Constructing Trust

in acute inpatient mental healthcare facilities:

the role of physical, social and symbolic

environments of care in supporting therapeutic safety

"Architecture, of the all the arts,

works most slowly, but most surely, on the soul."

Ernest Dimnet: *What We Live By* (1932)

Mary Therese Potter Forbes

CERTIFICATE OF ORIGINAL AUTHORSHIP

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the field.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis has been acknowledged. In addition, I certify that all information sources and literature are indicated in the thesis.

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Signature of Student:

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Dedications

This work is dedicated to the many people who have had the fear and suffering arising from an acute episode of mental illness compounded by the places in which they have sought help. My hope is that it goes some way toward preventing vulnerable people experiencing *sanctuary trauma*, surely the most insidious and unrecognised of adverse medical events.

It is also dedicated to Alan Hodgkinson, former Deputy Head of the School of Public Health and Community Medicine at UNSW, who died prematurely and unexpectedly on 2 June 2011. Alan was a psychiatric nurse by training and took a special interest in this research. I will be forever grateful to Alan and thoughts of him always inspired me when I began to flag.

PREFACE

On 31 August 2015 amendments to the New South Wales (NSW) *Mental Health Act 2007* came into effect. The objects of the Act are no longer to provide for the "*...care, treatment and control*" of people who are mentally ill or mentally disordered but to provide for their care, treatment and *"recovery",* which has been defined elsewhere as: *"the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability"* (Commonwealth of Australia 2010).

The legislative change reflects changing perspectives of, and attitudes towards, mental illness but whether the change will affect the planning and design of acute inpatient mental healthcare units is uncertain.

Current practices and facilities fall well short of creating the physical, social and symbolic environments of care conducive to recovery. The risk management paradigm, with its focus on controlling perceived hazards and uncertain futures, has come to dominate approaches to the built environment in acute inpatient mental healthcare. Safety, from this perspective is approached in very narrow and concrete ways, through overt security, surveillance and external controls, making tangible Jeremy Bentham's ideal of the 'panopticon carceral' (Curtis et al. 2013; Foucault 1975). Even the Australian National Standards for Mental Health Services defines 'safety' merely as *"*freedom from hazard*" (Commonwealth of Australia 2010)* and this definition is applied in the relevant safety standard (Standard 2) to the activities and environment of the mental health service for the protection of consumers, carers, families, visitors, staff and community .

Such a narrow approach has the potential of privileging controls aimed at protecting people from consumers over implementation of the United Nation's (UN) principles for the protection and improvement of those with mental illness, which are incorporated into the NSW Charter of the Rights of People with Mental Illness *(Mental Health Drug & Alcohol Office 2011)*, including Principle 9 that:
"..every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment.." (United Nations 1991)

The British *Royal College of Psychiatrists* (the College) rejects the view that safety in acute inpatient mental healthcare is produced by controlling access to external concrete hazards, rather the College argues that safety is created by:
"*good relationships and interactions and the trust that is built up between those individuals" (Royal College of Psychiatrists 2011).*

Trust is understood from this perspective as fundamental to a therapeutic relationship and the essence of the recovery model of care wherein risk taking is required. It involves a mutual willingness to take risks in the therapeutic relationship where both the consumer and clinician are vulnerable to the acts of the other. When concerns about hazard reduction dominate institutional ideas about safety and the material/built environment is devised to address perceived hazards, the development of entrusting social milieus enabling the growth of self-efficacy and the reclaiming of identity are likely to be disrupted.

This perspective made me - a nursing academic and lawyer who taught risk management, patient safety, leadership and organisational change, and who had

once worked in health facility planning, curious as to how acute inpatient mental healthcare environments are made safe without the use of oppressive architectural responses to perceived risk. The perspective of the Royal College of Psychiatrists presumes that an over-emphasis on surveillance and control in a building impedes the construction of therapeutic relationships, thereby compromising safety and leading to consumer and care provider harms. The perspective equates the concept of a trusting therapeutic relationship with therapeutic safety.

I set out to understand how the physical habitat/material environment of these places supported or hindered the creation of trust and thus therapeutic safety, and not simply the technical safety of hazard reduction.

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ACRONYMS

AHS	Area Health Service
AMHU	Acute Mental Health Unit
CAMHS	Child and Adolescent Mental Health Service
CSP	Clinical Services Plan
DD&C	Design Development & Construct procurement methodology
D&C	Design & Construct procurement methodology
DH	Department of Health (UK)
EssenCES	Essen Climate Evaluation Schema
EOI	Expression of Interest
FF&E	Fixtures, Fittings & Equipment
GMHIU	General Mental Health Inpatient Unit
HERD	Health Environments Research and Design Journal
HFBG	Australasian Health Facility Building Guideline
HI	Health Infrastructure
HDU	High Dependency Unit
IADH	International Academy for Design & Health
IIMS	Incident Information Management System
MH-CoPES	Mental Health Consumer Perceptions and Experiences of Services
MHDAO	Mental Health and Drug & Alcohol Office
MHICU	Mental Health Intensive Care Unit
MHPC	Mental Health Planning Council

MHU	Mental Health Unit
MOH	Ministry of Health
NHS	National Health Service
NSIII	National Health Service Institute for Innovation and Improvement
PI	Project implementation (Stage 3 POFP)
PFI	Private Financing Initiative
PFP	Private Financed Project
PICU	Psychiatric Intensive Care Unit
POFP	NSW Health Process of Facility Planning
PPP	Public-Private Partnership
RCPsych	Royal College of Psychiatrists (UK)
SSP	Services Procurement Plan
SSDB	State-wide Services Development Branch
VPU	Vulnerable Persons Unit

DEFINITIONS

Biophilia	An hypothesis proposed by E.O. Wilson that human beings have a genetic propensity to respond to other living organisms which design properties should harness.
Cartesian Analysis	Modernist paradigm which sees the world as objects, sets of objects, and objects acting and reacting upon one another.
Ethnography	The study and systematic recording of what people do in their daily life using qualitative research techniques.
Evaluation	Systematic examination of a policy, program or project aimed at assessing its merit, value, worth, relevance or contribution.
Grey Literature	The term used for information or research output produced by organisations outside of academic publishing and distribution channels, which is generally not peer reviewed, including: government reports and policy documents, non-peer reviewed commercial studies and proprietary knowledge.
Haptic	Any form of interaction involving touch.
Hapticity	A system (not limited to touch) that yields information about solid objects in three dimensions. Used by

	neuroscientists to refer to the emotive and multisensory experience of architecture, not limited to the ocular.
Index Admission	An admission with a principal diagnosis of a specified condition which is the starting point for analysing repeat hospital visits for that condition (denominator).
Inpatient	Denotes consumers who have been admitted to an acute mental healthcare facility located on a general hospital site.
Patient Safety	A whole system approach to minimizing harm affecting patients; it extends the idea of 'clinical risk management'.
Phenomenology	The study of subjective experience with its roots in the philosophical work of Edmund Husserl. It involves the systematic study of the structures of consciousness and the phenomena that appear in acts of consciousness. Ontologically differentiated from Cartesian analysis.
Photo-elicitation	Where photographic images are used as an interview tool to extract attitudes, opinions and views.
Repertory Grid Technique	A technique to elicit underlying semantic constructs held by individuals about people, places and spaces.

Salutogenesis	A construct conceived by Aaron Antonovsky focusing on human health and the factors underlying physical, social and emotional well-being, rather than pathogenesis.
Somatic	Of or relating to the body, especially as opposed to the mind.
Somatosensory	Sensory receptors. The somatosensory system is the part of the sensory system concerned with the conscious perception of touch, pressure, pain, temperature, position, movement, and vibration, which arise from the muscles, joints, skin, and fascia.
Therapeutic Milieu	A therapeutic milieu is a supportive environment in which clinical staff work with clients to provide safety and structure while assessing the patient's relationships and behavior. A consistent routine is maintained, which fosters predictability and trust. A milieu is considered therapeutic when the program's community provides a sense of civility, membership, belonging, care and accountability.
Triangulation	A multi-method research or evaluation design that draws from pluralist sources to illuminate a phenomenon.

Vulnerable Persons Unit	A protective environment for patients who are susceptible to physical or emotional injury or attack.

NOTES ON STYLE AND LANGUAGE

The terms **consumer** and **service user** are used interchangeably to refer to the **acute mental healthcare inpatient.** They are preferred as they remind us that these people should be in control of their recovery and should be accorded the respect to do so. The word **patient** is used on occasion to retain the authenticity of the speaker's voice and where the context makes it appropriate to do so.

The terms **participant** and **key informant** are also used interchangeably for although it is usual in qualitative research to refer to subjects as 'participants' that term is also used when referring to members of health facility planning teams. To avoid confusion, key informant is generally used for those study participants who were interviewed.

The term **general hospital** and **non-mental healthcare facility** are used to distinguish those facilities from acute inpatient mental healthcare facilities/units.

Square brackets [...] denote an insertion by me to make sense of a quoted passage.

ABSTRACT

This multi-method, multi-case study was a philosophically pragmatic and realist inquiry into how the physical habitat/material environment supports or hinders the creation of therapeutic safety in acute inpatient mental healthcare facilities.

The literature review indicated that trust is integral to therapeutic relationships but acts of trust were unlikely without manifest organisers and signifiers of trustworthiness. The *Constructing Trust Model* that emerged from the review postulated that the *Environmental Determinants of Care,* comprised of physical, social and symbolic elements, moderated therapeutic trust in the development of safety. The *Determinants* were incorporated into James Reason's (1995) *Swiss Cheese Model of Accident Causation* to illustrate how environments emphasizing surveillance and technical safety do not create therapeutically safe environments but introduce latent error, leading to patient harms such as violence, seclusion and sanctuary harm.

Four sites were purposively selected for participation in the study. Initial site visits were made to three newly commissioned facilities and data were collected using key informant interviews, document and artefact analysis. Alterations were made at the fourth site, including: acoustic dampening, wall murals, gardens, increased circulation space, new colour scheme, and new outdoor furniture. Data collection also included focus groups, a safety climate survey, spatial data, incident data and seclusion data. The frequency and duration of seclusion was reduced during renovations. Staff reported consumers found the work a welcome distraction, providing hope that a poor environment would be much improved. On completion

staff reported reduced patient agitation, increased patient satisfaction, and fewer incidents of vandalism. Seclusion practices, however, soon reverted. Funding was not provided for changes to address environmental problems known to be linked to seclusion use, that is, overcrowding and social density.

Three major findings emerged in the cross-case analysis. Firstly, participants held dichotomous beliefs about safety. I labelled those who viewed safety as arising from the control of concrete hazards requiring custodial environmental designs, '*Risk Warriors'*, and those who considered trusting relationships the precursor to safety, requiring environments signifying care, trustworthiness and refuge, '*Trust Advocates'*. Secondly, at all four facilities decision-makers did not follow the advice of *Trust Advocates* and introduced unintended risk into the care system, creating the latent conditions for iatrogenic harm. Thirdly, collocation of acute inpatient mental healthcare facilities on general hospital sites encouraged the cultural dominance of *Risk Warriors*, leading to an over-emphasis on surveillance and the control of risks, to the detriment of trust development strategies and therapeutic safety.