

Briefing Brilliance: Better Briefs for Better Mental Health Environments



Welcome, please feel free to introduce yourself in the 'Teams chat'

Better Briefs, Better Outcomes

Why the most important decisions happen before design begins





Why Briefing Matters

We often focus on what we can see:
buildings. layouts. materials rather than what matters most:

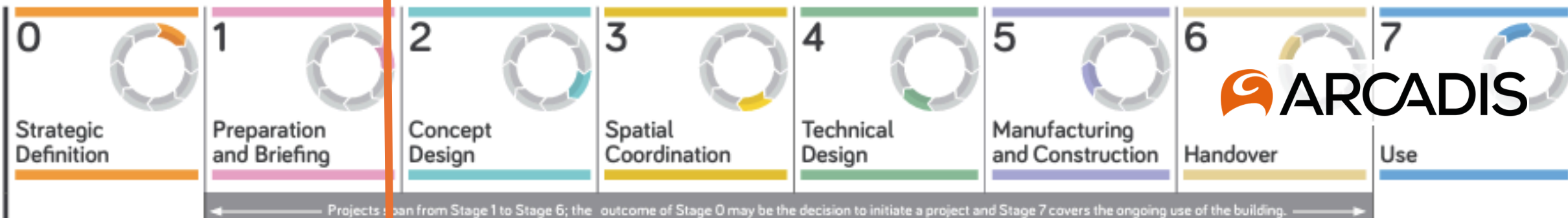
- **The brief locks in outcomes** before design begins — including model of care, risk profile, and how a building will function day to day
- **Brief quality is undervalued** compared to design quality; in mental health projects, the brief determines how care is delivered, how risk is managed, and how service users experience the space
- **Briefing is a critical phase** aligned with RIBA Stages 0–2, where the purpose is to determine the best means of achieving client requirements – assess and plan - a building may not always be the answer!



RIBA Guidance



The RIBA Plan of Work organises the process of briefing, designing, delivering, maintaining, operating and using a building into eight stages. It is a framework for all disciplines on construction projects and should be used solely as guidance for the preparation of detailed professional services and building contracts.



Stage Boundaries:
Stages 0-4 will generally be undertaken one after the other.
Stages 4 and 5 will overlap in the Project Programme for most projects.
Stage 5 commences when the contractor takes possession of the site and finishes at Practical Completion.
Stage 6 starts with the handover of the building to the client immediately after Practical Completion and finishes at the end of the Defects Liability Period.
Stage 7 starts concurrently with Stage 6 and lasts for the life of the building.

Planning Note:
Planning Applications are generally submitted at the end of Stage 3 and should only be submitted earlier when the threshold of information required has been met. If a Planning Application is made during Stage 3, a mid-stage gateway should be determined and it should be clear to the project team which tasks and deliverables will be required. See Overview guidance.

Procurement:
The RIBA Plan of Work is procurement neutral - See Overview guidance for a detailed description of how each stage might be adjusted to accommodate different procurement routes.

Procurement Strategy:
ER: Employer's Requirements
CP: Contractor's Proposals

Stage Outcome at the end of the stage	0 Strategic Definition	1 Preparation and Briefing	2 Concept Design	3 Spatial Coordination	4 Technical Design	5 Manufacturing and Construction	6 Handover	7 Use
Core Tasks during the stage	<p>Prepare Client Requirements</p> <p>Develop Business Case for feasible options including review of Project Risks and Project Budget</p> <p>Ratify option that best delivers Client Requirements</p> <p>Review Feedback from previous projects</p> <p>Undertake Site Appraisals</p>	<p>Prepare Project Brief including Project Outcomes and Sustainability Outcomes Quality Aspirations and Spatial Requirements</p> <p>Undertake Feasibility Studies</p> <p>Agree Project Budget</p> <p>Source Site Information including Site Surveys</p> <p>Prepare Project Programme</p> <p>Prepare Project Execution Plan</p>	<p>Prepare Architectural Concept incorporating Strategic Engineering requirements and aligned to Cost Plan, Project Strategies and Outline Specification</p> <p>Agree Project Brief Derogations</p> <p>Undertake Design Reviews with client and Project Stakeholders</p> <p>Prepare stage Design Programme</p>	<p>Undertake Design Studies, Engineering Analysis and Cost Exercises to test Architectural Concept resulting in Spatially Coordinated design aligned to updated Cost Plan, Project Strategies and Outline Specification</p> <p>Initiate Change Control Procedures</p> <p>Prepare stage Design Programme</p>	<p>Develop architectural and engineering technical design</p> <p>Prepare and coordinate design team Building Systems information</p> <p>Prepare and integrate specialist subcontractor Building Systems information</p> <p>Prepare stage Design Programme</p>	<p>Finalise Site Logistics</p> <p>Manufacture Building Systems and construct building</p> <p>Monitor progress against Construction Programme</p> <p>Inspect Construction Quality</p> <p>Resolve Site Queries as required</p> <p>Undertake Commissioning of building</p> <p>Prepare Building Manual</p>	<p>Hand over building in line with Plan for Use Strategy</p> <p>Undertake review of Project Performance</p> <p>Undertake seasonal Commissioning</p> <p>Rectify defects</p> <p>Complete initial Aftercare tasks including light touch Post Occupancy Evaluation</p>	<p>Implement Facilities Management and Asset Management</p> <p>Undertake Post Occupancy Evaluation of building performance in use</p> <p>Verify Project Outcomes including Sustainability Outcomes</p>
Core Statutory Processes during the stage:	Strategic appraisal of Planning considerations	Source pre-application Planning Advice Initiate collation of health and safety Pre-construction Information	Obtain pre-application Planning Advice Agree route to Building Regulations compliance Option: submit outline Planning Application	Review design against Building Regulations Prepare and submit Planning Application	Submit Building Regulations Application Discharge pre-commencement Planning Conditions Prepare Construction Phase Plan Submit form F10 to HSE if applicable	Carry out Construction Phase Plan Comply with Planning Conditions related to construction	Comply with Planning Conditions as required	Comply with Planning Conditions as required
Procurement Route	Traditional	Design & Build 1 Stage	Design & Build 2 Stage	Management Contract	Construction Management	Contractor-led		
Information Exchanges at the end of the stage	Client Requirements Business Case	Project Brief Feasibility Studies Site Information Project Budget Project Programme Procurement Strategy Responsibility Matrix Information Requirements	Project Brief Derogations Signed off Stage Report Project Strategies Outline Specification Cost Plan	Signed off Stage Report Project Strategies Updated Outline Specification Updated Cost Plan Planning Application	Manufacturing Information Construction Information Final Specifications Residual Project Strategies Building Regulations Application	Building Manual including Health and Safety File and Fire Safety Information Practical Completion certificate including Defects List Asset Information	Feedback on Project Performance Final Certificate Feedback from light touch Post Occupancy Evaluation	Feedback from Post Occupancy Evaluation Updated Building Manual including Health and Safety File and Fire Safety Information as necessary



Design With People in Mind

Stakeholder Engagement Toolkit

Design in Mental Health Network

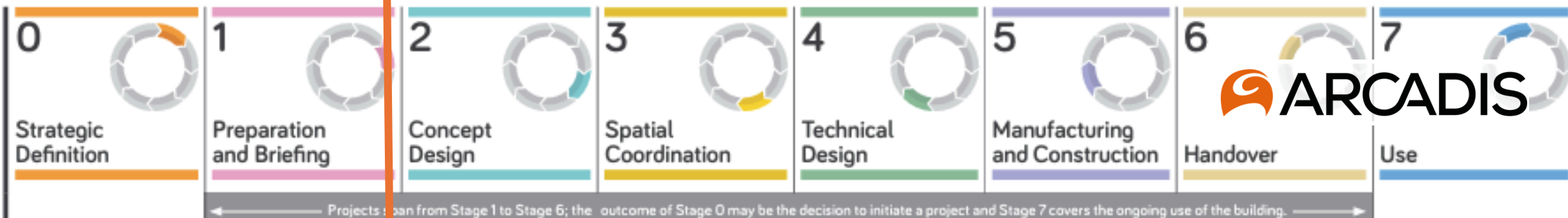
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Stage Outcome at the end of the stage	The best means of achieving the Client Requirements confirmed <small>If the outcome determines that a building is the best means of achieving the Client Requirements, the client proceeds to Stage 1</small>	Project Brief approved by the client and confirmed that it can be accommodated on the site	Architectural Concept approved by the client and aligned to the Project Brief <small>The brief remains "live" during Stage 2 and is derogated in response to the Architectural Concept</small>	Architectural and engineering information Spatially Coordinated	All design information required to manufacture and construct the project completed <small>Stage 4 will overlap with Stage 5 on most projects</small>	Manufacturing, construction and Commissioning completed <small>There is no design work in Stage 5 other than responding to Site Queries</small>	Building handed over, Aftercare initiated and Building Contract concluded	Building used, operated and maintained efficiently <small>Stage 7 starts concurrently with Stage 6 and lasts for the life of the building</small>
Core Tasks during the stage	Prepare Client Requirements Develop Business Case for feasible options including review of Project Risks and Project Budget Ratify option that best delivers Client Requirements Review Feedback from previous projects Undertake Site Appraisals	Prepare Project Brief including Project Outcomes and Sustainability Outcomes Quality Aspirations and Spatial Requirements Undertake Feasibility Studies Agree Project Budget Source Site Information including Site Surveys Prepare Project Programme Prepare Project Execution Plan	Prepare Architectural Concept incorporating Strategic Engineering requirements and aligned to Cost Plan , Project Strategies and Outline Specification Agree Project Brief Derogations Undertake Design Reviews with client and Project Stakeholders Prepare stage Design Programme	Undertake Design Studies , Engineering Analysis and Cost Exercises to test Architectural Concept resulting in Spatially Coordinated design aligned to updated Cost Plan , Project Strategies and Outline Specification Initiate Change Control Procedures Prepare stage Design Programme	Develop architectural and engineering technical design Prepare and coordinate design team Building Systems information Prepare and integrate specialist subcontractor Building Systems information Prepare stage Design Programme <small>Specialist subcontractor designs are prepared and reviewed during Stage 4</small>	Finalise Site Logistics Manufacture Building Systems and construct building Monitor progress against Construction Programme Inspect Construction Quality Resolve Site Queries as required Undertake Commissioning of building Prepare Building Manual <small>Building handover tasks bridge Stages 5 and 6 as set out in the Plan for Use Strategy</small>	Hand over building in line with Plan for Use Strategy Undertake review of Project Performance Undertake seasonal Commissioning Rectify defects Complete initial Aftercare tasks including light touch Post Occupancy Evaluation	Implement Facilities Management and Asset Management Undertake Post Occupancy Evaluation of building performance in use Verify Project Outcomes including Sustainability Outcomes <small>Adaptation of a building (at the end of its useful life) triggers a new Stage 0</small>
Core Statutory Processes during the stage:	Strategic appraisal of Planning considerations Planning Building Regulations Health and Safety (CDM)	Source pre-application Planning Advice Initiate collation of health and safety Pre-construction Information	Obtain pre-application Planning Advice Agree route to Building Regulations compliance Option: submit outline Planning Application <small>See Planning Note for guidance on submitting a Planning Application earlier than at end of Stage 3</small>	Review design against Building Regulations Prepare and submit Planning Application <small>See Planning Note for guidance on submitting a Planning Application earlier than at end of Stage 3</small>	Submit Building Regulations Application Discharge pre-commencement Planning Conditions Prepare Construction Phase Plan Submit form F10 to HSE if applicable	Carry out Construction Phase Plan Comply with Planning Conditions related to construction	Comply with Planning Conditions as required	Comply with Planning Conditions as required
Procurement Route	Traditional Design & Build 1 Stage Design & Build 2 Stage Management Contract Construction Management Contractor-led	Appoint client team	Appoint design team	ER CP Appoint contractor ER CP Appoint contractor ER CP Appoint contractor	ER CP Appoint contractor ER CP Appoint contractor ER CP Appoint contractor	ER CP Appoint contractor ER CP Appoint contractor ER CP Appoint contractor	ER CP Appoint contractor ER CP Appoint contractor ER CP Appoint contractor	ER CP Appoint contractor ER CP Appoint contractor ER CP Appoint contractor
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RIBA Stages – Overview



RIBA Stage 0 Strategic Definition

What to consult on:

Need

- Strategic brief and vision
- Capacity planning
- Geography / service location
- Clinical specification, models of care
- Business model
- Business case requirements
- Current challenges to be addressed by the project
- Pre occupancy evaluation of existing facilities
- Post occupancy evaluation targets

Outcomes

- Consultation plan established
- Design champion selected
- COC improvement targets established, if possible
- External Advisor need established
- Confirmation of functional requirement; bed numbers, etc
- Key areas for improvement identified

Who should be involved

- Strategic Management Teams: Estates and Maintenance, FM, IT, Clinical, Financial
- Communication Team
- Care Quality Commission, if possible
- Clinical Commissioning groups as required
- NHS England as required
- Procurement



RIBA Stage 1 Preparation and Brief

What to consult on:

Establishing the brief

- Functional content
- Vision: likes and dislikes, precedents, hopes and fears, exemplar visits
- Departmental adjacencies
- Model of care
- Bed numbers / ward sizes for in-patient services
- Current challenges to be addressed by the project; capture for Government soft landings
- Procurement options

Outcomes

- Design brief (evolving)
- Exemplar visit summaries
- SOC
- COC targets established, if possible
- External advisors appointed
- Confirmation of functional requirement; bed numbers, etc
- Key areas for improvement quantified
- Compliance statement

Who should be involved

- Communication Team
- Design Champion
- Service User Experts by Experience, current or former
- Clinical Teams: Ward Managers, OT, Psychologists
- Carers and Families
- Client Specialist Advisors: Fire, Security, IT, Infection Prevention, Catering, Cleaning, Pharmacy, Mental Health Act / Legislation Leads, etc
- Maintenance Teams
- Senior Management Teams
- Local Community Groups
- Clinical Commissioning Groups as required
- NHS England as required

The Importance of Stages 0 and 1



RIBA Stage 2 Concept Design

What to consult on:

Developing the brief

- Options appraisal
- Functional content
- Internal adjacencies
- Key room design / P22 repeatable rooms
- Outline building specifications
- Outline engineering systems specifications: patient care, fire, etc
- Innovations, product design
- Arts co-ordination
- Procurement options

Outcomes

- Design brief (evolving)
- Strategic layout, site and building
- Planning pre-application advice if appropriate
- Building regulations advice
- External advisors appointed
- Outline business case with sufficient detail (if possible)
- Draft / proposed programme schedule

Who should be involved

- Communication Team
- Design Champion
- Service User Experts by Experience, current or former
- Clinical Teams: Ward Managers, OT, Psychologists
- Service Users, current or former
- Carers and Families
- Client Specialist Advisors: Fire, Security, IT, Infection Prevention, Catering, Cleaning, Pharmacy, Mental Health Act / Legislation Leads, etc
- Senior Management Teams
- Maintenance Teams
- Local Community Groups
- Local Planning Authority if complex / sensitive site
- Building Control if complex building / site



RIBA Stage 3 Developed Design

What to consult on:

Developing design

- Detailed internal building layouts
- Elevation design
- Outline building specifications
- Innovations, product design
- External spaces
- Interior design concepts
- Artwork co-ordination
- Procurement options

Outcomes

- Design brief (evolving)
- Planning pre-application building regulations advice
- Outline Business Case
- Peer review

Who should be involved

- Communication Team
- Service User experts by Experience, current or former
- Clinical Teams: Ward Managers, OT, Psychologists
- Carers and Families
- Client Specialist Advisors: Fire, Security, IT, Infection Prevention, Catering, Cleaning, Pharmacy, Mental Health Act / Legislation Leads, etc
- Maintenance Teams
- Senior Management Teams
- Trust Boards (governance approvals)
- Local Community Groups
- Local Planning Authority if complex / sensitive site
- Building Control: Local Authority or Approved Inspector
- Clinical Commissioning Groups as required
- NHS England as required



RIBA Stage 4 Technical Design

What to consult on:

Technical detail

- Detailed internal building layouts
- Elevation design
- Detailed building specifications
- Innovations, product design
- External spaces
- Interior design
- Artwork co-ordination
- Full co-ordinated design

Outcomes

- Building Regulations application
- Tender information
- Full Business Case
- Peer review
- Accepted / signed-off derogations

Who should be involved

- Communication Team
- Design Champion
- Service User Experts by Experience, current or former
- Clinical Teams: Ward Managers, OT, Psychologists
- Carers and Families
- Client Specialist Advisors: Fire, Security, IT, Infection Prevention, Catering, Cleaning, Pharmacy, Mental Health Act / Legislation Leads, etc
- Maintenance Teams
- Senior Management Teams
- Trust Boards (governance approvals)
- Building Control: Local Authority or Approved Inspector
- Clinical Commissioning Groups as required
- NHS England as required



RIBA Stage 5 Construction

What to consult on:

During construction

- On-site mock-up testing
- Final setting out
- Final interior design
- 1st brush decoration
- Final equipping
- Key decisions if site conditions dictate a design change

Outcomes

- Key stages
- Handover preparation

Who should be involved

- Communication Team
- Design Champion
- Service User Experts by Experience, current or former
- Clinical Teams: Ward Managers, OT, Psychologists
- Senior Management Teams
- Trust Boards (governance approvals)



RIBA Stage 6 Handover and Close-out

What to consult on:

Preparing for handover

- Final artwork co-ordination
- Final decoration
- Site familiarisation and training

Outcomes

- Soft landings handover
- Building opening event
- No should be involved
- Design Champion
- Service User Experts by Experience, current or former (for review and orientation)
- Clinical Teams: Ward Managers, OT, Psychologists
- Carers and Families
- Client Specialist Advisors: Fire, Security, IT, Infection Prevention, Catering, Cleaning, Pharmacy, Mental Health Act / Legislation Leads, etc



RIBA Stage 7 In Use

What to consult on:

In use

- Post occupancy evaluations, year 1, 2 and 3
- Lessons learned review

Outcomes

- Post occupancy review
- Lessons learned report
- O-C visits and reporting when available

Who should be involved

- Communication Team
- Design Champion
- Service User Experts by Experience, current or former
- Clinical Teams: Ward Managers, OT, Psychologists
- Carers and Families
- Client Specialist Advisors: Fire, Security, IT, Infection Prevention, Catering, Cleaning, Pharmacy, Mental Health Act / Legislation Leads, etc
- Maintenance Teams
- Senior Management Teams
- Design and Construction Team

• Industry awareness of Stages 0 and 1 needs to grow — discussions in these early stages are critical, yet often overlooked — time to assess and plan

• Brief development in early stages is where project success is determined — architects should advocate for the importance of robust Stages 0 and 1 engagement including time to assess and plan

• A good brief generally equates to a good project — clients who understand what's available, the limitations, and the opportunities will be clearer on aspirations and project outcome



Stage 0 – Essential Criteria

RIBA Stage 0 Strategic Definition

What to consult on:

Need

- Strategic brief and vision
- Capacity planning
- Geography / service location
- Clinical specification, models of care
- Business model
- Business case requirements
- Current challenges to be addressed by the project
- Pre occupancy evaluation of existing facilities
- Post occupancy evaluation targets

Outcomes

- Consultation plan established
- Design champion selected
- COC improvement targets established, if possible
- External Advisor need established
- Confirmation of functional requirement; bed numbers, etc
- Key areas for improvement identified

Who should be involved

- Strategic Management Teams: Estates and Maintenance, FM, IT, Clinical, Financial
- Communication Team
- Care Quality Commission, if possible
- Clinical Commissioning groups as required
- NHS England as required
- Procurement

Purpose: Determine the best means of achieving the client’s requirements. A building may not be the most appropriate solution.

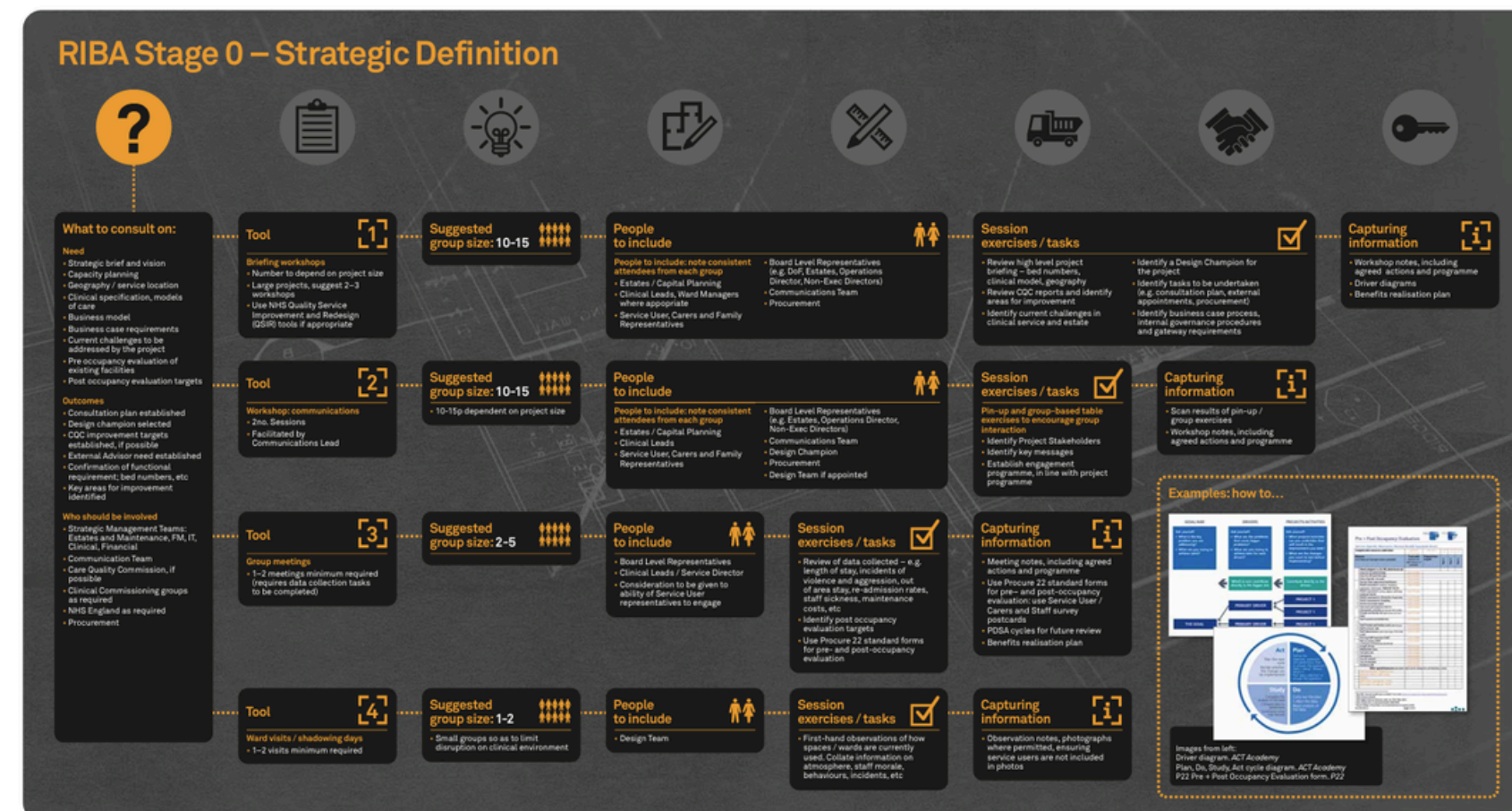
Common Misapplications:

- Using Stage 0 to prepare a detailed brief instead of keeping it strategic
- Design team services commencing too early – not needed until Stage 2
- Spatial requirements set that are unaffordable within the Project Budget

Key Recommendations:

- Keep Stage 0 strategic: define Business Case and Client Requirements
- Stage 0 team should differ from Stage 1 team – select skills for strategic challenges
- Align Client Requirements with Project Budget before proceeding to Stage 1
- Consider an RIBA Client Adviser for strategic guidance in the early stages

[Stakeholder-Engagement-Toolkit.pdf](#)





Stage 1 – Essential Criteria

RIBA Stage 1 Preparation and Brief

What to consult on:

Establishing the brief

- Functional content
- Vision: likes and dislikes, precedents, hopes and fears, exemplar visits
- Departmental adjacencies
- Model of care
- Bed numbers / ward sizes for in-patient services
- Current challenges to be addressed by the project; capture for Government soft landings
- Procurement options

Outcomes

- Design brief (evolving)
- Exemplar visit summaries
- SOC
- CQC targets established, if possible
- External advisors appointed
- Confirmation of functional requirement; bed numbers, etc
- Key areas for improvement quantified
- Compliance statement

Who should be involved

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- Clinical Commissioning Groups as required
- NHS England as required

Purpose: Develop the detail of the brief and ensure everything is ready for the design process at Stage 2.

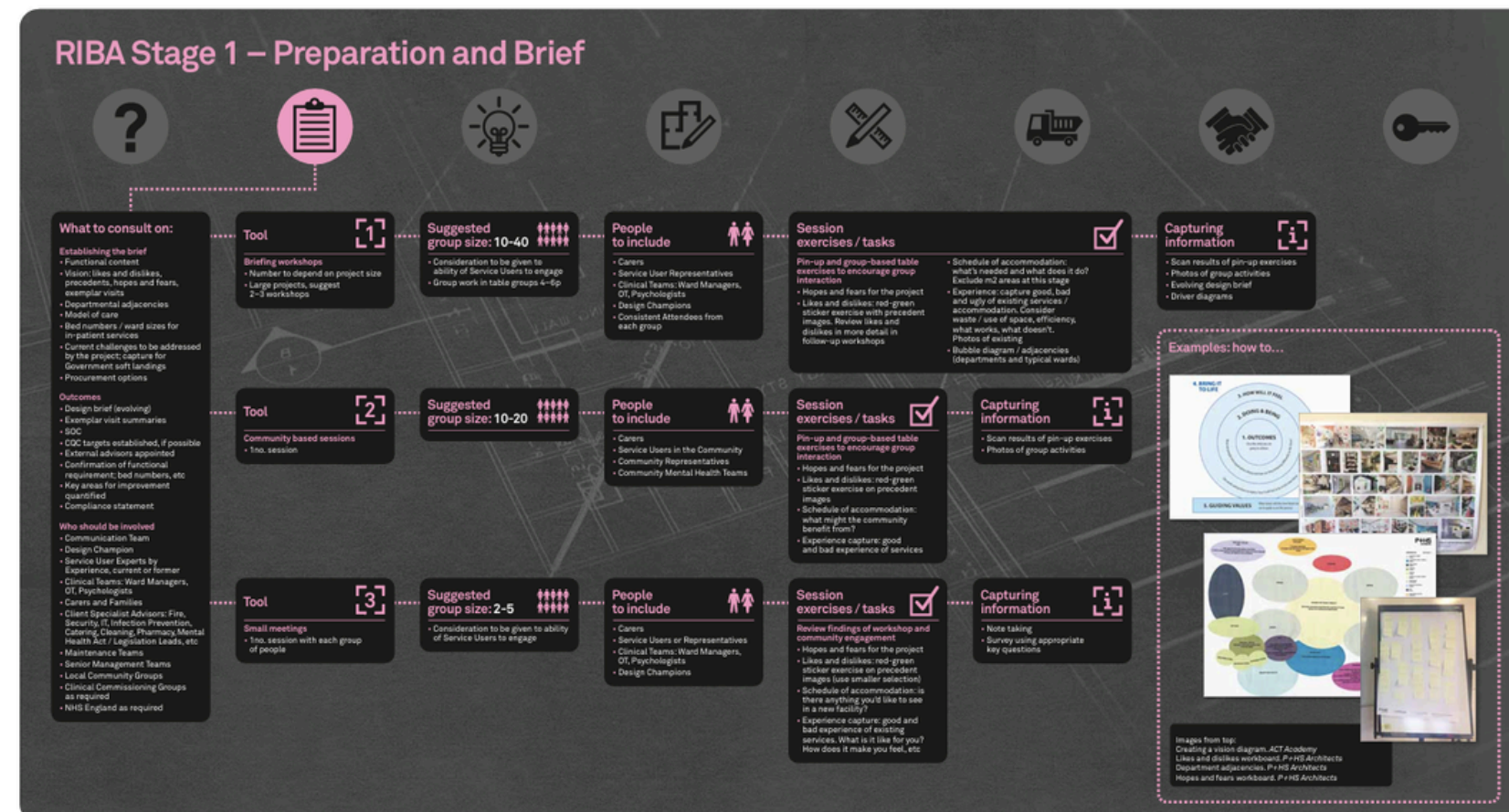
Common Misapplications:

- Feasibility studies treated as the start of design – they are part of briefing, not design
- Briefing process rushed to start Stage 2 earlier – causes delays and rework
- Information requirements framed around traditional 2D deliverables, adding waste

Key Recommendations:

- Brief must cover Project Outcomes, exemplar projects, Spatial Requirements and budget
- The better the brief, the more engaged the design team at Stage 2
- Define Information Requirements early – consider digital survey and BIM technologies
- Consider RIBA Client Adviser support for developing a robust Project Brief

[Stakeholder-Engagement-Toolkit.pdf](#)





Stage 2 – Essential Criteria

RIBA Stage 2 Concept Design

Purpose: Get the design concept right – ensure look, feel and budget are aligned with the client’s vision and brief.

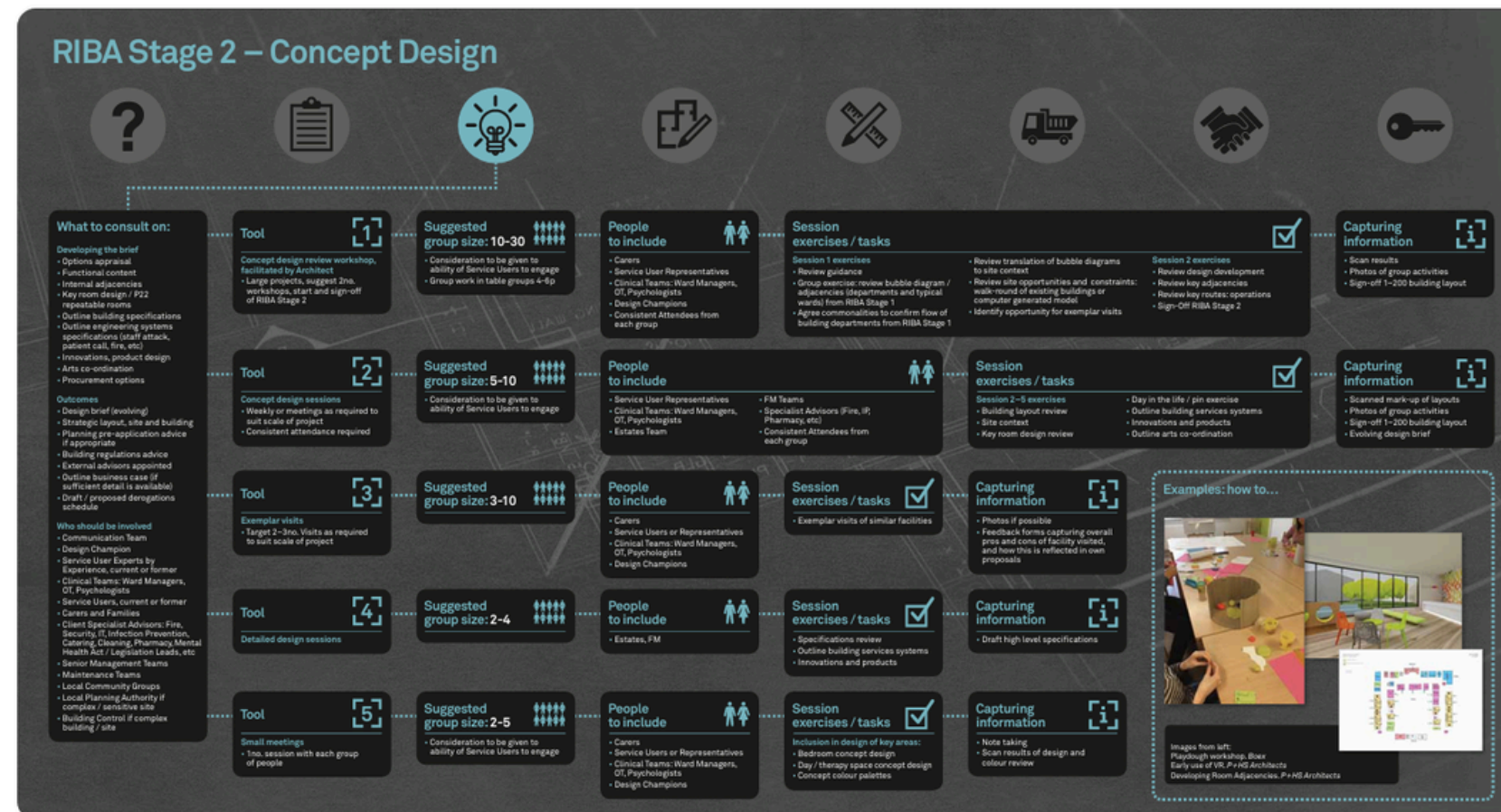
Common Misapplications:

- Early planning applications creating project risks without proper management
- Over-focus on BIM model detail rather than the tasks needed to underpin the design
- Requesting comprehensive deliverables without considering if they serve stage outcomes

Key Recommendations:

- Balance detail: too much too early diverts effort; too little makes Stage 3 inefficient
- Focus design team on tasks that support stage goals and build design resilience
- Determine Stage 2/3 boundary carefully – one of the most complex decisions
- Use 3D technologies including VR and augmented reality for Design Reviews

[Stakeholder-Engagement-Toolkit.pdf](#)



What to consult on:

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Why Is Briefing the Most Critical Stage?

We talk about design quality — but not enough about brief quality

In mental health projects, the brief determines:

- How care will be delivered
- How risk will be managed
- How staff will work
- How service users will experience the space.





Where Briefs Go Wrong

Being given a solution instead of a problem

- **Common pitfall:**
- For example room lists and layouts pre-defined without identifying underlying challenges
- **Other issues:**
- unclear estate-wide policies
- late operational decisions
- weak engagement structure
- unclear priorities.





Real World Impacts:

Poor vs Good Briefing

- **Poor briefing:** creates pressure across the system — especially for service users and staff
- Disengagement of staff
- Delays can mean years in outdated, unsuitable environments
- **Good briefing:** calmer service users; improved staff retention — staff say they want to stay
- Reduced costs.





A Good Brief Includes:

Key Elements

- **Model of care:** who, how long, what a typical day looks like
- **Decision-making and change control:** who decides, when, how changes are managed
- **Genuine co-production:** start engagement before design; evidence what was heard and acted on
- **Operational clarity:** catering, waste, laundry — small details, huge implications
- **Safety and risk strategy:** observation, ligature risk, patient management
- **Future-proofing:** flexibility and adaptability designed in early.





A Good Brief Includes:

Time to assess and plan

Occupancy

- Staffing numbers
- Visitors
- Service Users
- Community
- Expansion

Operational

- FM/Maintenance
 - Catering
 - Laundry
 - Security
 - Waste
 - Fire
 - Community
-



Examples of Changes Affecting Programme

Changing the brief = not a 'brief' programme

Lack of Clarity on:

- Model of Care eg Patient profiles
- Inpatients – Functions – dementia design vs reduced ligature, flexibility eg swing beds
- Level of assistance – Frail / older / bariatric
- Catering models – cook/chill – local regen on wards vs fresh cook on site
- Expansion space & requirements – impacts
- IPC Policy – numbers of WCS – who can share?

Impacts:

- Catering
- Car parking
- Staff facilities – staff rooms, staff change areas, lockers, office space
- Fire strategy
- Waste storage and collections
- FM provision – sizes of rooms eg stores
- Plant provision

Results:

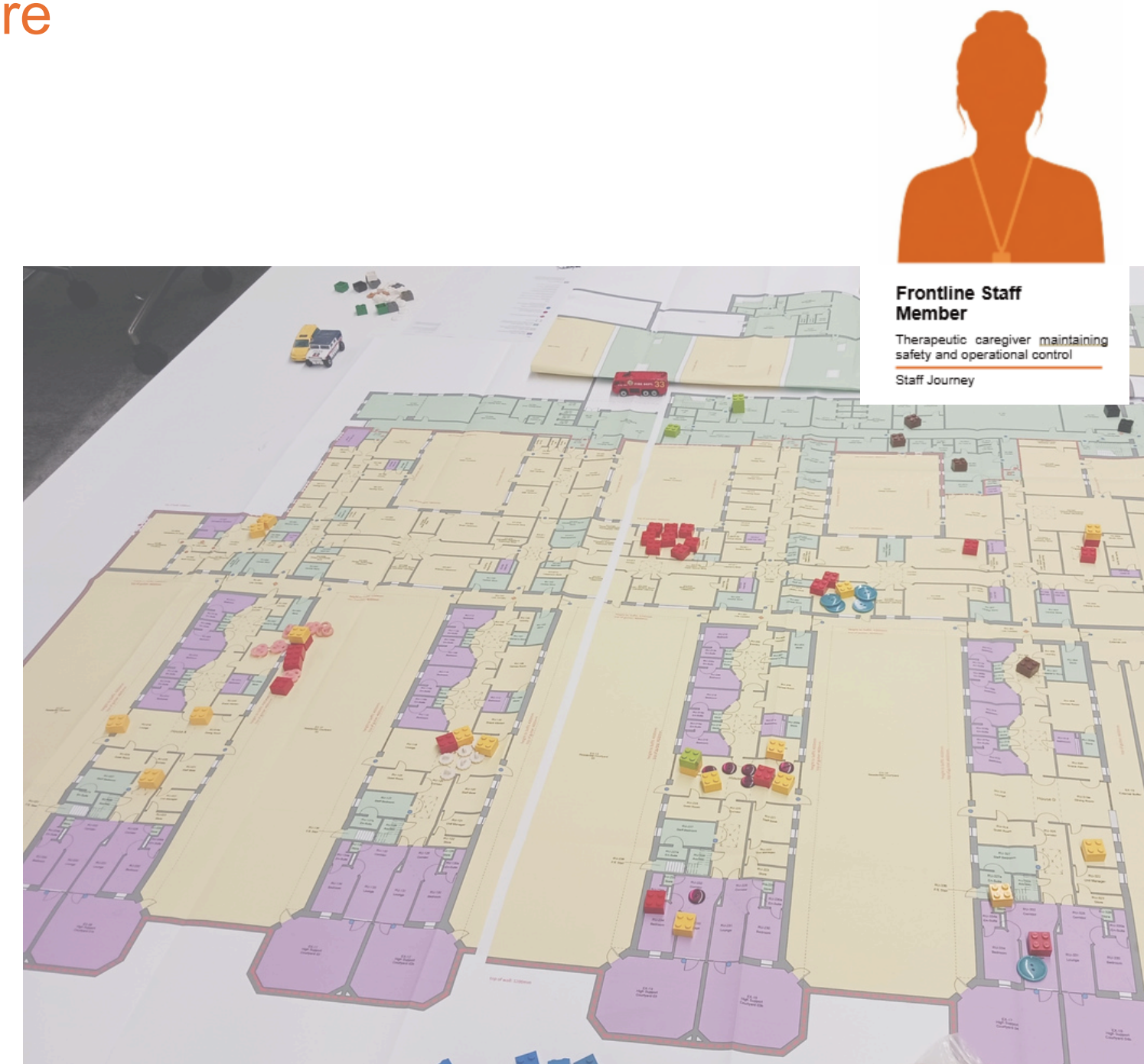
- Inability to fix the building blocks ie SoA, ward typology / bedroom design
- Inability to move on
- Redesign
- Delay
- Cost increases



What if We Have a New Service?

MHEDS / Neighbourhood Centres / New Models of Care

- Ambiguity – lack of clarity about these new models of care
- New partnerships – ways of working can be confusing
- Staff know what the problems are with the existing service
- Take time to assess what the existing issues are
- Listen to staff and service users about the issues
- Use of personas can help to focus and inform the brief



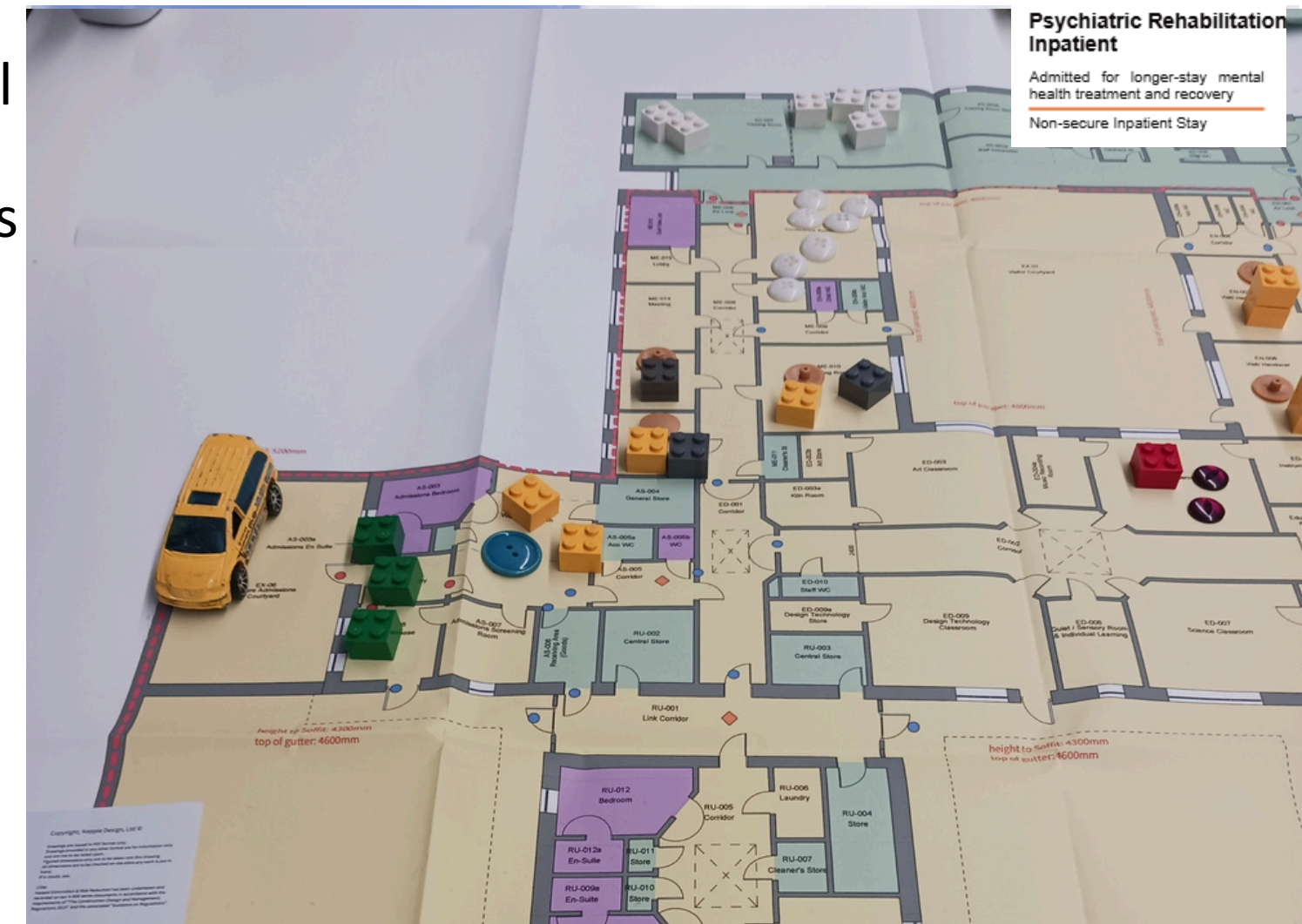


Making the Brief Real

Day in the Life Scenarios & Personas



- Scenario-based walkthroughs simulate how the building will actually function
- Use plans and personas; sometimes simple physical markers
- Walk through: admissions/discharge, routines, incidents, staff workflows, night operations
- Reveals small misses with big wellbeing impacts (e.g., staff access to toilets/tea points)

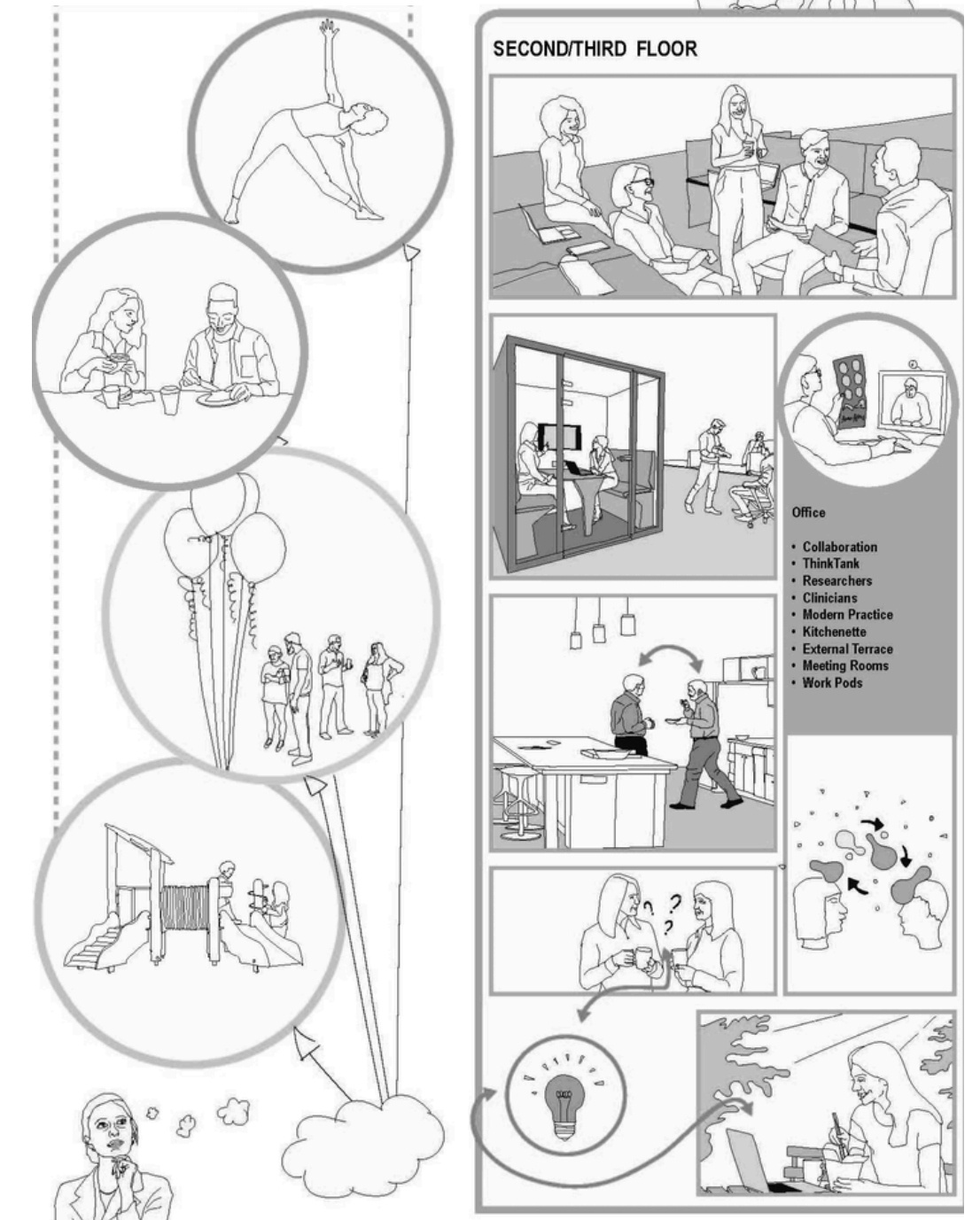




Looking Ahead

Briefing As An Ongoing Process

- **Future of briefing:** less about a perfect document, more about a robust process
- **Trends:** earlier and deeper co-production; continuous testing; more scenario-based design; growing use of digital tools
- **Key recommendation:** do not treat briefing as a quick front-loaded stage — resource it properly and identify the decision makers
- **Takeaway:** Better briefs align stakeholders, reduce redesign, reduce costs, and deliver environments that support dignity, de-escalation and recovery.



Poll

Questions



Personas in Practice:

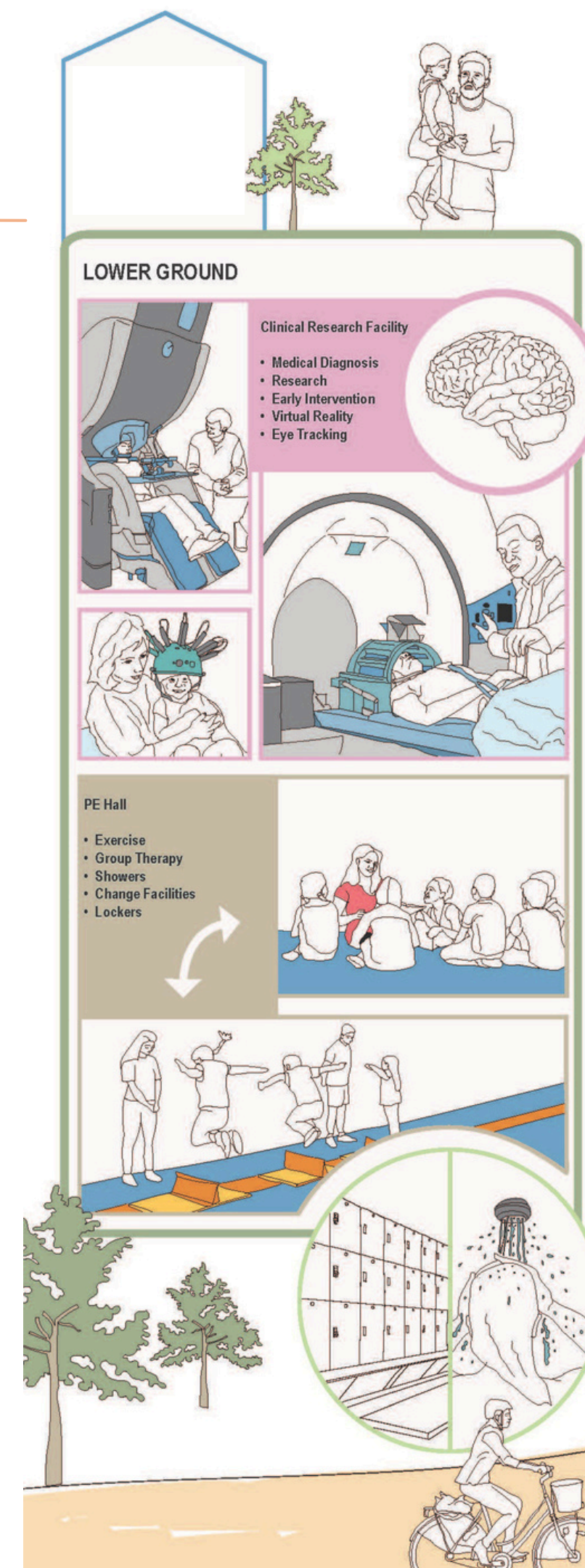
Designing for Mental Health Why Use Personas for Mental Health Design?

Build empathy: Understand users' feelings, challenges, and needs.

Focus design: Avoid generic "one-size-fits-all" solutions.

Prioritize well-being: Address mental health triggers, recovery, and support mechanisms.

Improve outcomes: Better user engagement, satisfaction, and impact on mental health.



Identify Key Dimensions for Mental Health Personas

Focus on attributes that affect mental health experience and design needs:

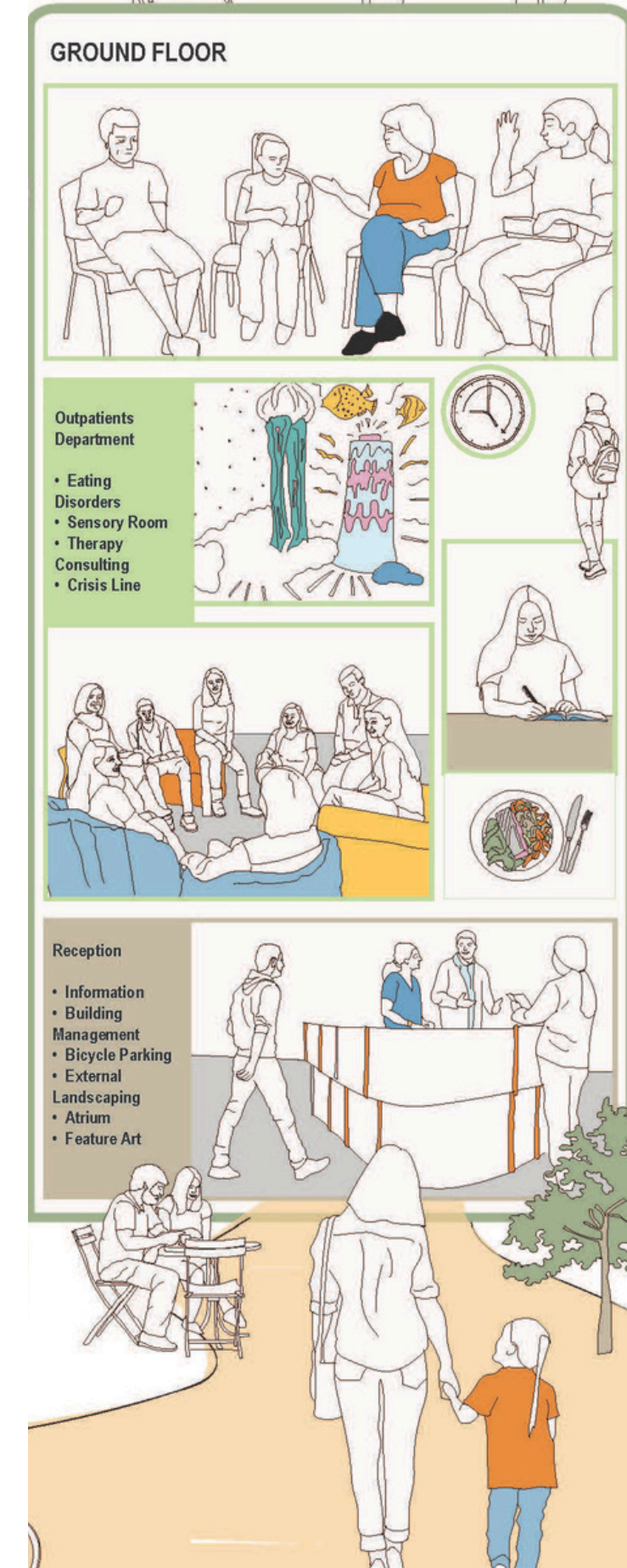
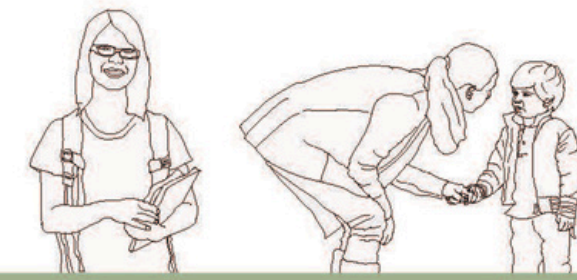
Emotional states (anxious, isolated, resilient).

Triggers (noise, overcrowding, lack of nature).

Support systems (family, therapy, digital tools).

Accessibility needs (sensory sensitivities, cognitive load).

Environmental preferences (quiet spaces, social zones).



Limit to 3-5 Core Personas

Keep it manageable for quick impact.

Each persona represents a distinct mental health profile or challenge.

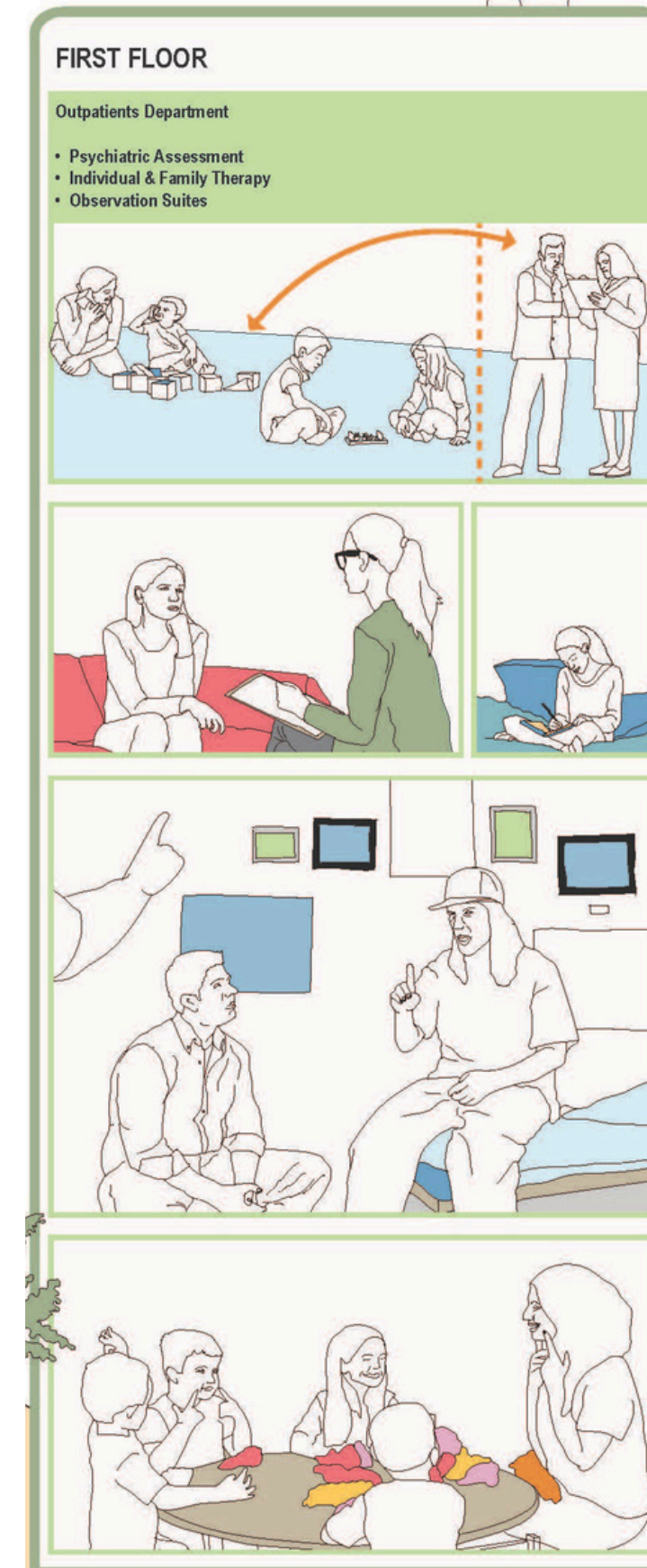
Give them names, photos, brief backstories to humanize.

Use Visual, Story-Driven Formats

One-page personas: photo, key quotes, mental health needs, pain points, design implications.

Scenario storytelling: short narratives showing how the persona interacts with your design.

Infographics highlighting mental health triggers and coping mechanisms.





Dan

“I don’t need everything fixed overnight... I just need things to feel manageable again.”

Age: 34

Occupation: Former electrical technician (currently on extended sick leave)

Living situation: Lives alone in a one-bedroom flat in a suburban area; limited contact with family

Background & Story

Dan grew up in a close-knit family just outside Leeds. He was always practical and hands-on, choosing a career in electrical engineering straight out of college. He took pride in his work - reliable, dependable, the person colleagues would call when something needed fixing.

A few years ago, Dan’s life began to shift. After a workplace accident that left him with a prolonged recovery period, he struggled with chronic pain and had to take time off. During this period, his routine collapsed - he stopped seeing colleagues daily, lost his sense of purpose, and gradually became more isolated.

At first, he thought he was just “having a rough patch.” But over time, he experienced persistent low mood, insomnia, and increasing anxiety about returning to work. He began avoiding social situations, even declining invitations from close friends. Small tasks - like going to the shop - started to feel overwhelming.

Eventually, after encouragement from his GP, Dan was referred to mental health services. He is now engaged in community-based support and occasional outpatient appointments.

Current Experience

Challenges:

- Feels a loss of identity tied to his job
- Anxiety in unfamiliar or busy environments (e.g. waiting rooms, public transport)
- Difficulty navigating complex healthcare settings
- Tends to withdraw when overwhelmed rather than asking for help

Needs:

- Clear, simple environments that reduce cognitive load
- Friendly, approachable staff interactions to build trust
- Spaces that feel safe, calm, and non-clinical
- Opportunities to reconnect with purpose (e.g. vocational support or peer activities)

Motivations:

- Wants to “feel like himself again”
- Values independence but recognises he needs support
- Responds well to practical, solution-focused approaches

Align Personas with Design Goals

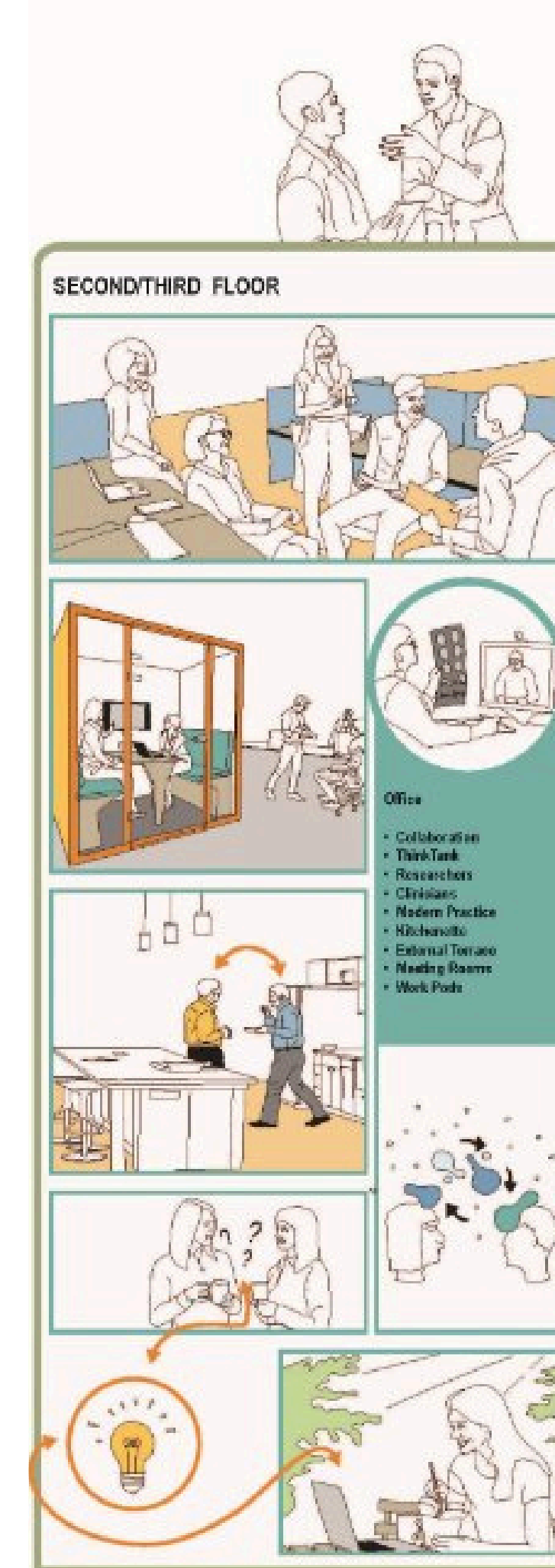
Map personas to specific design challenges (e.g, calming waiting areas, promoting social interaction, reducing stress).

Identify priority features or interventions for each persona.

Validate and Iterate

Quickly validate personas with stakeholders or users if possible.

Update based on feedback to ensure relevance and accuracy.

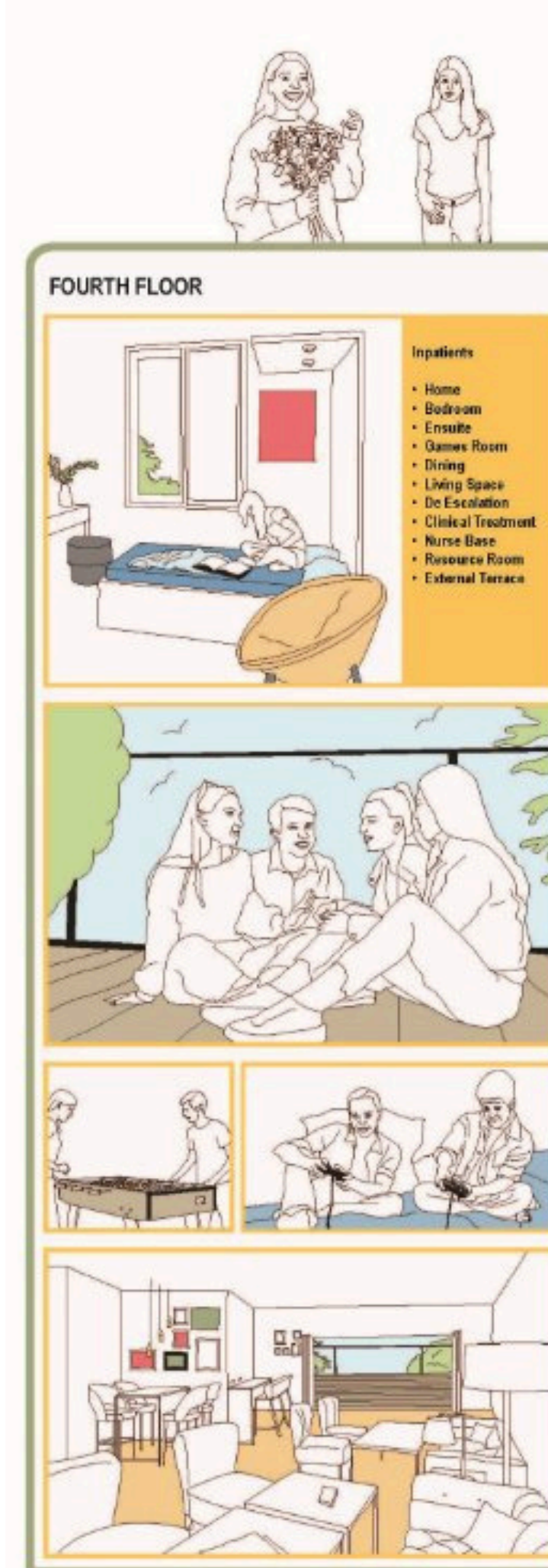


What makes a persona genuinely useful rather than a tick-box exercise?

A useful persona is:

- Grounded in real insight, ideally co-developed with people with lived experience, not stereotypes
- Purpose-led, linked clearly to the decisions it needs to inform
- Dynamic, evolving as understanding deepens rather than fixed on day one
- Actionable, helping teams answer practical questions like *“What would this mean for them?”* at key decision points

Most importantly, a good persona is used repeatedly - in workshops, option testing, risk reviews, and briefing conversations.



How do personas help teams make better design decisions in complex or high-risk environments?

In complex systems, personas act as a shared reference point when priorities compete. They:

- Translate abstract risks into human impact, supporting more balanced decisions
- Help teams hold multiple needs in view at once, rather than designing for an “average” user
- Support clearer conversations between disciplines, reducing misalignment early
- Provide a defensible rationale for decisions where safety, dignity, and experience are critical

In high-risk environments, personas help teams design with empathy and foresight, not just compliance.



What should teams be careful to avoid when using personas in mental health design?

There are a few important pitfalls:

- Over-simplification, which can flatten complex lived experiences
- Pathologising language that defines people by diagnosis rather than circumstance or agency
- False representation, where personas are created without genuine lived-experience input
- Assuming one persona fits all, rather than recognising diversity, fluctuation, and intersectionality

Personas should support dignity, voice, and choice — not reinforce assumptions or institutional bias.



LOWER GROUND

Clinical Research Facility

- Medical Diagnosis
- Research
- Early Intervention
- Virtual Reality
- Eye Tracking

PE Hall

- Exercise
- Group Therapy
- Showers
- Change Facilities
- Lockers

GROUND FLOOR

Outpatients Department

- Eating Disorders
- Sensory Room
- Therapy Consulting
- Crisis Line

Reception

- Information
- Building Management
- Bicycle Parking
- External Landscaping
- Atrium
- Feature Art

FIRST FLOOR

Outpatients Department

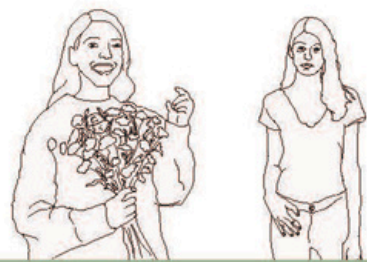
- Psychiatric Assessment
- Individual & Family Therapy
- Observation Suites

SECOND/THIRD FLOOR

Office

- Collaboration
- ThinkTank
- Researchers
- Clinicians
- Modern Practice
- Kitchenette
- External Terrace
- Meeting Rooms
- Work Pods

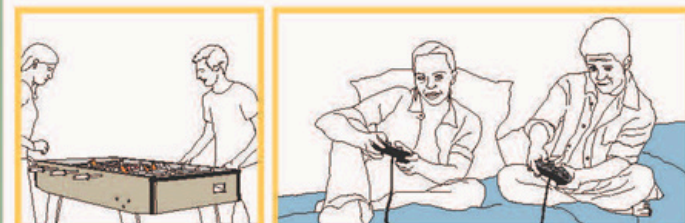




FOURTH FLOOR

Inpatients

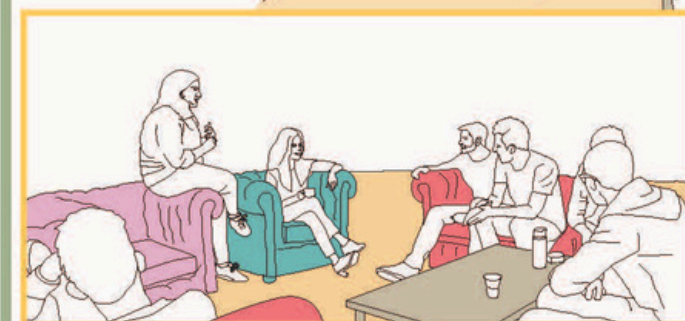
- Home
- Bedroom
- Ensuite
- Games Room
- Dining
- Living Space
- De Escalation
- Clinical Treatment
- Nurse Base
- Resource Room
- External Terrace



FIFTH FLOOR

Inpatients

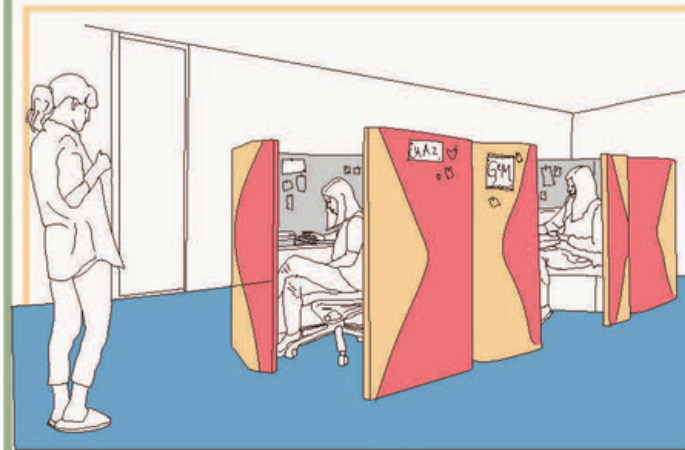
- One to one Therapy
- Activities of daily living
- Community Step Down
- Arts Room
- Group Therapy
- Staff Rest
- Inpatient Staff Offices
- Sensory Room



PLANT



SEVENTH FLOOR

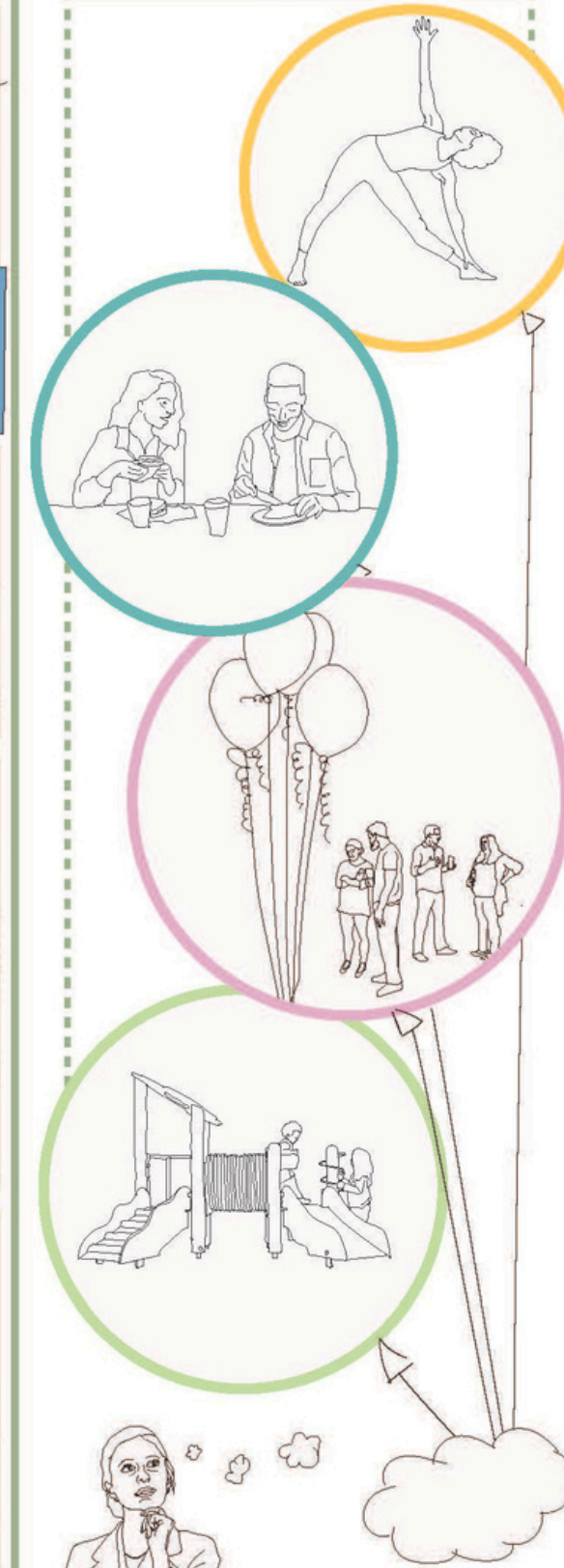


School

- Education
- One on One learning
- Variety of Space
- Separation from Inpatients space
- Science
- Art
- Music
- Horticultural Therapy
- Exam Room
- Staff Office
- Headmasters Office



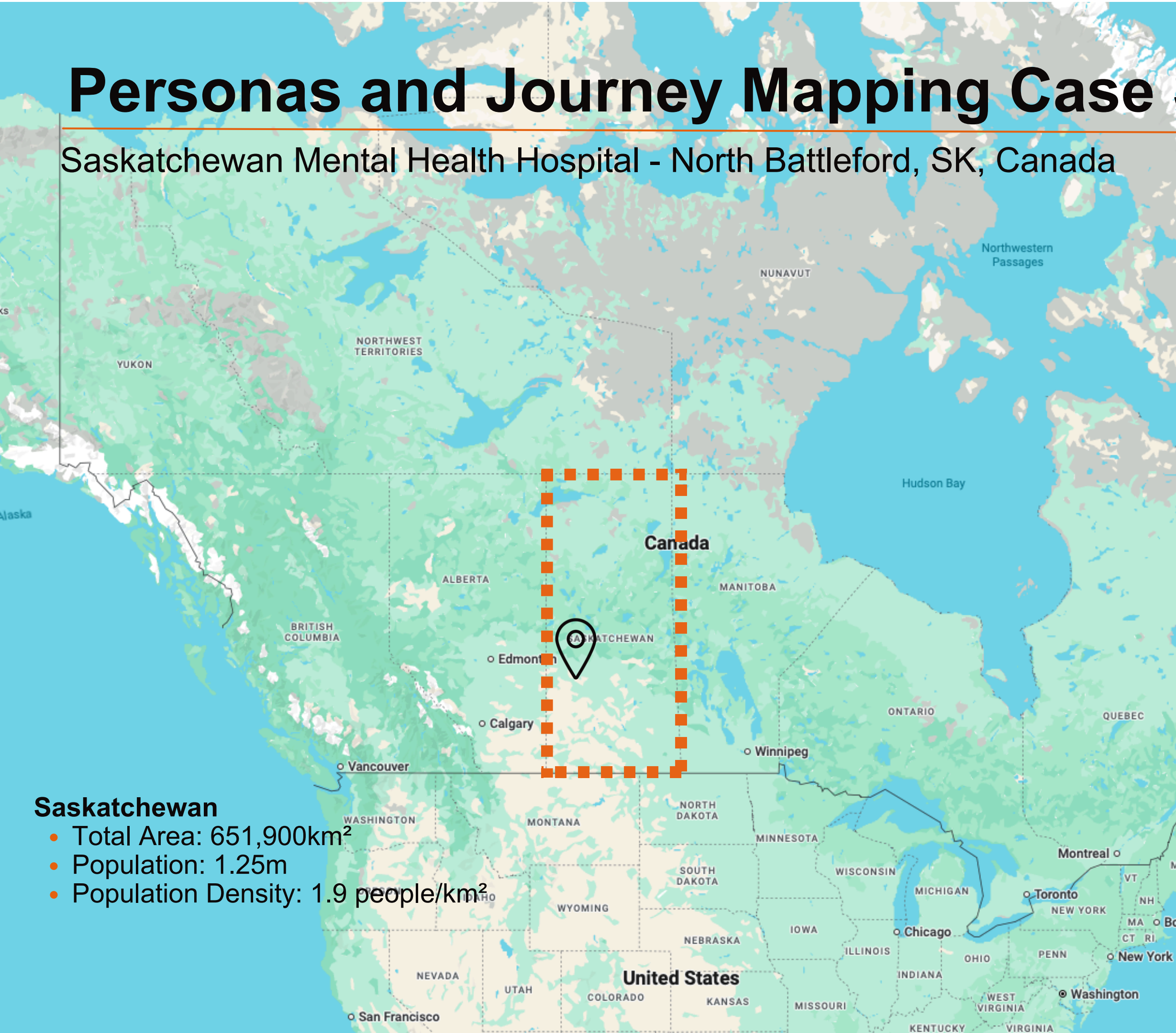
ROOF



Personas and Journey Mapping Case Study

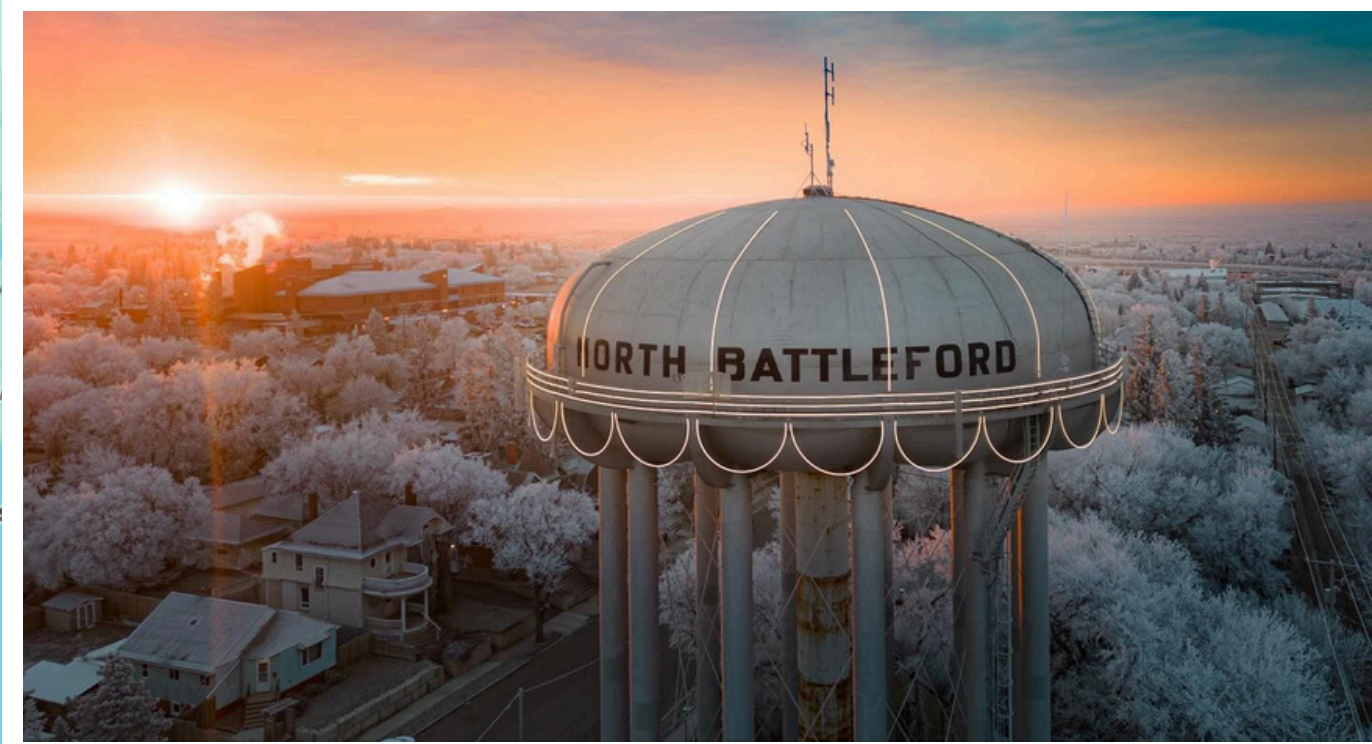
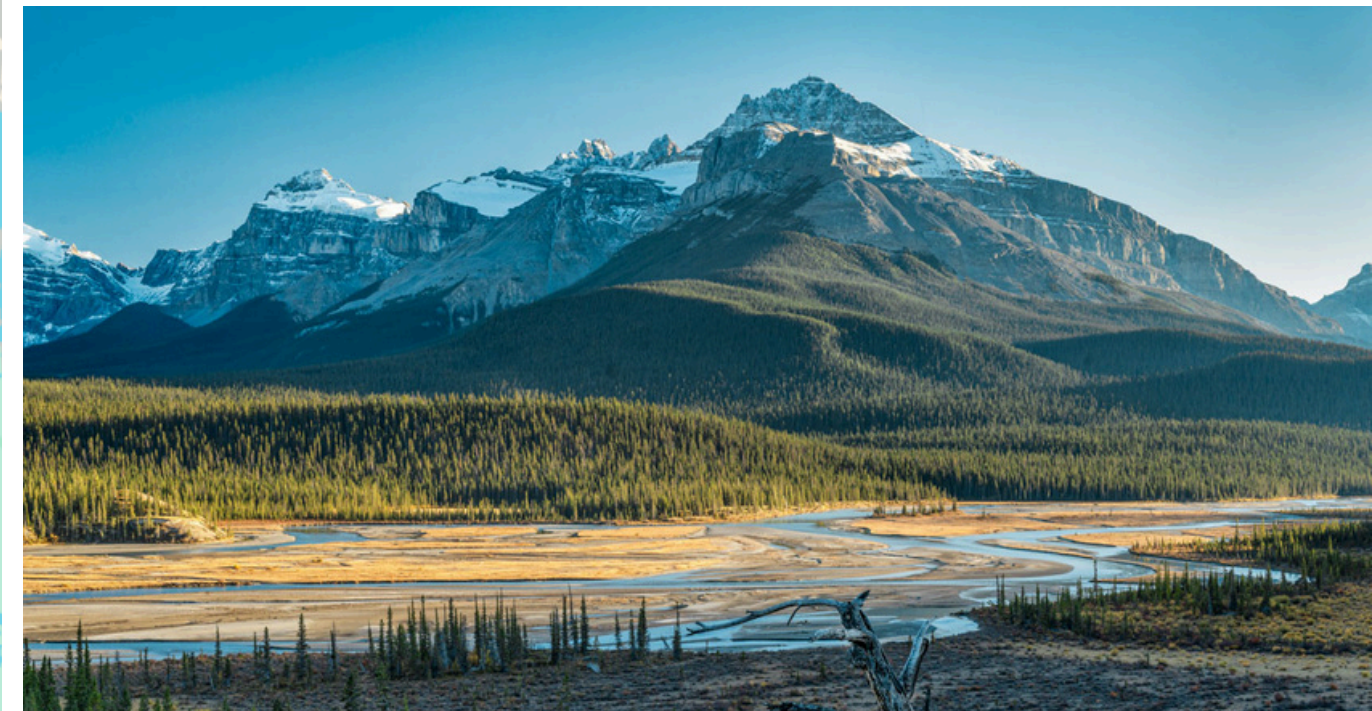


Saskatchewan Mental Health Hospital - North Battleford, SK, Canada



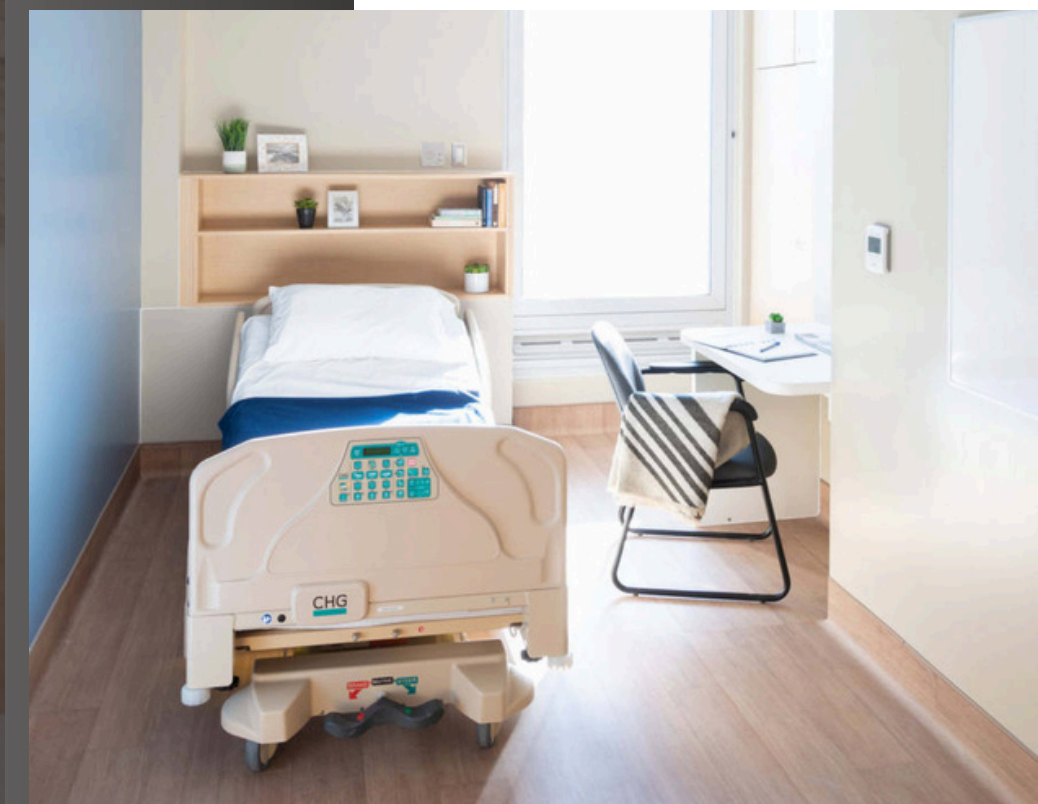
Saskatchewan

- Total Area: 651,900km²
- Population: 1.25m
- Population Density: 1.9 people/km²



Saskatchewan Mental Health Hospital

North Battleford, Canada



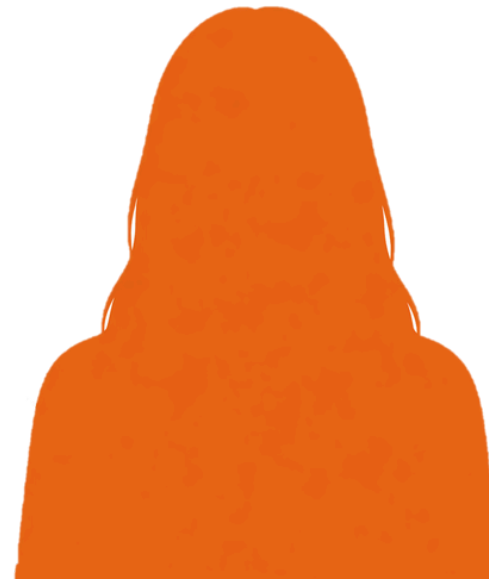
Key Features

284 bed provincial psychiatric facility serving tertiary and forensic/corrections pathways
Designed to move forensic pathway from custodial model toward rehabilitation-led model
Non-institutional feel, therapeutic spaces, recovery focussed programming

Saskatchewan Mental Health Hospital



Stakeholder Profiles



Psychiatric Rehabilitation Inpatient

Admitted for longer-stay mental health treatment and recovery
Non-secure Inpatient Stay

Adult inpatient in the non-secure pathway, with needs too complex to be met in a local mental health unit. They may be anxious, easily overwhelmed and unsure how to navigate an unfamiliar environment. Their experience is shaped by how easy it is to orient themselves, access therapy and activity, and get help without added stress.



Secure Forensic Patient

Receiving care within a secure and supervised forensic setting
Secure Inpatient Stay

Adult patient receiving treatment within the secure wing. Their movement is more controlled, their access to shared spaces is more structured, and they may be highly alert to surveillance, authority and restriction. Their experience is shaped by whether safety is delivered with dignity, clarity and calm.



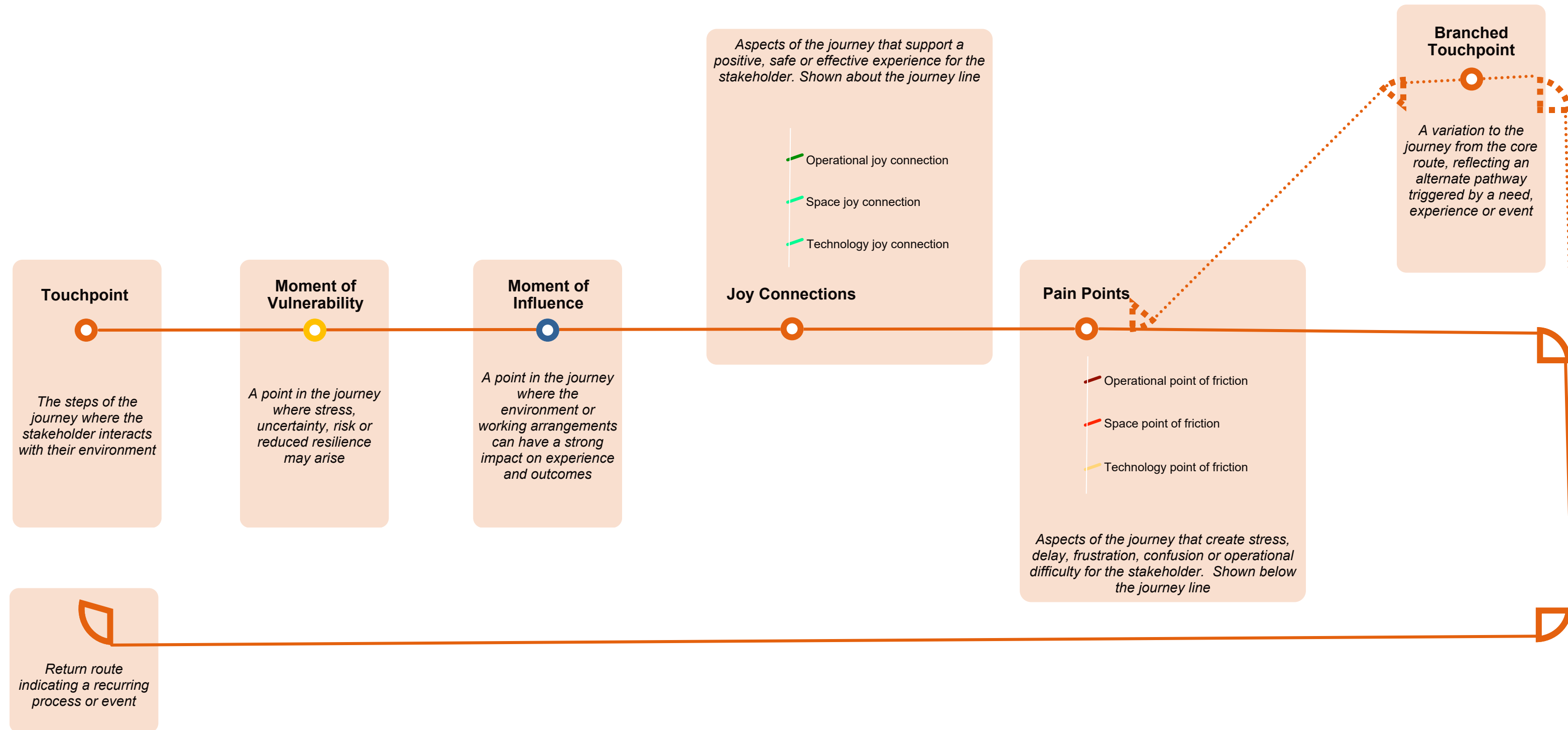
Frontline Staff Member

Therapeutic caregiver maintaining safety and operational control
Staff Journey

A nurse, clinician or support worker balancing therapeutic care, observation, movement management and incident response. Their experience depends on whether systems are integrated, communication is immediate, and shared spaces can be managed safely without constant friction.

Saskatchewan Mental Health Hospital

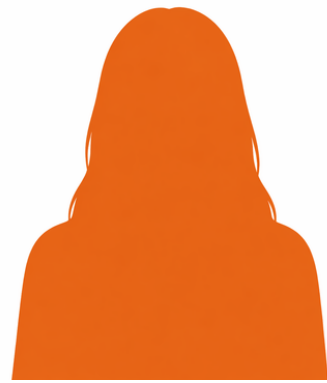
Overview of Journey Model



Saskatchewan Mental Health Hospital



Journey Model | Non-secure Inpatient Stay



Psychiatric Rehabilitation Inpatient

Admitted for longer-stay mental health treatment and recovery

Joy Connections

- Clear point of entry
- Calm welcome from staff
- Clear explanation of next steps
- Reassurance from staff
- Private room and personal space supports calm
- Simplicity of room layout
- Environment feels safe and dignified
- Daily structure is explained clearly most of the time
- Expectations are reinforced consistently
- Support available at key moments during the day
- Key destinations are easy to find
- Movement is well coordinated
- Movement from unit to activity space is not intimidating
- Route is simple
- Staff support is present without being intrusive
- Space feels calm and welcoming
- Environment supports focus and participation
- Calm staff response
- Communication remains reliable during moments of stress

Admission / Arrival

Settling In

Orientation & Routine

Move to Therapy

Therapy Participation

Seeking Help

- First impression feels clinical and restrictive
- Excessive noise and visual clutter
- Waiting area feels exposed
- Multiple staff interactions create confusion
- Arrival feels procedural rather than supportive
- Fragmented admissions process
- Check in systems are slow
- Information overload
- Left unsure of how the unit operates
- Bare room lacks warmth
- Poor personal control of room
- Little sense of ownership or personal anchoring
- Limited cues about where things are located or how the space works
- Monitoring and security feels intrusive or unexplained
- No obvious route to seek help
- Messaging from staff can be inconsistent
- Unsure what happens when
- Daily routine is understood in fragments rather than as a whole
- Some areas are difficult to navigate
- Spaces feel repetitive or insufficiently differentiated
- Security features intimidating
- Poor coordination between department staff
- Bottlenecks at access points build anxiety
- Access control causes delay / confusion
- Visible controls make movement feel restrictive
- Staff attention split between care and logistics
- Security processes interrupt the activity
- Space feels too exposed or controlled
- No variation in participation space
- Difficult to relax enough to engage
- Comfort, acoustics and visibility undermine participation
- Observation and security dominate certain activities
- Unsure where to go for help
- Support feels procedural
- No obvious calm space to pause or regroup
- Systems support escalation over reassurance

Key

- Touchpoint
- Moment of Vulnerability
- Moment of Influence

- #### Joy Connections
- Operations
 - Space
 - Technology

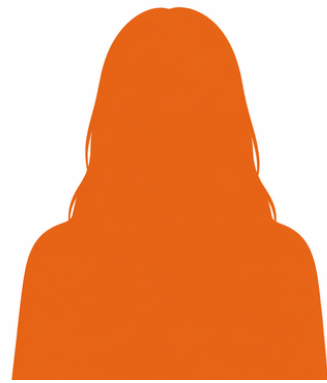
- #### Pain Points
- Operations
 - Space
 - Technology

Pain Points

Saskatchewan Mental Health Hospital



Journey Model | Non-secure Inpatient Stay



Psychiatric Rehabilitation Inpatient

Admitted for longer-stay mental health treatment and recovery

Joy Connections

OPERATIONS

- ✓ Calm welcome from staff
- ✓ Clear explanation of next steps
- ✓ Reassurance from staff
- ✓ Daily structure is explained clearly most of the time
- ✓ Expectations are reinforced consistently
- ✓ Support available at key moments during the day
- ✓ Movement is well coordinated
- ✓ Staff support is present without being intrusive
- ✓ Calm staff response

SPACE

- ✓ Clear point of entry
- ✓ Private room and personal space supports calm
- ✓ Simplicity of room layout
- ✓ Environment feels safe and dignified
- ✓ Key destinations are easy to find
- ✓ Movement from unit to activity space is not intimidating
- ✓ Route is simple
- ✓ Space feels calm and welcoming
- ✓ Environment supports focus and participation

TECHNOLOGY

- ✓ Communication remains reliable during moments of stress

Pain Points

OPERATIONS

- ✗ Multiple staff interactions create confusion
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SPACE

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TECHNOLOGY

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- ✗ Access control causes delay / confusion
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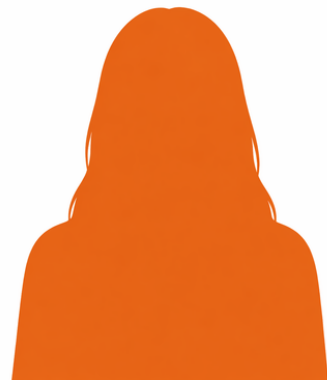
Key

- Joy Connections
 - Operations
 - Space
 - Technology
- Pain Points
 - Operations
 - Space
 - Technology

Saskatchewan Mental Health Hospital



Journey Model | Non-secure Inpatient Stay



Psychiatric Rehabilitation Inpatient

Admitted for longer-
stay mental health
treatment and recovery

“

I need to know what happens next, where I am meant to go, and how to get help without asking three times.

”

OPERATIONAL INSIGHTS

- Arrival should be managed as a therapeutic encounter, fewer handovers, less repetition and clearer ownership of the patient experience.
- Early orientation needs to be reinforced, not treated as a one-off explanation at admission.
- Daily routine should be communicated coherently, using consistent language across staff and settings.
- Staff coordination between the unit and therapy/activity areas needs to be tighter, so movement feels planned and calm rather than delayed and procedural.
- Movement to therapy spaces should be treated as part of care, not just a logistical or security exercise.
- Therapy sessions need greater protection from operational interruptions to reduce staff distraction.
- Help-seeking pathways must be clear to patients and matched by a response model that feels calm, visible and relational.
- The operating model should reduce the sense of being passed between people, places and systems, which is a recurring source of stress.

PHYSICAL ENVIRONMENT INSIGHTS

- Arrival should feel calm, legible and non-institutional, with a clear point of entry and waiting areas that do not feel exposed.
- Private areas should support dignity, warmth and ownership, with simple layouts, personal control and clear places for belongings.
- The unit should use strong spatial cues and differentiation so patients can understand where they are and how the environment works.
- Routes to therapy and activity spaces should be direct, simple and low-friction, reducing bottlenecks and anxiety at thresholds.
- Shared therapeutic spaces should offer more variation and choice, including settings that feel less exposed and better support different levels of engagement.
- Comfort factors such as acoustics, visibility, privacy and sensory load need to be designed deliberately, to facilitate participation.
- Calm, easy-to-access pause or de-escalation spaces should be available near key transition points and help-seeking moments.
- Safety and observation should be integrated discreetly, so spaces feel therapeutic first and controlled second.

TECHNOLOGY INSIGHTS

- Admissions and check-in systems should be streamlined and joined up to reduce repetition, delay and information overload on arrival.
- Staff communication tools should support clear, consistent messaging about next steps, routine and patient needs across the journey.
- Intercommunication and help-seeking systems should give patients an obvious, simple route to ask for help without having to search for staff.
- Access control should support smooth, predictable movement to therapy spaces without creating delay, confusion or a punitive feel.
- Monitoring and security systems need to feel proportionate and unobtrusive, especially in bedrooms, activity spaces and moments of stress.
- Technology should support reassurance and early intervention, not only activate once a situation has escalated.
- Communications reliability is critical in therapy transitions and distress moments, where poor system performance quickly becomes part of the patient experience.

Saskatchewan Mental Health Hospital



Journey Model | Non-secure Inpatient Stay



Psychiatric
Rehabilitation Inpatient

Admitted for longer-
stay mental health
treatment and recovery

**CLARITY AND
ORIENTATION**

**THERAPEUTIC
FEEL OVER
INSTITUTIONAL**

**CONTINUITY
ACROSS
PEOPLE,
PLACES AND
SYSTEMS**

**LOW FRICTION
TRANSITIONS**

**SUPPORT
REGULATION
AND CALM**

**EASY ACCESS
TO SUPPORT**

**DISCREET,
REASSURING
SUPPORT**

**PROTECT
THERAPEUTIC
ENGAGEMENT**

Saskatchewan Mental Health Hospital



Journey Model | Secure Inpatient Stay



Secure Forensic Patient

Receiving care within a secure and supervised forensic setting



Key

- Touchpoint
- Moment of Vulnerability
- Moment of Influence

Joy Connections

- Operations
- Space
- Technology

Pain Points

- Operations
- Space
- Technology

Saskatchewan Mental Health Hospital



Journey Model | Secure Inpatient Stay



Secure Forensic Patient

Receiving care within a secure and supervised forensic setting

Joy Connections

OPERATIONS

- ✓ Calm, respectful handover to unit staff
- ✓ Clear initial explanation of next steps
- ✓ Early reassurance reduces fear of the environment
- ✓ Unit and basic expectations explained
- ✓ Routine is timely
- ✓ Escorting feeling respectful
- ✓ Daily structure is explained clearly most of the time
- ✓ Expectations are reinforced consistently
- ✓ Routine feels consistent
- ✓ Therapy feels genuine rather than tokenistic
- ✓ Feeling of participation, not just a risk to be managed
- ✓ Therapy gains are protected
- ✓ Response is calm and proportionate
- ✓ Re-entry is calm

SPACE

- ✓ Layout of unit is easy to understand
- ✓ Room feels safe, simple and understandable
- ✓ Physical space supports routine
- ✓ Clear boundaries separate therapy space from routine space

TECHNOLOGY

- ✓ Technology in the background during transition

Pain Points

OPERATIONS

- ✗ Rules and restrictions explained inconsistently
- ✗ Early support depends too much on discovery
- ✗ Secure routine feels imposed before understood
- ✗ Admission feels dominated by control rather than care
- ✗ Inconsistent information given
- ✗ Escalation is treated as disobedience rather than distress
- ✗ Information overload
- ✗ Movement can be subject to delays, or rescheduling
- ✗ Access feels like a privilege rather than part of care
- ✗ Routine management and control quickly reinforced
- ✗ Therapy feels tightly bound by timings and supervision
- ✗ Therapy can feel compromised by the surrounding logic of custody
- ✗ Difficulty understanding what drives access, timing, supervision decisions
- ✗ Permissions and restrictions feel inconsistent between staff

SPACE

- ✗ Lack of control is reinforced by technology
- ✗ Space offers little privacy
- ✗ Noise and crowding add to escalation
- ✗ Too many cues of surveillance
- ✗ Spaces feel repetitive or insufficiently differentiated
- ✗ Boundaries between spaces feel harsh
- ✗ Secure environment feels custodial rather than therapeutic
- ✗ Sensory discomfort makes it hard to settle
- ✗ Environment feels heavily surveilled
- ✗ First impression feels punitive
- ✗ Visibly locked thresholds create anxiety immediately
- ✗ Contrast between therapy and secure space is stark
- ✗ Decompression is seen as isolation and containment

TECHNOLOGY

- ✗ Technology contributes to denials of privileges
- ✗ Visible controls reinforce authority more than reassurance
- ✗ Monitoring and security feels intrusive
- ✗ Access control feels like being processed through security layers
- ✗ Technology dependency heightens feeling of vulnerability
- ✗ Surveillance systems very visible and intrusive
- ✗ Technology reinforces monitoring rather than trust
- ✗ Re-entry feels mechanical and punitive
- ✗ System noise adds to unease
- ✗ Security systems highly visible
- ✗ Staff attention is on systems rather than patient
- ✗ Systems used support therapy delivery without becoming the focus

Key

- Joy Connections
 - Operations
 - Space
 - Technology
- Pain Points
 - Operations
 - Space
 - Technology

Journey Model | Secure Inpatient Stay



Secure Forensic Patient

Receiving care within a secure and supervised forensic setting

“

“I need to understand why things are restricted, what happens next, and how my rehabilitation is measured.”

”

OPERATIONAL INSIGHTS

- Admission should be experienced as care within a safe setting, not control before understanding.
- Rules, restrictions and secure routines need to be explained consistently and early, so patients understand the logic of the environment rather than only feeling its constraints.
- Orientation should proactively explain permissions, timings, supervision and movement decisions, rather than leaving patients to work this out through trial and error.
- Escorting and supervised movement should feel respectful, calm and proportionate, not purely custodial.
- Routine should feel predictable and stable, with consistent reinforcement across staff rather than variation in how decisions are applied.
- Therapy should be protected from unnecessary delays, rescheduling and overly restrictive supervision, so it feels like a genuine part of care rather than a conditional privilege.
- Escalation should be interpreted and managed as distress first, not defaulted to disobedience or rule-breaking.
- Permissions and restrictions should feel consistent between staff and across shifts, reducing uncertainty and mistrust.

PHYSICAL ENVIRONMENT INSIGHTS

- Bedrooms and day spaces should balance safety with dignity, offering more privacy, simplicity and sensory calm than a purely custodial setting.
- The physical environment should support routine and predictability, with clear spatial cues that help patients understand what happens where.
- Boundaries between secure, routine and therapeutic spaces should be clear but not harsh, so movement does not feel like repeated processing through control thresholds.
- Therapeutic spaces should feel meaningfully different from secure circulation spaces, without such a stark contrast that the journey to therapy undermines the therapeutic benefit.
- Visibly locked thresholds, repetitive layouts and heavy surveillance cues should be reduced where possible, as they heighten anxiety and reinforce a punitive feel.
- Acoustic comfort, crowding and sensory conditions need careful design, because noise and overstimulation can quickly contribute to escalation.
- Decompression spaces should feel supportive and regulating, not like containment or isolation.

TECHNOLOGY INSIGHTS

- Security and monitoring systems should sit in the background wherever possible, especially during routine transitions and therapy access.
- Access control should support smooth, predictable and understandable movement, rather than feeling like passage through successive layers of permission.
- Surveillance, monitoring and security hardware should be less visually dominant, so technology does not become the defining feature of the experience.
- Systems should support care progression and therapy access, not only denial, restriction and control.
- Alarm noise, system noise and other intrusive technical signals should be minimised, as they can add to unease and reinforce institutional control.
- Technology should enable staff to remain relational and patient-focused, rather than drawing attention toward devices, controls and monitoring workflows.
- The overall design intent should be that technology supports therapy delivery without becoming the experience itself.

Saskatchewan Mental Health Hospital



Journey Model | Secure Inpatient Stay



Secure Forensic
Patient

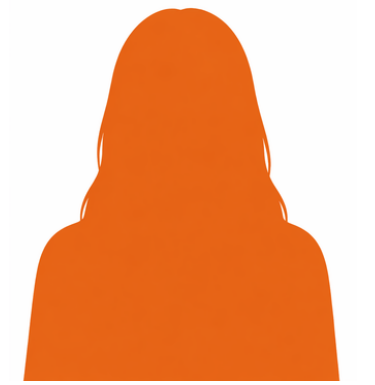
Receiving care within a
secure and supervised
forensic setting

CARE BEFORE CONTROL	EXPLAIN RESTRICTION LOGIC	CALM AND LEGIBLE SECURITY	PROTECT THERAPEUTIC VALUE
SOFTEN CUSTODIAL ENVIRONMENT	TECHNOLOGY IN THE BACKGROUND	SUPPORT DISTRESS WITHOUT ESCALATION	MAKE REHABILITATION FEEL REAL

Saskatchewan Mental Health Hospital



Journey Model | Crosscutting Themes



Psychiatric
Rehabilitation Inpatient



Secure Forensic
Patient

CLARITY AND ORIENTATION	EASY ACCESS TO SUPPORT	LOW-FRICTION TRANSITIONS	SUPPORT REGULATION AND CALM	PROTECT THERAPEUTIC ENGAGEMENT
THERAPEUTIC OVER INSTITUTIONAL	DISCREET, REASSURING SAFETY	LEGIBLE MOVEMENT AND THRESHOLDS	CONSISTENCY ACROSS PEOPLE, PLACES AND SYSTEMS	PROTECT DIGNITY THROUGH DESIGN
CARE BEFORE CONTROL	EXPLAIN RESTRICTION LOGIC	CALM AND LEGIBLE SECURITY	SOFTEN CUSTODIAL ENVIRONMENT	MAKE REHABILITATION FEEL REAL

Saskatchewan Mental Health Hospital

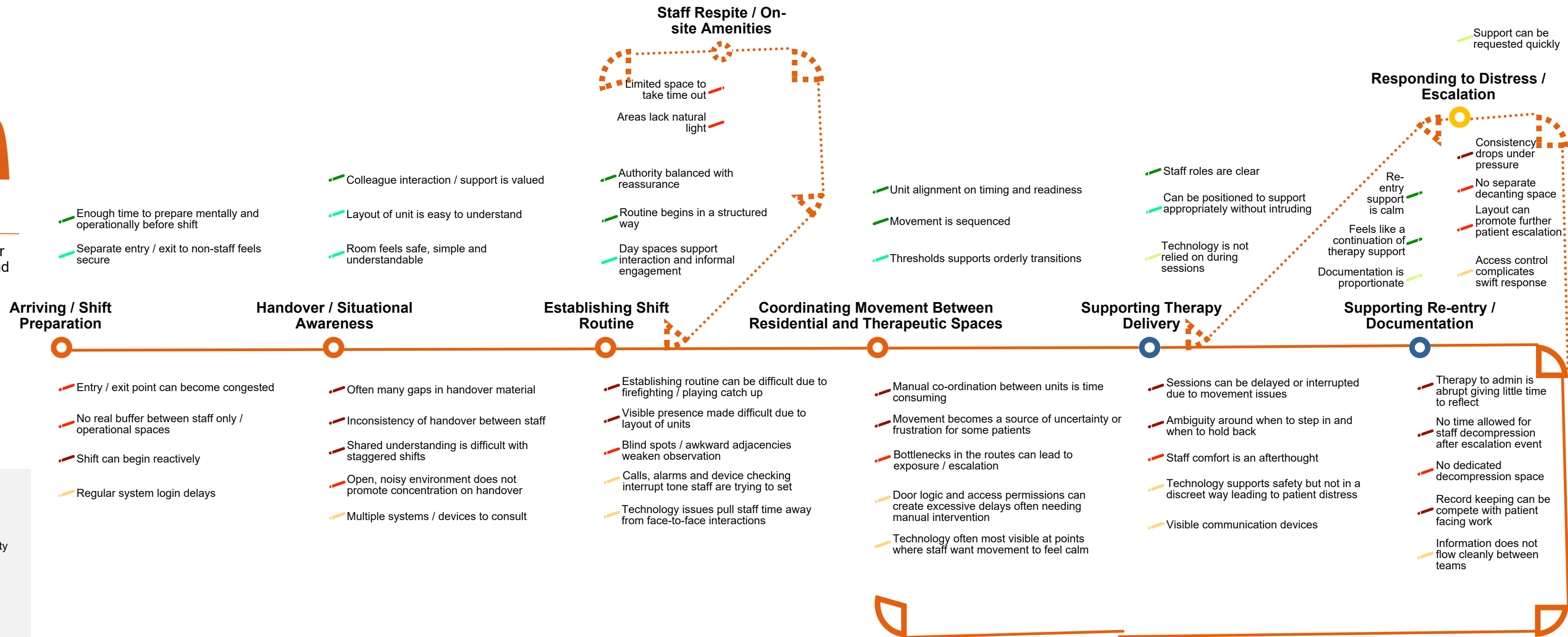


Journey Model | Frontline Staff Journey



Frontline Staff Member

Therapeutic caregiver maintaining safety and operational control



Key

- Touchpoint
- Moment of Vulnerability
- Moment of Influence

Joy Connections

- Operations
- Space
- Technology

Pain Points

- Operations
- Space
- Technology

Saskatchewan Mental Health Hospital



Journey Model | Frontline Staff Journey



Frontline Staff Member

Therapeutic caregiver maintaining safety and operational control

Joy Connections

OPERATIONS

- ✓ Enough time to prepare mentally and operationally before shift
- ✓ Colleague interaction / support is valued
- ✓ Authority balanced with reassurance
- ✓ Routine begins in a structured way
- ✓ Unit alignment on timing and readiness
- ✓ Movement is sequenced
- ✓ Staff roles are clear
- ✓ Feels like a continuation of therapy support
- ✓ Re-entry support is calm

SPACE

- ✓ Layout of unit is easy to understand
- ✓ Room feels safe, simple and understandable
- ✓ Separate entry / exit to non-staff feels secure
- ✓ Day spaces support interaction and informal engagement
- ✓ Thresholds supports orderly transitions
- ✓ Can be positioned to support appropriately without intruding

TECHNOLOGY

- ✓ Support can be requested quickly
- ✓ Documentation is proportionate
- ✓ Technology is not relied on during sessions

Pain Points

OPERATIONS

- ✗ Shift can begin reactively
- ✗ Often many gaps in handover material
- ✗ Inconsistency of handover between staff
- ✗ Shared understanding is difficult with staggered shifts
- ✗ Establishing routine can be difficult due to firefighting / playing catch up
- ✗ Visible presence made difficult due to layout of units
- ✗ Manual co-ordination between units is time consuming
- ✗ Movement becomes a source of uncertainty or frustration for some patients
- ✗ Sessions can be delayed or interrupted due to movement issues
- ✗ Ambiguity around when to step in and when to hold back
- ✗ Therapy to admin is abrupt giving little time to reflect
- ✗ No time allowed for staff decompression after escalation event
- ✗ Record keeping can be compete with patient facing work
- ✗ Consistency drops under pressure

SPACE

- ✗ Entry / exit point can become congested
- ✗ No real buffer between staff only / operational spaces
- ✗ Open, noisy environment does not promote concentration on handover
- ✗ Blind spots / awkward adjacencies weaken observation
- ✗ Bottlenecks in the routes can lead to exposure / escalation
- ✗ Staff comfort is an afterthought
- ✗ No dedicated decompression space
- ✗ No separate decanting space
- ✗ Layout can promote further patient escalation
- ✗ Limited space to take time out
- ✗ Areas are closed of with no natural light

TECHNOLOGY

- ✗ Calls, alarms and device checking interrupt time staff are trying to set
- ✗ Technology issues pull staff time away from face-to-face interactions
- ✗ Door logic and access permissions can create excessive delays often needing manual intervention
- ✗ Technology often most visible at points where staff want movement to feel calm
- ✗ Regular system login delays
- ✗ Multiple systems / devices to consult
- ✗ Technology supports safety but not in a discreet way leading to patient distress
- ✗ Visible communication devices
- ✗ Information does not flow cleanly between teams
- ✗ Access control complicates swift response

Key

- Joy Connections
 - Operations
 - Space
 - Technology
- Pain Points
 - Operations
 - Space
 - Technology

Saskatchewan Mental Health Hospital



Journey Model | Frontline Staff Journey



Frontline Staff Member

Therapeutic caregiver maintaining safety and operational control

“
I need to start my shift knowing what matters, move people safely without incident, and stay focused on care rather than chasing systems.”

OPERATIONAL INSIGHTS

- The shift should begin with clear role allocation, mental preparation and shared priorities, rather than staff being pulled straight into reactive work.
- Handover needs to be more structured and consistent, particularly where shifts are staggered and shared understanding can quickly fragment.
- Establishing routine is a frontline care task in its own right: staff need enough operational headroom to set tone, reassure patients and create predictability before firefighting takes over.
- Staff need to balance authority with reassurance, and the operating model should support that.
- Movement between residential and therapeutic spaces should be treated as a joint operational and therapeutic process, not simply a transfer or security event.
- Coordination between units and therapy areas should be tighter, so staff are not relying on repeated manual intervention to keep movement working.
- The journey suggests that the operating model should do more to shield therapeutic time from avoidable interruption.
- After escalation, re-entry should feel like a continuation of care, not an abrupt switch from therapeutic work into paperwork and process.

PHYSICAL ENVIRONMENT INSIGHTS

- Handover needs a dedicated, quiet and concentrated space that supports focused discussion and reduces noise, interruption and fragmentation.
- Blind spots, awkward adjacencies and poorly resolved observation lines should be reduced
- Day spaces should support informal engagement, reassurance and routine-setting, not just passive supervision.
- Routes between residential and therapeutic spaces should be designed to minimise bottlenecks, exposed waiting and escalation risk during movement.
- Thresholds and access points should support orderly transitions, avoiding layouts that make movement feel abrupt, or operationally cumbersome.
- Following escalation, the environment should provide appropriate decompression and regrouping space for both patients and staff, rather than forcing an immediate return to routine or admin.
- Staff wellbeing spaces should not be an afterthought; the journey suggests a need for short reset space after high-pressure events.

TECHNOLOGY INSIGHTS

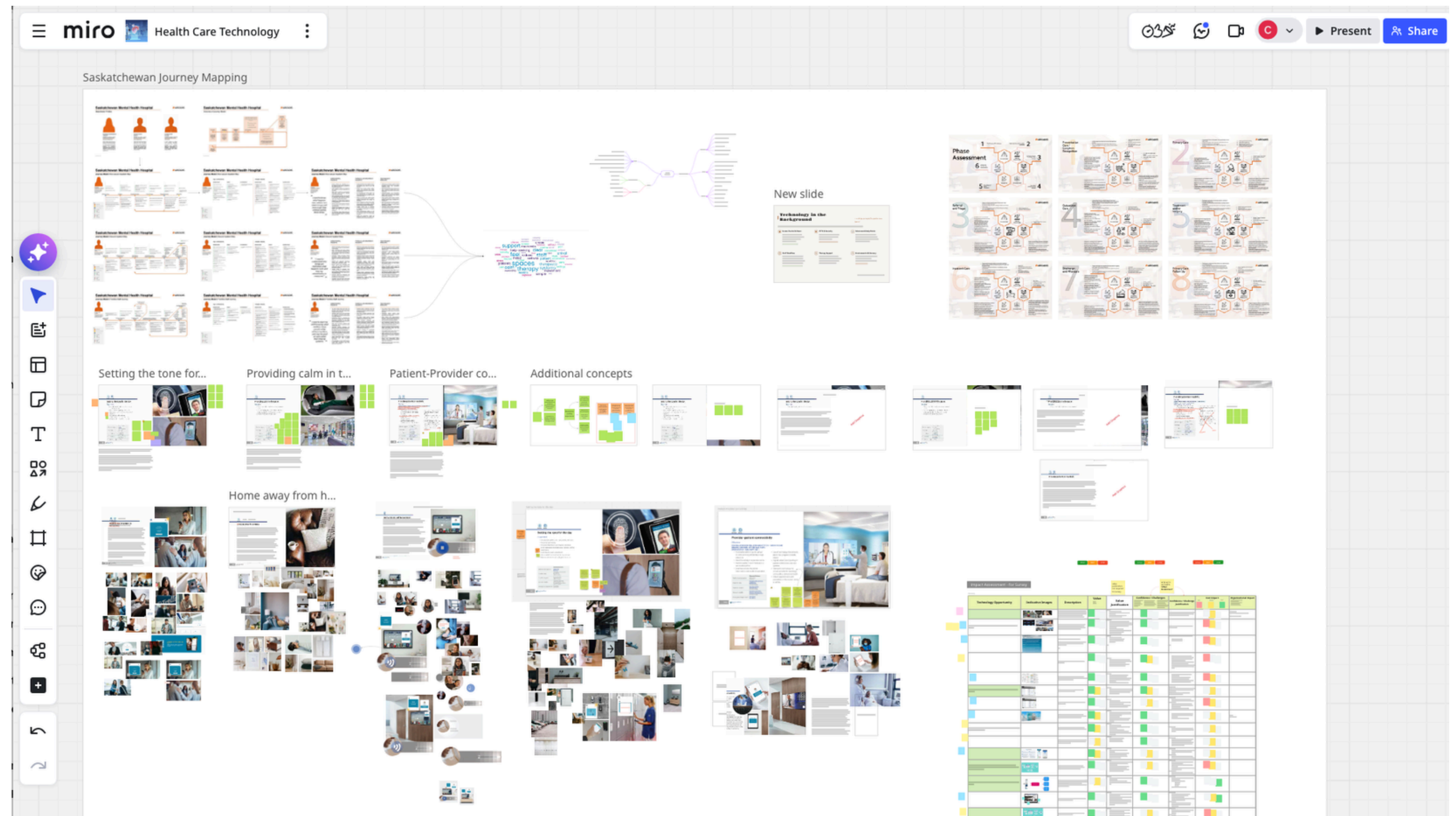
- Core systems need to support a quick, reliable start to shift, with minimal login delay and immediate access to the tools staff need.
- Technology should support staff coordination without pulling attention away from face-to-face care.
- Calls, alarms and device-checking behaviours should be designed to be less disruptive, as they directly undermine the calm tone staff are trying to establish.
- Communication tools should support real-time coordination between units and activity areas, reducing manual chasing and workarounds during movement.
- Door logic and access permissions need to support predictable, timely movement, rather than creating delays that staff must manually override.
- Technology should be least visible at the moments where calm matters most.
- Safety systems must be discreet in therapeutic settings, so staff can protect safety without introducing additional patient stress.
- Staff need to be able to request support quickly and unobtrusively during escalation, with systems that aid response rather than complicate it.
- Information needs to flow more cleanly between teams and shifts.

Saskatchewan Mental Health Hospital

Insight Analysis – Technology Brief

Make Technology Quieter

1. Adopt a “technology in the background” design principle across all disciplines
2. Minimise visible tech clutter
3. Reduce the notion of ‘technology as authority’



Saskatchewan Mental Health Hospital

Technology Innovation



Security

- Graded security strategy by pathway and space type
- Design thresholds as integrated assemblies
- Reduce custodial feel of secure components
- Dim surveillance and control visibility



ICT Network Design

- Resilient full coverage digital infrastructure
- Network designed around real stakeholder journeys
- Segment and protect services appropriately
- Reduce digital friction at the point of care



Audio / Visual

- AV-ready vs AV-embedded
- Selective placement of AV aligned to care requirements
- Clear, inclusive communication at key interaction points
- Discreet communication interfaces



Systems Engineering

- Care model = coordinated system behaviours
- Define standards for technology expression
- Coordinate technology domains as cohesive unilateral system



Integration & Automation

- Coordinate movement and transition with access control / security protocols
- Support quieter, proportionate responses
- Improve continuity across communications and information sharing
- Integration to support care, not just control





Design in Mental Health

CONFERENCE | EXHIBITION | AWARDS



**Design Thinking Workshop:
Enhancing the Mental Health
Patient Journey**

**Time: 14:30 - 15:30
Date: 3 June 2026
Theatre: Workshop**