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Environ-mental.

Bev Lamey
University of Central Lancashire

Carol Bristow
Morecambe Bay Primary Care Trust

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Primary Care Trust

Background

Loony Bins and madhouses; does the environment contribute to the wellbeing of mental health patients (clients)? Have the large Victorian asylums, where patients were hidden from public view, disappeared? Evidence suggests otherwise. People struggling with the distress and disruptive consequences of mental illness, are still kept in oppressive, unsympathetic environments. Research into patient focussed design and architecture has concentrated on physical health care environments and ignored psychiatric health care. As a result many psychiatric patients are still housed (and locked up) in former asylums with their outdated facilities and arrangements.

Objectives

… Establish methodologies of design consultation with reference to moods, emotions and wellbeing. … Enhance wellbeing within care facilities through effective design solutions. The project: At the Lonsdale Unit, Ridgelea Hospital, Lancaster a plan was introduced in 2002 to commit funding to a new building. A user group was established to discuss and advise on the design. This approach would be standard in most building projects, but it is unprecedented within mental health services to consult patients about their living environment. The "client group" meets regularly to discuss their environment. Programme content of the group has been user-led, involving discussion, practical involvement, decision making and confidence building. Co-ordinated by care-staff and supported by design academics, the SEED project (Supportive Environment Encouraging Development) reflects the vital interdependence of patients' emotions and wellbeing, and the design of the care environment. A new self-confidence has been established through deployment of design processes and design thinking. In this project, the patient user group has always been the primary client. Their growing confidence in design jargon and thinking creates an unusual turnaround in the power relationship with the staff. The project is using this to bring up to speed the staff involvement in the design of the new build. The process has revealed attitudes, preconceptions and prejudices that prevent the application of good design to similar situations. The introduction of creative thinking to the user-group has already resulted in a radical rethink amongst the clients, staff, and managers. This research is practice-based. The designers are transferring a standard design procedure of consultation with clients to an unusual context. The meetings are documented and recorded. At separate meetings the research team reflect and evaluate the observations, results and findings. Presentation of outcomes takes different formats, visual, verbal, written, digital, and physical. Clients are also involved in presenting findings and reporting back. Presenting initial findings: This project has a number of outcomes. The primary result will be a new or refurbished building for the patients of the Lonsdale Unit that reflects the therapeutic consultative process that has been established by the project. The monitoring, recording, reflecting upon and reporting of the process and outcomes will facilitate future design for similar facilities. A design methodology that respects the moods, feelings and well being of clients as well as physical needs, and practical function is transferable to wider applications. The team are motivated to report and record the findings of this research in order to influence interior design in other public places and institutions.

Conclusion

The "Environ-mental" project and SEED is about design for wellbeing in addition to design for physical need and practical function.

Environ-mental: Supportive Environments Encouraging Development.

Design as therapy? Can psychiatric patients participate in the design of their physical environment and as a direct consequence improve their emotional environment?

Introduction

The S.E.E.D. project explores design for mental health care environments, it references recent developments in design thinking related to process and client participation, design for healthcare buildings and healthcare interior design, and observes the relationship between well-being, environment and the effects of self-determination. Design activity is deployed to confront ideas about 'place', 'home' and 'designer' and outcomes are reported through the experiences of psychiatric service users and observations of their responses. The integrated S.E.E.D project brings together design academics and health care professionals who work to establish a methodology that empowers psychiatric service users and encourages participation and inclusivity in developing design proposals for the environment in which they live. Evaluation of the research project outcomes uses evidence of client development and increased confidence as one indicator. Other indicators reported are the potential for psychiatric patients to inform the thinking at the heart of healthcare environment design, and the potential for inclusive informed decision-making as 'treatment' towards normality.

Accounting for perspectives and defining the issues

Service user and client (patient): The terminology can be illuminating; *patient* implies passivity, helplessness, someone who waits to be cured, uninvolved in their treatment; client implies customer, someone who takes advice or services. The term client is often used within social and health care situations as a politically correct synonym for *patient*, but in design the client pays the wages; *service user*, implies active participation, a user of a service. For the sake of clarity and accuracy, throughout this paper we will use the terminology *service user.* At the start of the project the service users' viewpoint was undervalued and unheard.

Project co-ordinator: Not only co-ordinator, but also instigator and motivator, the project co-ordinator was inspired by a strong emotional perspective and empathy with the service users. The knowledge that anyone of us or someone we love could one day be a service user is powerfully emotive.

Staff: The staff perspective was sceptically neutral, particularly about the value of Design to their situation.

Academic researcher/Designer: The usual perspective of an academic researcher is that of observer and recorder, these are important roles. Similarly the traditional role of the designer is one of objective dissociation, "the cool-headed, objective professional" (McCoy 2003). However, this project necessitates emotional involvement, participation, subjectivity and the utility of practical design skills and knowledge.

Looney-bins and Madhouses.

Looney: (slang term) a person who is not right in the mind.
Bin: a container for waste or trash.

The Victorians discarded their mentally ill in 'madhouses' specifically constructed for the purpose but for the psychiatric service user today their 'ward' is as distant from contemporary domestic reality as the old asylums were to the Victorian service user. Many of the old buildings have been closed, but many are still in use. Here, patients with mental illness are still kept hidden away from the view of the rest of society.

The Lonsdale Unit at Ridge Lea Hospital was built in1916 as the 'ladies villa' of Lancaster Moor Asylum. The unit is no longer used to house the disgraced daughters of wealthy families, but provides care and treatment for men experiencing the distress and disruptive consequences of enduring mental illness. It aims to provide rehabilitation in a low secure environment. The recognisable style of the current building is "Institutional". Some of the old indicators of this style no longer exist, but new indicators have taken the place of the pale green walls and dark green dado rails. The impersonal atmosphere of a functional hospital ward still persists, with flat fluorescent lighting, shiny surfaces, hard edges and empty corners. Currently the décor reflects the rules and regulations of the place. Anything that personalises the space is perceived to encroach upon it's efficiency. Patients are unable to personalise their spaces or paint the wall. The limited choice of furniture (which can only be purchased through an NHS catalogue) diminishes opportunity for personal choice.

The Lonsdale Unit is hospital ward, workplace and home. The building is little different to others still in occupation as psychiatric units - across the world. Within these environments there are many successes to report but the impression the first time visitor gets is an environment unfit for purpose and unsuitable for effective therapeutic care. "If care is what everyone in contact with a patient should give, then again from the patient's viewpoint, providing healthcare entails providing ideal conditions for them to do so. These conditions also include the quality of the environment for the carers as well as the service users and again common sense suggests that the quality of the environment can help or hinder caring."(Scher1996).

The building has high ceilings, wide corridors; windows have been added to internal walls which provide ease of surveillance for staff but reduce privacy for the service user. The air is oppressive and stale. There is an absence of intimate, cosy spaces, ornament, soft furnishings, and sensual stimulation through pattern or texture. The position of the bathrooms prohibits private use by individual patients. Bedroom provision is primarily in dormitories. The position of the kitchen and dining room mean reduced opportunities for service users to access rehabilitative cooking and domestic practice. The "garden" area is reminiscent of a prison exercise yard, with very little planting, colour or texture, and no views of the beautiful grounds that exist outside the high perimeter walls. There are few opportunities to look out at the landscape from inside the unit, despite the large Edwardian Bay windows. Inconsiderate planning in the past

has resulted in the positioning of temporary buildings and extensions in front of the external windows of the unit.

Notions of "home" and "hotel".

What do we understand by the notion of "home"? Most people mean a place of their own, with their own things, "personal space", somewhere to be private, a place where you have choice and control. It is also a place of retreat, a sanctuary, and a reflection of self. (Candy 2004) The service users often have a confused sense of self due to their illness, should it be an important part of a rehabilitative therapy to rebuild that sense of self through a relationship with their surroundings? The word has other emotional connotations to do with comfort, warmth and security. Asked to draw "home" people often produce images of fireplaces and cosy chairs. Most domestic environments evolve naturally through a process of gathering. It is not surprising that people make reference to the notion of "nest-building". The approach in design for domestic and public situations needs to be different. However, if people have important emotional needs from their environment, these needs have to be accounted for. The needs of service users to feel "at home" must be listened to by designers of institutional spaces. A reference to hotels is noteworthy; hotels are public spaces that often imitate the notion of "home" through the use of images of fireplaces, cosy chairs, soft furnishings, cushions, etc. However, a hotel is still an impersonal environment, intended for temporary habitation, not permanent residence. It imitates "home" but isn't home. Significantly the NHS Plan has suggested hotel-style accommodation of en-suite single rooms for future NHS Mental Health provision. This is a challenge that has already been taken up by some architects. (Evans, 2002)

Personal Identity

From the start this project was different because it involved the service users in the project. This extent of user involvement is unprecedented in the NHS. Is this because people with mental illness don't know what's best for them? Is it that they are not worth consulting because managers assume they will make outrageous demands and will be disappointed when they can't have everything they want? It may also be that such consultation takes time, thought, and planning. However, people with mental illness are just that, people, who feel and emote, and have an opinion about their own wellbeing.

There are other examples of new build projects that have consulted with the user-groups, but often these user groups have, in fact, been staff users, not service users. Most architects focus on the functional needs of the building, constraint, control and how to help the staff do their jobs. But staff can go home at the end of their shift. Service users spend many years of their lives in these units; this is their home, the space that is intended to provide rehabilitation and therapy. Staff needs are important, but patient needs should be even more important. Naïve, non-health professional visitors to the Lonsdale Unit wonder how anyone could work or live in such conditions.

Gaining Independence

On admission to the service patients lose control of their lives. They make very few decisions for themselves, yet part of the therapeutic function of the unit is to prepare patients for life in the community but there is little support for this in the physical environment of the unit. Patients sleep primarily in shared accommodation, there is limited access to privacy, and little opportunity to practice domestic skills.

The Project

In 2002 the multi-disciplinary professional health care team, who manage the unit, identified that the unit's care facilities were unsuitable for mental health care in the 21st century. Carol Bristow, project development co-ordinator, Lonsdale Unit, and Howard Davis, North West Secure Commissioner, recognised the importance of involving the current service users in planning and designing a new facility. Service users have the expertise and experience which are vital for quality and effectiveness, which can result in building environments that are valued as places of healing and caring. The project recognises the importance of providing a connection between service users and people with the skill and knowledge to help them develop their own thinking and to explore options. The processes and experience developed provide examples and learning that can be utilised elsewhere.

The aims of the project:

The project aims to:

- Establish methodologies of design consultation with reference to moods, emotions and wellbeing.

- Enhance wellbeing within care facilities through effective design solutions.

A service-user group was established that meet every week to discuss their environment. A range of consultation methods were developed to engage the service users in the process. The designer/client consultation is a well-established information gathering exercise that occurs at the start of most commercial design projects. However, conventional consultation relies heavily on the knowledge and expertise of those employing the designer. Service-users in the unit are unfamiliar with design language and have been deprived of the usual reference points as a result of years of institutionalisation. It is important to connect with the quality of the user's experience through dynamic and multi-sensory activities. A similar approach is beginning to be applied to other design contexts (Suri 2004).

A board game was designed to help the group to look at environments in an informal way. The "project planner game" allowed the client group to identify and prioritise the important parts of an effective environment.

Service-users were also asked to express their ideas through drawing. These included typical images of "home", (houses with front doors, and gardens), plans

of “soft” curved-walled buildings with central communal areas encircled by private bedrooms. Gardens are also prominent in the visualisations.
Design academics introduced design skills and projective practices to the user group. They were introduced to mood boards and encouraged to talk about their feelings and to express them in visual terms. Some service users have a problem articulating their thoughts and do not easily communicate their feelings about their environment. The mood board process enables them to clarify some important issues by gathering appropriate images and colours that can speak for them.
The group looked for ways to seek the views of a wider group of secure service users. A questionnaire was designed and sent to similar units in the region. The aim of the questions was to discover what types of environments service users currently have and would like to have in the future. A significant finding was that those users currently housed in new buildings expressed an overwhelming preference for the old buildings because of the greater feeling of space created by the high ceilings. Low ceilings in new units create feelings of claustrophobia.
The group applied creative and lateral thinking skills to a survey of the existing facility and the functional management of the space. It identified inappropriate use of space, challenged the functional layout and considered alternatives. A number of priorities were identified. Rough plans established by the group were passed to an architect who redrew them as realistic architectural plans based extremely closely on the service users design proposals.
In effect; the service-users were involved in the whole of the design process and they continue today to be involved in the decisions about decoration, colour, organisation and process of personalisation of space.

A shift of power?

There is growing acknowledgement of the fact that the service user group is the primary stakeholder in this design process.
The group has slowly grown in confidence and has taken control of a number of fundamental decisions about their environment and about the function of the group. A significant discussion about ‘group identity’ and ‘recognition’ resulted in the naming of the project. Design academics had been asked to suggest an identity name for the group, which could be worked up into a logo, letter headings, etc. Suggestions focussed on the empowerment of service users, the idea that they should embrace the negative connotations associated with mental illness. The group felt this was too radical and after months of discussion and debate, opted for a much more life affirming nomenclature, the acronym of SEED; Supportive Environments Encouraging Development. The user group have developed ideas for a logo that references imagery of growth and new life.
Service users have solicited opinion from a number of interested parties, including the Trust’s Property Manager, a Secure Commissioner, the Director of Mental Health Services to name but a few. In December 2002 there was a presentation to launch the project to the Commissioning Team, Trust Board, and staff. The SEED group were involved in the co-ordination and one member

presented a piece of work. Several of the group members were also present and contributed their views at the end of the formal presentations.

New perspectives

Service User: There is evidence of increased confidence and personal development amongst the service user group. This is largely qualitative and evidenced by numerous anecdotal accounts. Some changes are small yet all are significant (from a number of perspectives). In this environment all changes are difficult to evaluate; the value of the feeling of ownership, for example, or the emotions of pride, achievement, and responsibility are very clear to see but hard to document. The smallest incidents can be significant. A passing reference by one service user to the quality of the furniture on a Television programme demonstrates vividly his developed awareness and confidence to express a point of view. One service user has increased in confidence so much that he is considering an application to study at University when he is well enough; a target and an aspiration with which to build a future in the community.

Project co-ordinator: Is very happy with the progress of the project, and to find that some of her role as co-ordinator has been usurped by the service users themselves.

Staff: The initial uncertainty and mistrust by many of the staff of the design consultation process deployed is dissipating. Now 18 months after the start of the project they demonstrate a growing interest in the SEED activities and are increasingly involved.

Conclusion

Documenting emotional change is problematic. At worst it may say as much about the researcher as it does about the outcome. At best it may need to reference other sources to support findings. Yet, in reality, there is nothing wrong with taking pleasure in the effect a process can have on an individual. Increased confidence, expressing an opinion, giving a damn, even anger, all have their place in the evidence trail. It may be very small but for the individual suffering the degradation of long term psychiatric illness it is radically significant.

The project will go on to evaluate and record, but at this stage the most visible outcome will be the significant change to the physical environment of the Lonsdale unit, a refurbished building for the service users that reflects the therapeutic, consultative process that has been established by the project. And ownership, the change is theirs. Evaluated by them, originated by them and designed by them in a thorough and effective manner.

The less apparent outcome is the psychological change to the service users, both staff and patients as identified in above in the New Perspectives paragraph. Future physical improvements will alter the lifestyle of the service users but the greatest impact is derived from their involvement in the process.

Empowered to express themselves in visual terms, this project is not about buildings, it’s about people.

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