Improving Safety and Care through Smarter Design in Secure Treatment Facilities
Using open, softer environments to encourage behavioral change and reduce need for restraints and seclusion

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EXECUTIVE SUMMARY

The system for treating people with mental illness in America is under crisis. A combination of fiscal and legislative policies has shifted the responsibility of treating a significant portion of the mentally ill population to the correctional system and, now, to a growing number of high security treatment facilities through the civil commitment process. These secure treatment environments, that place a premium on security and control but care for the civilly committed mentally ill, have come into question about their quality and effectiveness. At the same time, staff providing care question the effectiveness of many safety measures and treatment procedures. New design strategies, though, are helping to address both care and safety issues by creating environments that reduce the chaos and stress commonly associated with harsher, more sterile environments. As agencies from the county to federal level respond to the high monetary and legal pressures of treating people with mental illness, these design strategies can be part of a larger effort to change the culture in secured treatment facilities to provide better and more effective psychiatric care.

INTRODUCTION

The numbers are quite sobering: in 1955, it is estimated that there was one psychiatric bed for every 300 people in the United States; by 2004, there was one bed for every 3,000 residents (Torrey, Kennard, Eslinger, Lamb & Pavle, 2010).

At the same time, the need for mental health treatment is as prevalent as ever. According to the Bureau for Justice Assistance, approximately five percent of the nation’s 300 million residents suffer from a serious mental illness, equaling about 15 million people (US Department of Justice, 1999). These are people who suffer from psychotic illness, major depression, personality disorders, and anxiety ranging from post-traumatic stress disorder to traumatic brain injury (NAMI, 2011). Still others may be affected by developmental disorders, including attention-deficit, hyperactivity disorders, mental retardation, and Asperger’s syndrome (NAMI, 2011; NIMH, 2012).
With a decline in places for treatment and a greater need for mental illness treatment, this problem manifests itself in ways that differ from physical illnesses. People suffering from mental illness may resort to self-medication, including alcohol and illicit drug use; behave more publicly, creating disturbances; or fall into an indigent lifestyle (NAMI, 2011). A 2003 report by Pres. George W. Bush’s New Freedom Commission on Mental Health found nearly a third of people who experience homelessness have serious mental illnesses (President’s New Freedom Commission on Mental Health, 2003).

The result of such behaviors is that people suffering from mental illnesses increase their chances of coming into contact with the criminal justice system. “Regarding the odds of a seriously mentally ill individual being in jail or prison compared to a hospital, the odds for all 50 states were 3.2 to 1 that they would be in a jail or prison. This means that in 2004-2005, throughout the United States, there were more than three times more individuals with serious mental illnesses in jails and prison than in hospitals,” wrote the authors of a widely respected report from the Treatment Advocacy Center (Torrey et al., 2010).

A myriad of reasons have come together that has resulted in a diversion away from community health services for treatment to jails and prisons. From mandatory sentencing guidelines under get-tough-on-crime legislation to fiscal decisions that deinstitutionalized community-based mental health services, the factors are putting a disproportionate burden of mental health treatment on facilities that were not necessarily designed to treat people with mental illnesses. The widely accepted number of jail and prison inmates who display signs of serious mental illness is a little more than 16 percent of the total incarcerated population, with some studies showing as much as 24 percent of jail inmates reporting at least one symptom of psychotic disorder (Torrey et al., 2010). In Los Angeles County where about 15 percent of the jail inmates are classified as mentally ill, Sheriff Lee Baca has publicly said that he runs the largest mental health system in the United States (Leonard & Faturechi, 2012).

The situation is unlikely to change soon as there is little political or fiscal appetite to change the factors that have led to prison crowding and the rising population of inmates suffering from mental illness. To deal with the pressure this special population is placing on both staff and facilities, some governments are turning to specialized facilities that can provide both treatment and protection for staff and communities. The question that is challenging designers of such facilities is whether a therapeutic environment can be created in a secured facility, and, if so, how can the environment support evolving practices avoiding the use of restraints and seclusion without jeopardizing staff safety?

**THE CHALLENGES PRESENTED BY SECURED FACILITIES FOR MENTAL HEALTH TREATMENT**

The issue of jails and prisons for mental health treatment is not a new topic. Experts from the sectors in health care, law, social justice, and law enforcement have written extensively about the pitfalls of the justice system being used to house the mentally ill (Torrey et al., 2010; Daniel, 2007; O’Grady, 2007; Metzner et al., 2007; Vlach & Daniel, 2007; Schlosser, 2006). When examining the idea of jails and prisons as de facto centers for those suffering from mental illness, the issues fall generally into both treatment and lack of an environment for care:

For many facilities, these mandates have led to some of the same designs that speak prison environment, not therapeutic environment, and critics say that is limiting the ability for people to actually heal or for staff trained in health care to provide effective care.

Prison conditions are hard on mental health in general, because of overcrowding, violence, lack of privacy, lack of meaningful activities, isolation from family and friends, uncertainty about life after prison, and inadequate [mental] health services. The impact on these problems is worse for prisoners whose thinking and emotional responses are impaired by schizophrenia, bipolar disease, major depression, and other serious mental illnesses (Fellner, 2006, p 391).

Dr. James Orlando, an Ohio-based psychologist who has worked as Summit County (Ohio) Jail’s only part-time counselor, describes the effect of the environment on a mentally ill individual as less than therapeutic despite having the same medications and same counselors as they would have outside of the jail. “Sort of imagine what it’s got to be like being mentally ill and being in that
position where you’re trapped, in a small cell with your own demons? Certainly, there’s no way you’re going to get better under those circumstances (Hirschkorn & Mitchell, 2011).”

The idea of a jail or prison, in general, is counterintuitive to what an idea of a therapeutic environment would be. On one level, a prison is designed as a place to correct the habits and traits of people who have displayed an inability to follow the laws and rules of communities. On another level, they are a place to punish people who have violated laws by denying them freedoms and choices enjoyed by the general public.

In either circumstance, they are in a place that puts a premium on security and safety for staff and communities alike. From furnishings and fixtures that prevent items from being used as weapons; to bedding that can’t be used for suicide attempts; to building materials that are both durable but also less-than-hospitable to fit the punitive nature of the incarceration, the environment is designed for the purpose to convey and maintain order and uniformity.

The environment is also a reflection of culture. “Correctional staff see their mission as maintaining order through the use of reward and punishment. Inmates are viewed as people not to be trusted, who have done wrong and are likely to repeat past behaviors,” writes Dr. Erik N. Schlosser, a clinical psychologist who has worked at the Central Utah Correctional Facility in Gunnison, Utah (Schlosser, 2006). As Jamie Fellner notes in his Harvard study, this culture presents a number of problems for people suffering from mental illness since they may not have the mental capacity to comply with the same rules other prisoners must follow. From refusing to follow routine orders, to self-injury and mutilation, they may act in ways that could increase their punishment in the prison system, regressing them further into their mental illness (Fellner, 2006). For prison staff not trained to recognize mental sickness, they are not able to react appropriately to the adverse behavior.

This is not to argue that anyone suffering from mental illness who breaks the law should not be incarcerated. There are obvious crimes that are so heinous that these individuals must be separated from society. However, many corrections officials recognize that there are people whose infractions are so minor that putting them in the prison system or jails is only harming the people who are sick, and putting a greater burden on a corrections system already strained for physical and monetary resources. “Some people definitely need to be in prison, but not all of them do. If our goal is to get those [non-dangerous] people better, the worst place to do that is in prison,” noted Michael Lawlor, who was appointed chief of criminal justice planning and policy by Connecticut Gov. Dannel Malloy in 2011 (Chedekel, 2011). Jon De Morales, director of California’s Atascadero State Hospital, paints a bleaker picture: “There are criminals who happen to exhibit symptoms of a mental disorder...There are mentally ill people who happen to have committed crimes. They all end up in the same place (Jaffe, 2011).”

THE INTERSECTION BETWEEN SECURITY AND HEALING

While there is much debate on whether or not people who suffer from mental illness have a behavioral disorder, there is agreement found from those working in secure facilities who want to improve how people suffering from severe mental illness interact with others. As Schlosser (2006) notes, mental health patients receive services to become more stable and change problematic behaviors. “While mental health staff are aware of the games and behaviors of inmates, the focus is on their potential for change.”

On the other side, Schlosser (2006) recognizes that correctional staff routinely see the dirtier side of the work, such as violence and abuse and those games inmates play, which influences their view of inmates. Even using the term “inmates” sets the disposition apart from people needing care, who nurses, care assistants, psychologists, and psychiatrists would call “patients” or “residents.” Calling the people “inmates” creates a hurdle for providing care.

Schlosser (2006) says finding the balance comes through evolving the thinking: “Good therapy makes for good security, and good security makes for good therapy.”

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The rising cases of people with severe mental illness entering the corrections system have not gone unaddressed. Due both to a recognition of the rising population of people with mental illness in prisons as well as an unwillingness to release some prisoners back into society without specific treatment for their illness, some states and jurisdictions have moved to create secured facilities for mental health care, although they have varied in look and design. Some agencies have moved back to a model of state-run hospitals for inmates with mental illness, while others, like the State of Minnesota, have moved to create more residential-like treatment centers that are secured facilities.

In both approaches, though, the challenge facing administrators remains on security and safety. While the facilities are not prisons, they must be designed at nearly the same protection level as many prisons — secured entry points; staff stations located behind shatter-proof glass; furnishings and fixtures that cannot be used as weapons or for suicide; durable flooring and walls; and no areas, including ceilings, that would allow people to hide weapons or contraband. Additionally, there is the added dimension of politics: secured facilities designed for treatment must account for an electorate whose tax dollars are leveraged to treat people who have been charged with crimes, some for very violent crimes.

At times, these mandates have led to some of the same designs that speak prison environment, not therapeutic environment, and critics say that is limiting the ability for people to actually heal, or for staff trained in health care to see their work as providing effective care (Hirschkorn & Mitchell, 2011; Hillbrand & Young, 2008; Schlosser, 2006).

LOOKING AT ENVIRONMENT TO ENCOURAGE BEHAVIOR CHANGE

Accepting that professionals who provide security and those who provide treatment have the same goals — to influence behavioral change in people — then we must consider how the environment affects the culture that can lead to behavioral modification.

There are two goals here which appear to compete for prominence but are not mutually exclusive: behavior modification and injury prevention. In a secured environment, behavior is restricted in order to maintain safety. In a therapeutic environment, behavior is allowed to evolve despite the hazards that may exist in the environment. This creates a tension between “active” approaches — described as “approaches [to] encourage or require people to take an active role in protecting themselves — and “passive” approaches — “approaches [that] rely on changing products or environments to make them safer for all, irrespective of the behavior of individuals (Gielen & Sleet, 2003, p 65).”

In the world of public health, though, the idea of active and passive approaches go hand-in-hand to positively and effectively change behavior. Called an ecological perspective, it looks at the dynamic interaction that biology, behavior, and the environment have on health and well-being. “The definition conveys the notion of multiple levels of influence on health and makes clear the importance of both individual-level and community-level factors in shaping health and health-related behaviors (Gielen & Sleet, 2003, p 67).”

Secured treatment facilities, like many prisons, are functioning communities, from places for people to work to places for recreation to sleep accommodations and cafeterias. Designed like a prison, the environment becomes cold and sterile, with little stimulation to encourage behavioral change. Borrowing from health care models, though, the environment can become more therapeutic, and such an environment then encourages positive behavioral change that reduces incidents of violence and adverse behavior.
Previous studies have established the relationship between the designed environment and human behavior from a wide range of perspectives (Kopec, 2006; Zeisel, 2006; Chein, 1954). While very specific research may not yet exist for all design scenarios, we can begin to translate environmental behavior research for unique facility designs by examining the most closely related topics. Kopec (2006) states “understanding the relationship between stimulation and human responses is an important component of good design.” Psychiatric treatment facility design that strives to reduce environmental stimuli, lessen stress, and preclude existing mental and behavior conditions may enhance care approaches and allow them to be more effective.

Learning from strategies that are already being employed in mental health hospitals, there are planning principles that can help create a therapeutic environment in secure treatment facilities:

- Wide corridors without nooks and open dayrooms can encourage socialization between patients and allow the staff to maintain visibility of the space and interactions.
- Daylighting brings warmth into the space and creates a more hospitable atmosphere for both patients and staff.
- Lounge space provides a place for relaxation and normalcy outside of the holding cells.
- Elimination of acute corners or alcoves help patients suffering from paranoia rid themselves from the sense of unwanted surprises awaiting around the corner.
- Transitional spaces reduce anxiety as patients move from a private setting to a group setting.
- Thoughtfully designed spaces reduce incidents of escalation by mitigating the sense that the patient feels cornered or trapped.
- Central dining area that is less chaotic, less institutional.
- Creating a café-like experience produces a pleasant atmosphere and can reduce the noise and stress that is more indicative of an institutional cafeteria environment.
- Adding color, texture, and warm materials creates space that is respectful and soothing compared to a more sterile environment.
- Large outdoor recreational areas along with views overlooking indoor and outdoor courtyards promotes activity participation and encourages behavior that is relaxed and controlled.
- Larger windows instead of slit-style windows provide a brighter and more normalized environment.
- Flexible architecture and spaces provide administrative staff the ability to shape the environment according to acuity and need.
- Professional, restorative spaces for staff allow them to decompress and find social support from colleagues.
- Passive and active technological security measures maintain control but encourage a sense of autonomy and privacy as patients progress through their treatment.
- Personal space for the patient to read, or study is oriented so the patient can see when others are approaching.

The goals of the design strategies are to create flexible operations, maximum security, and best behavioral care that support patients and staff alike. In health care settings where they have been employed, they are showing signs of success. In 2006, Avera Behavioral Health Center in Sioux Falls, S.D., moved from a tight, fourth-floor location inside a larger facility that featured white walls and small corridors and patients held in rooms during a significant portion of their treatment. In the new space, patients have more freedom to move about a unit. The unit features an open floor plan bordered by patient rooms. Dining areas are smaller and more intimate, and daylight is a prominent component of each unit.

The results have been transformational, with staff reporting more satisfaction with their work and patients reporting better outcomes than in the previous unit. As important, administration reports fewer behavioral issues and a less chaotic atmosphere in which to provide care, despite assumptions typically tied to more open environments. “On the previous unit, I could walk onto the unit and know immediately what the census was based on the noise level. Here, even when we are full, I have to ask the manager on duty what the census is (Lindquist, 2011).”
Improving Safety and Care

REDUCING RESTRAINTS AND SECLUSION, RESTORING HOPE

While not a security hospital, the lessons learned at Avera — where treatment units are accessed through secured entry points — are not isolated and reinforce findings discovered in facilities designed for more maximum security. Across the nation, supermax correctional facilities that once featured solitary confinement for much of its programming have been converted and remodeled to allow for greater interaction and privileges. Reprogramming has included the creation of group dining areas and outdoor recreation facilities. In one case, violence in the facility dropped, inmate behavior improved, and the use of protective isolation was reduced to less than 30 percent (Goode, 2012).

A study in Great Britain on strategies to reduce the use of seclusion and restraint in psychiatric facilities also discovered that environment played a significant role, both for staff and patients. In the literature review, the researchers noted three studies reporting facilities with redesigned environments reduced the likelihood that patients would be placed in seclusion, and in two of those facilities the physical environment was improved. The change in environment and culture shifted from a paradigm of “fear and control to one of patient empowerment and collaborative relationships (Gaskin, Elsom, & Happell, 2007).”

While some administrators in both the health care and correctional fields have been pleasantly surprised by the outcomes that resulted from a reduction in the use of restraints and seclusion, the findings support the arguments calling for such reductions that many professionals in the United States have made, including the American Nurses Association, the American Psychiatric Nurses Association, the Federation of Families for Children’s Mental Health, the National Association of State Mental Health Program Directors, and the National Mental Health Association, among others (SAMHSA, 2006). The findings also affirm the measures other health care professionals have advocated for treating patients with severe mental illness using more supportive methods rather than confrontational methods. “Patients may view physicians who use a confrontational approach as being critical rather than supportive. Relapse during any treatment program is viewed as a failure by the patient and the physician. A feeling of failure, especially when repeated, may cause patients to avoid... treatment altogether (Zimmerman, Olsen, & Bosworth, 2000).”

Studies have shown that in environments that convey despair more than hope, people feel they have nothing to lose and become more susceptible to feelings of despair, increasing the likelihood they become dangerous (Goode, 2012; Hillbrand & Young, 2008; Kopec, 2006). “Patients have revealed after being restrained in a violent episode, that during the incident they thought that, since
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their violent behavior had resulted in restraints, they might as well hurt a few people in the process (Hillbrand & Young, 2008).”

An environment that conveys a sense of empathy, validation, and encouragement is necessary to help patients struggling with ambivalence and doubts over their ability to change (Goode, 2012; Hillbrand & Young, 2008; Kopec, 2006). Simplified, an environment that creates hope for something better can be used to reduce aggression and encourage behavioral change:

One means to accomplish this is within the framework of positive behavior support planning. This conceptual model switches the treatment focus away from problem behaviors to adaptive behaviors. The treatment is focused on teaching new coping skills rather than on containment of maladaptive behaviors. These include healthy use of leisure time, proper illness management, strengthening self-esteem and self-efficacy, and promoting reciprocity in interpersonal relationships. Central to this conceptual model is emphasis on hope as a force that propels individuals on a trajectory toward greater autonomy and freedom from heretofore incapacitating psychopathological symptoms (Hillbrand & Young, 2008, p 93).

In addition to reducing the likelihood for violence and encouraging changes in behavior, in a more supportive and empowering environment, staff satisfaction increases since they can see how their work is making a difference and benefitting patients. Again, learning from the model adopted by Avera Behavioral Health Center, one staff member noted after working in the new facility: “I take pride in working here, and, on the other hand, as a family member coming here [to visit a patient] (Focus Group, 2011).”

CONCLUSION

Although not a panacea for all the challenges secure treatment facilities face, design strategies can establish an environment that is conducive for staff to provide care and patients to progress through a healing process in a secure environment. Open dayrooms, large corridors, flexible spaces, abundant daylight, and texture and materials that convey a more humane and normal existence have shown to have a positive effect on patients and staff alike.

At the same time, it is possible to apply these strategies in an environment that still provides safety and security for staff and patients and reduces the need for more confrontational tactics such as the use of restraints and seclusion. From the choice of materials to proper space planning, staff have the ability to maintain the control necessary for day-to-day operations and the delivery of care. The design strategy itself becomes the security strategy by encouraging and promoting behavior that leads to a calm and organized environment. In such an atmosphere, staff can then provide the effective therapy that helps patients manage their mental illness and improve.

With critics and the public increasingly questioning the cost and legality of providing care for those in secure facilities for severe mental illnesses, adopting these design strategies can support the changing models health care professionals are advocating for treating severe mental illness. Policies that have created the crisis are unlikely to change in the near future. By focusing on the secure treatment facilities tasked with providing care for the mentally ill, we can create environments that are safe and appropriate and raise the hope and expectations that people can get better.
REFERENCES


The BWBR author team of Richard Dahl, AIA, John Strachota, AIA, LEED AP BD+C, and Mark Ludgatis, AIA are actively involved in leading organizations to discover innovative facility design strategies for behavioral and mental health care and secure environments. BWBR is a design solutions firm with expertise in planning and design for specialized facilities, including behavioral and mental health care and secure environments.