SAFETY AND SECURITY IN THERAPEUTIC ENVIRONMENTS FOR THE MENTALLY ILL

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The closure of big psychiatric institutions moved clients in the community. Various strategies have been employed for the treatment and care of the acute mentally ill. Scientific knowledge on the design of facilities is still limited. The purpose of the study is to explore client focused architecture in the community for clients in the acute stage of their illness or recovering from an acute episode, and to investigate if design can be therapeutic for them. The thesis revisits and re-evaluates the concept of domesticity. It is proposing that more "domestic" environments, with respect to clients' needs, could contribute to the therapeutic procedure. The project intends to identify the degree the domesticity of the buildings. The buildings were analysed based on three compartment models: **safety/security, competence and personalisation/choice**. The cultural character of care indicated a comparative approach. The Acute Mental Health Unit in the UK and the French "Foyer de Post-cure" provided the research basis. The 7 year study set out to compare the provision of care in 5 UK and 5 French units and involved the participation clients and staff. Three research methods were employed: semi-structured interviews, questionnaires and architectural checking of the building. The issues of safety and security are examined in relation to the restrictions that may adversely affect the domesticity of the units. Yet, domesticity can seriously compromise the safety and security of the clients. Aggressive behaviour and tendency to harm themselves is high among clients. The building has to cope rather than ignore these facts. Furthermore, safety and security are juxtaposed to the competence of the clients as another possible cause of deviation from a domestic environment since it might require spatial adaptations. Also, safety and security are compared to regimes that relate to space personalisation and choice. The effects of the environment, in the form of the three parameters on clients are examined. The issues taken into consideration regard the size and layout of the unit, its location, connections to other services, its external appearance, decoration, fittings and furniture, availability of interior and exterior space. The study concludes with design guidelines that enhance therapy.

Introduction

Psychiatric care has gradually moved from hospital to community based options,

not necessarily under the same pattern around the world. Experimentation and lack of sound scientific knowledge was a major parameter behind the de-institutionalisation attempts. Variations rotated around the role of the hospital in the new regimes, from central in the system to being replaced by community based services, again varying even in the same country both in terms of network and facility provision.

Facilities for the mentally ill in the community

The varying approaches provided a web of options but which have not being thoroughly researched to allow the movement from experimentation to a more evolved model of care. The plethora of facility options combined to the fact of inadequate funding regarding the architectural research of those settings generated a gap in scientific knowledge regarding environments for the care of the mentally ill. In other words, the architects, when asked to design for mental health could not refer in evidence based guidelines to back their solutions. Anecdotal evidence and "personal" references together with the frequent lack of briefs were problems that professionals frequently come across in most countries when dealing with mental health projects.

Precedent Research

This piece of research, which is part of a PhD programme at UCL Bartlett School of Graduate Studies, aims to put together the knowledge from various fields, to provide a ground of dealing with the issue. Literature review started with the history of mental health and its physical milieu of "treatment", to locate the origin of stigma and institutional remnants that can still find their way as prejudices among the system. Then, it dealt with the theories and trends of community psychiatry and care provision so that the proposed solutions could come to terms with the care they are asked to serve. Architectural theories were also gathered to identify the areas of current focus and knowledge.

Defining Domesticity

A common factor that rose was the move from more coercive to more "client friendly" options, following the gradual movement of people to the community. Domesticity was the term that could identify this trend, but which needed definition to fit in to context. In other words "what means domestic or domestic looking" in a psychiatric environment?" which should be the limits of domesticity so that oversimplification does not limit the therapeutic role of the environment? The study revisits the concept of domesticity in psychiatric environments for acute mentally ill, as opposed to institutional origin design, to identify its meaning 'boundaries". Here a brief introduction to the people it is intended to serve is necessary, be it a client – focused study.

The client group

The adult mentally ill are an heterogeneous group of people aged between 18-65 who could be: "Formally diagnosed as suffering from mental illness, who might suffer substantial disability as a result of their illness, or display florid symptoms or are suffering from a chronic, enduring condition and might experience frequent admissions or frequent need for intervention as well as being at risk of harm and self harm (Royal College of Psychiatrists, 1998). Dependency level and pathology are two broad criteria for their classification and the stage of the illness can influence both behaviour and needs.

According to pathology, clients could be broadly divided in two groups design implications-wise: the agitated and aggressive on one side and the depressed that stay quiet and withdrawn (Davis et al 1979). Historically there were attempts to segregate clients according to pathology, but recently acute wards have tended to cater for a variety of diagnoses and the two groups co-exist in the wards. Therefore, the environment has to be able to cope with both of those contradictory situations. In this project the client grouped constituted of clients of both genders in an acute stage or recovering of an acute episode, who were admitted in CMHC for the UK and foyer de Post cure in France. Sixty five clients of the ten facilities were recruited according to their willingness to participate in the interviews. Pathologies varied, as it was expected by the current admission policy, with psychotic disorders forming the majority. Fifty five members of staff were also interviewed on issues related to clients' safety, competence and choice and the visited buildings.

The three parameters model

In the architectural literature domesticity in psychiatric care was not related with family housing. Facilities ranged between normal housing and a clinical environment with "touches of normality", like the scale or materials. Yet, domestic was the term predominantly used, as opposed to other accommodation forms like student hostels or hotels that appeared as positive building stereotypes in health-care architecture.

It is also understandable that in a discussion about domesticity cultural issues and differences between the countries may arise. Differences in mental health can be found both in theoretical background, i.e., Cartesian vs Empirical school, and in diagnostic tendencies (Prayer 1988). Helman (1994) confirmed the relation to culture and normality, and therefore culture and mental illness, and specified differences in diagnosis influenced by the Anglo-Saxon and the French rationalism respectively.

In this study domesticity is examined in the first step closer to the community than hospital. Because of cultural aspects two countries from entirely different theoretical contexts, were examined. Thus, the UK ward in Community Mental Health Centre and the French Foyer de Post Cure provided the physical milieu for the research. Ten case studies were examined in architectural and policy terms.

In order to measure the domesticity of the psychiatric facility, a model of three parameters was created. It comprised of three axes' that gathered the therapeutic elements and purposes of space in order to cater for the needs of the mentally ill. Those parameters included Safety/security, Competence and finally Personalisation

and choice

Mental illness has implication in several practical aspects concerning the life of the individual, some of them with disabling effect as they encounter various difficulties in coping with stresses in their personal, social and vocational lives and even if they recover, there is always the possibility of relapse. Risks include harm and self-harm violence and abuse, vulnerability, substance abuse, self neglect and noise (Royal Colledge of Psychiatrists 1988). The danger of harm or self-harm formed an important area of psychiatry, under the term dangerousness. Under this term, psychiatrists bore responsibility to assess the possibility of an act of violence in the future and impose obligatory hospitalisation (Liaskos 1990). In acute wards the risk of harm towards other patients or staff was 1:20 and the risk of self-harm 1:8, which was small, but still real (Sainsbury Centre 1998). Safety and security in psychiatric environments are not solely architectural issues, since people and policies are important to this, but the buildings could be of significant importance on the issue.

Competence refers to the clients' ability to retain a degree of independence in terms of sustaining oneself both physically and socially with capability for independent living being the optimum. About the disabling effect of the illness Osmond in 1957 made a grouping of issues regarding visual perception, auditory sensation, time, tactile and olfactory senses, perception of own body and mood. Yet, reasons other than pathology, like poor resources, can compromise clients' offers and increase boredom or "incapacitate" them. The Audit Report on violence indicated direct connection of boredom and violence (2005).

Personalisation and choice refer to the degree of freedom that the client can achieve inside a facility. Personalisation and choice were limited in institutional environments of the past, which started as coercion mechanisms, with a gradual increase of those elements in recent years to even more liberal attempts of "anti-psychiatry" movement. Staffing levels and training, stigma, resources and design could interfere with the clients' interaction with the facility.

The Checklist

Architecturally, for that Purpose a checklist of 212 points was constructed. Checklist aims to quantify and put on a scale from Institutional to Domestic the participating projects according to purely architectural and spatial characteristics. Those spread from the exterior to the interior, from the broader area location and the general layout to details like curtains and WC fittings. Each question corresponds to one institutional point. The organisation of the checklist is, from the general to the specific, but further analysis can regroup the findings according to the three parameters: the questions that refer to safety, or to competence or choice. So each facility or country gets an overall score according to domesticity and this can be juxtaposed with the peoples view or the architects view of the project but then again it can be subdivided in sub-scores related according to physical areas (like the location, the garden or the living room, so there is again direct comparison to peoples view of those areas) as it is also feasible the division and re-grouping of the questions according to the three parameters. Thus, if a unit is relatively institutional compared

to the rest the next step is to see if that is because of increased safety measures, or low personalisation opportunities or does not allow clients skills to develop or incapacitates them which again this can be correlated to the relevant topics on the client and staff interviews. That way one can triangulate that the spatial organisation comes to terms with therapeutic aims of thr building, according to the architect-researcher interpretation and if that perception is validated by the users and experience it from inside, be it clients or staff. That way, priorities are viewed under a new perspective. Conditions that architects might consider institutional on the first place might increase people's safety sense of the building, so being after all not as threatening as the word implied or architectural interventions that intended the best, such as elaborate corridors might compromise the sense of safety. Under that perspective architectural opinion and perspective gets tested by the professionals that strongly interact with the clients (mainly nurses and nursing assistants), but who again might have their own motives and the voice of clients themselves, who come again with their limitations (motivation, understanding of topics, trying to sound politically correct, healthy etc).

Conclusions

Detailed results are still pending. However, so far data analysis that has not been yet finalised indicates that spatial design should take domesticity theory implications into account to create safe, dignified and adequately stimulating environments that can ease people's lives. Yet, immediate translation to design implications of theories could lead to oversimplification, unless architectural and policy parameters are juxtaposed to staff and clients views.

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