



Service designing in psychiatric care

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Abstract

Designing services for care for a psychiatric precinct within the context of a major hospital development project is challenging. This paper reports on research that contributes to contemporary discourse on the interconnections between service design and infrastructures of healthcare. This is what Bitner (1992) named as a 'servicescape'- the integrated, multidisciplinary, physical, sensorial and experiential sites of care provision. Between 2016 -2018 the authors undertook a design anthropology evaluation that identified the experiences of situated service provision by people within a psychiatric precinct located within a regional hospital. In this discussion we identify some of the insights from this project.

Keywords: psychiatric services, co-located healthcare, maintenance-led designing, design anthropology

Introduction: Co-locating psychiatric services at the new hospital

Psychiatric Hospitals are for many people sites of mystery, intrigue and stigma. Psychiatric units are demanding in physical and emotional care, and models of care must extend to both patients and carers. Depending on the patient cohort, the type of psychiatric care facility and other unknown factors, including responses to everyday sensorial inputs, a psychiatric unit can be a place of ease, congeniality or tension. Designing services of care within this context is challenging, and increasingly healthcare providers desire to do so inclusively and collaboratively.

This paper explores some of the dimensions and challenges in the design of psychiatric hospital services, through a design anthropology approach that endeavours to make sense of people's experiences of services designed through the integration of a patient-centric model of care and architectural design practice. Patient-centric care is the equivalent of human-centred or user-centred design its focus is on developing actions of care that place the patient at the centre of the process (Rise Fry 2019. p. 379). Our research showed that the design of services for a psychiatric facility requires a subtle and multi-faceted approach to service design. This approach should recognise that experiences of such places often arise from unpredictable relationships between built environment, models of care and the multiple other services that must all work together in a sometimes highly-charged environment.

Bendigo Health is a Regional Health Service located 150kms from Melbourne in the Provincial Coty of Bendigo with patients being drawn from Central and North East Victoria, Australia. The award-winning new facility, opened in 2017, is widely recognised as an improvement on the previous facilities, partly through its co-location strategy. Within the context of a psychiatric facility, the provision of medical care is the key service provision, yet care facilities require a much broader series of services to ensure that they run effectively. During the period of this research (2016-2018) the Bendigo Health services of care included:

- Domestic cleaning, maintenance, security and food.
- Healthcare, physical and mental, spiritual care, allied health, and legal support.

This research contributes to contemporary discourse on the interconnections between service design and infrastructures of healthcare. This is what Bitner (1992) named as a 'servicescape' - the integrated, multidisciplinary, physical, sensorial and experiential sites of care provision. In this research we have, through a design anthropology lens, undertaken a multidisciplinary evaluation of the sensorial dimensions of the services of care as realised within a new environment, which is itself the physical manifestation of a 'model of care' whose primary focus is 'patient centred care'. This is argued by Lee (2011) as being the most effective way to evaluate patient, carer and family experiences of care services, and these cannot be separated from the material environment.

Meta narratives in service scholarship

Contemporary meta narratives in service scholarship include:

- the phenomenological view on co-designing services "as a reflexive, embodied process of discovery and actualisation" (Akama & Prendiville 2013 p.30);
- the situated view in which attention to "emergence" has gained attention as the potential entry for the development and refinement of services, for example in "service ecosystem well-being" from a business and marketing perspective (Frow et al., 2019); and
- the intersection of Transformative Service Research (TSR) and service design, as argued by Anderson et al., (2018) "it is time to move services from being 'transformative by nature' to 'transformative by design'" (p. 109).

The granularity of these emergent, situated and collaborative transformations are open to maintenance-led designing in which all stakeholders play key roles contributing with their service areas (e.g. domestic, medical or management). It is a mode of designing which brings value to services (Holmlid 2012), and the resultant servicescapes include the physical environment (Lee 2011), and the "affective environment" (Andrews et al., 2014). These are all grounded in a material and relational view of services experiences, and are particularly needed in understanding services situated in, and composing of "therapeutic landscapes" for health care (Gesler 1992; Curtis et al. 2007).

Methodology: Design anthropology for wellbeing

Technically the engagement was with Exemplar Health, the Public Private Partnership Company established to deliver the New Bendigo Hospital, to undertake a design evaluation of the new psychiatric units. The study was conducted over three years and included fieldwork at the old and new hospital facilities. The old facilities were three separate units geographically distant from one another. The new facilities, co-located these 3 units (with the 4th addition of Parent and Infant Unit PIU), and integrated these into the general hospital building. Participants were drawn from a breadth of stakeholders (patients, carers, service providers, medical staff, family and other allied carers, the project architects, landscape architects and management). The majority of the design decisions of the project were complete when our research commenced. As such, a design anthropology (Gunn et al. 2013, Smith et al. 2016; Ventura and Gunn 2017) and a sensory ethnography approach (Pink 2015) have been used as a means to make sense of people's experiences of the site and its service provision. An embedded approach that builds on Blomberg & Darrah's (2015) call for the value that an "anthropology of services" can bring for zooming into the everydayness of interactions with designs. A total of 152 people, representing the full spectrum of the units' stakeholders consented to participate in the study. A total of 79 days of on-site ethnographic research was undertaken.

The Bendigo Health design and development was guided by the New Bendigo Hospital Project Functional Brief (a document provided by the State Government procuring body to the Project Consortium). This included the Psychiatric Unit and is underpinned by the Unit's model of care and the guidance of the State's Chief Psychiatrist and representatives of the Victorian State Government. The Functional Brief is the key means for realising Lee's (2011) proposition that services of care must be understood within the environment of their provision. The data collection and analysis in this research was guided by and situated within this framework - and people's subsequent experience of it.

Service and hospital design approach

The design process used by the project architects and leaders was both consultative and traditional (see Figure 1 below). The architects used prototyping in order to engage stakeholders in innovative spatial, aesthetic and service solutions, and to work through material and care challenges. The design of services for the facility and the greater hospital development

were done within a supply service provision approach – realised through outsourced and contracted service providers for food, cleaning and maintenance.

The Project Brief and the Model of Care express the intention to design and implement better care services than those provided through the old psychiatric facilities. This was done through an innovative yet conventional organisational frame, what Robert & Macdonald (2017) identify as a quality improvement activity combined with organisational creativity and innovation. They note that the service environments in healthcare contexts differ from other sectors in their “scale, variety and complexity as well as the (often) fragility, vulnerability and dependency of its clients” (Robert & Macdonald 2017 p. 118). Through this evaluation we have identified how the new hospital services have been experienced by the care service providers in this psychiatric health facility.

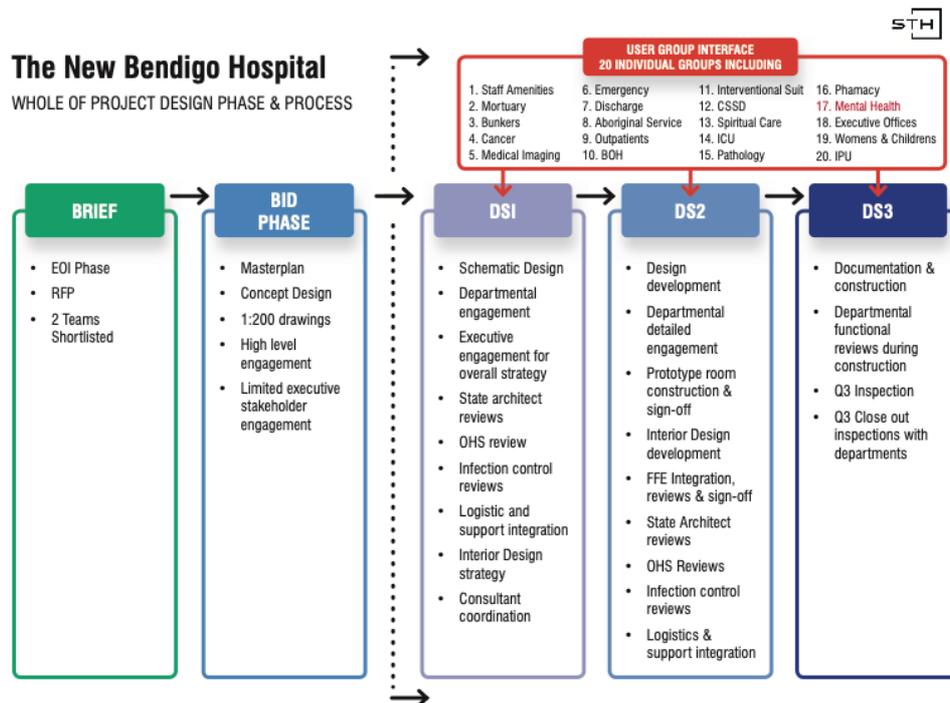


Figure 1 – Architects’ consultation model as a surrogate for co-design

Identifying experiences of service provision

Our research endeavoured to identify the experiences and ambitions of the various stakeholders throughout the design and occupation phases of the project. It became apparent that even though a collaborative approach

was used, people's experiences differed based on their current and prior roles. Moreover, changes in systems and processes affected how people experienced their new work context. In the accounts below, we show three different perspectives on the co-location of the Psychiatric Units in the main hospital buildings, from one of the architects who designed the new building, a new services manager, and a longstanding member of the cleaning staff who had worked in the Units for many years before the construction of the new building.

During the design phases (Figure 1), the architects acknowledged the value of the collaborative approach with all the stakeholders involved and overall expressed pride in the process. As one of the architects interviewed said: *"I've done a lot of mental health design and I think this one has probably had more rigor applied than any other project I know"*.

The effort to integrate psychiatry with the wider health services in the hospital had also been at the centre of the agenda for the health service executives, who emphasised expectations *"partly from the point of view of de-stigmatising psychiatry... to break down the barriers"* (Psychiatry Manager). The move to the new hospital included a service change by contracting the operational management of all domestic services to one company for 25 years. Below, the Domestic Services Manager explains how taking on-board this responsibility required continual teamwork with the psychiatric unit managers, and ongoing dialogue with domestic services staff who were required to learn new service systems and to accommodate to new management hierarchies. As he details:

Soft-services are all your cleaning, portering, food services, everything [including maintenance and gardening], so, yeah. We're the only Spotless PPP [public private partnership] at the moment that delivers all five services to the hospital ... So, we're relying on the clinical staff to make sure they're reporting all that stuff. It's breaking habits from the old hospital where, "oh, while you're here, can you just do that". We now have our management system. Every job needs to be logged in... to the computer... and then it gets sent to us straight away and we can act on it straight away. (Services Manager)

After a year's experience, he highlights that the delivery of domestic services for psychiatric care has *"been a pretty steep learning curve, but it's been a good one."* This learning process resulted in a maintenance-led design approach, to the renewal of things, processes and contexts.

This has been an opportunity to document a service adjustment and to provide insights for future design briefs and the construction of other psychiatric hospitals.

The change in services management that oversees psychiatry and the whole hospital, has had implications in the everyday routines of staff. As the Service Manager mentioned, the move had required “breaking habits” of staff from the previous units who were used to working in smaller teams and spaces and with a familiarity that some feel has been lost (and was being rebuilt) with the move to the new site, which requires working with new colleagues and with more explicit hierarchies than before

The participant accounts show that while the embedding of the Psychiatric Inpatient Units within the main hospital building was aimed at reducing stigma – and indeed was felt by staff to have succeeded in this – it also created conditions for unanticipated effects on the provision of services beyond clinical psychiatric care. Services such as maintenance, cleaning and catering were all recognised as important to creating conditions that could support care and wellbeing. Uncovering the effect of co-location on these services was an important outcome of the study.

Discussion: Engaging with tensions to foster plurality in psychiatric care services

Through the analysis of the service and care experiences of the various participants in the research, we have identified three key contexts for service provision within the hospital. These each represent different needs, stakeholders and expectations and are consistent with observations by Anderson et al. (2018) in that they evidence that designing services within such a complex and dynamic context is challenging and requires a breadth of approaches to service design.

Domestic services

The delivery of domestic services by Bendigo Health includes the provision of food, cleaning, security, maintenance, and gardening services. The procedures, teams and tools to deliver these services changed from the old psychiatric units, and are unique to the new hospital. Changes included adding technological devices to log activities, manage tasks and keep track of services delivery. For instance, at the new hospital

food is prepared at the main kitchen hospital, following each patient's specific dietary requirements and food preferences and allergies. It is stacked in trays delivered by robot trollies, and subsequently wheeled into the Units by staff who serve the meals in communal dining areas. The use of linen tablecloths is an example of a practice of care, valued by catering staff and brought from the old Units to the new hospital. Likewise, security, maintenance and cleaning services at the new hospital have developed procedures in response to the social needs of the Units, in conjunction with contractual and technical requirements. Domestic services and the staff who provide services as everyday routines thus create environments of care that contribute to the provision of psychiatric healthcare services and wellbeing.

Healthcare services

The integration of psychiatric care services within the main hospital has had implications for the delivery of medical services, for broadening cultural shifts aimed at de-stigmatizing and normalising community perceptions towards psychiatric care. Medically, the co-location of psychiatry has made clinical services more accessible in terms of distance, time and costs. For example a chute connects each Unit to the pharmacy, and ambulances are no longer needed to transfer patients between departments. Shifts in psychiatry supported its de-stigmatization, through, for instance, the co-location of Adult Acute, Older People, Extended Care, and Parent and Infant Unit (PIU) and the delivery of ECT (electroconvulsive therapy) services now in the hospital theatre.

Management services

The term 'management services' refers to a meta layer that combines domestic and healthcare services, their management staff, and their daily work to maintain dialogue between Units and across services and departments from the hospital. Management services include each of the four psychiatric Unit managers, the manager of the Psychiatric precinct, managers of other clinical departments and hospital offices, and the domestic services manager. This sphere of management cares for the overall wellbeing of the psychiatric precinct, its staff, patients, operational systems, the Unit's physical maintenance and the adaptation of services to meet emergent needs. It is at this sphere of management services that decisions are negotiated.

Conclusion and implications

In this paper we reviewed how services for psychiatric care came into practice through the design process. Through this research we have identified the complexities of servicescapes within a psychiatric care context. We have provided some insight into the dynamic and fluid nature of service provision in a complex context such as a psychiatric unit by providing examples of different perspectives on the co-location of psychiatric services within a main hospital building and identifying the different contexts that service design must consider.

In doing so, we have identified how the new structure and management of these services has brought both benefits and challenges to everyday work practices in the hospital. We have presented accounts from people about the challenges and opportunities created by moving to the new hospital and co-located psychiatric care services. By presenting how psychiatric care services became integrated with wider medical services and the community at a central regional hospital, our aim was twofold. First, to highlight the work being done in psychiatric care to engage with tensions such as stigma and/so as to advance service designing for healthcare plurality. Second, by using design anthropology and sensory ethnographic methods, to demonstrate how the outcomes of service design are negotiated in daily routines and develop into a continual, everyday and maintenance-led service designing for wellbeing. Overall, we have highlighted some of the complexity of service designing for wellbeing in a psychiatric healthcare setting, and some of the considerations required to address that complexity.

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