Episode: *Ethics Talk: Participatory Design in the Spaces and Structures of Mental Health Caregiving*

Guest: Stefan Lundin, MA
Host: Tim Hoff
Transcript: Cheryl Green

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[00:00:05] [mellow theme music]

TIM HOFF: Welcome to *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff. Picture an inpatient psychiatric health care facility. Chances are likely that you imagined an older building, probably with whitewashed walls. Maybe there are patients in shapeless gowns. Some of this image likely comes from media portrayals of these institutions, movies like *One Flew Over the Cuckoo's Nest* and similar. But the image of psychiatry being housed in older and less desirable buildings, or in those originally designed for other specialties, is one grounded in fact. Our guest today, architect Stefan Lundin, has observed this trend throughout his career.

STEFAN LUNDIN: A lot of psychiatric care inherited premises from the somatic care, but it's obvious that in many places, psychiatric clinics had to, I wouldn't say they are not the first one to put up their hand and said, "We need new facilities," and they won't be listened to.

HOFF: When psychiatric health care is relegated to secondhand buildings, especially those like inpatient psychiatric units, which are physically distanced from other commercial and residential buildings, the social status of those receiving treatment and of psychiatry itself is undermined by stigma around mental illness. This can mean that patient care suffers. When patients at inpatient psychiatric units are not cared for in spaces that meet their needs, the design elements of these buildings can negatively influence how patients and how staff interact with their environments. Building layout can limit outdoor access and natural light. It can introduce difficulty for staff in carrying out the duties of their positions, and it might require the institution of patient safety measures that potentially compromise patient healing. Stefan Lundin, an architect with over 40 years' experience in healthcare facility design, joins us to discuss the design of inpatient psychiatric units and how architects and health care staff can work together to design spaces that promote patient care and healing. Stefan, thank you so much for being on the podcast. [music fades]

LUNDIN: Yeah, thank you for having me.

[00:02:20] HOFF: The relationship between architecture and design choices that promote patient health and those that promote patient safety, this relationship being what you call the "healing and safety complex," can be represented by three principles used by your team when designing new health care facilities. So, to begin with, can you introduce our listeners to these principles and how they influence both the delivery of care and the patient experience in the health care setting?

LUNDIN: Yes, I'll do my best. But first of all, I think as an architect, I think the most challenging thing in this kind of project exactly to find a good mix between healing and safe environment. And I think that's the most, as I said, the most important challenge, because that will have a great effect of what we could say the atmosphere. And that has a great importance, I think, for

patients and so on. So, I think that's the most important thing as an architect and very important questions when you start a project like this.

Coming back to the three points that we had at that time, the first thing was good care and high degree of safety should work hand in hand. And I think that should be, has to be understood in the context of the old facility at that time, because their working environment was quite hard. And there was I would say obstacles in the everyday work. And they, as a staff, you want to get rid of them because the main thing as a professional is, of course, to take care of the patient and treat them and take care of them. So, that is maybe the core problem. But another thing or maybe that's a main idea or concept that is the aspect of healing architecture, that if you could offer a healing architecture, that would always, I would say, increase even the safety for the good of the patient and the staff.

[00:04:39] Secondly, we said safety must not compromise the healing environment. And maybe that could sound a little bit provocative, but because at that time, I would say, when you're talking about safety, you always talked about safety for the staff. That was always number one. Now we start to talk about the physical environment and if that could be a tool to increase... increase the safety, then you have to deal with the question about the physical environment. So, that was very, very important. And I think looking back, that was a trend around the millennium shift that you find out that the physical environment and you know all about the stuff about evidence-based design, all these questions come up and have a newer, brighter, more...a discussion with some kind of depth.

And the third thing was said safety must be there, but hidden and non-provocative. And that was quite interesting because I think both architects and staff realized that if you had a very, could we say, hard environment that was influenced by safety measures, that could be perceived as negative or tricking the patients, and I think, and that could have a counterproductive aspect. And I think the staff and the architect agreed on this. So, things that should be visually apparent and less aesthetically pleasing, I would say, that was things that we tried to, could we avoid them, or could we hide them? And we're talking about things like bars, sluices, fences, vandalism-proof finishes and so on. And the thought, and even other things like the rattling keys from staff and noisy and blinking call systems were things that we thought could we avoid them, it should be in the good for the patients and so on.

[00:06:58] And we later on, we have also seen some research showing that an environment where you have the, your number one idea to increase safety by more safety measures, it now and then seems like they have a counterproductive effect actually. So, at this time we were looking for an environment, we talk about non-institutional appearance. That were things that we looked for at that time. And all of this, I would say, ends up or start with an idea about what we call "negative reminders." And that's a concept or could be connected to the concept within the environmental psychology that's called "positive disorders." I mean, things that could get the patient to think of good things and not just of his own situation and his ill-being or sickness. And that was the idea that we shouldn't have safety measures that could get the patient to think, "I'm here. I'm not worth your caring," and doing all this negative thinking. We try that to turn that around, to actually get the patient to, and the environment, to tell him or her that not thinking about his own problems, so to speak. Yeah, that was kind of some kind of introduction to a very long discussion that we had. But I think we all agreed on the importance of the physical environment as a tool, even, to decrease the problems with safety questions.

[00:08:54] HOFF: At the beginning of your response, you mentioned obstacles that the staff were facing in carrying out their duties in caring for patients, in doing all the administrative work

that health care workers need to do. Can you elaborate on what some of those obstacles were with a poorly designed environment?

LUNDIN: Yeah, I would say they would.... I would say kind of small problems in one way, not that shouldn't appear, I would say, in a facility in a good condition. But at this time they had problems with alarms. They had problems with sluices, locks. They had problems when they should escort persons to doctors, to the garden, and so on. So, it was kind of a lot of small practical problems, I would say.

[00:09:46] HOFF: You also mentioned that the primary focus of discussion used to be on the safety of staff as they cared for patients in psychiatric facilities. But obviously, we're also interested in balancing the safety and healing of patients themselves, and that balance in the design of psychiatric spaces can at times seem contradictory. For example, health care workers and architects might believe that patients require both an open and free experience, while also requiring a closed and locked environment to keep some patients safe. So, how does an understanding of the healing and safety complex help resolve those apparent conflicts?

LUNDIN: Yeah. [chuckles]

HOFF: It's another hard one.

LUNDIN: Yeah, another hard one. Yeah. I mean, if I start in this way, I mean, it's obviously there, when we're talking about psychiatry, we have a lot of different diagnoses, different patients with different disorders. And then they all need their special care and their all special staff, so to speak. So, and of course, that is also reflected within the physical environments that should support all those different demands. But I think normally when we're talking about psychiatry, we're talking about we try to find generic design wards that could be used for many different kind of disorders from depression, bipolar, abuse, and so on. So, but within all those different wards, they also have to deal with the problem and what you kind of call both the private or public demands. I mean, we all want to have those more open, free and open, spaces for the areas where the staff and patients are supposed to socialize and because resocialization is a great part of how to recover as a patient. But on the same time, we know from research that you have to have your own place where you can rest and you could recover and increase your power, so to speak. I would say every clinic that know their patients and what kind of the degree of illness of the patient to decide whether such facilities and what actually are needed in the special case. It's hard to tell by a discussion like this.

[00:12:33] HOFF: Hmm. Yeah, that leads well into this next question I have about participatory design, which is the practice of including staff members in the planning work of architectural design. And apparently, it's a relatively common practice in Sweden, but our US-based listeners are likely to be unfamiliar with it. So, can you introduce us to participatory design and outline the types of contributions that health care staff members might make to the design process?

LUNDIN: Of course. Participatory design could be done in different ways, but I think in Sweden, there has been for the last 30, 40 years I would say a standard approach to have this participatory design process. And I think that it has a good value for the planning itself, and it's important even for the staff when they're getting to work within the new building. But as I said, I mean, participatory design is all, it could also be seen as a renaissance from political ideas that was formulated in Sweden during the '60s, '70s, and so on, where you were supposed to have...could contribute to your work environment and so on. But I think even for the future, I think, as I said, a good day, is a good point to have start working from both the floor and the

management. But I think looking forward, and I think it's an idea that we're dealing with now and then it's we also would have patients and relatives involved in that process, in the problem in the future. How this will be done could be discussed, of course.

[00:14:32] But another thing that might be a little bit special for Sweden is that almost all those hospitals we're talking about here, they are owned and driven by the county council. And the county councils in Sweden, there are 21 of those. They have a very great discussion and information conferences in between each other. So, it's a very open discussion that might not be relevant or natural in a more market-driven society. But I think when it comes to, I think the most important thing in this process is actually to what we could say inform the architect to make a better work. How could the architect, by doing these all different proposals by drawings, models, and so on, how can they start a discussion, a dialogue that would be inventive to start innovation in some way? And I think that's what actually happened now and then. Of course, you've got a lot of input on small details that you should take care of during when you're making all the drawings and so on. But there will also now and then have great influence how the organization, how you would organize the ward, the treatment and so on. So, that might have a big impact on all the how you organize the treatment, the health care itself. And I think that's a very important part of all this process that actually could have a very great value in the long run.

[00:16:28] HOFF: In a recent piece, you referred to an "architecture of psychiatry." How would the design elements to promote healing and safety differ in the architecture of other specialties, or I guess, would they? And what do those differences tell us about what health care workers and health care space designers think is important to patients?

LUNDIN: Yeah. In general, I would say, I mean, architecture for psychiatric, it's just like an ordinary architectural task. You must try to understand how the environment is experienced by the users. You have to, [chuckles] to walk a mile in their shoes. You need to have the discussion with the profession and I think maybe even with patient and patient's organization in a broader perspective. So, I think to say it short, in a wide sense, as an architect, you always have to do what you call maybe an artistic interpretation of the prerequisites. So, we had a number of those programmatic standpoints. I could just number a few here. A good first impression, a dignified environment, avoiding the institutional stigma, a free and open atmosphere, directly accessible gardens, successive enlargement of the personal sphere, neutral consultants' rooms on the patients' terms, and so on, and we had a few of those programmatic standpoints. And of course you can say a lot about each of them, but I think sometimes it could be hard to find out whether those are fulfilled or not. But I think it could work as a tool when you have the discussion with the architect and you can see the different proposal, I mean, then you can judge, did this proposal give you as a patient, as a staff, or a relative, a good first impression? Do they find the environment dignified? Do you think, would it avoid, would it talk about an institutional stigma and so on? Would you find the atmosphere free and open or not? I mean, all those things, it's things that you actually could talk about within this design dialogue between staff, management, and architects. And in some way, you can judge the proposal in that way good or bad: Does it fulfill these demands or not?

[00:19:17] HOFF: Yeah. Let's talk a little bit more about avoiding institutional stigma, because stigma is a big part of both providing and receiving psychiatric care that we haven't really talked about yet. So, what are some of the ways that architecture is trying to dismantle and avoid the stigma traditionally associated in part through architectural and design choices with facilities like inpatient psychiatric units?

LUNDIN: I mean, if I take the example of the Östra Hospital that I know quite well, I think maybe I could point out two different things. The first, one of the first things that the clinic wanted, they wanted how could the patient get access to gardens? I mean, we know all that nature has a good influence on recovery and so on. And that meant that we should avoid buildings more than two floors. Maybe even one floor would be the very best. So, I think we try to, and we managed at Östra, to make small gardens. And those gardens in the Swedish context were enclosed within the locked wards so the patient could walk out into the garden at different times of night and day. I would say that was the original idea. Now it's, I would say, restricted, but you can get a good access to gardens. The other thing that was kind of you can say we were asked, could you make a non-corridor ward without? Because corridors, I mean, that's a kind of, that's kind of an institution, I would say. And we tried to organize a plan around a small art room. And I think we were lucky to find an atmosphere that I would say is non-institutional, and that's of course, depending on what you compare with. But you can get the reflection of maybe a hotel or something like that, or so it's kind of other typology in some way.

[00:22:00] HOFF: Hmm. Yeah. I'm glad you brought up Östra, this new, I guess at this point, new-ish facility that you and your firm worked on. But unfortunately, most clinicians work in facilities that are already built, and they lack the opportunity for input on design choices as early as the initial construction, or to engage in any of this participatory design that we were talking about earlier. So, what can clinicians and other health care staff do to increase the healing and safety capacity of their workplaces that don't require, for example, installing more windows or rearranging corridors or things like that?

LUNDIN: Yeah, and of course, that's a very tricky question. And I feel like, I don't know, an academic. I'm sitting on my back at the office and just having a glimpse out of different premises all over the world. I mean, I would say the first thing you can do that you could try to open your eyes and look, and what do you see? I think that could be a starting point. And as I mentioned before, the concept from environmental psychology, when we're talking about positive distractions and negative reminders, you can think when you look at the environment, what give you positive vibes? What give you negative vibes? What would decrease or increase your stress on your possibilities to heal and recover? Because if we think that the physical environment is important—and I think that most of us think it's important—and it seems like now and then it has a very great impact. Of course, it's the staff is the most important tool within care and treatment, of course, but the environment, physical environment may play an important role. So, what we see now and then that is that you don't look at upon your environment. And we're talking about something that I think in English would be called "everyday deterioration." Do you know what I mean by that?

HOFF: Right, like wear and tear.

[00:24:23] LUNDIN: Yeah. I mean, you don't, other, you don't see what's around you and whether it's tidy and maintained and so on. It seems now and then, and it could be, of course, due to economics and other things, but if you find that the physical environment is important, you have to deal with those questions. And I know that this deterioration is going on, on more or less every hospitals in Sweden. And what you can do is stand up, and I think small changes may give big improvements. [theme music returns]

[00:25:13] HOFF: Stefan, thank you so much for your time and expertise on the podcast today.

LUNDIN: My pleasure.

HOFF: That's our episode for this month. Thanks to Stefan Lundin for joining us. Music was by the Blue Dot Sessions. To read this month's full issue on the *Psychiatric Inpatient Environmental Architecture* for free, visit our site, journalofethics.org. While you're there, you can find all of our content, including past issues, more podcasts, and continuing education opportunities. Follow us on social media @journalofethics for all of our latest news and updates. And we'll be back next month with an episode on Global Supply Chain Security. Talk to you then.