BRIDGING THE GAP :

Adaptive Reuse of Carrington Hospital as a **'Missing Middle'** for Mental Health Care in Tāmaki Makaurau

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Figure 1. *Render showing the Carrington exterior. Created by Author*

ABSTRACT

This thesis responds to a critical gap in mental healthcare systems, a challenge particularly acute in Aotearoa New Zealand but relevant globally: the "missing middle" This term refers to people with moderate to severe mental health needs who are too unwell for primary care alone yet do not meet the threshold for specialist or inpatient services. Caught between these systems, they often face social isolation, housing insecurity, and cycles of crisis. The research explores how architecture can respond to this gap, proposing that adaptive reuse can create supportive, community-based environments that promote recovery, dignity, and belonging

The project is situated in Tāmaki Makaurau Auckland and focuses on the adaptive reuse of the former Carrington Hospital (Building One), a Category 1 historic place with a complex legacy of mental health care. Located within the Wairaka Precinct Masterplan, a site of ongoing urban regeneration, Carrington serves as a test case to explore how heritage structures can host new models of care while respecting their historical and cultural significance. The research is guided by the question: *How can the adaptive reuse of the former Carrington Hospital create a new architectural model for the "missing middle" in mental health care, one that promotes recovery through de-institutionalised design, community integration, and a meaningful dialogue with its heritage?*

The methodology combines qualitative literature review and analysis of existing policy frameworks, such as the He Ara Oranga report and the Auckland Unitary Plan and evidence-based precedent studies to develop a set of design principles. These principles are then applied and tested through design-led inquiry, resulting in a proposal that reimagines Carrington as a Community Wellness Hub with integrated transitional housing. The design establishes a “stepped care” framework within one connected site, enabling residents to move gradually from supported to independent living while remaining engaged with community and nature.

This thesis concludes that this specific approach to adaptive reuse functions as a multi-layered act of healing: it provides a therapeutic environment for the "missing middle," fosters social integration for the wider community, and heals the building's stigmatised past by inverting its narrative from one of confinement to one of care. The project demonstrates a replicable model where architectural regeneration is intrinsically linked to social and psychological wellbeing.

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ATTESTATION OF AUTHORSHIP

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor used artificial intelligence tools or generative artificial intelligence tools (unless it is clearly stated, and referenced, along with the purpose of use), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

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I would like to express my heartfelt gratitude to my supervisors, Stacy and Andrew, for their invaluable guidance and support during the development of this thesis. I am especially grateful to Chessa for generously taking the time to provide thoughtful guidance and insight during this process.

Figure 2. *View through the window from the abandoned Building: One (Former Carrington hospital). (Adapted from Urbex Central, 2022)*

PREFACE:MOTIVATION

My engagement with the realities of mental health care in Aotearoa New Zealand began shortly after my arrival in February 2024, through volunteer work with the Elim Christian Centre. Our visits to transitional care facilities and aged-care homes were simple in intention, to bring moments of connection through carols, conversation, and small acts of kindness. We sought to remind residents that they were seen, valued, and not forgotten.

Yet these visits revealed a deep and troubling truth. Despite efforts to make these environments feel “homely,” with soft furnishings and friendly staff, the spaces still carried an atmosphere of confinement. I met young adults living alongside elderly residents, disconnected from family and community. Doors were locked not only for safety but in ways that cut people off from the outside world. The architecture, however softened remained institutional, defined by separation rather than connection, control rather than care.

This experience exposed the gap between the intention of care and the reality of the built environment. It revealed how people who are not acutely unwell yet still need ongoing support, the so-called *“missing middle”* are too often placed in settings that fail to nurture recovery or dignity. It became clear to me that architecture has a profound role to play in this missing space of care.

This personal witness forms the foundation of my thesis. It motivates my exploration into how architecture can bridge the “missing middle” by creating environments that are restorative, inclusive, and connected to community. It is a pursuit to understand how spaces can move beyond managing illness to actively supporting healing and belonging.

GLOSSARY

Adaptive Reuse
The process of repurposing buildings for new uses while retaining their heritage significance, extending a structure's life through sensitive adaptation (Douglas, 2006).

He Ara Oranga (2018)
The report of the Government Inquiry into Mental Health and Addiction in New Zealand. It is a foundational document that identified systemic failures, including the "missing middle" (He Ara Oranga, 2018).

The “Missing Middle”
A term from the He Ara Oranga report describing people with moderate to severe mental health needs who are too unwell for primary care alone, yet do not meet the threshold for specialist inpatient services (He Ara Oranga, 2018).

Wairaka Precinct
A large-scale urban regeneration project on the former Unitec campus in Auckland. The former Carrington Hospital is located within this masterplan area (Grimshaw, 2019).

Deinstitutionalisation
The movement away from large psychiatric hospitals toward community-based care models that promote independence and recovery (Pirret, 2017; Mental Health Commission, 1998).

Healing Architecture
A design philosophy recognising the built environment’s impact on wellbeing, using spatial and sensory elements to support recovery (Sternberg, 2009).

Transitional Housing
Short- to medium-term accommodation supporting individuals as they move from institutional care or crisis toward independent living (Pirret, 2017).

Therapeutic Environment
A setting intentionally designed to promote psychological wellbeing, incorporating principles such as safety, autonomy, and access to nature (Ulrich, 1991; Kaplan & Kaplan, 1989).

Heritage Conservation
The process of protecting and managing change to a heritage place to sustain its cultural significance, as guided by the Burra Charter (Australia ICOMOS, 2013).

Difficult Heritage
Sites associated with painful or contested histories, where conservation requires sensitive interpretation to transform meaning without erasing the past (Logan & Reeves, 2009).

Stepped Care Model
A mental health framework providing varying levels of support matched to an individual’s needs, allowing movement as recovery progresses (He Ara Oranga, 2018).

Community Integration
The process of reconnecting individuals with community networks to foster belonging and reduce isolation in mental health recovery (Mental Health Commission, 1998).

De-institutionalised Design
An architectural approach avoiding institutional aesthetics, favouring domestic scale, choice, and openness to promote dignity (Goffman, 1961; Sternberg, 2009).

Evidence-Based Design (EBD)
A design approach grounded in empirical research that uses data and measurable outcomes to inform decisions and improve wellbeing (Ulrich et al., 2008).

Cultural Significance
The aesthetic, historical, social, spiritual, or scientific value of a heritage place to a community, as defined by the Burra Charter (Australia ICOMOS, 2013).

Biophilic Design
An architectural approach that seeks to connect occupants to nature through natural light, materials, and vegetation to improve health and wellbeing (Kellert, Calabrese, & Browning, 2015).

Te Whare Tapa Whā
A holistic Māori health model developed by Sir Mason Durie, describing health as a wharenui with four dimensions: taha tinana (physical), taha hinengaro (mental), taha whānau (social), and taha wairua (spiritual) (Durie, 1994).

1

INTRODUCTION

1.1 THE "MISSING MIDDLE"

The “missing middle” in mental health care represents a critical architectural and systemic failure, both in Aotearoa New Zealand and globally. This term describes individuals with moderate-to-severe mental health needs who are too unwell for primary care alone but do not meet the threshold for acute inpatient services (He Ara Oranga, 2018). In the UK, this is recognized as a “treatment gap” (Clark, 2018), and in Australia as a “mid-tier service vacuum” (Rosenberg & Hickie, 2020). The universal consequence is a cycle of crisis, hospital recidivism, and social disintegration for a vulnerable population (World Health Organization, 2021).

In Aotearoa, this gap is acute. The *He Ara Oranga* report (2018) notes that individuals in this category are often told they are “not unwell enough” for specialist care yet are too unwell to recover without support. Left without appropriate options, they face “fight and beg” for help, frequently deteriorating until a crisis forces acute admission (p. 12). This systemic failure manifests spatially as a void in the designed environment: a stark dichotomy between inadequate, isolating housing and institutional, separation-focused clinical facilities. What is missing is a third typology, a therapeutic, supported environment that acts as a “secure base” for recovery (Tickle & Fisk, 2023).

Figure 3 Chart showing the position of the missing middle within the mental health care continuum. Created By Author.

1.2 ARCHITECTURAL FAILURE

The current response to the missing middle often constitutes an anti-therapeutic architectural act. The widespread practice of placing younger adults in aged-care facilities, a practice condemned as a systemic failure (He Ara Oranga, 2018; Mental Health and Wellbeing Commission, 2023), places individuals in environments designed for frailty and passivity, directly contradicting recovery principles of autonomy, hope, and social connection (Le Boutillier et al., 2021). Similarly, discharge into insecure, unsuitable housing without integrated support creates settings where environmental stress itself impedes healing (Foye et al., 2022).

The core failure is the artificial separation of ‘housing’ from ‘therapeutic care’. Modern recovery models are built on dignity, self-determination, and community integration (Slade et al., 2023). The current fragmented model violates these principles, offering shelter without therapy, or therapy without a supportive home. This gap is not merely clinical; it is spatial. The missing middle requires an integrated model where the built environment itself becomes the primary therapeutic intervention, providing the “scaffolding” for a graduated journey back to community life (Tickle & Fisk, 2023).

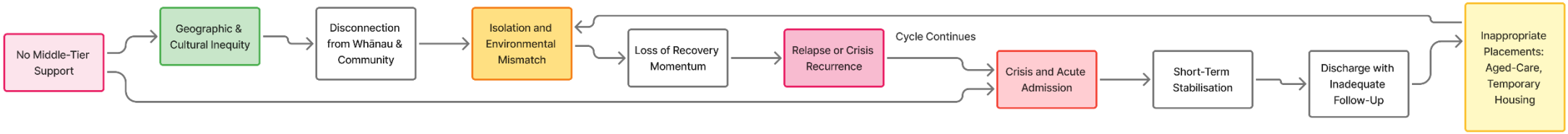

Figure 4 Consequences of the "Missing Middle". Created *By Author.*

1.3 THE CARRINGTON OPPORTUNITY

The former Carrington Hospital presents a unique convergence of need, history, and urban potential to prototype this new architectural typology. As a Category 1 historic place and former "total institution" (Goffman, 1961), its adaptive reuse offers a powerful opportunity for narrative and spatial healing, transforming a symbol of confinement into one of community care. Simultaneously, its location within the regenerating Wairaka Precinct provides the essential urban "scaffolding", new transport links, parks, and a mixed-use community necessary for genuine social integration (Grimshaw, 2019).

This thesis therefore proposes that the adaptive reuse of Carrington Hospital can create a replicable architectural model for the missing middle. Employing a heritage-led, values-based approach guided by the ICOMOS New Zealand Charter (2010**)** and the *Burra Charter* (Australia ICOMOS, 2013), the project will focus transformative intervention on the building's lesser-significance wings to test a "Vertically Integrated Stepped Care" environment, a single site synthesizing transitional housing, on-site support, and community facilities to create a visible pathway from crisis to independent living.

Research Question

How can the adaptive reuse of the former Carrington Hospital create a new architectural model for the "missing middle" in mental health care, one that promotes recovery through de-institutionalised design, community integration, and a meaningful dialogue with its heritage?

1.4 RESEARCH OBJECTIVES

1 For the Resident: To Define a Therapeutic Architectural Framework

To translate the principles of mental health recovery into specific architectural strategies that foster a sense of dignity, agency, and safety without confinement.

2 For the Building: To Establish a Heritage Reuse Strategy for "Difficult Heritage"

To develop a method for adaptive reuse that respectfully engages with the building's complex and contested history, often termed "difficult heritage" (Logan & Reeves, 2009) not by erasing it, but by performing a narrative inversion. The objective is to transform its legacy from one of institutional isolation into one of community care and support, giving the heritage asset a viable and meaningful new life.

3 For the Community & Masterplan: To Propose an Integrated Social Anchor

To demonstrate how the building can be reprogrammed as a vibrant community hub, fulfilling the Wairaka Masterplan's goals by creating a permeable, mixed-use facility. The objective is to use architecture to foster casual encounters, reduce stigma, and seamlessly weave the new mental health support infrastructure into the daily life of the precinct.

To synthesize the above into a cohesive architectural proposition that serves as a proof-of-concept. The final objective is to provide an evidence-based model for how adaptive reuse can simultaneously address the "missing middle" crisis, conserve heritage, and activate master planning, offering a transferable strategy for similar contexts.

1.5 SCOPE AND LIMITATIONS

The scope of this thesis is focused on the architectural and experiential strategies for enabling recovery and integration. The primary focus is on the sensory and phenomenological aspects of the design, how space, light, materiality, and spatial sequencing can be crafted to create a therapeutic environment.

This project does not address detailed engineering, structural, or servicing solutions, as these lie beyond the scope of its architectural focus. Similarly, while operational funding and management structures are acknowledged as essential to long-term success, they are not examined in depth within this thesis.

The intended outcome is a persuasive architectural proposition that demonstrates the *potential* of this building type and reuse strategy, providing a robust framework for future development.

1.6. Methodology Map

RESEARCH QUESTION

How can the adaptive reuse of the former Carrington Hospital create a new architectural model for the "missing middle" in mental health care, one that promotes recovery through de-institutionalised design, community integration, and a meaningful dialogue with its heritage?

THEORETICAL FRAMEWORK

Mental Health & Recovery Theory
Understand users' psychological, emotional, and social journey.

METHOD
Literature review, behavioural health research and evidence-based studies.

Architecture of Healing Environments
Explore how spatial and sensory design can foster recovery and wellbeing.

METHOD
Literature review and precedent studies

Adaptive Reuse & Heritage Theory
Define the philosophy and principles guiding repurposing of historic buildings.

METHOD
Literature review, ICOMOS and NZ Heritage charters, case studies of adaptive reuse.

Design Principles and Precedents (Method of Synthesis)
The three theories above converge to form design principles as the methodological tools. Each principle is tested and evidenced through precedent analysis (evidence-based design method).

CONTEXTUAL ANALYSIS

Multi-scalar reading of the project's physical, regulatory, and social context.

Wider Context
- Historical evolution of Carrington Hospital and its social stigma.
- Relationship between site, people, and the "missing middle" population.
- Broader urban and heritage context of Mt Albert.

The Masterplan and Policy
- Study of Unitec Masterplan: zoning, density, open space, connectivity.
- Policy alignment with Auckland Unitary Plan and heritage rules.
- Examination of infrastructural and community proposals.

The Site (Carrington Building)
- Architectural history, material decay, structural logic, and adaptive potential.
- Identification of significant elements to preserve and reinterpret.
- Spatial mapping: circulation, light, and environmental qualities.

SYNTHESIS AND DESIGN DEVELOPMENT

To integrate theoretical and contextual insights into a coherent design response.

DESIGN RESPONSES
- Programme & Activation: translating social and health needs into spatial programmes.
- Architectural Response: reconfiguring the existing building to enable recovery and connection.
- Landscape Response: integrating nature and movement pathways for therapeutic value.

FINAL DESIGN
- Final design iteration incorporating floor plans, sections, material studies, and renderings.
- Demonstrates how architecture bridges systemic and environmental gaps for the "missing middle."

Figure 5 – Methodology Map. Created *by Author.*

2

THEORY

2.1. FROM DEINSTITUTIONALISATION TO MODERN RECOVERY

The architectural response to mental healthcare has been fundamentally shaped by the seismic shift from institutional containment to community-based recovery, providing the critical historical context for a new spatial typology.

The mid-20th-century asylum, exemplified by Carrington's original design, was the physical manifestation of Goffman's (1961) "total institution" a space engineered to systematically erode identity and autonomy through controlling architecture. Long corridors, locked wards, and spatial segregation were not merely functional but ideological, enforcing a regime of confinement and surveillance (Pirret, 2017), where the architectural goal was custodial management, not healing. The deinstitutionalisation movement was a direct reaction to this model, but its implementation is now widely critiqued as a structural failure. While it successfully dismantled the asylum, it failed to provide adequately designed and resourced community alternatives (Tickle & Fisk, 2023), creating the very "service vacuum" now termed the missing middle (He Ara Oranga, 2018). The lesson is stark: removing a harmful architecture is insufficient without creating a therapeutic one to replace it.

Emerging from this failure, the contemporary Recovery Model reframes success from mere clinical stability to "living a satisfying, hopeful, and contributing life even with limitations" (Mental Health Commission, 1998, p. 5), a philosophy now central to policy (He Ara Oranga, 2018). Crucially, modern scholarship understands recovery as a personal and social process scaffolded by environment (Slade et al., 2023), a journey supported by safety, connection, and hope (Le Boutillier et al., 2021). This provides a powerful new brief for architecture: the built environment must be an active agent in enabling this journey, directly countering the legacy of the total institution by fostering the very agency and connection it sought to destroy.

2.1.1. PRINCIPLE 1: SPATIAL SEQUENCING FOR GRADUAL AUTONOMY

Drawn from: Recovery theory (Slade et al., 2023; Le Boutillier et al., 2021), critique of the total institution (Goffman, 1961; Tickle & Fisk, 2023), and Trauma-Informed Design (Mazuch, 2023).

This principle responds to the architectural failure to provide a "ladder of support" for the missing middle, whose journey is currently marked by sudden, unmanaged transitions between confinement and abandonment (Tickle & Fisk, 2023). The traditional asylum offered undifferentiated control; the contemporary gap offers a void of supported transition. Both deny the agency central to recovery.

A graduated spatial sequence, from private sanctuary to semi-private buffers to social hearths to community interfaces allows residents to self-regulate their social engagement, rebuilding confidence through manageable choices. This operationalises Appleton's (1975) Prospect-Refuge Theory and Pallasmaa's (2012) embodied cognition, where transitions in materiality, light, and scale subconsciously signal territorial shifts. For the missing middle, this essential scaffolding counteracts learned helplessness and provides the "middle ground" currently absent from their housing options.

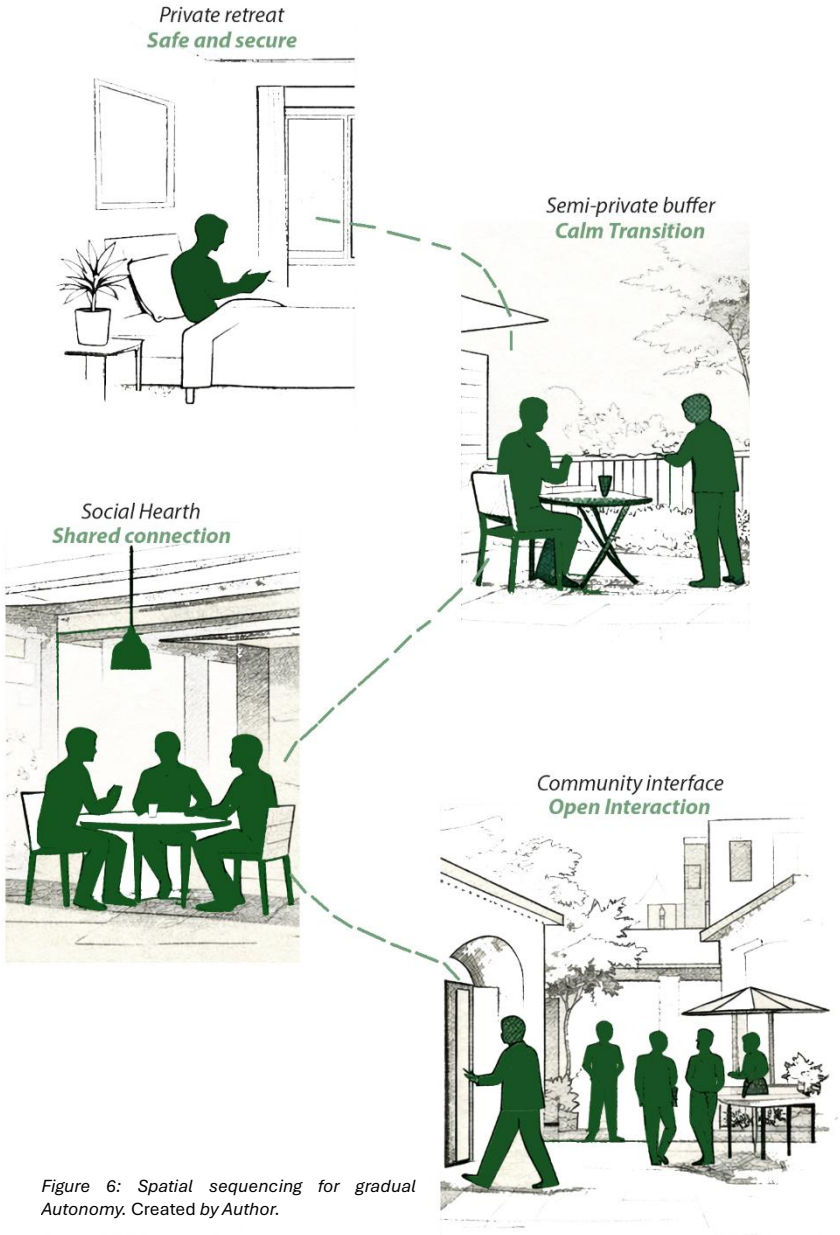

Figure 6: Spatial sequencing for gradual Autonomy. Created *by Author.*

2.2. ARCHITECTURE OF A HEALING ENVIRONMENT

The translation of recovery philosophy into built form is guided by Evidence-Based Design (EBD), a field that has matured from establishing foundational links to exploring nuanced, human-centric applications.

Seminal work by Ulrich (1984) and Ulrich et al. (2008) established the empirical connection between design decisions and health outcomes, proving that views to nature reduce stress and that environmental control improves wellbeing. However, contemporary EBD has moved beyond general wellness to address specific populations and traumas. This evolution is documented across multiple strands of research that, while developed independently, collectively converge on a shared understanding: the environment must actively regulate physiological and psychological states.

Trauma-Informed Design (TID) emerged from healthcare and psychosocial research, focusing explicitly on avoiding re-traumatisation through occupant control, sensory zoning, and psychological safety (Mazuch, 2023). For the missing middle, many of whom have experienced institutional or unsafe environments, a locked door may trigger memories of confinement; TID therefore seeks security through visual connectivity and perceived safety (Hansen, 2021).

Concurrently, Neuroarchitecture developed from cognitive neuroscience, investigating how spatial qualities, ceiling height, visual complexity, material texture subconsciously influences stress responses, cognitive load, and social behaviour (Coburn et al., 2020; Sternberg & Wilson, 2006). This suggests architectural elements can act as non-pharmacological regulators of the autonomic nervous system.

Biophilic Design, rooted in environmental psychology, has evolved from Ulrich's (1984) Stress Reduction Theory and Kaplan & Kaplan's (1989) Attention Restoration Theory into a recognised therapeutic infrastructure. Recent research quantifies its impact on sleep quality, aggression reduction, and cognitive restoration in psychiatric settings (Browning et al., 2014; Ryan et al., 2024), positioning biophilia as essential for regulating the circadian rhythms and hypervigilance common in mental health recovery (Evans, 2022).

These three fields - TID, Neuroarchitecture, and Biophilic Design, developed along separate trajectories but share a convergent imperative: the built environment must function as an active, passive therapeutic agent. They are not competing approaches but complementary layers. For this thesis, TID provides the ethical framework of safety and choice; Neuroarchitecture offers the mechanistic understanding of spatial perception; Biophilic Design delivers the sensory palette for restoration. Together, they form a multi-sensory therapeutic toolkit that directly responds to the missing middle's need for daily, non-clinical regulation.

2.2.1 PRINCIPLE 2: BIOPHILIC INTEGRATION AS PREVENTATIVE REGULATION

Drawn from: Stress Reduction Theory (Ulrich, 1984), Attention Restoration Theory (Kaplan & Kaplan, 1989), contemporary biophilic research (Ryan et al., 2024; Browning et al., 2014), and Trauma-Informed Design (Mazuch, 2023).

This principle responds to the chronic, low-grade stress and cognitive fatigue that erode the missing middle's coping capacity (Tickle & Fisk, 2023). Their current environments, sensorially harsh, nature-deprived, demand constant directed attention without offering restorative counterpoints.

Biophilic design is therefore not an amenity but a form of primary prevention. Nature functions as non-pharmacological regulatory infrastructure, lowering cortisol, restoring directed attention, and providing multi-sensory anchoring to the present moment (Pallasmaa, 2012). For a population that cannot wait for clinical intervention, their everyday environment must perform this therapeutic function continuously. The principle demands a layered, immersive application of biophilic patterns where connection to nature is inescapable, not optional.

Figure 7: Biophilic Integration as Preventative Regulation. Created by Author.

2.2.2. PRINCIPLE 3: VISUAL AND CIRCADIAN CONNECTIVITY

Drawn from - Circadian science (Brainard & Hanifin, 2005), Prospect-Refuge Theory (Appleton, 1975), Stress Recovery Theory (Ulrich, 1991), and embodied cognition (Pallasmaa, 2012).

This principle addresses the destabilising effects of spatial confinement and biological de-synchronisation. The missing middle's unmanaged environments often lack temporal cues, disrupting sleep and spatial prospect, both active contributors to decline.

Light is the primary *Zeitgeber* for circadian rhythms; architectural provision of morning light is chronobiological scaffolding for stable sleep and mood (Brainard & Hanifin, 2005). Simultaneously, long views to nature function as "positive distraction" (Ulrich, 1991) and satisfy the innate need for prospect from a place of safety (Appleton, 1975). Together, these strategies provide biological regularity and psychological spaciousness, passive supports that help maintain normalcy without institutional oversight. The architecture must choreograph light and view as fundamental spatial experiences, regulating time and space through orientation, axial transparency, and modulated light quality.

In the context of Aotearoa New Zealand, these principles align with *Te Whare Tapa Whā*, Sir Mason Durie's holistic Māori health model, which understands wellbeing as the balance of taha tinana (physical), taha hinengaro (mental and emotional), taha whānau (social), and taha wairua (spiritual) (Durie, 1994). Spatial sequencing supports *taha hinengaro* by restoring psychological safety and agency; biophilic integration engages both *taha tinana* and *taha wairua* through embodied connection to light, land, and nature; and community integration reinforces *taha whānau* by situating recovery within networks of belonging. This alignment grounds the architectural framework within a culturally responsive understanding of wellbeing specific to Aotearoa.

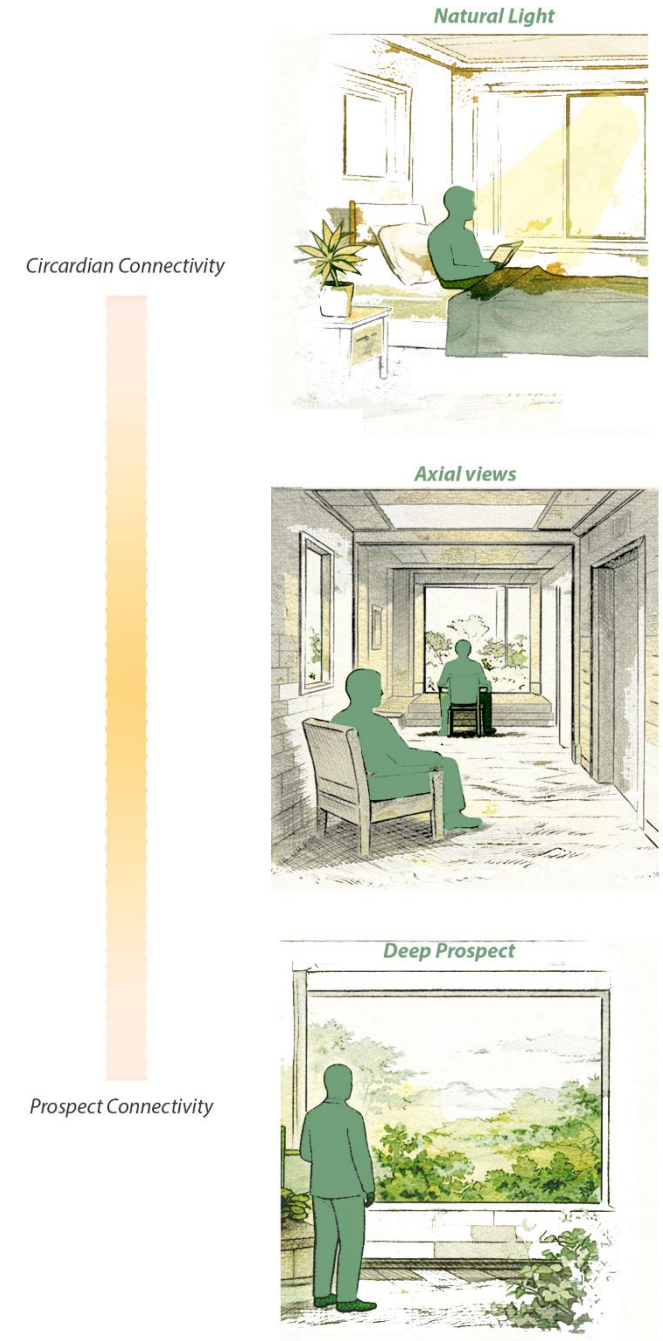

Figure 8: Visual And Circadian Connectivity.
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2.3 ADAPTIVE REUSE AND COMPLEX HERITAGE

Adaptive reuse is fundamentally a process of re-evaluating and re-energising existing structures. Moving beyond Douglas's (2006) pragmatic definition, contemporary theory frames it as a socially sustainable practice that maintains community memory while supporting evolving identity (Wong, 2016) a critical shift from solving physical problems to engaging vessels of cultural meaning.

The Philosophical Shift

Traditional conservation, codified in the Venice Charter (1964), prioritised physical authenticity, the fabric as historical document. The Burra Charter (Australia ICOMOS, 2013) marked a radical evolution to a values-based approach, where retaining cultural significance through compatible use and managed change is paramount. This is operationalised in Aotearoa by the ICOMOS New Zealand Charter (2010), which states significance is "best retained by maintaining a responsible and compatible use" (Article 6.1).

For sites of complex or contested heritage often termed "difficult heritage" (Logan & Reeves, 2009) a purely preservationist approach risks freezing the site in a state of negative legacy. Carrington, as a former asylum, embodies this challenge. The contemporary stance is that conservation must orchestrate a critical dialogue with the past, allowing a building's narrative to evolve and heal through new, positive use.

Adaptive Reuse as Social Sustainability and Climate Action

This framework aligns with two contemporary imperatives. First, social sustainability: Wong (2016) argues adaptive reuse reconciles community with its past while addressing present needs. Transforming a place of confinement into one of community care performs a narrative inversion not erasure, but re-signification that actively reduces stigma and fosters inclusion. Second, climate-responsible practice: As documented in *Auckland's Heritage Counts 2025* and frameworks for sustainable climate adaptation (*Preserving the Past, Protecting the Future*), reusing existing buildings is among the most effective forms of climate mitigation, retaining embodied carbon and avoiding demolition waste.

These are not separate agendas. For Carrington, social and environmental sustainability converge: the most ecologically responsible building is the one that already exists, and the most socially responsible act is to give it a new life that heals its stigmatised history.

Reuse as Healing

For this thesis, the most critical insight is adaptive reuse's unique capacity as social and therapeutic catalyst. The concept of narrative inversion directly addresses the building's legacy: a former asylum reclaimed for community mental health care becomes a physical manifestation of recovery. Residents and community alike witness a symbol of confinement transformed into one of support. This aligns with the Recovery Model's emphasis on hope and the ICOMOS NZ Charter's mandate for responsible use. The intervention must be legible as a new layer, contemporary in form and material, ensuring the building's journey from "total institution" to "therapeutic community anchor" is visually undeniable.

2.3.1 PRINCIPLE 4: ADAPTIVE REUSE AS NARRATIVE HEALING

Drawn from: Values-based heritage conservation (Australia ICOMOS, 2013; ICOMOS NZ, 2010), difficult heritage theory (Logan & Reeves, 2009), social sustainability (Wong, 2016), and climate adaptation frameworks (*Auckland's Heritage Counts 2025*).

This principle responds to the dual failure of Carrington's current state: physical vacancy and stigmatised legacy. Preservation alone cannot heal either.

Adaptive reuse must perform narrative inversion, transforming a symbol of confinement into one of community care through legible, respectful intervention. New work must be clearly contemporary, creating a visible dialogue between the weight of history and the lightness of care. This is not aesthetic preference but therapeutic and ethical necessity: residents must not feel they inhabit an old asylum, and the community must witness the building's transformation. Simultaneously, reuse is an act of climate responsibility, retaining embodied carbon and modelling sustainable development. For Carrington, these agendas converge: the building's new life must be both culturally meaningful and environmentally sound.

2.4. THEORETICAL FRAMEWORK

Principle	Theoretical Foundation	Architectural Mandate
1. Spatial Sequencing for Gradual Autonomy	Recovery Theory (Slade et al., 2023); TID (Mazuch, 2023); Prospect-Refuge (Appleton, 1975); Embodied Cognition (Pallasmaa, 2012)	Create legible gradient from private sanctuary to public engagement, enabling choice and self-regulation of social contact
2. Biophilic Integration as Preventative Regulation	Stress Reduction Theory (Ulrich, 1984); ART (Kaplan & Kaplan, 1989); Contemporary Biophilic Research (Ryan et al., 2024; Browning et al., 2014)	Embed multi-sensory, inescapable connection to nature as daily, passive therapeutic infrastructure
3. Visual & Circadian Connectivity – Anchoring Stability	Circadian Science (Brainard & Hanifin, 2005); Prospect-Refuge (Appleton, 1975); Positive Distraction (Ulrich, 1991)	Engineer light and view to regulate biology, reduce confinement, and provide orienting prospect
4. Adaptive Reuse as Narrative Healing	Values-Based Conservation (ICOMOS NZ, 2010; Australia ICOMOS, 2013); Difficult Heritage (Logan & Reeves, 2009); Social Sustainability (Wong, 2016); Climate Adaptation Frameworks	Perform legible, respectful intervention that transforms stigma into care through material and formal dialogue

Table 1: Theoretical framework. Created *by Author.*

3

PRECEDENT ANALYSIS

3.1 MAGGIE'S LEEDS CENTRE BY HEATHERWICK STUDIO

Principle Demonstrated: Spatial Sequencing for Gradual Autonomy

Maggie's Leeds replaces the monolithic medical model with three domestic-scaled brick pavilions, directly countering Goffman's (1961) "total institution." This fragmentation dismantles intimidating scale, creating a legible environment where users can orient themselves without the anxiety large buildings induce (Mazuch, 2023). For the missing middle, whose daily environments often overwhelm, this legibility is itself therapeutic.

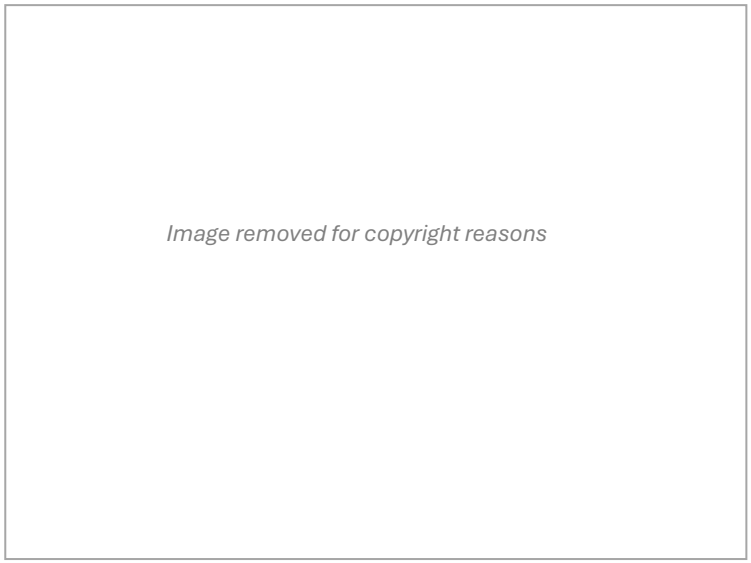

Figure 9 Exterior view of the Maggie's Centre showing the large-scale planter structures and the materiality. (Heatherwick Studio, n.d.)

The Kitchen as Social Condenser

Circulation radiates through a central, open kitchen transforming movement from functional necessity into low-pressure social encounter. This operationalises the recovery principle of "connection" (Mental Health Commission, 1998) by making interaction a natural byproduct of daily activity, not a forced event. For a population isolated by inadequate housing, this demonstrates how spatial organisation can scaffold social re-integration organically.

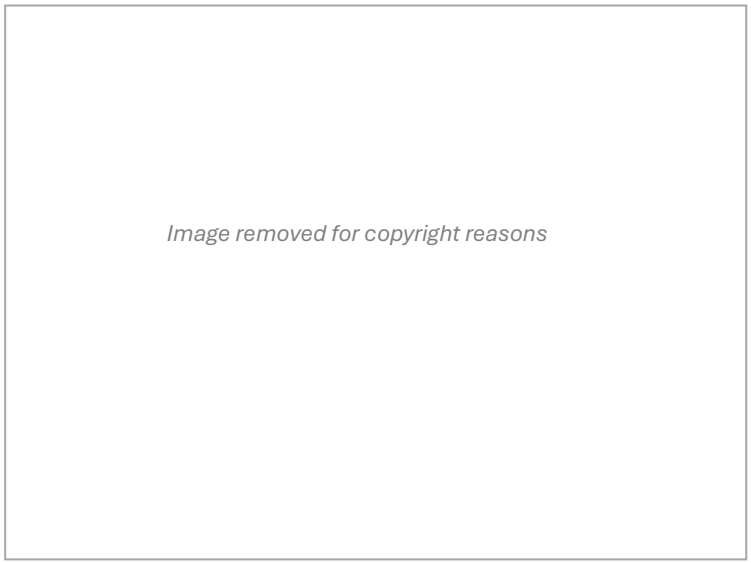

Figure 10 The central open kitchen view. (Heatherwick Studio, n.d.)

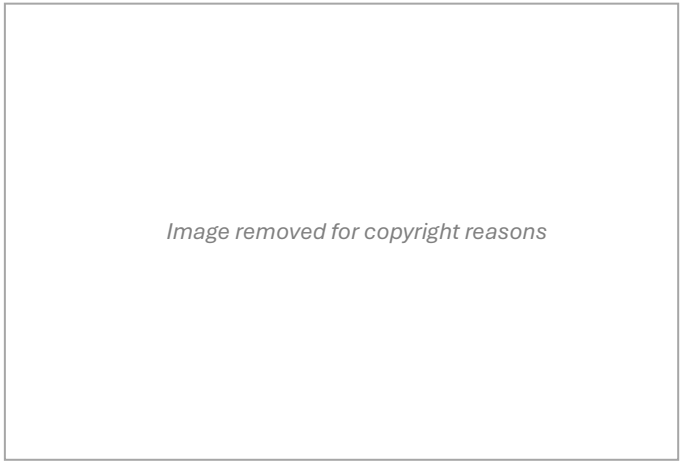

Figure 11 The zoning of spaces showing the spatial hierarchy from social to private nooks. (Heatherwick Studio, n.d.)

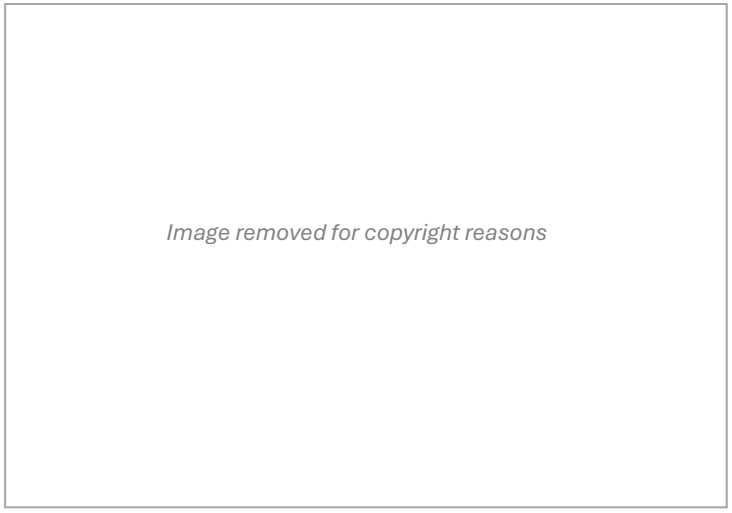

Figure 12 Floor plan showing the spatial hierarchy (Heatherwick Studio, n.d.)

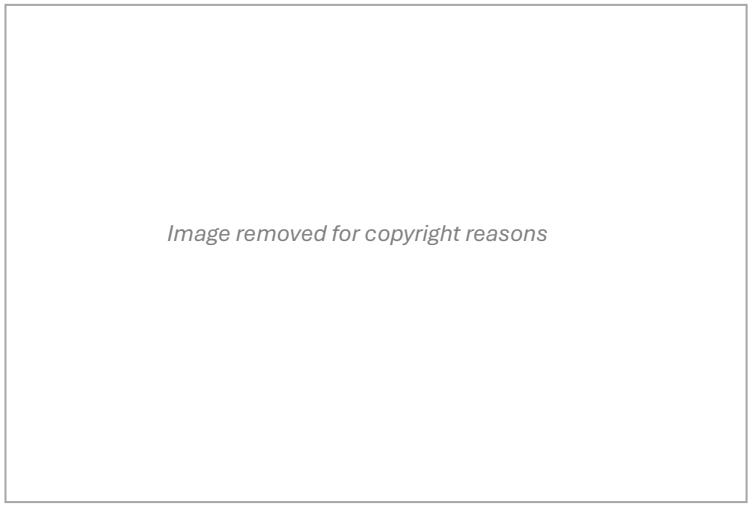

Figure 13 View of the private nooks. (Heatherwick Studio, n.d.)

Hierarchy and Choice

The plan establishes a clear gradient: vibrant public core (kitchen) surrounded by private pavilions (counselling, library). Users can choose to engage at the social heart, linger in transitional nooks, or retreat entirely, a spectrum of privacy that grants autonomy to regulate social exposure according to fluctuating capacity (Tickle & Fisk, 2023).

Limitation and Adaptation: Unlike Maggie's, which is a drop-in centre, Carrington must also provide 24/7 residential sanctuary. Therefore, the principle of a central social condenser must be calibrated to also ensure residents have secure, private pathways like direct garden access that allow them to bypass social spaces when needed, preserving absolute personal agency.

3.2 KHOO TECK PUAT HOSPITAL (KTPH), SINGAPORE

Principle Demonstrated: Biophilic Integration as Preventative Regulation

KTPH transcends biophilic "elements" by making nature the fundamental organising logic of its architecture. The "Y"-shaped plan maximises facade exposure to light, air, and greenery for every space, ensuring contact with nature is inescapable and integral, not an optional amenity. For the missing middle, who cannot rely on scheduled "therapy in the garden," the building itself becomes the delivery mechanism for continuous environmental therapy.

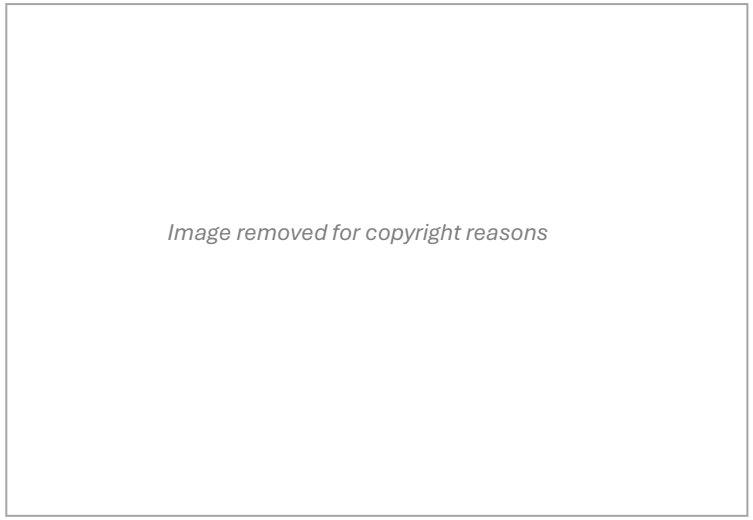

Figure 14 Exterior view of the building showing the garden themed hospital
Lee, J. (2015)

The hospital's genius lies in its multi-sensory engagement, which directly applies Pallasmaa's (2012) theory of haptic, embodied perception:

Figure 15 Site plan showing the "V"-shaped plan
(Green in Future Pte Ltd., 2018).

Programmatic Nature: Gardens are not passive; they are therapeutic medicinal plots and productive vegetable gardens. This provides purpose, engagement, and a tangible connection to growth and cycles activities that can foster hope and agency, key recovery principles often eroded in the missing middle.

Sensory Masking and Enrichment: The sound of water features masks clinical noise, the scent of fragrant plants stimulates olfaction, and the attraction of wildlife provides dynamic visual interest. This creates a rich, absorbing sensory environment that facilitates the "soft fascination" described in Attention Restoration Theory (Kaplan & Kaplan, 1989), offering a cognitive refuge from internal or external stressors.

Eroding the Institutional Threshold: Open-air lobbies and corridors that terminate in gardens dissolve the hard boundary between inside and outside. This reduces the psychological weight of entering a “treatment” setting, making the environment feel more permeable, normalised, and less clinical, a crucial design move for reducing stigma and encouraging engagement for a population hesitant to seek formal “clinical” help.

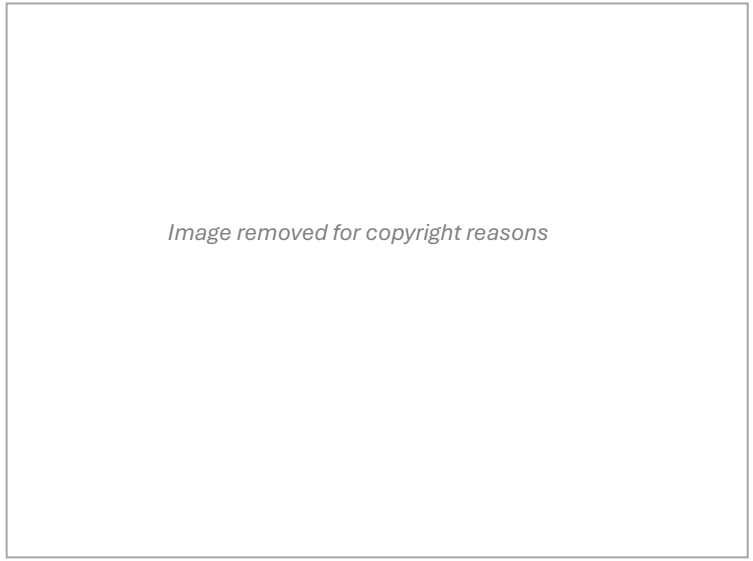

Figure 16 View of a central garden courtyard with a water features.
Lee, J. (2015)

For Carrington, KTPH’s model validates transforming the site into a therapeutic landscape where courtyards become productive gardens and wings are punctured for indoor-outdoor flow. However, as a home rather than a hospital, the biophilic strategy must be calibrated for domestic scale and personal agency: sensory richness should support calm, not overwhelm, and private outdoor spaces must allow residents to regulate their own “dose” of nature and engagement.

3.3 SÖDRA ÄLVSBORGS SJUKHUS (SAS) – PSYCHIATRIC CLINIC, SWEDEN (BY WHITE ARKITEKTER)

Principle Demonstrated: Visual and Circadian Connectivity

The Södra Älvsborgs Sjukhus (SAS) clinic is a masterclass in designing architecture as a non-pharmacological regulator, demonstrating how deliberate manipulation of light and view can be engineered to actively stabilise biology and psychology, a critical need for the missing middle, whose stability is often undermined by poor environmental cues.

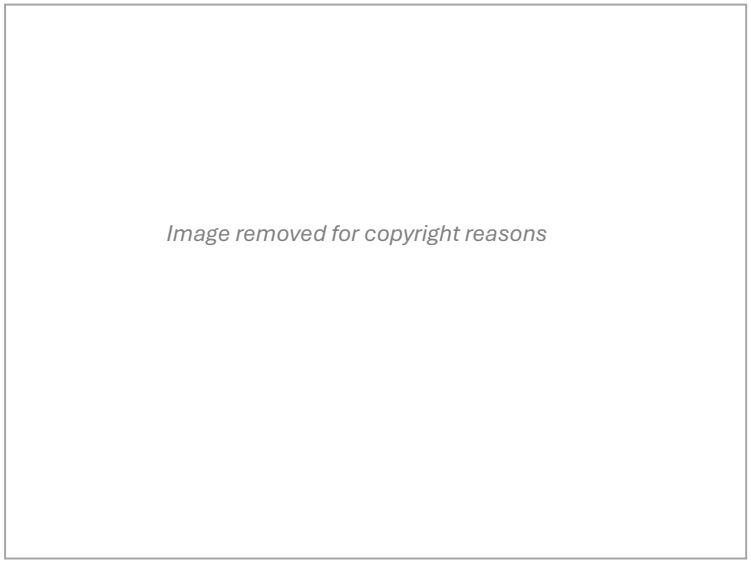

Figure 17 Exterior View showing the openings and the axial views from exterior to interior.
(White Arkitekter. n.d.)

Figure 18 Patient rooms with visual connection to the exterior and ample daylight (White Arkitekter. n.d.)

SAS moves beyond merely providing windows; it architecturally enforces therapeutic exposure. The courtyard masterplan is a strategic device ensuring every patient room receives a dual orientation, guaranteeing exposure to the dynamic path of the sun throughout the day. This is a direct, built application of circadian science (Brainard & Hanifin, 2005), designed to systematically recalibrate sleep-wake cycles. For the missing middle, whose fragile routines are easily disrupted, this model proves that the building itself can provide the daily chronobiological structure often missing from their lives, acting as a preventive measure against the sleep disturbances that exacerbate mental health symptoms.

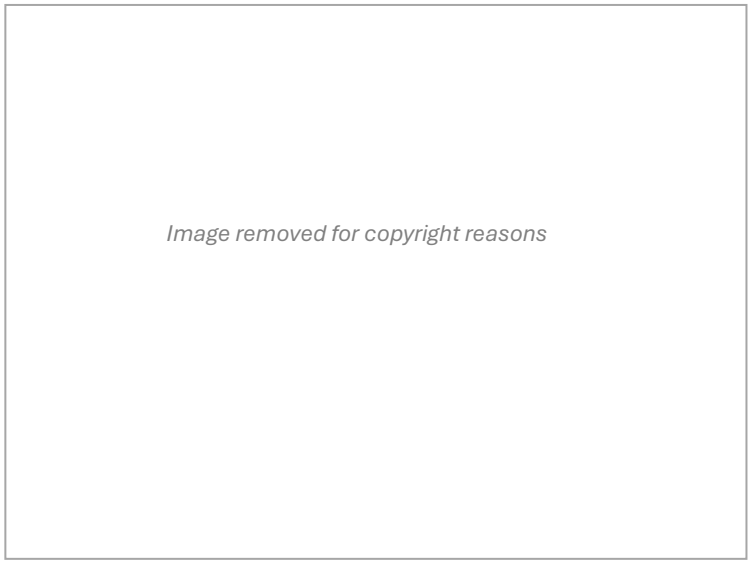

Figure 19 Interior views showing the material colour palette inspired by nature's milder hues. (White Arkitekter. n.d.)

Prospect, Refuge, and a Spectrum of Light
The clinic's organisation of space directly operationalises psychological theory:

Axial Views for Psychological Escape: Internal circulation is organised around long, terminating vistas that consistently frame views of sheltered courtyards or natural landscapes. This directly satisfies Appleton's (1975) Prospect-Refuge Theory, offering occupants a sense of safety (*refuge*) coupled with the ability to visually survey a calming, non-threatening environment (*prospect*). This combats feelings of entrapment and provides a continuous "visual vent," reducing anxiety by offering a mental escape from internal distress.

A Luminosity Spectrum for Personal Agency: The architecture intentionally creates a "spectrum of light", from brightly daylit social hubs to softly illuminated retreats. This allows users to self-regulate by choosing an environment that matches their immediate psychological state whether they need the energising stimulus of a bright common room or the calming refuge of a dimmer space. This grants a sense of control and aligns with Pallasmaa's (2012) understanding of light's profound emotional potency.

SAS demonstrates that circadian regulation and psychological prospect are interdependent therapeutic outcomes of architectural design. Its courtyard plan and axial vistas prove that strategic orientation and framing of views can actively engineer stability, providing a replicable model for using form to deliver non-pharmacological care.

For Carrington, SAS shows that light and view must be architecturally enforced through dual-oriented rooms and terminating garden vistas to provide the daily stabilising cues the missing middle lack. However, as a residential model, Carrington must domesticate these strategies: the "luminosity spectrum" should feel homely, and views should connect to community life, not clinical treatment, reinforcing normalcy and belonging.

3.4 THE PRINCE & PRINCESS OF WALES HOSPICE (GLASGOW, UK)

Principles Demonstrated: Spatial Sequencing, Biophilic Integration, Visual Connectivity

The hospice masterfully replaces institutional corridors with a central, daylit “street,” transforming circulation into a socially engaging heart space that terminates in garden views. This move deinstitutionalises movement and creates a legible, hierarchical plan that radiates from public to private, directly enabling user agency and choice.

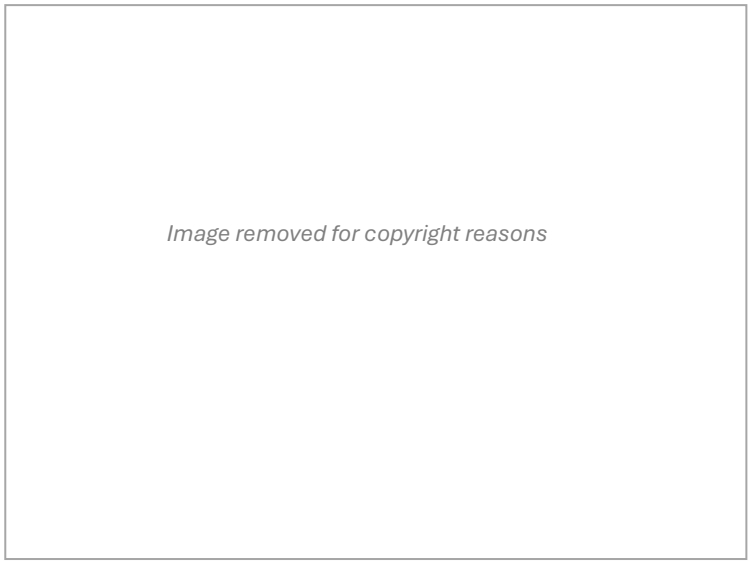

Figure 20 The garden-facing facade of the PPWH, showing direct patient access to the landscape (Glasgow Architecture, 2018)

The core architectural move is replacing institutional corridors with a central, double-height "street." This space functions as a social and orienting heart, flooding the interior with daylight and providing terminating views to gardens. It transforms circulation from a clinical necessity into a positive, socially engaging experience, actively dismantling an institutional feel.

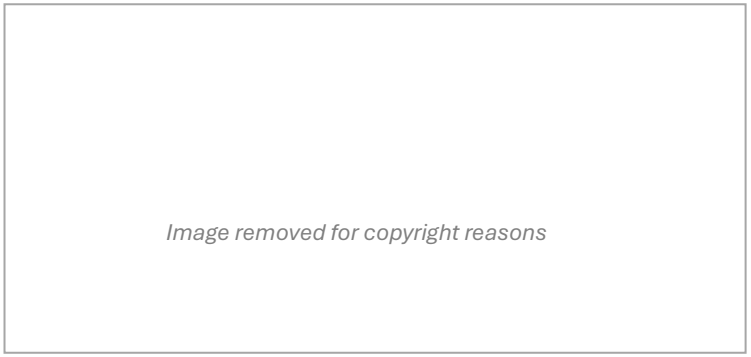

Figure 21 Ground floor plan showing the interpretation of the Sengetun plan (Garden Bed) (Glasgow Architecture, 2018)

The plan is a clear hierarchy radiating from the public "street" to the private patient room. This graduated zoning provides users with clear and intuitive choices regarding their social engagement, directly restoring a sense of personal agency. A patient or family member can be in the midst of the social heart space, retreat to a quiet nook off it, or withdraw completely into their room with a private garden. This spatial legibility and choice are a direct architectural translation of the empowerment central to the Recovery Model.

Biophilic Integration: The connection to nature is the foundational sensory fabric of the hospice.

Macro: The building wraps around landscaped gardens, making nature the central focus.

Micro: Every patient room has direct access to a garden, providing a personal, tactile connection to the outdoors.

Material: The pervasive use of warm timber and stone provides a continuous, haptic connection to the natural world, engaging what Pallasmaa (1996) terms the "eyes of the skin." This multi-sensory saturation ensures a constant, low-level engagement with restorative natural elements, fulfilling the patterns of biophilic design (Browning et al., 2014) and providing the stress-reducing benefits documented by Ulrich (1984).

The hospice, like Maggie's Leeds, serves a non-residential palliative population with finite stays and family presence. Carrington, as a long-term residential mental health sanctuary, requires stronger differentiation between public and private realms. While the central "street" model is valuable for community activation, residents need clearly delineated, secure pathways such as separate residential entrances and private garden access that allow them to bypass the public heart entirely when their capacity for social engagement is low, preserving absolute agency and control over their environment.

Figure 22 Domestic Scale & Welcome space, evident in the non-institutional entrance and materiality. (Glasgow Architecture, 2018; Ryder Architecture, n.d.).

Figure 23 Spatial Sequencing & Visual Connectivity, showcased by the central, daylit 'heartspace' that provides orientation and long views (Glasgow Architecture, 2018; Ryder Architecture, n.d.).

Figure 24 Biophilic Integration, manifested through direct garden access from every patient room and the pervasive use of natural materials. (Glasgow Architecture, 2018; Ryder Architecture, n.d.).

3.5 SCHELDEHOF RESIDENTIAL CARE CENTRE (NETHERLANDS - BY ATELIER PRO ARCHITECTS)

The Scheldehof Residential Care Centre stands as a seminal precedent for the adaptive reuse of large-scale institutional heritage buildings for sensitive healthcare purposes. Its transformation of a monumental, vacant orphanage into a nursing home for the elderly and psychiatric patients provides a directly applicable methodological blueprint, demonstrating how to reconcile the preservation of historic fabric with the imperative to create a human-scaled, therapeutic environment.

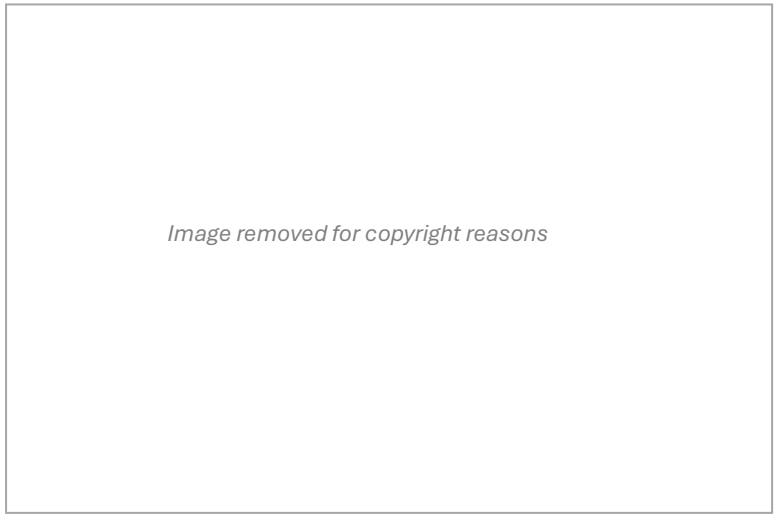

Figure 25 Exterior showing the preserved Historic Shell, where the original brick facade maintains the building's civic presence. (ArchDaily, 2019).

The core architectural concept is the strategic insertion of a new, lighter structure within the U-shaped orphanage's existing courtyard. This "building-within-a-building" is not merely a functional addition; it is a critical device for dismantling institutional scale. By placing a new social heart containing communal living rooms and a restaurant inside the historical shell, the architects fundamentally re-centered the user's experience around an intimate, domestic core. This intervention transforms the vast, potentially alienating courtyard into a series of sheltered, manageable gardens, effectively creating a "village" within the monolithic form. This approach demonstrates that the most effective way to humanize a vast heritage structure is not only by working on its periphery but by surgically implanting a new social condenser at its very center.

Spatial and Material Strategy:

The plan is reorganized to establish a clear hierarchy. The original long corridors are repurposed as orienting "main streets," from which smaller, distinct "households" branch off. Each household functions as an autonomous unit with its own kitchen and living room, creating a crucial gradient from public circulation to semi-public socializing and private retreat. This spatial sequencing is vital for users with cognitive impairments, reducing disorientation and providing a sense of belonging and control, directly supporting the principles of agency central to recovery.

The architects masterfully employ a dialectical material strategy. The original shell with its exposed brick, timber structures, and large windows is preserved and celebrated, maintaining the building's historical narrative and sense of permanence. In stark contrast, the new interventions and interior fitouts introduce a warm, domestic palette of wood, soft colours, and residential furniture. This deliberate contrast makes the new function legible and ensures the living environments feel intentionally homely and contemporary, not institutional. This strategy physically manifests the building's transformation, creating a tangible narrative of change from a place of collective custody to one of individual care.

Scheldehof provides a direct methodological blueprint for Carrington. Like the orphanage, Carrington's monumental shell can contain new inserted volumes that create intimate scale. The strategy of repurposing long corridors as "main streets" with branching autonomous "households" directly translates to Carrington's wings. The dialectical material approach preserving historic fabric while inserting light, warm, contemporary elements ensure the narrative inversion is visually legible, transforming a former asylum into a place of domestic care without denying its complex past.

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Figure 26 Preserved Historic Shell, where the original brick facade maintains the building's civic presence. (ArchDaily, 2019).

Figure 27 The Inward-Looking "Heart", created by inserting a new, glazed communal volume into the courtyard to bring light and social focus (ArchDaily, 2019).

Figure 28 Domestic Interiors, showcasing warm, wooden finishes and residential furniture that contrast with the historic structure to create a homely feel. (ArchDaily, 2019).

4

SITE CONTEXT AND ANALYSIS

4. INTRODUCTION

This chapter establishes the Former Carrington Hospital and its place within the Wairaka Precinct as a site of unparalleled opportunity for transformative architectural intervention. The analysis unfolds through two interconnected scales. The first investigates the wider context, focusing on the strategic government and council-level planning that frames the Wairaka Precinct's development. This includes an analysis of Auckland's growth narrative, the specific policies of the Auckland Unitary Plan, and the future vision for the area as outlined in the Reference Masterplan. The second lens focuses on the architectural subject: the Former Carrington Hospital building. This analysis delves into its layered history, heritage significance, architectural evolution, and current state of neglect, establishing it as the critical site for intervention. Together, these two scales of inquiry will identify the opportunities and conflicts that the subsequent design proposal must resolve.

4.1 THE WIDER AUCKLAND CONTEXT

The Wairaka Precinct is a direct manifestation of Auckland's response to growth pressures and the strategic mandate of the Auckland Plan 2050 for a "quality compact city" (Auckland Council, 2018). This 64.5-hectare brownfield site represents a critical test case for sustainable intensification, transforming underutilised land into a high-density, mixed-use urban village.

The landforms part of the Ngā Mana Whenua o Tāmaki Makaurau collective Treaty settlement, establishing a statutory and ethical foundation requiring development that actively recognises Mana Whenua (Grimshaw, 2019, p. 4). For my proposal, this cultural context demands that the adaptive reuse of Carrington Hospital, a colonial institutional layer within this whenua must engage respectfully with this deeper history, not merely preserve European heritage in isolation.

While the masterplan provides the urban framework for intensification, my intervention must extend beyond housing delivery to address the specific social infrastructure gap the missing middle represents. The precinct's mandate to prototype resilient city growth creates the perfect policy context for testing a therapeutic housing model that integrates care, community, and heritage directly responding to both the cultural and demographic complexities this site embodies.

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Figure 29 View of Building One from Northwestern Motorway. Grimshaw Architects (2019).

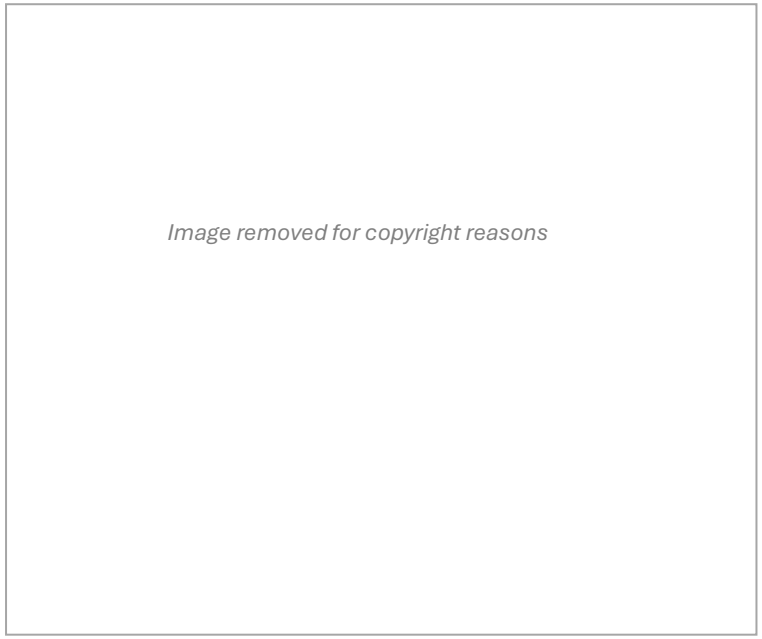


Figure 30 Construction of motorway 1961 (Photograph by Whites Aviation)

4.2 THE LOCAL CONTEXT: POINT CHEVALIER - PAST, PRESENT, AND FUTURE

A Brief History

Point Chevalier's history is deeply layered. In pre-colonial Tāmaki Makaurau, the area was a significant Māori node, with the Whau inlet forming a vital portage route between the Waitematā and Manukau Harbours (Auckland Council Heritage Unit, 2014). This strategic location was later recognised by the colonial government, which purchased land from Ngāti Whātua and constructed a blockhouse in 1860 (Point Chevalier Community, 2021). The suburb evolved from rural farmland into a seaside resort, cementing its character as a distinct "village" community prized for coastal proximity and strong local identity.

This layered history, Māori portage, colonial military outpost, seaside village establishes Point Chevalier as a place of continual transformation. For Carrington's reuse, this context normalises change while demanding sensitivity. The site's evolution from asylum to academic institution to vacant heritage asset is another layer in this ongoing narrative.

Crucially, the suburb's cherished village character and community identity provide the ideal social fabric for integrating missing middle residents. Unlike isolated greenfield developments, Point Chevalier offers existing amenities, public transport, and community networks, the very "scaffolding" for recovery that isolated institutional sites lack (Tickle & Fisk, 2023). My design must therefore stitch Carrington into this existing community fabric, not retreat from it, using the precinct's new connections to make the site a permeable part of the village.

Figure 31 Ariel view of Point Chevalier, Auckland. Adapted from Google earth

Present Character & Challenges

Point Chevalier's cherished village character, defined by its established housing and community-focused amenities, now faces the direct pressure of Auckland's intensification agenda. The suburb embodies the central tension of the "quality compact city": the conflict between preserving valued local character and accommodating necessary growth (Auckland Council, 2018). This tension is acutely felt at its boundary with the Wairaka Precinct, where the suburb's low-scale identity confronts the imminent transformation into a high-density urban village.

Future Vision

The Wairaka Precinct is the physical enactment of regional policy on Point Chevalier's doorstep. While its proposed pedestrian and cycle linkages promise better connectivity (Auckland Council, 2016), the primary challenge is one of scale and character integration. The success of the precinct hinges not just on its internal logic, but on its ability to perform a sensitive urban surgery stitching a new, dense community into the existing fabric without eroding the social and architectural qualities that define the host community. The project thus becomes a critical test case for whether Auckland's growth model can achieve genuine integration or will result in contested edges and community dissonance.

Figure 32 Ariel view of masterplan showing proposed mix of Housing, educational and commercial redevelopment. Base Map from Grimshaw Architects (2019).

4.3 THE WAIRAKA PRECINCT MASTERPLAN

4.3.1 OVERARCHING VISION AND KEY STRUCTURING MOVES

The Masterplan advances three core ambitions, each with specific implications for this thesis:

Selective Heritage Integration: The plan targets Carrington Hospital as a "community and commercial" anchor, yet this vague programme reveals no architectural strategy for adaptive reuse merely preserving fabric without defining how it serves community (Grimshaw, 2019, p. 42). This thesis addresses this gap by proposing a purpose-built mental health hub that gives "community" genuine meaning through transitional housing and integrated wellness facilities.

cological Infrastructure: Te Auaunga (Oakley Creek) is repurposed as a green spine integrating stormwater and recreation, framing ecology as essential infrastructure (Grimshaw, 2019, p. 43). The proposal extends this ecological logic into Carrington's grounds, creating therapeutic gardens that connect to the broader green network and make nature inescapable for residents.

Pedestrian Priority: The plan champions reduced car access and active transport, supporting a calm, permeable site edge (Grimshaw, 2019, p. 44). However, the proposal must also resolve the missing vehicular access for service, emergency, and resident arrivals, a logistical gap the masterplan overlooks while maintaining the pedestrian-focused character.

Heritage and character *A distinct open space network*

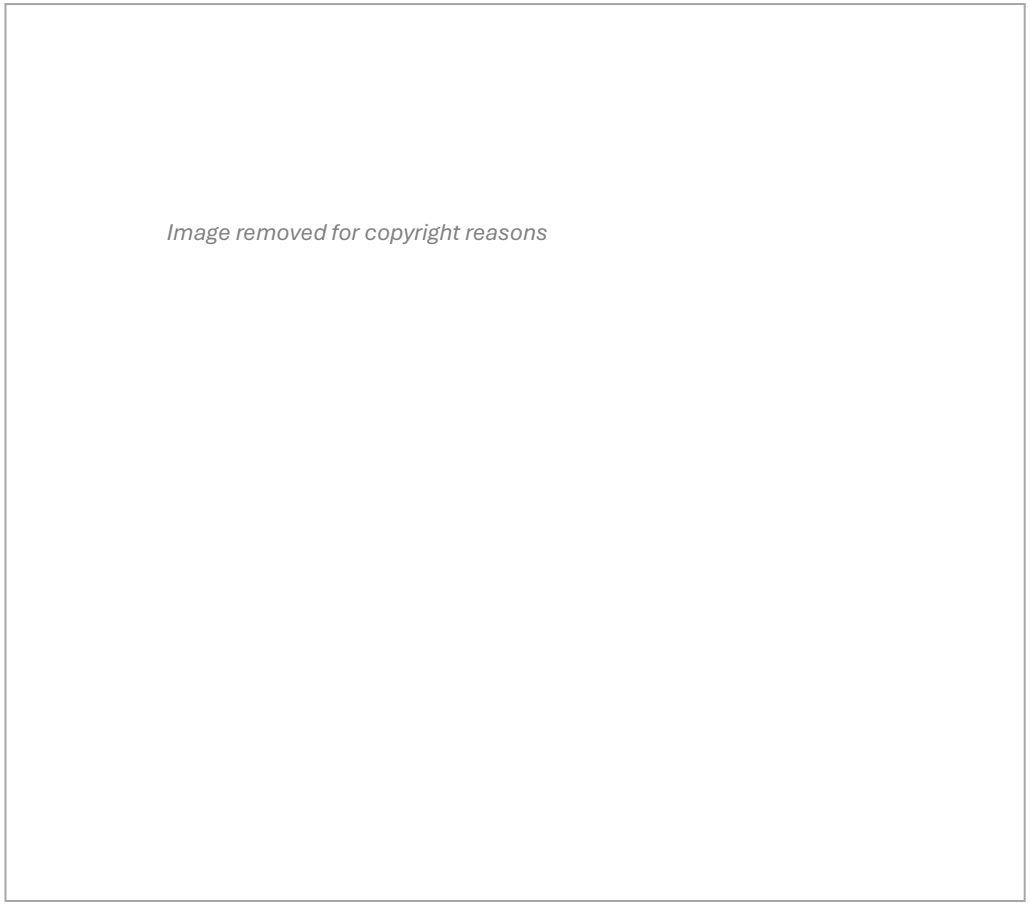


Figure 33 KEY MOVES OF THE MASTERPLAN.

Grimshaw Architects. (2019).

4.3.2 DENSIFICATION

The Masterplan organises the development area into seven precincts with varying densities, from 8-storey high-density cores to 2-3 storey terraces that interface with Point Chevalier (Grimshaw, 2019, p. 58).

Precinct 2 – Oakley Hospital

This precinct is defined by the heritage building, retained within a large, landscaped lot. Crucially, the Masterplan earmarks it for vague "community and commercial" activities without any residential intensification on its immediate site (Grimshaw, 2019, pp. 58, 85).

This omission is the central opportunity for this thesis. While surrounding precincts deliver housing density, Precinct 2 remains underutilised, a heritage object in a green field rather than an active participant in the new community. The proposal addresses this gap by introducing transitional housing within the building itself, activating the site residentially while preserving its heritage significance. This approach densifies the precinct responsibly, integrating care infrastructure directly into the urban fabric rather than relegating it to peripheral locations.

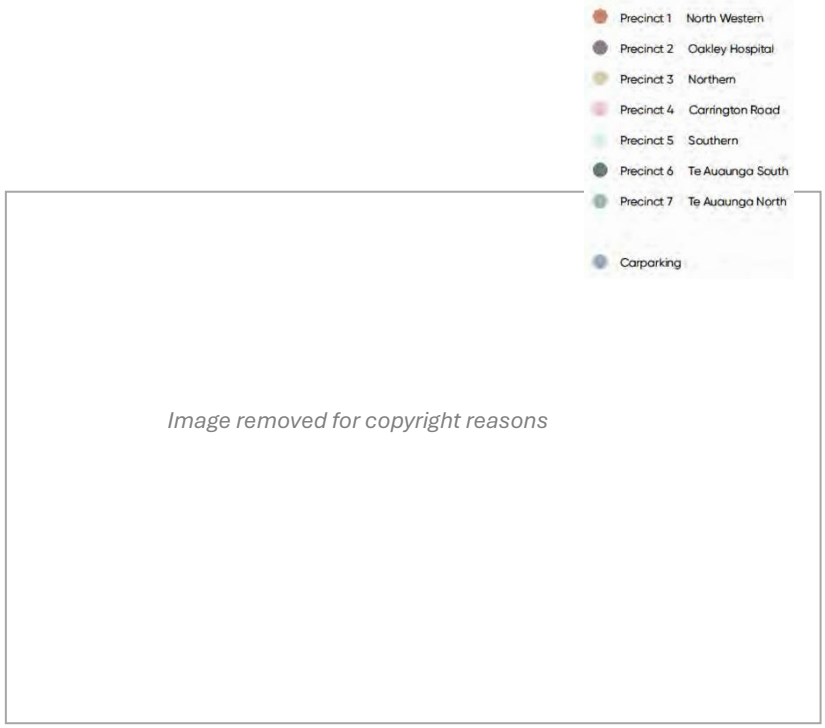


Figure 34. 7 Precincts

Adapted from Grimshaw Architects. (2019).

4.3.3 CONNECTIVITY AND MOVEMENT

The Masterplan's primary strategy for overcoming the site's institutional legacy is a multi-layered connectivity framework designed to shift it from private campus to public urban quarter.

Strategic Vehicular Integration: A connected internal street network with controlled southern connections integrates vehicular access without overwhelming existing residential streets (Auckland Council, 2016, Policy I334.3(9)). However, as noted earlier, this framework lacks designated access for the Carrington building itself—a gap this thesis addresses by proposing a dignified arrival sequence that serves both residents and public visitors while maintaining the pedestrian-priority character.

Prioritisation of Active Transport: A dedicated network of pedestrian and cycle ways, linked to regional paths and a proposed bus node, structures the precinct around sustainable mobility (Grimshaw, 2019, p. 76). This supports the proposal's goal of community integration, allowing residents to access Point Chevalier's amenities and the wider precinct independently, reducing isolation.

Open Space as Linear Connector: The green corridors of Te Auaunga and Wairaka Stream function as continuous ecological and recreational ligaments, transforming open space from destination into a primary system for movement and cohesion (Grimshaw, 2019, p. 66). This thesis extends this logic into Carrington's grounds, positioning the site's therapeutic gardens as an integrated node within this green network, making nature inescapable for residents while inviting the wider community into the site's edges.

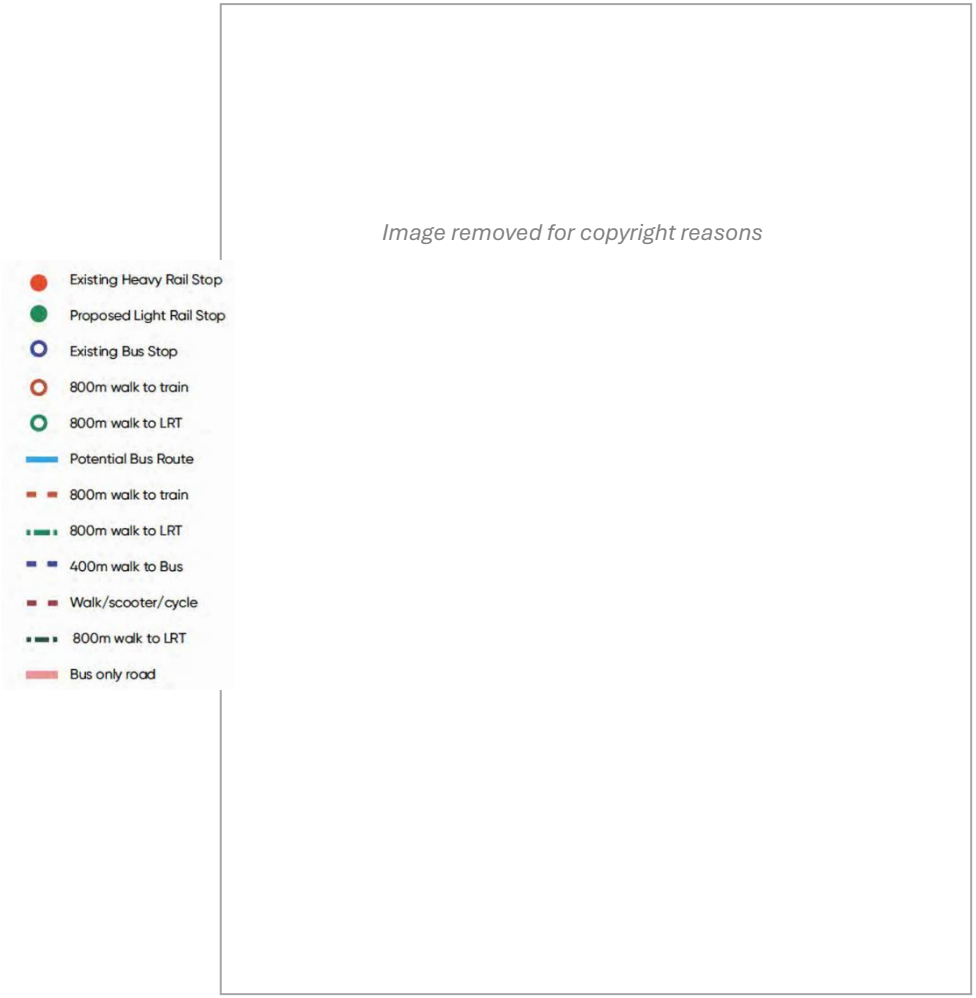


Figure 35 Connectivity map. Adapted from Grimshaw Architects (2019).

4.3.4 PRECINCT 2 – Oakley Hospital

The masterplan's interventions create a supportive urban framework, with the new internal road and junction integrating the building into the precinct as a potential landmark (Grimshaw, 2019). However, the plan only provides pedestrian-level connectivity and a crossing, failing to designate dedicated vehicular access for the building itself.

This omission is significant for a mixed-use community anchor requiring service access, managed resident arrivals, and emergency vehicle provision for both transitional housing and public facilities. The proposal addresses this logistical gap by introducing a carefully calibrated arrival sequence separating service, resident, and public access while maintaining the pedestrian-priority character. This ensures functional viability and a dignified, safe entry experience that does not compromise the therapeutic quality of the environment.

Figure 36 Map showing the proposed new internal road. Adapted from Grimshaw Architects (2019).

4.3.5 Site Clearance and Demarcation

The proposed demolition is more than heritage management; it is strategic curation of the therapeutic edge. By removing low-significance additions, the masterplan clears the visual and physical “noise” of institutional decline, creating a legible perimeter for intervention.

This clearance exposes the building's primary historic mass and, crucially, opens the site's northern and eastern flanks. This creates the critical spatial opportunity to wrap the building with new, light-filled therapeutic volumes and landscaped gardens, establishing the direct indoor-outdoor connection and sensory relief the existing fabric currently denies. The cleared site becomes the canvas for applying biophilic integration transforming once-isolated grounds into restorative landscapes that serve both residents and the wider community.

Figure 37 Map showing the proposed demolition blocks. Adapted from Grimshaw Architects (2019).

4.3.6 The Northern Landscape and Open Space

The proposed northern open space functions as a therapeutic and social mediator, drawing the wider community to the building's perimeter and enabling stigma-reducing interaction between public and residents (Grimshaw, 2019).

This landscape provides a platform for a gradated social spectrum from private therapeutic gardens to active public zones. The proposal calibrates this edge condition by transitioning from semi-private resident gardens to communal gathering spaces and public parkland. This spatial sequencing supports recovery through controlled retreat and managed community engagement, allowing residents to determine their level of social exposure while normalising mental health housing within the wider neighbourhood.

Figure 38 Map showing the proposed Northern landscape. Created by Author.

4.3.7 THE PROGRAMMATIC GAP

While the masterplan provides connectivity and landscape, its vision for Carrington is critically underdeveloped and generic, illustrated in the Grimshaw framework only by generic exterior precedents of café umbrellas and public seating (Grimshaw, 2019, p. 42). This fails to engage the building's complex history or profound interior potential.

This vagueness is the central opportunity. The convergence of new infrastructure, therapeutic landscapes, and the need to heal the building's stigmatised legacy creates the perfect mandate for a transitional housing model for the "missing middle." This programme actively leverages the masterplan's framework to deinstitutionalise the building's character, transforming it from a symbol of exclusion into a vital, integrated social heart that directly addresses a defined crisis, fulfilling the precinct's social potential.

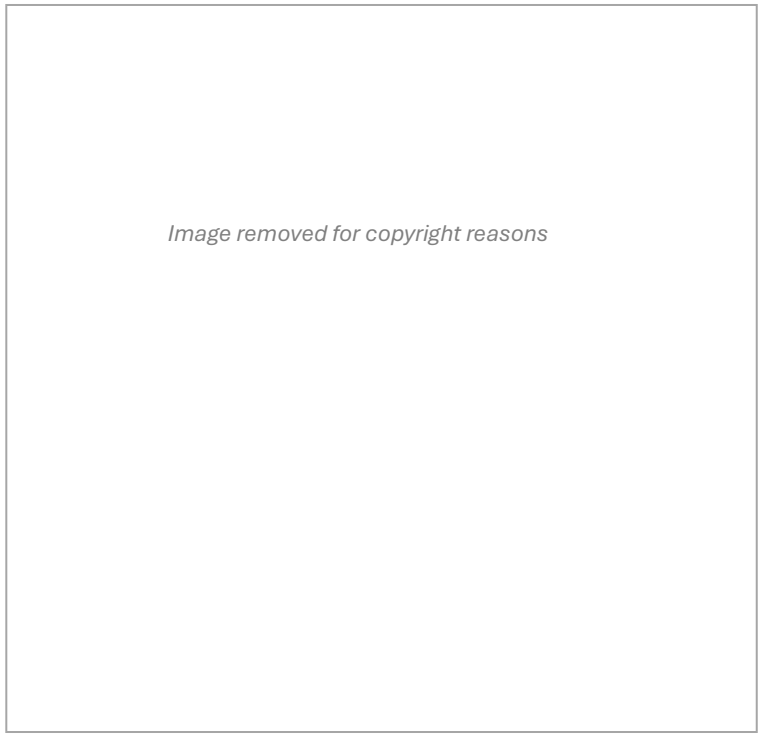


Figure 39 Masterplan precedent imagery for the Carrington Hospital adaptive reuse, focusing solely on exterior public activation. Highlighting proposal's lack of a defined interior programme or engagement with the building's internal spatial potential. Grimshaw Architects. (2019).

4.4 A LAYERED HISTORY

4.4.1 HISTORY: THE AUCKLAND LUNATIC ASYLUM

The building's origins as the 'Whau Lunatic Asylum' (opened 1865) establish its foundational narrative as a place of institutional segregation (Auckland Council Heritage Unit, 2014). The dominant basalt stone structure, designed by Philip Herapath and opened in 1877, projected an image of permanent authority through its Victorian institutional style (Auckland Council Heritage Unit, 2014).

Critically, the asylum operated as a self-contained moral treatment colony, where patient labour on the extensive grounds was considered therapeutic (Auckland Council Heritage Unit, 2014). This established an early, albeit controlled, connection between the site's function and its landscape, a relationship that a contemporary design must reinterpret to support genuine recovery and autonomy.

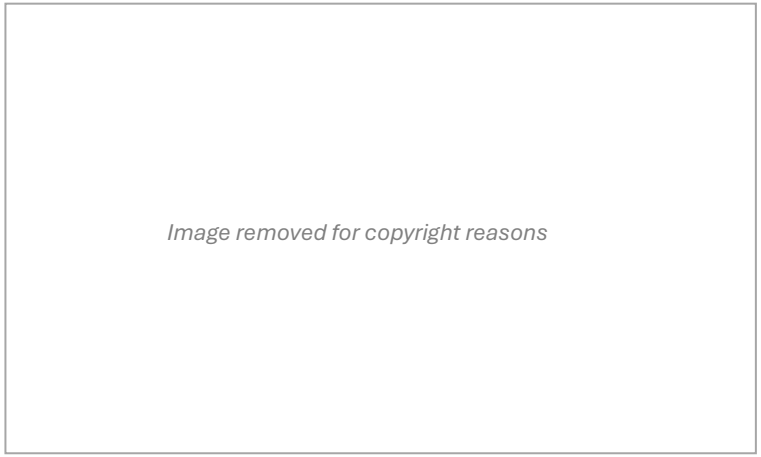


Figure 40 Carrington Hospital building from the north entrance ca.1895 (Auckland institute and Museum)

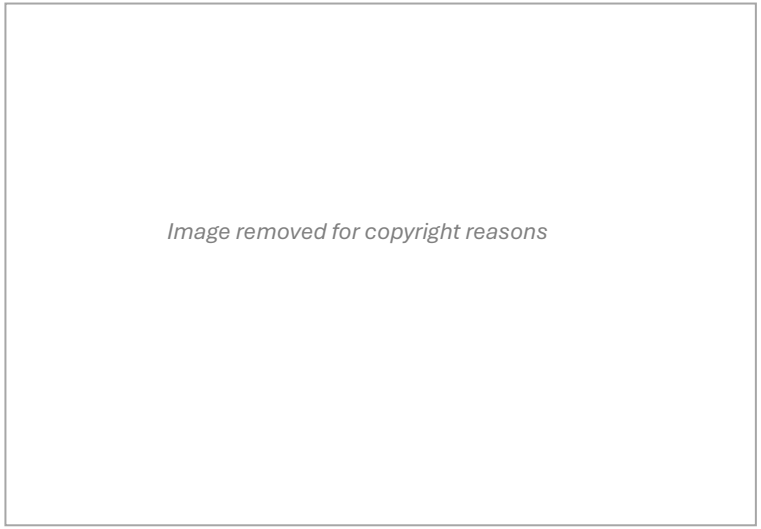


Figure 41 Bowling Green SW of Building One. Archives NZ - File Sheet. Oakley Hospital (Wellington, 1930-1966)

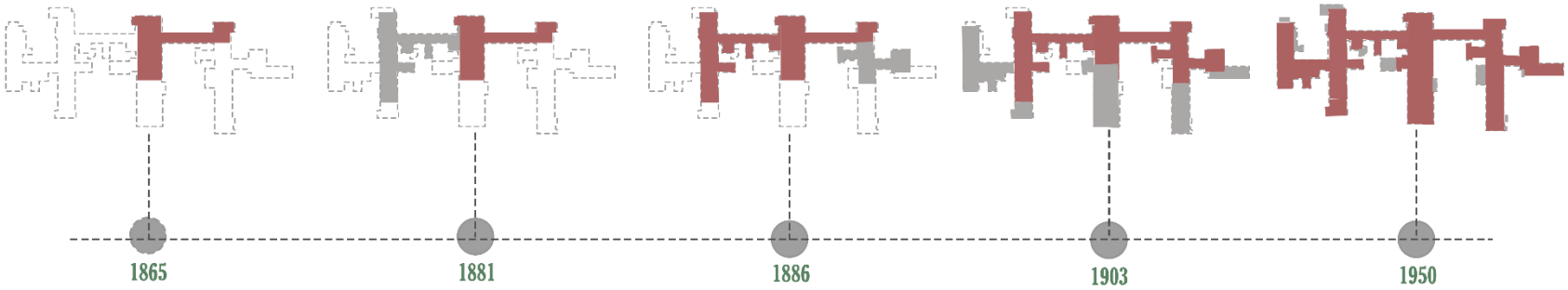


Figure 42 Evolution timeline. Created by Author.

4.4.2 EVOLUTION AND EXPANSION

The building's physical form chronicles evolving attitudes toward mental healthcare. Early expansions (1881-1903) added specialized wards that reinforced institutional segregation in response to chronic overcrowding (Auckland Council Heritage Unit, 2014).

A critical turning point occurred in the 1950s with destructive modernisation, where original fabric was sacrificed for clinical hygiene glass louvres and sprinkler systems compromising heritage integrity. This period marks the transition from a therapeutic landscape to a clinical facility (Auckland Council Heritage Unit, 2014).

Subsequent repurposing as Unitec's 'Building 01' represents preservation through neglect, where minimal adaptation failed to provide viable long-term function. This history of reactive, unsympathetic alteration establishes a clear mandate: intervention must be deliberate and transformative, not another layer of inadequate adaptation.

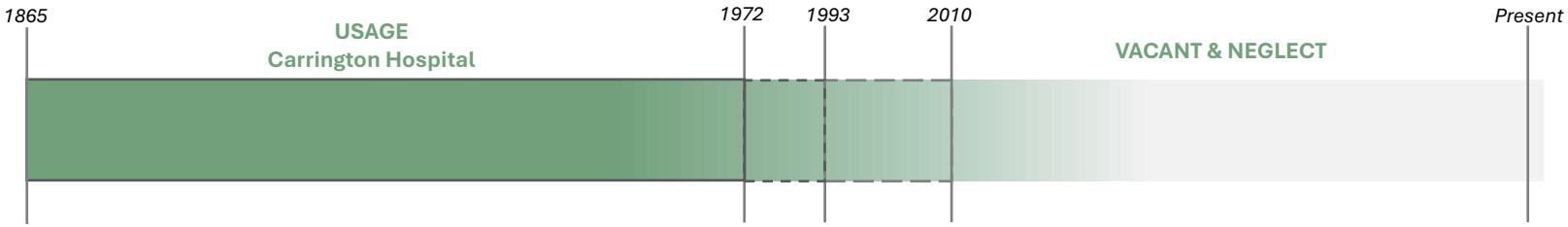


Figure 43 Timeline of use and neglect. Created by Author.

4.4.3 A TIMELINE OF USE, DECLINE, AND NEGLECT

For over 125 years (1865-1993), the building's identity was inextricably linked to mental healthcare, evolving from custodial asylum to Carrington Hospital and embedding a complex social narrative into its fabric (Auckland Council Heritage Unit, 2014).

The 1993 closure marked a pivotal rupture, rendering the complex obsolete as care shifted to community-based models. Acquisition by Unitec in 1994, while saving it from demolition, initiated preservation through neglect. Rebranded as anonymous "Building 01," it served only peripheral functions, its significance slowly eroding through underuse (Auckland Council Heritage Unit, 2014).

Now fully vacated for the Wairaka Precinct development, the building exists as an abandoned monument, its fabric deteriorating without active use. This critical juncture presents the central thesis opportunity: a heritage asset of major social and architectural importance, its potential entirely locked away, awaiting transformative intervention to restore public relevance and secure its future.

4.5 HERITAGE SIGNIFICANCE AND ASSESSMENT

Dave Pearson Architects' Heritage Assessment (2014) provides a critical framework by distinguishing between the building's authentic historic core and later, less significant alterations.

Elements of High Significance

The assessment identifies non-negotiable elements that must be preserved and engaged in legible dialogue:

- 1865-1877 Core Fabric: Primary structural and spatial layout
- Principal Façades and Materials: Local basalt stone and original brickwork elevations
- Key Internal Spaces: Central halls, main staircase, vaulted corridors defining historical spatial experience
- Original Roof Forms: Critical to architectural integrity and silhouette
- Relationship to Landscape: Historical connection to grounds as remnant of self-sufficient asylum farm (DPA, 2014)

This classification establishes a clear conservation ethic: high-significance elements must be preserved, with new intervention entering into legible dialogue rather than imitation or erasure. The building's essential historical narrative remains intact while accommodating contemporary therapeutic function.

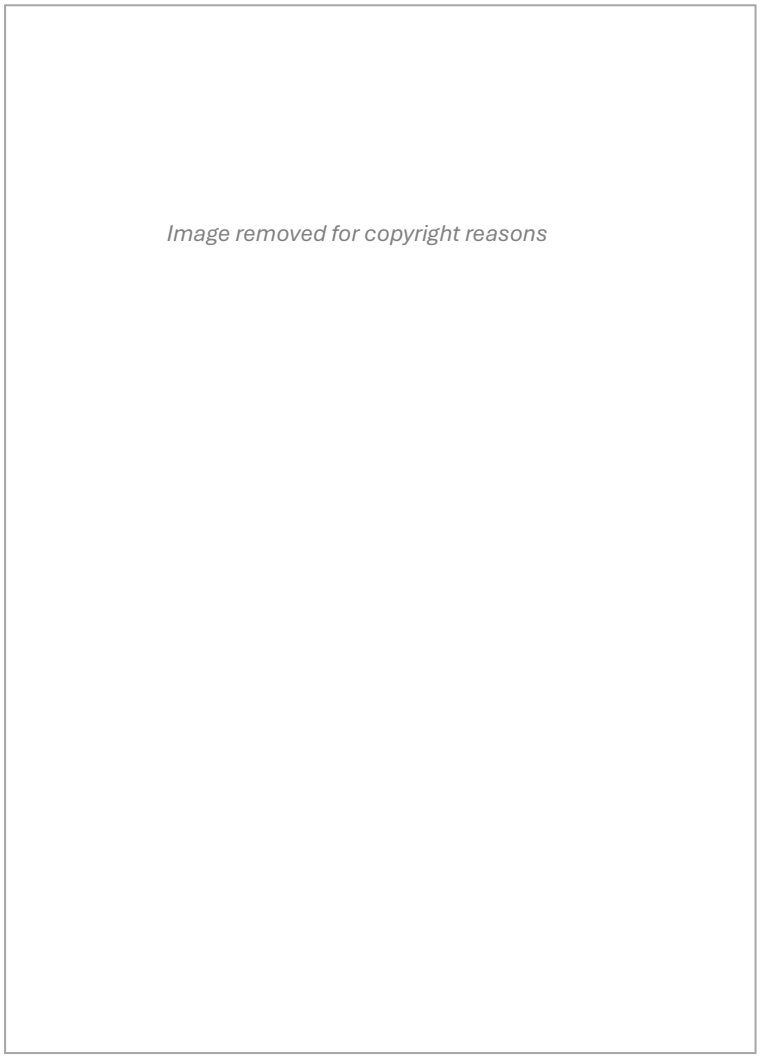


Figure 44 Floor plans depicting heritage significance of various building parts. Adapted from (DPA, 2014)

Elements of Lesser Significance

The heritage assessment identifies 20th-century utilitarian wings as "lesser-significance" elements visible in Fig. 45 as distinct roof forms and colours. These are not merely low-value additions but physical records of institutional decline. Their targeted removal or transformation presents the primary opportunity for intervention, creating both physical and narrative space for new therapeutic architecture.

The site exists within the rohe of Ngāti Whātua Ōrākei (Grimshaw, 2019). The intervention must therefore address both colonial and institutional layers, fostering renewed connection to *whenua* that supports *taha wairua* (spiritual wellbeing) as articulated in Te Whare Tapa Whā (Durie, 1994). The lesser-significance fabric becomes the appropriate site for this respectful, forward-looking dialogue where removal of declining additions allows new work to engage with both heritage fabric and cultural landscape in a manner that heals

Figure 45 Ariel view of building showing the high significant old structures and the later additions in different roof forms and colour. Adapted from Google Earth

Figure 46 Differences in brickwork, material finish, and construction detail illustrate the building's staged development, indicating multiple periods of addition and alteration across its institutional lifespan. Adapted from In Loving Memory of.(2021)

4.6. ARCHITECTURAL ANALYSIS: MATERIAL LEGIBILITY AND NARRATIVE HEALING

The subtle material differences in Carrington's brickwork record its institutional evolution. For a therapeutic reuse, however, maintaining this coherent "institutional" aesthetic risks perpetuating the building's stigmatising narrative of confinement.

As established in Chapter 2, adaptive reuse of complex heritage requires narrative inversion (Logan & Reeves, 2009). A seamless repair that preserves monolithic institutional appearance fails to perform this psychological healing. The new function “care” must be legibly distinct from the old confinement. Residents should not feel they inhabit an old asylum; the environment must visibly signal change through design.

This proposal therefore strategically differentiates new interventions from historic fabric, following the dialectical approach observed in Scheldehof. Primary historic basalt and brick facades are preserved for their cultural significance and civic presence. However, less-significant later additions and interiors become sites for bold, light-filled contemporary interventions using timber cladding and extensive glazing.

This creates a legible dialogue between old (the weight of history) and new (the lightness of care). Contrast functions as a therapeutic and narrative tool, ensuring the building's future identity as a place of healing is visually undeniable directly applying the adaptive reuse theory of re-signification (Wong, 2016).

Material Degradation

The documented decay of failed roofing, moisture ingress, vandalism is more than a condition report (UrbexCentral, 2022). It is the physical manifestation of societal neglect, mirroring the systemic abandonment of the "missing middle" this building could serve.

Intervention is required on two fronts: to preserve significant heritage fabric from irreversible loss, and to perform symbolic repair that transforms decay into deliberate, hopeful contrast between a neglected past and a cared-for future.

The proposal engages this dual imperative by making the act of repair itself part of the building's new narrative of healing where meticulous restoration of significant fabric and bold transformation of degraded additions collectively signal renewal.

Figure 47 Collage illustrating the current state of advanced material degradation and neglect within the Carrington Hospital. Evidence includes widespread moisture ingress, vandalism (graffiti), broken windows, peeling paint, and interior decay. (Source: Haunted Auckland, n.d.; UrbexCentral, 2022)

4.7 CONCLUSION

The analysis reveals a fundamental disconnect between the Wairaka Precinct Masterplan's ambitious urban framework and its impoverished vision for Carrington Hospital. While the masterplan creates a powerful platform for renewal through infrastructure and landscape, it fails to provide a meaningful architectural proposition for the heritage building at its core.

The current "community and commercial" designation represents a critical failure of imagination. This vague prescription treats the building as a static relic, risking continued decline through underuse and ignoring its potential as a social catalyst for the new community. More significantly, it misses the vital opportunity to actively heal the building's stigmatised history through purposeful new identity.

This analysis therefore establishes the central design challenge: to create a transformative intervention that synthesises heritage conservation with social utility. The proposal for a transitional housing model serving the missing middle, integrated with community facilities, directly leverages the masterplan's infrastructural opportunities while fulfilling the need for deinstitutionalisation. This offers a viable and socially transformative future that the current masterplan critically lacks.

5

DESIGN RESPONSE

INTRODUCTION: A SITE OF CONVERGENCE

The Wairaka Precinct Masterplan delivers ambitious urban infrastructure yet leaves the Category 1 heritage-listed Carrington Building programmatically undefined designated only as generic "community and commercial" space (Grimshaw, 2019). While surrounding precincts gain housing, connections, and amenities, the building at the site's heart lacks a clear future.

This context of transformation, however, provides the generative condition for intervention. New roads, open spaces, and surrounding density create the urban framework within which a purposeful reuse can emerge. This proposal responds by positioning Carrington not as a preserved relic, but as the active social centre of the emerging community, one that simultaneously addresses the missing middle crisis, heals the building's institutional legacy, and gives substantive meaning to the masterplan's unfulfilled ambitions for the site.

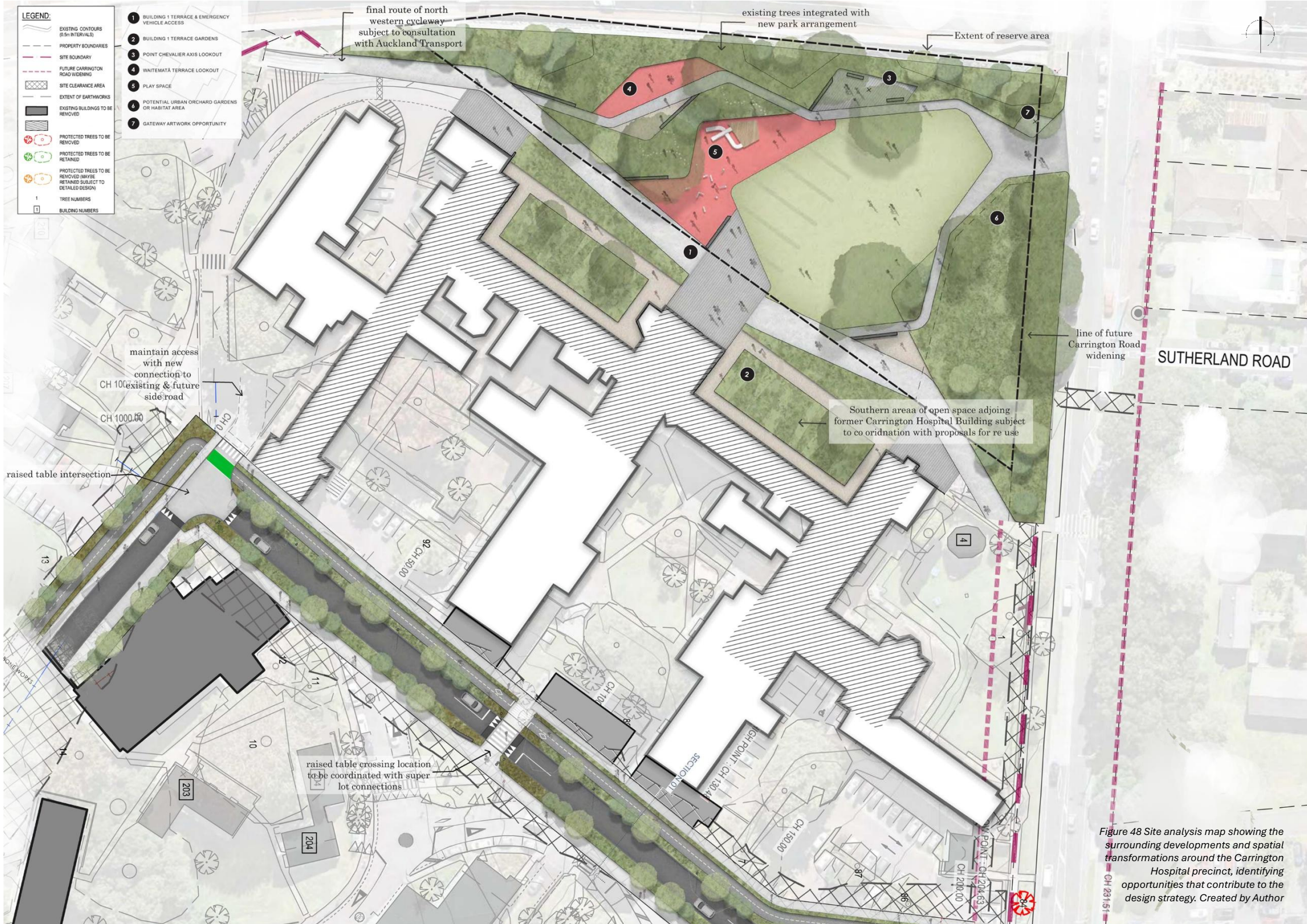
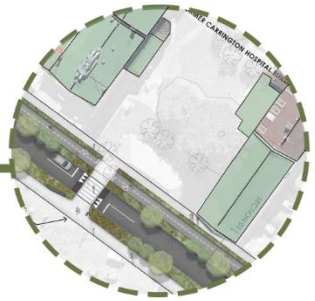
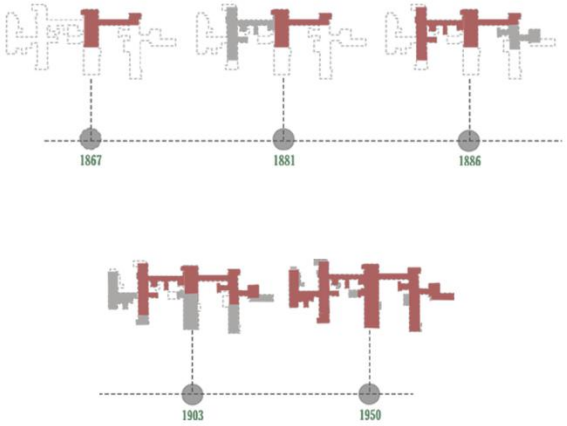
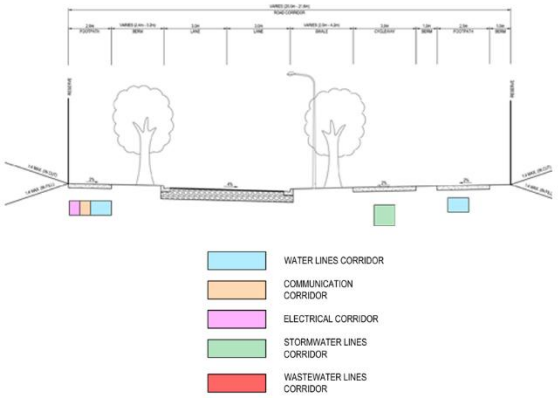


Figure 48 Site analysis map showing the surrounding developments and spatial transformations around the Carrington Hospital precinct, identifying opportunities that contribute to the design strategy. Created by Author



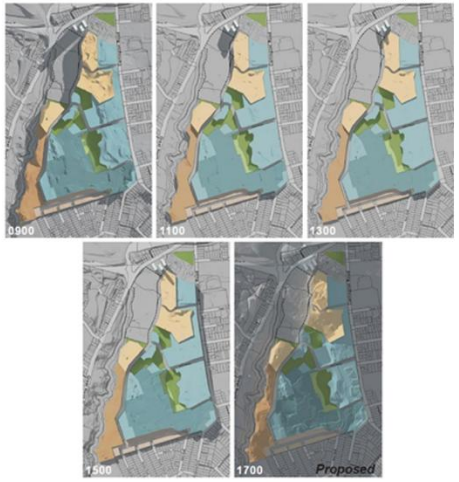


Aerial analysis differentiating pre-1903 primary heritage fabric from post-1903 secondary additions. This delineation identifies the less-sensitive western and southern wings as the optimal site for adaptive reuse, allowing for a design that respects the core historic value while enabling transformative change.

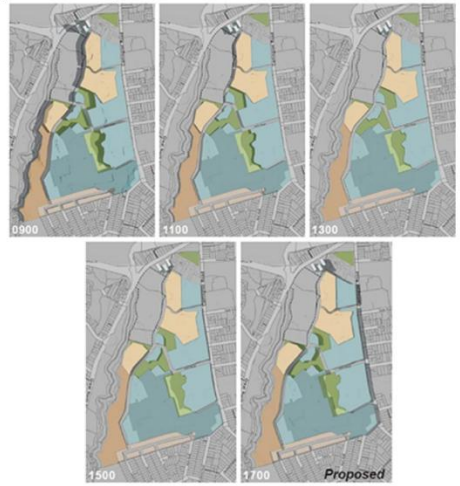


The consented 'Backbone Road' creates a new infrastructural edge and a primary point of arrival. Its proximity to the south side of the hospital presents a critical opportunity to engage with the new community and define a new, active frontage for the adapted building.

Shadow Study prepared by Boffa Miskell, Winter Solstice



The approved plan change introduces three landmark towers (72m, 54m, 43.5m) immediately to the west. This establishes the overwhelming vertical scale of the new urban context that the design must engage with and mediate.



A comparative perspective view and sun study analyzing the relationship between the new towers and the historic hospital. The shadow analysis confirms that the articulated tower forms mitigate overshadowing, particularly on the primary north façade, protecting its heritage values.

Figure 49 Site analysis. Created by Author

Heritage-Led Strategy

The adaptive reuse strategy is guided by the Dave Pearson Architects (2014), which distinguishes the high-value 1865-1877 core from lower-significance 20th-century additions. This hierarchy directs transformative interventions towards the latter, minimising impact on cultural significance.

The pre-1900 core is preserved as a conserved monument. The relationship between new and old is designed to be legible and respectful. From within the new interventions, occupants will be consciously aware of the historic fabric through strategic openings and spatial sequences that frame views of the original stone walls and vaulted corridors. This ensures the building's chronology remains readable, creating a tangible dialogue between the contemporary programme and the enduring heritage structure, rather than a seamless or opaque insertion.

Figure 50 Map highlighting the primary areas of design focus within the Carrington Hospital precinct. Created by Author

A SYNTHESIS OF HEALING, HERITAGE, AND URBAN INTEGRATION

The design proposal for the Carrington Building is the physical synthesis of this thesis's central investigations. It represents a direct architectural response to the intertwined crises of the "missing middle" in mental health care, the social and cultural imperative for heritage adaptation, and the urban opportunity presented by the Wairaka Precinct Masterplan. The design does not address these challenges in isolation but weaves them together into a single, coherent intervention.

Therefore, this chapter outlines the architectural proposal through three integrated, evidence-based lenses. These lenses correspond directly to the core pillars of the research: creating a therapeutic environment grounded in the principles of recovery; executing a culturally and physically sustainable adaptive reuse that respects the ICOMOS Charter; and fostering community integration to ensure the project's long-term viability and social value. The design interventions are logically grouped and explained according to the following three response categories:

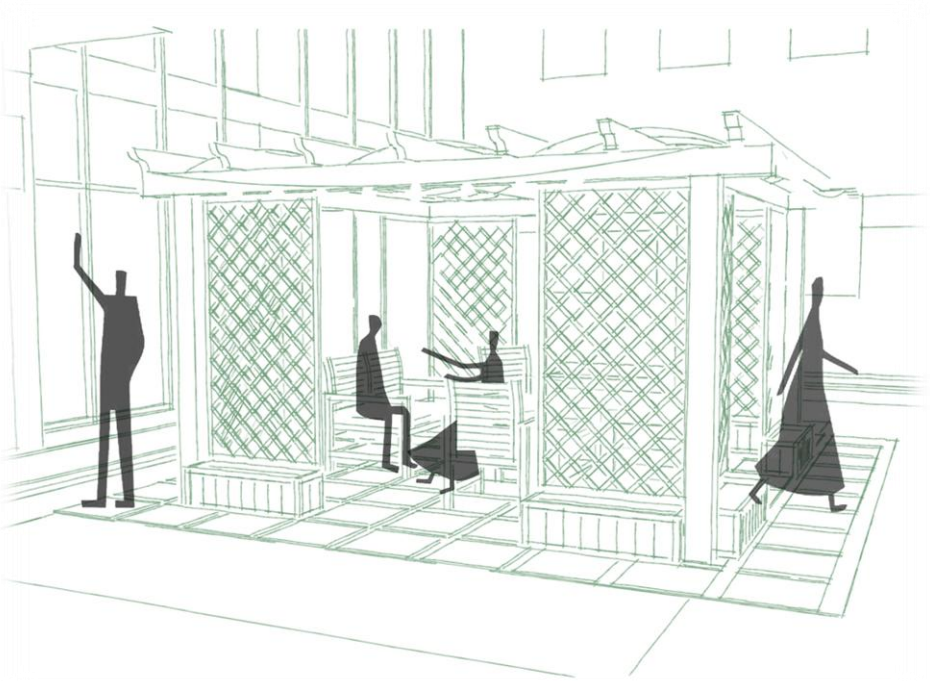
1 PROGRAMME AND ACTIVATION

2 ARCHITECTURAL RESPONSES

3 LANDSCAPE RESPONSE

5.1. PROGRAMME AND ACTIVATION

This section defines the social and operational heart of the proposal. It translates the identified "missing middle" into a specific, actionable Vertically Integrated "Stepped Care" Masterplan. It details the spatial program and user journeys that facilitate gradual autonomy, from private sanctuary to public engagement, ensuring the building is activated by a therapeutic and inclusive mix of functions.



The Vertically Integrated "Stepped Care" Masterplan

This proposal is founded on a Vertically Integrated "Stepped Care" Masterplan, designed specifically to fill the "missing middle" service gap. This model creates a holistic therapeutic ecosystem on one site, moving beyond crisis response to provide a spectrum of community-based support. It co-locates services from early intervention to supported independence, allowing for seamless transitions based on fluctuating need. Crucially, a person can visually comprehend their pathway to wellness: from the public Community Hub, they can see the supportive transitional housing; from there, they can view the integrated independent apartments within the neighbourhood. This visual continuity makes the journey tangible, transforming the site from a symbol of institutional confinement into a daily, visible narrative of hope and progression, fundamentally countering the exclusion of the current system.

Figure 51 Masterplan illustrating the Vertically Integrated "Stepped Care" concept. Adapted from Grimshaw (2019)

Key Design Drivers and Users

The "Missing Middle" Resident: Individuals excluded by the current system are the central focus. Their need for a secure, domestic-scale environment that supports a journey from retreat to community engagement dictates the spatial hierarchy.

The Whānau: Their integration is crucial for sustainable recovery. Spaces are designed to welcome and accommodate them, reinforcing the Taha Whānau dimension of health.

The Wider Community: As beneficiaries of the Wellness Centre and public amenities, they are active participants. The design facilitates positive, casual encounters that normalize mental health and build a culture of inclusivity.

This programmed activation ensures the building is not merely occupied but is *alive* with purposeful and therapeutic interaction, fulfilling its role as a true anchor for the new precinct.

Spatial Program for a Transitional Mental Health Housing Model

The programme is organised using the core principle of Spatial Sequencing for Gradual Autonomy, moving from the most private to the most public, while integrating community engagement at multiple levels. The new Transitional Housing and Wellness Centre acts as the central anchor, connecting the masterplan's existing components (Community Residential Units, GP/Consulting Suites, Satellite Independent Housing) with vibrant public life.

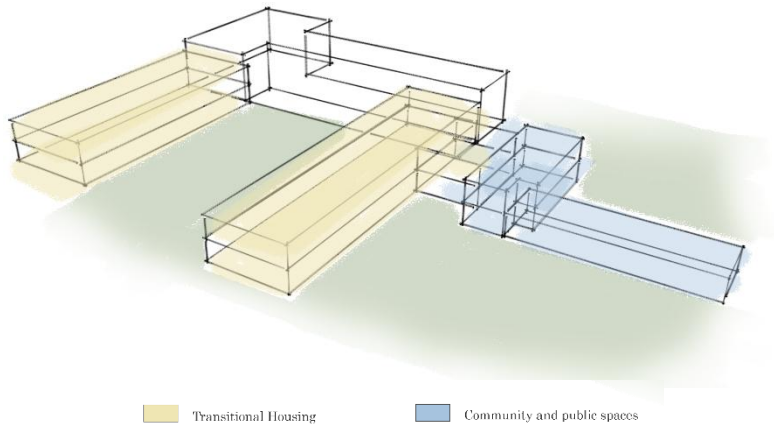


Figure 52 Spatial programme zoning. Created by Author.

Level 1: The Private Sanctuary (The Self)

- Spaces: Private Bedrooms (Single Occupancy with ensuite), Personal Secure External Space (balcony/patio).
- Provides a secure retreat for individual rest, reflection, and control, supporting the recovery principle of agency and dignity.

Level 2: The Social Hearth (The House / Whānau)

- Spaces: Residential Unit Kitchen & Dining (for 6-8 residents), Living & Quiet Lounges, Whānau / Family Suite.
- Fosters a small-scale community. Shared meals become daily social rituals; the family suite normalizes whānau involvement; the sensory room provides a tool for self-regulation. This level builds confidence in a supportive, domestic-scale setting.

Level 3: The Community Hub (The Village)

- Spaces: Wellness Centre (Shared with Public). Community Kitchen & Café, Therapy Pool, Gardens & Greenhouses (Productive Landscapes), Multi-Purpose Workshops, GP/Consulting Suites.
- This is the heart of integration and purpose. The café and market garden create vocational training and public commerce. The workshops host art therapy and public classes. The pool provides holistic exercise. This hub dissolves stigma by making the facility a destination for the entire community, not just its residents.

Level 4: The Integrated Neighbourhood (The World)

- Spaces: Satellite Independent Housing, Public Parklands & Pathways.
- Represents the final "step" to independence within a supportive community. Public pathways and parks weave the site back into the urban fabric, ensuring the project is a permeable part of the neighbourhood, not an isolated enclave.

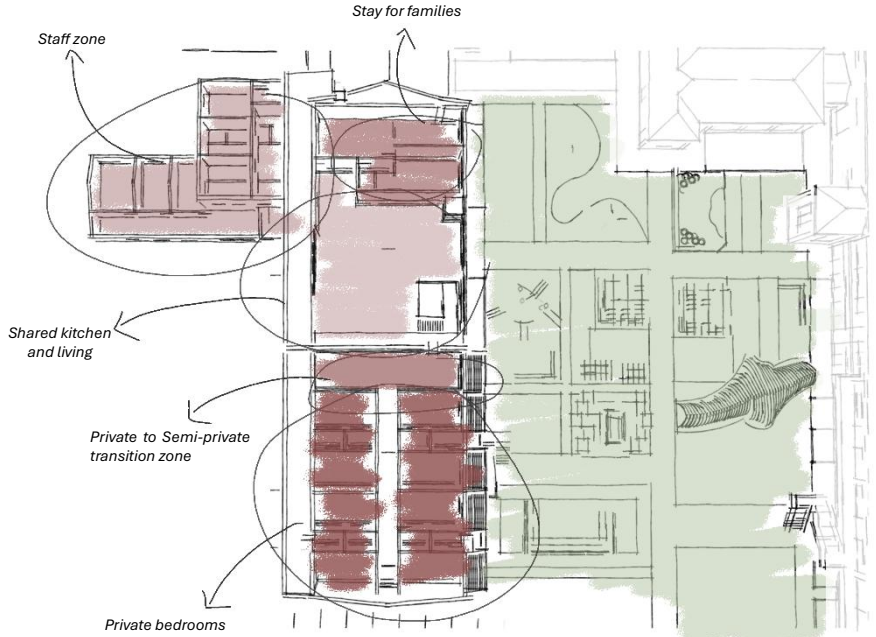
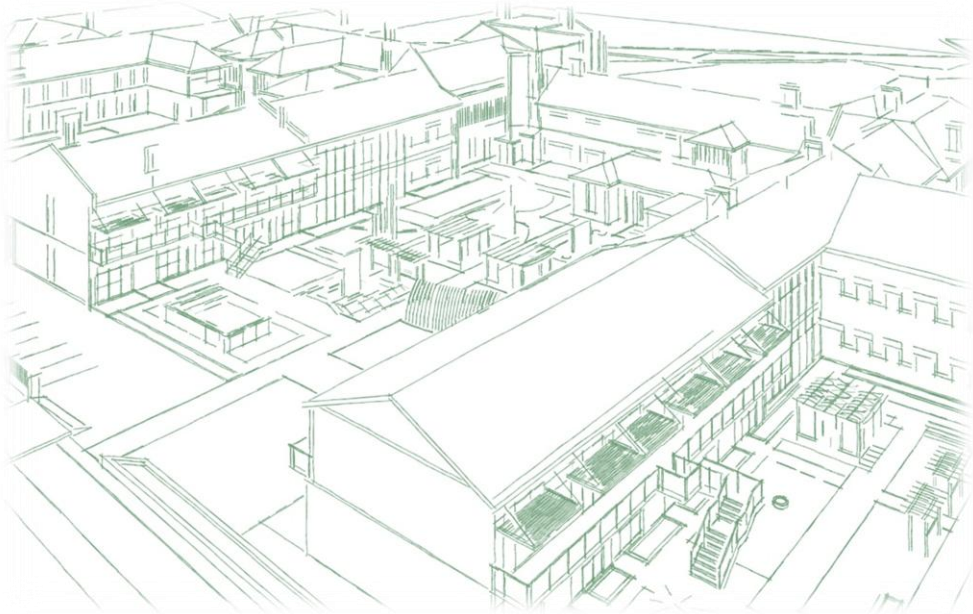


Figure 53 Plan showing the spatial hierarchy transitioning from private areas through semi-private zones to interactive communal spaces. Created by Author.

5.2. ARCHITECTURAL RESPONSE

The physical transformation of the heritage fabric is detailed. This section demonstrates how the principles of deinstitutionalization, biophilia, and safety are embedded into the architectural language. It showcases the strategic balance between conservation and intervention, outlining how new elements dialogue with the old to create a healing environment while honouring the building's history and complying with best-practice conservation standards.



Site-Level Changes

1. A primary entry point is created from the new precinct road, directly aligned with the heart of the proposed programme. This establishes a dignified and legible point of arrival, replacing ambiguity with a clear, welcoming identity that avoids institutional character.

2. The existing pedestrian crossing, which conflicted with the secure residential zone, is strategically relocated. This critical move actively separates public and private circulation, enhancing resident security while intentionally channelling community activity toward the public-facing amenities like the café and workshops. This spatial filtering creates a more secure and functionally coherent site organisation.

Deinstitutionalizing the Heritage Fabric

The architectural design for Carrington is a direct translation of the theoretical principles established in the literature review into a physical, therapeutic environment. The strategy is twofold: to systematically deinstitutionalize the existing spatial structure and to carefully balance conservation with necessary intervention. This is achieved by applying the core design principles to the heritage fabric, beginning with the fundamental reorganization of space.

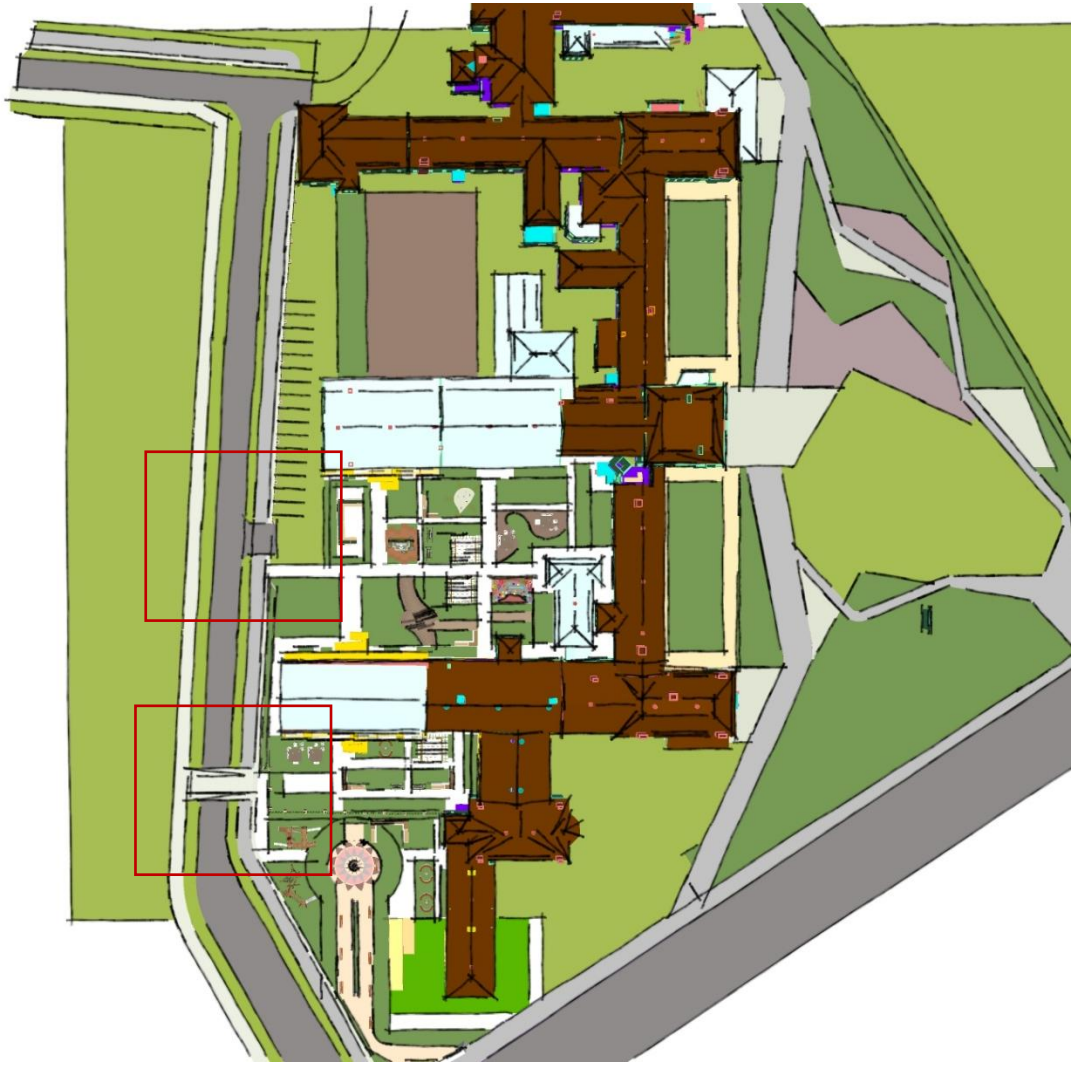


Figure 54 Site map showing the proposed vehicular entry for transitional housing access and the relocated pedestrian crossing. Created by Author.

Figure 55 Zoning Option 1 - Private bedrooms are buried in the plan, isolating them from natural light and exterior views. This fails the critical therapeutic principle of 'Visual Connectivity'. Created by Author.

Figure 56 Zoning Option 2 - Public spaces placed in the west wing create inefficient site access and parking conflicts. Transitional housing on the east does not require this high level of vehicular access. Created by Author.

Figure 57 Zoning Option 3 - Placing private rooms directly next to public spaces violates the 'Spatial Sequencing' principle, lacking the necessary acoustic and psychological buffers for residents. Created by Author.

Figure 58 Zoning Option 4 - This option successfully establishes a clear hierarchy from public to private. All bedrooms receive light and views, and circulation supports gradual autonomy, making it the most resolved scheme. Created by Author.

Zoning for Spatial Hierarchy

The existing Carrington building, like the "total institutions" described by Goffman (1961), was originally characterized by a monolithic plan that segregated residents from the community and offered little personal autonomy. The design intervention fundamentally restructures this by implementing a clear Spatial Sequence for Gradual Autonomy, creating a legible gradient from public to private realms.

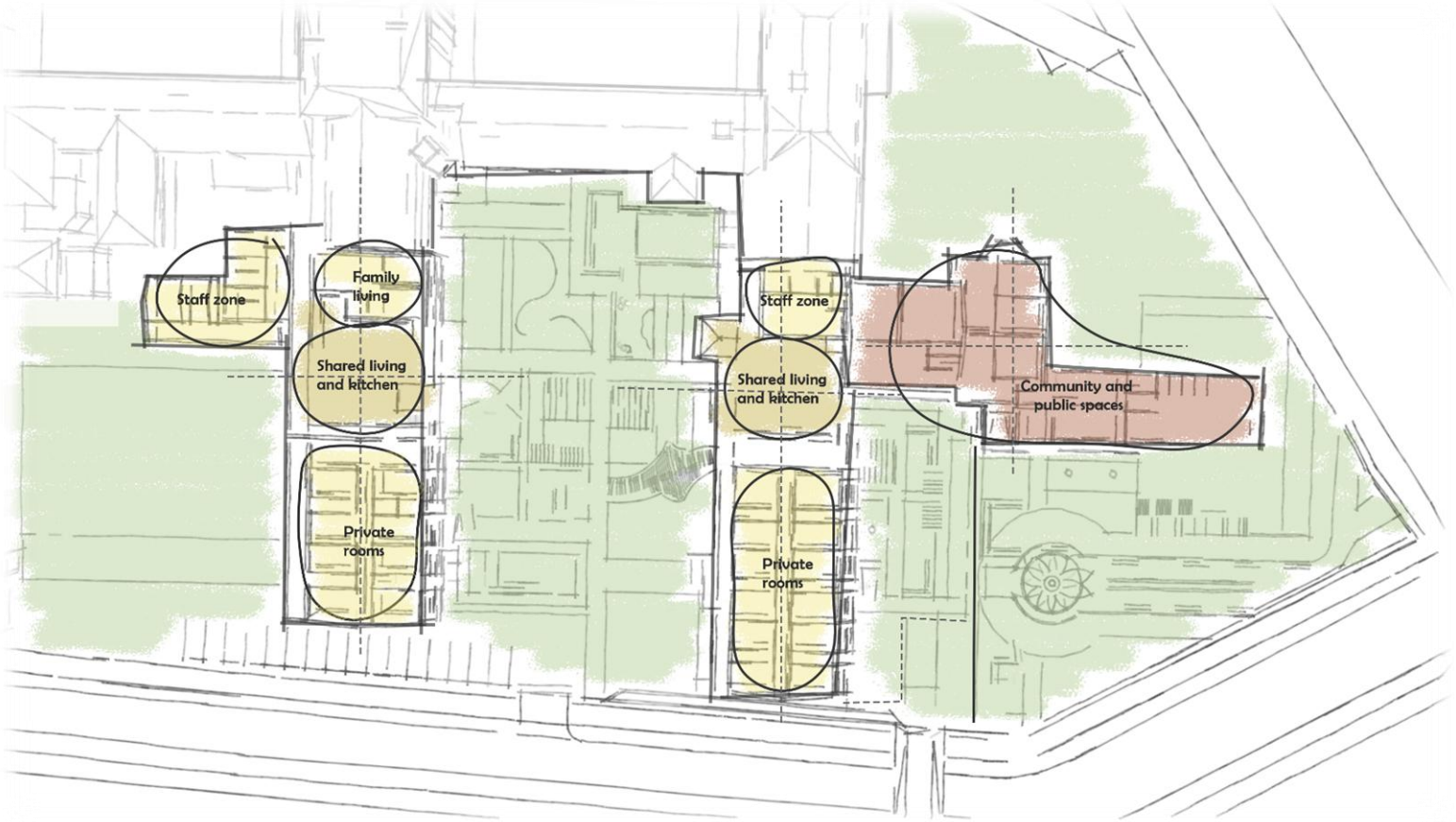


Figure 59 Zoning showing the spatial hierarchy from private to public areas, with transition zones positioned between to facilitate gradual movement and interaction. Created by Author.

Circulation and Access: Fostering Dignity and Choice

The circulation strategy is fundamentally designed to deinstitutionalize movement, replacing surveillance with resident empowerment. This is achieved through a clear separation of staff and resident pathways, enabling passive oversight without intrusive presence and establishing the residential units as autonomous territories.

The core innovation is the dual-access system for private rooms. Each room features two doors: one connecting to internal social spaces and a second providing direct, independent access to a private balcony.

This configuration operationalizes the principle of agency, giving residents complete control over their social engagement. They can choose to participate in community life or retreat directly to restorative outdoor spaces without surveillance or requiring permission, fundamentally transforming their experience from being managed subjects to active participants in their own recovery.

Figure 60. Circulation plan showing separated movement paths for staff and residents. Created by Author.

New Additions for Autonomy and visual Connection

A new external staircase provides private, direct access from all bedrooms to the therapeutic gardens. This gives residents an independent pathway to nature, allowing them to control their social engagement and directly embodying the recovery principle of Spatial Sequencing for Gradual Autonomy.

A new glazed social volume dissolves the boundary between inside and outside. Acting as a transparent connector, it floods shared spaces with daylight and frames expansive garden views. This directly operationalizes Biophilic Integration and Visual Connectivity, creating an uplifting social heart that reduces feelings of confinement.

The strategy extends to private realms, where each room features large windows and direct access to external space, ensuring a continuous restorative connection to the landscape for every resident, fundamentally supporting their recovery journey.

Figure 61. Illustration showing proposed exterior additions and modifications to the Exterior. Created by Author.

Expanding Views: Visual Liberation from Confinement

The design strategically introduces new openings to combat confinement, a direct response to the failures of institutional architecture. Generous glazing in all primary spaces from private rooms to social areas frames constant views of the therapeutic gardens. This pervasive Visual Connectivity provides a sense of freedom and acts as a "positive distraction," directly applying Ulrich's (1984) Stress Reduction Theory.

To protect heritage value, these significant alterations are concentrated on less-significant later additions. This ensures the therapeutic benefit of expansive views is achieved while fully respecting the authenticity of the original historic fabric, following ICOMOS conservation principles.

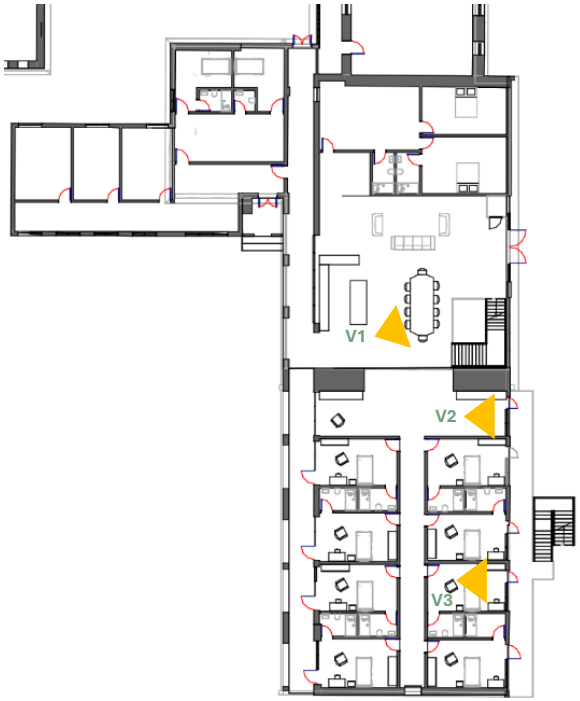
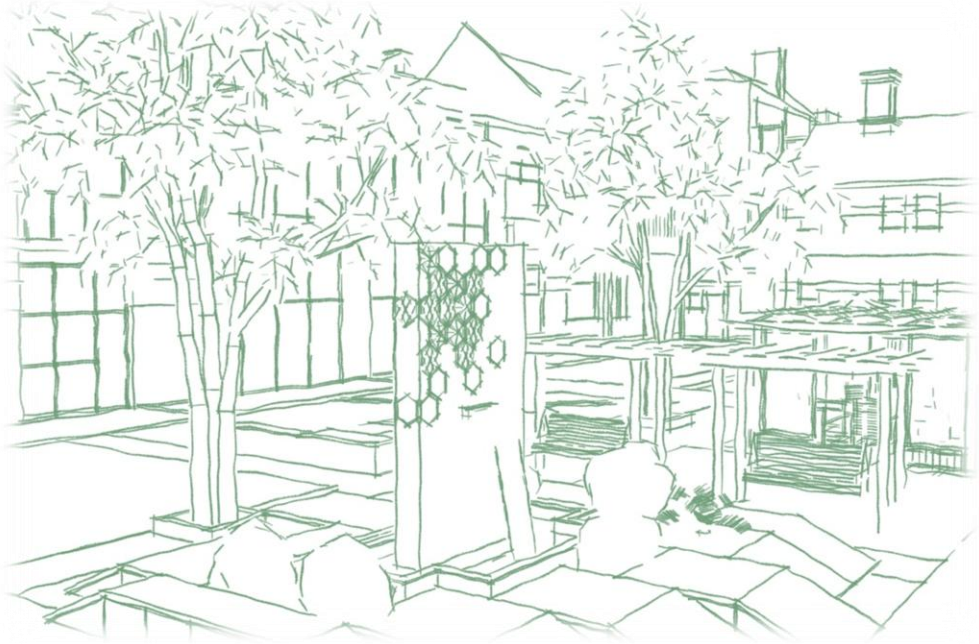


Figure 62. Floor plan and 3d views showing the visual connection and expansion of views. Created by Author.

5.3. LANDSCAPE RESPONSE



The landscape is designed as a therapeutic core, situated between the shared living blocks and private bedrooms. It functions as a series of restorative outdoor rooms featuring secluded seating, sensory walkways, and calming waterscapes. A carefully curated planting palette of scented flowers and native, bird-attracting trees creates a vibrant, sensory-rich environment. This biophilic strategy provides a safe, engaging, and healing outdoor space for residents, promoting wellbeing through direct connection to nature.

Figure 63 View of the garden and relaxing zones. Created by Author.

The landscape also serves to subtly delineate the private therapeutic gardens for residents from the more active public community spaces. The design employs graded changes in planting, gentle landforms, and low seating walls to define territories. This approach ensures a visual connection is maintained beyond each space, preventing any sense of confinement for residents while still providing a clear and secure sense of place. The result is a flowing, integrated landscape where different zones are perceptually separated without being physically closed off.

Figure 64 View showing subtle delineation of the transitional house garden and the public garden. Created by Author.

6

FINAL DESIGN

ARCHITECTURAL DRAWINGS AND RENDERS

CARRINGTON HOSPITAL (FORMER)

LOCATION: Carrington Road, Point Chevalier, Auckland

PROGRAMME: Transitional Housing with Integrated Community & Public Spaces

Figure 65 Masterplan highlighting the focus area of design intervention. Base Map from Grimshaw, 2019

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Figure 66 Site plan. Created by Author.

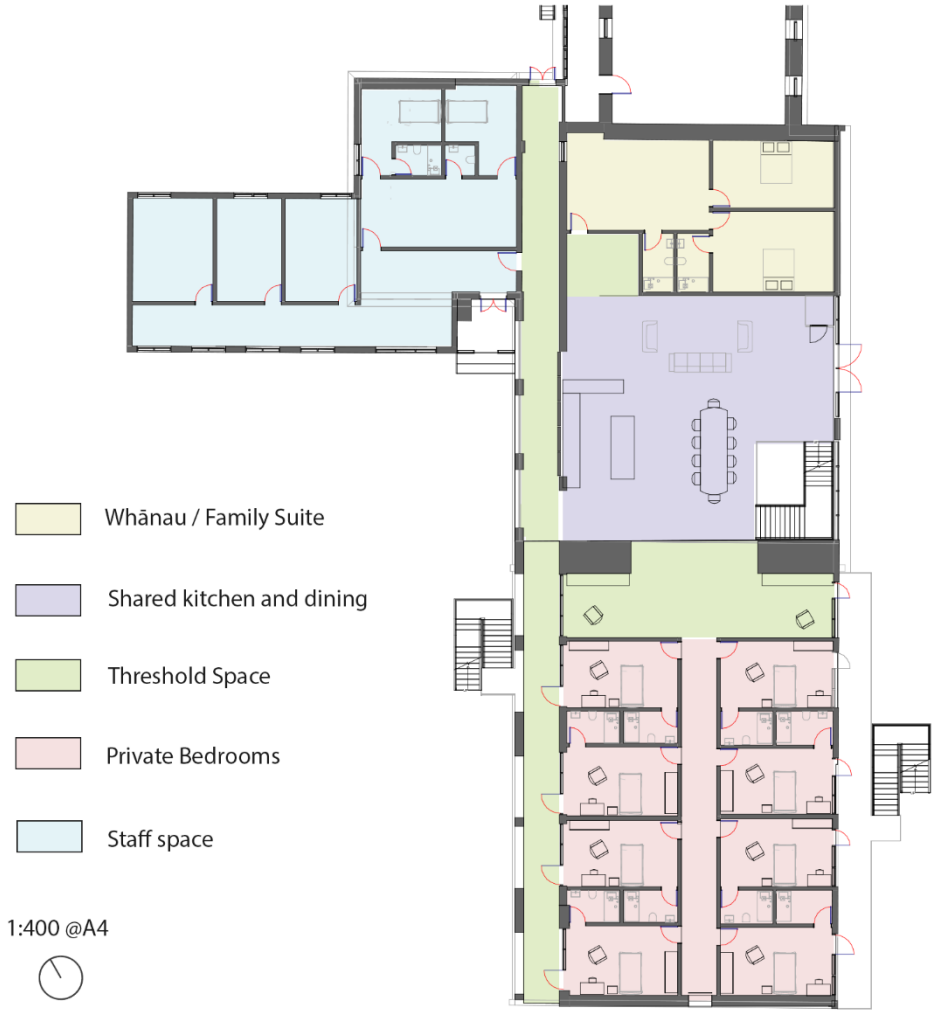


Figure 67 Ground level floor plan. Created by Author.

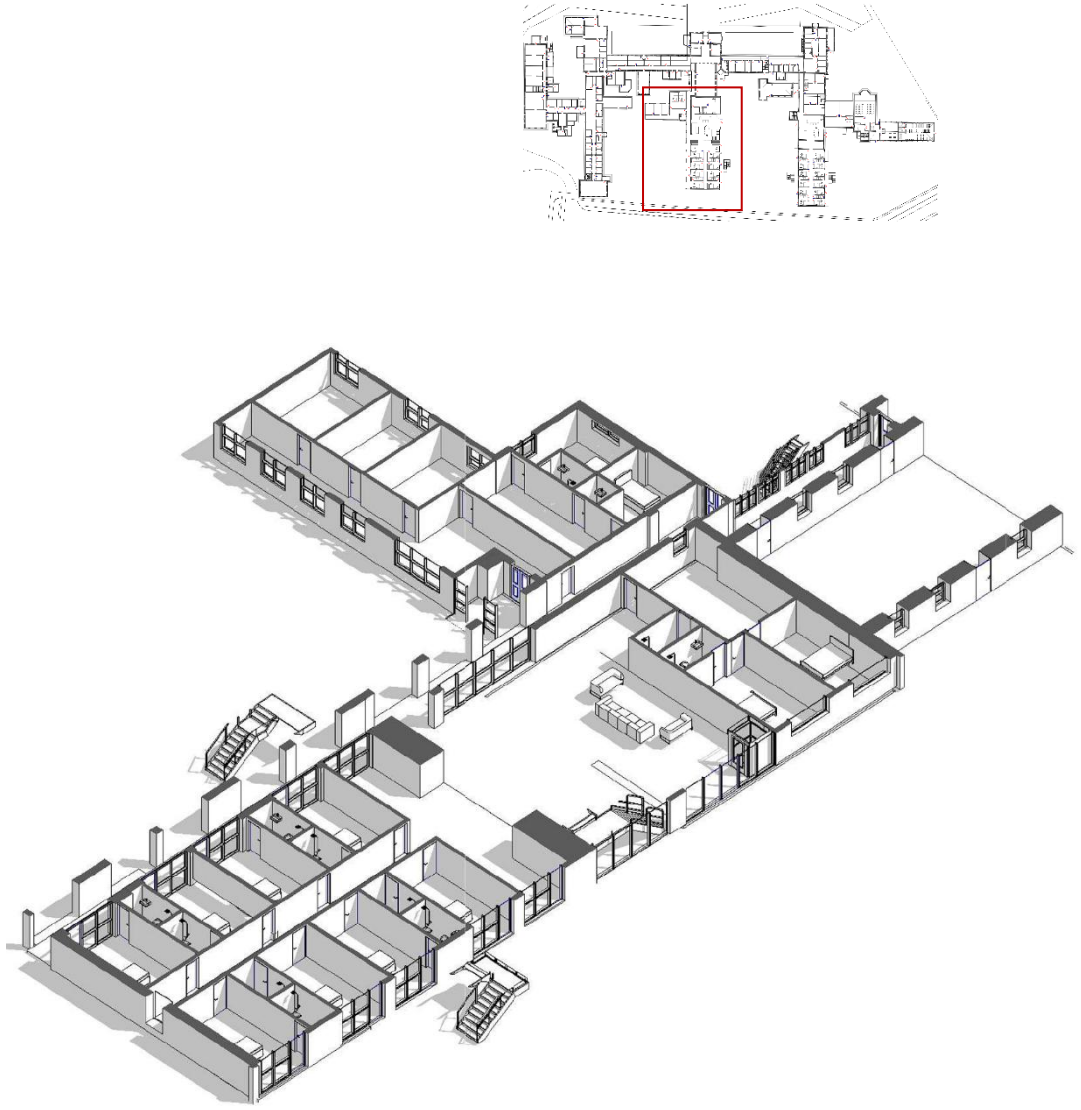


Figure 68 Ground level isometric. Created by Author.

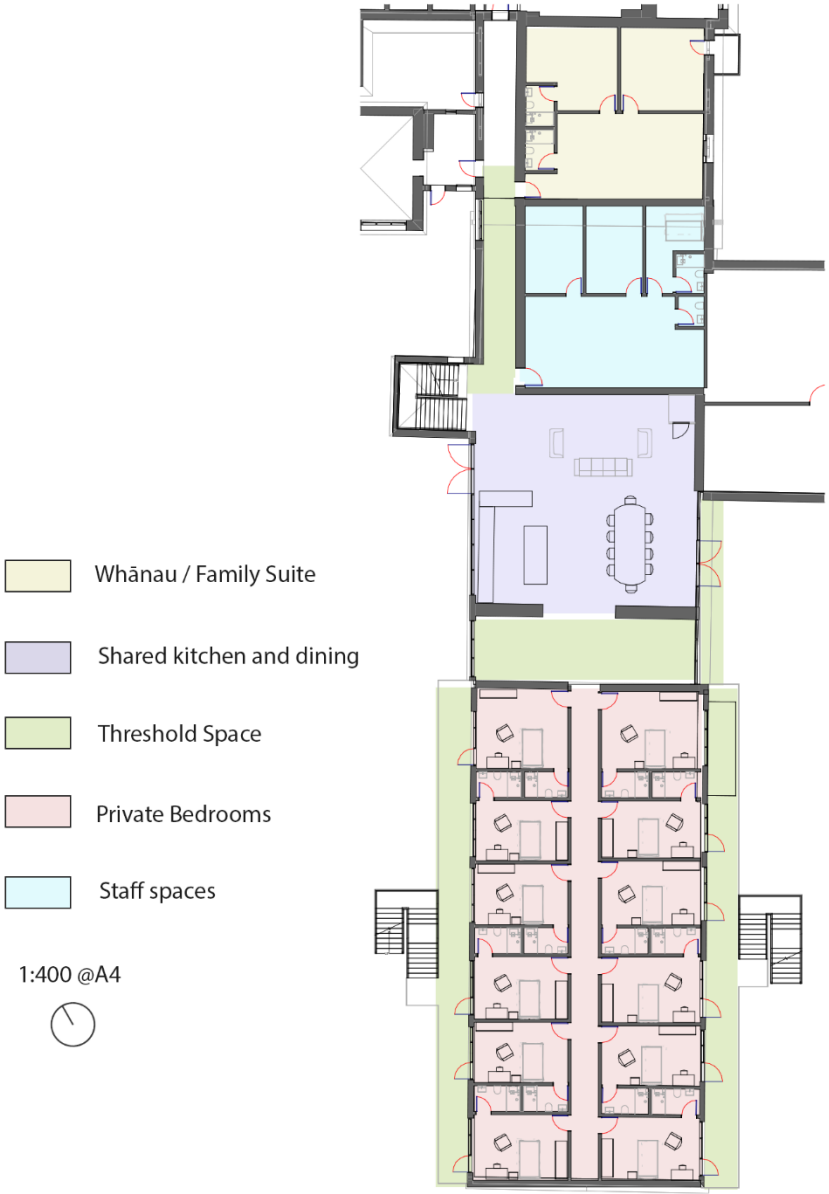
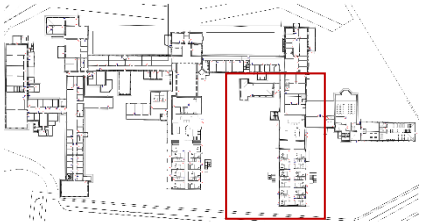


Figure 69 Ground level floor plan. Created by Author.



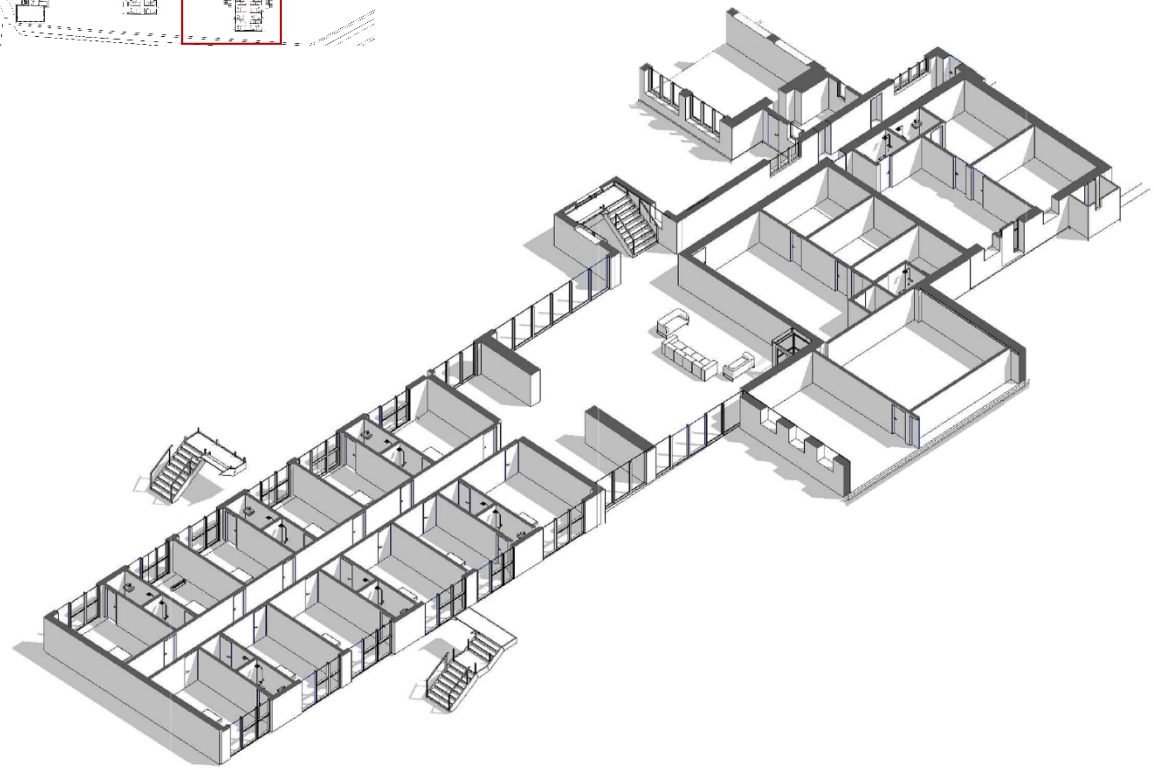
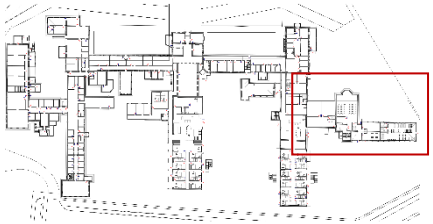


Figure 70 Ground level isometric. Created by Author.



Multi-Purpose Workshops

Gym

Community kitchen and public cafe

Wellness centre

Multi-Purpose hall

Yoga and fitness space

1:400 @A4

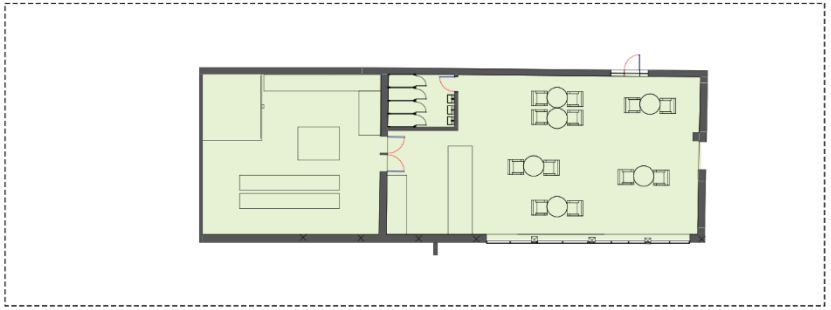


Figure 71 Basement level plan. Created by Author.

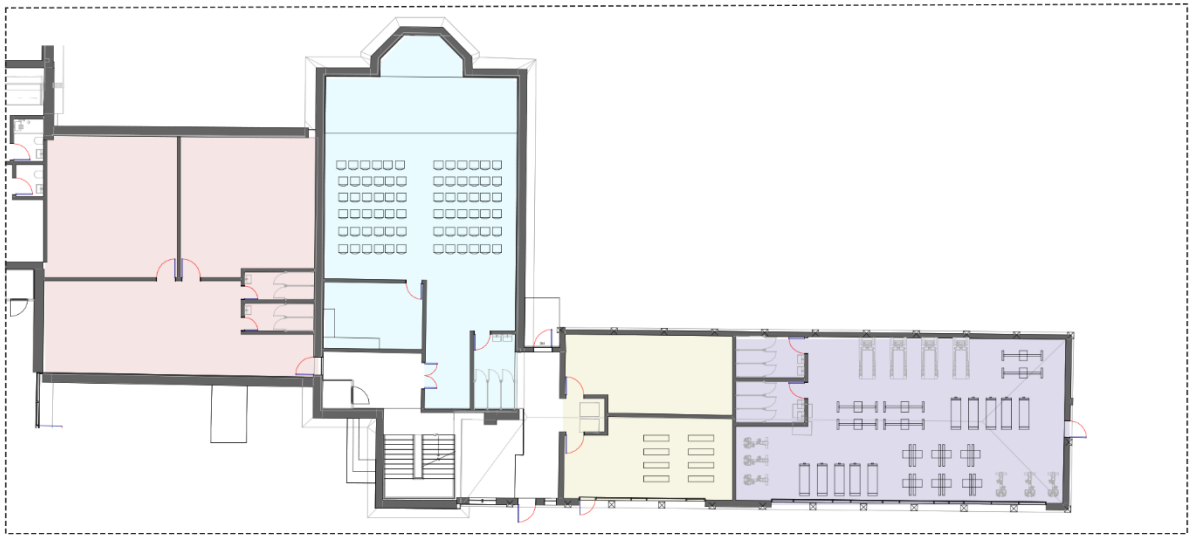


Figure 72 Ground level plan. Created by Author.

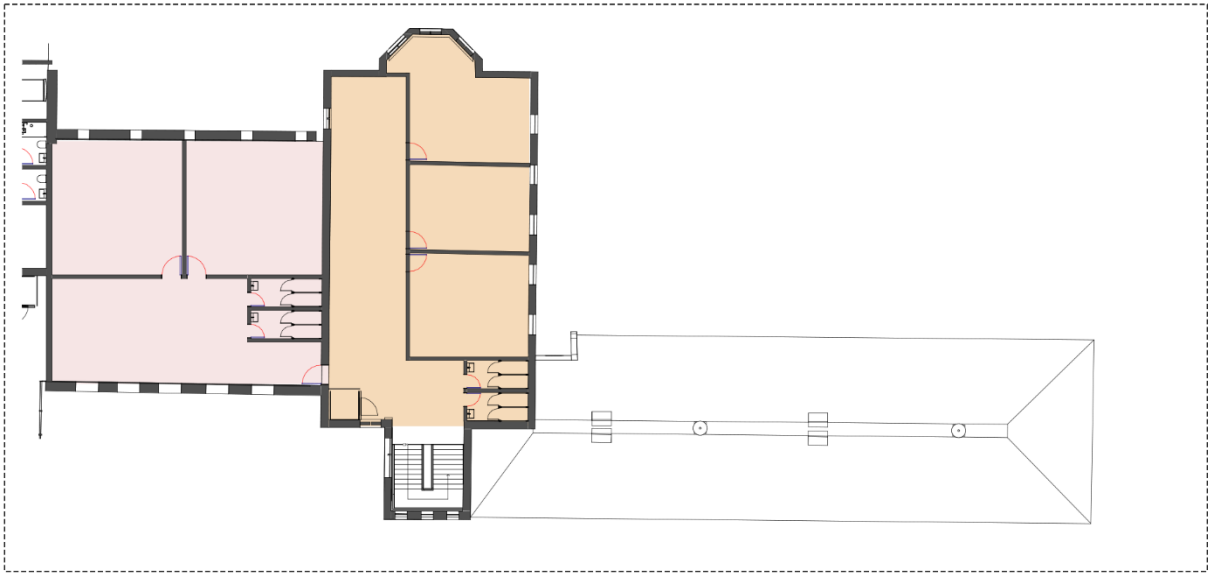


Figure 73 Level 1 plan, Created by Author.

Figure 74. Diagram illustrating the principle of 'Visual Connectivity,' showing the strategic framing of garden views from all primary spaces to reduce feelings of confinement and provide constant restorative outlooks. Created by Author.

Figure 75. Private bedroom demonstrating the application of 'Visual & Circadian Connectivity,' where ample natural light and garden access support physiological regulation and a non-institutional sense of well-being. Created by Author.

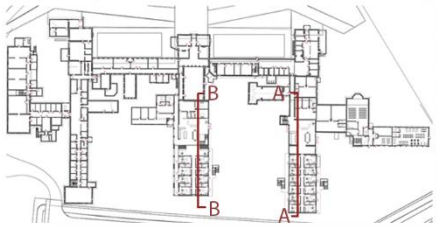


Figure 76. Section A. Created by Author.

Figure 77. Section B. Created by Author.

1:200 @A4

Figure 78. Collage synthesizing the thesis's core proposition: bridging the critical gap in mental health care by adaptively reusing heritage fabric to create a therapeutic community, healing both the building and its future residents. Created by Author.

Figure 79. Interior view of Shared living and dining, Created by Author.

1. Expansive Views & Visual Connectivity: Generous glazing and open planning provide continuous visual connection to the therapeutic landscape, directly countering feelings of confinement and implementing the principle of 'Visual Connectivity' to reduce anxiety.provide continuous visual connection to the therapeutic landscape, directly countering feelings of confinement and implementing the principle of 'Visual Connectivity' to reduce anxiety.

2. Deinstitutionalised & Homely Atmosphere: The residential-scale volume, warm timber cladding, and domestic-style kitchen work to dismantle the institutional legacy of the asylum, creating a non-clinical, homely environment that supports a resident's identity and sense of belonging.

3. Biophilic Material Palette: A material palette of timber and stone, inspired by nature's milder hues, fosters a calming and grounded sensory experience. This indirect biophilic connection provides subtle, continuous therapeutic benefit.

4. Spatial Sequencing & Social Gradation: This shared 'Social Hearth' acts as a semi-public zone within the spatial sequence, offering a graduated step between private rooms and the wider community. It facilitates both planned and casual social interaction, fostering connection.

Figure 80. Interior view of window nook. Created by Author.

1. Semi-Private Threshold: The window nook acts as a critical transition space, offering a sheltered refuge with visual prospect over the garden. This allows residents to regulate social engagement at their own pace, directly supporting personal agency.

2. Biophilic Restoration: Framed views of the restorative garden provide a 'positive distraction' and connect to nature, fulfilling biophilic design principles to lower stress and support cognitive recovery without leaving the building.

3. Gradual Autonomy & Choice: Located between private rooms and social hubs, this nook provides a choice of setting within a clear spatial sequence. This empowers residents, offering an alternative to social spaces and embodying the 'Spectrum of Space'.

4. Seamless Accessibility & Freedom: The open, accessible design and lack of physical barriers ensure easy, dignified movement throughout the facility. This eliminates the feeling of confinement, contrasting sharply with the locked-door legacy of institutional care.

Figure 81. Exterior view of the garden and relaxing spaces. Created by Author.

1. Therapeutic & Functional Landscaping: The garden is a prescribed therapeutic environment. Planting is strategically designed to provide shade, create privacy buffers for bedrooms, and introduce sensory stimulation through scent and movement, actively supporting resident wellbeing.

2. A Legible Dialogue with Heritage: The exterior intervention demonstrates a respectful dialogue with history. New additions adopt the scale and brick materiality of the original structure, while remaining legible as contemporary elements, following ICOMOS conservation principles.

3. Direct Access & Gradual Autonomy: Each private bedroom has direct, independent access to the garden. This dual-access system is a core feature of deinstitutionalization, giving residents control over their movement and a private connection to nature.

4. Clear & Empowering Wayfinding: Pathways are designed to be intuitive and welcoming, ensuring easy navigation between the building, therapeutic gardens, and the wider community. This clarity reduces disorientation and supports resident independence and confidence.

Figure 82. Interior view of private bedrooms. Created by Author.

1. Visual Connection to Nature: Every bedroom is oriented to provide an unobstructed view of the therapeutic gardens, fulfilling the evidence-based principle of 'Visual Connectivity' to reduce stress and provide a restorative outlook.

2. Personalisation for Identity & Agency: A dedicated 'personalisation wall' allows residents to display their own artwork and photographs. This simple feature actively supports the recovery of self-identity and personal agency, countering the anonymity of institutional care.

3. Circadian Regulation with Ample Daylight: Large windows ensure all rooms are flooded with natural light. This is a deliberate strategy to support residents' circadian rhythms, improving sleep patterns and overall physiological regulation.

4. A Non-Institutional, Homely Retreat: The combination of warm materials, residential-scale furniture, and personalised elements creates a serene, homely retreat. This environment is deliberately designed to feel the antithesis of a clinical or institutional bedroom.

Figure 83 Exterior view of the landscape. Created by Author.

1. Soft Boundaries for Integration & Safety: The design uses gentle landforms, low planting, and subtle level changes to delineate between private therapeutic gardens and public spaces. This provides a sense of security for residents without the visual confinement of solid walls.

2.Empowering Direct Access: Every bedroom opens directly onto the therapeutic landscape, granting residents autonomy over their connection to nature and choice between private retreat and community interaction.

3.Non-Intrusive Staff Presence: Staff support areas are strategically positioned to be accessible yet visually separated from resident zones, ensuring help is available without creating a feeling of constant supervision or a clinical atmosphere.

4. Managed Prospect & Refuge: Residents can observe the vibrant public life of the community from the perceived safety of their own garden, a direct application of Appleton's (1975) Prospect-Refuge Theory that supports engagement at a self-determined pace.

7

CONCLUSION & REFLECTION

CONCLUSION

Key Findings

This thesis set out to address the research question: How can the adaptive reuse of the former Carrington Hospital create a new architectural model for the "missing middle" in mental health care?

The investigation developed a conceptual framework synthesising recovery theory, trauma-informed design, biophilic principles, and adaptive reuse theory. This framework established three core design principles - Spatial Sequencing for Gradual Autonomy, Biophilic Integration as Preventative Regulation, and Visual and Circadian Connectivity, which together informed both the site analysis and the subsequent design response.

The key finding is that a heritage-led, evidence-based design approach offers significant advantages in addressing the dual goals of adaptive reuse and the "missing middle" in mental health care. The proposed "Vertically Integrated Stepped Care" masterplan demonstrates how a single site can co-locate a spectrum of support from transitional housing to community integration by strategically repurposing the existing building's fabric.

The design validates that the core principles of Spatial Sequencing, Biophilic Integration, and Visual Connectivity are effective tools for deinstitutionalisation. The strategy of focusing new interventions on the building's less-significant wings, while preserving the historic core, proved a viable method for balancing adaptive reuse imperatives with heritage conservation. This approach directly leverages the opportunities presented by the Wairaka Precinct Masterplan, using its new infrastructure to integrate the facility into the community, thereby addressing the isolation that has historically plagued both the building and the "missing middle" population.

Reflection on the Design Process and Limitations

The application of the theoretical framework was fundamental in translating the complex needs of the "missing middle" into a coherent architectural language. The principle of Spatial Sequencing for Gradual Autonomy was critical, successfully manifesting in features like the dual-access system that provides both ground and upper-level residents with independent pathways to the therapeutic gardens, actively countering feelings of confinement.

A primary design challenge was the scale of the existing building. The strategy of a phased, heritage-led intervention means that only specific, less-significant wings are activated in this initial proposal. Consequently, a necessary and deliberate limitation is the physical restriction of access to the vast, unused portions of the building. This is not a failure of the design but a pragmatic and safe approach to implementation, ensuring the facility operates at a manageable, human scale and that residents are not overwhelmed or placed at risk within a partially active construction site or decaying heritage structure. This creates a clearly defined and secure therapeutic environment within the larger shell.

Furthermore, while the design is conceptually informed by the holistic framework of Te Whare Tapa Whā, it is acknowledged that this thesis does not employ specific Māori design principles developed through direct engagement with Mana Whenua. The framework is referenced as an ethical lens to ensure the design moves beyond a purely Western clinical perspective, but deeper collaboration with Ngāti Whātua Ōrākei and other Mana Whenua would be essential in a fully realised project to ensure cultural safety, authenticity, and a genuinely responsive approach to the site's layered history. This remains a critical limitation and an opportunity for future development.

Significance and Future Work

This thesis proposes an architectural framework and a proof-of-concept for a new model of care. Future work to advance this proposal would include:

The conservation strategy defined here provides a clear mandate. Advancing this would involve the creation of a comprehensive Conservation Plan, a detailed document specifying materials, repair techniques, and a phased construction methodology to ensure the physical preservation of the historic fabric aligns with the design vision (Kerr, 2013). Such a plan would guide all heritage decisions through subsequent design stages and construction.

A long-term post-occupancy evaluation would be a critical tool to quantitatively measure the project's success. Studying its impact on resident recovery rates, community integration, and the building's therapeutic performance would provide invaluable data to validate and refine this model for future applications.

The architectural framework establishes the spatial prerequisite for the "Stepped Care" model. The next essential phase would be to develop a detailed business case and operational plan in partnership with healthcare providers and community housing organisations to ensure its long-term sustainability.

This project demonstrates that architecture is not merely about creating shelter but about constructing a scaffold for recovery. This thesis proposes an architectural response to a defined national crisis, physically manifesting the core recommendation of the *He Ara Oranga* (2018) report by creating a new model of care that expands access beyond the top 3%. By correctly serving the broadly underserved "missing middle," the proposal moves beyond being a mere step-down facility to become vital, proactive community infrastructure.

By treating the adaptive reuse of Carrington Hospital as a form of social and narrative healing, this thesis offers a transferable model for how our existing building stock, particularly sites with complex or contested heritage, can be reconfigured to address pressing societal needs. It demonstrates that the most sustainable and meaningful building is not always a new one, but an old one that has been given a new purpose, serving as both an anchor for community and a beacon of hope for recovery.

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