Considering Behavioral Health.

A better understanding of mental health has led to greater awareness and laws that make insurance coverage more equitable. These, in turn, are making treatment available to millions of Americans. Facilities where treatment occurs are being designed with familiar, residential elements that communicate healing, comfort, and a sense of optimism.

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Forty or fifty years ago, a person described as "'high-strung'" could be institutionalized for one or two months. This was not uncommon. Patients such as these would come to the hospital with their own clothes, books, furniture, even china. Patients could roam the grounds, often without supervision. These hospitals were built with gardens and acreage in the plan.

Today, only people with severe mental illness are admitted into inpatient units. There are no grounds or gardens within today's hospitals, short of a courtyard, which may be accessible to less psychotic patients. And patients must be supervised at all times.

Outpatient treatment has become the norm. People are treated in private offices, in group meetings, in hospitals, in clinics, and in pediatric and geriatric facilities. Treatment lengths and approaches vary significantly. Yet, a greater acceptance of mental illness and behavioral health conditions, both in terms of societal awareness and insurance coverage, means that treatment is available to millions of affected Americans—from the indigent to the affluent, from children to the elderly.

Greater acceptance marks a significant and welcome shift, especially given that half of all Americans will experience some type of mental health problem in their life, according to the U.S. Centers for Disease Control and Prevention. One out of four adult Americans will experience some form of diagnosable behavioral or mental illness in a given year.[1] These conditions run the gamut from substance abuse and eating disorders to post-traumatic stress and mild to severe depression.

The National Institute for Mental Health concurs that about a quarter of U.S. adults are diagnosable for one or more disorders in a given year, but it also notes that the main burden of illness is concentrated among a much smaller proportion.

About six percent, or one in 17, suffer from a seriously debilitating mental illness.[2] Veterans are also dealing with high levels of behavioral health conditions. A better understanding and acceptance of post-traumatic stress has resulted in patient increases in Veterans Affairs (VA) behavioral health facilities and continues to change the face of the historically typical VA facility.[3]

Awareness Begets Legislation

As understanding of behavioral health has deepened among Americans, it has resulted in a number of legislative efforts. Diverging views on the definition of behavioral health have complicated this process, however.

The term "behavioral medicine" was formally introduced in 1978. It was described as "the interdisciplinary field concerned with the development and integration of behavioral and biomedical science, knowledge and techniques relevant to health and illness and the application of this knowledge and these techniques to prevention, diagnosis, treatment and rehabilitation.[4]

In 2008, the Mental Health Parity and Addiction Equity Act was adopted, both to close several loopholes left by the ground-breaking 1996 Mental Health Parity Act and to extend equal coverage to all aspects of health insurance plans. The coverage extensions included day and visit limits, dollar limits, coinsurance, co-payments, and deductible and out-of-pocket maximums. It preserves existing state parity and consumer protections laws while extending protection of mental health services to 82 million Americans not protected by state laws.

Commenting on the law, the American Psychological Association notes that, "Research shows that physical health is directly connected to mental health and millions of Americans know that suffering from a mental health disorder can be as frightening and debilitating as any major physical health disorder. Passage of this law will lead the health care system in the United States to start treating the whole person, both mind and body." [5]

Another law, The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which went into effect in 2010, requires that the costs for treating mental health and additional conditions be equal to those of treating physical health conditions. [6]

Affect of Laws and Awareness on Facilities

It is a positive trend that people suffering from frightening, severe mental illnesses are now being treated in places that communicate healing, comfort, and a sense of optimism.

The systems and facilities in which these people are treated are dealing with a number of issues. Increased patient loads, the diversity of patient conditions, and the complexity of treating patients with multiple conditions (a common occurrence with the mentally/behaviorally ill) are some. These, along with many others, make psychiatric and behavioral care units and facilities as diverse as their occupants.

In the last several years, a broader trend in healthcare facility design has resulted in residential environments that steer away from institutional, clinical designs. There is a greater focus on a patient's psychological needs and greater attention on healthcare environments that enhance the healing process.

The Planetree philosophy promotes a holistic approach to healing, one that considers the mental, emotional, social, physical, and spiritual aspects of healing. Applying this philosophy to the design of the places in which people heal is resulting in more humane, personal, and comfortable environments—including behavioral health facilities.

Understanding the unique requirements of behavioral health facilities, particularly inpatient environments, is critical to their design. Safety is the first concern and always top of mind in making design choices. But safety is no longer considered

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in isolation. "Developing mental health facilities that are safe and healing are not incompatible processes or goals," states the VA Mental Health Facilities Design Guide. [7]

The VA health system has been undergoing a "culture of transformation" for several years now. This movement, which seeks to institute the Planetree philosophy, is now finding its way into the VA's behavioral health system.

In December 2010, the Mental Health Facilities Design Guide became available. It supplies technical architectural and engineering specifications, but also provides guidelines for what reflects a significant shift in approach, as this excerpt from the Guide's introduction show.

> This Design Guide reflects a new vision and philosophy for designing mental health facilities that is rooted in hope, healing, and recovery. Strong emphasis is placed on design approaches that incorporate home-like, non-institutional, and patient-centered environments that imbue healing, familiarity, and a sense of being valued.
>
> The design of mental health facilities affects how services are provided and the efficiency with which care is delivered. Equally, if not more important… is the psychological impact mental health facility design has on its users. Facility design impacts the beliefs, expectations, and perceptions patients have about themselves, the staff who care for them, and the services they receive…. The Design Guide also places important emphasis on patient safety. Developing mental health facilities that are safe and healing are not incompatible processes or goals. [8]

The VA Ann Arbor Healthcare System, in Ann Arbor, Michigan, is affiliated with the University of Michigan Health System. It recently completed a new facility, which supports the vision of the VA Design Guide. The VA facility includes outpatient and inpatient programs and houses an 18-bed acute psychiatry unit.

The unit features nurse pods at each end of the unit, providing staff with spaces to work that are closer to patient rooms. Staff work areas offer lines of sight into group rooms and open areas. This design provides more continuous visual monitoring, an added safety benefit over the older, walled-in nurses' stations and group rooms. And it results in more efficient work flow, since staff can see more of the unit without having to leave their work areas. The open design has another benefit. Light passes throughout the unit. The environment is pleasant and calm; patients are less agitated.

Trish Palmer is an experienced designer who has worked for VA hospital systems located in the southeastern US. While changes are being made to the physical buildings within the VA, Palmer also cites changes within the VA patient population itself. "We've gone from treating geriatric vets with Alzheimer's to treating young men and an increasing number of women with new conditions—post-traumatic

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stress being a significant one. A fresh look at how we create facilities aligns with a new and different group of vets. I see shifts in understanding and attitude. Changes in how we approach treatments." [9]

Palmer acknowledges the difficulty of designing transformative environments while balancing safety. "We use color, finishes, and flooring to warm the environment and make it more home-like. Nothing can pose a safety risk to patients or to staff, which decreases our options. But architecture and color provide us with tools that really can make a difference in the feel and look of the psychiatric units." Palmer notes that patients treat their new spaces differently, as well. "Patients respect these nicer environments. We don't see them scuffing up the walls or floors. It's a positive change for them." [10]

Jennifer Schlosser, a designer with Sparrow Health System, understands the restrictions in designing intensive care psychiatric areas. "Within patient rooms, we have to focus on furnishings that can't cause harm to patient or staff. Furnishings are sparse and bolted down, but I'm seeing furniture designs that are less institutional looking. And lighting, color, and flooring help to warm even these high-risk areas." [11]

Kathleen Frybarger, Sparrow Health System's clinical director of behavioral health services, connects the environment to treatment approaches. "Medications have changed the face of psychiatry. Thirty years ago an average length of stay might have been 45-60 days. Now we are returning to a very milieu-oriented therapy, where specific activities and social interactions are prescribed according to that patient's needs and condition. And the physical environment is an important element in that therapy. Dreary buildings promote dreary outlooks on healing and caregiving. Optimistic healing environments promote positive outlooks." [12]

Designing humane behavioral health spaces is paramount to Deanna Birchmeier, a facility designer with Hurley Medical Center, in Flint, Michigan, for a specific reason. "Hurley is the area's safety net. People can come to Hurley and get treated whether or not they have insurance. With the economy the way it is now—and especially on Michigan's east side—we are seeing more people. Inpatient care in our adult behavioral health unit is in demand. I realize that for some of our patients, this hospital, these spaces I design, may be the most beautiful places they have ever slept." [13]

The National Association of Psychiatric Health Systems (NAPHS), with authors David Sine and James Hunt, published the *Design Guide for the Built Environment of Behavioral Health Facilities (Edition 5.0)* in February 2012. [14] Designing behavioral health facilities that are more residential and less institutional is the goal. So is balancing healing environments with safe environments. "The recent focus on patient and staff safety has had the tendency to push the aesthetics of [behavioral health] units toward the appearance of a prison environment. It is important to constantly strive for the safest possible healing environment while also striving for as much of a non-institutional appearance as possible." [15]

Designing behavioral health facilities that are more residential and less institutional is the goal. So is balancing healing environments with safe environments.

Pine Rest Christian Mental Health Services, headquartered in Grand Rapids, Michigan, is a comprehensive network of inpatient and outpatient services. It has a central campus in Grand Rapids, 18 outpatient clinics, and satellite offices throughout Michigan and Iowa. Its inpatient psychiatric units house a total of 172 beds. Pine Rest is now in the process of constructing a 22-bed adult unit. The NAPHS guidelines were instrumental in the design of this new unit.

Heather Treib, Manager of Operations for Pine Rest's hospital-based services, says the Guidelines informed a number of their design approaches, from a more open architecture to decisions on materials and colors. "Our goal was to create a welcoming and pleasing environment that is a safe one in every way." [16]

Mary Wiersma, in the Facility Services department, compares the new approach to an older facility model. "Hallway with bedrooms off it, enclosed nurses' station, one active room, and one quiet room. This new unit is a large space with bedrooms off of it, an open area for group activities, and an open nurses' station that sits in the middle of the unit. Everything about this design is open and connected. It has an optimistic and positive feel." [17]

> "We want our patients to interact with other people. Socialization is an incredibly important part of our therapeutic approach."

"This open design was very intentional," says Treib. "We want our patients to interact with other people. Socialization is an incredibly important part of our therapeutic approach. Fostering relationships and encouraging commingling is part of healing. We don't want our patients to be or feel isolated." [18]

Exercise and relaxation are also offered to patients by way of a pacing loop designed into the floor. "Since regulations and insurance requirements specify patients remain within locked units, the pacing loop gives them a place to walk, either for relaxation or exercise," says Treib.[19] The unit also has floor-to-ceiling windows at each end of the unit and skylights throughout.

The environments described in this paper are integrating familiar, residential elements into environments that used to be stark and institutional in their design. They reflect the transformation that is happening in designing behavioral health facilities. Transforming facilities into places that communicate to patients a message that says, "We're available, we're accessible, and we're here for you" is an important step in helping people heal.

Notes

[1] Centers for Disease Control and Prevention, *"Mental Illness Surveillance Among Adults in the United States,"* CDC, <http://www.cdc.gov/mentalhealthsurveillance/fact_sheet.html> (accessed April 2012), September 1, 2011.

[2] National Institute of Mental Health, *"Any Disorder Among Adults,"* NIMH, <http://www.nimh.nih.gov/statistics/1ANYDIS_ADULT.shtml > (accessed April 2012).

[3] Department of Veterans Affairs, *"Mental Health Facilities Design Guide,"* DVA, <http://www.cfm.va.gov/til/dGuide/dgMH.pdf > (accessed April 2012).

[4] G.E. Schwartz and S.M. Weiss, S.M., "Behavioral medicine revisited: An amended definition," *Journal of Behavioral Medicine*, 1, 249-251, 1978.

[5] American Psychological Association, "How does the new mental health parity law affect my insurance coverage?" APA, <http://www.apa.org/helpcenter/parity-law.aspx> (accessed April 2012).

[6] Jayme Zage, PhD, "Reform Improves Mental Health Services Access." SGR webinar, December 6, 2010.

[7] Department of Veterans Affairs, *"Mental Health Facilities Design Guide."*

[8] *Ibid.*

[9] Trish Palmer, personal interview, April 2012.

[10] *Ibid.*

[11] Jennifer Schlosser, personal interview, April 2012.

[12] Kathleen Frybarger, personal interview, April 2012.

[13] Deanna Birchmeier, personal interview, April 2012.

[14] James M. Hunt, AIA, NCARB, and David M. Sine, ARM, CSP, CPHRM, "Design Guide for the Built Environment of Behavioral Health Facilities," National Association of Psychiatric Health Systems, <https://www.naphs.org/Design%20Guide%205_0_Updated2_7_12.pdf> (accessed April 2012), February 2012.

[15] *Ibid.*

[16] Heather Treib, personal interview, April 2012.

[17] Mary Wiersema, personal interview, April 2012.

[18] Heather Treib.

[19] *Ibid.*