Psychiatric healthcare has moved from a focus on in-patient treatment to care within the community over the past 60 years. However, hospital care is still an integral part of mental healthcare services. In 2010/11, in the UK, in-patient services accounted for 38% of all direct investment in mental health services for working-age adults – an estimated cost of approximately £2 billion. Moreover, new reports suggest growing evidence of severe overcrowding of a case-load of increasingly challenging patients, and a need to expand in-patient provision in mental health.2

In-patient psychiatric wards must balance many needs: being a supportive, therapeutic and caring environment, preparing patients to return to the community, providing a place of safety from external hazards, and being a home where people live as well as work and visit. It is increasingly acknowledged that the physical environment of healthcare facilities has a considerable role to play in addressing such needs. However, the relationship of psychiatric ward design to patient outcomes, as well as to the overall experience of treatment, is a particularly under-researched area. This is rather surprising, given the growing policy investment in the evidence-based design of healthcare facilities. Evidence-based design can be defined as ‘the process of basing decisions about the built environment on credible research to achieve the best possible outcomes’.3 Current policy in the UK promotes evidence-based design as central to the process of renovation of existing hospitals and the construction of new facilities under the private finance initiative (p. 144).4 UK Department of Health recommendations for the physical environment of psychiatric wards highlight the importance of ‘future proofing’ healthcare buildings; that is, ensuring that facilities can adapt to meet future needs in an increasingly challenging economic and epidemiological context. Moreover, they urge that psychiatric as well as general in-patient facilities should be client-centred, with the aim of maximising well-being – now recognised as an important health outcome in its own right.5,6 Robust research is therefore all the more necessary to highlight the priorities and directions for ‘future proofing’ as well as determining the specificities of client-centred design.

There is now a rapidly growing literature on the contribution of healthcare facility design to treatment outcomes. In some of that literature there is an attempt to establish a more or less direct link between design and outcomes. The work of Ulrich has argued that plentiful light, views of nature, naturalistic art and an overall sense of control have measurable effects on stress reduction and, through this, on the likelihood of more favourable outcomes.7 These findings are frequently cited in accounts of optimum psychiatric facilities and recommended for the design of new buildings.8 Additionally, there is now widespread consensus that in order to be therapeutic, such facilities must preserve a sense of privacy and dignity, be well apportioned and maintained, and contribute to a sense of stability and safety.9 However, the links between specific design features and specific health outcomes are not conclusive and, furthermore, such links are shown to vary according to the characteristics of patient populations.9

Research in environmental psychology has presented us with a more complex picture. Here the therapeutic environment is constituted in the interaction between ‘physical and architectural variables’ of a particular space and ‘atmosphere’ or social climate – the organisational, social and relational dimensions of that space.10 Furthermore, and with reference to psychiatric environments, Holahan has argued that clinical or behavioural findings following a design intervention may be mediated by a series of interrelated organisational systems – for example, negative staff responses may act as an inhibitor of clinical changes following a unit redesign.11 More recently, health geographers have started applying the interpretative framework of the ‘therapeutic landscape’ to healthcare environments, as an expansion and modification of environmental psychology work.12 Here, the impact of the physical environment on its users is constituted in a dynamic interaction with its social and symbolic dimensions. In other words, the efficacy of healthcare design may not only depend on how it functions, and on the kinds of social relations embedded in it, but also on the implicit messages it communicates to different users. For example, a well-maintained ward may signify expectations for improvement. Conversely, an abundance of safety features, or
old and worn fittings might prime service users to acts of vandalism. Although a small number of reviews on this topic already exist for general healthcare facilities, we contend that there is considerable merit in examining the evidence for psychiatric wards separately, since the needs of patients and staff are very specific, not least because the former are often held there under a legal sanction. Furthermore, we argue that the strength of existing evidence needs to be assessed so that robust links between design and outcomes may be established. We consider quantitative, qualitative and mixed-methods evidence, seeking to investigate which therapeutic outcomes have been examined in the literature and what aspects of the physical environment may be seen to mediate these outcomes. We pay special attention to whether and how different stakeholders’ responses to the same ward environment have been examined. Finally, we explore the extent to which the social or symbolic dimensions of the built environment are taken into account.

Method

Literature searches were carried out in November 2013 in the PsychInfo (1806–2012), Medline (1946–2012) and Embase (1980–2012) databases. The search terms were: ‘psychiatric ward’ or ‘psychiatric hospital’ with ‘design’, ‘architecture’, ‘atmosphere’, ‘environment’ ‘milieu’ ‘building’ or ‘interior’. The literature searches yielded 150 non-duplicate potential papers but 129 of these were either not relevant to the topic of the design aspects of psychiatric wards or not written in English. The majority of excluded papers considered non-physical aspects of the ward environment only, with interventions on ward-based activities, time allocated to patients by staff, length of stay and organisational change. Papers relating to psychogeriatric and child and adolescent wards were excluded, as the physical design of such wards involves very specific safety features. Additionally, papers correlating ward atmosphere to patient outcomes or staff satisfaction were excluded, unless the physical environment was also included in the experimental design. After hand searching and a review of the grey literature, including health service and government reports, 23 papers remained.

Review of psychiatric in-patient design

Methodological issues

The difficulty for new designers is the lack of hard evidence on which to base the construction and decoration of psychiatric wards. This is despite some efforts to assess design aspects that might produce more acceptable and more therapeutic surroundings. Our literature search found two types of papers: first, studies with specific outcome measures (observations, audit data or questionnaires); and second, qualitative studies of patient and front-line staff perceptions of acute wards. The robustness of the methodologies and designs varied considerably across all categories of study. Many studies use a before-and-after method of assessment of the effects of an intervention with no control group – a method that lacks rigour. The well-known Hawthorne effect suggests that, merely by virtue of being studied, behaviour will change, even if the changes are detrimental to the working environment. But as these studies may still provide some indication of the types of benefit that might accrue from adopting a more flexible approach to design, they are included in this review. Some studies omit any mention of patient characteristics that may affect behaviour, as well as not measuring what activities take place and where (e.g. spending time in bedrooms), both of which factors may have an impact on outcomes such as length of stay. Some studies do not take into account considerable differences in the types of populations compared, although these differences might confound the results.

Quantitative and mixed method studies on the effect of environment on patient and staff behaviour

Twenty studies sought to investigate the therapeutic effects of in-patient ward designs (online Table DS1). Three linked design with symptom outcomes and the remaining 17 studies investigated the impact of ward design on patient or staff behaviour, treatment satisfaction and perceptions of ward atmosphere. In some cases, data on clinical outcomes were also gathered but were not the main focus of the study.

Links with symptoms

Only three studies focused specifically on a correlation between design features and clinical outcomes.13–15 A 1970 study found that patients displayed less pathological behaviour after a move to a more ‘physically attractive’ ward as measured on the Brief Psychiatric Rating Scale and an observational measure, compared with a control group.13 More recently, a Canadian study found a positive correlation between staying in east-facing rooms and faster recovery rates for patients with major depression compared with a control group (by a difference of 15%).14 This study, however, did not report on any other factors that may affect recovery rates, such as severity of illness, medications and most importantly whether or not patients spent daylight hours (and how many) in their bedrooms or elsewhere on the ward. An Italian study also reported shorter recovery times for patients with bipolar affective disorder staying in east-facing rooms. However, this study also found that increased sunlight had no effect for patients with unipolar depression.15 Similarly, that study did not report on any patient characteristics at all apart from gender, and the amount of time spent in their rooms was not measured.

Links with social interaction and behaviour

Several studies used behaviour mapping to trace the relationship between the physical environment and social interaction for both staff and patients. The existence of private or semi-private spaces was shown to have a positive impact on social behaviour. Two studies by Holahan and colleagues reported increased interactions after extensive changes (the redecoration and creation of semi-private two-bed bays) as well as modest ones (furniture rearrangement).16,17 A 1970 comparison between an open dormitory and single-bedroom wards by Ittelson and colleagues showed increased social interaction in the latter.18 However, the Ittelson study has considerable limitations, including large variation in the populations being served by the hospitals, non-random room assignment and one ward actively limiting time spent in bedrooms.18 An increase in social interaction was also observed in one 30-bed ward following redesign of the facilities into a more open-plan space, and patients responded positively to the change.19 A 1987 observational study of the effects of ward renovation on behaviour showed mixed results. The addition of more home-like features (matching furniture, repainting, carpeting, plants) in this New England ward for challenging patients resulted in some increase in social behaviour and a significant decrease in patient stereotypy (from a pre-renovation 9% to a post-renovation 0.8% of the total observation session).
However, the remaining slight behavioural changes proved more difficult for the researchers to assess clinically (e.g. a decrease in lying down in the hall and an equivalent increase in sleeping in the dorms). This study did not involve a control group and the findings could be confounded by seasonal variation. An environmental design survey undertaken in this ward, as well as an additional three wards, showed that staff rated some of the new additions highly but there was no significant improvement in staff morale or perceptions of the ward as an overall stimulating environment. Wykes observed increases in social interaction and occupational activity in new residential units with home-like features in South London (kitchen, garden, laundry and reduced regulation) compared with a control ward environment.21 McGonagle & Allan reported that patients in more home-like rehabilitation facilities showed faster improvement as assessed by the Social Behaviour Schedule at two time points, compared with patients in a long-stay ward.22

Two studies focused specifically on staff/patient interactions: the removal of the glass panel from the nurses’ station in one ward facilitated an increase in interactions compared with an identical control ward, whereas a move to a more patient-friendly design that allowed for more private spaces resulted in increased socialising and more positive exchanges between staff and patients compared with the old ward.23,24

Link with violence and seclusion

Three studies considered a possible association between physical environment and violence/seclusion. A UK study in the early 1980s involving seven experimental and three control wards found that time-limited interventions such as furniture rearrangement may contribute to a reduction in seclusion incidents and violence as well as an increase in socially acceptable behaviour by the patients. The improvements observed correlated with the duration of the interventions, but the causal links were uncertain, as the control wards were not matched to the intervention wards.25 A controlled clinical trial conducted in the late 1980s in a New York psychiatric centre monitored behaviour patterns as well as staff and patient morale before and after extensive ward renovation (new finishes and fittings, soft furnishings, art and plants). As well as consisting of pre- and post-renovation assessments, the study involved the additional assessment of four control wards at both time points. Although the results showed no difference in patient function between renovated and control wards, patients in the renovated ward reported an improvement in self-image and function between renovated and control wards, patients in the renovated ward were significantly reduced in comparison with a control ward, and significant change in symptoms, yet violent incidents were negatively assessed by staff. 17 Another intervention, which included a pre- and post-test assessment, found no significant differences in WAS ratings for either group.26 Moreover, the authors reported no increase in the use of seclusion or violence and suggested that the physical elements of a nursing station do not in themselves make a significant contribution to the treatment environment. However, the lapse of 1 year between pre- and post-test assessments may represent a confounding factor. Finally, Urbanoski et al noted that a ward redesign creating a more ‘client-centred’ space in a ward in Canada (stepped-down care environment, private en-suite rooms and accessible kitchen) led to overall improvements in ward atmosphere and treatment satisfaction. However, these improvements were negatively correlated with global functioning, assessed on the Global Assessment of Functioning.31 The authors noted that since the intervention also included a change in clinical routines, it was not possible to attribute perceptions of the ward or indeed changes in patient functioning to the effect of the physical environment alone.

Some of the above studies also addressed the impact of new facilities on staff and reported that design interventions may be responded to in conflicting ways by staff and patients. Thus, the introduction of an open nurses’ station, although welcomed by patients, was initially resisted by staff, who felt that such changes would impede their work or compromise confidentiality. 19,23 Similarly, the provision of two-bed bays in one study was negatively assessed by staff.17 Another intervention, which improved patient privacy and correlated with increased interaction between staff and patients, did not minimise staff burnout or enhance job satisfaction.24

Finally, a study using multilevel modelling of the relationship between design characteristics (assessed through a Ward Design Checklist developed for the study) and staff satisfaction in 98 wards across England between 2007 and 2009 showed that non-corridor designs and the existence of en-suite bedrooms were positively correlated with staff satisfaction. By contrast, safety features, modern fittings and good lines of sight did not have a significant effect. However, in line with all cross-sectional studies, a causal mechanism could not be established. Moreover, the researchers suggested that the lack of patient perspectives may limit the applicability of the Ward Design Checklist tool for a broader evaluation of ward design.32

Qualitative studies of patient and staff perceptions of in-patient wards

Qualitative research on patient and staff perceptions of the built environment of in-patient wards is very limited. The three qualitative studies assessed used focus groups with different stakeholders for post-occupation evaluations of new units in
danger.34 Wood both a feeling of incarceration and one of refuge from external disincentive for patients to return to the community. Similarly, the ward were ambivalent: for example, the homely aspects of more onerous. Additionally, responses to particular features of parts of the ward, and wished for home-like elements such as contact with nature and the facilitation of social interaction. The authors homeliness, the availability of private spaces, ample light, contact on healthcare building design: that is, patients and staff prized study, Curtis and colleagues found that the priorities of the methodological rigour as appropriate to qualitative research: high continuity of care and hence to patient well-being.35

Several studies suggested that the provision of private or semi-private spaces to behaviour or evaluations by different stakeholders. Several studies suggested that the provision of private or semi-private spaces, and of a more home-like environment, correlates with more social interaction and a reduction in violence and vandalism.16,17,20–22,26,27 Increased social interaction and reduced

The psychiatric interior in the UK

Few of the studies discussed here measured the relationship between design and clinical outcomes in the strictest sense. Instead, most tracked the contribution of particular design elements to behaviour or evaluations by different stakeholders. A different set of limitations apply to the qualitative studies examined in this paper. Although these studies were well designed in their own terms (pre- and post-intervention discussions, high interrater reliability in framework development), their small number does not allow for the emergence of generalisable findings. Furthermore, only two out of the three studies considered the possibility of conflicting responses to the same ward design by different patients, as the third study involved staff members only.33 Additionally, the remaining two studies did not necessarily achieve representative sampling, as participants were self-selecting.34,35 This makes it difficult to draw definitive conclusions from the emergent themes, and a meta-synthesis of

The authors in both the London study and the Northern England study concluded that their findings showed an inter-action between physical, social and symbolic aspects of the environment, thus lending credence to the ‘therapeutic landscapes’ framework. They suggested that in order for psychiatric units to promote well-being they must be designed as ‘permeable’ spaces, providing spaces for carer and patient encounters and for social relationships more broadly. Additionally, the authors argued that the therapeutic potential of modern mental healthcare units is constrained not only because they need to accommodate the needs of different groups, but also because such units crystallise an inherent tension between two contradictory policy requirements: first, that they function as spaces of seclusion; and second, conversely, that they facilitate a transition to and integration within the community.

The findings on conflicting perceptions between patient and staff that are supported by both quantitative and qualitative studies also have strong policy implications. For example, staff’s overwhelming concern with safety features and their ambivalence regarding the provision of private spaces for patients raises questions about the potential of a ward environment to be patient friendly while also providing a low-risk environment.24,30 However, findings also suggest that conflicting responses may be a result of staff preconceptions which may not be borne out in reality.19,23 Moreover, qualitative study findings point to the importance of the symbolic aspects of design more broadly understood: feelings of homeliness, containment or familiarity, elicited by particular design features. Such findings suggest that attention to such symbolic dimensions may enrich our understanding of how particular environments might promote or inhibit well-being.33,34

Many of the above findings are inconclusive, however. Not all studies discussed in this paper used equally robust measures of change: true randomisation was effected in only one case.17 Notably, four studies did not use a control group20,29–31 and one of these did not control for seasonal variation, which could have contributed to changes in behavioural patterns post-intervention.26 Another study failed to consider social class of the populations being served and indeed the quality standards of the hospitals themselves in its comparison of bedroom use between three wards.18 Additionally, organisational changes following the design intervention were mentioned as a confounding factor in several cases.17,24,31,33 Notably, in the Canadian study, patients on the home-like ward showed lower improvements in function compared with the control ward, and this negative effect was attributed to staff changes post-intervention.31 One study reporting a significant drop in violence post-intervention was located in a ward with very low incidence of violence.26 It is clearly possible to collect large data-sets, but often other factors are not taken into account. For example, two studies using multilevel modelling on large ward samples (199 and 98 wards)28,32 and one audit involving a large patient sample (n = 602)35 reported the presence of other confounding factors that were not addressed (differences in pharmacological regimes, differences in staff numbers and time patients spent in the assessed environments, respectively). Moreover, the long-term effects of design interventions were not monitored, with the exception of the Norwegian study, where the elimination of vandalism in the more home-like ward was shown to have persisted for at least a year.17

A different set of limitations apply to the qualitative studies examined in this paper. Although these studies were well designed in their own terms (pre- and post-intervention discussions, high interrater reliability in framework development), their small number does not allow for the emergence of generalisable findings. Furthermore, only two out of the three studies considered the possibility of conflicting responses to the same ward design by different patients, as the third study involved staff members only.33 Additionally, the remaining two studies did not necessarily achieve representative sampling, as participants were self-selecting.34,35 This makes it difficult to draw definitive conclusions from the emergent themes, and a meta-synthesis of
the results cannot be attempted. More sustained efforts in bringing quantitative and qualitative elements together in the same study, thus allowing for triangulation, may allow for the emergence of more generalisable and robust findings.

The presence of these limitations leads us to conclude that this is an area that merits further study. What is missing are well-designed randomised controlled trials involving nursing staff and patients throughout, which are adequately powered and have outcome measures appropriate to answer the questions posed, to be able to draw robust conclusions about what design features matter. Furthermore, attention must be paid to potential confounding factors such as severity and chronicity of illness, or how patients and nurses spend their time on the ward, which is often missing in studies in this area. The study design should also account for the role of organisational changes in mediating outcomes. In addition, close attention needs to be paid to any potential negative outcomes as a result of a change in environment, especially as patients and staff might have conflicting needs. The possibility of conflicting assessments by staff and patients suggests that study design would need to consider both staff and patients and measure behaviour and clinical outcomes, while also eliciting ward evaluations from different stakeholders.

Moreover, the complex nature of different stakeholders’ responses to the ward as a physical, social and symbolic environment merits further investigation. Qualitative and participatory studies would be particularly useful here because, although not definitive, such methods allow for a more nuanced understanding of how particular physical settings become meaningful for different people (what the ward connotes for people, how it makes people feel, how it might relate to their sense of identity). They may also help identify the systemic factors that might mediate how new designs affect well-being. But there are problems with this approach, as it might be difficult to understand the impact of specific design features through interviews and focus groups alone. This is because the effects of physical environments may not easily lend themselves to verbalisation – there is some evidence that such environments may be experienced in more physical, embodied ways. We have therefore suggested methods below that might improve the research evidence for both building models of links with design features and guidance on physical designs to avoid.

A novel method: photographic representations of staff and patient experience

Novel visual methods might capture experiences of psychiatric ward design. Such methods would demonstrate what is valued about existing provision and why. Interviews with patients and front-line staff combined with and illustrated by photographic representation of their environment could then be further analysed to produce an understanding of the everyday experience of the ward space. Photography has been gaining a foothold in participatory health research in recent years. For example, a novel method: photographic representations of staff and patient experience could be particularly well suited for an analysis of the social and symbolic aspects of design that this review has highlighted. Additionally, photographs can be used as props, enabling participants to reflect on their own experience from a fresh perspective. Furthermore, the use of a camera as a research tool tends to be welcomed by participants, as it is perceived to be an empowering and creative way of eliciting data. Finally, the use of visual tools may offer a way of negotiating language and reading barriers, thus enabling the participation of disenfranchised service users.

Implications

Therapeutic design is thought to be important but data on its impact on treatment outcomes in psychiatric settings are scarce. Existing studies show a correlation between the availability of private spaces and home-like features and an increase in social interaction and improvements in well-being. However, as findings are inconclusive, more rigorous randomised controlled trials and more attention to qualitative studies and novel methods are called for. A more holistic approach to the physical ward environment that takes into account organisational structures as well as symbolic and social dimensions is recommended, so that the design of psychiatric facilities may be aligned to current policy on patient-centred healthcare.

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<th>Author et al., 1970</th>
<th>Effects of gross environmental change upon behavio...</th>
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<td>Seating patterns and patient behaviour in an experimental dayroom</td>
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<td>Behavioural and attitudinal effect of large scale variation in the physical environment of psychiatric wards</td>
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<td>Ittelson et al, 1970</td>
<td>Bedroom size and social interaction of the psychiatric ward</td>
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<tr>
<td>Whitehead et al, 1984</td>
<td>Objective and subjective evaluation of psychiatric ward redesign</td>
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<td>Devlin, 1992</td>
<td>Psychiatric ward renovation: staff perception and patient behaviour</td>
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<td>Wykes, 1982</td>
<td>A hostel ward for ‘new’ long stay patients: an evaluative study of ‘a ward in a house’</td>
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<td>McGonagle &amp; Allan, 2002</td>
<td>A comparison of behaviour in two differing psychiatric long-stay rehabilitation environments</td>
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<tr>
<td>Edwards &amp; Hults, 1970</td>
<td>‘Open’ nursing stations on psychiatric wards</td>
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<tr>
<td>Tyson et al, 2002</td>
<td>The impact of ward design on the behaviour, occupational satisfaction and well-being on psychiatric nurses</td>
</tr>
<tr>
<td>Baldwin, 1985</td>
<td>Effects of furniture re-arrangement on the atmosphere of wards in a maximum security hospital</td>
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<tr>
<td>Christenfeld et al, 1989</td>
<td>How physical settings affect chronic mental patients</td>
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**Table DS1** Quantitative studies on the impact of ward design on treatment outcomes and well-being for patients and staff

<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Study design</th>
<th>Participants</th>
<th>Main findings</th>
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</thead>
<tbody>
<tr>
<td>Higgs, 1970</td>
<td>Effects of gross environmental change upon behaviour of schizophrenics: a cautionary note</td>
<td>Pre-post observational/survey study with control group</td>
<td>68 experimental group, 125 control group</td>
<td>Observations and Brief Psychiatric Rating Scale scores demonstrated an improvement in the experimental group</td>
</tr>
<tr>
<td>Beauchemin &amp; Hays, 1996</td>
<td>Sunny hospital rooms expedite recovery from severe and refractory depressions</td>
<td>Audit of length of stay days (sunny v. dull rooms)</td>
<td>174 patients with severe depression</td>
<td>2.6 days shorter length of stay for those in sunny rooms</td>
</tr>
<tr>
<td>Benedetti et al, 2001</td>
<td>Morning sunlight reduces the length of hospitalisation in bipolar depression</td>
<td>Audit of length of stay days (east v. west rooms)</td>
<td>602 patients with bipolar or unipolar affective disorder</td>
<td>3.7 days shorter length of stay in those with bipolar depression in east-facing room, no difference for those with unipolar depression</td>
</tr>
<tr>
<td>Holahan, 1972</td>
<td>Seating patterns and patient behaviour in an experimental dayroom</td>
<td>Observational study of groups of patients randomly assigned to four distinct furniture arrangements in day room</td>
<td>120 patients</td>
<td>Greater social interaction observed in sociopetal and mixed arrangements compared with sociofugal and free (patient chosen) arrangements</td>
</tr>
<tr>
<td>Holahan &amp; Saegert, 1973</td>
<td>Behavioural and attitudinal effect of large scale variation in the physical environment of psychiatric wards</td>
<td>Observational randomised controlled trial</td>
<td>25 patients in each group</td>
<td>Patients’ perceptions improved and spent more time engaged in social activity on remodelled ward than control ward</td>
</tr>
<tr>
<td>Ittelson et al, 1970</td>
<td>Bedroom size and social interaction of the psychiatric ward</td>
<td>Observational study</td>
<td>Female patients, number unknown</td>
<td>More social activity was observed in single or double room than dormitory rooms</td>
</tr>
<tr>
<td>Whitehead et al, 1984</td>
<td>Objective and subjective evaluation of psychiatric ward redesign</td>
<td>Observational study and survey before and after ward redesign</td>
<td>Patients and staff in a 30-bed ward, number unknown</td>
<td>Increased social interaction in redesigned ward, positive responses to ward changes by patients</td>
</tr>
<tr>
<td>Devlin, 1992</td>
<td>Psychiatric ward renovation: staff perception and patient behaviour</td>
<td>Pre-/post-observational survey study</td>
<td>82 patients, 83 staff</td>
<td>Positive changes in patient and staff behaviour – significant decrease in patient stereotypy</td>
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<tr>
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<td>A hostel ward for ‘new’ long stay patients: an evaluative study of ‘a ward in a house’</td>
<td>Observational/survey study with control group</td>
<td>13 patients in ward in a house, 12 patients in hospital-based ward</td>
<td>Time spent doing nothing or watching TV was greater in the hospital-based ward, whereas occupational and social activities were more frequent in the ward in a house</td>
</tr>
<tr>
<td>McGonagle &amp; Allan, 2002</td>
<td>A comparison of behaviour in two differing psychiatric long-stay rehabilitation environments</td>
<td>Assessment of patients in rehabilitation ward, hospital bungalow and community units with Social Behaviour Schedule and Social Functioning Questionnaire</td>
<td>37 hospital ward residents, 18 bungalow residents, 11 community unit residents</td>
<td>Social Behaviour Schedule ratings lower for bungalow residents compared with ward residents. Both groups show comparable ratings on Social Functioning Questionnaire so no evidence of selection bias</td>
</tr>
<tr>
<td>Edwards &amp; Hults, 1970</td>
<td>‘Open’ nursing stations on psychiatric wards</td>
<td>Time study/survey/interviews on two identical wards at two time points, with open nursing station and control ward</td>
<td>80 male patients, 26 staff</td>
<td>Staff spent more time interacting in ward, whereas patients spent less time near the nursing station in the experimental compared with the control ward</td>
</tr>
<tr>
<td>Tyson et al, 2002</td>
<td>The impact of ward design on the behaviour, occupational satisfaction and well-being on psychiatric nurses</td>
<td>Pre-/post-observational survey study with Maslach Burnout Inventory and interviews</td>
<td>80 staff</td>
<td>Increased socialising between staff and patients, but no difference in staff burnout. Staff perceived improved patient privacy as stressful for staff</td>
</tr>
<tr>
<td>Baldwin, 1985</td>
<td>Effects of furniture re-arrangement on the atmosphere of wards in a maximum security hospital</td>
<td>Observational study, survey and pre-/post two time-limited interventions</td>
<td>7 intervention and 3 control wards (20 patients and 6 staff per ward)</td>
<td>Some improvement in social interaction, non-significant decrease in violence and seclusion rates, improved perception of wards. Causal relationship not established</td>
</tr>
<tr>
<td>Christenfeld et al, 1989</td>
<td>How physical settings affect chronic mental patients</td>
<td>Pre-/post-ward redesign survey study with control group</td>
<td>Staff: 27 experimental group, 44 control group, Patients: 37 experimental group, 44 control group</td>
<td>Improved perceptions from both staff and patients in the group moved to the redesigned ward. 50% violence reduction, no changes in Ward Atmosphere Scale</td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Study design</th>
<th>Participants</th>
<th>Main findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaaler et al., 2005&lt;sup&gt;27&lt;/sup&gt;</td>
<td>Effects of different interior decorations in the seclusion area of a psychiatric ward</td>
<td>Pre–post observational/survey study with control group</td>
<td>27 experimental group (27 control group)</td>
<td>Violence and vandalism were significantly reduced on the redesigned seclusion area of a ward. No change in Positive and Negative Syndrome Scale assessed symptoms.</td>
</tr>
<tr>
<td>van der Schaaf et al, 2013&lt;sup&gt;28&lt;/sup&gt;</td>
<td>Impact of the physical environment of psychiatric wards on the use of seclusion</td>
<td>Multilevel regression analysis correlating design features of wards and episodes of seclusion</td>
<td>Data from 199 wards and 14,834 patients</td>
<td>Specific design features either increase the risk of seclusion (presence of garden, safety features) or decrease it (private spaces, higher level of comfort, visibility).</td>
</tr>
<tr>
<td>Corey et al, 1986&lt;sup&gt;29&lt;/sup&gt;</td>
<td>Psychiatric ward atmosphere: a before and after look at how refurbishing affects staff and patient perceptions of the psychosocial environment</td>
<td>Pre- and post-intervention assessment of ward atmosphere (Ward Atmosphere Scale) on three wards</td>
<td>3 intervention wards (Staff: 65/56 test/retest Patients: 66/60 test/retest)</td>
<td>Some improvement in Ward Atmosphere Scale scoring, particularly in acute psychiatric ward and Involvement, Order and Organisation subscales.</td>
</tr>
<tr>
<td>Southard et al, 2012&lt;sup&gt;30&lt;/sup&gt;</td>
<td>Enclosed versus open nursing stations in adult acute care psychiatric settings</td>
<td>Cross-sectional, pre–post study</td>
<td>81 patients (25 nursing staff)</td>
<td>No increase in aggression after nursing station opening, no significant change in patient and staff perceptions of therapeutic milieu.</td>
</tr>
<tr>
<td>Urbanoski et al, 2013&lt;sup&gt;31&lt;/sup&gt;</td>
<td>Does the redesign of a psychiatric inpatient unit change the treatment process and outcomes?</td>
<td>Pre- and post-intervention assessment of perceptions of ward (Ward Atmosphere Scale, Client Satisfaction Questionnaire-8) and of functioning (Global Assessment of Functioning)</td>
<td>290 patients in one ward (16-bed before redesign and 24-bed after redesign)</td>
<td>More positive atmosphere and greater treatment satisfaction post-renovation. Negative association between renovation and Global Assessment of Functioning improvement.</td>
</tr>
<tr>
<td>Sheehan et al, 2013&lt;sup&gt;32&lt;/sup&gt;</td>
<td>Evaluating the built environment in inpatient psychiatric wards</td>
<td>Multilevel modelling of relationship between ward design characteristics and staff satisfaction</td>
<td>98 wards (1540 staff)</td>
<td>Non-corridor design and en-suite bedrooms associated with staff satisfaction. No significant effect for ease of observation, safety features and modern furnishings.</td>
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<td>Novotna et al, 2011</td>
<td>Client-centred design of residential addiction and mental health care facilities: staff perceptions of their work environment</td>
<td>Pre-/post-occupancy behavioural mapping and focus groups</td>
<td>17 staff members</td>
<td>Changes which had a positive impact on patients, had negative impact on staff (increased patient privacy, more open spaces)</td>
</tr>
<tr>
<td>Curtis et al, 2007</td>
<td>Therapeutic landscapes in hospital design: a qualitative assessment by staff and service users of the design of a new mental health unit</td>
<td>Focus group/interviews of staff and patients discussing a newly built ward, qualitative</td>
<td>10 nurses, 3 psychiatrists, 7 patients</td>
<td>Symbolic aspects of space important to staff and patients. Respondents felt that combination of design elements more significant for well-being than elements in isolation</td>
</tr>
<tr>
<td>Wood et al, 2012</td>
<td>Creating ‘therapeutic landscapes’ for mental health carers in inpatient settings: a dynamic perspective on permeability and inclusivity</td>
<td>Interviews/focus groups of carers, patients and staff on a newly built ward, qualitative</td>
<td>9 carers, 1 nurse, 1 patient</td>
<td>Addressing social as well as physical needs of both carers and patients through ward design is important for promotion of well-being</td>
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The psychiatric ward as a therapeutic space: systematic review
Constantina Papoulias, Emese Csipke, Diana Rosé, Susie McKellar and Til Wykes
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