

CONVERSATIONS



Using the Design Process to

# CREATE SAFE AND COMFORTABLE

## Behavioral Health Environments

An Interview on Behavioral Health with Francis Murdock Pitts

### INSIDE YOU WILL LEARN ABOUT:

Why relationships are at the heart of successful psychiatric treatment strategies.

How effective designs can facilitate positive interactions between clinicians and patients.

The benefits of using a community treatment model that allows patients to access services in carefully designed “neighborhood treatment malls.”

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**Francis Murdock Pitts**

Francis (Frank) Murdock Pitts is the founding partner and president of architecture+. He has more than 30 years of experience in the planning and design of psychiatric healthcare facilities for special populations, long-term care, and secure institutions. He is a leader of the AIA Academy of Architecture for Health and the American College of Healthcare Architects. He previously served on the FGI Guidelines for Design and Construction of Hospital and Health Care Facilities committee.

## Using the Design Process to Create Safe and Comfortable Behavioral Health Environments

### **How did you get interested in the behavioral health field, and how have your early experiences influenced your approach to design and planning for long-term stay psychiatric facilities?**

I worked as a recreational therapist to put myself through college. This provided me with a first-hand view of how patients and staff interact and helped me understand the challenges and opportunities that exist in behavioral health facilities. About four or five years later, I was working at an architectural firm and a project came through to renovate a 30-bed forensic hospital. I had just completed a monastery project and I had an idea that these two types of facilities were similar. The challenge for both settings was how to create a space where people could come together to live and work and where interpersonal relationships were a driving force. I realized that it was not the facility, nor the services or the buildings, that mattered most in a hospital but rather, how the doctors and nurses related to the people they treated. The design could serve as a framework to support these interactions and make them more effective.

I also had two conversations that reinforced my belief in this approach. First, a physician told me that the best safety measure in his hospital was his understanding of his patients. This meant that we could use all of the safest hardware and furniture, but if it was not in an environment where the staff members could understand the patients, they couldn't do their jobs.

Then, another psychiatrist also shared with me a dream he had of the hospital being a treatment village. This made me think about the fact that a lot of therapy is done in remotely located rehab centers and you have to invest a lot of work to get patients there. This reminded me of the early treatment mall models used in New York state in the early 90s, which were found effective to shorten patients' length of stay in long-term settings.

Over the years, these insights have had a profound impact on how my colleagues and I approach the design and planning of behavioral health facilities for different populations.




**Can you explain more specifically how you applied these early insights to strengthen your design approach for special populations? What have you done differently based on what you learned?**

I ultimately applied what I had learned to adapt the general treatment mall idea to create a broader community treatment model that includes homes, neighborhoods, and downtown areas in our longer stay and tertiary care hospitals. This design model locates the treatment mall close to the inpatient unit and includes a downtown area with all of the services you would find in a community or on a college campus, such as a gymnasium, café, and library.

My firm's most effective use of this strategy is the Worcester Recovery Center and Hospital in Massachusetts completed in 2014. This is a replacement hospital that is a long-term stay facility. What we discovered was that with this community/neighborhood model, patients begin to use the movement through the community as a way of expanding their world outside of their room. Such a community/neighborhood treatment model enables staff to understand patients better as they watch them interact in different settings. It also gives staff a chance to see how patients' confidence grows as they venture out into new territory.

We also moved the consult, group, and treatment rooms into the mall. This means that treatment malls and neighborhoods ended up being more like public spaces in schools and community centers and patient residences ended up being a more normative residential setting like a college dormitory suite. We try to tuck away the nursing support so the patient experience can be focused more on their own residential space but with safety checks in place. For instance, we have to be able to clearly position the bedrooms so that they are all in view of the nursing station and are no further from the nurses than they would be in a traditional model.

Further, as we were experimenting with this design, I realized that if we could take a 24-bed inpatient unit and make it into three suites that each contained eight private bedrooms and a living room shared by the eight residents, the smaller cohorts of patients would be more family-like and this would make it easier to navigate relationships. I also found that this could help reduce violence and aggression among patients. This was something I had learned in the past

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when working with artist colonies. I had noticed that smaller colonies operated well without rules, while larger colonies required posted formal regulations. This helped me realize as you bring more people together, the need for rules to maintain order grows.

### **What advice based on your experiences can you offer others working on these types of projects?**

It's important to understand that there is significant diversity in how people approach treatment for the mentally ill. Therefore, designers need to ask a lot of questions. You need to understand the person in front of you. No two hospitals should be the same; each one is different. We typically share with new clients what the drivers have been for other clients as a way of exploring the possibilities in their own psychiatric hospital.

Some of what I believe that was once unusual in the field has now come to be grounded by research. For example, I feel it's important that architects and designers do whatever they can through the built environment to relieve stress and use environmental features to reduce violence and aggression. Some of the factors that can have a positive impact are all of those things that The Center for Health Design and the concept of patient-centered care has taught us, such as incorporating natural light, ensuring views of nature, providing access to the outdoors, offering a choice of one activity room or another, and offering a choice of where to sit in public rooms, such as by a window or in a quiet alcove. When people have a choice of where to be, they are less likely to become dangerous to themselves or others. Designers should also plan spaces at the end of hallways with light where patients can sit and look out, still in a public area but where they also have privacy.

Another consideration for designers is about patient safety. We helped develop a patient safety guide for the State of New York about 10 years ago. There was a huge change from the past in terms of the theory about patient safety, both related to the breadth of things you have to be concerned about in regard to patient self-harm, and also in the need to make things bulletproof and to use corrective fixtures. We have to be dedicated to doing this in a caring and respectful way, though, and avoid looking like a correctional facility. We need to



create a warm, comfortable place of caring, but now we know it must be safer than the psychiatric hospitals that date to about 10 years ago.

Our focus on creating facilities that are safe but also comfortable for patients has led us to do a lot of work with the industry to help develop products that are safe and don't look like they came directly out of a correction facility. Now, we have a huge market for such products because CMS and Joint Commission put a huge emphasis on patient safety. The new construction and renovation markets in mental health have grown significantly, creating a real need for them. To give you an example, when we began our work in the field, our bathroom design included a lavatory that stuck out with an ugly trap and supply enclosure below and a stainless-steel mirror above. The arrangement was ugly and the lavatory could be looped, posing a suicide risk. Now, we have a built-in lavatory in a niche with a mirror filling the area between the niche walls from the backsplash to the soffit and the light above the mirror. This is safe but it also looks like it could be in someone's home.

### **What are some of the specific challenges that you recommend other architects and designers think about when planning behavioral health facilities?**

Compliance is always a concern in medicine. You want someone to get treatment when they leave the inpatient facility. There are some models in urban settings that co-locate outpatient services and they take in patients to the outpatient location for a short period before discharge. This helps patients become comfortable in the setting and more likely to continue when they are discharged from an inpatient stay. When there is a flow of patients moving up and down along a coordinated continuum of care, staff gets to know the patients better and there is more consistency.

Another challenge that people are grappling with is how to integrate psychiatric emergency department (ED) services with general ED services. Some options include setting up a separate ED for behavioral health visits, creating freestanding services focused on mental health, or offering integrated services. It boils down to figuring out who is in charge of medical clearance when medical and psychiatric professionals co-exist.



### **Can you describe some of the other types of design models you've seen and/or are working on for a behavioral health population?**

We are currently working on a very large child crisis facility, where we have created a freestanding ED. We also have medical staff at the psychiatric crisis center to provide medical care. Additionally, there's very interesting work going on in Portland, Oregon, where crisis services' staff are teaching police and paramedics how to identify and manage psychiatric patients in ways that avoid hospitalization, including the use of trained mobile mental health crisis teams. This does change the utilization of the crisis center and the ED.

Twenty years ago, when we did our first major psychiatric ED department, a 24-hour stay was about average. Today, we are working with people who are targeting four to five-hour stays on average. That's actually quite remarkable. To manage a shorter stay, staff must be able to manage the volume, have a mobile crisis team to divert people to services, manage inpatient beds, and have access to a bed when there is a need. Patients also need to be able to access outpatient services when they are discharged from an inpatient stay.

### **When approaching the design of a behavioral healthcare long-term facility, do you focus only on the interior or is the exterior important as well?**

Both the interior and exterior are essential in creating a warm, welcoming environment for patients.

Look at the Worcester project and at The Vermont Psychiatric Care Hospital. Both of these are very good psychiatric hospitals but neither one of them looks like one. That's deliberate. You can look at the common spaces in Worcester and see how much they look like a college. Further, Vermont recently received two awards from the International Academy of Design and Health, including winning the category for interior design. This is unheard of for a behavioral health facility and really speaks to our growing focus on aesthetics, while still incorporating all of the necessary safety measures.

Then there's Nationwide Children's in Columbus, Ohio, which is building a freestanding behavioral health facility. Nationwide Children's is a place that has a strong brand-driven idea of what constitutes their patient experience and how



the campus should look. They were able to stay true to their brand's look and feel while creating a safe place where behavioral health needs can be met. What all of this illustrates is that a psychiatric facility does not have to look like one, inside or out.

### **How have things on the treatment front changed since you began working in this field and how have these changes influenced the design process?**

There are three major advances in medicine that are starting to have a big impact on the design process and scope of facilities. They include: imaging, genomics, and a focus on early diagnosis and treatment.

First, let's talk about imaging. This is thought to be a missing piece of the diagnostic puzzle in treating mental illness. Mental illness is an organic illness that manifests itself in behaviors, so imaging to understand the illness is going to be increasingly important. People are doing interesting things when we are able to locate imaging suites near psychiatric hospitals so that access can be gained while mental health usage volumes are still low. In Ontario, a community's imaging facility is right on a psychiatric hospital site, which is very rare to find. There are other technologies that also have to be incorporated into the design of facilities. For instance, at the Kings County Hospital, there's a clinician who uses acupuncture as an adjunct in the treatment of addiction. I think the question for designers to ask clients is around the types of procedures a facility is using and the types of patients being treated. It makes a huge difference in the design. Another example is with anesthesia, since the use of general anesthesia or relaxants that might impact a patient's capacity for self-preservation has huge implications for safety that need to be considered when creating the design for an electro-convulsive therapy (ECT) suite.

Then, there's genomics. Keep in mind that part of the hard truth of mental illness is that it is partially a matter of genetic predisposition. So, genomics is going to be increasingly important. There are places like the University of Colorado Medical Center developing facilities where personalized medicine and psychiatry are brought together.



Finally, epidemiological studies have looked at the onset of mental illness and how and when it is diagnosed. One study looked at the relationship between the length of time between the first onset of psychosis and the treatment and outcomes. It is not unusual for someone to go two years between their first psychotic break and their first treatment. Think of a heart attack. Can you imagine anyone going two years after a heart attack before seeking treatment? In both mental illness and cardiac events, a lot of damage happens in the interim. The reality is that a lot of work in long-term stay hospitals is dealing with people whose course of disease was not addressed earlier. The cost burden of mental illness is the highest of any other disease in the United States. A lot of the cost burden stems from lack of treatment. As we get better at intervening at an earlier stage, the effectiveness of treatment may be improved.

### **Looking to the future, what should designers think about in order to build effective and flexible facilities?**

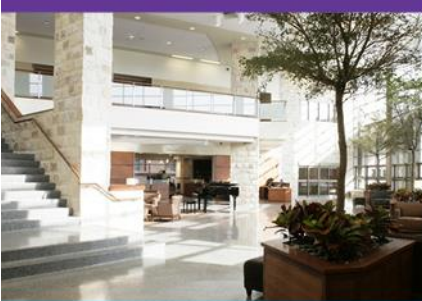
Think about this. If people begin to get treatment earlier, you may suddenly find that the volume changes, as will the need for, and the nature of, long-term care facilities, so it's important to think about flexibility. We are not far from the place we were with tuberculosis hospitals in the past. The minute someone figured out how to treat tuberculosis, the need for these hospitals went away. A lot of people are coming to understand now that the needs for psychiatric hospitals will be changing, too. It is still a way off into the future but already, we have a lot more outpatient services going on now than we did 20 years ago.

When we began the Worcester project, the average length of stay was three years. Their care model aimed to drop this down to 365 days, but it actually ended up going down to 100 or so days. That is a dramatic change for a long-term stay facility. Getting the treatment mall model in an intermediate and long-term stay hospital gets active treatment off the units and locates them in a place where as many people as possible can access this without adding burdensome patient transport costs.

Another important thing to reflect on is that the act of designing the building is as important as the building itself. That's because building a building, or renovating a unit, in psychiatry is a rare event. It happens far less often than at a general hospital. It's important to see the capital event as an opportunity for

 Planning and designing a new facility, or renovating an existing one, is not just about changing the physical environment but rather, using the design process to help a hospital transform the culture.





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institutional change, and to offer a way for the design process to encourage and allow the clinical staff to re-invent their culture and clinical processes.

Planning and designing a new facility, or renovating an existing one, is not just about changing the physical environment but rather, using the design process as an opportunity to transform the culture and experience of care.