

Therapeutic environments for the mentally ill Domesticity aspects

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**This presentation contains part of a Ph.D. research
carried out at the Bartlett School of Graduate Studies
under the supervision of Prof. Julienne Hanson**

De-institutionalisation



aim

- the suitable physical milieu as opposed to institutional environments in community care facilities for mentally ill people.

Common concern between countries

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 the available “tools” to professionals.

Domesticity

“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 client group

- both genders
- in an acute stage or recovering of an acute episode
- admitted in CMHC for the UK and foyer de Post cure in France

Client focused

Involvement of 65 adult clients of mixed pathologies and of both genders, in two countries

Involvement of 55 staff members who spent time with clients (like nurses, assistants, ward managers) in two countries

The three parameters model

- Safety and security
- Competence
- Personalisation and choice



Safety
and
security



- 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



Rene Capitant. Client's shared accommodation. (Triple room)



ELAN. Client bedroom.

- 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



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- Personalization and choice refer to the degree of freedom that the client can achieve inside a facility. Staffing levels and training, stigma, resources and design could interfere with the clients' interaction with the facility



Small Health. Watch panel window on ward's bedroom doors.



Les Geraniums.
Client shared bedroom, with en suite facilities.

The Checklist

- included 212 points
- Categorised according to a scale from Institutional to Domestic the participating projects
- Comprised purely architectural and spatial characteristics.

Interviews

- 23 broader topics for clients
- 30 broader topics for staff

- All staff and client interviews gave valid responses and the percentage of valid and accurate responses were very high among both user groups.
- The interview questions had been prior been piloted in a non participating in the final sample acute unit in London, and the changes that rose from the pilot were directed to increase the clarity of the questions.
- All clients and staff interviews of the ten case studies were of the required quality to include them in the final group, and the majority of the individual replies were to the topic and in particular for the clients, did not justify their exclusion from the sample group due to their state.

- Not only staff, but clients as well can be included in the dialogue for the assessment of the old services and the delivery of new facilities

- The checklist produced a ranking of the participating projects according to the domesticity factor regarding the facilities.
- The results were not related to the stage of the illness the facility was designed to cater for.
- Acute wards could score higher than post cure both in the Checklist and among the participants, if the therapeutic regime and the environment were in good co-operation.

Institutional features per building

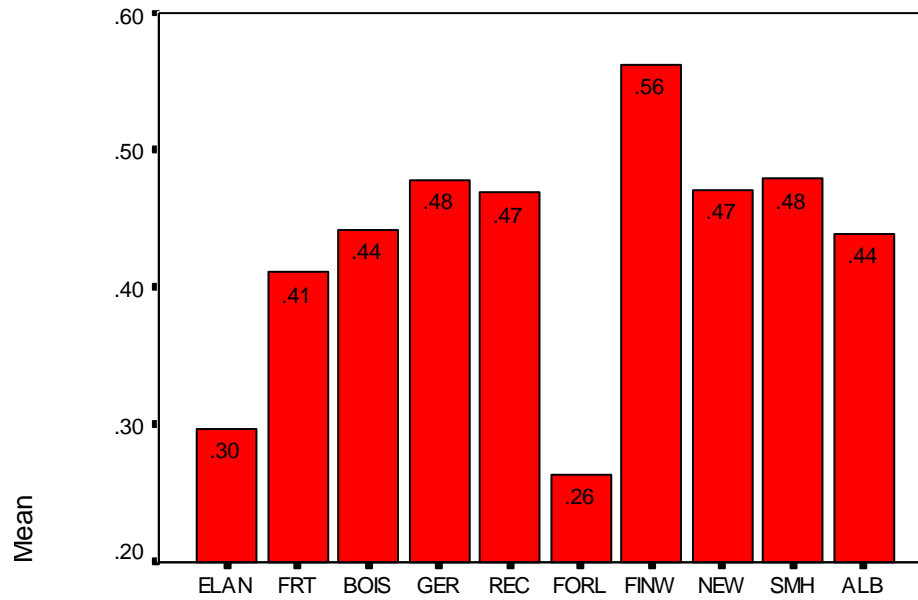


Figure 1

- in order to have environments that support therapy, architectural good intention are not enough. As among others, the actual function was related to the staffing levels and the links to the community, not as theoretical availability but as actual use determined by the functional limitations.

- Yet, poor premises with low standards scored low in domesticity terms, even if they catered for more stable clients, as the example of Rene Capitant and Geraniums foyers de post cure indicates, and their spatial inadequacies found their ways in the interview responses.

Conclusions

spatial design should take domesticity theory implications into account to create safe, dignified and adequately stimulating environments that can ease people's lives

Yet, to achieve that staff and clients should be actively involved.

- . Users can be actually involved from the planning stage, and that could include both staff and client representatives groups.
- Avoiding user involvement, might lead to compromise in the therapeutic procedures and overall satisfaction despite big investment in infrastructure.
- Research based data from existing facilities, together with briefing from the staff who will operate the facility and client representatives groups can lead to designed tailored to the needs of the care program, the most effective use of the facility and its better fitting in the broader spectrum of services, as well as the smooth running of the life inside it.
- The list advanced above can bridge the gap between the brief and the actual planning while allowing enough creative space in the design of each mental health facility. At its minimal usage the checklist provides the red lines in architecture design for the mentally ill.

Thank you