms (where care farming constitutes an additional source of funding alongside food production) to farms that offer care services as their main or sole activity, delivered though charitable organisations or social enterprises.

Table 1. The care farms.

Care Farm 1	
Location:	East of England
Farm Type:	Mixed 7 acre smallholding with areas of woodland, pasture and fruit and vegetable growing areas. Animals include alpacas, goats, chickens, quails and bees.
Staff:	Family run business with 2 part time members of staff.
Client Groups:	Autism Spectrum, Learning Disabilities, Mental Illness and Dementia
Activities offered:	Animal care, fruit and vegetable growing, woodworking and crafts, farm maintenance projects, conservation activities and woodland management.
Funding Sources:	Client fees paid by local authorities or social services and self-generated funds.
Care Farm 2	
Location:	South West of England
Farm Type:	100 acre working organic beef farm with areas of high conservation value. Other animals on the farm include hens, donkeys and pigs.
Staff:	4 full time permanent members of staff with experience of working on a farm and/or supporting people with Autism.
Client Groups:	Autism Spectrum Condition
Activities offered:	Animal care, planting, wetland and woodland care, personal development with health and safety, woodwork, training for work, cooking and leisure and recreation in the countryside.
Funding Sources:	Client fees paid by local authorities or social services; charitable donations; central government; commercial food production.
Care Farm 3	
Location:	South West of England
Farm Type:	Organic commercial farm rearing free-range chickens, sheep, beef cattle and pigs.
Staff:	6 permanent, part time members of staff with farming, teaching and/or care work experience.
Client groups:	Autism Spectrum Condition and people with intellectual disabilities
Activities offered:	Animal care, horticulture and vegetable growing, educational courses and work based training, cooking, leisure and recreation activities.
Funding sources:	Client fees paid by local authorities or social services; charitable trusts/donations; central government; commercial food production.

Participants

This project recruited 7 people with ID as case studies. A case study approach was chosen as this allowed for a detailed and intensive analysis of a single case and provided an in-depth investigation into the lives of these individual participants, both at the care farm settings that they attend, and outside the care farm organisation. In adopting this particular methodological approach, it was therefore possible to explore the experiences of people with ID engaged in care farming activities in far more detail than when trying to deal with a large number of research participants, using a variety of qualitative data sources.

Case study participants were selected on the basis that they had recently been enrolled on a care farming programme and were identified as having an intellectual disability[1] (n=7 participants in total. See table 2). In selecting new starters, it was hoped that this particular sampling strategy would enable me to track the progress of case study participants during their first year on the care farming programme and to observe any changes that were perceived to be direct or indirect result of participation in care farming activities. This study also recruited additional individuals that make up case study participants' wider networks of professional and personal relationships. This included care farm staff based at the care farms that case study participants attend as well as family members and/or paid carers with primary care responsibility for case study participants (usually 3 additional participants per case study, n=13 additional participants in total. See table 2). In doing so it was intended that this study would gain a more holistic and comprehensive picture of case study participants' life worlds. What is more, by including sector professionals in the research, this study also sought to gain a deeper understanding of the views and experiences of those directly involved in delivering care farming initiatives, and whether these kinds of initiatives are perceived by them to produce positive outcomes for people with ID.

Permission to contact potential case study participants was sought through the care farm settings included in this study, after which initial meetings were set up with prospective participants (accompanied by a family member/carer where

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[1] This was normally confirmed through the relevant care farm organisations via referrals from social workers and/or learning providers

requested) either at the care farm setting which they attended or at another location of their choosing. Potential participants were offered the choice to decide whether to take part in the study at the time of the initial meeting, or to take more time to decide. In circumstances where an individual chose to wait to take time to think over the decision about participating, I provided them with a copy of the project information sheet explaining the research (produced in an accessible format where requested) to take away and review before making their decision. I then arranged to meet with potential participants after a minimum of seven days to discuss the study and answer any further questions. When an individual did decide to take part in the research they were then asked to sign a written consent form, produced in an accessible format. Upon gaining informed written consent from case study participants, I then sought to obtain consent from additional participants associated with each case study individual (i.e. parents/carers and care farm staff) following a similar procedure.

Table 2. Study participants

Name *	Age	Gender	Participant Type	Care Farm
Jack	37	Male	case study	1
Simon	22	Male	case study	1
James	23	Male	case study	1
Neil	23	Male	case study	3
Robert	46	Male	case study	3
Eliot	21	Male	case study	2
Jed	19	Male	case study	2
Lisa	45	Female	care farm staff	1
Liam	54	Male	care farm staff	1
Linda	54	Female	care farms staff	2
Sarah	62	Female	care farm staff	2
Sian	38	Female	care farm staff	3
Sandra	50	Female	care farm staff	3
Wendy	59	Female	parent	1
Cassandra	63	Female	parent	1
Tilly	58	Female	parent	1
Janice	57	Female	parent	3

Matthew	55	Male	carer	3
Sally	56	Female	parent	2
Carol	53	Female	parent	2

*For this study pseudonyms are used in place of participants' real names in order to ensure participant anonymity

The empirical data collection

Data was collated longitudinally over a period of 10 months in order to ascertain the impacts of care farming on case study participants' wider lives, over a sustained period of time. Fieldwork commenced with a preliminary phase, where time was spent at the care farm settings included in this study, getting to know farm staff and case study participants. This also provided me with an opportunity to familiarise myself with these environments and the activities performed there and helped everyone to feel more comfortable with my presence prior to the commencement of data collection. This preliminary phase was followed by two rounds of data collection; the first took place in September and October 2014 followed by a repeat round approximately 6 months later, in March and April 2015 (see table 3). This particular research strategy was designed to track the progress of case study participants during their first year on the care farming programme and to observe any changes in behaviour or relational capabilities that were perceived to occur during this time.

Table 3. The process of data collection.

Care Farm visits and Participant Observation *(July/August /Sep 2014)*	**Video-ethnography sessions and participant observation: follow-up** *(March & April 2015)*	**Photographic Participation Project: 2nd round** *(March & April 2015)*
Farm staff and parent/carer interviews: baseline *(Sep & Oct 2014)*	**Farm Staff and parent/carer interviews: follow-up** *(March & April 2015)*	**Visual Elicitation Interviews: follow-up** *(March & April 2015)*
Video-Ethnography sessions and participant observation: baseline *(Sep & Oct 2014)*	**Care Farm visits and Participant Observation** *(Jan 2015)*	
Photographic Participation Project: 1st round *(Sep & Oct 2014)*	**Visual Elicitation Interviews: Baseline** *(Sep & Oct 2014)*	

As table 3 indicates, a range of qualitative ethnographic methods of data collection were used to gather information on each case study participant (outlined in more detail below). These included:

- Video methods
- photographic participation and elicitation
- ethnographic participant observation
- qualitative interviews

Video methods

It has been argued that the use of video in research has the potential to engender participatory approaches that actively engage people in the research process (Pain, 2004; Mistry et al 2012; Kindon, 2003). This is because video focuses on the capacity rather than incapacities of participants 'by enabling them to show, rather than tell of their experiences' (Alridge, 2007). Indeed, the use of video can

encourage research participants to use their whole bodies and material environments to communicate their experiences (Pink, 2009). Such approaches therefore aim to listen and give voice to people with ID who may use nonverbal means of communication, recognising that people with ID have views, opinions and beliefs and that they have a right for these to be heard.

Video-data was collated longitudinally over a period of 9 months, where time was spent with each of my service user participants at the care farm they attend (approx. 6 days with each participant) video recording them as they went about their normal daily activities. The purpose of this part of the research was to capture service users embodied and multi-sensory place experiences as they engaged with and moved through the farm environment and also provided a means through which to understand the meanings people attached to these experiences and how they contributed to wellbeing.

Photographic Participation

As well as providing a detailed exploration of service users embodied and material engagements with various features of the care farm environment, it was also my aim to examine how these different forms of socio-environmental engagement impacted on participants' wider network of social, material and spatially situated relationships. This required me to access a whole range of places that may facilitate (or hinder) wellbeing, including service users' homes, friends or families homes, places of work and leisure and other public spaces.

Whilst the use of video proved to be an effective research tool when used in the care farm environment it was decided that it would not be possible to replicate this at other settings, such as service users homes, where video might feel too intrusive and may therefore hinder rather than facilitate access to participants lived experiences. Given this, I decided to give service users disposable cameras so that they might take photographs of the people and places that were important to them. This enabled me to capture important aspects of participants' life worlds where it may be ethically and/or organisationally problematic for me to be physically present. These photographs also provided a valuable visual resource

during the participant interviews through which to gain a deeper insight in to participants' wider network of place experiences (Dodman, 2003).

Visual elicitation interviews

This study invited service users to participate in two qualitative visual-elicitation interviews. The first took place soon after service users' enrolment on to the care farm programme, the second 8-9 months later. The purpose of this part of the research was to gather longitudinal data on participants' experiences of care farming and to explore the wider impact that participation in this activity had on people's lives.

For this study, each round of visual-elicitation interviews took place soon after the video and photographic sessions in order to ensure that service users had relatively fresh memories of the events, activities or social interactions being presented to them. The first stage of the interview involved inviting service users to watch edited versions of their video footage. Selected scenes included those where an individual was perceived to be gaining some form of enjoyment or benefit from participation in a particular activity, certain events that may have constituted a negative experience for participants or scenes that evidenced a change in behaviour or relational capabilities. Service users were asked to describe in their own words what was taking place during these scenes and to recall any of the sights, sounds or smells that they experienced whilst these video recordings were being taken. Service users were also asked to describe what they most enjoyed or disliked about a particular event, social interaction or activity; how they felt emotionally during these scenes (e.g. happy, nervous, proud, excited, confident, scared); and whether (and in what ways) care farming had helped them to think and feel differently.

The primary purpose of presenting service users with edited versions of the video footage was to provide them with certain visual cues designed to guide the interview process, prompt discussion and provide a basis for reflection. During this stage of the interview, I also encouraged service users to call out when they considered something to be important, and paused the video to allow for further comment with the aim to develop participants' 'selective attention' by focusing on a range of different events presented. It has been suggested that the use of video

elicitation techniques also provides a useful way for researchers to cross reference and/or validate their own interpretations of the video data (Henry and Fetters, 2012). This was important for my own methodological approach, which recognised that there was no 'correct' way to interpret the audio-visual data, and that these images may well be given different meanings depending on who is viewing them. It is important to note here however, that given the impracticality (and implicated time constraints) of asking service users to view and comment on hours of video footage, I decided to present participants only with the substantially edited versions. Given this, whilst this aspect of the research was able to generate new and interesting insights into the specific events and social interactions presented, service users were not being asked to collaborate on the analysis of the visual data as a whole. Rather, the purpose of presenting service users with these visual images was primarily to incite discussion and elicit a greater depth of response from those individuals who find verbal communication challenging.

Following the video element of the interview process, service users were then asked to discuss the photographs they had taken with the disposable cameras I had given them. During this phase of the interview, I asked service users to describe in as much detail as they were able to provide, the people and places depicted, why they had decided to take these particular images and to describe any emotions, sensory experiences or memories that these photos evoked. The primary purpose of this part of the research was, therefore, to gain an insight into service users lived experiences of places other than the care farm, and ways in which these place experiences may facilitate (or hinder) wellbeing.

Participant Observation

During the fieldwork phase of this project, a significant period of time was spent at the care farm settings included in this study (40 days approx. over a 10 month period) in order to immerse myself in the research context. Whilst a large proportion of this time was devoted to video-recording participants as they went about their daily activities, I felt it was also important for me to spend time with participants without the video camera. Indeed, whilst the video camera proved an extremely useful method of data collection, its operation significantly limited my ability to physically participate in farm activities, given that my hands, and entire body, were

otherwise occupied. It was decided, therefore, that time spent filming should be balanced against time spent simply 'being there,' getting to know service users, talking to them and helping with different chores around the farm. Through extensive field noting, attempts were made to be attentive to participants and my own behaviour, thoughts, feelings and actions, where these observational field notes primarily performed a supportive and guiding element to the interpretation of interview and video material and as a resource for researcher reflexivity.

Qualitative interviews with staff, parents and carers

Whilst this study was primarily concerned with accessing the experiences, beliefs and actions of ID people, I felt it was also necessary to hear from other people that make up service users' wider network of professional and personal relationships. To this end, service users' family members and/or carers, as well as care farm staff were asked to participate in two semi-structured qualitative interviews (n=13, 26 interviews in total). Whilst these interviews aimed to cover several key questions or topics that were relevant to my research, I was relatively flexible in my approach so as to ensure that both the interviewer and interviewee were given sufficient room to explore certain ideas or pursue responses in more detail.

The first round of interviews were designed to collate baseline information on the views and experiences of those directly involved in delivering care farm services to people with ID, their motivations for setting up/being involved in a care farm, the perceived benefits of care farming activities for people with ID and the impact that these activities are perceived to have on people with ID's everyday lives. The qualitative interviews with family, friends or carers also aimed to provide some insight into the lives of individual people with ID participants, their motivations for enrolling on these care farm programmes and what they hope to gain from their participation. A second round of interviews was then conducted following an 8-9 month interval. During these interviews, participants were asked to give their views on the extent to which care farming has met the objectives set out for individual service users and the impact (positive or negative) that care farming as had on the people with ID's wider lives. Specific topics discussed included any observable changes in mood, behaviour or relational capabilities; social networks (or lack

thereof); the impact on relationships with friends or family; participants' emotional wellbeing and any perceived lifestyle changes or improvements to health.

Data analysis

The qualitative interviews were transcribed and typed up in Word and both the text based and audio visual data were analysed using ATLAS ti. Audio-visual data were annotated with information on camera angles and distances, spoken narrative and visual content including a running commentary on body language and movement (i.e. gestures, looks, expressions). If video footage contained significant verbal dialogue this was also transcribed and linked to the relevant video segments in ATLAS. All the data were analysed using an inductive and interpretive approach. This involved carrying out a preliminary reading of the data marking all significant sections of the interviews/video segments and annotating these with initial comments and ideas. Following this, thematic analysis was carried out on the multiple forms of data generated and some emerging themes were identified (see section 5).

Research Ethics

This study has been reviewed by the Faculty of Health and Medicine research ethics committee and approved by the University Research Ethics committee at Lancaster University. Whilst details of the ethics protocol shall not be included in their entirety here, I shall give a brief overview of some of the key ethical considerations that were relevant to this study.

Obtaining informed consent

For people with ID there may be potential problems of understanding what the research is about, what their role in the research will be and how the research will be used. Hence obtaining informed consent can be problematic and special care was taken to develop appropriate strategies for communicating the implications of involvement in this study. This included producing accessible consent and information sheets explaining the research, which people had the option to take away and review before deciding whether to participate. It is also important to note that formal consent, whether written or oral, cannot always ensure that consent in longitudinal ethnographic research continues to be informed or voluntary. In view of

this I sought to renegotiate consent at every major stage of the research process and ensure that participants had a continued understanding what the research is about and implications of their involvement.

Issues of anonymity and confidentiality

The visual methodological element in this study raises some important ethical issues with regards to participant anonymity and confidentiality. Indeed, guaranteeing anonymity and confidentiality are long established principles in social research, yet much visual material makes the anoymisation of individuals or locations problematic, if not impossible. Moving visual images portray clearly identifiable individuals, where these sorts of images can only be anonymised by altering the image in some way so as to obscure participants' identity. For this study, it was decided that the visual material should be presented in its entirety thereby enabling individuals to be identified, with their consent. This required me to ensure that participants understood what the implications of identifiable images being disseminated might be. In the case of people with ID, this required me to present this information in an accessible format where special care was taken to ensure that service users fully understood what was being asked of them. In addition all participants will be given the opportunity to view (and approve) their visual images prior to their dissemination at public events i.e. academic conferences.

Avoiding exploitation and causing of distress

Qualitative researchers may be said to invade the space and psyche of their participants and whilst the interview process can be a therapeutic or cathartic experience for some, for others it may be an emotionally charged experience. Research can also cause harm to vulnerable participants through the feeling (or reality) of being exploited or through psychological and emotional distress from questioning about personally disturbing matters. Given this, significant steps were taken to ensure that participants understood that their participation was entirely voluntary and that they were able to cease filming/interviews should they experience any feelings of distress or discomfort. In addition, I ensured that follow-up support was available if needed and a resource list support options was included in participant information sheets.

5.   Emerging themes

Care farming - meaningful work

A key characteristic of care farming that emerged from the data was the way in which it enabled service users to participate in meaningful and productive activities. Service users often described time on the farm as their 'work'. Some service users also spoke of the activities they performed on the farm with a real sense of pride and they clearly took pleasure in their position at the farm as someone who knew how things worked and what was required of them.

Care farming was perceived by staff and parents to be important activity because of its ability to structure service users' days in ways that were meaningful and constructive. What is more, it was suggested that service users experienced happier and more fulfilled lives because time spent at home with family or with friends was perceived to be earned leisure time, in much the same way as someone who works Monday to Friday might view their weekends.

The care farm environment was also shown to contribute significantly to service users' sense of self and self-identity and service users typically described themselves first and foremost as farm workers. This was also described as contributing significantly to service users' self-esteem and sense of self-worth, in part because it endowed them with a sense of purpose and the feeling that they have something relevant and interesting to say when asked what they did during the week.

When compared to other forms of social care provision, such as day care centres, care farming was described as lacking that 'institutional element'. As one member of staff highlighted, service users want more than to be cared for and kept safe, they also want to be given the opportunity to exert more choice and control over their daily lives and to engage in activities that they perceive to be meaningful and worthwhile.

Farm staff did however express some concerns about the way in which care farming is perceived by 'outsiders' who might question who the primary beneficiaries of care farming are. For example, if care farming involves service users participating in so-

called real work, why are they paying for these services as opposed to receiving a wage? As a rejoinder to this, care farm staff were keen to highlight that service users are free to work at their own pace and were always given a choice concerning the activities they would like to perform each day. What is more, whilst the activities employed were meaningful in the sense that they fulfilled a specific purpose (i.e. feeding and cleaning animals) these were always done with some additional benefit in mind, such as therapeutic gain or skills acquisition. Given this, the therapeutic potential of care farming appears to reside in its ability to provide service users with opportunities to participate in meaningful and productive work in an environment where individual care and support needs are carefully considered in order to ensure maximal wellbeing.

Social inclusion and a sense of belonging

The facilitation of social networks and associated psychological benefits was an important outcome for the service users recruited for this study. Service users and farm staff both placed great value on the care farm as a community of supportiveness and acceptance. Analysis of the audio-visual data and participant interviews demonstrated how engaging in care farming activities facilitated close social bonds between services users. Similarly the perceived equality of the relationship between service users and co-workers served to emphasise the potential and qualities of service users thus facilitating feelings of trust and solidarity. For service users, just being accepted and respected for who they are and being part of a social group was found to have an overwhelming impact on their overall wellbeing.

Participation in care farming activities also has the potential to facilitate meaningful connections with members of the public thereby enhancing service users' sense of belonging within their local community (e.g. through selling produce, attending farm fairs and workshops and meeting new visitors to the farm).

However, whilst care farming may facilitate more social contact between service users and the local community during time spent at the farm, encouraging service users to engage with non-disabled people in their everyday lives can present more of a challenge. What is more, whilst service users are likely to have more regular contact with members of the local community than they might otherwise, time spent

with non-disabled people (other than family) appeared to remain a relatively uncommon phenomenon. Indeed for participants in the current study, the majority of their time was spent with farm staff and other service users or with family when not at the farm. It is important to note here however, that service users may not always want to socialise with people that do not make up their pre-existing social networks of friends and family, and some participants expressed concerns about speaking to new people because they might not be friendly or nice to them.

Whilst facilitating greater social integration may be an important step for many people with ID this may be harder to realise for those individuals who have had negative experiences in their dealings with non-disabled people and who might therefore seek 'safe' spaces of acceptance. On the other hand, participation in activities, like care farming, may serve to reinforce existing stereotypes of what people with ID can and want to do. Given this, careful attention needs to be paid to the ways in which participation in care farming activities can facilitate and/or hinder social inclusion, both within these more segregated spaces of acceptance and the wider community.

These concerns were echoed by farm staff and parents alike, and it was felt that it was important for care farms to continually challenge services users and offer new activities and opportunities wherever possible. This may be especially important for service users who have been enrolled on a care farm programme for a long time (i.e. over a year) who run this risk of becoming too entrenched in their everyday routines. For these care farms, the ultimate goal for service users is to enable them to achieve a level of independence in their lives appropriate to individual needs and abilities. For some, the ultimate goal may be paid employment where for others this may be living independently or doing more things for themselves, such as making their own lunches or using public transport independently.

Contact with animals

Engaging with and caring for farm animals formed a central part of service users' day and participants spend a significant amount of time with farm animals, undertaking tasks such as collecting eggs, mucking out, grooming and feeding. When analysing participants' interviews and video sessions, participants evidently enjoyed spending time with these animals and were confident in their ability to care

for them. This was especially evident when participants were required to work with particularly large animals, like horses or cows, where a certain amount of skill and training are required.

Subsequent interviews with farm staff and with service users suggest that interacting with farm animals endowed service users with a real sense of pride at being able to perform these kinds of skills activities, and perform them well. In this way, service users' interactions with farm animals served to significantly boost confidence and self-esteem and enabled them to become more assertive in other aspects of their life.

Service users perceived their relationship with the animals on the farm as relying on a duty of care and service users demonstrated a constant sensitivity to the needs of these animals, characterised by the careful and methodical way in which they interacted with them. One member of staff described how caring for the animals taught service users something important about empathy for others, observing how individuals became increasingly considerate in their relations with other service users and staff as a result of working with farm animals.

Participants commented on the sensory nature of their experiences when working with the farm animals and the way in which this impacted on their enjoyment. For example, when asked why she liked working with horses the most, one participant said it was because she loved the way they smelt. Conversely, another participant commented that the pigs were his least favourite animal because of the smell when mucking them out, and the noise they made which he often found annoying and distracting and which prevented him from concentrating on his work.

Service users are repeatedly encouraged to actively engage with the farm animals, either by grooming or petting them or by just being with them and watching what they do. One participant commented how being with these animals, particularly the horses, had a positive effect on their wellbeing and helped them to manage their anxiety. It is important to note however that whilst being with these animals often constitutes a calming experience for service users, this is not always the case, and participants commented that the unpredictable nature of some of these

animals required them to be mindful and alert which might, in turn, impact on their therapeutic potential.

Care Farming- the wider impact

Whilst time spent on care farms was shown to be an enjoyable and rewarding experience for service users, assessing the wider impact of care farming on people's lives is more difficult to pinpoint and will require a detailed and careful analysis of the data upon completion of the fieldwork phase of this study. Some initial thoughts on care farming's wider impact are outlined here.

Increased independence

Some of the service users included in this study have discovered new levels of independence, which may be a direct or indirect result of participating in care farming activities. The rural locations of these farms mean that service users are often required to travel some distance to attend and therefore have to plan carefully for how they are going to get to there each day. For some service users, this motivated them to begin travelling more independently (e.g. by bus or taxi) to care farm settings. This was also shown to encourage some services users to travel independently when doing other things, like going to the shops or seeing friends and family. Other areas where participants demonstrated increased levels of independence included, getting up and getting ready in the morning; making their own lunches; performing household chores, such as cooking or cleaning and helping in the garden.

Enhanced social networks

Some of the service users who took part in this study said that care farming had helped them to make friends. For these individuals, time spent socialising with friends had decreased significantly since leaving school or college and care farming provided them with new opportunities to form meaningful adult relationships. Whist some participants said they did not socialise with other service users outside of the farm setting, others had begun to spend time together doing things like, going to the cinema, going to the pub or attending local football matches. Enhanced social networks and opportunities for making friends was described as having a significant

impact on service users' confidence and self-esteem, and it was felt by parents and farm staff that service users were happier as a result of having more active social lives.

Healthier and more active lifestyles

As with other outdoor activities, care farming engages service users in a range of activities with the potential to improve or enhance physical health and wellbeing. Indeed activities undertaken on care farms, such as feeding and caring for animals, planting and growing food or general maintenance, require more physical effort than activities offered at regular day care centres and therefore have the potential to stimulate participants to stay active. Service users said that they felt healthier and stronger as a result of being out in the 'fresh air' and open countryside and were more physically active generally, with some taking up new activities, such as waking, swimming or going to them gym. Working on a care farm also provided service users with opportunities to grow their own food, as well as cooking and eating together. This helped to introduce service users to healthier and more balanced diets. Whilst this was not always replicated at home, exposure to new and healthier food options (in particular vegetables and fruit) has the potential to improve service users' eating habits.

6. Conclusion

Despite recent efforts to encourage marginalised groups to access outdoor environments for physical and mental health benefits, people with ID remain largely absent from this agenda. This is paralleled by a distinct lack of research on people with ID's place experiences and ways in which these experiences impact on health and wellbeing. Using insights from recent research in geography, this PhD project is examining the wellbeing effects of participation in care farming projects for people with ID over the longer term, through an exploration of the wider impact that this activity has on the everyday lives of these individuals.

Initial findings from this qualitative study indicate that care farming enables services users to participate in meaningful and productive activities that contribute

significantly to service users' self-esteem and sense of self-worth. Care farming's ability to foster feelings of social inclusion and belonging as well as the therapeutic potential of contact with farm animals were also shown to be beneficial. Whilst it is more difficult to ascertain care farming's wider impact at this early stage, some initial findings suggest that care farming also has the potential to enhance social networks, can increase service user independence and may facilitate more active and healthier lifestyles.

It is important to note here however that whilst care farming has been shown to confer numerous wellbeing benefits to people with ID, it may not always be possible for everyone to enjoy the same level of benefit. This reflects the fact that the outcomes achieved for different service users are largely dependent on the needs and abilities of the individual. Whilst a day spent on a care farm might be a rewarding and enjoyable experience for many service users (as well as a valuable respite for family and/or carers) the extent to which these experiences can provide a force for change is less clear. This is because, due to the complex needs of some service users, outcomes such as increased independence or enhanced social networks may be more difficult to realise. Similarly, the ability of care farming to impact on participants' lives outside of the farm is reliant on support from family members and carers as well as relevant health and social care providers. Developing good working relationships like these is a two-way process that takes time and effort and requires sufficient engagement from all relevant actors if benefits to service users are to be maximised.

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