CARE AND THE DESIGN OF A PSYCHIATRIC HOSPITAL ENVIRONMENT

ARTICULATIONS, IDENTITIES

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ABSTRACT

This pictorial submission presents some initial reflective observations from a project that is exploring transition and transformation that results from the design and build of a new hospital building and the psychiatric facilities in particular. Care is the fundamental guiding principle of this research, of the hospital development and the day to day practices of patients, hospital staff and associated care givers. This is realized as care for the unwell though processes, treatment and environments.

INTRODUCTION

Hospitals have long been considered sites of power relations. Faucault observed that hospitals are organisations that have 'pastoral power' (1982: 790), including power over freedom of choice about treatment of admittance for some. The adoption of contemporary models of health care have begun to challenge this perception and enactment of power that has been prevalent in the past. The evolution to new models of care within medical contexts, and particularly nursing (Curtis et al. 2013; Wagner 2010) marks a shift from a power manifest as treatment relationship, to one of patient care and health services. In this paper we explore how the design of a psychiatric unit might evidence this contemporary approach to the care of the mentally unwell.

RESEARCH CONTEXT

The site of the research is the psychiatric units at Bendigo Hospital located in regional Victoria, Australia. The methodology for the research is design ethnography and the research is being undertaken over a three-year time span 2016 - 2018. Year one focused on an ethnographic review of the various hospital stakeholders on their experiences of the existing hospital and their expectations of the new hospital facilities. Year two is a year of reflection by the researchers and habitation by the stakeholders in the new hospital facility which was occupied from January 2017. In 2018 the research team return to the hospital to undertake further ethnographic enquiry into the experience of the new hospital.

There are a number of significant issues from this project that will impact all of the unit stakeholders. These include the transition from three locations across the Hospital campus, to one integrated psychiatric facility that is co-located within the Hospital complex. This has resulted in the establishment of new contexts for care in the new facilities; the upgrade of facilities; the integration of current discoveries from research on the relationship between environments and health and well being through spatial design; and the integration of digital technologies for care and safety. In this paper we focus on the spatial qualities of the two hospitals – the Old Hospital and the New one. The aim of the paper is to begin to draw insights about the relationship between the design of the aesthetic qualities of environments and the alignment to the hospital's model of care.

The design and development of a New Hospital psychiatric facility is a complex process. There are many stakeholders to be considered within the design including operations and governance structures, as well as staff (medical, administrative and service), patients, families and allied community care services. There are also occupational health and safety requirements, and patient safety and therapeutic guidelines which need to be considered in design responses. Guiding all this is the hospital model of care – this is the foundation for the development of the project brief.

The images that comprise this pictorial essay were taken by the researchers during research visits to the two sites. They represent an external view of the spaces and not that of the patients, hospital staff or visitors who have deeper connection to these places. In many ways they reflect the limited knowledge that an external researcher can have of the real and lived experiences of the research subject. A methodology of noticing (Vaughan and Akama 2015) was used by the researchers as they walked through the two hospital sites – capturing in digital images that which drew their attention. At times these were aesthetics of light, use and wear, material qualities, colour, customization, light and arrangement; and at others they were of the transformation of the spaces once the established protocols of occupation had changed. The images of the Old Hospital were taken on the day of departure – the day that the patients were moved to the new site. The images of the New Hospital were taken on two occasions and feature two particular units. One series of images were taken during a site visit prior to completion of the parent/child unit. This is a particular innovation of the New Hospital and allows for parents and children to be co-located in the hospital during the time of the adult's hospitalization. The second series are taken in the Secure Extended Care facility prior to the occupation by the patients. Patients in this unit may be in hospital for several years.

This paper is propositional and inconclusive. The authors have endeavoured to see through the frame of camera lenses how the material qualities of the two hospital sites articulate the ambition of the project guidelines and the model of care that informs it. Images from the Old Hospital provide a frame for understanding the nature of a care space used over time and what has been the known environment for patients and staff. Images of the New Hospital are presented as images of hope of what is to come to be – how the model of care will be realized in place and in relation to materials, the natural environment.

CONSIDERING THE DESIGN OF PSYCHIATRIC HOSPITAL SPACES

Within the literature on the design of hospital spaces and psychiatric units in particular there are consistent themes of concern. These include evaluations of space and volume, serviceability to patient numbers, materials and their associated qualities, and spatial configurations that support care, safety (patients and staff), family and external (family and community) participation in day to day care (Curtis 2013; Wood 2013a; 2013b).

Wood et. al (2013a) argue that psychiatric hospitals can be classified as ''spaces of transition', intended to prepare the 'service user' to return to life in the community, by encouraging a degree of connection between the community setting and the clinical environment' (p. 123). They argue, based on the work of Schweitzer, Gilpin and Frampton (2004 in Wood 2013a), that there needs to be a degree of 'managed permeability' where by buildings encourage opportunities for 'social contact and engagement' (p. 123). It is in this way that psychiatric hospitals can be considered 'therapeutic landscapes'…which are not only efficient but also offer physical, social and symbolic features that are beneficial for one's sense of wellbeing and therefore help to promote healing in a more holistic sense' (p.123).

This proposition of permeability is an interesting one, it can be interpreted to manifest in the physical and systems aspect of hospital design, a well as in practices of care and engagement. Surveillance is a theme that is raised in the literature and refers to the ways that medical staff engage with patients throughout the day. The classification of the nursing station as a surveillance hub performing as a Foucauldian panoptican of power (1995) is a common reference in discussions of site lines and observation methods by clinical staff with patients (May 1992; Salzmann-Erikson et al. 2012). Salzmann-Erikson et al. observe that '(t)he patient spaces in the mental health institution are subtly linked to different mechanisms of control and surveillance' (p. 501). They propose that designing spaces that both allow for patient privacy whilst ensuring safety and care is one of the core challenges. Developing systems and processes of observation that both ensure patient wellbeing, whilst also honouring desires for privacy and separation are equally challenging. Too much observation can equal invasion of personal space but high levels of care, too little can be the reverse, high levels of personal space and low levels of care (Salzmann-Erikson et al. 212).

It is also noted within the literature that the material nature of therapeutic spaces impacts on both the physical and psychological wellbeing of patients. Wood et al (2013b) in a study of a new psychiatric hospital in the UK report it was noted that for hospital staff there is a need to 'match material security standards to provide containment as well as refuge' (p. 205). They go on to report that in this case ''(s)afe' spaces on the wards had predominantly 'smooth' surfaces. Protruding features were considered hazardous, such as free-standing metal poles… or sharp surfaces' (p. 205). Concerns within this hospital were related to opportunities for self-harm or suicide. To address the issue of any metal building materials left after construction, such as screws, the entire building was swept with metal detectors. This level of care about what might be seen as minor features of spaces is a real and lived concern for those working in psychiatric care.

From a design perspective these concerns about the material qualities of therapeutic spaces can be seen to be recognition of the material/physical nature of care. As argued by Tonkinwise, writing in conjunction with the work of Latour (1993) and Scarry (1985) it is possible for us to see the things of the material world as empathetic agents of care. Extending this proposition to the structure/spatial material world – the buildings and environments that we design as locations where care happens, is not a significant leap. What for Wood et al are material qualities of surfaces and things, are like Scarry's supportive chair (1985: 288), supportive environments performing acts of care in conjunction with the human actors (carers) in a synchronized environment of care.

THE PROJECT GUIDELINES/THE MODEL OF CARE

The project brief that has guided the development of the New Hospital clearly guided by the Model of Care for the unit. It states:

> The Model of Care outlines specific areas required for the management of acutely behaviourally disturbed, acute adult psychiatric patients, acute aged psychiatric patients, secure extended psychiatric patients and mother and baby psychiatric patients within the ED and the New Facility Psychiatric IPUs.
>
> BH is committed to providing culturally sensitive care to the people in its catchment. Ensuring cultural sensitivity in the Psychiatric IPUs is of particular importance. (p. 248)

Following this statement is a 120 page detailed specification for the needs of the hospital. It is too extensive to recount here, but what is notable are the key and consistent spatial and service requirements for this mix of patients. The following are some of these:

> The patient centred approach to psychiatric care will mean that, as far as possible, patients and carers are informed and involved in the decision making process in relation to all aspects of care (17.2: 252).

On the nature of facilities to address patient safety:'ensure new and refurbished mental health inpatient units meet new safety guidelines, including removing ligature points, installing air locks and facilitating gender separation' (p. 252). This includes 9 guiding principles spanning sight lines, lockable bedrooms, levels of security appropriate to patient population, separation of genders for some units (17.5.4: 257-258).

In the overall description of the accommodation (p. 258) the following are some of the listed requirements:

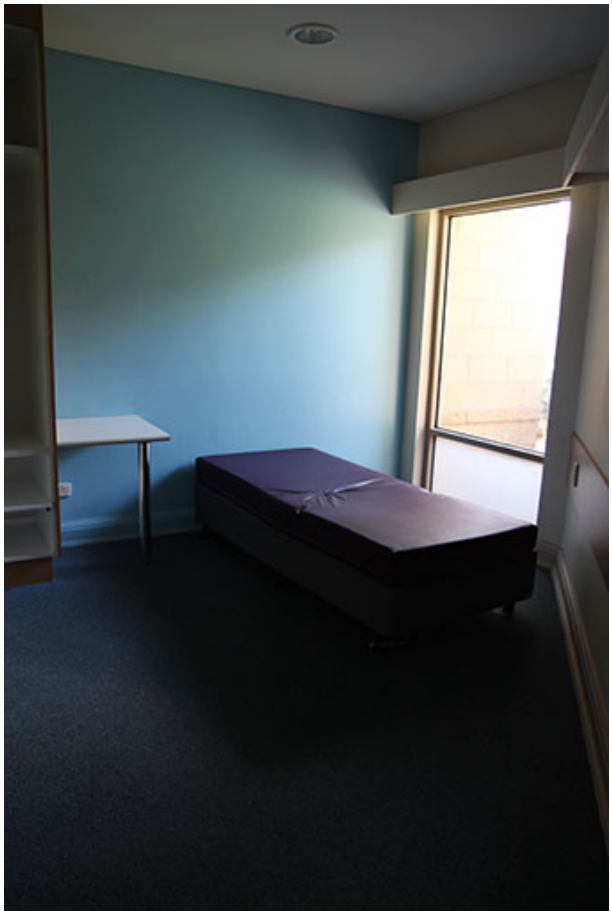
All services must be tamper proof
There must be no ligature points
No sharp corners, ledges, protrusions. Etc
Special consideration of the load bearing of potential ligature points such as curtain rails, towel rails etc. and hung in a manner that will collapse when 15kg or more is applied
Maximize opportunities for controlled privacy and recreation of patients
Provide a domestic rather than institutional-style setting

In the overall description of the accommodation (p. 258) the following are some of the listed requirements:

OLD HOSPITAL

The following images were taken minutes after the departure of the patients from two of the Old Hospital sites. Having visited the site on a number of occasions it was amazing how quickly the space had transformed from being a busy place of care to one of dereliction. Almost immediately the heartbeat of the units was gone. Apart from patient personal items, almost everything else was to be left behind. Most strikingly doors, that are normally locked were wide open. Remarkably in this short time what was a productive space of care, was rapidly transforming to a ruin (Edensor 2005). To return to Scarry and the proposition that buildings provide care, perhaps once the care was no longer needed the space too, like an employee was made redundant.

As we roamed the old hospital site, the arrangement of chairs, and the odd and aged collections of chairs was a constant source of fascination for the researchers. This furniture with its fatigue surfaces and lines of wear were an odd collection of things that both seemed to reflect those that had found respite in them, a disparate community brought together through issues of ill health, and a weary model of care that the new facility hoped to rejuvenate. In the ethnographic interviews people reported that the facility was 'homely,' now that it was empty of people, we sought to see if this quality was still there.



In the interviews of both patients, care staff and the architects, light was a theme that emerged. The carers and designers were keen that the new facility would offer light and air and the associated therapeutic advantages this would bring. Patients were not so sure, many found safety in the dark.

The message tree played a significant part in sense of community in the old hospital facilities. Departing patients were encouraged to leave messages of hope and well being to other patients. They would write messages on pieces of paper which the nursing staff would then stick to the tree. For the caring staff the tree performed an important role in building community and they were concerned about its demise in the new facilities. As well as being positive contributors to the life of the hospital community the tree was also at times put at risk by patients with messages being pulled down, trees kicked in or the like. The caring staff would make sure to copy the messages before posting them to the tree and if things went wrong they would then remake them and post them.

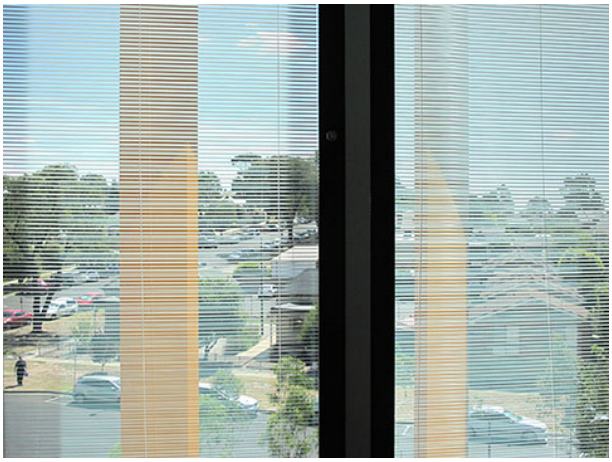
It was during one of the walks that we encountered a tree painted on a wall by a patient. This tree seemed much darker than the message tree, and presumably was painted not long before their departure to the new facilities.

Locks and security are essential to such psychiatric facilities. Designing the locks and handles for the new hospital was a substantial point of discussion for the design and development team. Locks that are secure but with handles that can't be used for self harm.

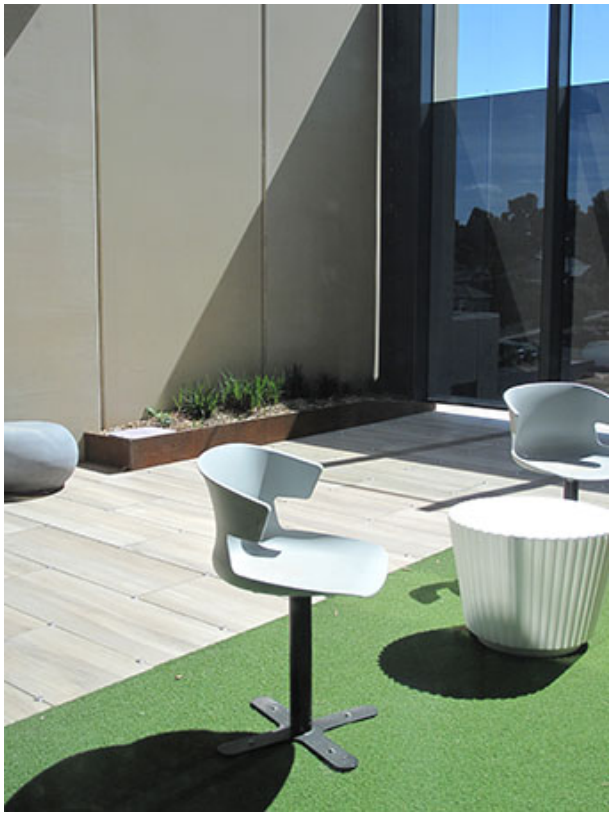
On walking through the empty spaces and encountering open doors and unsecured locks was a shock. It took the researchers a little while to realize what was different and almost wrong. We were free to move around the space unsupervised.

NEW HOSPITAL SPACES

The following are the images of the new hospital in waiting. Again as was the case with the Old Hospital site, the practice of noticing was applied to the documentation of the yet to be occupied zone. We encountered spaces, lines of sight, material surfaces, decorative patterns and built in structures that were waiting; again in a Scarry like way, to begin its work of care. Care for patients, and for staff – all of the agents of the ecosystem of care that is a psychiatric unit – material, spatial, environmental and human. This time however our practice of noticing seemed a little less pure or responsive to the ethnographic interviews. In this instance we found ourselves documenting in response to the first series of images, seeking out the same and the different.



It soon became apparent that the new hospital has been built with a grand vision and at a different scale of height and purpose to the old facilities. The grand facades and entrance ways, with their long views and almost corporate waiting areas reflect current aesthetics of interior design, material finish and qualities of light and air. The institutional qualities of the old hospital seem absent.



The new facility is elevated on the second floor of the hospital and the outside spaces are secured and private but not on the ground. They seem to have an extension to the pristine and colour coordinated interiors. The mix match of the furniture of the Old Hospital is gone, and the arrangements of the chairs, both indoors and out, seem to encourage connectivity.

As you make your way through the spaces it is not only this focus on colour and light that is mesmerizing, and there is also the explicit use of curves. Curves can be found everywhere – chairs, handles, floor patterns – presumably with the aim being to promote a sense of safety and calm.

CONCLUSIONS

None at this time – this is a work in progress. In this project we have coupled the greater research project intention with an exploration of noticing as a methodology to seek out lived experiences of habitation and care and propositions for future ones within a particular hospital context. The images are prompts for future insights that will be coupled with the extensive ethnographic work that is being undertaken.

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