

# Escaping the Asylum

Reimagining the Architecture of Psychiatric Care

By

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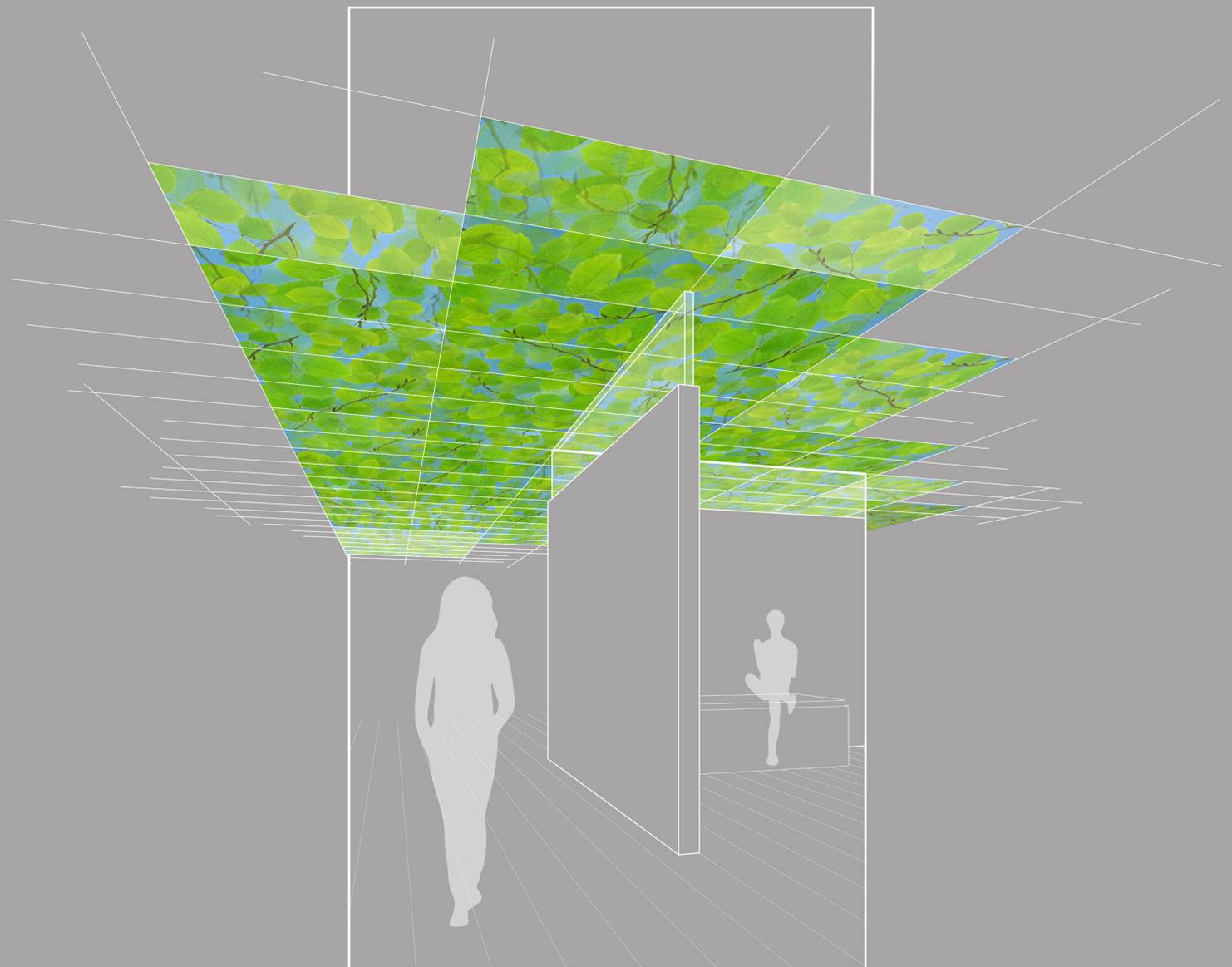
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## **Abstract**

While most individuals with mental illness currently receive treatment in the community, dedicated psychiatric care facilities are critical spaces for those in crisis or exhibiting severe symptomology. For safe care, these facilities mandate a low risk environment and architectural design is critical in mitigating instances of patient violence, self-harm and exit-seeking. Yet what is necessary for high risk patients may be counter-therapeutic and disengaging for those seeking support. In psychiatric care, the architectural environment can enhance or undermine patient wellness, staff interactions, and even public perception. To contribute to redefining the mandate of architecture in this context, this thesis proposes a renovation of the Psychiatric Emergency Services (PES) units at both the Civic and General Campus of The Ottawa Hospital. These renovations are approached through a series of details that seek to prioritize patient well-being and facilitate therapeutic interactions while remaining safe and appropriate for those in psychiatric crisis.

## Preface

Mental illnesses are at the forefront of various medical, social, and political discussions today, and some argue that radical new changes to established policies and practices are needed to adequately address the complex challenges of treating mental illness and the mental healthcare system in Canada. While it is always tempting, especially for a thesis in architecture, to begin with a blank slate and re-envision the current models and spaces of mental health care delivery, this often becomes far removed from the policies, practices, and infrastructure that exist currently and there is a lack of strong literature to work from. While new build situations are uncommon, there is ample opportunity to evaluate and optimize current care environments and develop architectural strategies that can be implemented within them.

From its onset, the intent of this thesis has been to better understand and address the present realities that impact the design and delivery of psychiatric care and to find ways to improve the lived experiences of patients, families, and care providers through the built environment. Architectural scholarship cannot only concern itself with new and idealized situations, especially in healthcare architecture. There is a need to improve and de-stigmatize existing spaces in creative ways that engage people and encourages them to seek care. Considering the present state of many mental healthcare environments, an incremental change is better than no change at all.

Therefore, in as much as this thesis advocates for a new approach to the way that

we design the spaces of psychiatric care, it is also an exercise in adapting and improving existing spaces to meet unforeseen realities and higher expectations for the quality of the architectural environment. This thesis situates itself within the larger question of how we care for those with mental illnesses and the challenges currently facing mental health care in Canada, and hopefully it will inspire others to think critically about how architecture can support the treatment and care of individuals with mental disorders both now and in the future.

## Acknowledgments

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# 1. Introduction

The thoughts, feelings, and behaviours that are currently associated with mental illness are intrinsic to the human experience and have been documented in society since antiquity. However, the ways that mental illness has been conceptualized and treated have undergone substantial transformations in the last two centuries. Changes in psychiatric practice have precipitated shifts in architectural thinking, and both mental healthcare and its architectural response continue to co-evolve as contemporary research furthers the scientific basis for mental illness and effective ways to care for those suffering from it.

The relationship between architecture and the treatment of mental illness was initially forged through the nineteenth-century asylum: purpose-built institutions designed to house those deemed to be suffering from a mental illness. At one time, asylum architecture aspired to effect a cure for those afflicted by providing a place for humane care in idyllic settings, but by the mid-twentieth-century the undifferentiated assortment of individuals accumulating in them discredited them as legitimately therapeutic environments.<sup>1</sup> As more patients were institutionalized without cure, the asylum typology was seemingly appropriated for quasi-carceral

detention and social control, thus galvanizing the notion of the asylum as a space of othering and inhumane custody.

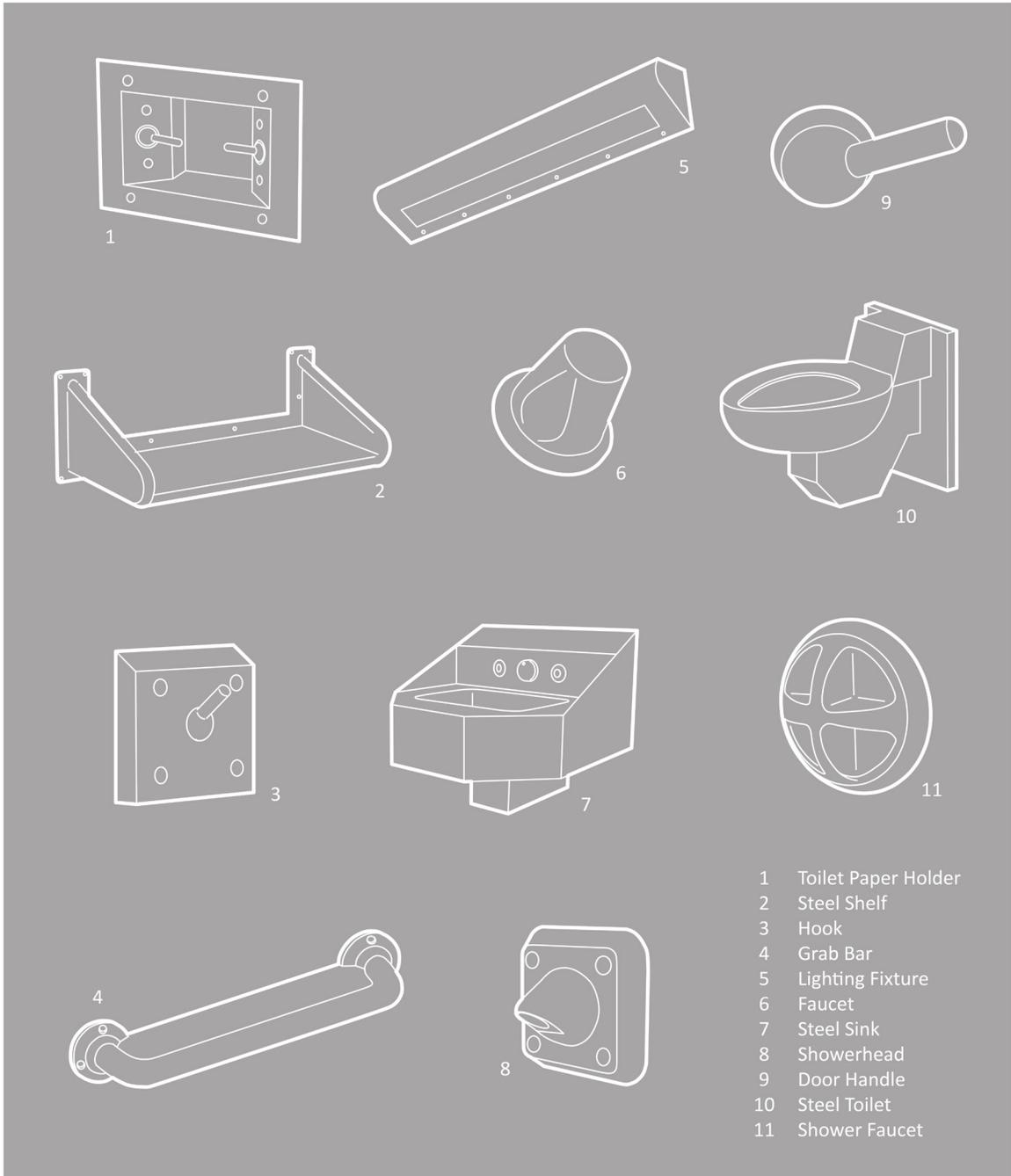
This conceptualization of the asylum remains at the forefront of society's cultural memory due to its persisting and perpetuated depiction in popular visual culture, as well as other negative and inaccurate representations of those with mental illnesses.<sup>2</sup> While asylums connote grim and sub-human conditions, they are far-removed from the realities of contemporary psychiatric care and the spaces that it takes place in. However, several environmental similarities often persist: a tendency towards reductivism and minimal environments, heightened surveillance, lack of privacy, and seclusion. The notion of escaping the asylum refers to the intent of the thesis to further distance spaces of contemporary psychiatric care from those of asylums by: highlighting a patient-oriented and comfortable experience in psychiatric care; changing the paradigms that drive the design of psychiatric care spaces and; reducing stigma around spaces of psychiatric care.

With deinstitutionalization shifting the delivery of psychiatric services, most individuals with mental disorders currently receive treatment in the community. However, there is still a need for dedicated inpatient psychiatric hospitals for individuals requiring voluntary or compulsory care in crisis periods. Thus, the role of the psychiatric institution has changed from being a place of long-term rehabilitation to one of acute care and stabilization in periods of crisis. With this organizational and clinical restructuring, the design mandates of the psychiatric hospital have also shifted. Rather than entertaining the notion of an environmental cure for mental illness or providing a residential-like setting, the paradigms of

modern psychiatric hospital architecture are increasingly focused on handling violence, self-harm, and exit-seeking with a secondary focus on patient comfort and perceived wellbeing. Therefore, the architecture and interior finishing of these spaces must anticipate and mitigate these kinds of incidents.

Unlike medical practice, the architectural setting of the psychiatric facility cannot easily adapt to the individual care requirements of each patient, so the environment of care is largely pre-determined from the onset of construction. A low tolerance for risk mandates that architecture and architectural decisions must anticipate and mitigate harm to both patients and staff (Figure 1.1). However, by designing for the most at-risk patient, the architectural environment presumes the same likelihood of risk for all patients, regardless of their individual diagnosis.<sup>3</sup> This reinforces a negative stigma of mental disorders being defined by the most severe cases rather than the average afflicted individual, and generally manifests itself as a reductionist and utilitarian approach to finishing patient rooms, washrooms, and even common areas, as well as separate and enclosed staff quarters. Seclusion and security are often given primacy in the design of these spaces, which is rationalized based on the understanding that an individual will only reside in them temporarily. However, when coupled with standard architectural elements used in general hospitals that are needlessly specified in psychiatric units, the architectural environment can reinforce an institutional atmosphere, stirring feelings of resentment, alienation, and external control.<sup>4</sup>

Considering the ongoing historic, ethical, legal, and medical discourse surrounding psychiatric care, the space of the psychiatric inpatient care carries a myriad of



**Figure 1.1** Standard architectural elements in psychiatric inpatient environments. While designed to reduce opportunities for self-harm and violence, these elements may also stigmatize patients and reinforce an institutional atmosphere within the space of care because they are the dominant architectural features.

opinions and experiences from professionals, patients, and the public. While architecture itself can neither cure mental illnesses nor provide an absolute measure against patient harm, it is the physical setting for inpatient care and therefore configures itself as a significant interface between the patient and the broader system of psychiatric services. The architectural environment is not a neutral factor in psychiatric care; it can enhance or undermine patient wellness, staff interactions, and visitor experiences. While past building typologies and design directives were created for segregation, safety, and control of those with mental illnesses, contemporary treatment encourages patient-centred care, shared decision making, and places a higher value on individual autonomy. This thesis is founded on the conviction that the built spaces of psychiatric care can better reflect this kind of care, supporting the emotional health and lifting the spirits of those that pass through them.

As a way to contribute to redefining the role of architecture in this context, this thesis proposes a renovation of two psychiatric care spaces in Ottawa: Psychiatric Emergency Services (PES) at The Ottawa Civic and General Campuses. The design approach focuses on architectural details that seek to prioritize patient comfort and facilitate therapeutic interactions while remaining safe and appropriate for those in psychiatric crisis. In architecture, details often represent a human-scaled gesture and provide a platform to prioritize the individual's experience and reaffirm their existence in the space. As such they are a significant way to promote well-being and grounding, especially in situations of personal crisis. Furthermore, designing through the detail is an opportunity to consider small-scale renovations and architectural gestures that can be implemented in existing spaces of care

that are in need of improvement either to adapt to new and unforeseen uses, or new and increased expectations of the quality of the architecture of care. At a broader level, the work seeks to contribute to the changing role of architecture in psychiatric care and advocates for design that has a humanizing role in spatially restrictive and potentially emotionally alienating situations.

## 2. History of Architecture and Treatment

As evidenced through history, the thresholds of mental health are easy to conceive but hard to define and diagnose. The simplified and dichotomous conceptualization of mental health as the absence of mental illness is still widely held, creating a problematic reference point for identifying, treating, and living with various mental disorders. A recent definition regards mental health as a dynamic state of internal equilibrium constituted by basic cognitive and social skills; an ability to recognize, express and modulate one's own emotions, and empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and a harmonious relationship between body and mind which ultimately enables individuals to function according to the universal values of society.<sup>5</sup> Therefore, it follows that a form of mental illness can be diagnosed when an individual is thought to lack one or more of these factors.

Yet without established and reliable physiological markers, mental health professionals must rely on observations, patients' self-reported symptoms, and their own clinical experience to determine if an individual may be suffering from a mental disorder. Today, medical evidence and scholarship suggests that

mental illness is the result of complex interactions of an individual's biological, psychosocial, economic, and genetic factors, occurring as short-lived episodes or chronic disorders.<sup>6</sup> While medically evidenced, mental illness is also socially constructed: cultural, social, and intellectual structures determine how various mental disorders are understood, identified, and viewed within society.

Before modern technology, the causes of mental illness have been misattributed to various biological, supernatural, environmental, and psychological origins, meaning that diagnosing and treating mental illness has been fraught with inaccuracy for much of human history. Just as today, a mental illness was identified through an individual's expressed thoughts, feelings, or behaviours which were considered abnormal to the society they belonged to. Therefore, the social construct of mental illness predates much of our current understanding of it, and continues to be a factor in how, when, and where it is treated.

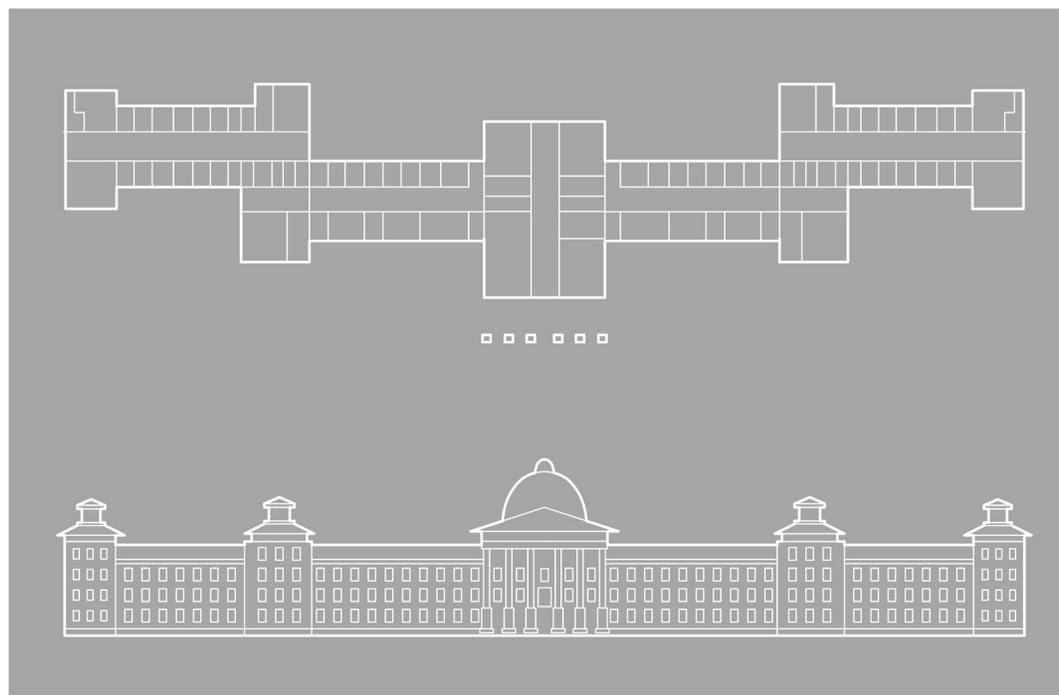
Psychiatry is a medical specialty wrought through the emergence of various theories and cultural contexts that have impacted the understanding and treatment of mental illness. Even where these theories have begotten therapies, vigorous debates have followed about whether such practices were efficacious, ethical, cost-effective, or humane.<sup>7</sup> Such is the historical and present state of mental health treatment, and by extension the contexts in which architects have been called to respond.

### **Institutionalization**

The origins of the modern psychiatric hospital lie in asylums built to house those with mental illnesses. Psychiatry emerged as a medical specialty through

the extensive construction of large state-funded asylums in the eighteenth and nineteenth centuries during a period that has come to be known for the institutionalization of mental health treatment.<sup>8</sup> Coinciding with the rise of the nation-state, asylums became widespread throughout Europe and North America due to political and social agendas to rationalize mental health care and replace the individual almshouses, poorhouses, and churches where those with mental illness were previously housed.

Early asylums were premised on confining and concealing those with mental illness- labeled as madness, insanity, and mania- in addition to others deemed undesirable to society, such as criminals and the homeless. Individuals were committed and held in asylums against their will, often physically restrained and



**Figure 2.1** Typical Kirkbride asylum plan and front elevation. In the eighteenth and nineteenth centuries, asylums were large-scale institutions dedicated to housing those thought to have mental illnesses.

forced to live in squalor, indistinguishable from prisons of the time. Paradoxically, the distinguished outward appearance and civic presence of asylums masked their living conditions in an attempt to win respect as a necessary and respectable social enterprise.<sup>9</sup>

In the mid-eighteenth century, the advent of 'moral treatment' sought to provide a more humane and benevolent approach to caring for the mentally ill. Translated from the French *traitement moral*, its name refers to an enlightened therapeutic program focused on mental rehabilitation, not a morally superior model of care.<sup>10</sup> Following this paradigm, psychiatric practice was directly and intimately tied to architecture through the notion that the physical environment- including architectural form- was a determinant of health and that mental illness could be treatable in specially designed institutional buildings. The removal of psychiatric patients from domestic and community environments which were labeled as 'degraded', was considered of utmost importance for moral treatment, and asylums were most often spatially dis-located from urban areas, featuring expansive gardens and pastoral landscapes envisioned to help restore the mind.<sup>11</sup>

Architecturally, the novel program of these asylums attempted to resolve a series of tensions between domestic and institutional space, benevolence and surveillance, medical progress and social control.<sup>12</sup> Many asylums in North America were built following the Kirkbride Plan (Figure 2.1), a system of asylum design proliferated by the psychiatrist Thomas Story Kirkbride in his 1854 book *On the Construction, Organization and General Arrangements of Hospitals for the Insane*. Although built in various architectural styles, their defining plan-form was a central administration

building flanked by segmented wings arranged en echelon to house patients with differing care requirements<sup>13</sup>. Each segment is limited in depth but features high ceilings to provide ample natural light and air circulation in each ward, which was thought to bring about a successful recovery<sup>14</sup>. Coupled with various operational recommendations, the therapeutic space created by the architecture of these asylums was to have a 'curative effect' on the patients it housed.

However, contemporary scholarship has re-framed moral treatment as a marketing technique to normalize transferring the care of the mentally ill from the family to the state. Urbanization, shrinking family size, and the separation of the home and the workplace undermined the ability of individuals to care for their relatives, and asylums presented a culturally legitimate and 'medically-sound' basis to commit loved ones to these institutions.<sup>15</sup> In combination with these social forces, a number of other factors have been attributed to the proliferation of asylums during the nineteenth century including an increase in affluence, consumerism, and a shift to a service economy.<sup>16</sup>

By the early twentieth century the notion of the architectural environment as a therapeutic asset to treat mental illness began to be discredited by the growing numbers of undifferentiated and untreated individuals housed in asylums. More than ever, measures of security and control were emphasized, and the number of patients in many asylums increased beyond their original capacity. Yet while the coherence between asylum architecture and psychiatric practice began to deteriorate, the scope of psychiatry as a medical profession was articulated and enshrined in legislation. Still, patients were increasingly institutionalized on

the basis of medical paternalism and the asylum remained the primary locale of psychiatric practice well into the mid-twentieth century.

As moral treatment was abandoned and asylums once again became quasi-carceral in nature, psychiatrists turned to more 'scientific' approaches to treat and manage those with mental illness. These included various combinations of experimental pharmaceutical, psychological, and physiological treatments. Although some of these approaches advanced psychiatric treatment, asylums were chronically underfunded and increasingly criticized for their geographic and professional isolation, poor accounting and reporting procedures, as well as inadequate inspection and quality assurance measures.<sup>17</sup>

Most concernedly, reports of widespread and systematic abuse towards patients arose from twentieth century asylums. Famously, the sociologist Erving Goffman described the term 'total institution' to convey the 'mortification of self' occurring in psychiatric hospitals of the 1950s, where patients were compelled to adopt a purely institutional identity through physical and social abuse.<sup>18</sup> The disconcerting nature of the mid-twentieth century asylum and new scholarship on the causes of mental illness prompted a number of other seminal sociological studies and fueled the anti-psychiatry movement. Ultimately, asylums and the institutionalism they represented had become ethically, socially, and architecturally invalid spaces for psychiatric treatment.

### **Deinstitutionalization**

The public and professional outcry surrounding the asylum model of mental health treatment, as well as clinical inadequacies and the financial burden of inpatient

care grew throughout the twentieth century and came to a head in the 1960s with the widespread deinstitutionalization of psychiatric care. Underpinned by broader sociocultural transitions, political restructuring, and economic conservatism, it resulted in the widespread depopulation of mental hospitals and a shift towards non-residential methods of treatment.<sup>19</sup> Between 1960 and 1976, the bed capacity of Canadian psychiatric institutions fell 68.5% with a net loss of 27, 630 beds from the network of psychiatric services.<sup>20,21</sup> Facilitated primarily through the use of pharmaceutical treatments, deinstitutionalization shifted the location of psychiatric treatment from residential asylums to small and specialized psychiatric hospitals, general hospital units and outpatient centres in the community.

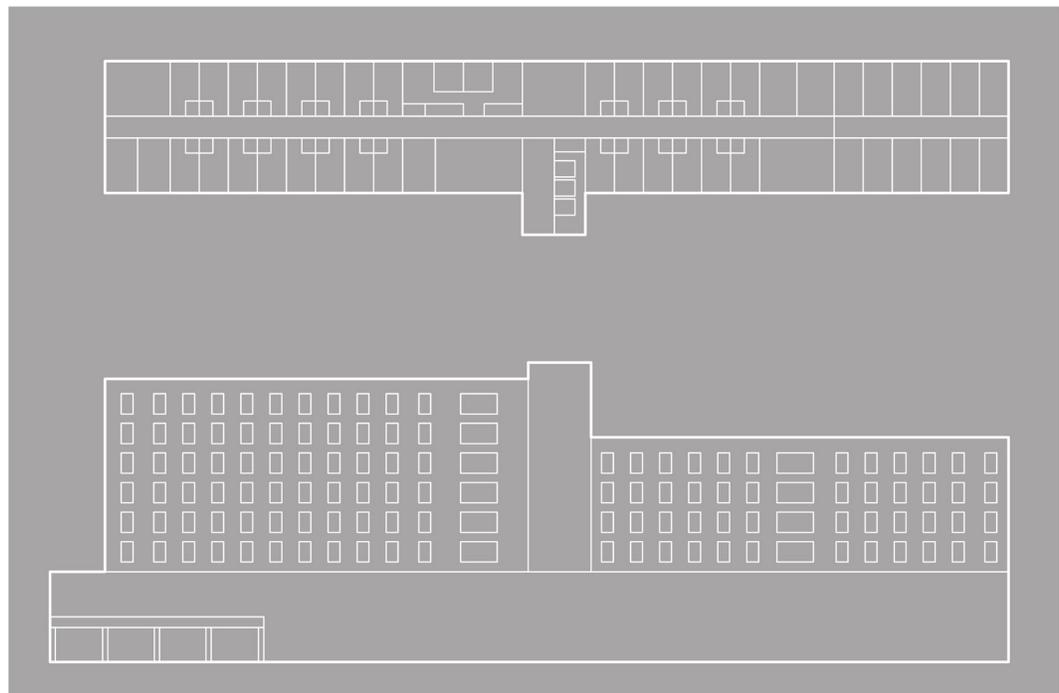
Though often politicized as such, deinstitutionalization is not solely the release of long-term patients from asylums and other residential institutions. It is also characterized by legal mandates to provide alternative treatment in non-residential facility types as well as the advent of new types of community-based support systems for those living with mental illness. Moreover, it represented a momentous transformation in the relationship between society and the mentally ill and in how mental illness was conceptualized and treated: it refuted the notions that the mentally ill had to be set apart from society and that secluded, secure institutions were the most therapeutically valuable spaces for recovery.<sup>22</sup> Previously, the lives of those with mental illness were centred around the institution, and deinstitutionalization sought to reintegrate them physically and socially into civic life. Therefore, it represented a new clinical structure and corresponding design ethic which demanded the treatment of psychiatric patients in the least restrictive environment possible.<sup>23</sup>

While pharmaceutical treatments replaced some dimensions of institutionalized care, they did not replace the need for psychiatric diagnostic and rehabilitation services, crisis care, and community support. During the early decades of deinstitutionalization, architectural projects focused on designing community mental health centres that would programmatically replace closed and downsizing psychiatric hospitals. Rather than being built in any architectural style or spatial arrangement, primacy was given to locating these centres where they could be easily accessible for those who needed them, soon being housed in converted storefronts and residences, offices, as well as purpose built buildings for the provision of outpatient care, partial hospitalization programs, and non-trauma emergency psychiatric care.<sup>24</sup>

However, the availability of these kinds of community mental health services and acute care hospitals did not meet the demand for them given the rapid closure of psychiatric institutions and movement of mental health patients into the community. Furthermore, in Canada deinstitutionalization involved a web of bureaucratic restructuring: the asylum model ostensibly offered medical, financial, and family support services, as well as met housing and employment needs that did not fall under the jurisdiction of a singular government department.<sup>25</sup> Eventually, mental healthcare services and psychiatric facilities were grafted into Canada's universal healthcare system which was being developed during the same time. As a byproduct of this transitional phase in the 1970s and 80s when demand for psychiatric care did not meet the healthcare infrastructure available, the number of patients receiving acute care in general hospital emergency rooms increased significantly.<sup>26</sup> Often, this resulted in general hospitals establishing

ad hoc psychiatric inpatient units and providing emergency psychiatric services (Figure 2.2).

Therefore, while deinstitutionalization may denote a reduced bed capacity in psychiatric institutions, it does not imply a reduced demand for mental health treatment.<sup>27</sup> This reality continues today, and many scholars suggest that the ultimate limitation of deinstitutionalization as a process is the chronic shortage of mental health treatment programs and long-term support available in the community. This has been attributed to requiring political and structural supports, which have been difficult to maintain over time.<sup>28</sup> Effectively, it has resulted in the consistent rise of individuals seeking emergency psychiatric care in general hospitals which were inadequately designed for their care, as well as large



**Figure 2.2** Typical contemporary psychiatric ward in a large general hospital. In many cases, acute mental healthcare takes place in existing general hospital wards which have been renovated to accommodate psychiatric inpatient care.

numbers of individuals with mental illness being 're-institutionalized' in residential homes, forensic hospitals, and prisons.<sup>29</sup> To function effectively, deinstitutionalized psychiatric care depends on strong and established networks of medical and social services, as well as continued political support.

While addressing the present shortcomings and future trajectory of mental healthcare is beyond the scope of this thesis, the ongoing process of deinstitutionalization can explain the architectural paradigms that underpin much of the design of psychiatric care spaces that exist today. Outpatient clinics and community support centres are often small-scale and approachable buildings and located in the communities they serve. Many transitional and group homes are indistinguishable from single detached houses and larger, long-term residences often employ clustered rooms in pavilion style plan-forms to create a community-like feeling.

Yet psychiatric care still necessitates various physical institutions in the form of general and specialized inpatient hospitals, which are an essential space of episodic care, as outpatient treatment may not be suitable for all patients and individuals may require inpatient treatment in crisis periods.<sup>30</sup> However, given the nature of this program, the architectural mandate of these spaces anticipates a user demographic that is simultaneously viewed as both having an acute illness and posing an imminent security risk. Accordingly, overwhelming emphasis is placed on architectural and finishing measures that mitigate harm to staff and prevent patient violence, self-harm, and elopement. Therefore, it can be argued that the architectural conditions of these spaces replicate those of the asylums they replaced, even amongst deep changes to psychiatric practice.

### **3. Design Ethic**

Contemporary medical ethics are guided by four principles: beneficence, nonmaleficence, justice, and respect for patients' autonomy. As in other medical professions, informed consent is the paragon for patient autonomy and therapy in psychiatry, yet psychiatrists often must often resort to paternalistic practices while treating those with mental illnesses, especially in acute and emergency psychiatric treatment. Many of these kinds of practices relate to the design and spatial operations of the environment of care: locked exterior doors and windows, wall-mounted furniture, tamper and vandal resistant fixtures, sparse furnishing, staff-patient separation, and even measures against privacy and free movement.

If deinstitutionalization emphasises the least restrictive forms of mental health treatment, the often-overt focus on measures of security, safety, and control in modern psychiatric hospitals appear as an architectural paradox. The overarching design directive of these spaces is consistently and increasingly focused on restricting patient movement, privacy, and choice, all of which undermine patient autonomy and seem to better represent the institutional characteristics of the asylum model of care. Even where the clinical atmosphere may be friendly and

welcoming, this 'architectural paternalism' can frustrate and alienate patients.

Paternalism inherently defies autonomy but is ethically permissible in medical practice when the principles of beneficence, nonmaleficence, or justice strongly contradict the patient's expressed will and there are convincing observations that indicate their autonomy is severely undermined.<sup>31</sup> While rarely the case in other medical care situations, this condition describes the very purpose why individuals are admitted to an acute or emergency psychiatric care arrangement in the first place: they are considered to be a threat to themselves or others. Moreover, occupational safety requirements for healthcare providers emphasise the physical segregation of staff from patients as a risk reduction strategy. Therefore, architectural measures that promote security and safety are necessary and valid in deinstitutionalized mental health care. Like the psychiatrist, the architects of these environments limit patients' freedoms based on ethic of patient beneficence at the expense of patient autonomy<sup>32</sup>.

Yet while the act of restricting patient autonomy through architectural decisions is ethically permissible and clinically necessary, it is not often perceived as therapeutically beneficial. Therefore, there is a significant opportunity for architecture to function as more than simply a way of enforcing paternalistic forms of patient beneficence. It can contribute more appreciably to the realms of beneficence and autonomy through intentional design that is rooted in dimensions of well-being. If an individual is hospitalized for their mental illness, it is because they are in a time of personal crisis. Therefore, the environment of care should also support patient dignity, coping, and recovery, while mitigating undue stress. Sense

of place is an emerging component of health and healing, and it impacts how emotion and the physical environment can interact for the benefit of patients<sup>33</sup>

The opportunity for a new design ethic that reconciles safety and security with patient comfort and well-being is fertile, especially in the spaces of acute psychiatric care. In environments that feature some of the most restrictive building codes and reductive interiors, thoughtful and intentional architectural decisions can provide a silent companionship in times of heightened stress.<sup>34</sup> Therefore, architectural measures can further support patient beneficence by virtue of prioritizing patient comfort and therapeutic interactions while remaining safe and appropriate. Such a design ethic contradicts the current design paradigms of psychiatric hospitals but does not undermine or compromise them.

## 4. Site, Program, and Present Conditions

To illustrate how the design ethic presented earlier may be expressed during redesigns of existing psychiatric care facilities, this thesis proposes renovations to the Psychiatric Emergency Services (PES) units of The Ottawa Hospital (TOH) Civic and General Campuses in Ottawa, Canada (Figure 4.1-4.2). PES is a specialized service within The Ottawa Hospital's emergency departments for assessing individuals deemed to be suffering from a psychiatric illness and who are in a phase of acute crisis. Therefore, it is generally the first place an individual will go when they need emergency psychiatric assessment or are facing a period of mental illness that cannot be treated in the community. Like psychiatric emergency suites in other hospitals, it was designed with the mindset that patient safety should be stressed above all, since the primary users of the space are acutely ill, may not have an established diagnosis, and fulsome assessment and treatment plans take time to develop. However, the focus of the hospital is now on encouraging therapeutic interactions and recovery, in addition to safety.<sup>35</sup>

PES at The Ottawa Hospital (TOH) was created in the early 2000s as a result of changes in mental health practice in Ontario outlined in a provincial policy titled

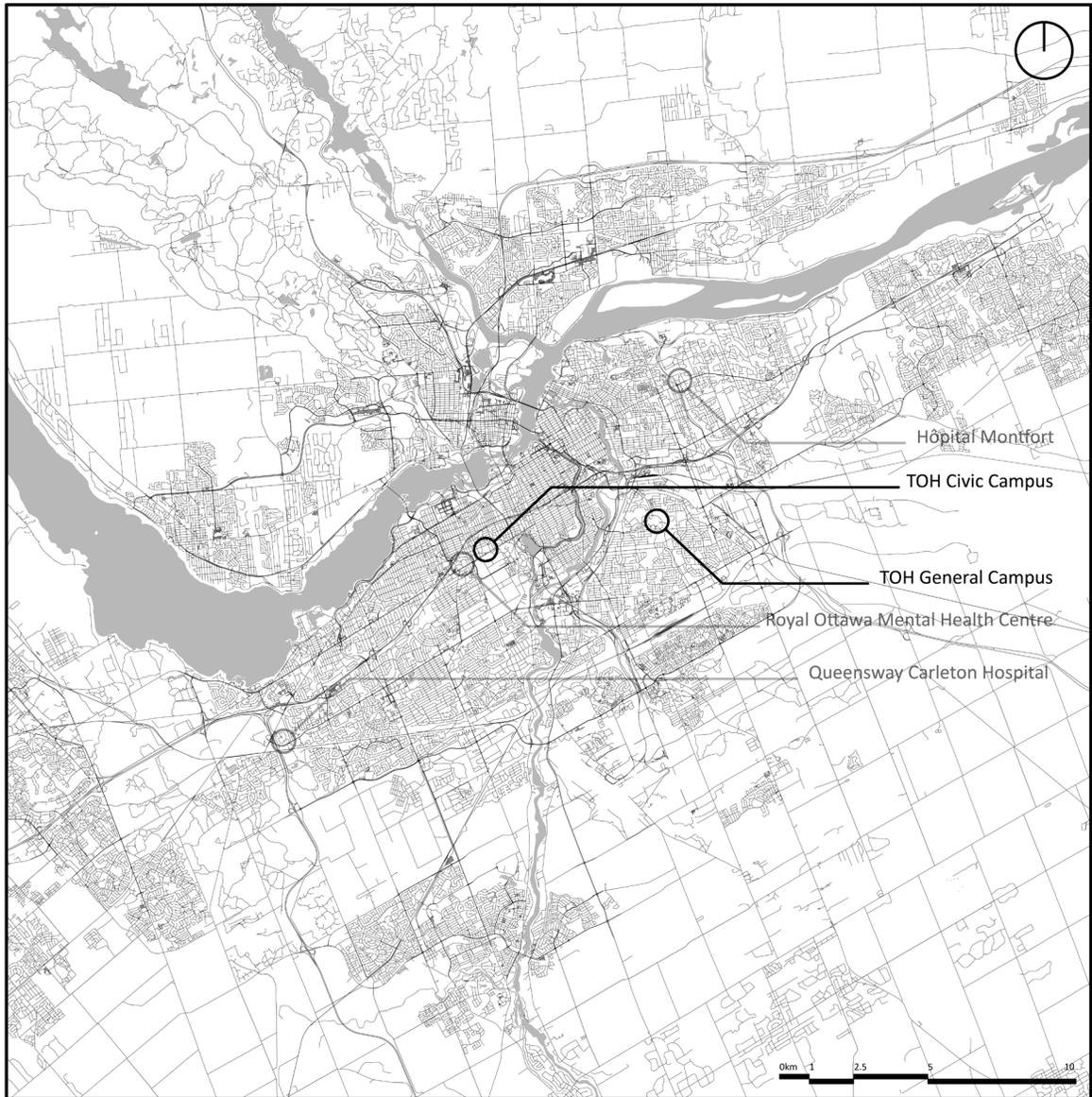
*Making It Happen: Implementation Plan for Mental Health Reform.* Prior to this, the majority of psychiatric emergency cases in Ottawa were handled by The Royal Ottawa Mental Health Centre's emergency department, and patients were only brought to the Civic or General Hospitals if they needed additional medical care. *Making it Happen* was developed to guide the implementation of a comprehensive and service-oriented approach to mental health care in the province, as well as increase the capacity of the mental health care system to provide integrated treatment among its component parts.<sup>36</sup> As part of this streamlining, general hospitals were to become coordinated access points to the province's broader system of psychiatric services. Designated as Schedule 1 Facilities (Figure 4.3) under Ontario's *Mental Health Act*, these hospitals provide inpatient and outpatient services, day care, emergency services, as well as consultation and education assistance for local agencies.



**Figure 4.1** The Ottawa Hospital General Campus (501 Smyth Road) and approximate location of PES.



**Figure 4.2** The Ottawa Hospital Civic Campus (1053 Carling Avenue) and approximate location of PES.



**Figure 4.3** Locations of Schedule 1 designated adult Psychiatric Facilities under the Mental Health Act in Ottawa, Ontario.

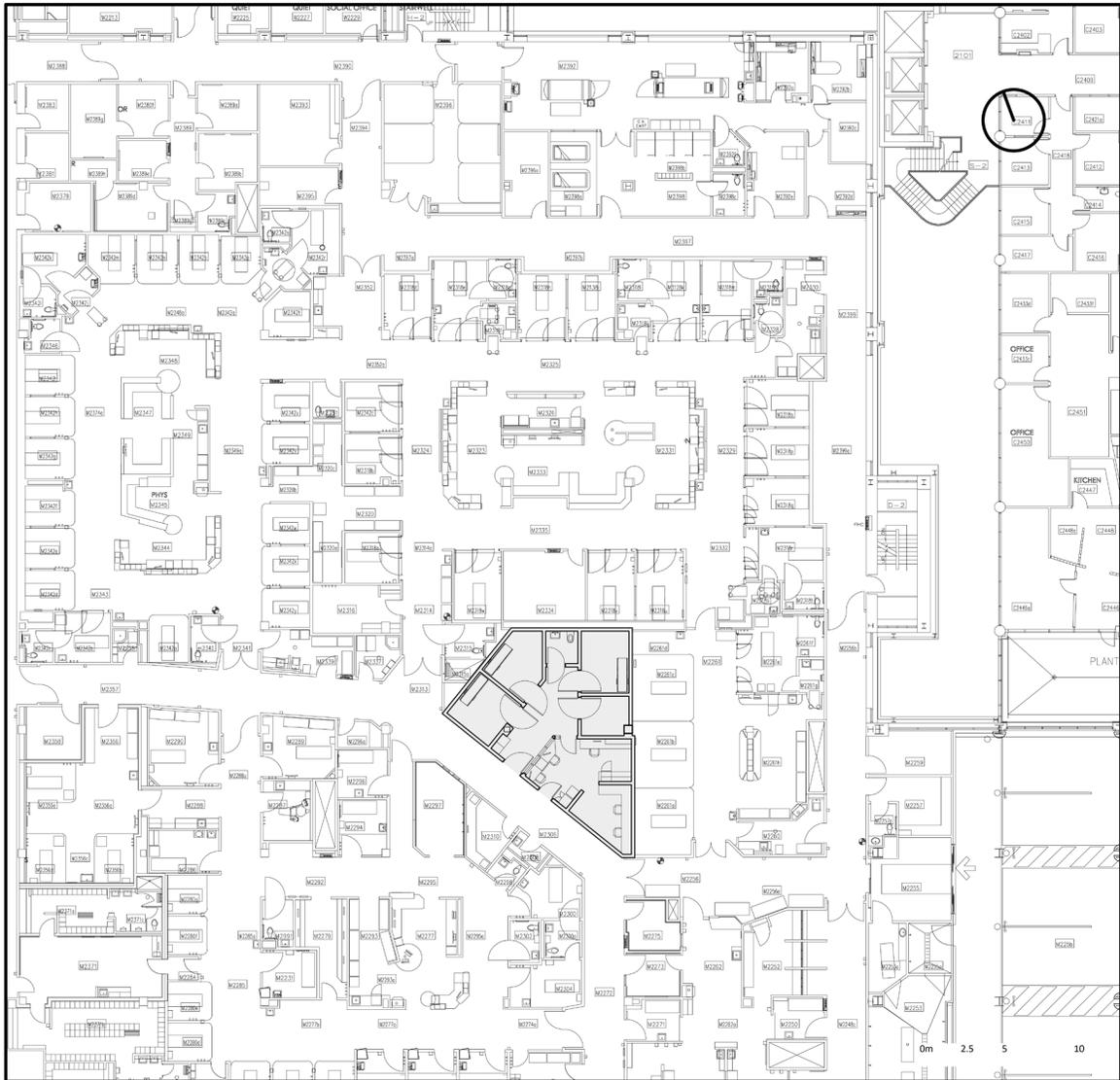


Figure 4.4 Location of the PES suite at TOH General Campus.

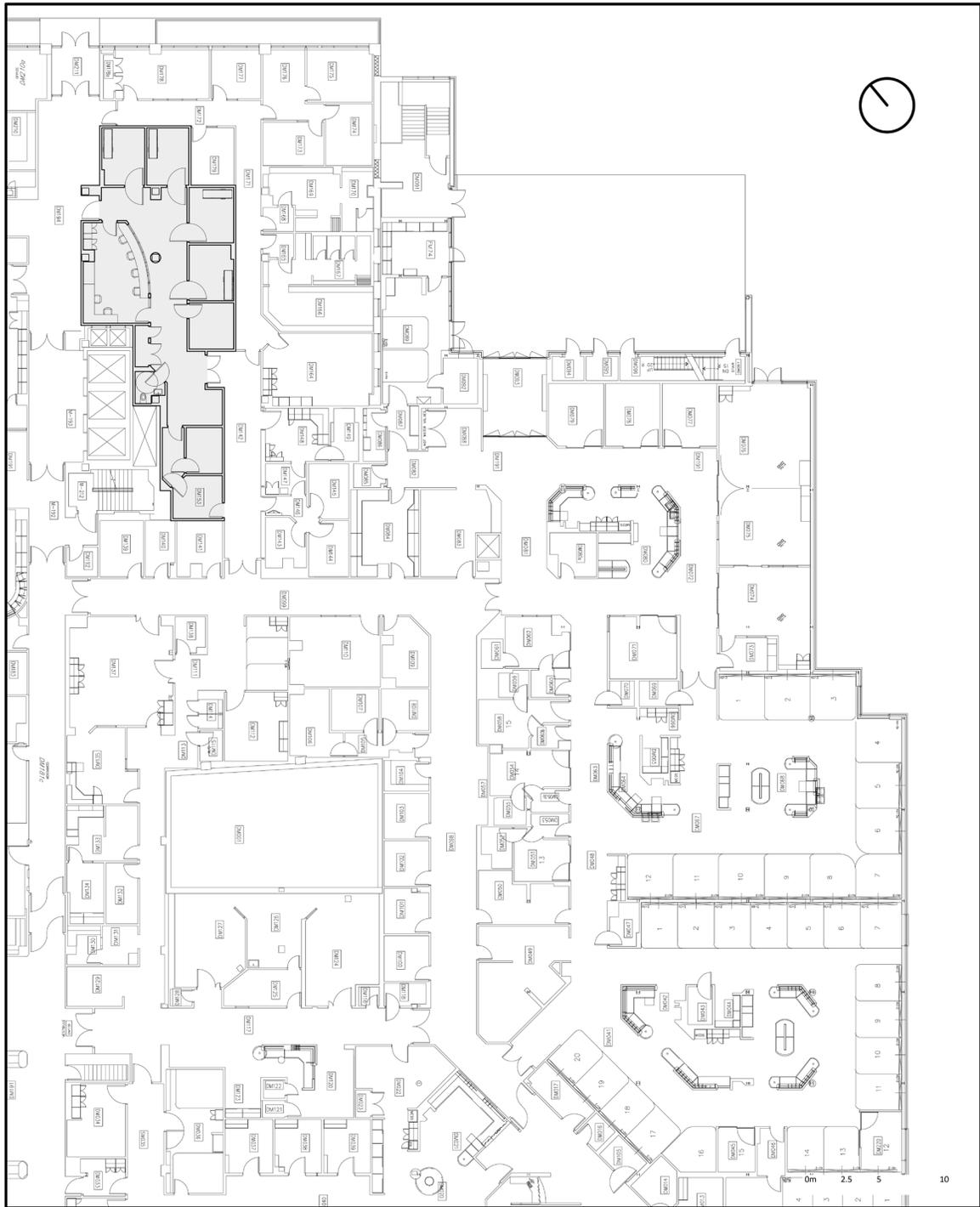
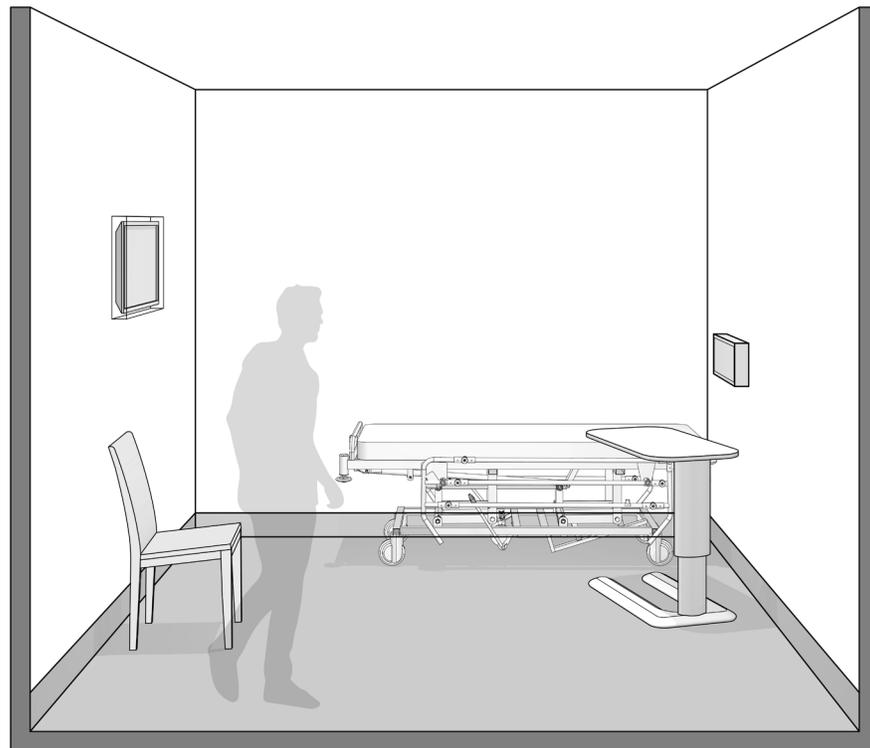


Figure 4.5 Location of the PES suite at TOH Civic Campus.

As its name suggests, PES is the emergency services component of the Schedule 1 operations at TOH. Presently, the areas dedicated for PES are relatively small, secure units within the emergency department that provide a low stimulation environment and elements to minimize safety risks to patients and staff. As shown in Figures 4.7 and 4.9, PES generally features a few single bed patient rooms, a washroom, as well as adjacent but enclosed staff workstations. Patient rooms feature a bed and wall-mounted and enclosed television. Extra furniture such as a chair or overbed tray table can be brought into the room if it is appropriate for the patient. To offer the necessary care and attention to patients in psychiatric crisis, the staff to patient ratio is high; at minimum, each unit is continually staffed by 2 mental health nurses, 1 security guard, and 1-2 physicians/residents.



**Figure 4.6** Typical patient room in PES.

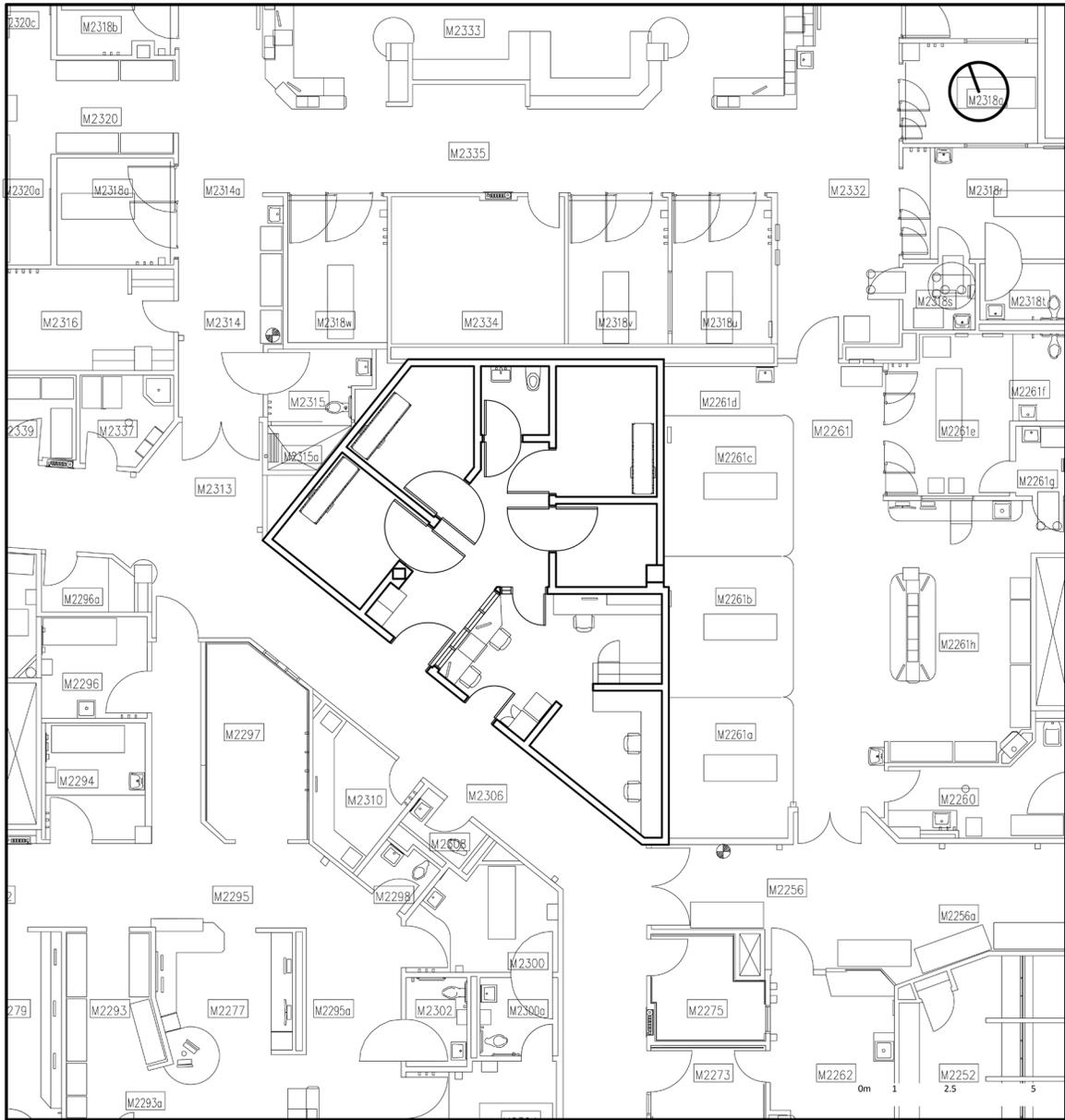
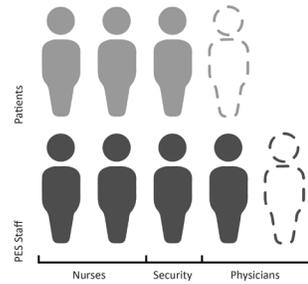
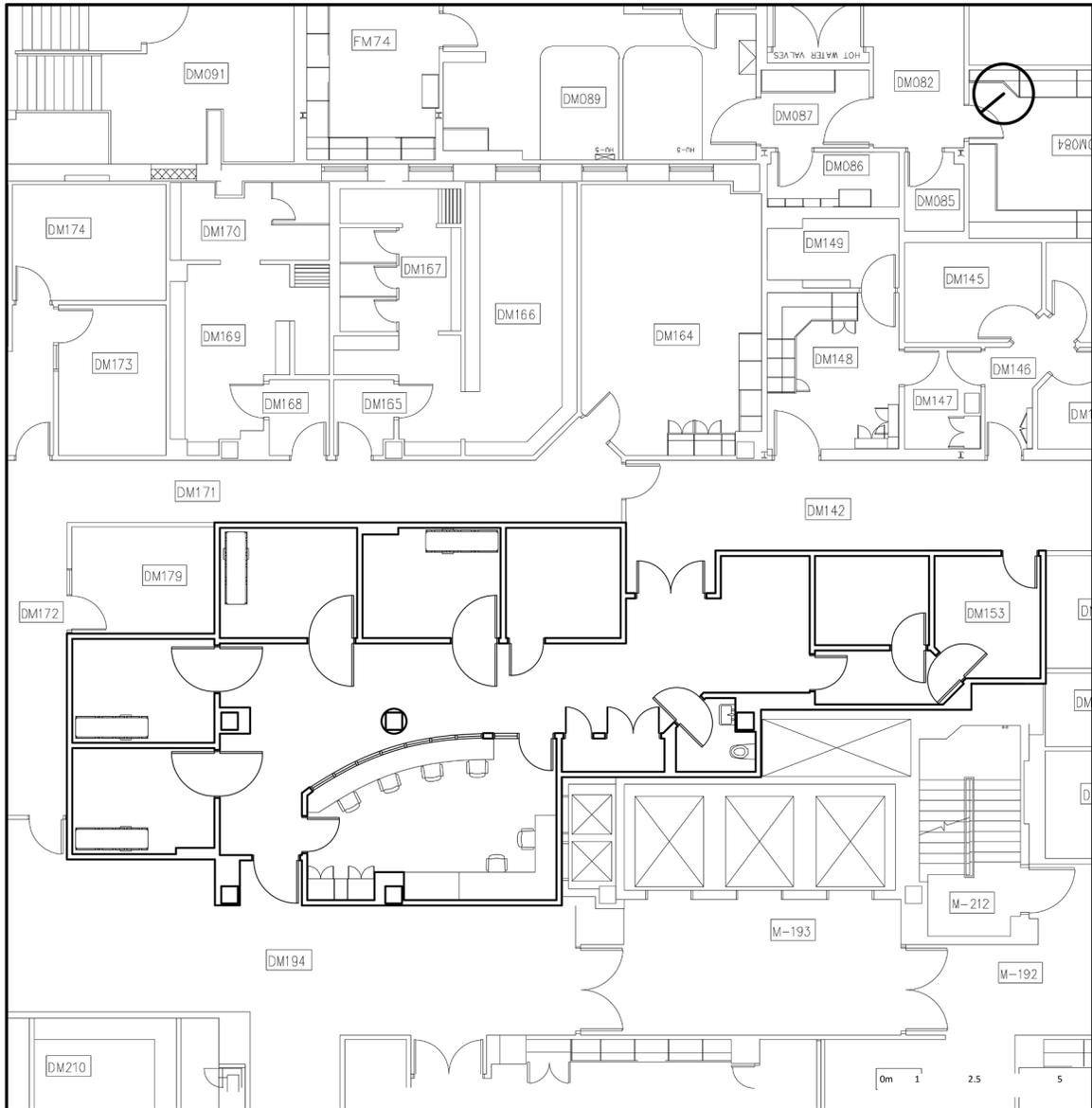


Figure 4.7 (Above) Plan of PES at TOH General Campus (Millen Ross Architects).

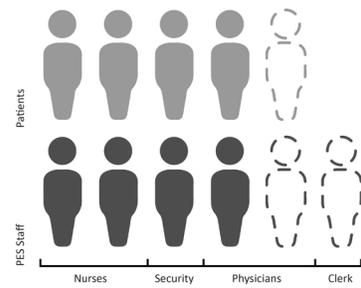
Figure 4.8 (Right) Typical staff and patient capacity for TOH General PES.

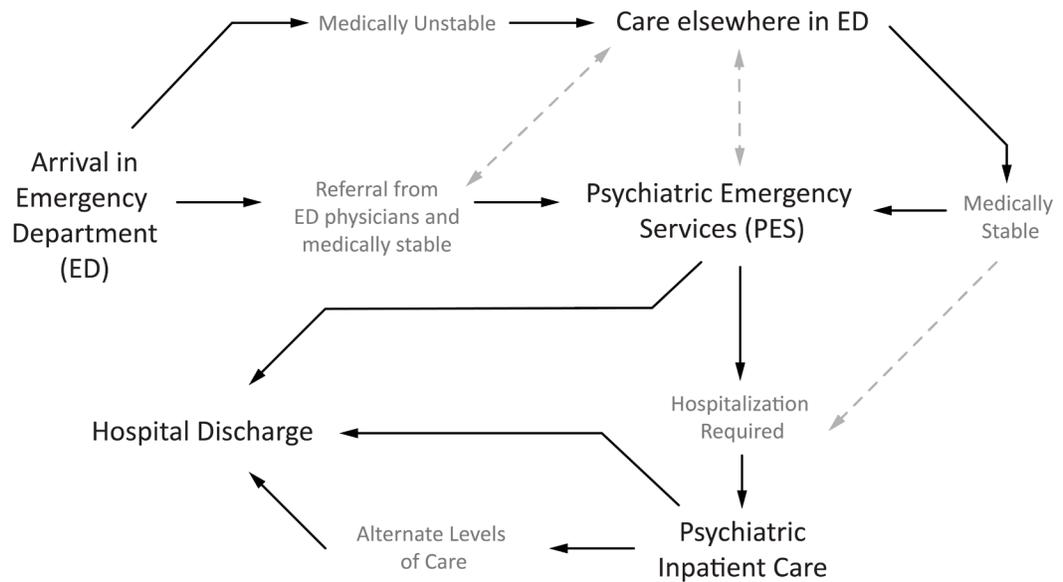




**Figure 4.9** (Above) Plan of PES at TOH Civic Campus (Lowry Erskin Architects).

**Figure 4.10** (Right) Typical staff and patient capacity for TOH Civic PES.





**Figure 4.11** Possible outcomes and flow for patients arriving at The Ottawa Hospital for treatment of a mental illness. The dashed lines indicate alternative pathways used when PES is at capacity and mental health patients receive care in either the emergency department or PES, depending on their acuity.

As outlined in Figure 4.11, PES is intended to be a space of transition within the hospital for those with acute mental illnesses. When an individual arrives in the emergency department requiring treatment for a suspected mental illness, they are first triaged to determine the urgency of their needs. If they are also medically unstable, they receive treatment elsewhere in the emergency department where there are beds available that align with their medical needs. However, if they are medically stable, they are ideally transferred directly to PES. Once there, they are assessed by a social worker or nurse in conjunction with an emergency physician to determine whether a consultation with a psychiatrist is required or if the patient can be discharged without specialist assessment. If a patient requires acute inpatient psychiatric care, they will stay in PES and be transferred to the inpatient mental health unit of the hospital. Ideally, the length of stay in PES is minimized as

much as possible, and usually less than 8-10 hours; enough time to be stabilized, assessed, and transferred to the appropriate next level of care.

However, due to the present demand for inpatient care exceeding the number of beds available in the hospitals' dedicated mental health wards, there is a risk that mental health patients might wait in PES for an extended length of time before a bed is available. Furthermore, when all rooms are occupied in PES, mental health patients may wait wherever there is room in the emergency department are sometimes swapped between PES and the wider emergency department, prioritizing the more acutely mentally ill to the PES environment. Over the last decade, the number of patient visits to PES have been steadily increasing. As a result, the length of time patients wait in PES has also increased: the total number of patient visits to PES at the Civic and General Hospitals numbered 5789 in 2018-19 and is expected to increase to 6600 by 2024-25<sup>37</sup>.

As a result of this chronic over-capacity, patients are spending much more time in PES than it was originally designed to accommodate. As such, it lacks features that are necessary to accommodate longer and more comfortable stays. The design atmosphere of PES overtly reflects the previous paradigm of containing and stabilizing patients and does not reflect the hospital's present goals of engagement and therapeutic care consistent with an inpatient admission. The PES suites are effectively land-locked inside the hospital, and there is no access to natural light via windows or skylights. The patient-accessible areas of PES such as rooms and corridors, feature limited furnishings for safety, yet they also limit the ability to normalize activities such as eating meals and hosting visits with loved ones.

Similarly, there are no showers in the suites, meaning that basic self-care requires being escorted by PES staff through public space to shower, introducing a further restriction on patient autonomy and a significant risk of avoidable altercations or absconding. Further clinical limitations include the lack of space for automated dispensing units to store medication and impeded sightlines from the nurses' stations to other areas in the suite. Due to these circumstances, the PES suites at the Civic and General Campuses are facing unforeseen challenges that have prompted internal reviews on how to improve the patient experience including options for renovations in the near future. Therefore, they are excellent sites to demonstrate how architecture can enhance patient wellness and experience and de-stigmatize the appearance of spaces of psychiatric care.

Although these limitations are addressed in the renovation proposals, PES was created as a space to stabilize and assess those facing an acute phase of psychiatric illness, with inpatient treatment to occur in dedicated units elsewhere in the hospital. Despite the realities of increasing lengths of stay in PES, it is clinically undesirable to simply design the space as a place to hold and treat mental health patients.<sup>38</sup> Instead, PES is better envisioned as a specialized assessment area where patients can receive flexible interim support, assessment, and treatment in an environment that is appropriate for their needs. Therefore, architectural measures that support well-being and diverse patient needs through these variable time periods of assessment and treatment can uphold patient beneficence by virtue of prioritizing patient comfort and therapeutic interactions. In this way, architecture can augment a service-oriented approach to mental healthcare by virtue of offering the patient dignity and relief rather than taking it away.

## 5. Details, Alterations, and Renovations

While the history of institutionalization is dominated by attempts to confine and conceal those with mental illness, the passing notion that architecture could offer a therapeutic dimension to their treatment is conceptually important to the design ethic presented earlier. Moral treatment was premised on the credence of an architectural cure for mental illness, and patients were held in asylums because they were deemed to be therapeutic spaces and a necessary element of a successful recovery. Therefore, during the formative era of institutionalization, the design ethic and spatial operations of the asylum were rooted in patient beneficence through therapeutic design.<sup>39</sup> Nevertheless, patient autonomy was heavily suppressed in these asylums, often through architectural measures analogous to those used today.

### **A Detail Approach**

However, a prominent figure in the design of these asylums, Thomas Story Kirkbride, believed that special attention to the design and deployment of architectural details could accomplish a safe and genteel environment without taking on the overt features and resulting perception of a prison environment.<sup>40</sup>

Kirkbride's strategies included sinking the asylum's perimeter walls in a trench to reduce the impression of confinement, adding decorative cast-iron sashes around windows so that they could be opened for fresh air but not escaped through, and design directives to mitigate unpleasant smells through forced air and natural ventilation.<sup>41</sup> Therefore, the role of the architectural detail was to emphasise and reinforce the conceptualization of the asylum as a therapeutic environment.

Yet this understanding of the therapeutic detail is rarely evidenced in inpatient psychiatric care today and appears to have been lost during the wholesale abandonment of environmental determinism. The premise that the architectural detail can still offer a therapeutic dimension to contemporary psychiatric care is the conceptual departure for this thesis. Accordingly, a detail must be understood as more than a decorative element or technical requirement in a building. While small-scale, details often represent a humanistic gesture and prioritize the individual's experience and reaffirm their existence in a space. As such they are a significant platform to promote well-being, especially in situations of personal crisis.

The notion that the architectural detail can factor into the experience and understanding of a building is well-established by architectural scholars. For instance, Marco Frascari presented the detail as a generator of significance and a grounding point for the grander narrative of a building.<sup>42</sup> As such, the detail is conceived as an articulating element and conveys an understanding of the whole building of which it is an integral part. Just as a detail can speak to the concept of a building it can also convey the ideals of a program or occupancy. Therefore, by

extension the architectural detail presents an opportunity to convey a broader ethic of care that is both immediate and tangible by virtue of its physical presence and function in the space. Especially in modern hospital settings laden with standardized finishes and endless corridors, thoughtful and intentional details can provide a sense of place in often placeless environments.

In addition to its historical precedent and theoretical underpinning, a detail approach also addresses a contemporary reality of architecture in acute psychiatric care. Today, many existing inpatient and emergency psychiatric care environments are smaller clinical suites in large general hospitals and were built out of the necessity to provide a safe and secure space for stabilization, assessment, and treatment. While there is significant academic and professional attention towards designing new healthcare buildings with the flexibility to adapt to changing services, technology, and delivery methods, there is less work focused on finding architectural strategies for renovating and retrofitting those that are already built. While new medical equipment and shifting operational requirements often prompt spatial reconfigurations and chances to redesign other areas of existing hospitals, changes to psychiatric treatment do not usually necessitate a wholesale renovation. Therefore, the realities of care for staff and patients often mean trying to adapt contemporary clinical ideals to psychiatric healthcare spaces that were originally designed decades ago.

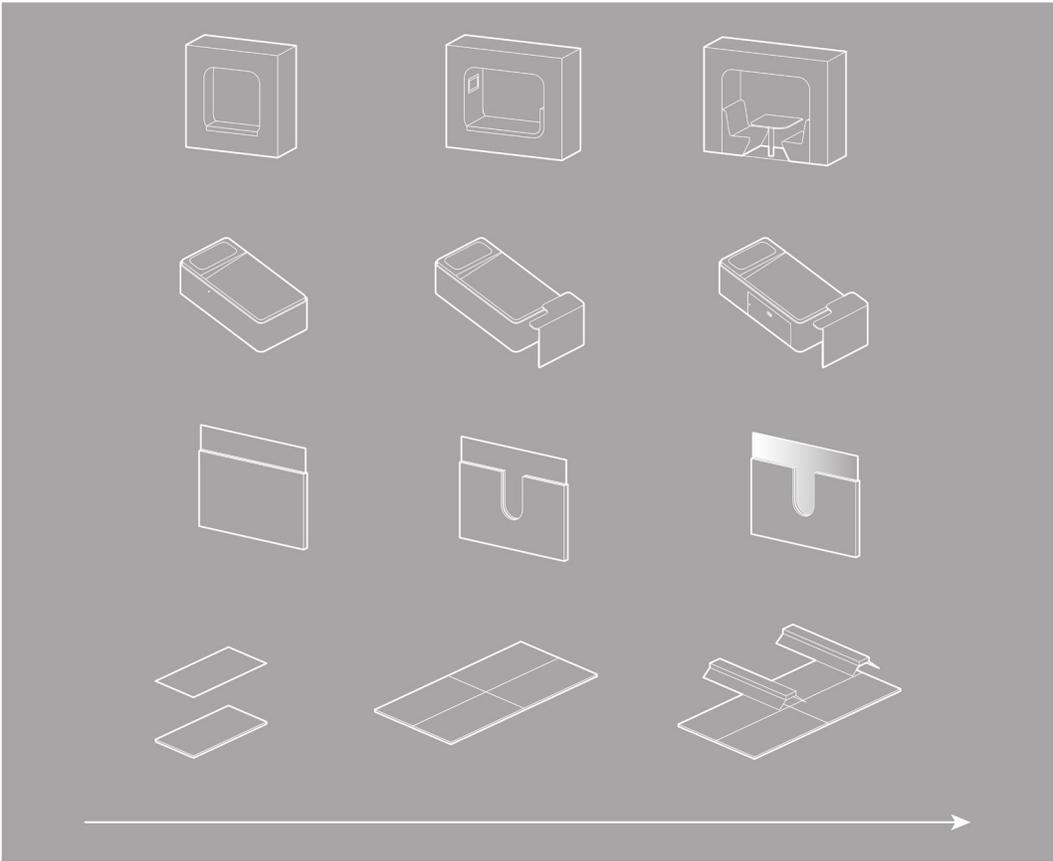
While available space, planning, and budget considerations may limit the implementation of best-practice architectural strategies for psychiatric care- such as natural light, access to the outdoors, and spaces for exercise and recreation- a

catalogue of therapeutic details provides ways to enhance the patient experience through smaller architectural instances and incremental changes. Moreover, these kinds of details could also be implemented with maintenance and renewal budgets where appropriate, making them much more accessible and transferable than a wholesale renovation. Therefore, approaching the renovation of PES through a series of architectural details allows the strategies developed in this thesis to be considered in other spaces of psychiatric care.

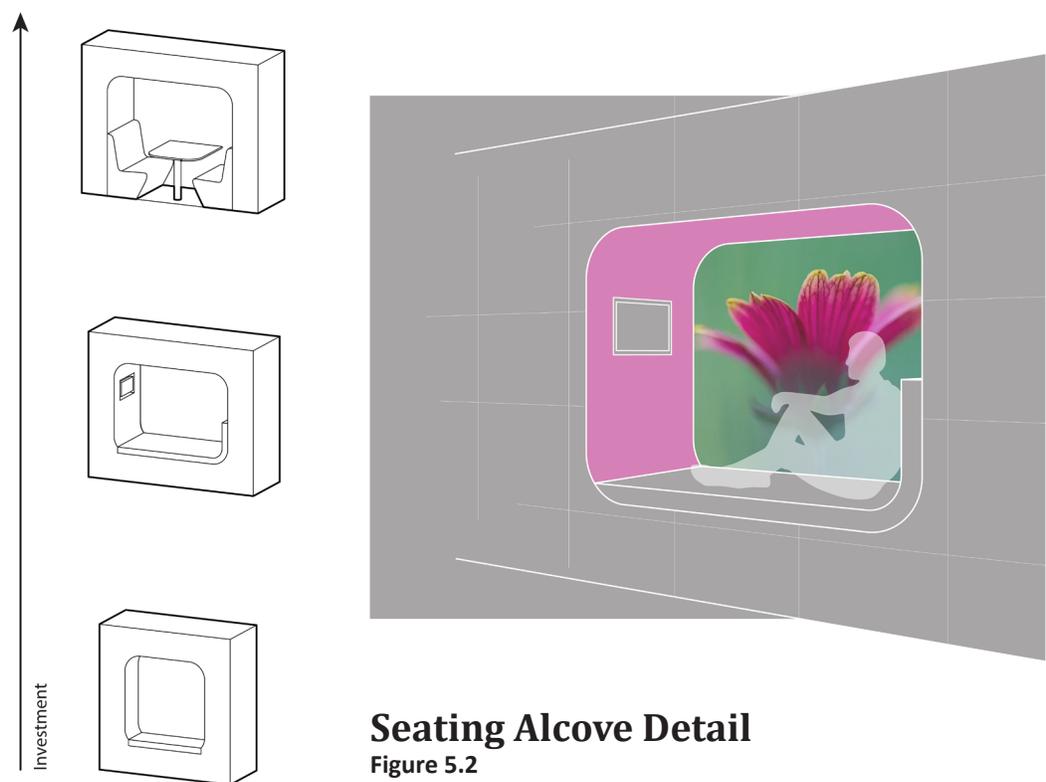
This series of details and their corresponding renovations cannot completely remedy the limitations of existing spaces of psychiatric care nor substitute the eventual need for a new and improved ones. Rather they represent an architectural strategy and specific approach to intervening in existing spaces to adapt them to new and unforeseen uses or new and increased expectations of the quality of the architectural environment. Especially with architectural projects that are public expenditures such as hospitals, incremental changes are often more feasible and financially responsible than new-build scenarios. They also provide opportunities to test strategies and inform both future renovations and new facilities. The demand for mental health services continues to rise and eventually new clinical models and spatial requirements will be developed to treat mental illnesses. In the meantime, it is necessary to critically evaluate and look for opportunities to elevate and adapt existing spaces that are already part of an established network of healthcare infrastructure. A detail approach represents a design direction that seeks to address the present limitations in many spaces of psychiatric care when it is not possible to implement a new build or complete renovation.

**Details**

This section introduces the series of architectural details that were developed in response to the specific site, program, and current challenges facing both PES suites at The Ottawa Civic and General Hospitals. However, the details are not limited to these spaces and may be considered in the design, renovation, and planning of other psychiatric inpatient spaces. Some details are presented as a series of variations along a continuum of investment to reflect that they can be implemented in different capacities depending on their intended use.

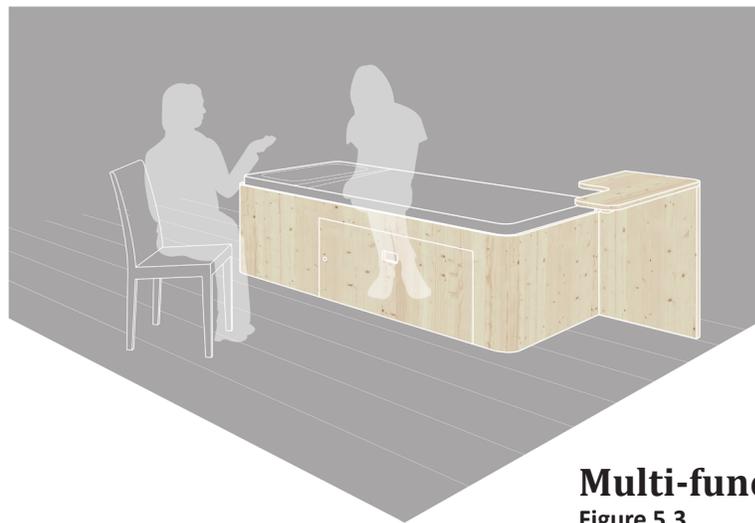
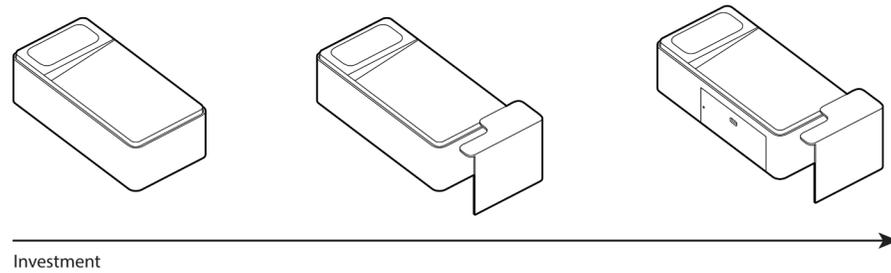


**Figure 5.1** Detail matrix showing details along a continuum of increasing investment.



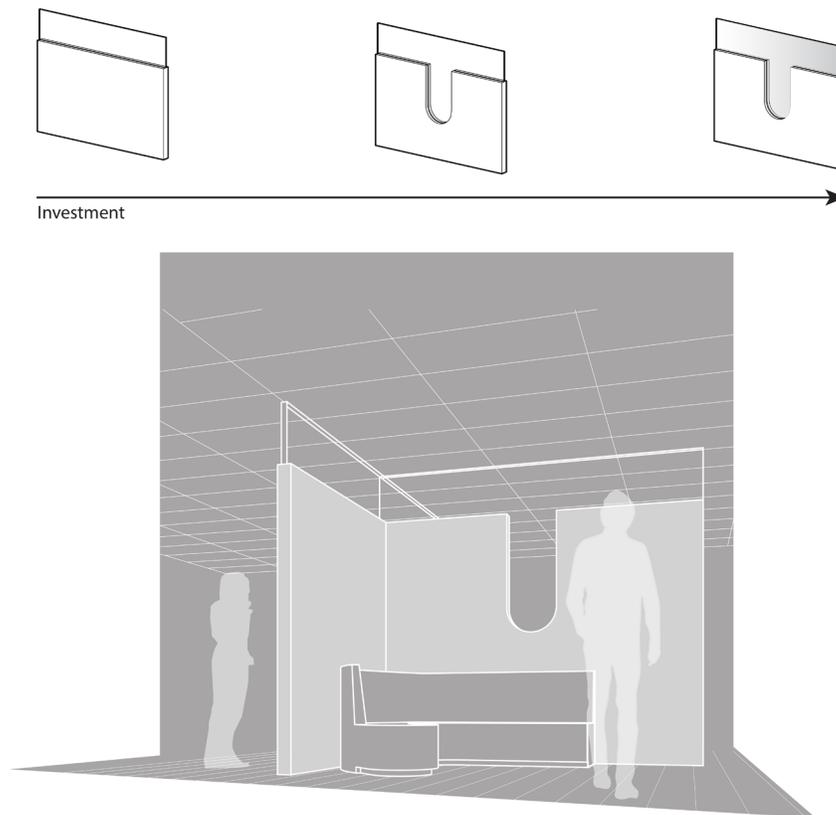
**Seating Alcove Detail**  
Figure 5.2

Semi-public spaces in psychiatric inpatient settings act as points of spatial decompression and locales of informal interactions<sup>43</sup>. However, the relatively small footprint allocated for the PES suites limits the space available for extra rooms or seating areas that would normally create semi-public spaces. Instead, seating and lounge alcoves can be built into walls to create these kinds of spaces without the risks associated with fully enclosed rooms or movable furniture in public areas. Especially through periods of longer waiting times, allowing patients to actively choose how or where to spend time when they become restless or have visitors provides a therapeutic benefit while upholding patient autonomy and independence without the need for increased security measures. Even where physical space and staff monitoring may be limited, these alcoves offer patients spaces to occupy without compromising safety or security needed in PES.



**Multi-function Bed Detail**  
Figure 5.3

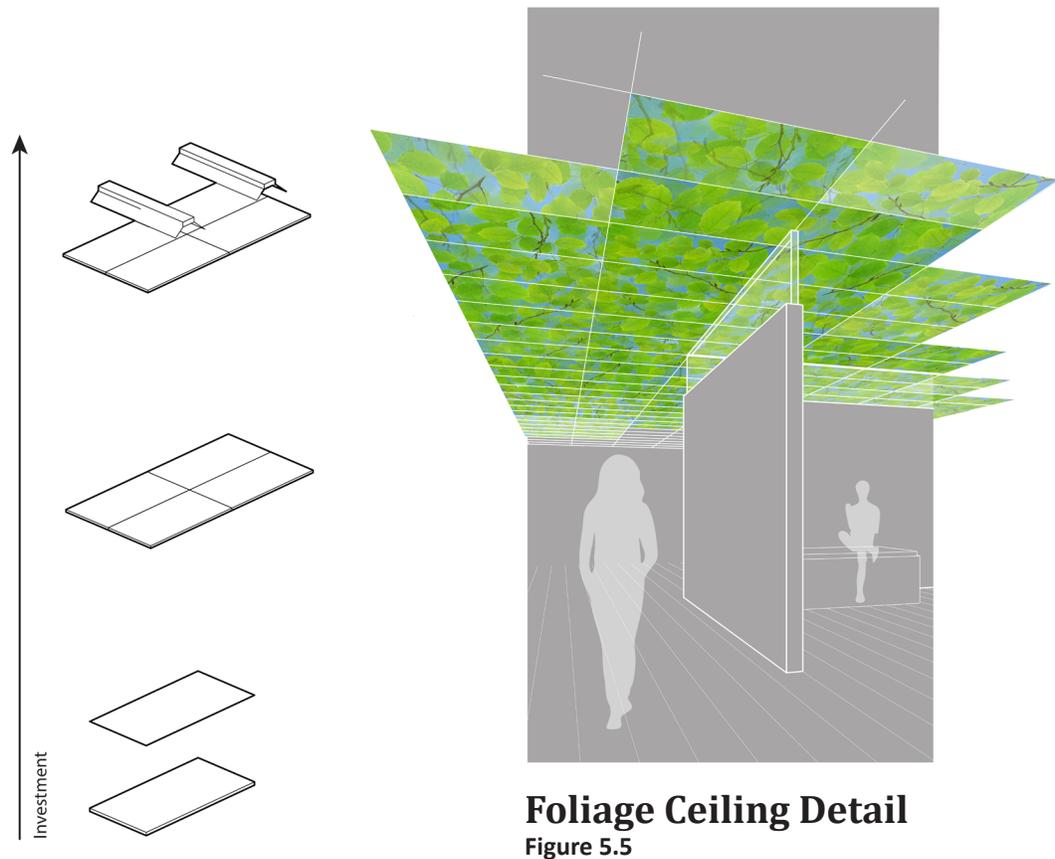
Since patients waiting in PES are generally medically stable, standard hospital and nursing care beds with adjustable height, side rails, and electronic controls and plugins are not as necessary as in other areas of the hospital. Residential-like wood bed frames can help to create a comfortable and familiar environment in psychiatric care spaces while remaining safe for use where patients have undiagnosed mental disorders and behavioural concerns. An option for an attached table at the foot of the bed creates a place to eat or place personal belongings without introducing extra furniture to the room. A secure drawer in the base of the bed can store personal belongings or additional chairs that can be brought out to provide extra seating for visitors. Furnishings that encourage normalized uses and appearances of rooms without compromising safety and security for their occupants can help combat an overtly institutional appearance in PES.



## Clerestory Window Detail

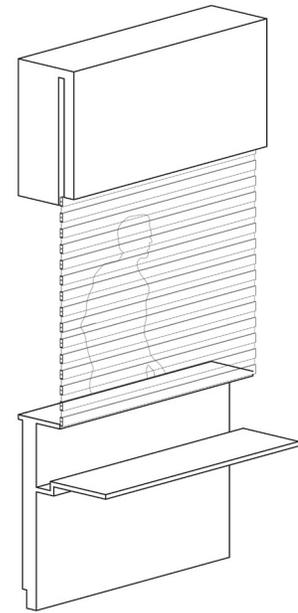
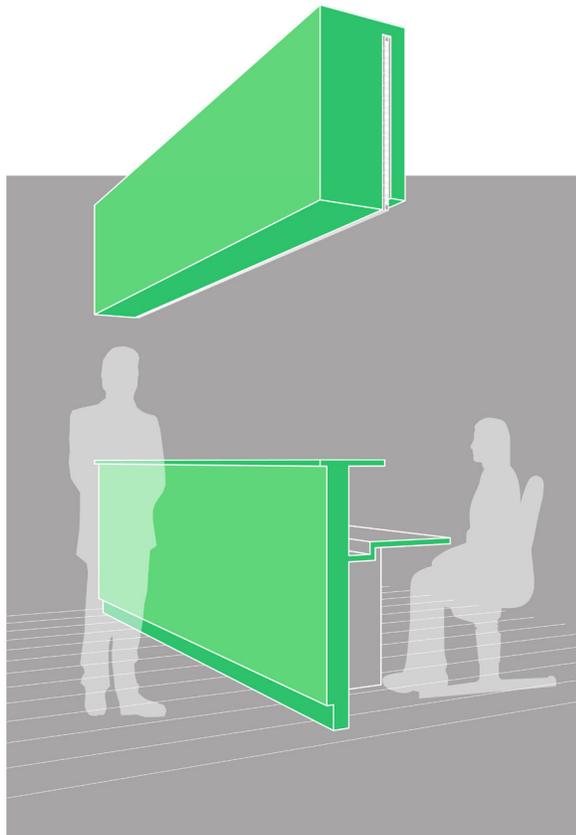
Figure 5.4

The patient room is the space occupied by an individual for the longest period of time while in PES, regardless of their diagnosis or any behavioural concerns. Clerestory windows can help combat feelings of enclosure and containment within the room by extending the line of sight beyond the wall, making the room feel larger. Conventional windows in patient rooms may undermine patient privacy, add unwanted stimulation, or create safety and security risks that are avoided with a higher window. For interview rooms, the clerestory window can be integrated with a lower window for informal observation or to check the room before entering it. When privacy or shading is periodically required, electrochromic glass can be used to control the tint of the clerestory window electronically.



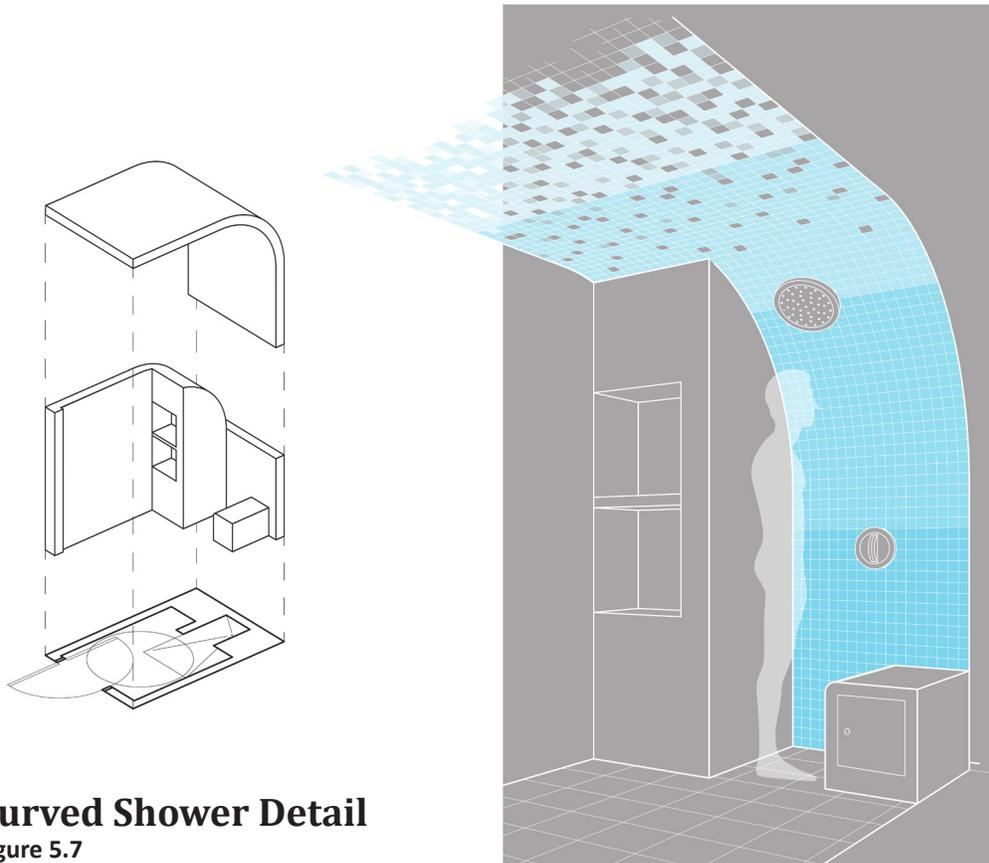
**Foliage Ceiling Detail**  
Figure 5.5

Views of vegetated settings have a calming effect on staff and patients, and the opportunity for visual contact with the outdoors is encouraged for inpatient care environments.<sup>44</sup> However, since the PES suites are effectively landlocked within the hospital, a ceiling patterned with natural or vegetated imagery creates an opportunity to provide a visual connection to natural settings where it otherwise would not be possible. Furthermore, unlike walls or floors where murals may become scuffed or peeled off, the ceiling holds the same visual presence in the space without being subject to the same conditions of wear. Depending on security and maintenance concerns, this kind of ceiling design can be accomplished with a vinyl adhesive or specially printed ceiling tiles. Since natural light is also limited by PES' location, artificial lighting that replicates it can be used to backlight ceiling tiles to create more dynamic lighting and help maintain and regulate individuals' circadian rhythms.



**Nurses' Station Detail**  
Figure 5.6

An open nursing station can make staff more available and accessible to patients, improving patient experience and perception of psychiatric staff.<sup>45</sup> Furthermore, it can help facilitate better auditory and visual monitoring of the space while encouraging therapeutic interaction between patients and staff. Especially in PES, where patients arrive with unknown disorders and behavioural considerations, there may be instances where the suite may need to be secured quickly. This design for a nurses' station balances the benefits of an open nursing station with those of an enclosed one with a concealed roll-down security shutter. Concealing the shutter in a bulkhead or wall reduces its visual presence in the space without compromising its availability and deployment. The shutter is made from transparent plastic to provide a durable but functional separation. Furthermore, glazing between the desk and counter reduces opportunities for patient access to monitors and other equipment.



## Curved Shower Detail

Figure 5.7

Given the increasing lengths of stay in PES, as well as seeing patients who have not been maintaining proper hygiene, access to a shower is an important consideration in providing normalcy and autonomy in PES. Aside from hygienic purposes, a shower can relieve stress, improve one's mood and provide a break in times of heightened emotion. This accessible shower is designed with a curved wall to provide a spacious and elevated experience in one of the most traditionally restrictive and potentially alienating spaces in psychiatric care. Tiled walls and ceilings handle water and vapour effectively, and the curved wall moves the shower head away from wall to allow a greater range of motion within the shower. The low ceiling creates a more intimate space for bathing than a conventional-height room. Built-in shelves keep clothing and towels away from the water without a shower curtain or introducing the safety risks of hooks or rods elsewhere in the space.

## **Renovations and Alterations**

The proposals outlined in the following section demonstrate how various details developed for PES can be implemented. For each PES suite, an alteration and renovation scenario are presented, reflecting various degrees of change from the existing configuration. Alteration proposals are focused on improving existing spaces through implementing the details presented earlier, as well as small space and programming changes. Renovation proposals represent a more extensive undertaking, including adding and rearranging existing programmatic spaces. Each proposal is intended to highlight how the details presented earlier can flexibly and interchangeably be designed into existing spaces of psychiatric care.

The alteration proposal for PES at the General Campus (Figure 5.8) includes renovating the nurses' station and staff offices to include the open nurses' station detail as well as create a more open work area. Maintaining part of the existing wall in the staff quarters creates public and private work spaces within the staff-secure area. The clerestory window, bed, and ceiling details are also added to the appropriate patient spaces and anteroom areas.

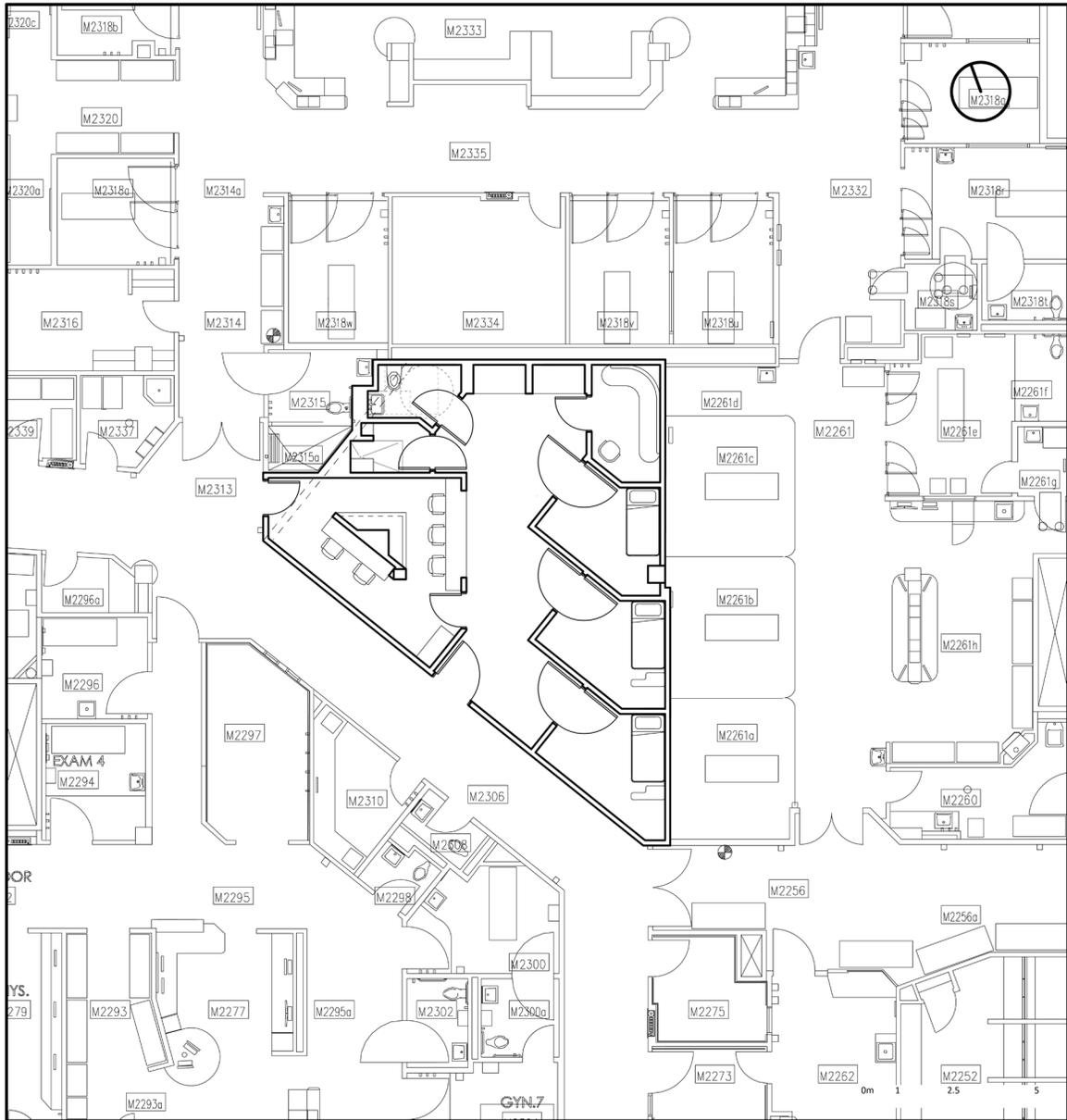
In the renovation for PES at the General Campus (Figure 5.12), the patient rooms are arranged linearly across from the nurses' station to provide better visual observation of the suite from it. The washroom and new shower room are located at the back of the suite to make use of their proximity to existing plumbing. An interview room and two seating alcoves create an informal lounge area. The six details presented earlier in the thesis are implemented throughout the renovation proposal.

The proposed alteration for PES at the Civic Campus (Figure 5.18) addresses a security limitation in the existing design by extending the staff-secure area to include the exit door to the hospital's public corridor. An accessible shower room replaces the former linen storage in the PES suite, and the underutilized existing seating area near the doors to the emergency department is expanded and opened by removing access to the adjacent office and corridor.

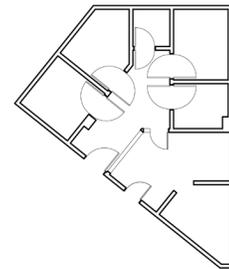
In the renovation proposal for PES at the Civic Campus (Figure 5.22), the patient rooms, washroom, and accessible shower are arranged linearly and perpendicular to the nurses' station. The nurses' station is positioned to provide better visual observation of all areas of the suite and includes two zones within the staff-secure area to create a more private work area. An interview room and lounge area near the nurses' station create a new zone within PES. The six details presented earlier in the thesis are implemented throughout the renovation proposal.

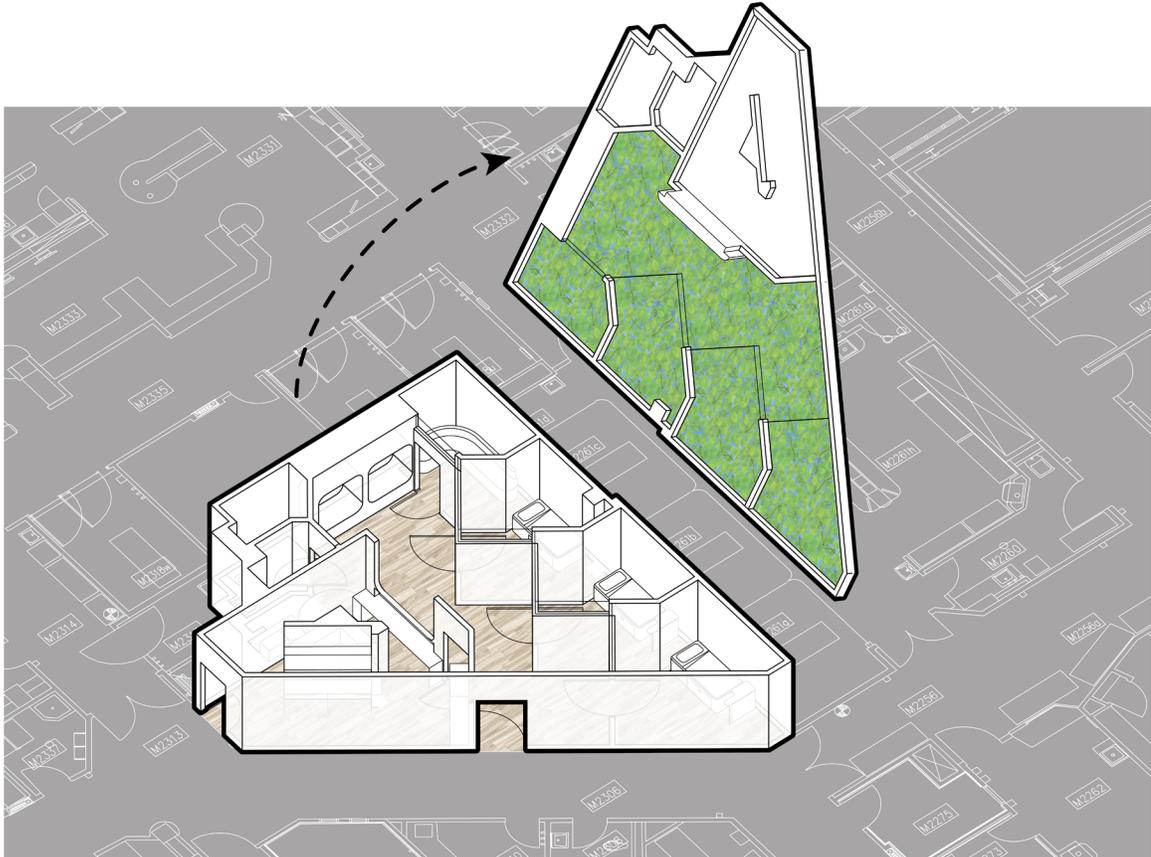




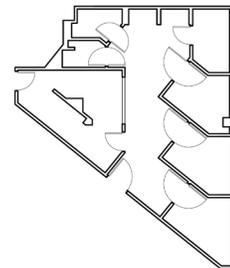


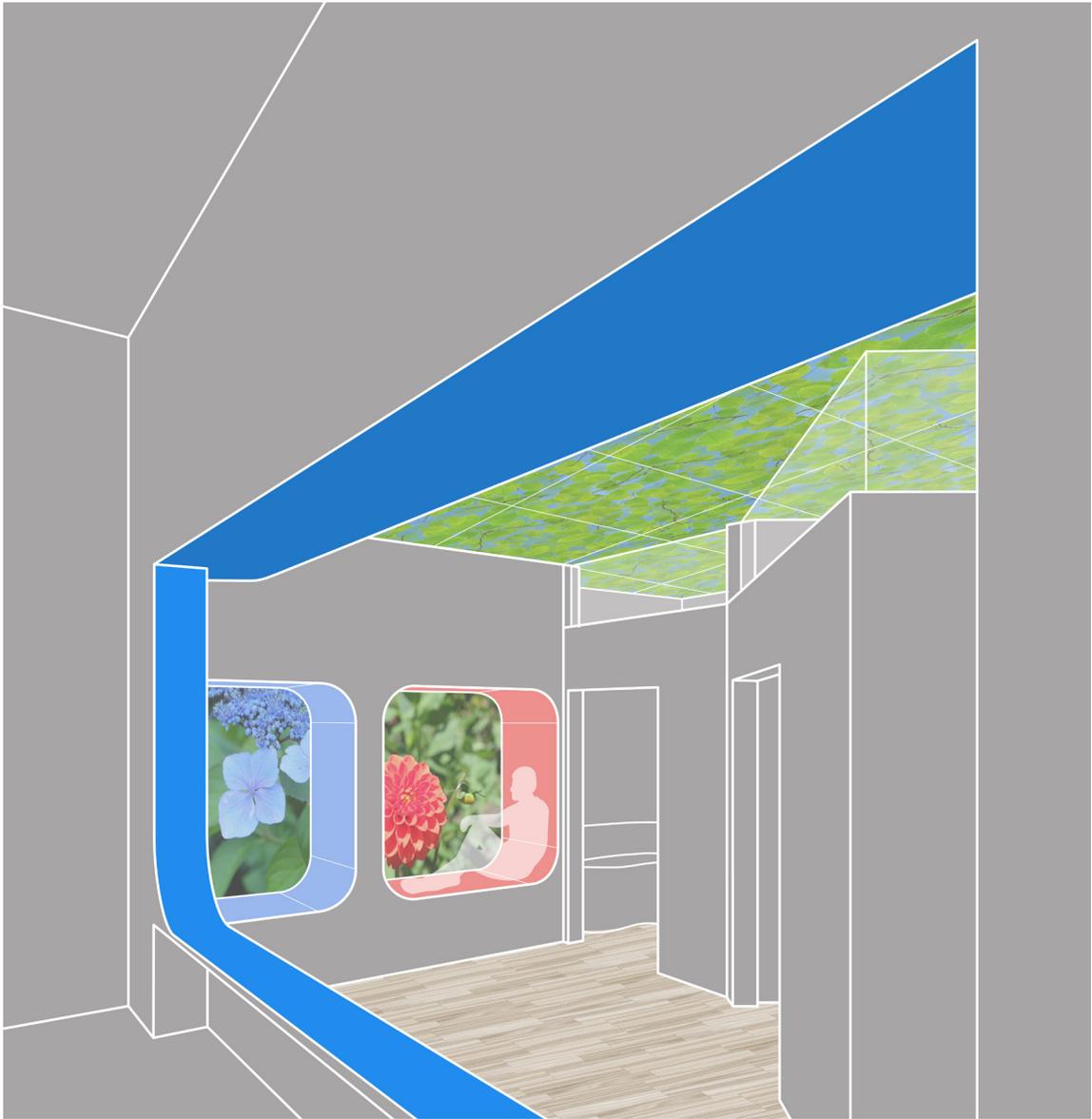
**Figure 5.12** (Above) Renovation proposal for PES at TOH General Campus.  
**Figure 5.13** (Right) Existing configuration of TOH General Campus PES.



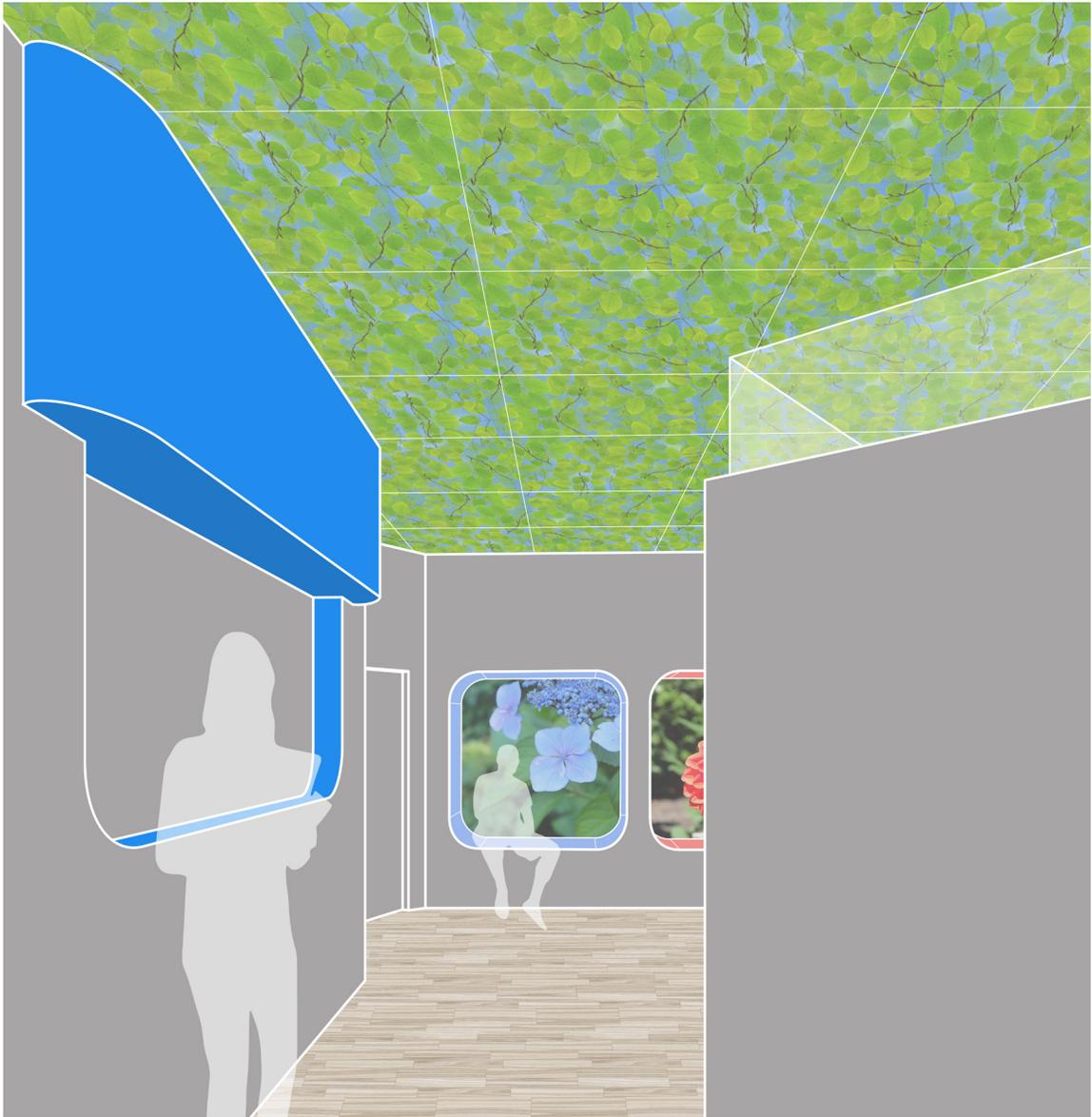


**Figure 5.14** (Above) Renovation isometric for PES at TOH General Campus.  
**Figure 5.15** (Right) Renovation plan for TOH General Campus PES.

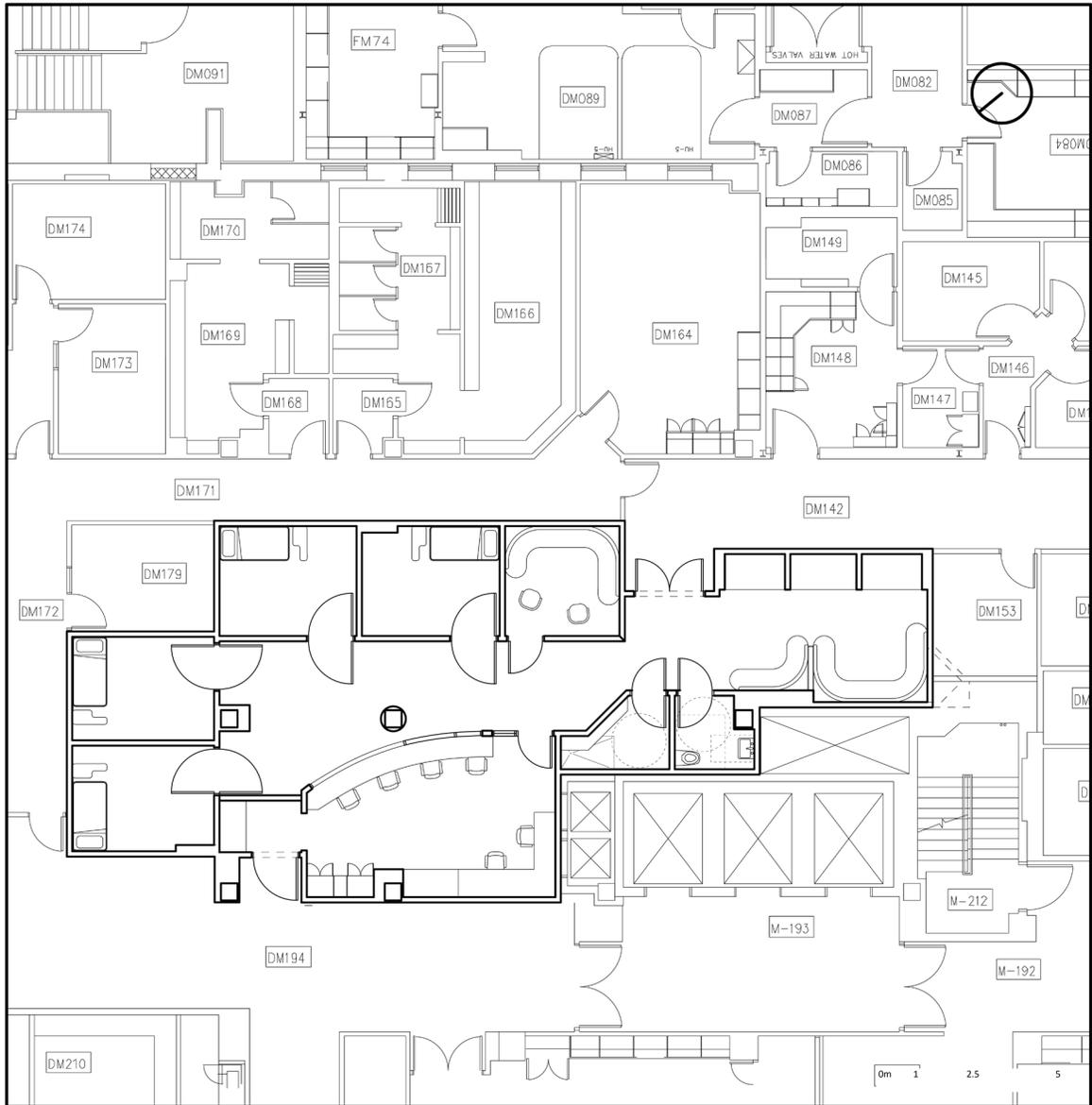




**Figure 5.16** Vignette of the General PES renovation from the nurses' station.

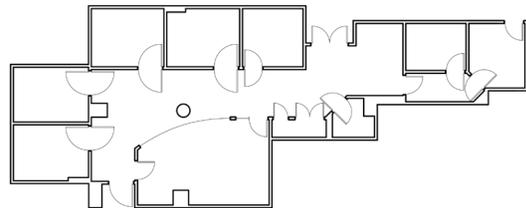


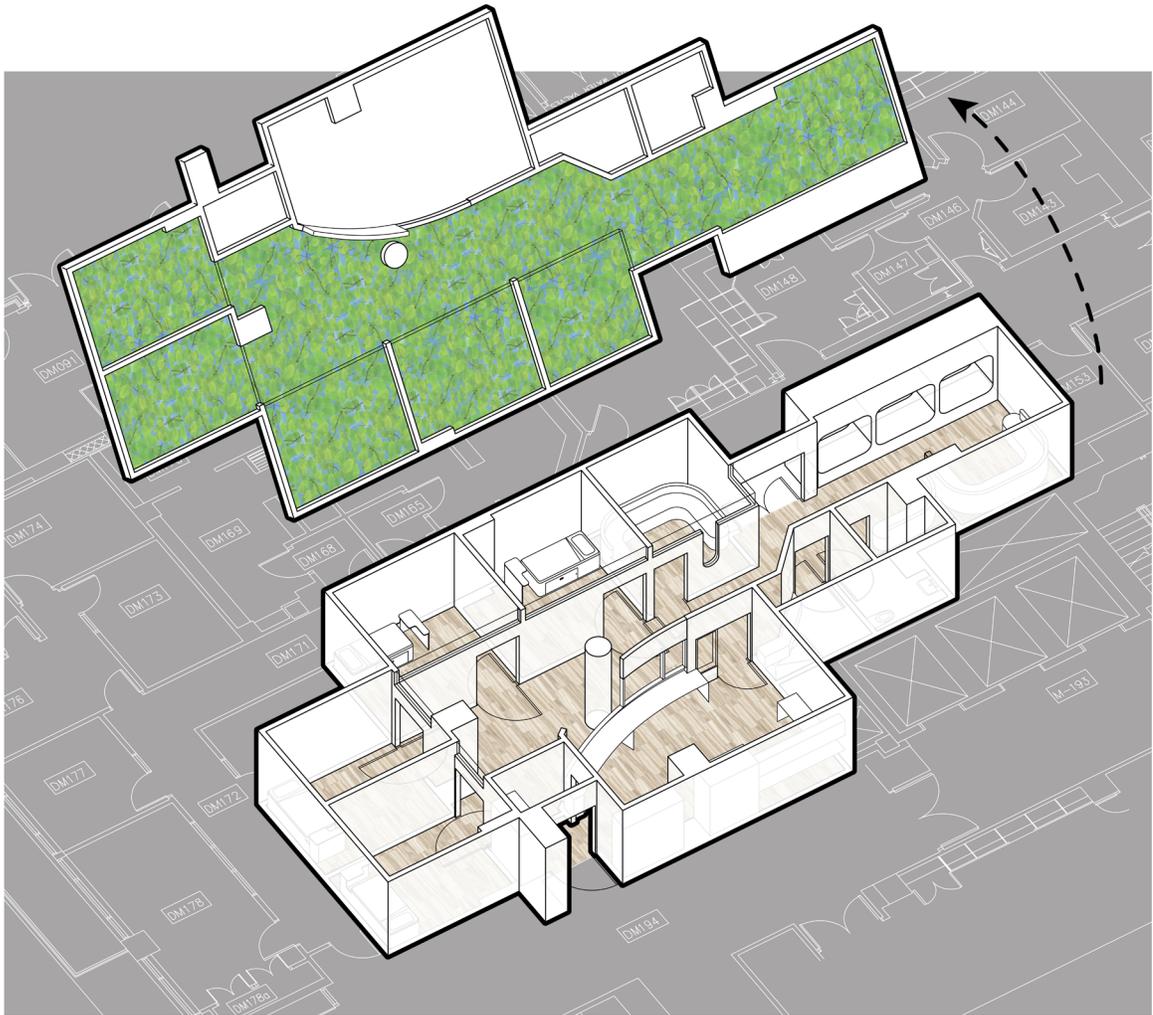
**Figure 5.17** Vignette of the General PES renovation from the patient entrance.



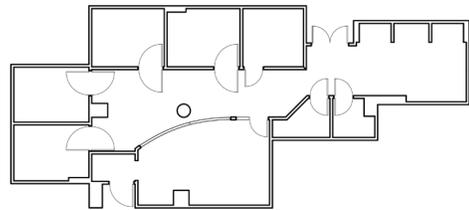
**Figure 5.18** (Above) Alteration proposal for PES at TOH Civic Campus.

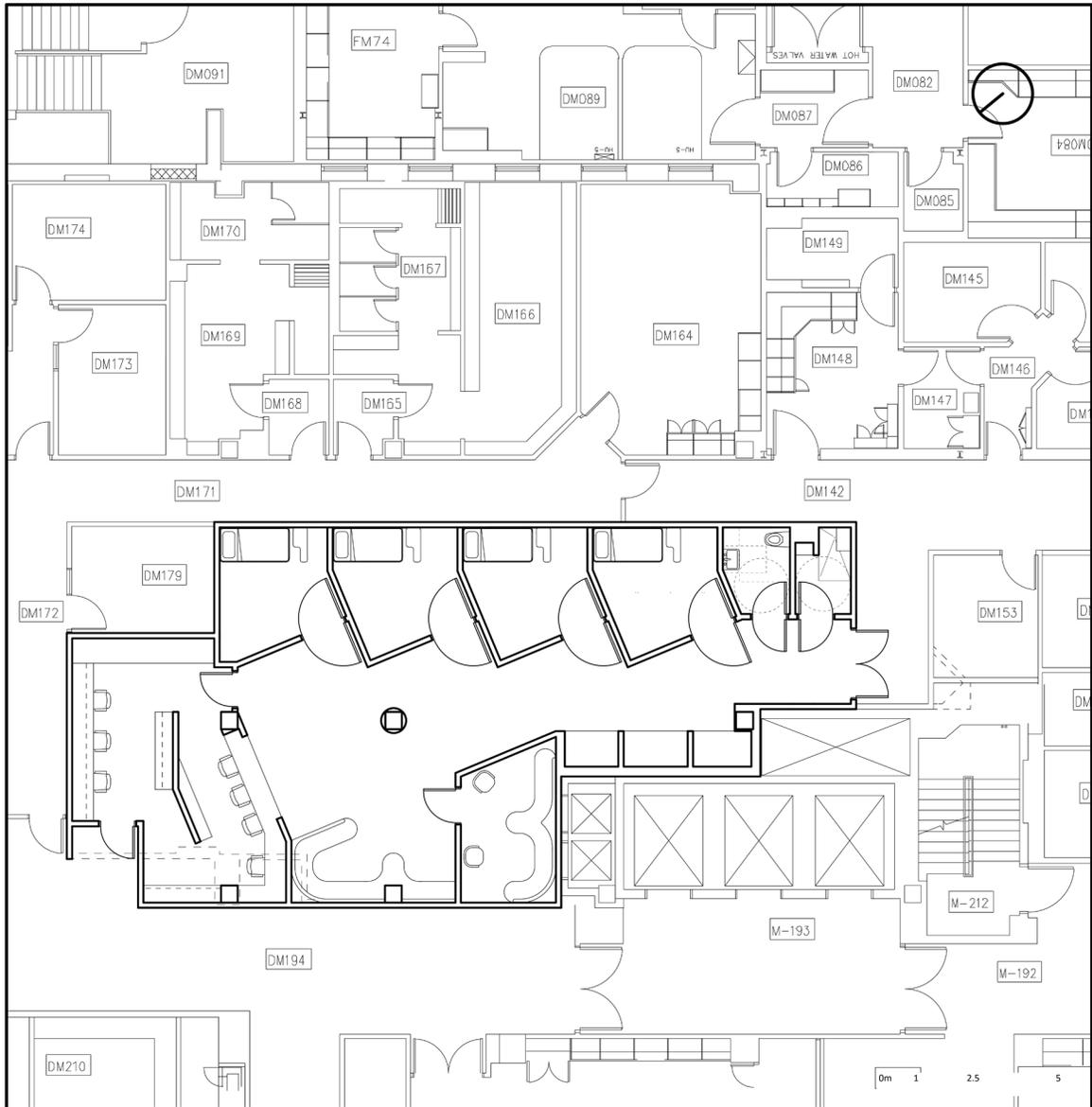
**Figure 5.19** (Right) Existing configuration of TOH Civic Campus PES.





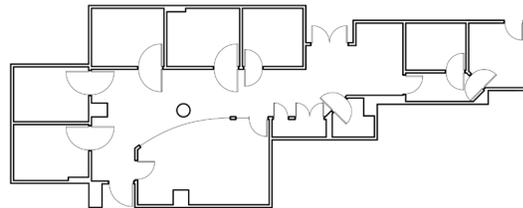
**Figure 5.20** (Above) Alteration isometric for PES at TOH Civic Campus.  
**Figure 5.21** (Right) Alteration plan for TOH General Civic PES.

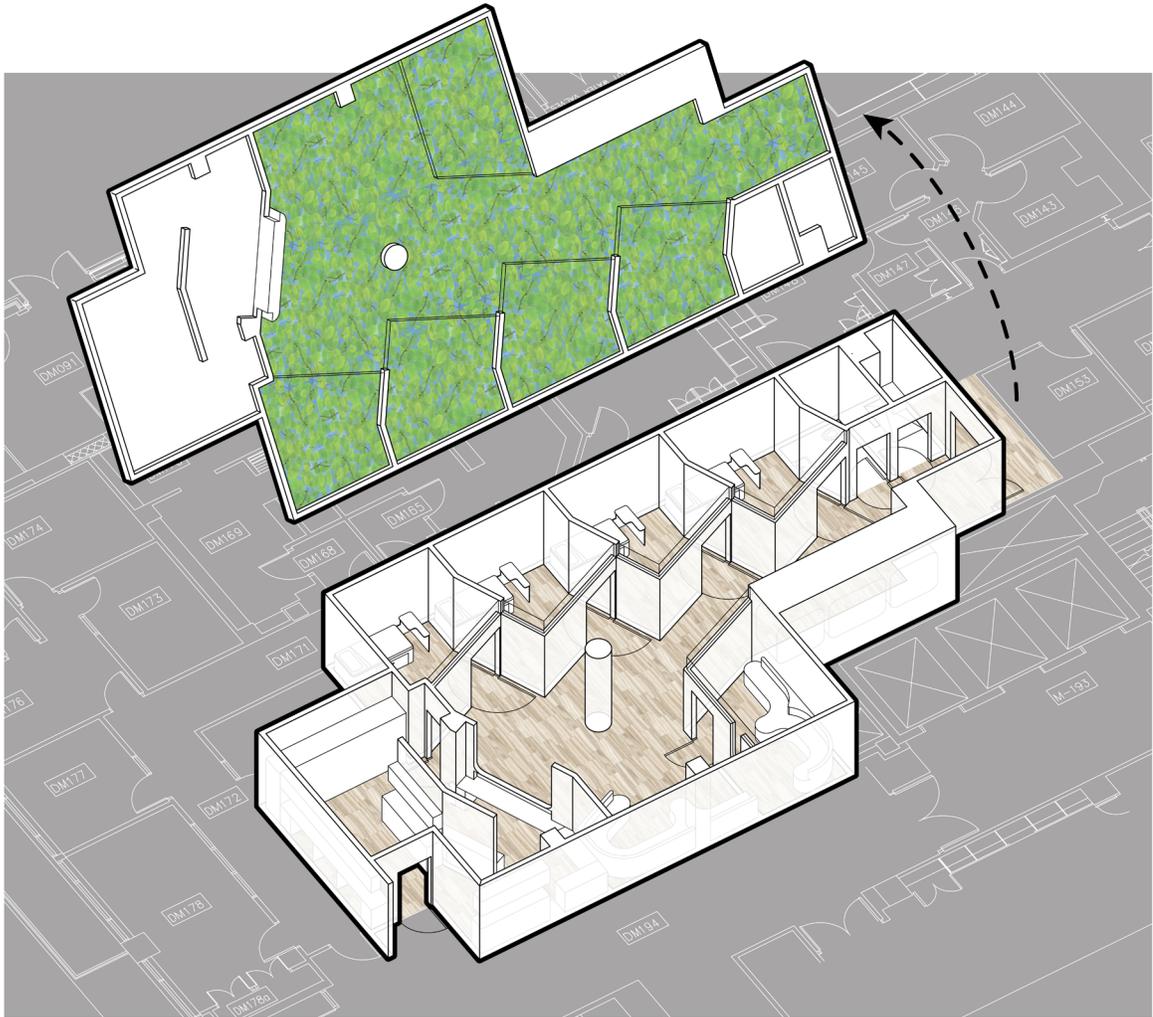




**Figure 5.22** (Above) Renovation proposal for PES at TOH Civic Campus.

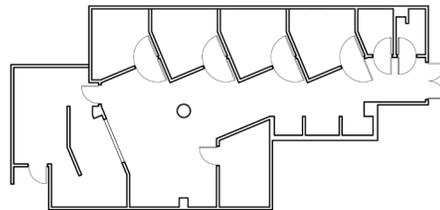
**Figure 5.23** (Right) Existing configuration of TOH Civic Campus PES.

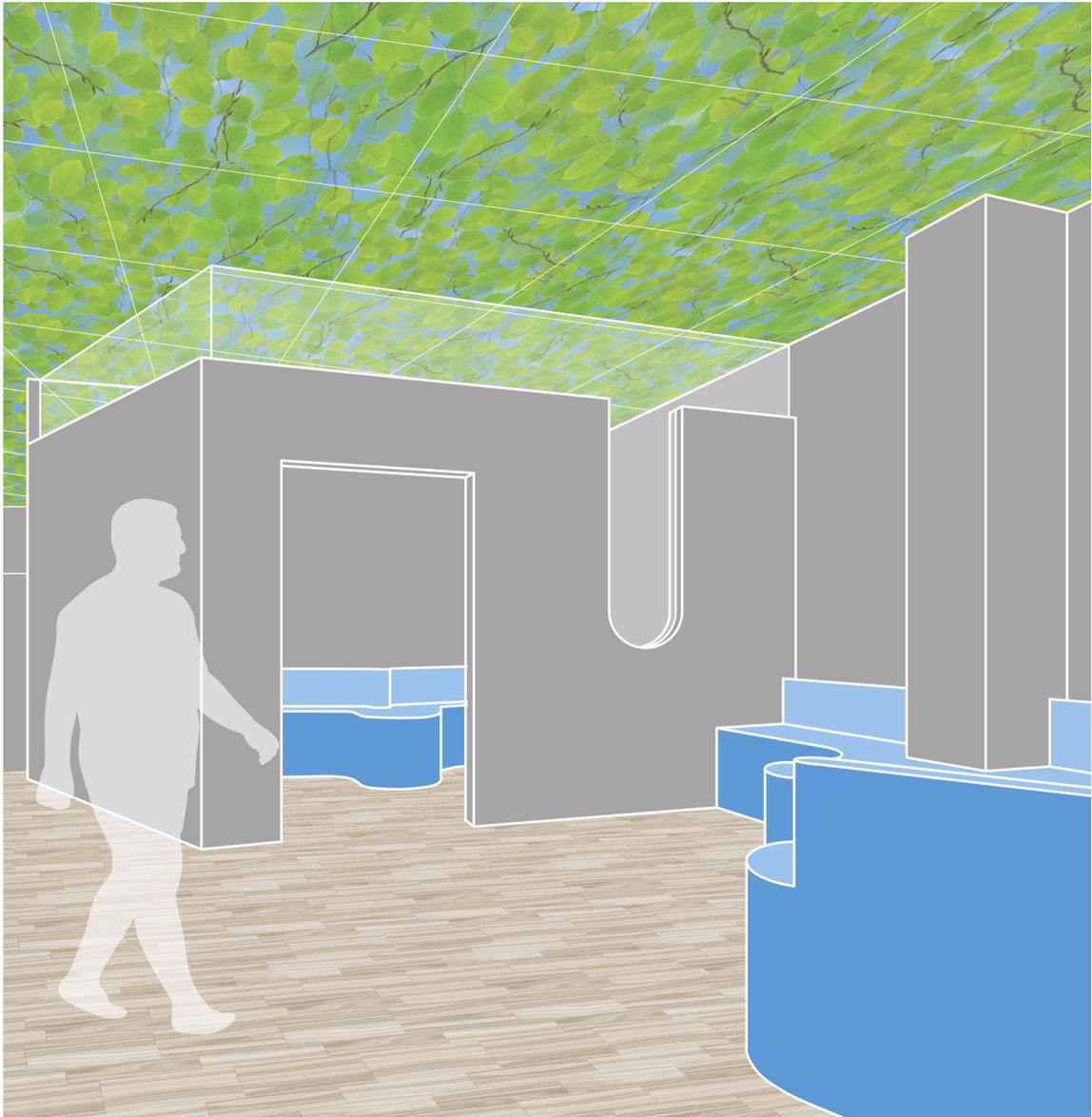




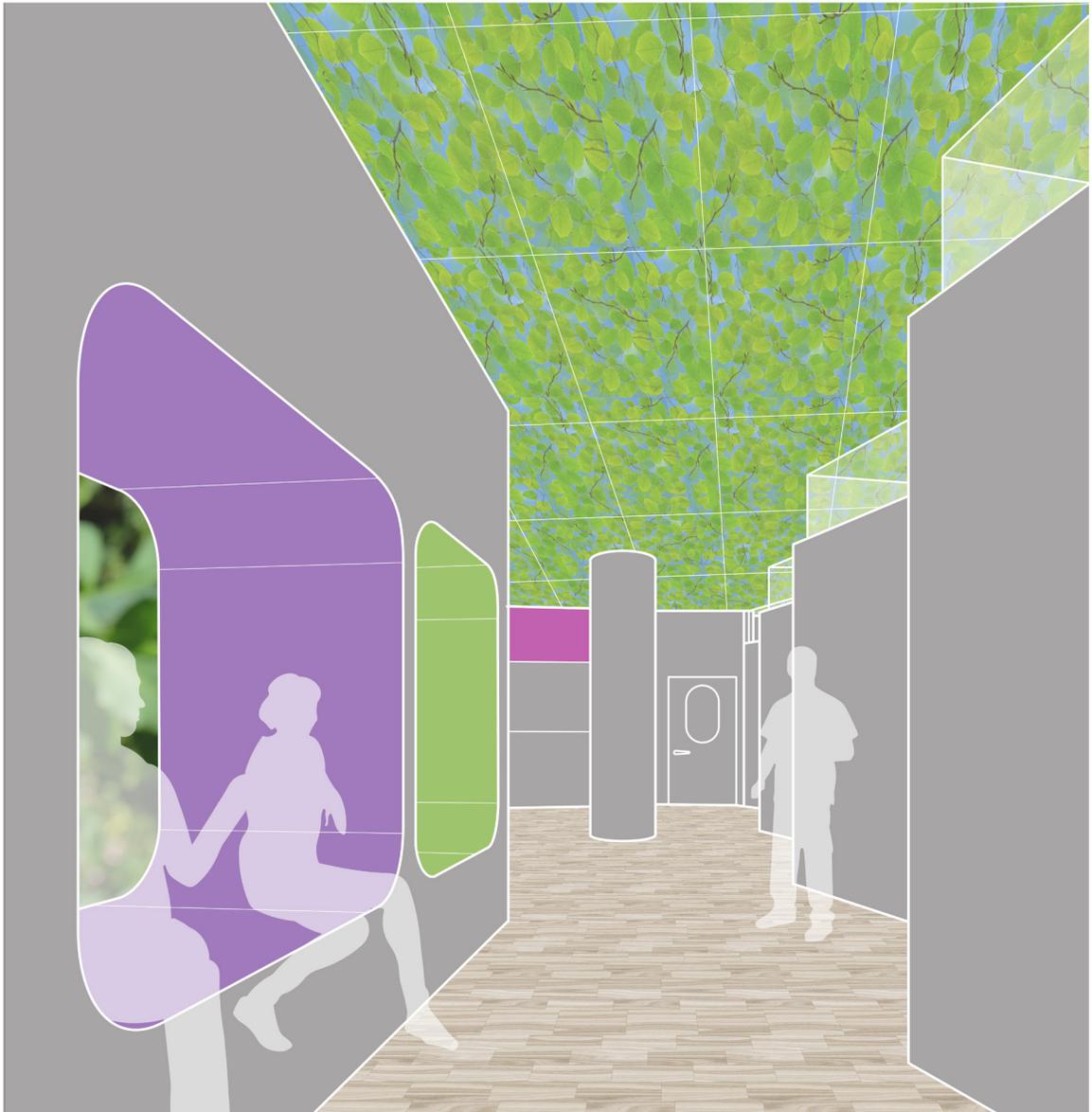
**Figure 5.24** (Above) Renovation isometric for PES at TOH Civic Campus.

**Figure 5.25** (Right) Renovation plan for TOH General Civic PES.





**Figure 5.26** Vignette of the Civic PES renovation from the nurses' station towards the interview room.



**Figure 5.27** Vignette of the Civic PES renovation from the patient entrance.

## 6. Conclusion

The history of mental illness and its treatment demonstrates that the spaces developed to house and care for those suffering from mental illness reflect both society's values and the contemporary understanding of mental illness. Changes in psychiatric practice have precipitated numerous shifts in architectural thinking, yet the architectural response in contemporary psychiatric inpatient facilities often produces environments that are reductive and uninspired. Place is an emerging determinant of emotional health and healing, yet the architectural conditions of these spaces often replicate principles of the asylums they replaced. Therefore, there is a need to change the paradigms that drive the design of psychiatric inpatient facilities and embrace a design ethic that contributes to patient beneficence by prioritizing patient comfort and therapeutic interactions while remaining safe and appropriate for psychiatric care. In doing so, the spaces of contemporary psychiatric care can be further distanced from the negative connotations of institutional environments that dominate the historic record and cultural perception of mental disorders.

To contribute to redefining the role of architecture in spaces of psychiatric care,

this thesis proposed a new design ethic and renovation of two psychiatric care spaces in Ottawa: Psychiatric Emergency Services (PES) at The Ottawa Civic and General Hospitals. A detail approach to designing and redesigning these spaces is based on a historic precedent and addresses contemporary realities in healthcare architecture. Architecture provides the physical setting for inpatient care and therefore configures itself as a significant interface between the patient and the broader system of psychiatric services. As such, it is an opportunity to convey and provide an ethic of care that is already emphasised in clinical practice. The work developed in this thesis represents one approach and one instance of design that aspires to aid in how psychiatric care is currently experienced and perceived. Furthermore, it seeks to address the present realities that impact the design and delivery of psychiatric care and find ways to improve people's lived experiences through the built environment. There is an opportunity to use thoughtful architectural interventions in existing spaces of psychiatric care to better support patient dignity, coping, and relief as well as mitigate undue stress. In doing so, the architecture of these spaces can provide a comfort to patients and augment a patient-centred approach to psychiatric care.

## Endnotes

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