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The times

Psychiatric wards in DGHs? An architect's comments

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"Little as we know about the way in which we are affected by form, by colour and light, we do know this, they have an actual physical effect." Florence Nightingale, *Notes on Nursing*

More funding may be available before long to provide much needed additional psychiatric accommodation in, or attached to, district general hospitals. It is likely that those responsible for organising the building programmes and preparing briefs for architects will think in terms of modifications of existing models of medical or surgical wards, but in my view this can so easily lead to the wrong design solution.

My own interest in design for mental health care started when I was invited in 1988 by the City and Hackney Health Authority to work on the conversion of a ward to form an acute psychiatric unit at St Bartholomew's Hospital. Very little had been published on designing for the treatment of acute mental illness, but thanks to an RIBA Research Award to study recent examples in the UK and abroad, I was able to visit a number of recently completed ward units and day centres in the UK, Europe and the USA. It was during these visits that I formed the opinions given in this article on basic design problems of accommodation for psychiatry.

I hold the view that the worst place to build an acute psychiatric facility is in a medical or surgical ward block of a general hospital. The envelope is fixed, the services are fixed, even the location of utility rooms has been fixed, and the problems of a brief which should be designed for therapeutic care of patients who do not spend their hospital days in bed, and who will have totally different day-time activities, cannot be solved satisfactorily by a standard hospital ward layout. No amount of empathetic care can offset the wrong basic layout; this was evident in most of the units in general hospitals which I saw on my tour.

Too often, a poor design results from either an inadequate brief, or the architect's failure for that reason to understand the method of therapy and the activities to be provided for within the unit. Thus an understanding of the day to day life within the unit, for patients, staff and visitors, should take one beyond the mere schedule of accommodation.

There are other aspects of design to be considered; the following are personal views, stimulated by seeing both good and bad examples in the countries visited.

Firstly, regarding open space; there are few patients who cannot enjoy and get benefit from a garden, courtyard or roof space, yet it is surprising how often opportunities to provide this are neglected. The degree of security required is a design factor, but if research has shown[1] that a patient's recovery is quicker after an operation if there is a pleasant view from the surgical ward window, it follows that usable outdoor space will help in the psychiatric ward. A private facility at Nashville, Tennessee designed for the Hospital Corporation of America has an excellent example of a small courtyard garden; nearby in the building is a conservatory rising through three stories of the building with opportunities for patients to handle plants. This was an original and imaginative feature in a splendid building.

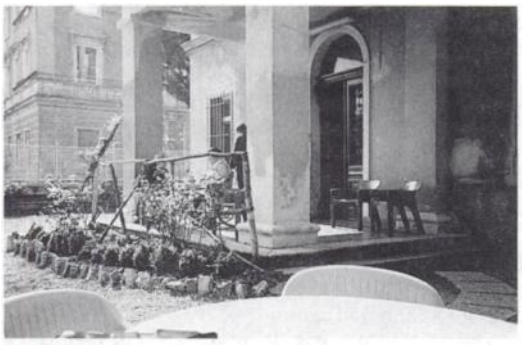
I was also impressed by the way in which some facilities aimed to provide a reassuring and domestic atmosphere. The patient, no longer in an institution, is now in a clinical environment, but to aid mental therapy and care, the ambience should be an extension of home, and a domestic approach is needed; this will be seen in the materials, the colour and textures of the surroundings. This goes beyond the choice of 'the right pictures'; by the time these are chosen, the damage may have been done.

To what extent can the design of the building, whether ward unit or MHC, provide in itself a form of therapy, through the patient's environment? Soon after I started my tour, I coined the word 'locotherapy' and in visiting about 25 widely differing units (the selection was empirical, but chosen with reference to psychiatrists and architects working in this field), I tried to find some common factors, and reached conclusions from what I thought included both good and bad examples.

A sense of location is all important. The race-track ward is a failure; one should avoid too the long corridor without windows. The reassurance of relating to outside orientation is vital. It can be done with corridor breaks giving pleasant views of the outside world. The architect/designer should be able to handle space and volume to advantage; particularly in conversions of old structures where interiors are often more generous in size and height. A superb

Gambini MHC, Trieste: day room in the attic, pleasant domestic environment achieved within a small budget.

Barcelona, Hospital of Sant Pau: spacious interior of the day room in the drug-dependency unit.



Barcola MHC, Trieste: the entrance portico; a sheltered space between the centre and the world outside.

example is a drug-dependency unit at the Hospital of St Paul in Barcelona; converted from a 'Gaudi-esque' building of *circa* 1902, in its time, a very advanced design. The arch-supported ceilings were exceptionally beautiful, and the day-room below opens on to a well planted courtyard.

Privacy and community are in a sense opposites; one needs a gradation, a progression of privacy, to have on the one hand an open and social environment, and on the other, a personal and private space. This aspect has been examined in great detail by a team at Berkeley led by Professor Alexander.[2] Incidentally, one of the first visits I made was to Trieste; the 'open door' policy never fails to produce argument and controversy in the UK when I have discussed it here, and sometimes even amazement in the USA. However, I felt that I learned much about the design possibilities of MHCs from my visit, and admired the way in which freedom of movement was respected throughout the Centres. I have described the planning of these facilities in my report to the RIBA.[3]

I sought out also the use of colour, light and texture. Bright colours can excite, but that is no excuse for keeping to a brown and cream colour scheme; as I was told in two hospitals in the US, "we're moving out of earth colours now". Some patients may benefit from a stimulus, but it is seldom realised that it is the colour of light itself that is as important, and this can be the source of apparent warmth; cold colours can be used too to offset warm ones, and rough textures such as wood seem warmer than smooth ones such as plaster or metal.

Finally, way-finding is as important for the patient in need of mental health care as any other, perhaps more so, not least on entering a strange building for the first time, and should be seen as part of the interior design, not as labels to be added later.

Buildings for mental health care have a function to fulfil, and their layout must facilitate clinical needs and medical requirements, but for the patient there is also a need to provide a background of re-assurance and comfort. It is my belief that design can assist therapy, given dialogue between designer and therapist, and in the first place the right choice of site.

Acknowledgement

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References

[1] 'A room with a view', a research programme at Pennsylvania reported in *Science*, US, 1984.

[2] C. ALEXANDER *et al* (1977) *A Pattern Language*. New York: Oxford University Press.

[3] Psychiatric Wards in DGHs and Some Alternatives, the author's full report to the Royal Institute of British Architects, London 1991.