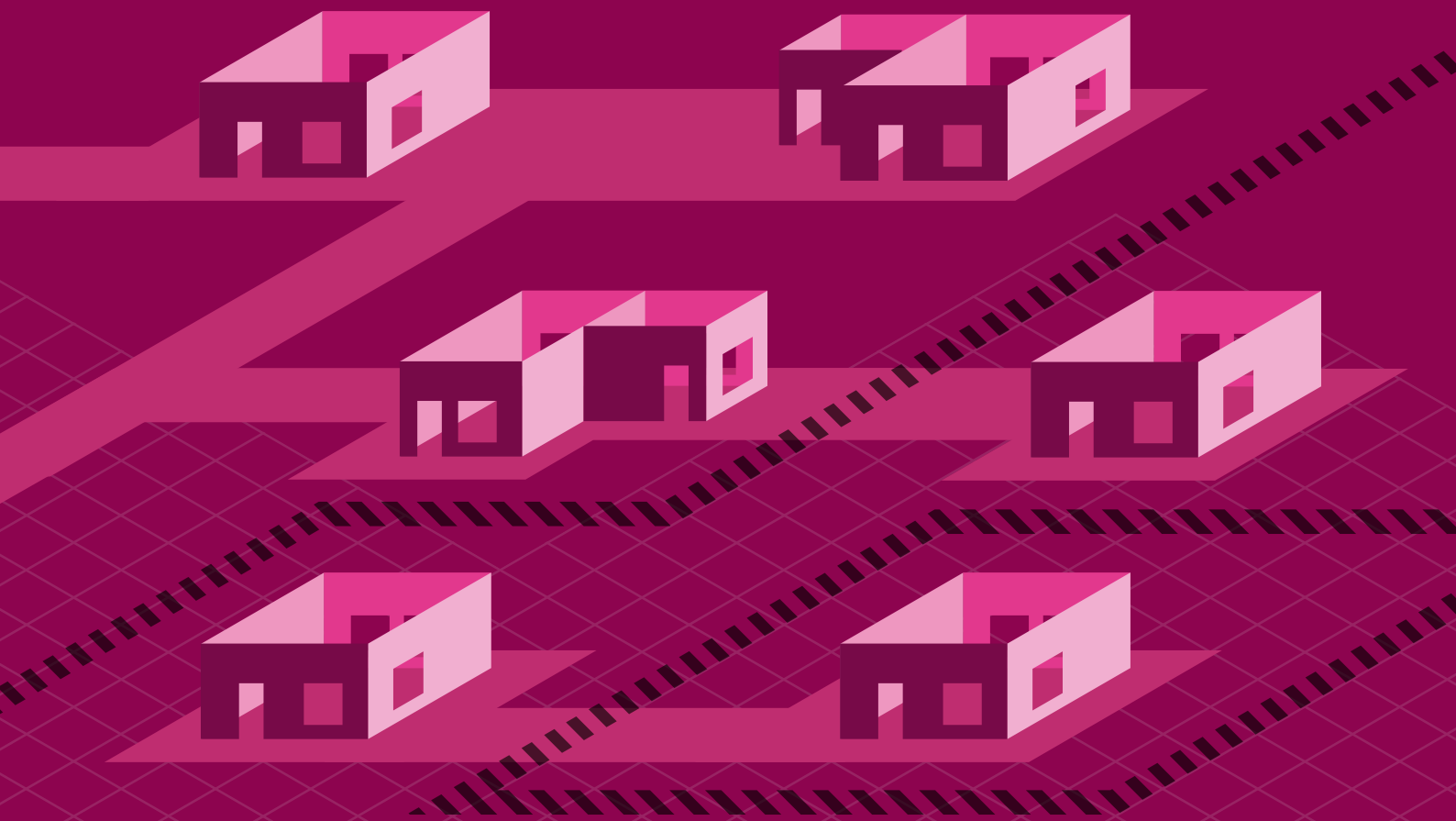
Design With
People in Mind

Borders & Boundaries



Design in
Mental Health
Network
LIGHT | SPACE | HOPE

Welcome to the Research and Education Workstream of the Design in Mental Health Network. We are committed to the development of an evidence based resource, to inform decision making and improve experiences within mental health services

Contents

Design with borders & boundaries in mind

This publication is the sixth in the Design with People in Mind booklet series and we are delighted this year to present material on the topic of borders and boundaries. So much of hospital design is about creating spaces for privacy and observation, whilst retaining dignity and reducing risk. How we make these decisions about dividing up space to create borders and boundaries requires us to consider not only the physical and material aspects, but also the psychological and social dimensions. This publication addresses these issues with these social and psychological dimensions in mind; in other words, with *people* in mind.

This edition reviews the available literature relating to a number of topics around boundaries and borders. In addition, we have interviewed a range of people who use mental health services, experts by experience, as well as buildings and estate managers and clinicians. The aim was to draw on their expertise of living and working within and across borders and boundaries and hear about what they have learned from reworking space to enhance well-being.

We are all aware that the pandemic has brought with it changes to the way in which we work and live. Many of us have changed to remote working and witnessed our homes transform into places where we live and work. This blurring of the boundaries between work and home has had a profound impact on how many of us feel about our homes and lots have struggled to know how to carve up our space in a way that creates sufficient boundaries between these different versions of ourselves.

We draw on the expertise here of people who have used or worked in mental health services, to learn from them about how they have created boundaries that enable liveable spaces that preserve privacy and retain dignity, which are the necessary foundations for recovery. We hope that what we can learn from COVID and from people who use services will enable us to think more closely about boundaries in the future, given their importance to our sense of well-being and belonging.

In keeping with all other editions, we wish to emphasise the importance of the relationship between environments and people; that treatments and interventions are shaped and emerge from the spaces that they operate within. Our vision, as always, is for this evidence to be put to good use and to benefit those who live and work in mental health care environments, both in services and in the wider community.

Professor Paula Reavey
(Director and lead for the Research and Education Workstream)
Professor Steve Brown
Donna Ciarlo
Katharine Lazenby

> *"Within* 15 steps *you should be able to get the sense of an environment, so the crossing of the border is also the crossing into a convivial experience."*
>
> [James]

Making Borders & Boundaries

The symbolic and psychological significance of doors and borders

The doors in and around mental health hospitals and wards are prime examples of the dual function of barriers. A door is not only a physical, material barrier but can also act as a symbolic barrier signifying power boundaries between patients and staff, a concrete reminder to patients about their lack of freedom (Muir-Cochrane et al., 2012). The main door to a ward may only be opened by authorised ward staff, which has been shown to provide patients with a feeling of safety, whilst simultaneously inducing feelings of helplessness (Lindgren et al., 2019).

Entry thresholds are the transitional spaces between the inside and outside world (Padmaperuma et al., 2020) and first impressions to mental health environments should be comforting (Chrysikou et al., 2020) and anxiety reducing. Whether patients are visiting a mental health hospital for the first time, returning from a walk, or for readmission, the entrance can evoke distress and stigmatise.

Frustration can be heightened when patients require ward staff to admit them in and out of the ward spaces. Security passes issued to staff confirm the hierarchy of accessibility in and around a ward (Muir-Cochrane et al., 2012). Duque et al. (2020) found that when door passes are provided to access wards freely, the spaces within the ward are experienced differently and corridors can become seen as places to circulate and socialise, or as 'break spaces' outside of units. Increasing access can alter the atmosphere of a ward, where a greater sense of agency is felt.

Whilst risk and safety in mental health environments are critical issues, the use of locked wards to keep patients safe from harming themselves and others has been questioned (Huber et al., 2016). Being in a locked environment can be experienced by patients as dehumanising and traumatising (Slemon et al., 2017).

In a 15-year, observational study across 21 German mental health hospitals, Huber et al. (2016) found that locked wards saw no reduction in suicide attempts and in contrast, hospitals with open wards saw a decrease in attempted suicide and absconding. The study suggests that for patients a sense of trust and liberty may increase well-being and in turn feelings of safety.

Counter-intuitively, attempting to abscond is not primarily related to open doors on the ward but instead with a lack of privacy (Slemon et al., 2017) and, in the case of forensic mental health units, with unsafe environments, overcrowding and low perimeter fences (Seppänen et al., 2018). Rather than locking wards, staff engaging with patients and developing a sense of trust and respect is more likely to reduce absconding or aggression (Kalagi et al., 2018).

The attitudes of student mental health nurses provide further support for the view that locked environments can increase service users' sense of loneliness and despair, and intensify conflict and aggression (Missouridou et al., 2020). Establishing open-door policies promotes social relationships and enhances patient morale, reduces stigma, providing further freedom in the "therapeutic space" and diffusing frustration.

There are design solutions that can give patients a sense of ownership whilst retaining overall control to ward staff. Door technology and access management software has been successfully installed in modern adult and adolescent ward environments allowing service users the ability to lock their own bedroom doors, which increases patients' self-worth and reduces interruption by staff (e.g., Safehinge Primera, 2021). Patient safety is still maintained by providing staff with an override option to use in emergencies.

Doors on a ward are a physical barrier which can symbolise a lack of freedom and isolation. Whilst risk and safety in mental health environments is undoubtedly important, the significance of doors and the potential negative psychological effects they can have on service users and staff should not be underestimated.

> *"90% of all contact between patients and staff took place at the doorway of the nursing station which was made completely out of glass."*
>
> (Simonsen & Duff, 2020a)

Designing the central hub of a ward

Foss Park Reception (image courtesy of P+HS Architects).

Wards are usually organised around a central hub. The nursing station is often at the very heart of the ward, for ease of observation and administration. It is a place where a great deal of interaction between patients and staff occurs (e.g., Shattell et al., 2015). The design of this physical and symbolic boundary can set the tone for the whole of the ward space.

Nursing stations are typically designed with an anti-tempered glass barrier as a safety measure for ward staff (Southard et al., 2012). This glass can also act as a divide that reinforces relationships of power between staff and patients in psychiatric care (Andes & Shattell, 2006). This is especially the case when staff use the nursing station to make themselves unavailable to patients, or as somewhere to retreat to in times of disruption or disturbance (Shattell et al., 2015).

In a study looking at patients and nursing staff perceptions of the ward atmosphere before and after removing the nursing station glass, (Southard et al. (2012) found that when the glass boundary was removed, patients appreciated having greater access to nurses and there was no increase in aggression. Rates of seclusion also dropped 26% within the first year of an open nursing station.

In a similar study, Shattell et al. (2015) showed how the removal of the glass from the nursing station on an inpatient mental health unit led to a complete change in the way patients and nurses experienced the space.

The nursing station was initially enclosed with anti-shatter tempered glass and a small window for patients to gain staff attention. Staff who previously managed the window were moved to the back of the office and nurses and assistive personnel to the front. Opening up the material boundaries between staff and patients still maintained role boundaries but allowed for more interaction and supported the therapeutic relationship, in turn increasing patients' sense of psychological and physical safety.

Using materials like glass to give a sense of 'openness' in the design of nursing stations intuitively seems like the right way to increase interaction between patients and staff. For example, the architects for a purpose-built state of the art mental health hospital in Denmark designed a glass walled nursing station to diminish some of the negative power relations and open important social interactions between staff and patients (Simonsen & Duff, 2020a). However, whilst the glass wall boundary suggested availability, Simonsen and Duff (2020a) found that staff were often unresponsive to requests from patients, which had the effect of heightening rather than reducing the power relationships and hierarchies between patients and staff. The transparent wall also made staff feel intimidated and self-conscious, particularly when engaged in sensitive discussions, which led to the glass being covered with posters and notes.

Private spaces for nursing and other staff can establish clear boundaries between staff and patients. However, as the study by Simonsen & Duff (2020a) highlights, problems can emerge when staff are unable to access 'backstage' spaces. Physical and spatial barriers between patients and staff are important (Andes & Shattell, 2006). Studies have highlighted that when nurses have a place to retreat, they become more satisfied with the work environment and subsequently, have more valuable time for patients (Tyson et al., 2002). Designs which open up the nursing station also need to include other kinds of spaces of privacy for staff on the ward.

In order to maintain clear professional boundaries between staff and patients, designers may want to consider the materials used as boundaries around the nursing station and create adequate private spaces for staff to retreat or manage sensitive situations.

Making open spaces that foster relationships and community

Ulrich's (1991) theory of supportive design highlights the important link between wellbeing and social support (the feeling of being cared for by others), especially in times of distress. There are a number of ways in which designers can make borders within and beyond the ward environments that allow for social support with family, friends and staff.

On a child and adolescent inpatient unit in Minnesota, designers created "front porches" outside of children's bedrooms to support the transition between the private space of a bedroom and the social spaces on the ward (Trzpuc et al., 2016). The overall aim of these porches was to provide patients with a sense of control and calmness in transitioning across private and public spaces. Staff also found the porches were a space that supported treatment and building relationships with patients.

In their systematic review, Jovanović et al. (2019) suggest designing a range of spaces that allow for social but private interactions, to improve feelings of safety, and support recovery and the patients' transition back into the community. Providing spaces for patients to replicate some of the interactions they would typically have in the community may help them to overcome some of the barriers to maintaining social relationships with family and friends. They suggest that creating spaces in between the secure and open areas of the ward environments can provide a balance between safety, recovery and social interaction.

The concept of 'third places' developed by Oldenburg and Brissett (1982) refers to places that are neither home nor work, but vital spaces (Brown & Reavey, 2019) within communities, where people connect socially outside of home and working life. A study in 18 hospitals across the UK and Italy found that availability of 'third places' for families to

> *"The inclusion of a café... will provide service users with access to [a] comfortable and familiar space in a discrete but secure setting, alongside staff and visitors."*
>
> [Marc, Greater Manchester Mental Health NHS Foundation Trust]

meet off the ward had a significant influence on patient treatment satisfaction (Jovanović et al., 2020). Creating more home-life environments may increase patient satisfaction and well-being, improve treatment outcomes and aid recovery, in turn reducing the likelihood of rehospitalisation.

Mental health hospitals often have designated family rooms, which are significant in helping patients to maintain their family relationships whilst in hospital. However, Isobel et al. (2015) found in one study based in Australia, that the family room in four inpatient mental health hospitals was used for clinical use 45% of the time, therefore disrupting the rationale and purpose of the space and restricting patients to traditional ward spaces.

The lack of 'family use' of these designated rooms may be also due to the location of the room within the unit. Patients are sometimes reluctant to have children visit when they have to walk through hospital spaces that may seem unfamiliar or even distressing to children. Isobel et al., (2015) suggests a less formal space for families to get together is needed, which does not resemble the space of the ward. Jovanović et al., (2019) suggest family rooms should be visible within the unit or placed just outside the unit entrance, be respectful of privacy, have a clear purpose, and be close to nursing staff.

Entrances to mental health hospitals designed with extended doorway spaces between the outside environment and the ward environment may provide a more calming and de-stigmatised experience too. It is widely understood that natural light is important for well-being (Connellan et al., 2015) and overcrowding in spaces can be stressful (Ulrich et al., 2018), therefore creating a larger and more open transitional space could alleviate some of the unsettling experience of going into hospital.

> "A discreet airlock where you come into the environment and it's large so you've got seating in there, a member of staff at reception, natural light coming in, so in theory you wouldn't know you were in an airlock." [Marc, Greater Manchester Mental Health NHS Foundation Trust]

Designers here are recognising the need for an open space which supports the patient experience of entering mental health care as well as maintaining safety.

Making spaces that allow for social interaction between patients, family and staff are necessary in mental health environments to support recovery; however, privacy and the availability of 'third places' for staff and patients are equally important.

Creating borders using sensitive lighting

The environment provides rhythms and cycles of activity that ground our mood and experiences (Cromby et al., 2013). Disruption to these cycles through the experience of acute distress and sudden hospitalisation can dramatically disrupt usual cycles of sleep, eating and other activities that are known to be associated with well-being. Designs which find ways to blur the boundaries and borders in hospital spaces, by making the space artificially resemble the 'outside world' can help to alleviate this disruption and subsequent disturbance.

It is commonly known that good lighting conditions may impact upon psychological well-being, task performance and motivation (Steidle et al., 2014). Sensitive lighting provides more than just a background to space; it is fundamental to how that space is experienced and the feelings and thoughts that arise there, affecting our mood, sleep patterns and overall well-being. Using dim and warm lighting can create a more informal and relaxing environment.

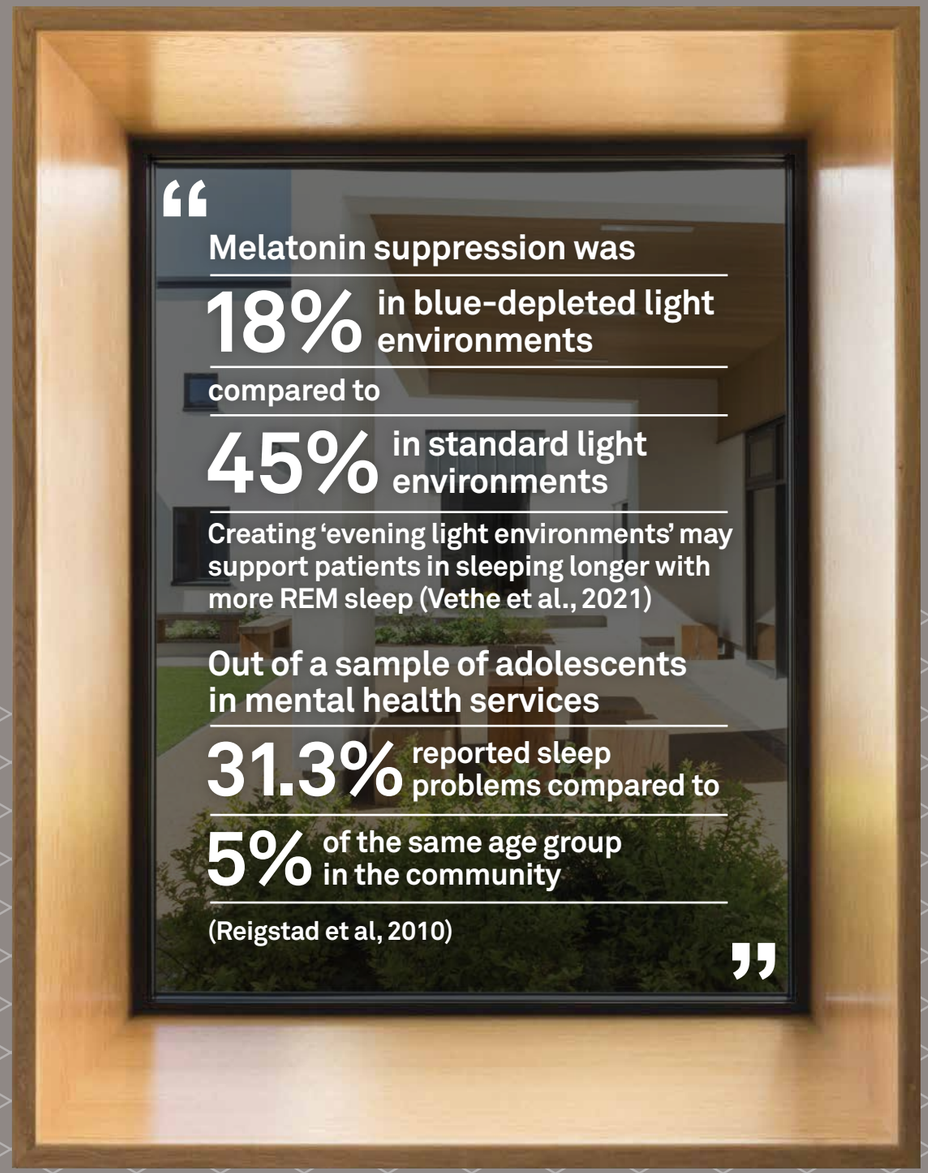
Sleep disruption is a common complaint among hospital patients, increasing feelings of distress and disturbance. Light affects the secretion of the hormone melatonin which carries 'time' information and is significant in maintaining a sleep-wake cycle, known to influence recovery and overall well-being (Scott et al., 2021). In contrast, poor sleep-wake cycles disrupt circadian rhythms and poor sleep exacerbates distress and suicidal behaviours, without appropriate sleep intervention (Novak et al., 2020).

Daytime and blue light have been linked to well-being, alertness, mood and cognitive performance and exposure to sunlight has been shown to relate to shorter stays in hospital. Circadian lighting blurs the boundaries between inside and outside. A Randomised Controlled Trial in a Norwegian hospital unit with blue-depleted lighting found that patients slept for longer and REM sleep was increased, compared with standard lighting (Scott et al., 2021).

Several hospitals across Denmark and Norway now use lighting systems that mirror circadian rhythms. There are several ways to adapt a ward with blue-depleted light; from installing bedside LED lights, supplying blue-lighting blocking screens for devices to changing the lighting system across the facility (Scott et al., 2021). Lighting systems that can improve sleep may be a welcome addition to mental health care environments where patients report high levels of insomnia (Veale, 2019).

Natural light has significant benefits to well-being and circadian lighting can improve sleep by blurring between day and night in mental health settings. Although, it must be acknowledged that there are other factors that may disrupt sleep such as intermittent nurse observations (Veale, 2019), with different sleep monitoring technologies available, there may be opportunities for blurring some of these barriers on a mental health ward.

Blurring Borders & Boundaries



> *"The limited available space on the ward was a real problem. This blurred the uses of the rooms, and when each space is associated with certain states of being… that created difficulties for some people."*
>
> [Katharine]

Maintaining boundaries and privacy through sight and sound

Occasionally, existing components of the built environment are repurposed for something other than their original use, without an accurate understanding of how people experience them. As an example, a dining room in an eating disorders service is often an uncomfortable and distressing space for patients. In situations where the room is used as a place of therapy, it is then experienced in another distressing way and can lead to unintended negative consequences.

It is well recognised that the patient's bedroom should be respected as their own private space (NAPICU, 2017). The bedroom is a space which allows patients some level of control over their psychological boundaries, resulting in a space where the individual can reflect on their time on a ward, as well as their past and future (Reavey et al., 2019).

And yet, the bedroom can also be a reminder of being detained on a forensic mental health ward when the bedroom door is opened and locked by ward staff. Technical risk features such as the removal of doors to an en suite bathroom or clearly visible door observational windows may also reinforce the sense of detention (Kanyeredzi et al., 2019). If patients are able to adapt and personalise the space without compromising security features this may help to blur the clinical design of the room.

The sound of a ward can also disrupt the privacy of the bedroom. One suggestion by the artist and service user David Parkin, has been to include micro soundscapes around the ward as transitional points between the ward and places of retreat (Brown et al., 2020). The bedroom may become a private space to retreat to and sanctuary if patients are able to control the soundscape of their room through calming music or natural sounds which mask the noise of the ward outside.

Bedroom spaces can sometimes be used for purposes such as dispensing medication or to run a therapy session. This blurs the symbolic boundaries of the division between private bedroom and public ward. Simonsen & Duff (2020b) describe staff using bedrooms to confine patients temporarily whilst managing an individual causing problems in the open space of a ward. This practice appears to run contradictory to the aims of the original design of the hospital space to balance privacy with social connection.

In a study looking at how patients experienced the purpose of specific 'zones' within hospital space, Donald et al. (2015) found that patients were often confused about how they were meant to use particular places on the ward, which in turn impacted upon recovery. Patients were confused about which spaces they could and could not use, whether the space was meant to be 'home' or 'hospital', and how to maintain privacy in outdoor spaces and on the ward generally.

Spaces can sometimes be designed without a clear vision of how they come to be actually used, due to constraints on staff time and resources or changing practices. A dining area designed to be used only for meals or 'confusing' glass walled treatment rooms may become spaces that are used sparingly or not at all, due to the lack of flexibility or privacy. Kanyeredzi et al., (2019), for example, describe how purpose built kitchens on wards in a medium-secure forensic unit ended up little used because staffing patterns were not sufficient to provide cover for cookery sessions with patients.

Donald et al. (2015) suggest one solution to the problem of use and flexibility is to designate a 'collective space of care' within the hospital where formal and informal interactions between staff, patients and peers is facilitated. Donald et al. (2015) suggest visible green environments, community gardens and areas that support social interactions and reduce feelings of boredom. The design, the use and planning, and the communication of spaces are all equally important to the social and physical dimensions of psychiatric environments.

Maintaining clear boundaries between the public and private is important, so that patients and staff can feel valued and respected; this involves not only maintaining visual boundaries in space, but also a consideration of acoustic boundaries.

Creating permeable boundaries during COVID

The COVID19 pandemic has presented numerous challenges to the functioning of environments which have continued to provide mental health services within their existing estates (Moreno et al, 2020). During the early phase of the pandemic, researchers in China rapidly identified that the relatively enclosed footprint of mental health hospital space, combined with levels of overcrowding, created perfect conditions for the rapid spread of COVID infections amongst patients and staff (Zhu, 2020). This led to the designation of some wards in units as 'isolation wards', with patients being transferred across wards to accommodate this new use of space (Chen et al., 2020).

Different strategies have been developed to create isolation space within mental health environments. Wang et al. (2020) describe how different hospital spaces were refurbished to create 'transitional units' to enable the isolation of patients with suspected COVID infection. In Germany, a strategy to create medium-term 'psychiatric COVID wards' within units was implemented. Adorjan et al. (2021) argue that these wards should be maintained for at least the next two years or for as long as the threat of COVID infection remains. An alternative to this is the repurposing of wards within infectious disease hospitals as dedicated 'psychiatric wards' (Wang et al., 2020). In the USA, patients with COVID symptoms were transferred into general hospital wards (Brody et al., 2021). In all cases there is a blurring of boundaries between mental health care and general health care, raising questions about the benefits and costs of physical co-location.

Changing the use of the space has been an inevitable feature of efforts to maintain social distancing and infection control during COVID. Moreno et al. (2020) note the use of less group sessions, along with reduced bed capacity and decreased admissions. This may have long term implications for the post COVID planning of mental health services or the 'new normal'. NAPICU guidelines produced in 2021 note that in some cases bedrooms and lockable areas of wards may have to be used as isolation spaces for infected patients who are experiencing crisis.

Again, there are potential negative impacts for patients here in blurring the boundaries between privacy and detention, especially in forensic mental health care. Gauderneck and Dudeck (2020) point to particular challenges on forensic wards around the compensatory measures which might be put in place to overcome social isolation in other mental health settings, such as providing keys to leave locked wards. They argue that different kinds of practices – 'a new forensic normal' – will emerge as the pandemic declines.

A CQC report in 2020 noted that social distancing measures and bans on visitors to inpatient units had been particularly damaging to patient mental health. A design challenge for the future will be to envisage how contact between patients and visitors can be maintained under future social distance or lockdown measures. The CQC report recommends relaxing restrictions on Wi-Fi access and use of mobile phones by patients to compensate for social isolation. Any normalisation of access to communication technology within inpatient mental health care is certain to impact upon future design strategies.

In Israel, experiments with the use of telemedicine have included conducting patient care and assessment over video-links in patient bedrooms (Pilsoff, 2021). Whilst this has circumvented the need for dedicated COVID wards, patient engagement with the technology was mixed and incidents of vandalism were observed.

The COVID pandemic has blurred both the symbolic and material boundaries of mental health care. Future ward designs will need to anticipate how infection control can be managed under similar conditions without intensifying social isolation. Planning for greater use of communication technologies appears to be an inevitable consideration.

Blurring Borders & Boundaries

"The learning [from COVID] is that with the lack of a facility, it makes you think more creatively on how to use the current space."

[Hamid]

Using outside spaces to break down the boundaries of hospital care

Outside spaces offer the opportunity to break down the boundaries of hospital care and relieve the pressure of confinement for patients and staff. Just 'being outdoors' was highlighted as a positive benefit to getting outside through an international online survey by those who discuss their experiences of outdoor therapy (Revell et al., 2014). Participants in the study highlighted that getting outside raised their self-awareness and opened them up to new experiences.

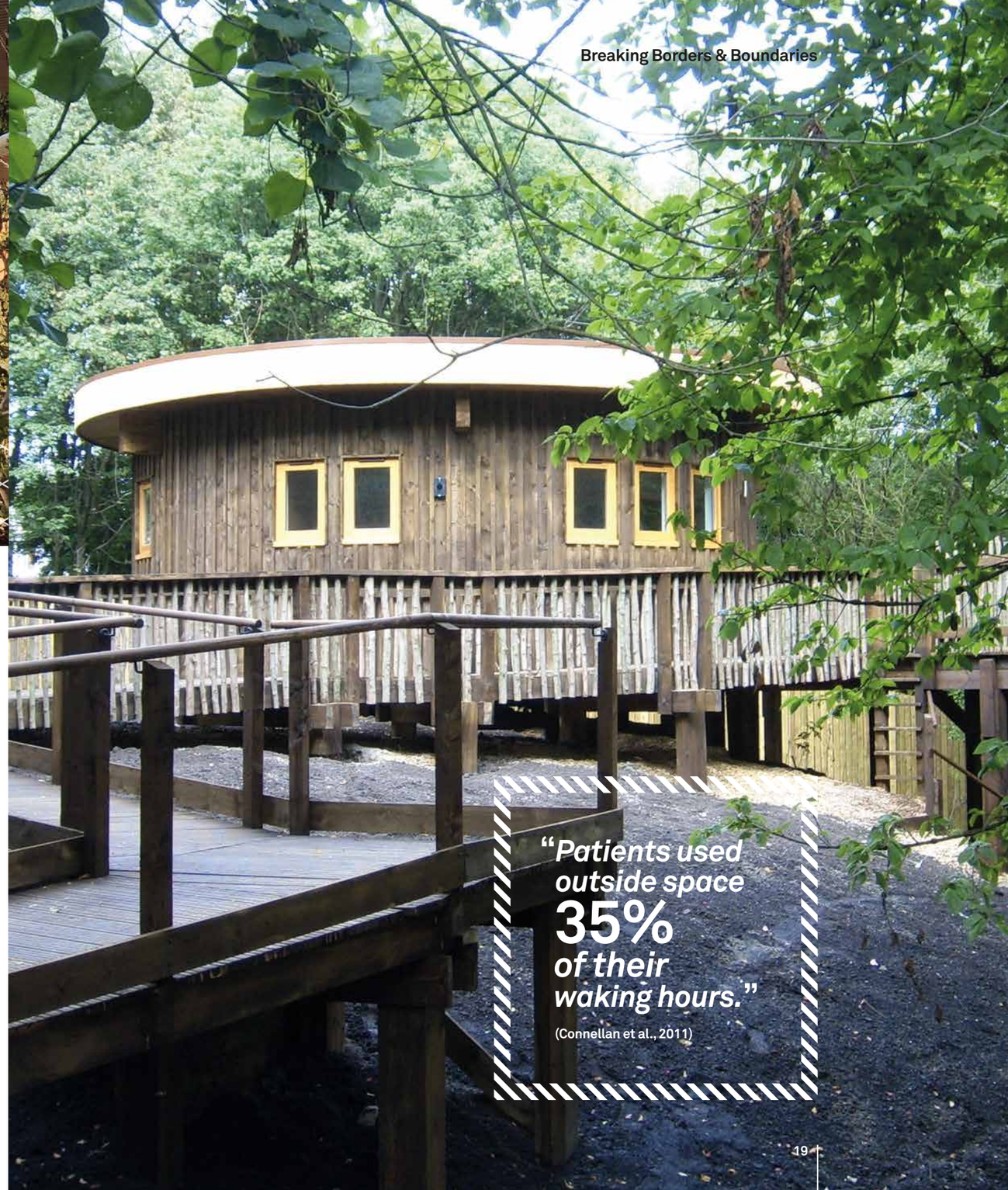
Substantial research has confirmed the physical health and mental well-being of adults spending time outdoors (Pearson & Craig, 2014) and of children and teenagers engaging in nature (Tillmann et al., 2018). Another important aspect that supports wellbeing within healthcare is the importance of control and positive distractions. Creating outside spaces that provide a place to retreat within the boundaries of the hospital environment can be a positive distraction (Ulrich, 1991). However, legislation such as smoke-free policies can hinder patient control and further stigmatise.

Trzpuc et al., (2016) reviewed 70 interventions to find that play and nature are significant for improving physical activity and social connectedness amongst children and youth in outdoor spaces. Areas such as secure playgrounds in child and adolescent mental health units can support physical, psychological and cognitive development, whilst connecting with nature can lead to a reduction in behavioural problems.

When patients are first admitted to a mental health ward, they report heightened anxiety and may feel frightened and confused (Chevalier et al., 2018). First impressions can leave new patients feeling claustrophobic, as they are shut off from the outside world (Chevalier et al., 2018; Connellan et al., 2011). In a high dependency unit, patients tend to be more restless and frustrated, but have little space to move and release tension (Connellan et al., 2011).

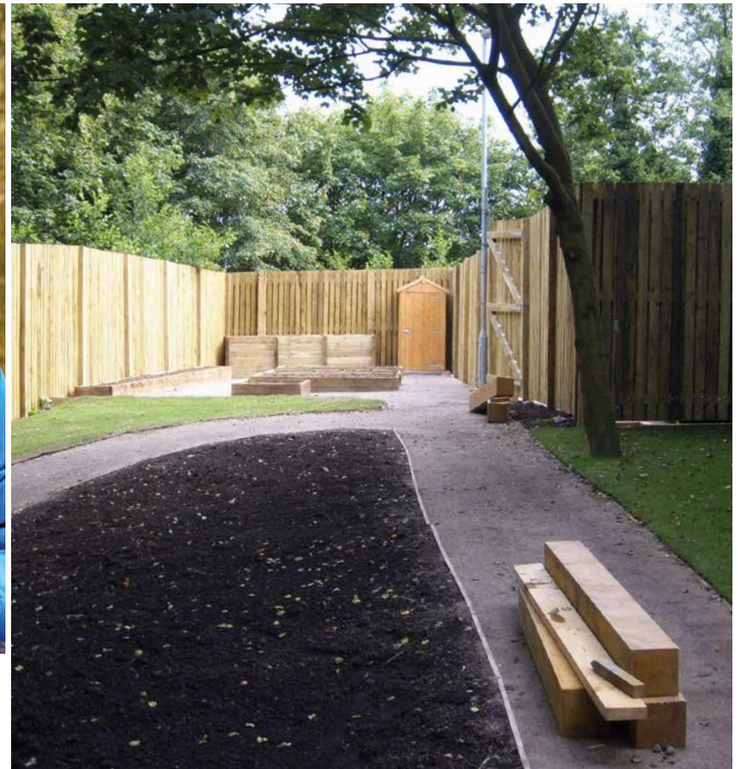
Through 30 hours of observation in a high dependency unit, Connellan et al. (2011) recognised patients needed more

Breaking Borders & Boundaries



> *"Patients used outside space* **35%** *of their waking hours."*
>
> (Connellan et al., 2011)

Speakers Corner at Woodlands mental health unit, Norfolk and Suffolk NHS Trust, designed by Tim A Shaw at the charity Hospital Rooms.



open and shaded gardens as a means to restore calm and a sense of privacy. Outside spaces should be large enough to take away some of the tension often felt inside the ward but shaded enough to ensure a degree of privacy. However, spaces that appeared less visible for staff, a further walk from the nursing station and large open spaces with little to do appeared unused.

The materials in the unused areas were predominantly concrete and had strict geometric patterns (Connellan et al., 2011). In a virtual reality experiment, natural environments including grass and trees compared to concrete, scored a higher positive affect rating after exposure to stress (Huang et al., 2020). Aligned with other studies, natural settings have shown to positively influence emotions.

The link between outside space and physical health is long acknowledged and in recent years, the relationship between mental health and the outdoors is now well established (Reavey et al, 2019). Recent smoke free policy in UK NHS sites has led to a re-purposing of outside spaces in mental health units, emphasising the importance of physical health for service users (who tend to have higher rates of poor physical health due to smoking, poor diet, medication side-effects and other life-style factors). Smoke-free policies create new boundaries resulting in challenges for service users who are negotiating the boundaries between mental ill-health and health (Huddlestone et al., 2018).

"So you're probably having one of the most psychotic episodes of your life, and they say "do come in we'll look after you, oh you can't smoke you know". You are at the worst moment of your life but you can't smoke either. Now there was a big thing historically where people weren't allowed to drink on the street so they put the bottle in a paper bag and that somehow changed it and I do think they need some clever little caveat that lets people smoke in the inside garden." [David]

The smoking ban can create relational boundaries between smokers and non-smokers, and psychological boundaries for smokers who can feel stigmatised and disempowered (Tan, 2013). These boundaries are emphasised by staff having the power of choice to smoke when they finish work and have left the premises (Huddlestone et al., 2018).

When designing outdoor spaces, it is worth noting that fences are symbolic and views from outside can make the environment look "prison like" and further symbolise being locked up to inpatients (Curtis et al., 2007). Simply changing the colour of the fence to blend into the background may not be enough to overcome the perception of a prison to those in secure mental health units (Brown et al., 2020) however, there are solutions to anti-ligature fencing that blend into the environment.

The new state of the art Slagelse mental health hospital in Denmark was built with adequate green spaces for patients and staff to retreat (Simonsen & Duff, 2020a). However, courtyard spaces became points of tension and conflict when staff were either unable or unwilling to supervise patients due to issues with access points (Simonsen & Duff, 2020b). Spaces of 'freedom' can become unworkable when their design is in tension with the ways of working adopted by staff.

"I appreciated moments where staff were willing to disrupt the boundaries themselves and take some risks. It was dependent on individual staff being confident enough to say "why don't we have this session outside in the garden?". That is not how it's usually done but the difference it made to me was huge. By doing that staff were placing trust in me, recognising that I am a human being with human needs. I think giving me that tiny bit of freedom and being more flexible was really powerful." [Katharine]

Opportunities outside of the hospital environment can also be beneficial in developing social relationships, providing a sense of purpose and enabling patients to learn new skills. Collingwood et al. (2021) discuss a horse stables programme 45 minutes' drive away from a hospital which allowed patients to develop new roles outside of the hierarchy within the ward and benefit from spending time in nature. Offering activities like this breaks down some of the professional boundaries, supports the therapeutic relationship between patients and staff and can lead to improvements back on the ward due to an increase in relational connection and trust.

Designing outdoor environments that allow service users to take responsibility and have choices may in turn break down some of the barriers to recovery. Creating a space that is less bounded or more fluid, where patients can form relational activities outside of the rigid roles contained within the hospital is highly beneficial.

Hospital Rooms think carefully about how the design and the visual aesthetic of a space impacts on patients and staff who are brought into the creative process as collaborators in the work.

The Atrium designed by Hannah Brown; a Hospital Rooms project at Hellingly Centre, Sussex Partnership NHS Foundation Trust.

Breaking Borders & Boundaries

The Outsider Project theatre was co-designed and built by one of the outsider artists who used to be a scaffolder. It means the space is really 'owned' by them.

Creating therapeutic spaces through radical design and collaboration

In the 1960s and 70s, radical attempts were made to break away from strict treatment boundaries, institutionalisation, and asylums, to a more patient focussed mental health care provision (McGrath & Reavey, 2018). This often involved radical design projects generated to break down existing boundaries between service users and their communities.

What can we learn from these projects about the contemporary design of both community and inpatient services in terms of the making and breaking of boundaries and borders?

The libertarian Paddington Day Hospital (PDH) in the UK developed a therapeutic community aimed at breaking away from rules and regulations in practice (Spandler, 2006). This community broke down treatment boundaries by taking over former clinic settings where patients gained some ownership of the space through art therapy and graffitiing the hospital walls. The community recognised the importance of patients being co-producers in designing the therapeutic space.

Other initiatives such as the theatre group, The Outsiders Project, are using creative projects for individuals to push personal boundaries and recognise self-worth. This project shows an understanding of the need to collaborate, something that service users have long highlighted as a powerful approach in design. The radical arts group are based in Bournemouth and 'give voice' to the unheard and marginalised individuals in the community. The project is based in a disused shop and mentors outsider artists to produce creative work which is shared with the local community in Bournemouth. Not only does collaboration

increase service user voice, it can serve to break down boundaries between professionals and service users and further democratise the system.

Mental health facilities located within the community may support social interaction which is a significant factor in many patients' recovery. Through a systematic review, Jovanović et al. (2019) found that small, newly designed or refurbished buildings that appear more homelike and resemble other buildings in the neighbourhood, can reduce stigma surrounding mental health care and enable patients' access to the community.

The borders between those 'with' mental health challenges and those 'without' are usefully broken down, reflecting the reality that many of us experience mental health challenges at some time in our lives. This breaking down of boundaries can reduce stigma, using creative design principles.

Through identifying favourite places within the community, Duff (2012) highlights the importance of 'enabling resources' in promoting recovery. These include social resources such as the ability to create and maintain social networks, material resources which relate to the spaces that foster social encounters and develop a sense of community belonging. Some of the places identified by adults living with mental health challenges were cafés, salons, and affordable shops, parks and gardens and these spaces can play a part in supporting well-being and the 'work' of recovery.

"They [the church or the bookstore] are both important places for me when I am trying to cope with some of my negative emotions, I guess you could call them. So I generally visit [the church or the bookstore] when I am feeling that way because I know they will help me. Just the feeling and the atmosphere of these places, it just helps me to relax, take my mind off things I suppose." [Peter] (Duff, 2012)

Enabling resources of the kind found in the community can be included in the design of statutory care facilities. In the early 2000s, the Dutch care provider Humanitas began rebuilding their elderly care homes to include bars, restaurants, hairdressing salons, supermarkets and even petting zoos at their centre (Letiche, 2008). The clinical facilities required were deliberately constructed on the periphery of the sites, so as to promote the idea of the homely, the everyday, rather than the standard associations with 'old people's homes' and/or ill-health.

The Margaret and Charles Juravinski Centre is a mental health hospital in Ontario which incorporates public facilities (gym, conference centre, library etc.) with the aim to break down mental health stigma barriers, by raising public awareness and allow inpatients to readjust to daily life (McLaughlan et al., 2020). Breaking down some of the barriers between hospital and community life, by designing similar facilities into hospitals may support individuals in finding 'enabling places'. Such places provide a transitional step into the community as they facilitate social interactions and create a sense of hope and connection with others (Duff, 2012).

Maytree respite centre in the UK, has created a home-from-home space, for those individuals who are feeling suicidal. Breaking away from institutionalised environments, the terraced house is a calm and relaxing space for those in suicidal crisis.

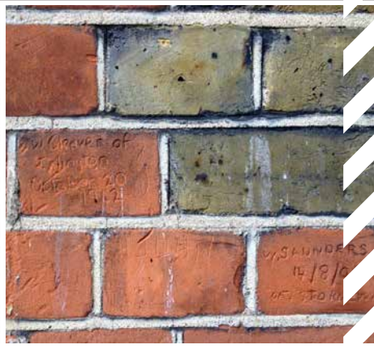
It is one organisation that has removed some of the existing barriers in mental health provision and breaks away the stigma associated with mental health and suicide by redesigning the space in a way that is homely and inviting, with the aim to make people feel valued, comfortable and not inside a hierarchical institution.

Briggs et al. (2007) analysed written guest records, ran interviews with guests and staff and observed interactions at Maytree over a 6-month period. The results indicate that Maytree offers a short-term respite from suicidal crisis and in keeping with Duff's (2012) 'enabling places' is a community space offering an inclusive environment for social interactions. Furthermore, the material space was such that recovery was felt by residents to be supportive and provided the resources that enabled feelings of belonging and hope.

What these organisations and experiments in radical design all show is that breaking the boundaries between therapeutic and community spaces tends to produce better experiences for service users, particularly when there is co-production in the design of the space itself (and not only around its build). Replicating the kinds of spaces that enable support within the community as part of the design of therapeutic space can add significant weight to many dimensions of recovery.

"They remind me of people being able to mark their territory and I find them so poignant. I think people need to have a sense that they are claiming their own identity."

[Katharine]



Images right: Bricks from the former boundary walls of St. Ann's Hospital in Haringey, marked with the names of patients and possibly staff.

The symbolic and psychological significance of doors and borders

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Design With People in Mind

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