INCOMPLETE LANGUAGE FOR COMMUNITY MENTAL HEALTH CENTERS

First, within the COMMUNITY, place these parts:

MENTAL HEALTH CENTER
PUBLIC GATHERING PLACE

according to the relationships given by these patterns:

Distribution of satellites
Boundary location
Location next to general hospital
Center location
Activity nucleus
Arena thoroughfare
Pedestrian density in public places

In the MENTAL HEALTH CENTER, now place these parts:

INPATIENT
OUTPATIENT
DAY CARE
PATIENTS SOCIAL AREAS
MAIN ENTRANCE
CIRCULATION

according to the relationships given by these patterns:

Elements of mental health centers
Inpatient outpatient continuity
Social areas as heart of therapy
Patients choice of being involved
Mental health center entrances
Entrance location
Reception nodes
Short corridors

In the MENTAL HEALTH CENTER, now place these parts:

INDOORS
OUTDOORS

according to the relationships given by these patterns:

Tapestry of light and dark
Light on two sides of every room

In the PUBLIC GATHERING PLACE, now place these parts:

ACTIVITIES
EDGE

according to the relationships given by these patterns:

Activity pockets
Stair seats

In the MAIN ENTRANCE, now place these parts:

RECEPTION
WAITING
WALLS

according to the relationships given by these patterns:

Reception welcomes you
Reception nodes (repeat from before)
Free waiting
Entrance shape

In the INPATIENT, now place these parts:

NURSES
BEDS
PATIENTS SOCIAL SPACE

according to the relationships given by these patterns:

Hierarchy of social spaces
Sixteen beds per nurse
No nurses station
Bed alcoves
Bed clusters

In the INPATIENT, now place these parts:

INTENSIVE CARE UNIT
PARKING
TREATMENT ROOM

according to the relationships given by these patterns:

Emergency facilities
Intensive care location

In the OUTPATIENT, now place these parts:

THERAPY ROOMS
GROUP THERAPY ROOMS
WAITING

according to the relationships given by these patterns:

Team organization for therapy
Group therapy room location
Waiting for therapy

In the OUTPATIENT, now place these parts:

STAFF LOUNGE

according to the relationships given by this pattern:

Staff lounge away from patients

In the DAY CARE, now place these parts:

HOME BASE
CHILDRENS DAY CARE

according to the relationships given by these patterns:

Day care home base
Separate childrens day care

In the CIRCULATION, now place these parts:

WALLS
DOORS
WINDOWS

according to the relationships given by these patterns:

Light as information
Look see familiarity

In the PATIENTS SOCIAL AREA for INPATIENT and DAY CARE, place these parts:

OUTDOOR ROOM
KITCHEN
LAUNDRY
DRUG STORE (for DAY CARE only)
ALCOVES
WINDOWS

according to the relationships given by these patterns:

Outdoor room
Patios which live
Patient laundering and cooking
Self service drug store
Family room alcoves
Window place
Light on two sides of every room

In the DAY CARE FOR CHILDREN, now place these parts:

WATER
ANIMALS

according to the relationships given by this pattern:

Child care contents

In the individual THERAPY ROOMS, now place these parts:

DOOR
WINDOWS
WORKSPACE

according to the relationships given by these patterns:

Interview office layout
Window heights in meeting rooms
Window on two sides of every room
Window overlooking life (for workspace)

In the INTENSIVE CARE ROOM, place these parts:

SECURE ROOM
ENTRANCE FOYER
TOILET
WINDOWS

according to the relationships given by this pattern:

Intensive care room interior

ACTIVITY NUCLEUS

Activity Nuclei

PEDESTRIAN PATHS

Activity Nuclei
Centripetal Pedestrian Paths

COMMUNITY FACILITIES

Activity Nuclei

MENTAL HEALTH CENTER

Activity Nuclei
Human Scale in Public Buildings

PUBLIC BUILDING

Human Scale in Public Building
Horizontal Communication
Building Shaped for Light
Buildings Surround Open Space
South Facing Open Space
Expansion Increments
Community Building Parking

OPEN SPACE

South Facing Open Space
Hierarchy of Open Space
Building Surrounded by Open Space
Expansion Increments

PARKING

Critical Parking Distance
Parking-Entrance Position

SERVICES

All Services off the Arena

SQUARE

Pedestrian Density in Public Places
Small Open Spaces
Building Stepped Back
South Facing Open Space
Building Thoroughfare

OUTPATIENT

Inpatient Outpatient Continuity

DAY CARE

Inpatient Access to Daycare

GARDEN

Half Hidden Garden
Hierarchy of Open Space
South Facing Open Space

TREES

Tree Places

ROAD CROSSING

Paths Interrupt Roads

PUBLIC OUTDOOR ROOM

Public Outdoor Room
Patios Which Live
South Facing Open Space

CIRCULATION

Circulation Realms

ENTRANCE

Entrance Location
Entrance Transition
Circulation Realms
Entrance Shape

CORRIDOR

Short Corridors
Circulation Realms

SOCIAL AREAS

Social Areas Heart of Therapy
Patients Choice of Being Involved
Sleeping OK

STAIRS

Obvious Main Stair
Staircase Stage
No Stairs for Infirm
Stair Seats

OFFICE AREA

Flexible Office Space
Windows Overlooking Life
Small Workgroups
Office Zones

RECEPTION

Reception Nodes
Office Zones
Light is Information
Reception Welcomes You
Workplace Enclosure
Information-Conversation

WAITING

Free Waiting
Office Zones
Waiting for Therapy

MEETING ROOMS

Meetings Up Front
Office Zones
Square Seminar Rooms
Group Therapy Location
Light on Two Sides of Every Room

FAMILY ROOM

Outdoor Room
Daycare Homebase
Light on Two Sides of Every Room

KITCHEN

Patient Laundry and Cooking

STAFF LOUNGE

Staff Lounge
Outdoor Staff Room
Outdoor Room
Staff Lounge Away from Patients
Light on Two Sides of Every Room

OUTDOOR ROOM

Outdoor Room
Patios Which Live
South Facing Open Space
Hierarchy of Open Space

CHILDCARE

Childcare Position

BATHROOM

Accessible Bathroom

PLAYSPACE

Adults and Children
Active and Passive Play

INTERVIEW

Free Waiting
Office Zones
Interview Booths

THERAPISTS

Team Organization for Therapy
Group Therapy Location
Workplace Enclosure

ALCOVE

Hierarchy of Open Spaces
Activity Pockets
Corridors Which Live
Reception Alcoves

COLUMN

Columns at Corners of Spaces

CEILING

Ceiling Heights

ROOF

The Feeling of Shelter

DISTRIBUTION OF SATELLITES

Unless mental health facilities are provided within distances which people can travel, they will not be used.

The critical distances are time distances, not physical distances. The maximum times people will travel regularly, for mental health services, whether they walk, bicycle, drive or take the train are:

	Brooklyn, N.Y. (Maimonides) Urban	Norman, Okla. CMHC Suburban	Hayes, Ka. CMHC Rural	
Day Care	20	20	30	minutes
Outpatient	20	20	90	"
Inpatient	20	60	180	"

Because mobility and the person's normal orbit of travel vary enormously according to the social group to which they belong, these time/distances have very different implications for different social groups, thus:

Derelicts and alcoholics on skid row move about three blocks per day. School children rarely leave the home-school orbit. Suburban families rarely leave the home-school-shopping center orbit or travel into the central city. Some groups can not travel unescorted for thier own physical safety. Some groups can not afford the cost of private or public transportation.

To give adequate service to members of each group, treatment facilities (outpatient, day care, crisis intervention) must be provided within their usual orbits. This suggests store front

operations: in skid row, in the local school, in the local shopping center, etc.

In poverty areas, there is also very little movement across neighborhood boundaries; therefore, as far as possible, each identifiable neighborhood should have a service within it - such a neighborhood may have a population ranging from 5,000 to 50,000.

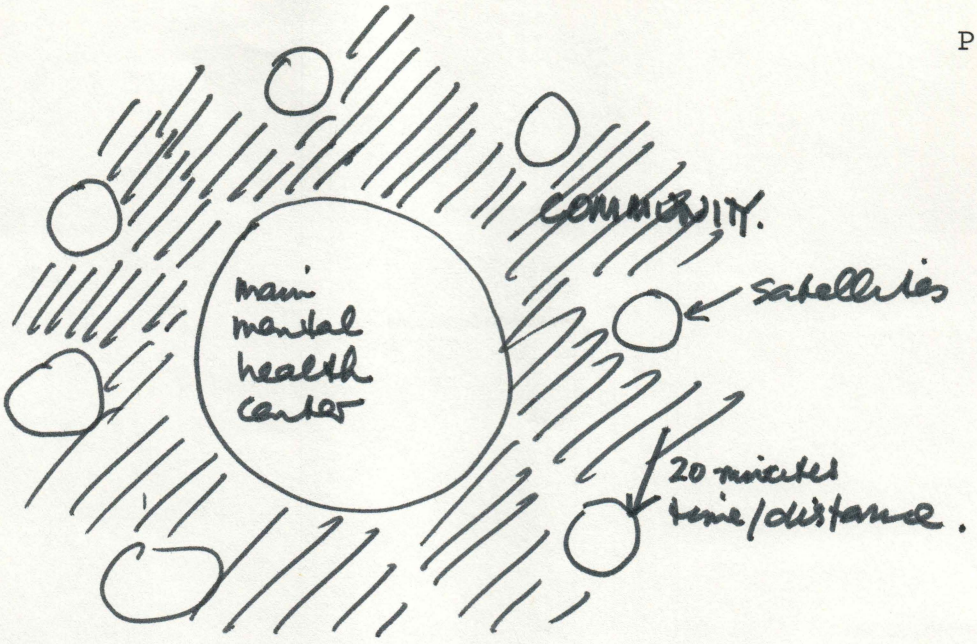
Therefore:

Provide one main mental health facility with a variety of satellite facilities.

The main mental health center will provide all services: inpatient, emergency, consultation and education, etc.: The satellites will, in general, provide outpatient and day care services, and walk-in referral, and will give special attention to children, geriatric patients, alcoholics, and target special programs of its immediate community as required.

Determine the distribution of satellites by the rule that everyone in the community must be within 20 minutes time distance of the nearest outpatient and day care programs.

Furthermore, place the satellites in such a way that each group in the community has one satellite within the normal, everyday "orbit" of its residents, and that every socially defined neighborhood has its own satellite.



Context

A community mental health system in any community serving low mobility groups, such as poverty groups, elderly persons, children, mothers with children, alcoholics, etc., with an inadequate transportation system, and large geographical areas.

BOUNDARY LOCATION

When two communities are antagonistic towards each other, and a mental health facility is placed in one community, the other community will not use it.

One solution to this problem might seem to be to create two distinct centers, one for each cultural group; however, this solution has a number of defects:

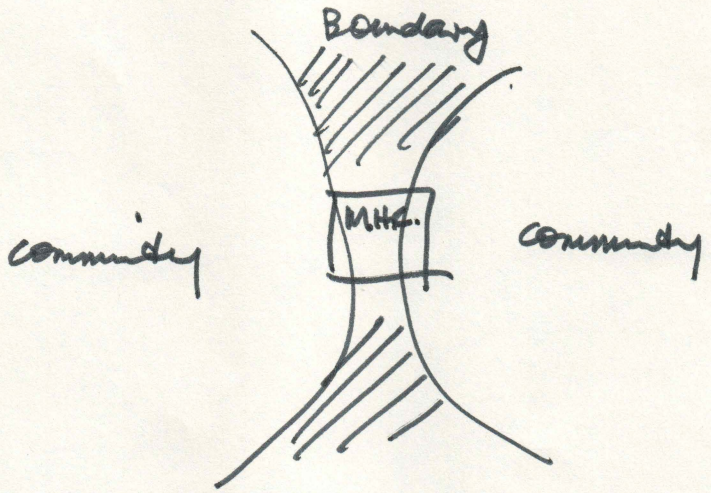
1. It tends to perpetuate segregation.
2. It reduces the effectiveness of each facility because all those services which can best be provided by pooling resources (i.e., resident specialists, special equipment, etc.) are either duplicated (usually expensive) or lost to one community or the other.
3. Experience shows that this "dual" solution tends to create serious administrative problems in the administration of the catchment area.

   Further, experience has shown that a "single" facility does work, contrary to expectation, if it is located on the boundary of the two communities so that people from both feel equally comfortable going to it and can reach it without going through foreign turf.

Therefore:

Place the mental health center on the boundary between the two populations.

There may or may not be satellite service facilities located inside each of the cultural communities. For other factors regarding satellite facilities, see pattern, Distribution of Satellites.



Context

A catchment area for mental health facilities of less than 200,000 population, bounded by the principles and regulations of NIMH, which contains two sharply distinguished community groups of people from different cultural groups who are traditionally at odds with each other.

MENTAL HEALTH CENTER LOCATION NEXT TO GENERAL HOSPITAL

Mental health centers need hospitals, and hospitals need mental health centers.

In locating a mental health center with respect to hospitals, there are two main points to consider:

a) Reasons for closeness:

1. Need to provide mental health services to general hospital - even if this already exists internally, the mental health center can provide extra know-how.
2. Shared programs - day care.
3. Use of support services which the hospital has or uses:

   Physical examination and physical treatment
   Emergency services
   Food preparation
   Laundry
   Central heating and ventilation

4. Most general hospitals have inadequate mental facilities and trained staff.

b) Reasons for mental health center not to be within the hospital:

1. Circulation systems for the mentally ill must be simple and direct and from the ground floor. It is very bad for a mental patient to have to find his way through the hustle and maze of passages, people and elevators typical of hospitals (see pattern, Patients Entering

Mental Health Center). Mental health programs also include both in and out door activities. General hospital planning requirements do not allow placing mental health facilities below the third floor.

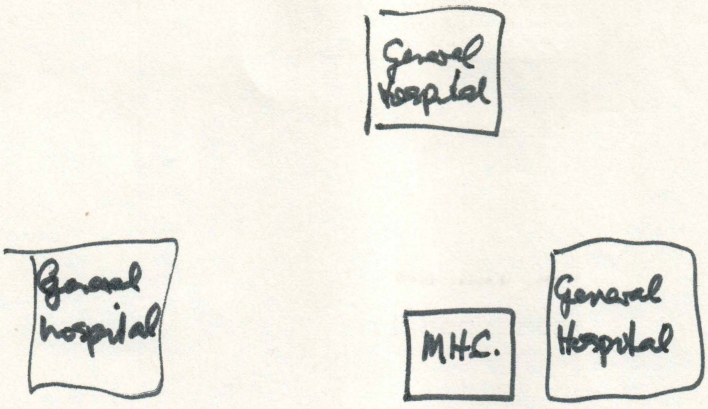
2. Very high cost of operations and facilities not necessary for mental health care. (Typical cost: $60/day room and board which may go as high as $80-100.)
3. Space utilized for medical care (nursing functions, sterile conditions, communication systems, life supporting systems and supply systems and privacy) is generally unsuitable for space used for socialization and development of a therapeutic milieu and therapeutic activities of the mental health center. See patterns for Inpatient Space.

If near a hospital, mental health center can use same back-up services, etc., without having the stated disadvantages of being in the hospital.

Therefore:

Locate the mental health center close to a general hospital (preferably within a block or so), but not inside it.

If possible, it should be located as near one of the hospitals in cluster of general hospitals common in most cities, so as to be able to serve as many of them as possible.



Context

This pattern applies, particularly, to community mental health centers which have inpatient facilities. A satellite center, with out patients and day care only, does not normally need to be near a hospital.

ELEMENTS OF MENTAL HEALTH CARE

People need many kinds of mental care, ranging all the way from an occasional chat with a counsellor, to round the clock intensive care.

To provide a full range of services (from occasional drop-in counselling, regular outpatient therapy, part-time day care for patients who sleep at home, evening care, night care for patients who work during the day, 24-hour living in and 24-hour intensive care, and many other combinations according to individual patient's needs), it has been found that this full range of treatment requires three distinct programs: Outpatient, Day Care, and Inpatient. This is discussed more fully in the NIMH booklets on essential services. (See ...)

In a particular community mental health center, the provision of these services and the provision for different user groups will depend on the other programs currently available in the community and must be tailored to interlock with these other programs.

In order to provide adequate care for different age groups and user groups, it is helpful to make the type of breakdown shown in the table since each of the different groups shown requires different types of care.

Therefore:

Provide the community mental health center with three main kinds of area: Inpatient, Day Care, and Outpatient. A satellite center may contain Outpatient and Day Care only (with an arrangement with the local mental health center or hospital for holding beds).

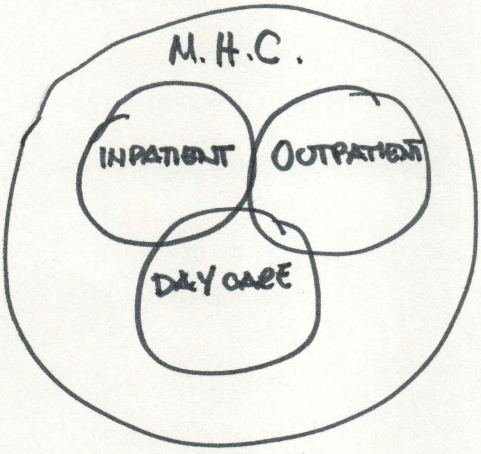
For a catchment area of population N thousand persons, the following figures give orders of magnitude for areas for each of the three kinds of space according to user groups. Not every program will cater to all these user groups.

Areas in square feet

	Inpatient	Outpatient	Day Care
Children 0-6			
Children 6-8			
Children 8-12			
Adolescent	10N-20N		
Adult	20N-40N	25N-50N	30N-60N
Aged			
Alcohol			
Drugs			

(Above figures are fictitious. Clyde Dorsett will give figures in next two weeks.)

These figures are approximate only, and must on no account be taken as mandatory. In any particular case, exact areas will depend on local programs.



Context

Any mental health center or mental health center satellite. If the center has satellites, the catchment population of each satellite will give areas for its programs, and these will then be subtracted from the "parent" centers program.

INPATIENT OUTPATIENT CONTINUITY

Any treatment program that violates continuity of care is bad for patients.

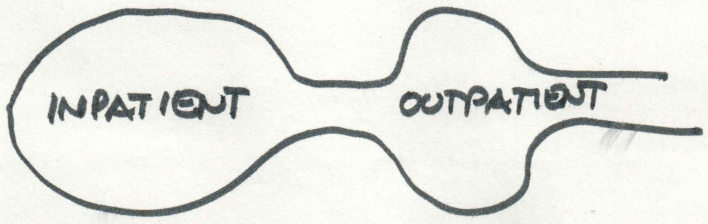
When they leave the inpatient unit, and go to the outpatient unit, patients should not have to go to another building since the place, the therapists, and the nurses will all be unfamiliar to them.

Ideally the transition should be smooth so that they can stay in a familiar theraputic situation while making the change from inpatient to outpatient.

This continuity can only be maintained, without outpatients having to go back into the inpatient unit as they get better, and without inpatients having to go into the outpatient unit before they are ready to, if there is an outpatient unit next to every inpatient unit.

Therefore:

In any mental health center with inpatients, locate an outpatient unit next to the inpatient unit.



Context

Any mental health center with inpatients.

SOCIAL AREAS AS HEART OF THERAPY

Mental health centers which emphasize private treatement instead of human relationships will fail.

The main purpose of therapy is to rehabilitate and resocialize patients, to encourage and allow them to participate, according to their growing capacities, in social activity.

Therefore, it is essential that the program areas be arranged so that patients on the way from one thing to another have maximum possible contact with activities, though always in such a way that they can ignore them if they wish. This requires that paths between programs run tangent to a "heart" social area.

There are also social areas which do belong to a particular group of patients. For inpatients and day care patients, their respective living rooms are their homes and they certainly don't want anyone wandering in at will. These areas, however, are the most likely areas from which patients venture out to the more open social spaces; therefore, these "owned" areas are tangent to the heart social area.

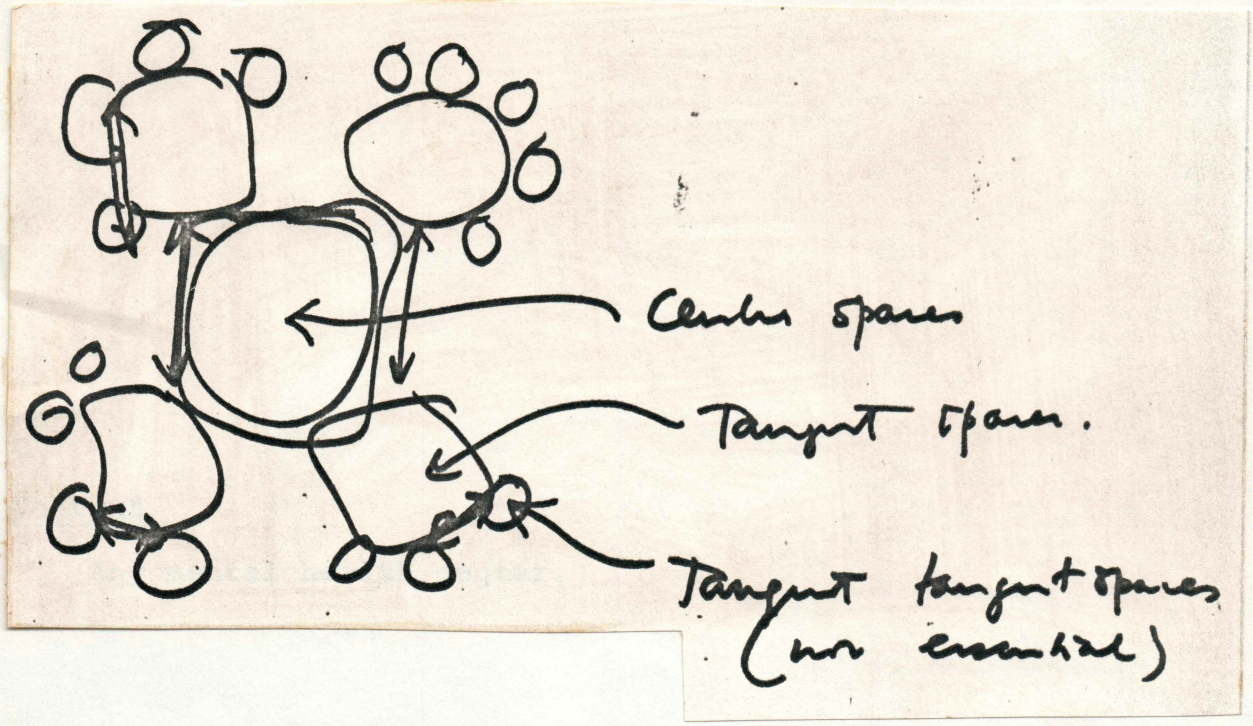
Therefore:

Divide the social areas of mental health centers into two classes; central areas (all social areas which are open to everyone) and tangent areas (areas which "belong" to a smaller group). Make the central areas highly visible and place them on any path taken by

a patient between two points. Place the tangent areas so they are sensed from outside the area so people can visit them, go into them, if they want to but such that they are not freely available to everyone.

Central areas include:
- Occupational therapy
- Recreational therapy
- Main reception, coffee, fireplace, etc. (off main entrance)
- Any additional social facilities provided (garden, terrace, piano, pool, games, etc.)

Tangent areas include:
- Main living area of an inpatient unit
- Eating areas
- Home base of the day care program



Context

Any mental health center.

PATIENTS CHOICE OF BEING INVOLVED

If patient's social areas are hidden away, patients will mix less with other patients, and will have less chance of getting better.

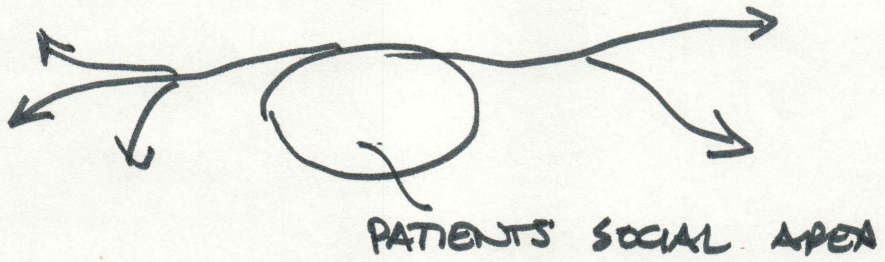
Human contact is crucial to the process of therapy. A large part of a patients therapy hinges on the extent to which he is able to relate to other people.

The patient, therefore, must have the maximum opportunity to mix with other patients, whenever he is in the mood to do so, or even feels the slightest urge to try it. However, when he feels withdrawn, he must be free to withdraw, lest a forced contact should make him withdraw even further into himself. If an activity area is located at the end of a corridor, a patient has to make a deliberate effort to go there, which won't happen if he is just beginning to explore social contacts.

Alternatively if the circulation path cuts through the activity area, he may feel too exposed, and be unable to turn away. To give patients the greatest opportunity to get involved, when they feel like it, activity areas should be placed so that everyone goes past them on the way to anywhere; they should be always visible from these paths.

Therefore:

Place activity and social areas in central positions, so that all paths to and from entrances, beds, bathrooms, dining rooms, etc, go past them, and are tangent to them.



Context

Areas of patient activity in a mental health center.

RECEPTION NODES

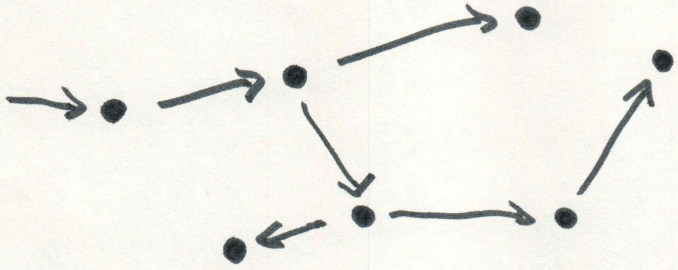
If patients have to ask directions and be led by the hand to go around a building they will feel humiliated and will not be able to develop a feeling of strength and independence.

The system of reception should allow the patient to use his personal and social skills independently if possible. Also, necessary support should exist so that the patient frightened or confused as to time and place does not need to wander about, retreat, or request assistance in a way that reinforces his insufficiency. He neither has to be "led" by the hand to the next place, nor will he be left wandering about without knowing where to go.

Patients must have a very definite point, or area, of arrival. Hence, there must be one clearly defined main entrance, and the reception clearly visible inside this main entrance. Each "next" receptionist the patient is directed to is visible from the previous one. Thus, each receptionist can point, very simply, to another receptionist, and say: "Go and see her, over there". The patient never has to wander about by himself on unfamiliar territory at any point, yet never has to be "taken" anywhere.

Therefore:

Make all the various reception points (i.e. main reception, outpatient, inpatient, occupational therapy, recreational therapy), form a system of mutually visible nodes - so that a person can go from one to the other, always seeing, from each point, to the point he has to go to next. Make the main reception clearly visible from the main entrance.



Context

This pattern was developed from the problem in mental health centers, however, we believe that it applies other buildings such as community service centers and other places where people are encouraged to be independent.

RECEPTION WELCOMES YOU

Have you ever walked into a public building, and been processed by the receptionist as if you were a package?

To make a person feel at ease, you must do the same for him as you would do to welcome him to your home; go towards him, greet him, offer him a chair, offer him some food and drink and take his coat.

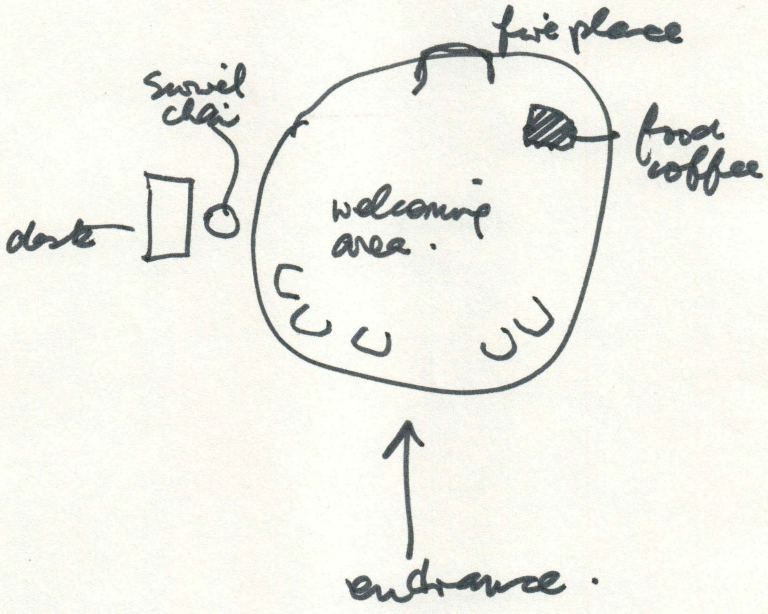
In most institutions the person arriving has to go towards the receptionist; the receptionist remains passive and offers nothing. To be welcoming the receptionist must initiate the action - come forward and greet the person, offer a chair, food, seat by fire, coffee. Since it is first impressions which count, this whole atmosphere should be the first thing a person encounters, and should be immediately visible from inside the entrance. There must be all the physical things needed to create this welcome.

In most cases, the receptionist also has other duties; typing, telephones, etc. The desk she works on, very often forms a barrier between her and the visitors, and the desk and equipment together help to create an institutional atmosphere, quite at odds with the feeling of welcome.

Therefore:

Immediately visible from the entrance, and directly in front of the person entering, place a collection of welcoming things: soft chairs, fire, coffee, food. To one side place the receptionist with her desk facing away from the welcoming area, so that visitors

can approach her directly, she can get up and approach them directly, and she can swivel her chair around to join them when they sit down.



HIERARCHY OF SOCIAL SPACES

No one level of social contact by itself can ever be satisfying.

Each person needs to have a place to be private, a place where it is combortable to be with/talk to one or two other people, and a place to experience substantial social contact with several people.

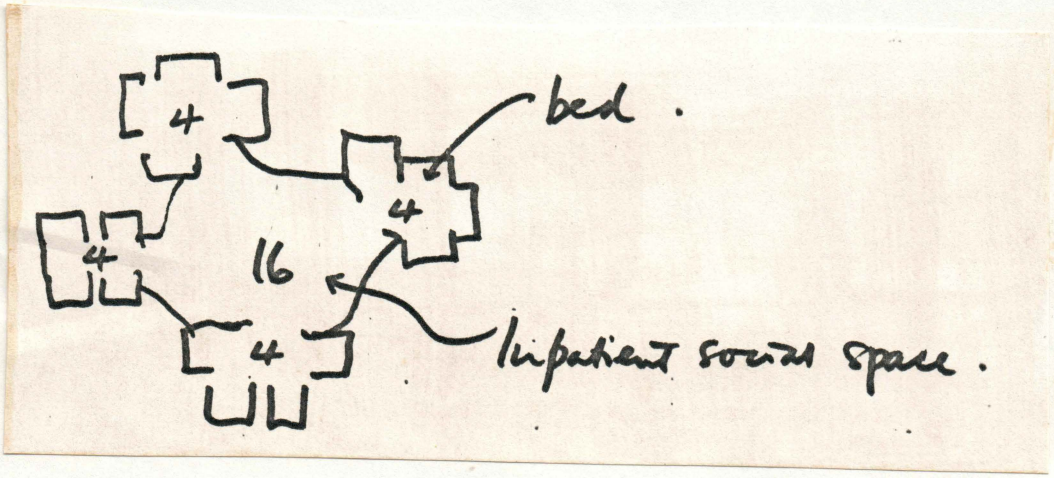
Current estimates of these problems suggest 2 to 6 (average 4) as the best number for clustering of beds and the smaller activity space and about 16 as the top number of people to share a single living space, the larger activity area, which indicates about four of the smaller clusters.

The two-level hierarchy from total privacy to the larger social space, is particularly important for mental patients. One of the major functions of therapy is getting patients back into a state of mind in which they can enjoy normal human relations. A patient in a bad state may be willing to venture out into a small group, and then, once used to this, venture out from the small group to a larger group - but he may not be willing to risk this venture all in one leap, hence the small (intermediate) group plays a vital role in this gradual process and leaves him the maximum opportunity of exploring new possibilities at every stage in the process.

Therefore:

Put each bed in a private room or curtainable space. Cluster the beds in groups of four around small activity spaces which are themselves clustered around larger social living spaces, at most

four clusters at a time, so that each living space typically serves 16 beds.



Context

In patient units of a mental health center.

SIXTEEN BEDS PER NURSE

If the nurse has too many patients to look after, she cannot give them the feeling that they are being cared for.

Most nursing units in large general hospitals do not provide the setting necessary for the fastest possible recovery of the patients; they are mechanized and impersonal. The usual arrangement is a long corridor with rooms lined up on both sides and a nursing station with some four or five nurses located in the middle. There is no sense of relatedness to anything or anybody for the patients to take ahold of; there is no sense of identity among the rooms.

Patients feel anxious that they are forgotten and that there are too many different people taking care of them. They feel that they are not getting enough personalized care and attention.

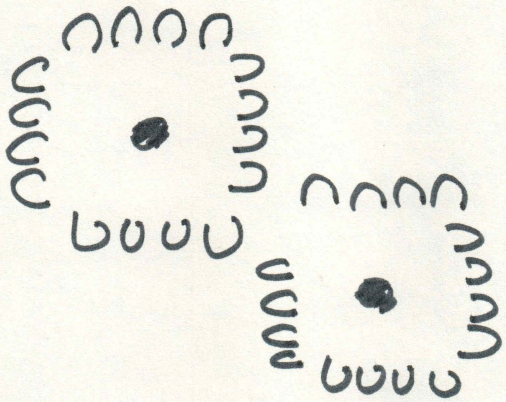
On the other hand nurses complain that the present method of practicing nursing is not what they thought it was or what led them into the profession. They have too little personal contact with their patients. There are too many nurses caring for the same patient so that a nurse never gets the gratification for being solely responsible for a patient, or cultivating a one to one relationship with the patient. In addition, she never is quite sure of what the last nurse has done for the patient.

Further, they find in most hospitals that rather than actually caring for the sick, they have become administrators, devoting most of their time to supervising nurses aides and orderlies and doing paper work. There is little time for personal contact with the patients. (continued over)

Therefore:

Arrange the hsopital beds in clusters of sixteen or less, with one nurses station central to each cluster.

Arrange the clusters in groups so that one nurse (on night duty) can supervise several clusters at the same time - these groups should contain no more than 32 beds.



Problem (continued)

The following points need to be considered:

1. People tend to get well faster (especially the elderly) if they have close contact with professional nurses and doctors.

   (Contact with other hospital personnel, and with other patients and visitors are also therapeutic but contact with those professionally responsible is of special importance. If contact with other people is limited, the contact with nurses is even more critical. This is especially true in urban areas where hospital patients do not have as many visitors as in a small town or in a rural area. Patients in urban hospitals are known to suffer more from lonliness and lack of contact, which are major deterrents to recovery.)

2. Nurses get more personal satisfaction from their work if they have close contact with, and sole nursing responsibility for their patients.

3. Patients learning to walk after an ailment have more incentive to do so if there are nearby goals to walk to and if people who can help are nearby.

   (A serious deterrent to recovery is the feeling of helplessness and dependency which arises in a hospital with a setting which does not provide motivation for people at least to do for themselves what they can.)

4. Medicine is becoming more specialized each day: treatment of different diseases is becoming more differentiated, involving highly specialized skills and the use of highly specialized equipment.

5. Ratios of different kinds of diseases to each other tends to shift over time: Kinds of diseases and degree of seriousness of diseases are unpredictable; therefore, staff to patient ratio is unpredictable.
6. Patients need to have a sense of domain and also a sense of community within the hospital. For the duration of their stay, their bed neighbors and the personnel who take care of them constitute their community.

The principle ideas contained in this pattern are:

1. There must be just one nurse who cares for a number of patients (ratio 1:N)
   a. The patient can then achieve a meaningful relationship with the nurse, rather than superficial ones with several nurses.
   b. The nurse gets the satisfaction of having sole responsibility for her patients and gets to know them better.
2. Further, grouping around the nurse must be intimate so that patients have a sense of nearness to the nurse and a sense of familiarity with their surroundings and the people around them.

   These beds, then, must be close to the nurse and close to each other. The beds should ideally be arranged so that a patient can see the nurse.

The nursing units must be clusters of not more than 20 beds in order to provide the sense of intimacy and community. One cluster should be differentiated from the next.

(20 is a guess for this upper limit and should be tested.)

3. There must be a certain amount of flexibility in the hospital to make it function efficiently in the face of unpredictable numbers and kinds of diseases to be treated and the specialized care required for each, therefore, shifting of nurse to patient ratios must be accommodated. The clustering of nursing units must be such that they can be reclustered into larger groups for night, since night-time nursing care, when most of the patients are asleep, is obviously less intensive and demanding than daytime care when most of the patients are awake. The maximum number of patients a nurse can look after in the night is 32.

   Further, the specialization of medicine and the need for grouping and separating them, demand smaller groups of beds and more nursing stations. If these nursing units can be combined to form larger ones, sizes of clusters can be flexible to accommodate different numbers of patients with different diseases.

4. The actual ratio of nurse to patient has an upper limit determined by the psychological need of the patients, for at least a certain amount of personalized attention of the nurse.

The crucial factor for considering nurse to patient ratio is the one of psychological need simply for personal contact with each other. If more intensive care is required, according to types of illness and seriousness, this can be met by other persons as long as the nurse at least provides some critical amount of it.

(As pointed out in the problem statement, nurses are now spending most of their time supervising aides, which indicates that aides are perfectly capable of handling most duties required in caring for the patients.)

What is the critical amount? We have arrived at a figure of at least 20 minutes per day based on say 5 minutes every two hours, within an eight hour period.

(This assumes that psychological needs of patients for contact with the nurse does not depend on degree of illness or the kind of illness - needs to be tested.

This estimate of time required per patient are averages and not fixed per patient. The nurse can spend more time with some patients and less time with others, depending on the patient's psychology.)

Although types and seriousness of diseases do not basically affect this ratio, they do affect the numbers of orderlies, nurses aides, technicians and so on who supplement the nurses work. For nursing the most serious illnesses, there might be eight of these persons working. Although it is difficult to estimate exactly how much time it may take a nurse to supervise them daily, we would assume that it would not take more than two hours per day.

(These estimates of time required for supervision are, again, averages. The nurse can spend more or less time with aides, depending on their ability, experience, etc.)

Considering the time required then for contact with patients and for supervision, the nursing unit should have a maximum of 16 beds.

NO NURSES STATION

Owing to the nature of her administrative work, a nurse's work place often cuts her off from the patients.

The conventional nurses' station from an ordinary hospital is behind a counter, often enclosed in glass. It invites the nurse to sit behind it and separates her from the patients.

In a mental patients' unit, it is essential that the nurse spend as much time as possible with the patients, sitting and talking with them, being among them, and therefore, it is crucial to break down the barrier between nurse and patient. The nurse should have a table which is large enough to play cards on, and the nurse can use it both for keeping up with her records, or as a place to sit and talk with patients, let them play cards, games, etc.

The idea of the nurses' station "on wheels" (meant metaphorically, not literally) captures the idea of the nurses' function, and is a helpful one for the staff to grasp.

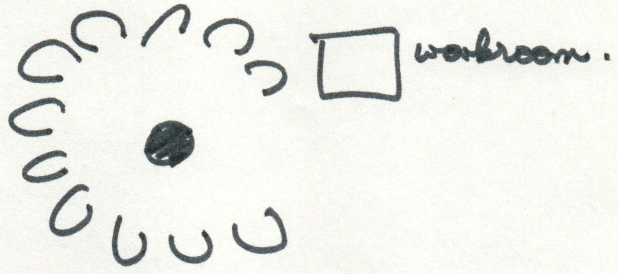
It is even helpful to make the grouping of patients' beds so enclosed that the nurse can only supervise them by being with them - and thus cannot supervise them from the distance.

Nurses need a closed workroom for conferences with doctors, to keep the medication cabinet, confidential calls, etc. This staff workroom is enclosed so that nurses are not tempted to use it as a nurses' station, but to spend the time out among their own patients.

It may, however, oversee the intensive care, since this requires a nurses' station in the more conventional sense.

Therefore:

Place every nurses' station in the middle of the space from which the patient's beds open, within sight and sound of these individual bedrooms or bed alcoves. Make the station no more than an open table or desk, large enough to play cards, etc., on. Provide a separate enclosed staff workroom where all the patients' records, medication, desks and phones are kept - this is not associated with individual nurses.



Context

Any nurses' station of an inpatient unit for mental patients.

INTENSIVE CARE LOCATIONS

Most emergencies occur at night with minimum staff on duty.

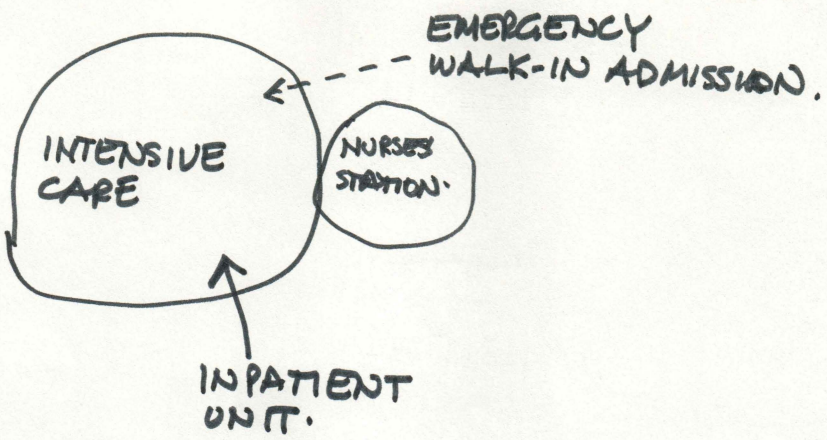
At this point the available staff will be in the inpatient unit; hence the intensive care unit should be adjacent to the inpatient unit, and the emergency entrance, so that it is easy for the staff to escort patients from the emergency entrance to the intensive care without leaving the rest of the inpatients unattended.

These intensive care rooms can be used for ordinary patients when not occupied by patients under intensive care. It may also happen that a patient is first under intensive care, then as he gets better, stays in the same room. Therefore, this usage and continuity of care suggests that the intensive care room be mixed in with other ordinary rooms, and not be segregated thus causing discontinuity.

Therefore:

Locate the intensive care unit as follows:

1. Next to the nurse's"station"with medical treatment and medications available. See pattern 'No Nurses' Station.
2. Directly accessible to all inpatient units and easily accessible to the walk-in admission and emergency entrance.
3. If there are several intensive care rooms, place them within the inpatient units (one per unit and two per center minimum). Also, when unit is used for alcoholism and physical illness treatment, increase this number according to the need.


EMERGENCY
WALK-IN ADMISSION.
INTENSIVE CARE
NURSES STATION.
INPATIENT UNIT.

INPATIENT ACCESS TO DAY CARE

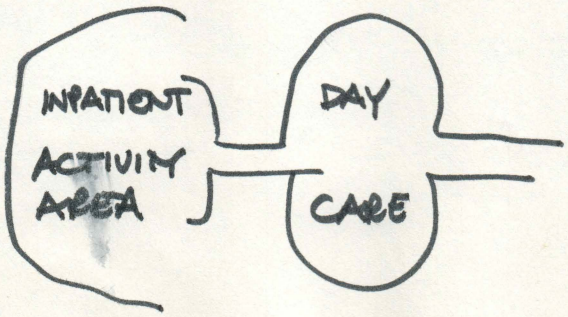
Inpatients need contact with people from the outside world.

A great number of the patients in an inpatient ward (sometimes 75 to 100%) are ambulant during the day.

Gradually enlarged contact with more and more people and larger spheres of activity is a critical part of the theraputic process for these people who are free to move around. Day care patients, provide the opportunity for inpatients to begin to regain their contact with the outside world. Hence access to day care is desirable wherever possible. Typically, the day care department has three main branches, the home base, recreational therapy, and occupational therapy. It will be best if the inpatient activity space looks directly into these three areas: if not then the activity space should lead directly to them

Therefore:

Place the inpatient activity space so that it looks or leads directly into the day care home base, occupational therapy or recreational therapy.



Context

Any mental health center inpatient unit.

SKELETON EMERGENCY FACILITIES

A mental health center needs only minimal emergency facilities.

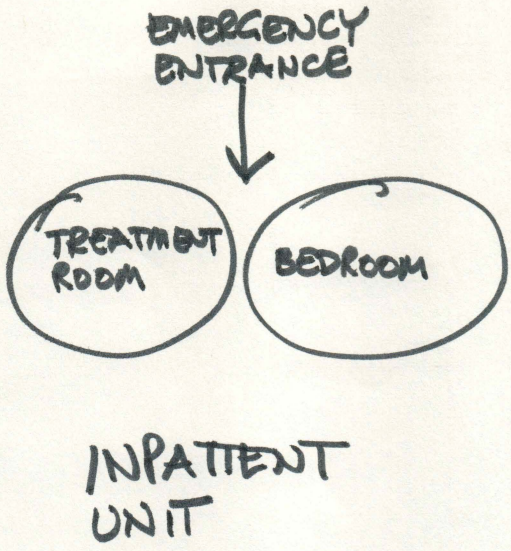
Under no circumstances will the CMHC be able to provide full scale emergency medical treatment. Thus in cases requiring this kind of treatment, the patient must first be taken to a nearby general hospital - and the hospital with which this arrangement is made must have, (a) a holding room, and (b) staff to escort the patient to the MHC after holding.

It is not necessary to provide a separate holding room, in the MHC, since the patient can be escorted directly to a bedroom. The only rooms required for emergency treatment, are a treatment room and bedroom. Since the emergency facilities are often used at night when there are only a few staff members there, the emergency facilities should be located in (or next to) the inpatient unit so the night staff there can be called upon.

A separate emergency entrance and parking space, must be provided for an ambulance, since it may be necessary to bring in an uncontrolled patient who would otherwise disturb patients and visitors in the main entrance.

Therefore:

Provide, a) skeleton emergency facilities which consist of a bedroom and treatment room, in or next to the inpatient unit, and b) a separate emergency entrance.



Context

Any mental health center.

TEAM ORGANIZATION FOR THERAPY

Therapists work best in teams and the patients have to be able to recognize them as a team.

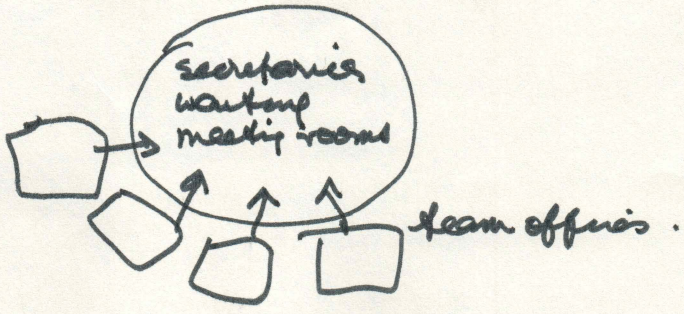
Therapy is best handled by teams of four to six, each team responsible for a particular segment of the catchment area. Each team contains, typically, a psychiatrist, psychologist, social workers (two or more) etc.

To function as a team members need to have their offices close together, share the same secretaries, waiting and meeting rooms.

It is also important for the patient to recognize this group of people as his treatment team, since he has different needs at different times and may work with different members of the team at these different times. If he does not perceive them as a team, and know them all, he will experience discontinuities, violating the continuity of care principle.

Therefore:

Cluster team offices with easy access to common secretaries, waiting, and meeting rooms.



Context

Therapy rooms in any mental health center.

SELF SERVICE DRUG STORE

Patients must become self sufficient once they get started in their therapy.

If drugs are handed out in the usual way, the strong element of over-protectiveness is not good for the patients, particularly those who need experience in gradually finding their feet among people.

With a small drugstore, functioning for inpatients and outpatients, people can be given a slip by a nurse or doctor and can then get the medication for themselves. Of course, some patients, who have to be carefully watched, will still be given their medication by a nurse and watched while they take it.

Most of the patients using the drugstore will be in the day care unit, although other patients will be using it too.

Therefore:

Place a drugstore in the day care unit. It is a small lockable room staffed either by a pharmacist, or at special times, by a nurse, and is accessible to all ambulant patients, inpatients, and outpatients.

Context

Day care unit for mental patients.

INTENSIVE CARE ROOM INTERIOR

Acutely ill patients need extra security, but they are often made to feel they are in a prison.

An acutely ill patient can be very destructive and will often harm himself. He must be where he can not hurt himself nor hurt anyone else, where the noise he makes does not disturb the whole unit. Hence, a locked double door system, no sharp corners, no breakable glass, etc. Such security measures also contributes to a feeling of security among others.

Patient needs a certain amount of extra feeling of security but the room must not be like a prison cell which makes him feel as though he has been "put away". Hence no bars on windows and use of safety glass, switches in the foyer not outside in the passage to make room seem reasonably normal.

Doors must swing outward so patient can not prevent staff from entering and be hospital size (3'4") for movable beds.

Therefore:

Provide the intensive care room with two zones: a secure room and an entrance foyer.

The secure room contains a minimum of doors, windows, mechanical and electrical devices, protruding corners, and surfaces which can be destroyed or misused by the patient.

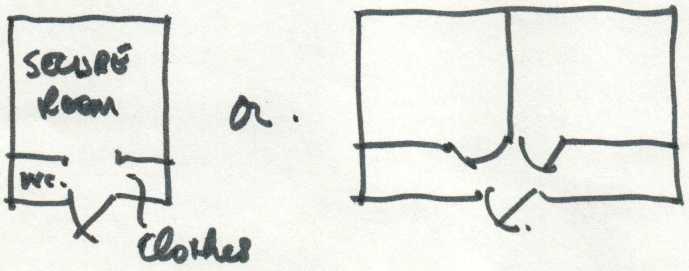
The entrance foyer is moderately secure, contains a toilet and the patient's wardrobe, and contains the light switch for the overhead light in the secure room. The entrance foyer may be shared by two secure rooms.

Note:

Windows should be fixed (non-openable) and made of non-breakable glass that looks exactly like ordinary glass (for example, a laminated safety glass) and the total window area should be fairly small.

The doors and door hardware should be extremely strong, lockable, and must swing outwards. The inner door should have a peephole in it. The door to the corridor also should be similar to inner door but should not have peephole and can swing into foyer. The toilet door must also swing outward. Width of inner and corridor door must be 3'4" wide.

The room and the toilet space must have a microphone installed with communication to the nurses' station so the nurses can listen in on the patient and also so a cry for help from a nurse can be heard.



Context

Intensive care for acutely ill patients in a mental health center.

GROUP THERAPY ROOM LOCATION

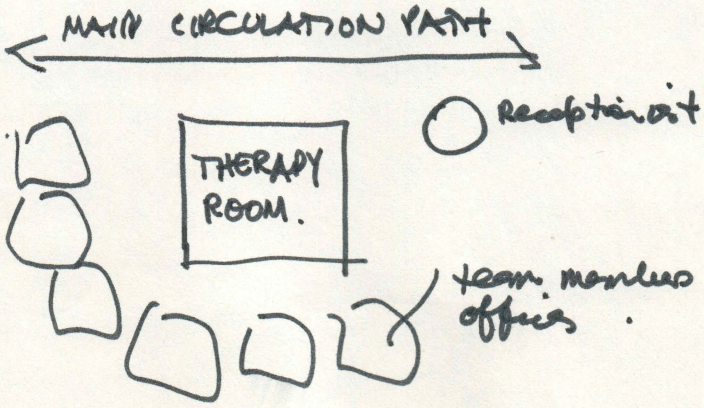
There is a lot of traffic to and from group therapy rooms, which disturbs other offices.

Traffic to and from group therapy rooms will be noisy, and may also involve meetings other than group therapy sessions. This means access to rooms must be direct from more public areas, not going past individual interview rooms which need peace and quiet.

Group therapy rooms should be near the receptionist so that she can help the patients with information they may need. The therapy room may serve several purposes for the therapy team, including meetings, and so there should be a therapy room for each team, easily accessible from the individual team members offices.

Therefore:

Provide each therapy team with a group therapy room, and locate it off main circulation paths, next to a receptionist and within easy access from team members offices.



WAITING FOR THERAPY

Forced isolation, or forced contact, are both uncomfortable.

While waiting, patients will be in a variety of different moods. Some will be anxious for conversation; others may want to be completely alone. Waiting in a large waiting area doesn't provide for either of these needs. Patients anxious for conversation, need small clusters of seats - more than four at a time is too large for comfort. Patients who want to be completely alone, need seats that are placed away from other seats - observations suggest at least 12' from all other seats in view. All seats, whether isolated or in clusters, should be single seats. Patients just don't sit together on couches.

Patients often have to wait their turn to see a receptionist, or for appointments with therapists and other staff members. Many of them bring children with them (otherwise they can't leave home): children are very active, and disturb other waiting adult patients - hence a separate area for them.

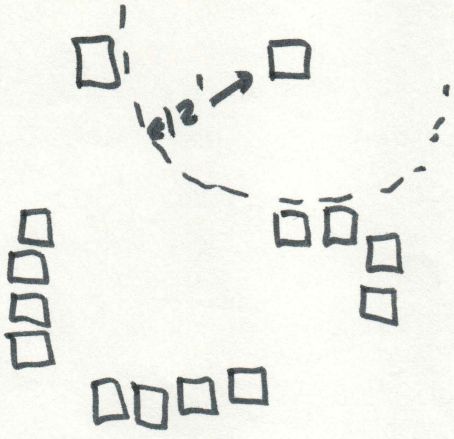
Also all seats should be in view of some staff person, so patients can feel secure and confident.

Therefore:

Break the waiting areas into a variety of small waiting areas, never one big milling space where everyone waits together. These waiting areas should range from small groups which hold four people, down to single seats which are faily isolated (no other seats

within a 12' radius). All seats should be single seats, no couches.

Put each of these waiting areas within view of some staff member, a receptionist, nurse or secretary, and make one childrens waiting area, separate from the others, in view of the receptionist, and so placed that at least one waiting position is direct across from it, so a mother can watch her children.



STAFF LOUNGE AWAY FROM PATIENTS

If the patients can see the staff going into the staff lounge they will feel the staff is avoiding them.

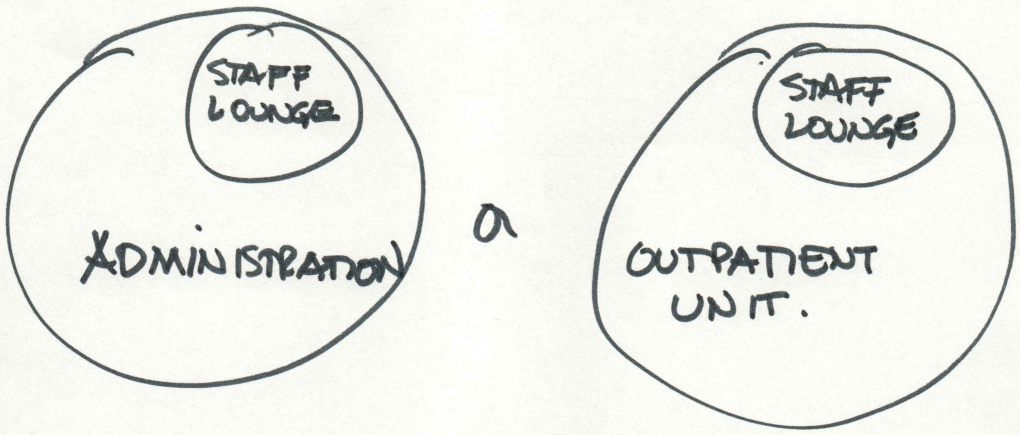
When the staff lounge is close to patient areas, and easily accessible to them, and visible from them, the patients easily become uncomfortable - they feel that the staff "retreat" to the staff lounge to get away from them, the patients, then quickly feel unwanted, unloved, and so on.

Also, if the staff lounge is near the inpatient areas, the nurses may actually be inclined to go there to get away. If the staff lounge is some distance away, it will discourage them from doing this. It means that when a nurse is on duty, she is with the patients; and on staff time, not with patients and involved with them, the patients need not be or feel ignored.

This means that the staff lounge should be located away from all patient areas. However, since the patients who come to the outpatient unit are there for specific appointments, these patients will not feel the problem to such an extent, if at all. The best place for the staff lounge is in the administration area, or if there is no administration area, in the outpatient area.

Therefore:

Place the staff lounge away from inpatient and day care patients, in the administration area, or in the outpatient unit.


STAFF LOUNGE
ADMINISTRATION
OR
STAFF LOUNGE
OUTPATIENT UNIT.

DAY CARE HOME BASE

Day care patients need a place to feel they belong to.

While they are at the mental health hospital day care patients socialize with each other, have group meetings and receive instructions from the staff. They therefore need a place where they can all come together, which has a family room atmosphere so the patients can feel at home, i.e. a "home base". Other activities which may go on there include, making coffee, having bag lunches if dining room space is not available, having a birthday party. In addition a bed should be provided for a patient who may need a short rest. The "home base" should be capable of supporting at least three different activities at the same time.

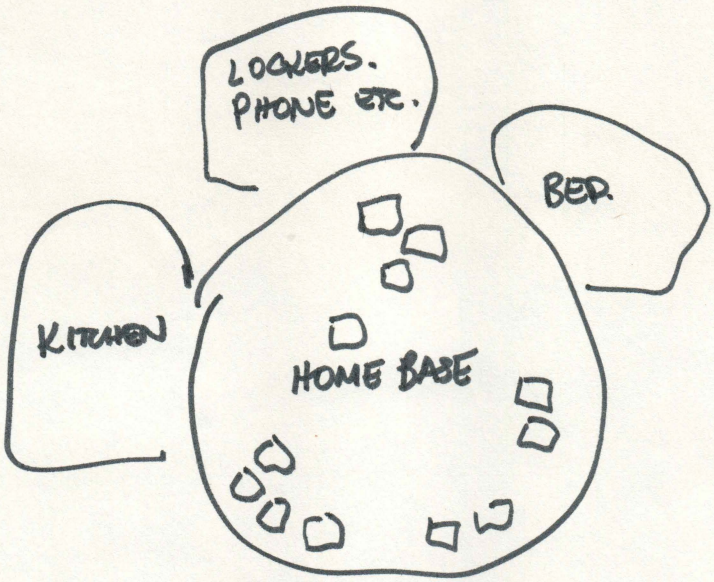
Accessible from the "home base" there should be lockers, for each patient, telephones and toilets.

Therefore:

Provide:

1. A family room-like space with flexible seating arrangements for small and large group discussions, and capable of supporting three activities at the same time.
2. A domestic type kitchen which allows a minimum of four people to serve and prepare food.

3. A public telephone, toilets, and lockers for each day care patient (large enough for coat, overshoes, purse and small articles adjacent to the "home base". The locker should be lockable by a combination type lock.
4. A bed for any patient who needs to rest.



Context

Day care in a mental health center.

LIGHT AS INFORMATION

If the places where the light falls are not the places you are meant to go towards, you will inevitably be confused.

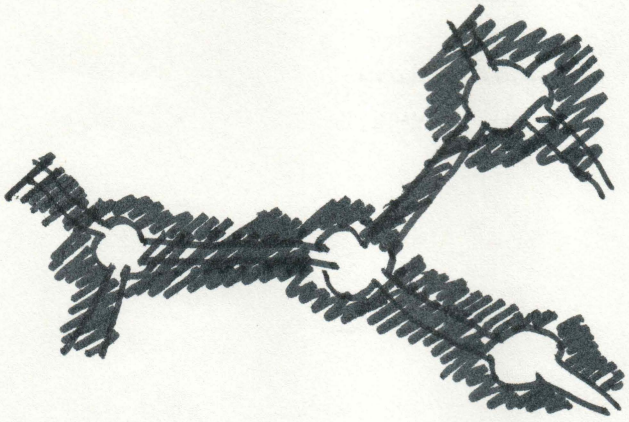
People are phototropic - they tend to move towards light.

When the light is uniform, or the arrangement of light and dark is different from this pattern, the environment is giving information which contradicts its own meaning. The environment can only function in a single-hearted manner, as information, when the lighter spots coincide with the points of maximum importance, or maximum information, or goals, in the circulation system.

This has the effect of enormously increasing the legibility of the environment - the light and dark function as sources. The arrangement of light and dark provides a prime source of information about the way the environment is to be used.

Therefore:

In the circulation system give all nodes which function as targets for people to walk towards (receptionists, entrances, access points, coffee, information) higher light intensity than the surrounding areas and than the passages between them.



Context

Any circulation system.

LOOK - SEE FAMILIARITY

Patients get turned off if they can't see what is going on around them.

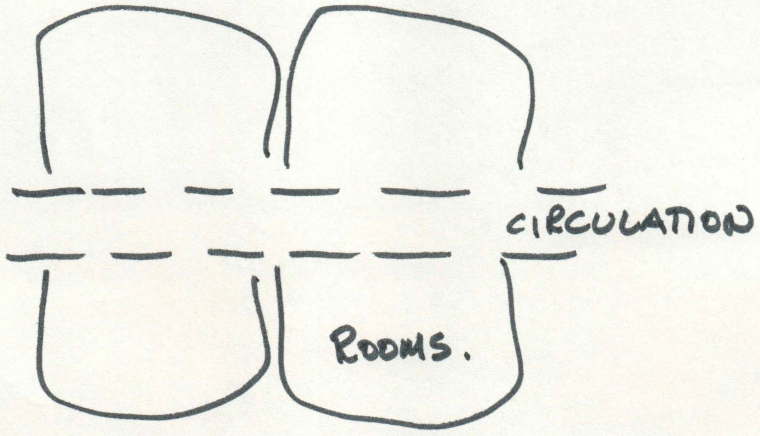
In existing mental health facilities, a patient who comes in often gets a sense that he is going to lose control over what happens to him and he is afraid he may lose all the power of decision over his treatment, be exposed to unwelcome or unaccustomed forms of personal contact and/or treatment, be put in an environment with which he can not deal (being put in a locked ward), or be subjected to frightening security provisions which are inappropriate.

This has a strong bearing on the design of circulation spaces in the mental health center. Such spaces should be designed to be sources of information to support the patient's sense of reality by making the treatment facility familiar to him as a non-threatening, non-secretive place to be.

It should therefore be open in plan in all areas designated for daily living and frequent use by patients to allow "openness" of the physical environment to prevent closed-off spaces from appearing to the patient which would cause him to be barred or feel threatened by secrecy from activities which are taking place in the closed area - or conversely, areas or barriers designed to prevent him from getting out, taking part, or being able to make "checks" on what is happening.

Therefore:

1. Eliminate doors where possible.
2. Use sliding doors, which stay open except when room is actually in use.
3. Place interior windows looking from corridors into adjacent spaces where possible.



Context

Circulation in a mental health facility.

PATIENT LAUNDERING AND COOKING

If patients can't carry out the activities of daily living, they will really feel institutionalized.

In the inpatient unit it is necessary that facilities for daily living be provided. Typically the laundry and kitchen, if they exist, are located outside of inpatient units and are not available for patients to do their laundering or prepare a snack in their evening leisure hours. The more visible they are, the more patients will be drawn to use them.

Social interaction of patients with other patients, and patients with staff, must take place within the inpatient unit. The kitchen and laundry are ideal for conversation and sharing settings.

Ideally, both these spaces should be too small to contain individual tables. One large table in the social area can serve as table for ironing, mending, sewing, making food, having a cup of coffee, playing cards, thus bringing the patients together.

Therefore:

Provide a laundry (laundry sink, two machines, and freestanding ironing board) in the mainstream of the social area, available to all patients, clearly visible, and domestic kitchen (food preparation, counter, storage, and stove) also in the main stream of the social area.

Both kitchen and laundry are, ideally, smaller spaces which open directly into the social area with no door or barrier between.

Context

Social area for inpatient unit in a mental health center.