



## KEY POINT SUMMARY

### OBJECTIVES

This study presents the benefits of participatory design and planning through three case studies that took place over a 15-year period.

## Including patients, staff, and visitors in the design of the psychiatric milieu

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### Key Concepts/Context

Most research addressing environmental design for healthcare facilities focuses on expert-determined and expert-driven outcomes. Little attention has been given to the perspectives offered by those who are ultimately using the facilities, namely the patients, staff, and visitors. Participatory design and planning (PDP) is a method that takes these non-expert opinions into consideration while operating under three assumptions. First, healthcare facilities are complex environments that require a team of people who can understand and maintain structured information necessary for optimum design. Secondly, workers will be more invested in their workplace if they understand the reasoning behind design decisions. Lastly, as healthcare facilities are ultimately about human relationships and caring for the ill, facilities need to be populated by these invested staff members who are actively engaged with the facility itself. Additionally, psychiatric patients especially present reactions to physical environments not understood by designers. Engaging and involving relevant communities or “clients” early on in the design process generates insightful information and social capital among designers and clients.

### Methods

The following three studies were explained and analyzed to assess the overall effectiveness and potential implications of PDP:

#### Case 1:

Psychiatric patient behavior and setting preferences were gathered through a multi-phase process to develop a 20-year master design plan for a large (212-bed) Canadian psychiatric hospital.

- In one phase, a computer with a proprietary program was used to confidentially ask patients questions about behavioral and environmental preferences through a touchscreen system.



- In another phase, the design team held a series of community meetings with patients and staff from around the hospital to gather information and perspectives on relevant issues.
- Finally, specialized studies involving patients with specific illnesses (eating disorders, bi-polar, addictions, etc.) were conducted to understand their behavioral preferences and use of the environment.
- Overall, more than 15 community meetings and six different research studies involving around 200 patients were conducted before the design team began developing a design program.
- These studies and meetings resulted in nine “design imperatives” that has stood as a template against which new design proposals were considered and subsequently implemented for more than a decade.

#### Case 2:

- A multi-step process was created to engage staff members at a Canadian hospital in redesigning the hospital’s garden area.
- Administrators, staff, and physicians from the hospital with no design background formed an ad hoc group known as the Outdoor Living Working Group (OLWG) to redevelop the therapeutic garden.
- OLWG meetings were held to ensure that patient, visitor, and staff needs were incorporated into the new design. For this reason, information regarding garden use (time of use, duration, activities) was gathered using a post-occupancy evaluation checklist, and patient abilities were assessed using questionnaires and focus group sessions.

Follow-up interviews were conducted a year later to judge effectiveness.

#### Case 3:

- A large number of planning and design teams were asked to help redesign an aging health complex known as the Centre for Addictions and Mental Health (CAMH) in a multi-decade process that began in the late 1990’s.
- A series of volunteer focus groups using Nominal Group Techniques (Cantrill et al., 1996) were held to help the design team understand the needs of different populations within the hospital.
- To avoid unrealistic and expensive proposals from patients and staff, an investigator asked participants a series of focused questions designed to extract the information necessary to develop a basic design program. These questions included, “What are your desired experiences while at CAMH?”, and “What are your desired behaviors?”



## DESIGN IMPLICATIONS

To improve relations between designers, staff, and patients, while also gaining unique and potentially well-informed design recommendations, designers and planners should consider engaging staff and patients for design input. All three case studies showed that patients and staff alike found benefits in access to outdoor areas, particularly where degrees of personal freedom could be exercised through exploring, meeting in groups, or sightseeing.

## Findings

### Case 1:

Nine “design imperatives”, or abstract objectives, including diversity, complexity, discovery, engagement, connection, ceremony, control, manipulation, and achievement were agreed upon and applied to the facility over time. The designs resulting from these imperatives include: a park-like environment with scenic views, accessible views of the hospital entrance as well as foot paths nearby, accessible views overlooking trails into nearby woods and planting beds, bird feeders, accessible views of pedestrians, access to natural settings, tree and wildflower identification tags, morning and evening flag raising and nostalgic furnishings, availability of varied seating arrangements with moveable chairs and picnic tables, encouragement of personalization, and an area designated for outdoor privileges with a wildflower and bird brochure that has check boxes for “sightings”.

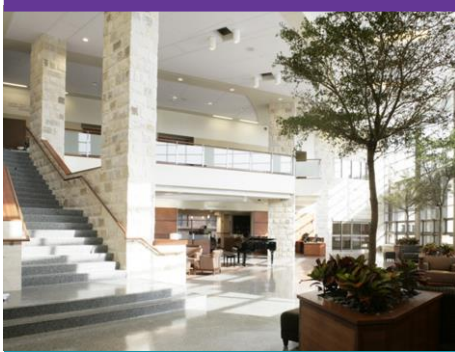
### Case 2:

After realizing the disconnect between patient sleep schedules and garden staffing, the OLWG began encouraging the use of the garden by changing staff schedules and proactively brainstorming ideas for engaging patients, visitors, and staff in garden activities. Follow-up interviews conducted a year later indicated that overall use of the garden had increased.

### Case 3:

Design recommendations resulting from the focus groups included seating areas for small and medium sized groups (three to 15 people), grassy outdoor areas for activities, gardening areas, and wheelchair- accessible pathways for strolling.

Overall, after applying a process that involved the participation of patients, staff, and visitors in designing various healthcare centers over the span of nearly two decades, it is evident that patients and staff have well-informed and unique knowledge pertaining to their environment and their needs. Considering this, Evidence-Based Design should not be the only tool used in facility design. Social capital often resulting in designs valued by patients and staff was often the result of these processes.



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Limitations

These findings are derived from a small number of case studies that focus on highly particular environments catering to patients with specific medical needs. No quantifiable measurements were taken to gauge improvements in facility efficiency or patient satisfaction.

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