Faculty of Design

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Designing for acute psychiatric care in a learning process of systems oriented design

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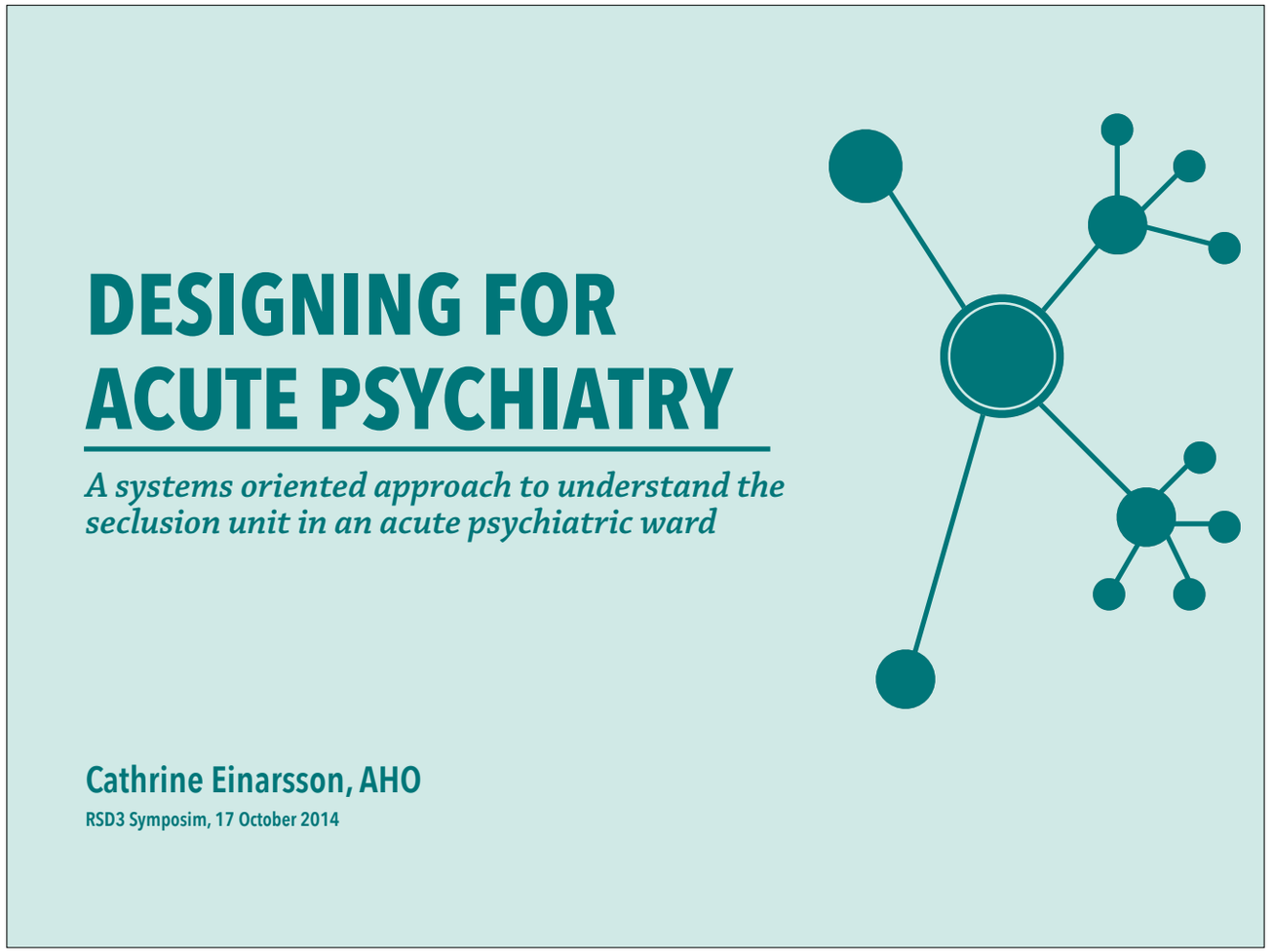


1 Hi and thank you all for being here to listen.

I am Cathrine Einarsson, I am a master student of service design here at AHO, currently doing my master thesis. Today I am here to tell you about a previous design project:

Designing for acute psychiatry -

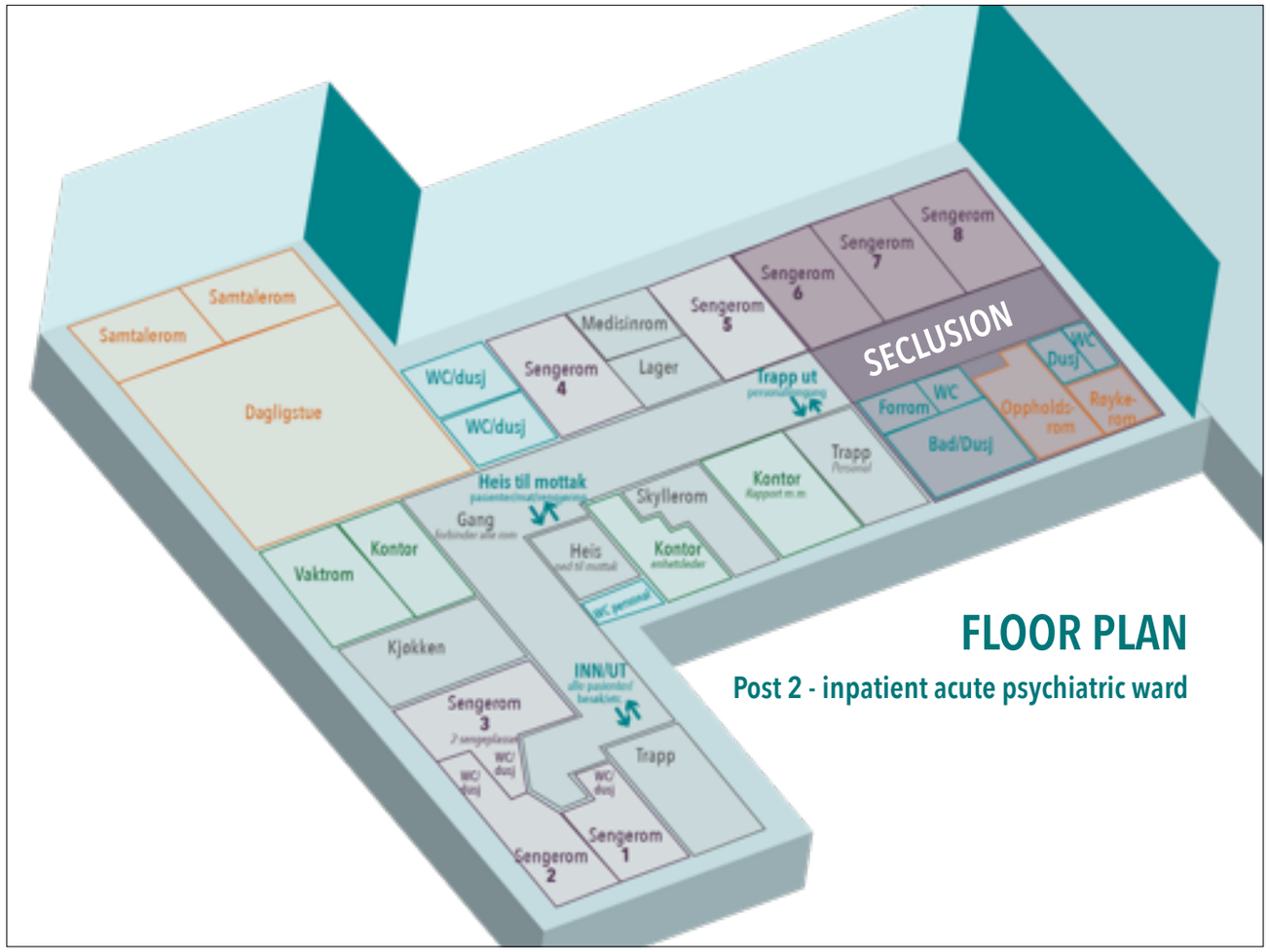
A systems oriented approach to understand the

seclusion unit in an acute psychiatric ward

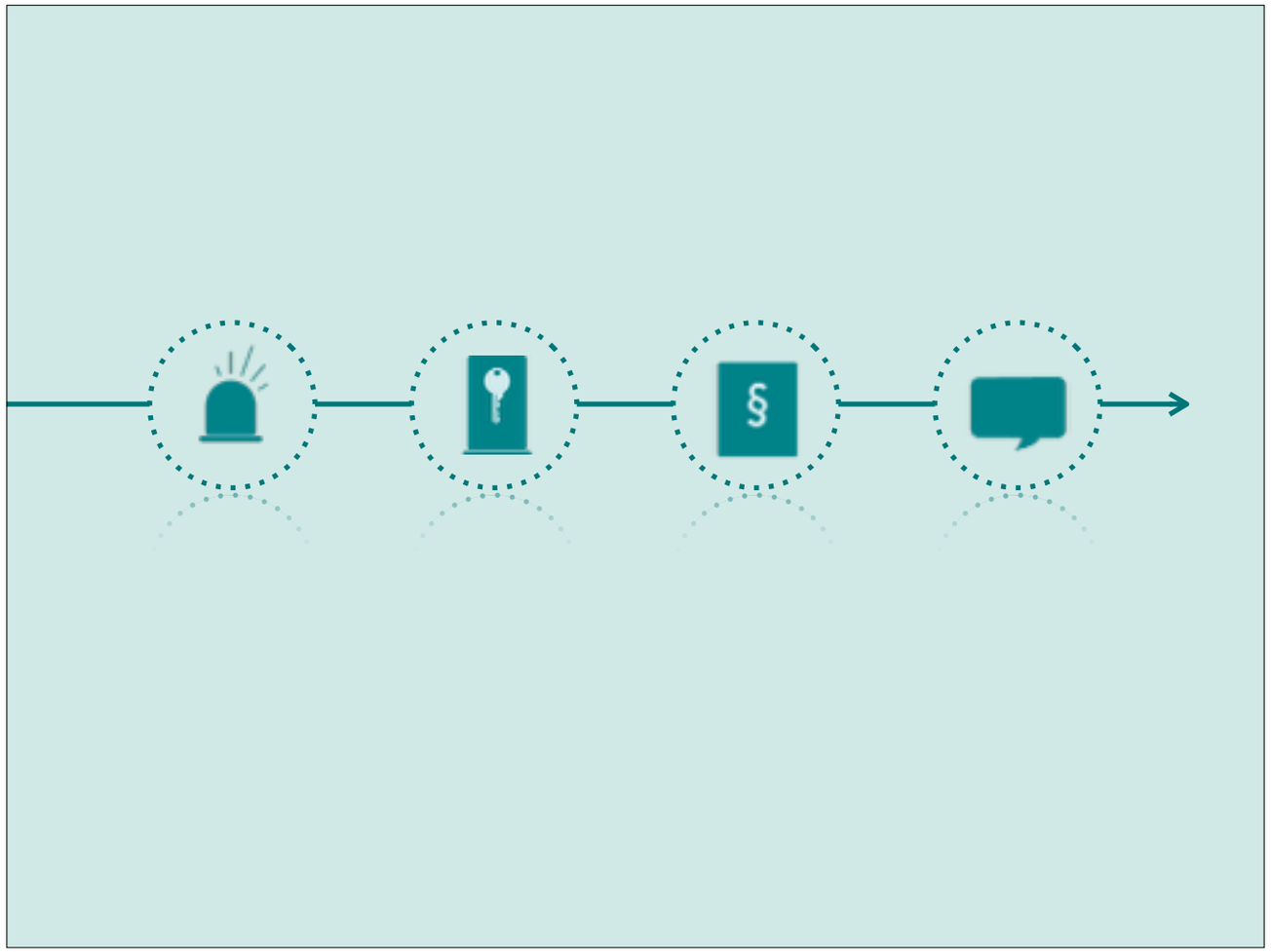
For the most industrious of you that have researched the talks and read the abstracts, I have a slightly different story to provide you with - since the abstract was written exactly in the middle of this project. I do hope that it will still be valuable, and understandable for the most of you, wether you are experienced system thinkers or students in the midst of learning about systems.

Considering this being a symposium on relating systems thinking and design, I will concentrate my presentation on the process and less about the solution.

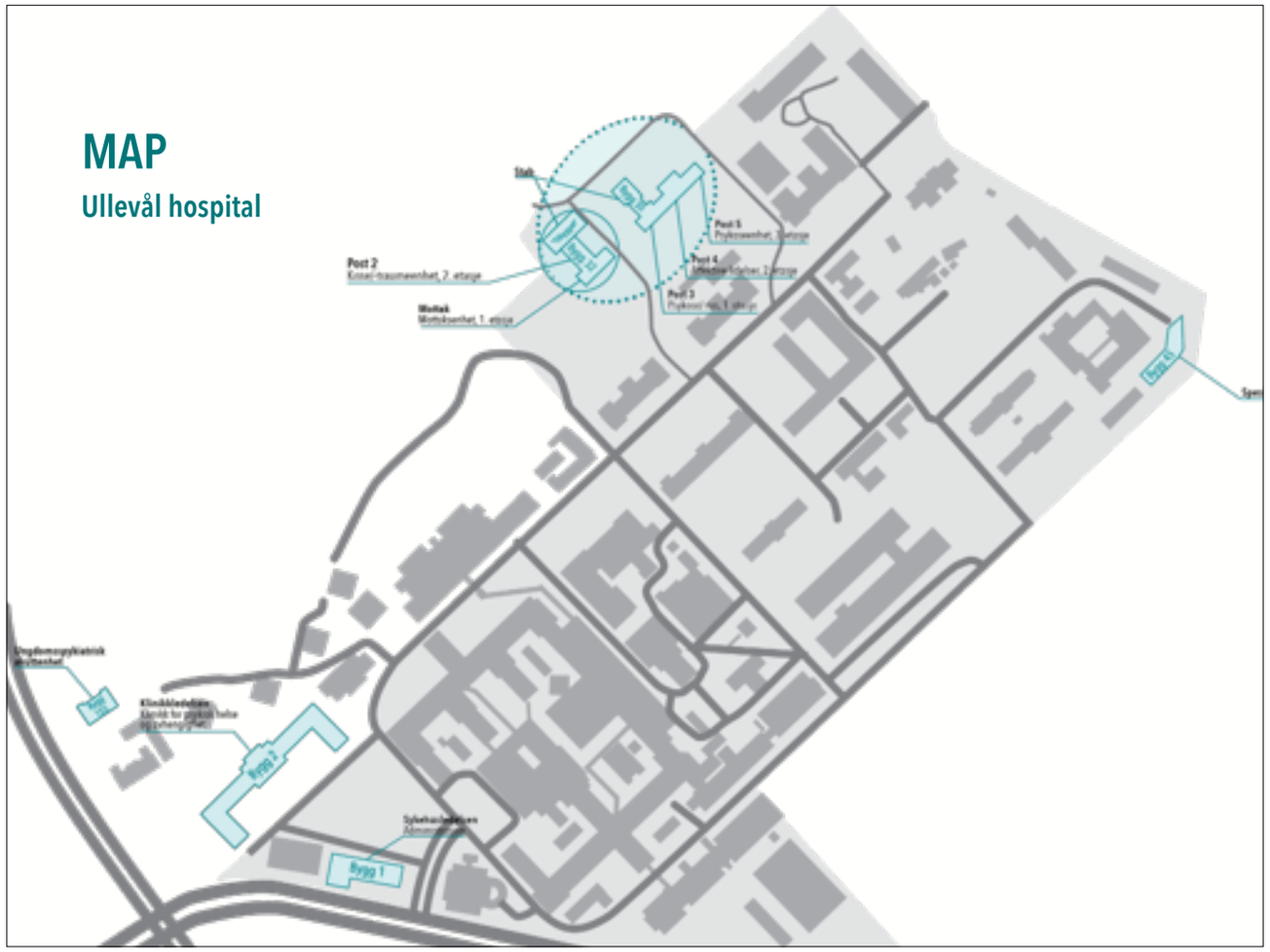
First I'll give you an **introduction** about the project,
I'll briefly tell you about the final **concept** and deliverable,
Then I'll continue to the **process and methods** used
After that I'll tell you about one crucial part of the project, being the examination of the **three perspectives** I worked with
And finally I'll round up the presentation with my **conclusion**.
Now, to the **introduction**



To design for an improved seclusion area in an acute psychiatric inpatient hospital ward it is not enough with only experiencing and understanding the situation in the seclusion area. Firstly, it is about understanding the connections within the seclusion area. These connections occur between the three patient rooms and the rest of the ward with a total capacity of nine patients. The image you see here is the floor plan of the inpatient ward I worked with. The burgundy area is the seclusion unit.



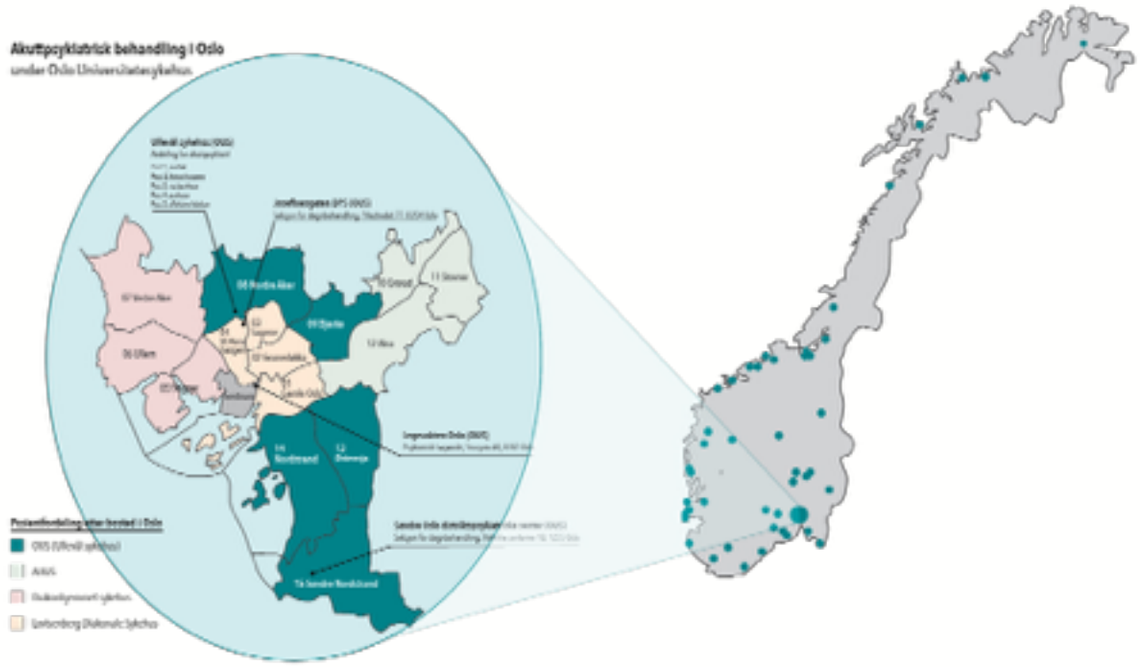
Second, it is about understanding the patients journey that eventually leads to such a situation that seclusion is understood as a way of treating the condition the patient is in, and also the journey afterwards. This area, with the dynamics of people and events was my focus area during the project.



This presentation discusses and explains the process of working with a psychiatric inpatient ward at one of the biggest hospitals in Norway, Ullevål hospital, and trying to improve the seclusion area at their ward.
This image shows Ullevål hospital as a whole, the green buildings provide different sets of psychiatric treatment.

ACUTE PSYCHIATRIC CARE

Regional, and national scale



Ullevål is only one of many units in the whole of the Oslo-region as well as Norway, they all work from a tradition of what mental health care should be and not, as well as regulations towards what who can do, to whom.

Seclusion

After the Mental Health Act § 4-3 first paragraph, it may be decided that the patient should be kept totally or partially separated from fellow patients and from personnel not participating in the examination, treatment or care of the patient.

The terms are that the patient's mental condition or antisocial behaviour makes seclusion required by either therapeutic reasons or for the sake of other patients.

NOU 2011: 9 Økt selvbestemmelse og rettssikkerhet
Balansegangen mellom selvbestemmelsesrett og omsorgsansvar i psykisk helsevern

A seclusion area is a part in an acute psychiatric hospital ward were the main objective is to protect the patient from stimulus that might trigger the patient ´s symptoms and intensify the experience of anxiety, psychosis, mania, suicide thoughts, attempts or other symptoms.

"After the Mental Health *Act § 4-3 says: it may be decided that the patient should be kept totally or partially separated from fellow patients and from personnel not participating in the examination, treatment or care of the patient.*

The terms are that the patient's mental condition or antisocial behaviour makes seclusion required by either therapeutic reasons or for the sake of other patients."

'Psykisk helsevern'

- Specialised hospital departments
- Decentralised specialist District Psychiatric Centers (DPS)
- Private specialists

Helsedirektoratet (The Norwegian health directorate)

Seclusion is a method applied in what we in Norway call "Psykisk Helsevern". This consists of **Specialised** hospital departments, Decentralised specialist District Psychiatric Centers (DPS) and Private specialists. Only the **specialised** hospital departments have the expertise and staff being able to use seclusion.

It is also important to emphasise that psykisk helsevern does not include special units like criminal care or institutions with long term inpatient treatments.

THE TEAM, POST 2

From the inpatient acute psychiatric hospital ward

The collaboration with the ward was been initiated by AHOs design for public services and the “Systems Oriented Design” MA course led by Birger Sevaldson here at AHO. The hospital team was led by one of the Chief doctors at the ward and supported by a team consisting of the unit manager, lead specialist nurse, other chief doctors as well as the chief psychologist and the social worker at the ward. In the workshops several of the nurses at the ward has been included as well as user representatives from the user council.

INTRODUCTION

CONCEPT

PROCESS & METHODS

THREE PERSPECTIVES

CONCLUSION

I will briefly try to give you insight into what the final **concept** was, in order to give you some hooks to hang the rest of this talk on.

In numbers

3 co-creative workshops with staff
- 1 including user representativers

24 Interviews with
- 3 former patients
- 3 user council representatives
- 3 relatives
- 15 representatives of various disciplines from the ward

3 Observation sessions at the ward

In numbers the process can be summarised like this:

3 co-creative workshops with staff

- 1 including user representatives

24 Interviews with

3 former patients

3 user council representatives

3 relatives

15 representatives of various disciplines from the ward

3 Observation sessions at the ward

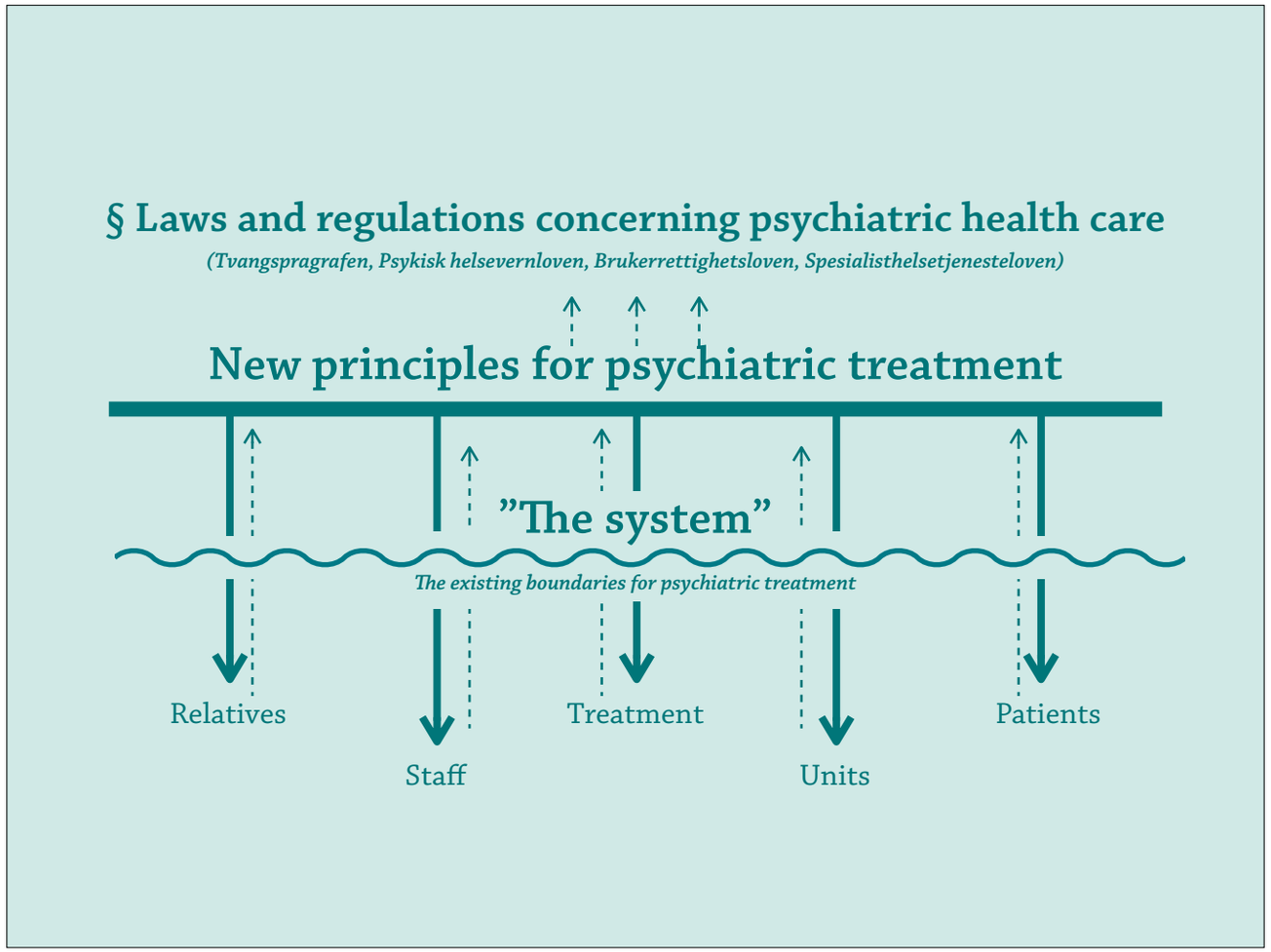
Ten principles for a human oriented psychiatric treatment

1. It is firstly about getting the space, and time, to be a compassionate human being.
2. Create an open and safe environment with space to relax and feel at home, despite it being a temporary place to be.
3. Give clear and consistent information in an understandable language and explain why rules and routines are as they are.
4. Clarify expectations, be open and honest about the treatment and what you can achieve but also what you can not achieve.
5. Explain and repeat important information and give it in writing so that it can be read later on, and shared with others.
6. Stick to agreements. If an agreement has to be canceled explain in a clear way why it had to be like that.
7. Listen, be considerate and acknowledge worry and turmoil, usually there is a reason why it exists and that it is being expressed.
8. Provide training in the shape of guidance and instructions to make it possible to make qualified choices, and open up to different perspectives to psychiatric treatment
9. Open up to different ways of treatment, make it possible to have a freedom of choice and strengthen the understanding of own situation and ability to influence.
10. Make room for privacy and a varied selection of physical and creative activities, as well as participation in everyday tasks.

The main delivery of this project were ten principles for a human oriented psychiatric treatment. These were created based on the insights from all the research done, and aim to include patients, relatives and staff as a whole in the future of psychiatric care.

During the project I worked with Daniella Meadows Leverage points on where to intervene in a system - to orient the deliverables, and reflect on where their impact might fit.

The principles are placed on the top where the goals of the system, and also the paradigm for which the system is grounded on.



The idea with the principles is for them to operate on a system level like this.

The main parts of psychiatric treatment today is **patients**, **relatives**, **staff**, **treatment** and the **units**.

Above that we have the **system**, which is the existing boundaries for psychiatric treatment such as administration, budgets and bureaucratic routines creating the service of psychiatric care.

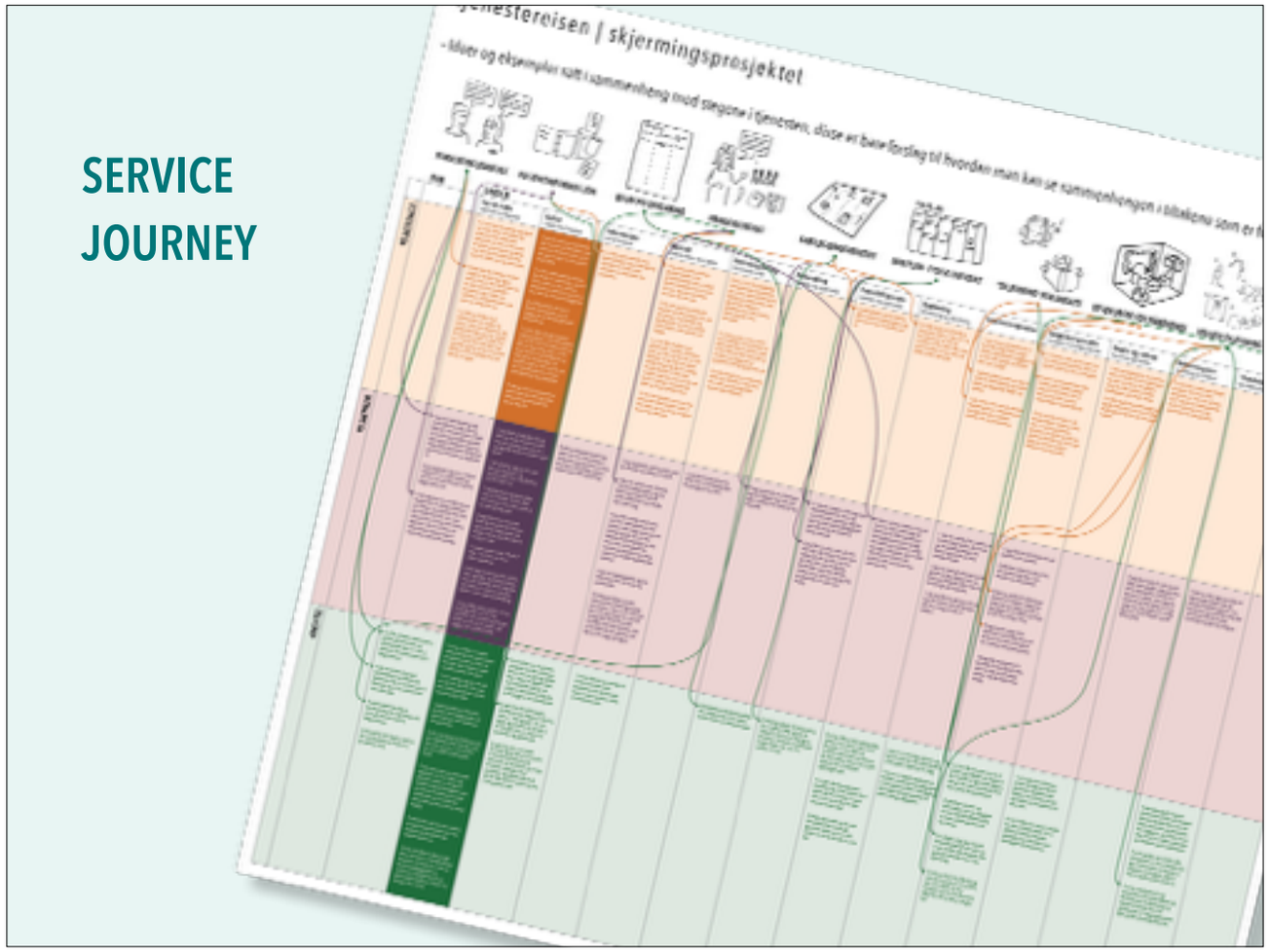
On the top resides the **laws** and regulations concerning psychiatric health care defining how the system organism behaves today.

The **principles** will be positioned **in-between** the system and the laws as they are today with the purpose of changing how we do in the daily practice, by considering the boundaries we have today, but also challenging them through the principles.

These will again shape the system defining the future psychiatric treatment and finally they will impact the laws and regulations.

Supporting material was developed to record the process and help the team design onwards after the end of my project. This is the Ward wiki, with information on all participants and their excellent skills and expertise.

SERVICE JOURNEY



A service journey connecting ideas and principles with patients, relatives and staff, to help the project team gain an overview of the process we had together, and easily pick ideas and things to improve on.

INSIGHT BOOK

An finally an insight book explaining the principles in detail, and recordings of the wards different wishes for the future of the project.

These three tools are operating at a lower level, with content relevant for the ward, aiming to facilitate a smoother process for the project team when developing the project further.

The ward got funding this summer and is now continuing the project in collaboration with Design for public services at AHO, and will be using the tools in the coming project.

INTRODUCTION

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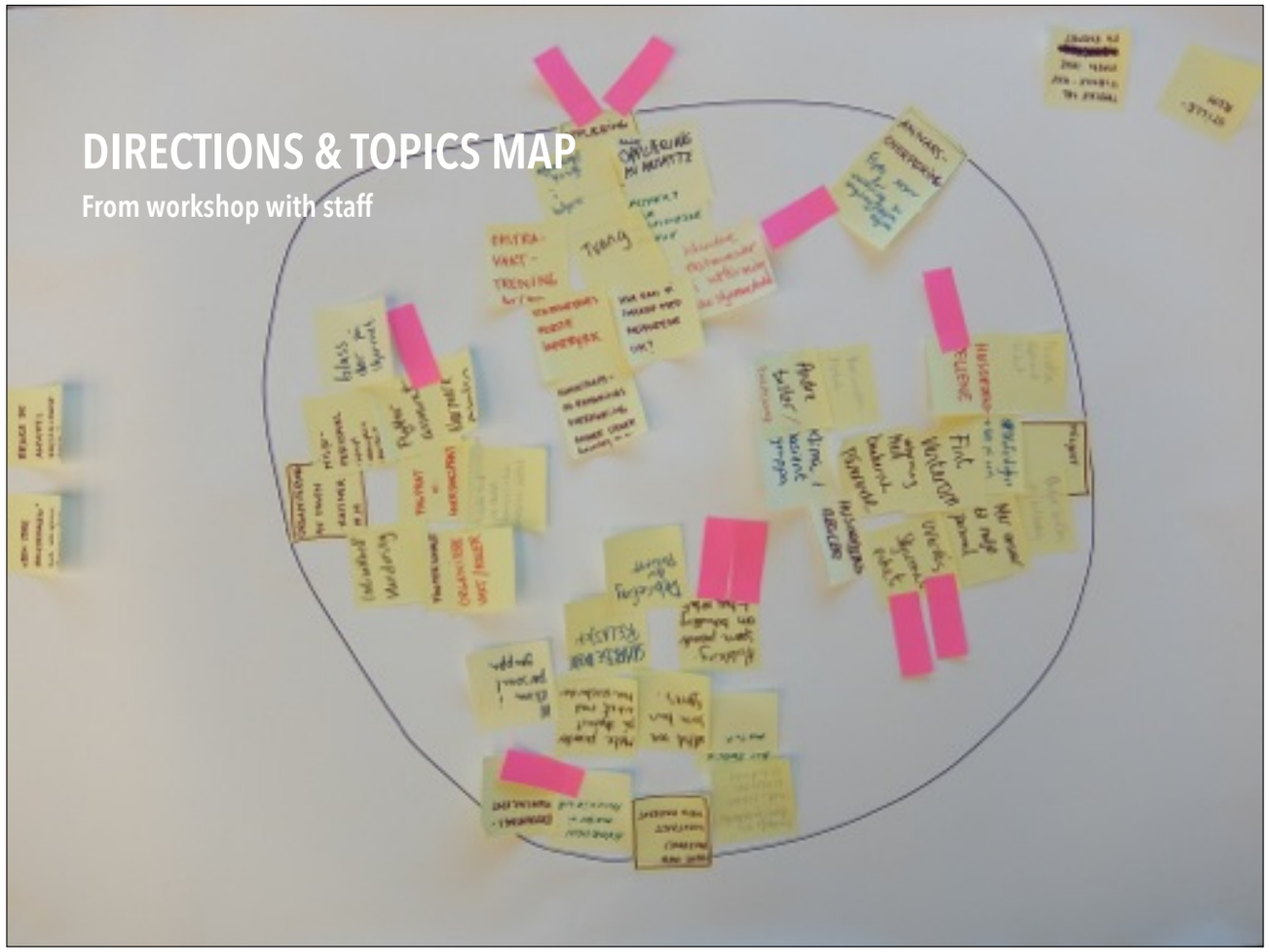
Now that you know the concept delivery I'll tell you about my **process** and the methods used.



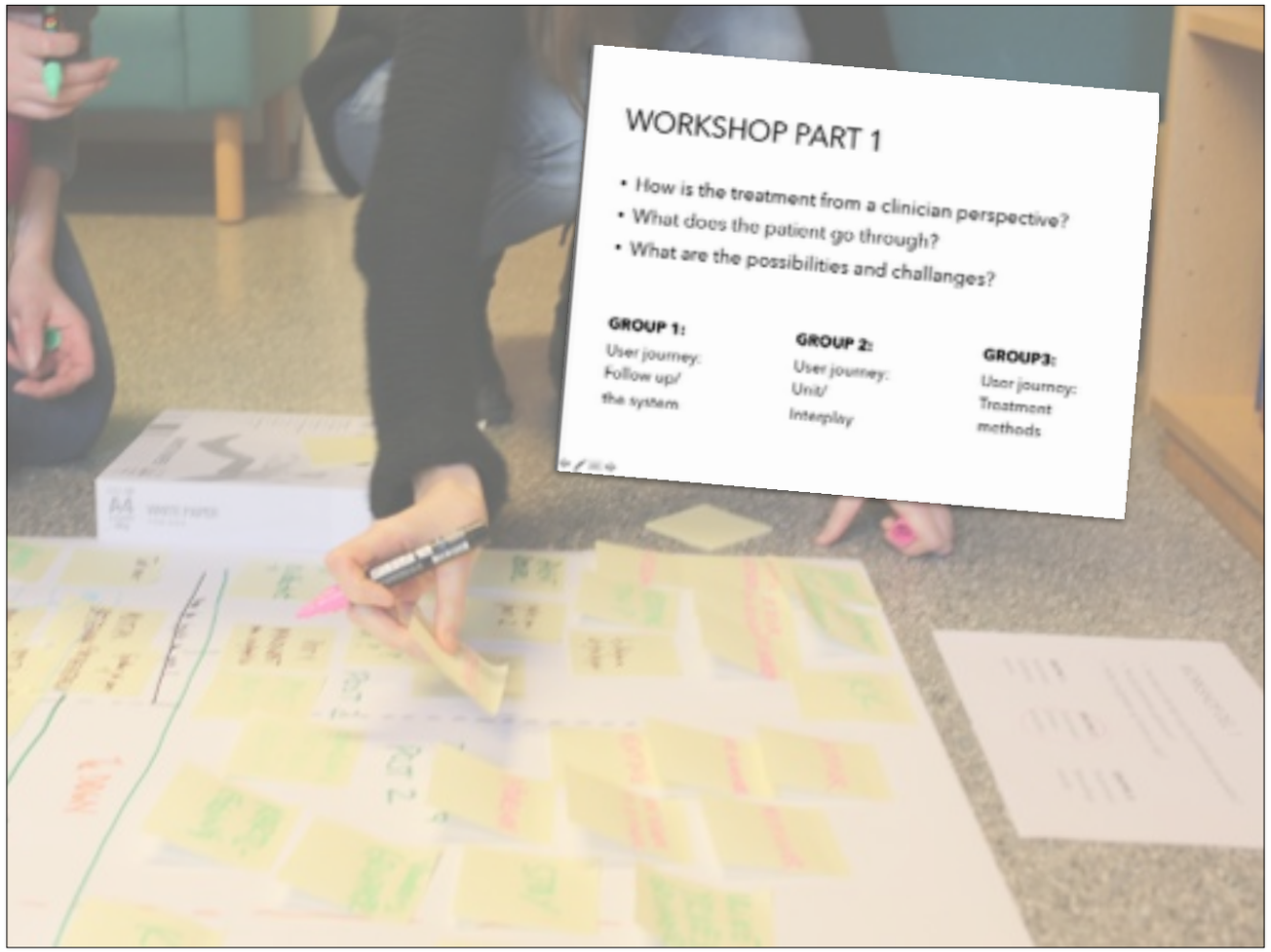
DIRECTIONS & TOPICS MAP

From workshop with staff

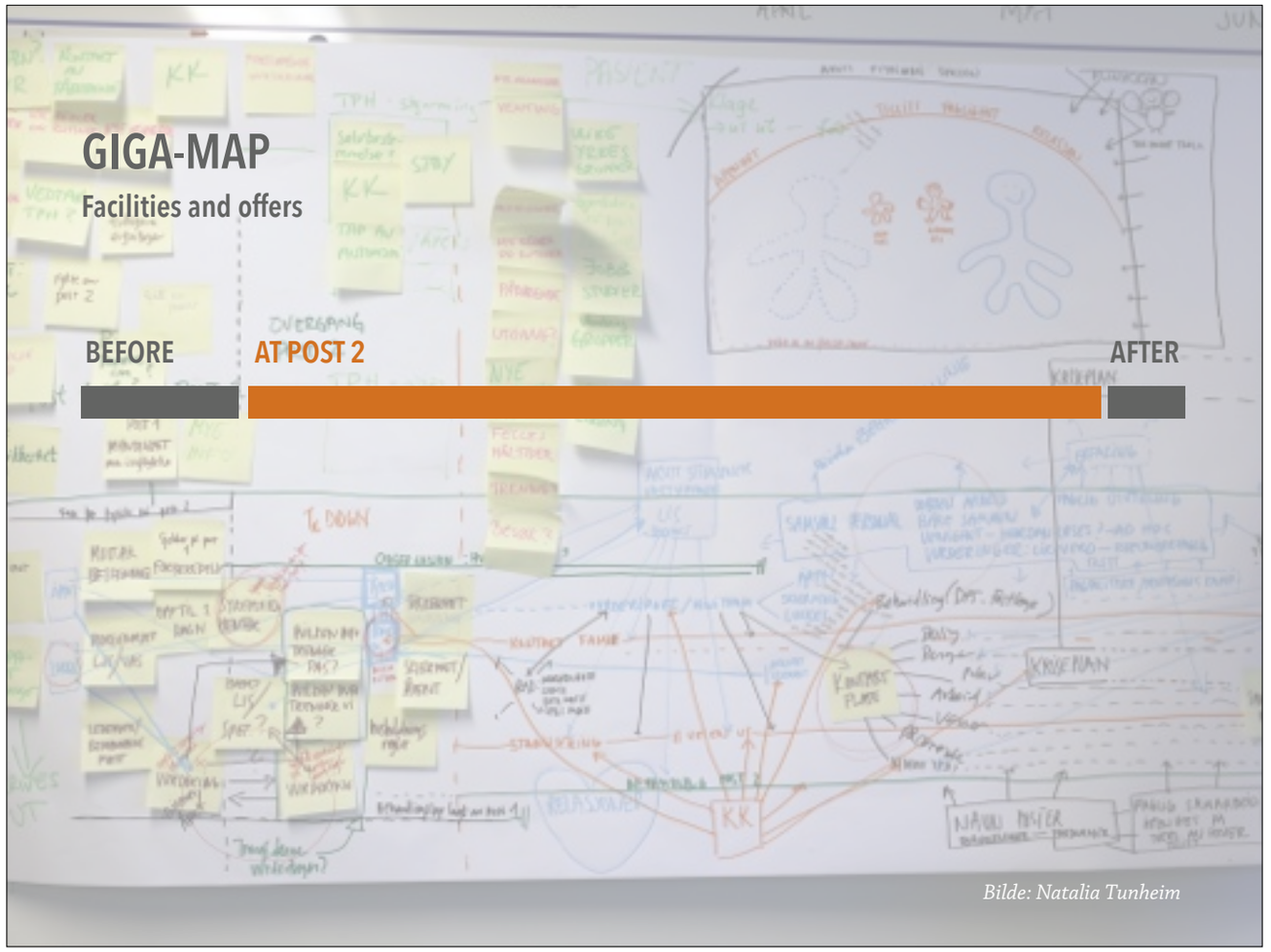
During this project I have led an explorative service design process with a Systems Oriented Design (SOD) approach using my familiar service design tool box in addition to Giga-Mapping, to examine and get the big picture of what seclusion is. During the research and insight phases I have used the patient journey, or user journey, as a timeline to map out the relevant points regarding seclusion with both staff at the ward and patients and users.

PROCESS & METHODS – Mapping with staff at Post 2

The first part consists of the mapping with staff at Post 2.



The mapping exercise with Post 2 took place in a workshop setting in which I shared insights from the process so far, and divided the participants into three groups with managers, doctors, nurses and one designer in each group. Besides a big paper and markers each group where armed with a scenario of a typical patient at ‘Post 2’ and a specific topic. The topics were important to reveal different perspectives.



Bilde: Natalia Tunheim

Each group had a different topic and a different scenario, and was facilitated by three different designers opening the conversation by asking about the user journey. One obvious point while looking at the maps in retrospect is how all of them are concerning **the point** in which the patient arrives at the hospital and the emergency reception and through the stay at the ward. Because Post 2 has some impact on the treatment that follows after staying at the ward, some of the maps also cover parts of the recovery

"We want to look into how to improve the seclusion area in the acute psychiatric hospital ward, and design for a dignified experience that enhances the patients sense of dignity, despite the inhumane situation they are in."

Acute psychiatric team at 'Post 2', Ullevål Hospital (a part of Oslo University Hospital)

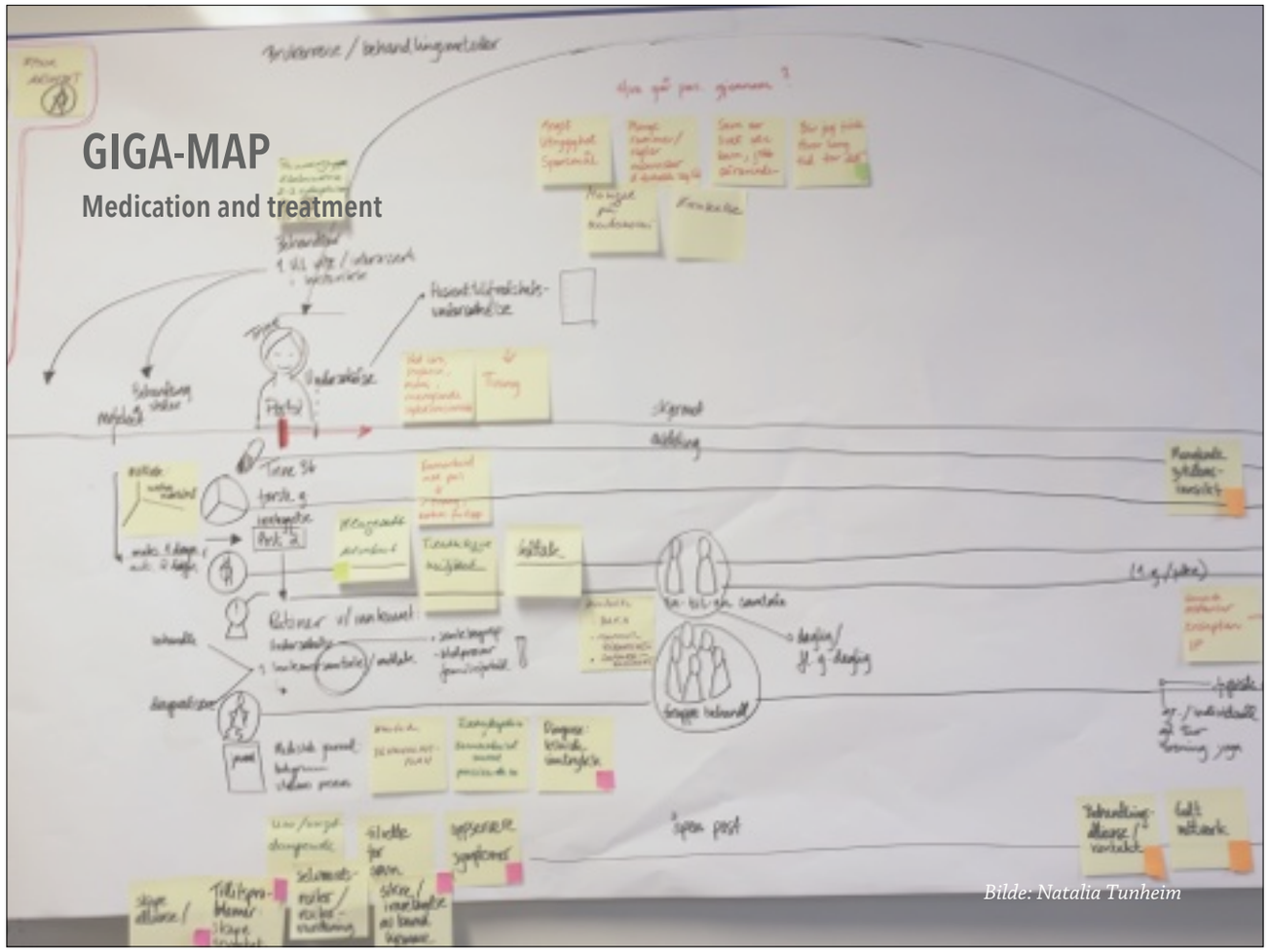
Here is a quote from the team about what they wanted to do in this project. It goes as follows:

We want to look into how to improve the seclusion area in the acute psychiatric hospital ward, and design for a dignified experience that enhances the patients sense of dignity, despite the inhumane situation they are in.

Which brings me to an interesting point, that even though the well-being and dignity of the patients experience is the topic discussed…

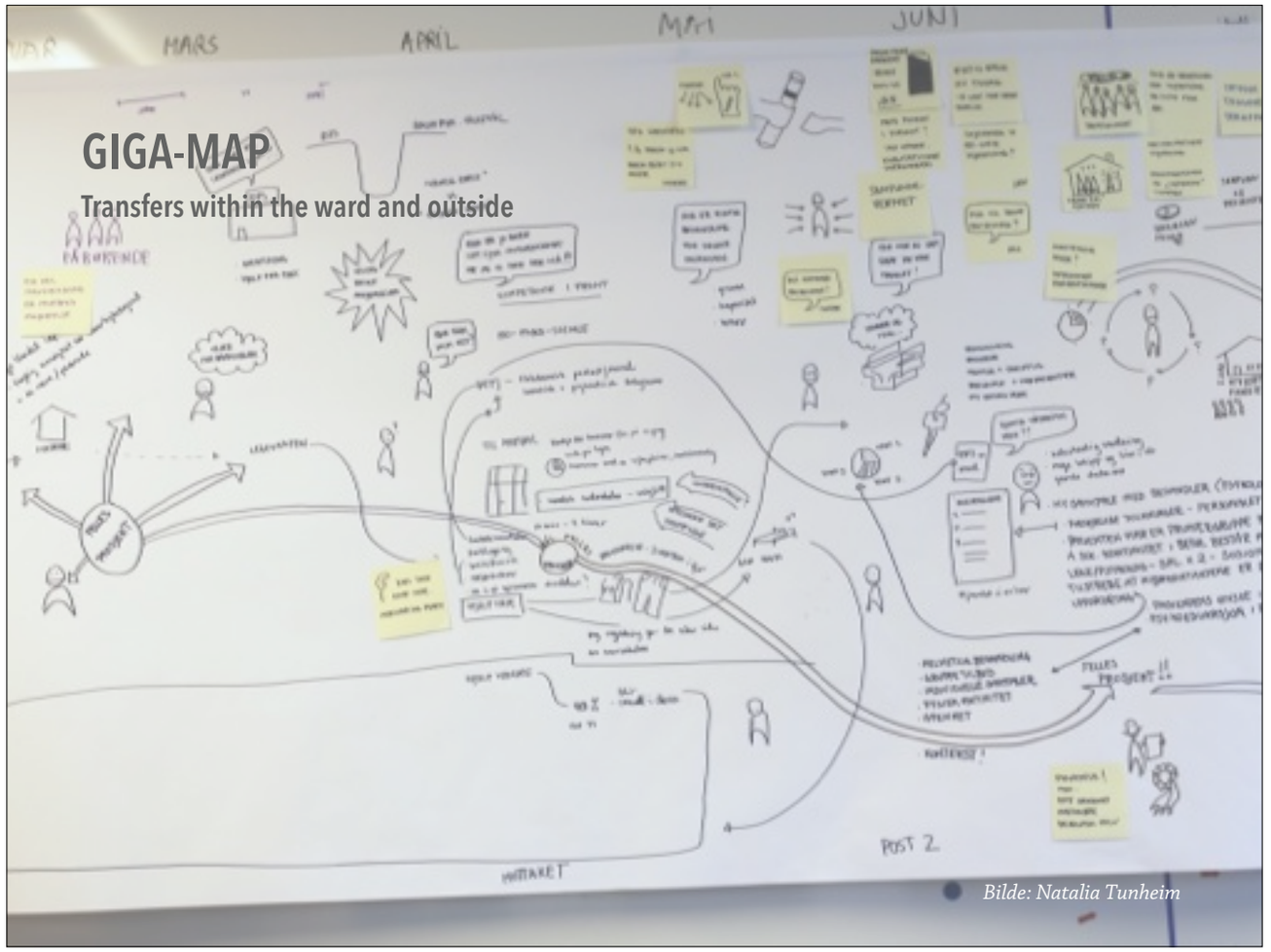
Bilde: Natalia Tunheim

…the logistics and emotional and ethical issues the staff is facing everyday is the content of the giga-maps created by the staff. An important insights from this observation is that as long as the operations on ward level are as they are, it is difficult for the staff to lift their view towards the making the whole experience more dignified, because the everyday doings must be done at all times, and their dynamics shape the amount of dignity given to patients in care.



Bilde: Natalia Tunheim

This is another map created by a similar set of diversity within the professions. The topic here was the medication and treatment methods offered. It looks different but like the first map, it starts and stops with reception and discharge.

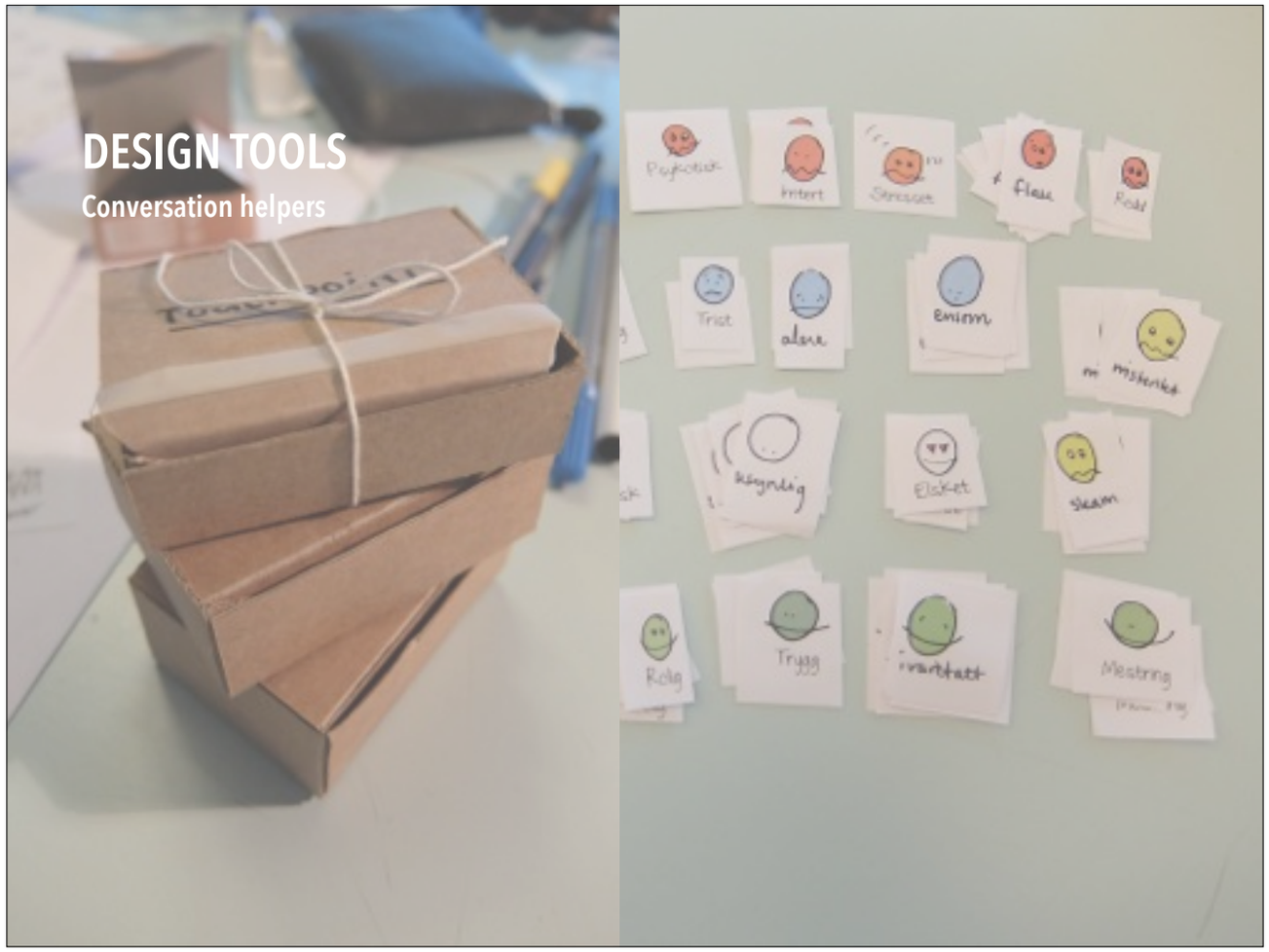


Bilde: Natalia Tunheim

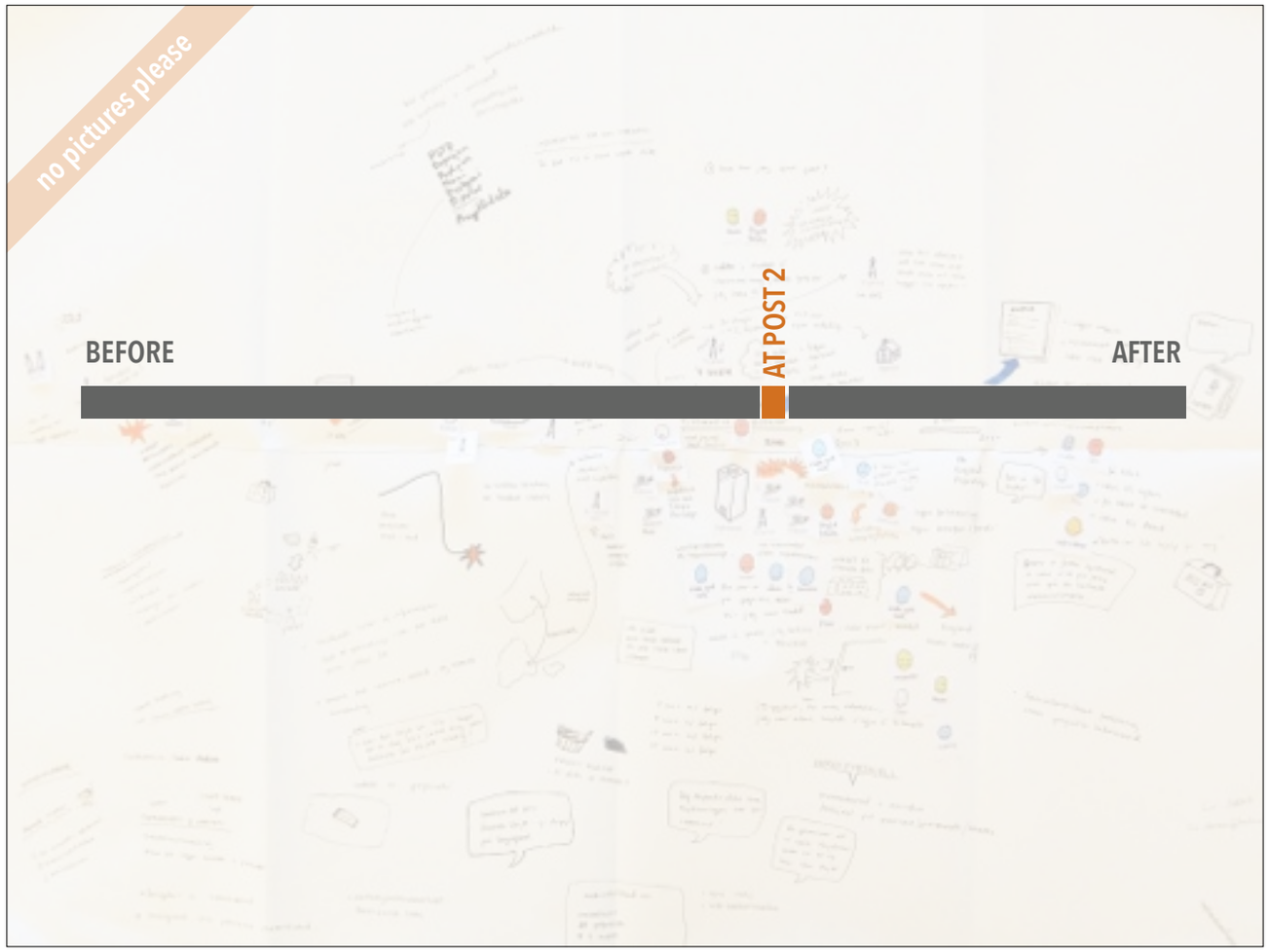
Finally the three different maps were very different, but they all contained elements of the same themes even though they had different topics. The groups itself has largely contributed to define the theme of the conversation and the maps uncovered similar points among the groups that proved to be important for the staff.

PROCESS & METHODS – Mapping with patients and relatives

Now, a look into the process of mapping with patients and relatives

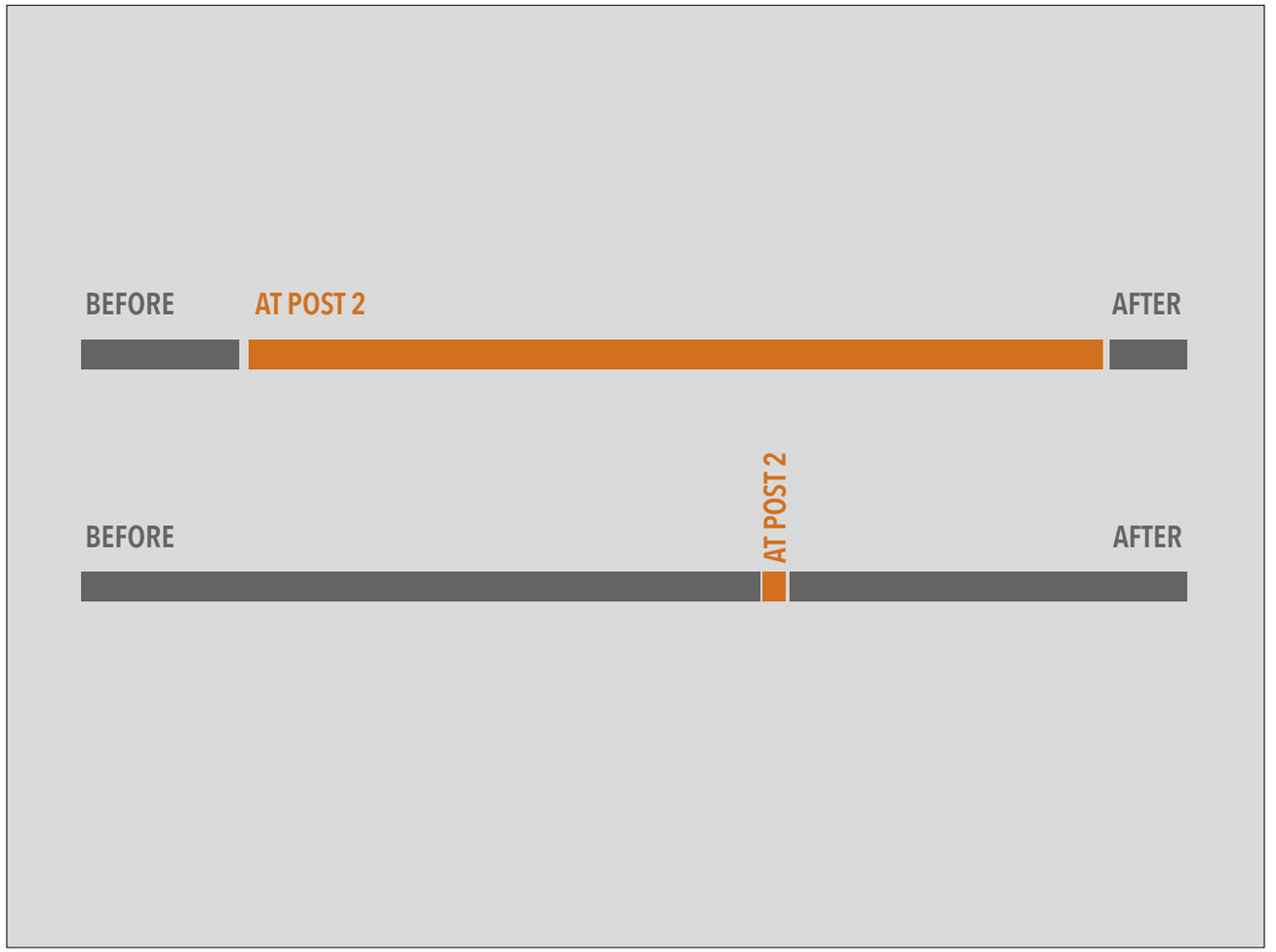


In order to map out the users and affected relatives experiences I developed a toolbox with a set of small notes with relevant actors, touch-points and feelings on them. These were intended as conversation and memory triggers as well as visualisations to add onto the journey as we collectively drew it onto a big white paper.



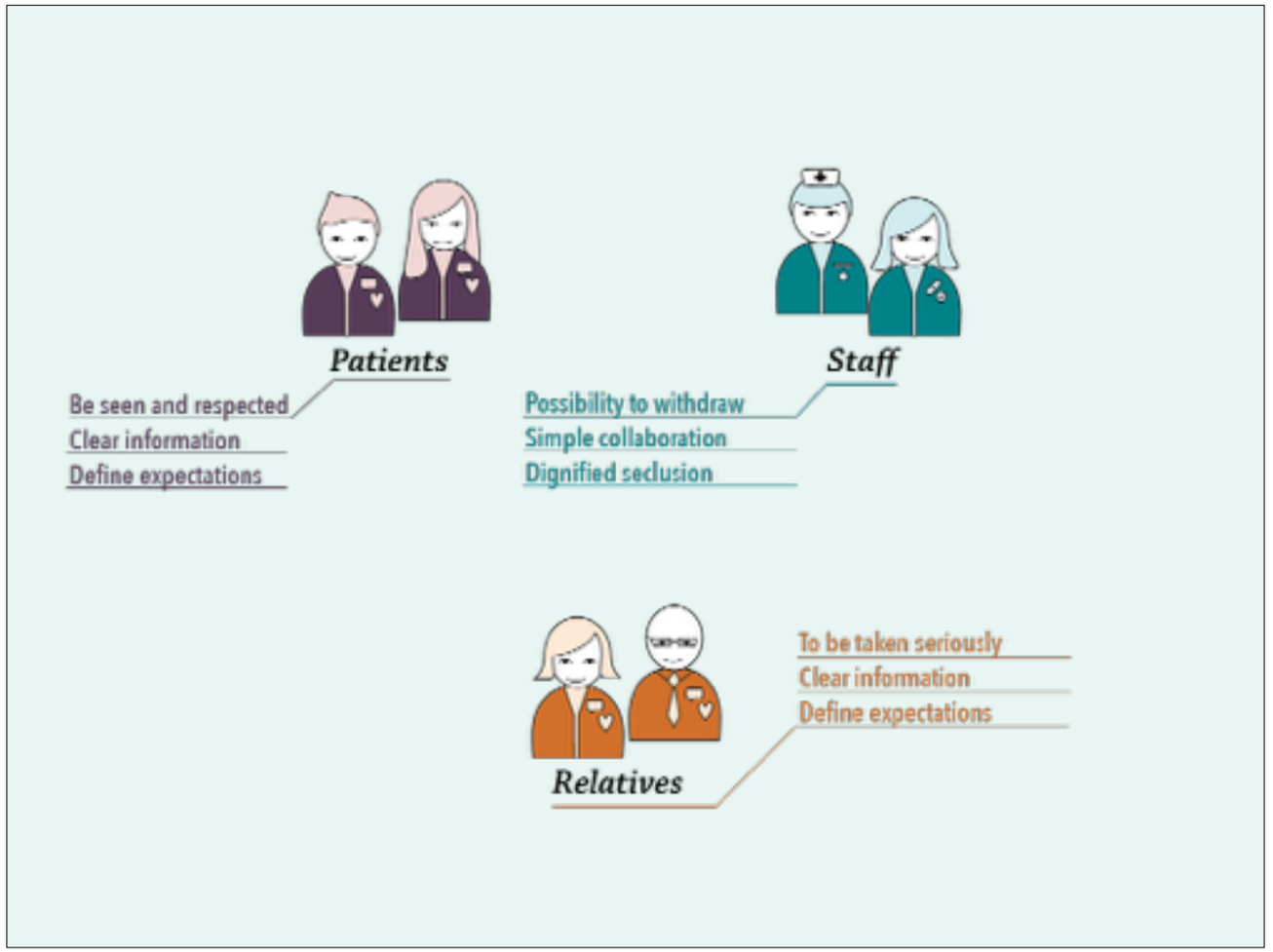
While mapping with users, it became obvious that their story contained not only the experience in the seclusion ward, but their whole life and all incidents connected to their illness, leading up to, and continuing after being in seclusion. In fact, the seclusion experience was a **small** part of their life, but left a big impression afterwards.

When I mapped with the affected relatives it was a very similar scenario as with the users, the biggest difference was that their story circled around their ill relative and the relative's experiences regarding the illness. Also here, every aspect of the illness from starting to see signs that something was not right and all the way to being in the hospital ward was included.



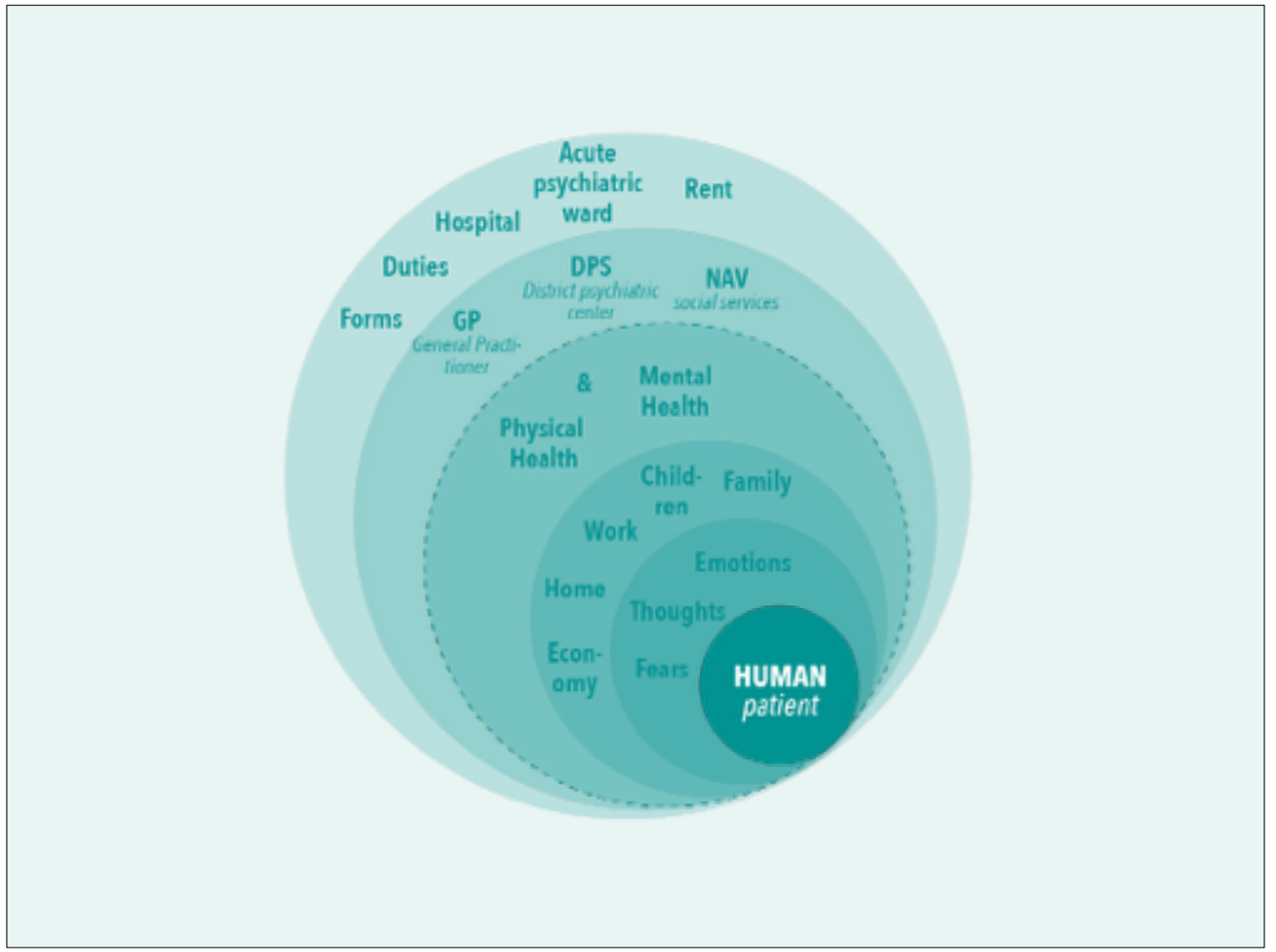
Together the contrast between staffs orientation towards mental health and the patients and relatives orientation is striking.

Now let’s look at the different aspects of these **perspectives**.



Using the same tools to map out the same topic with three different actors helps surface a varied and holistic perspective on the different needs that has to be taken in to consideration in a seclusion unit, but mostly it has highlighted differences in points of view that patients, relatives, and the staff at the ward have.

For patients and relatives the illness touches upon every aspect of their life, and takes big and small parts a long with everything else that is important in a human's whole life. For the staff however it is the time at the ward that is the important focus because that is the aim of their work and their mandate towards the patient is only valid while being at the ward.
I'll try to explain a little further.

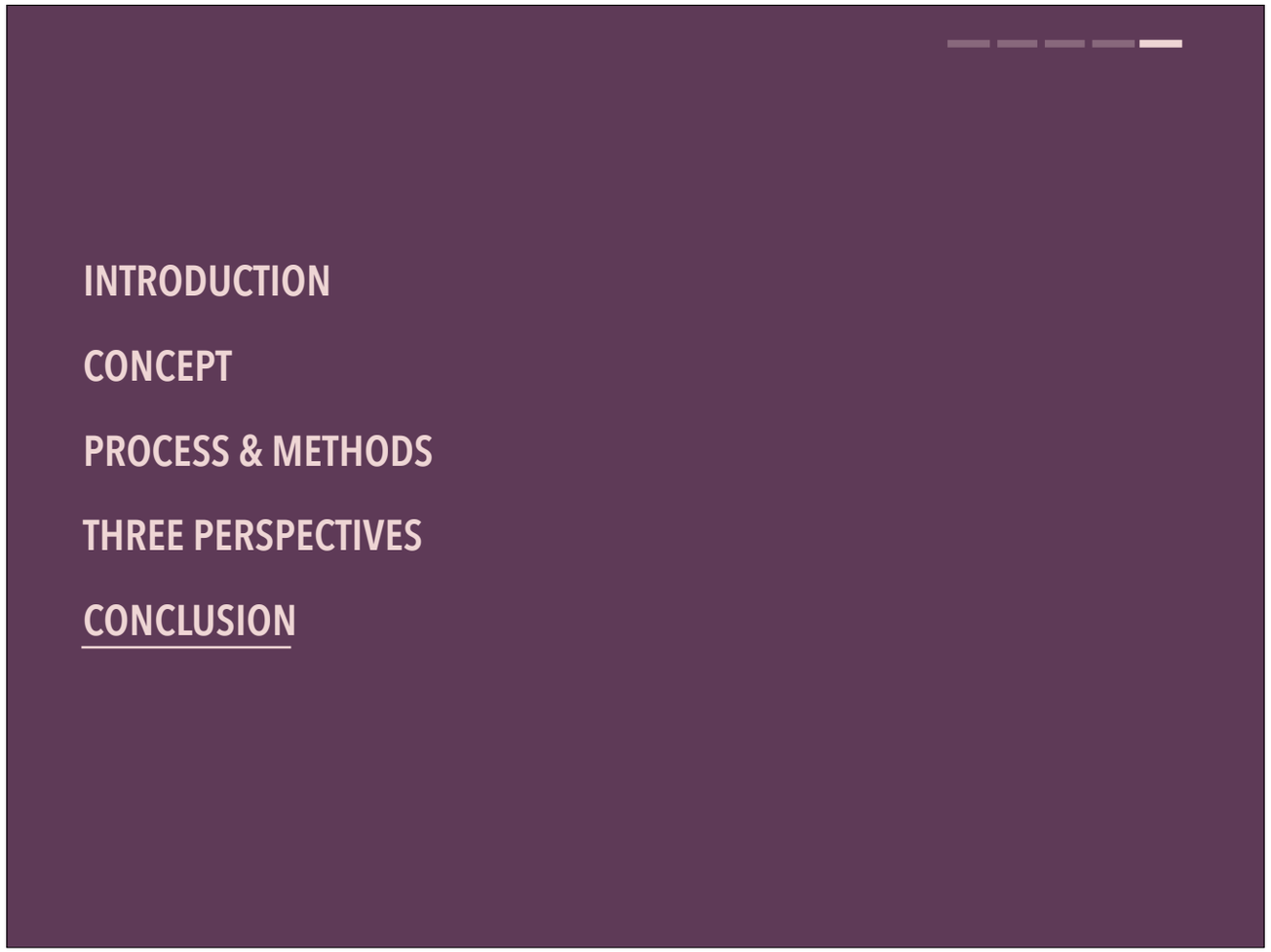


The first perspective is the **human,** becoming a patient, or a relative. Closest to the human is their **emotions**, thoughts worries and fears. Next to that comes **family** issues, maybe there are children involved and **other** practicalities and **so** it **continues**. In everyday life, but also if we get sick, issues of health, medical help and social services are not at the top of our mind. This is the mental state that a person, human or a patient has, also when arriving in mental health care, maybe even more so, because of their vulnerable situation.

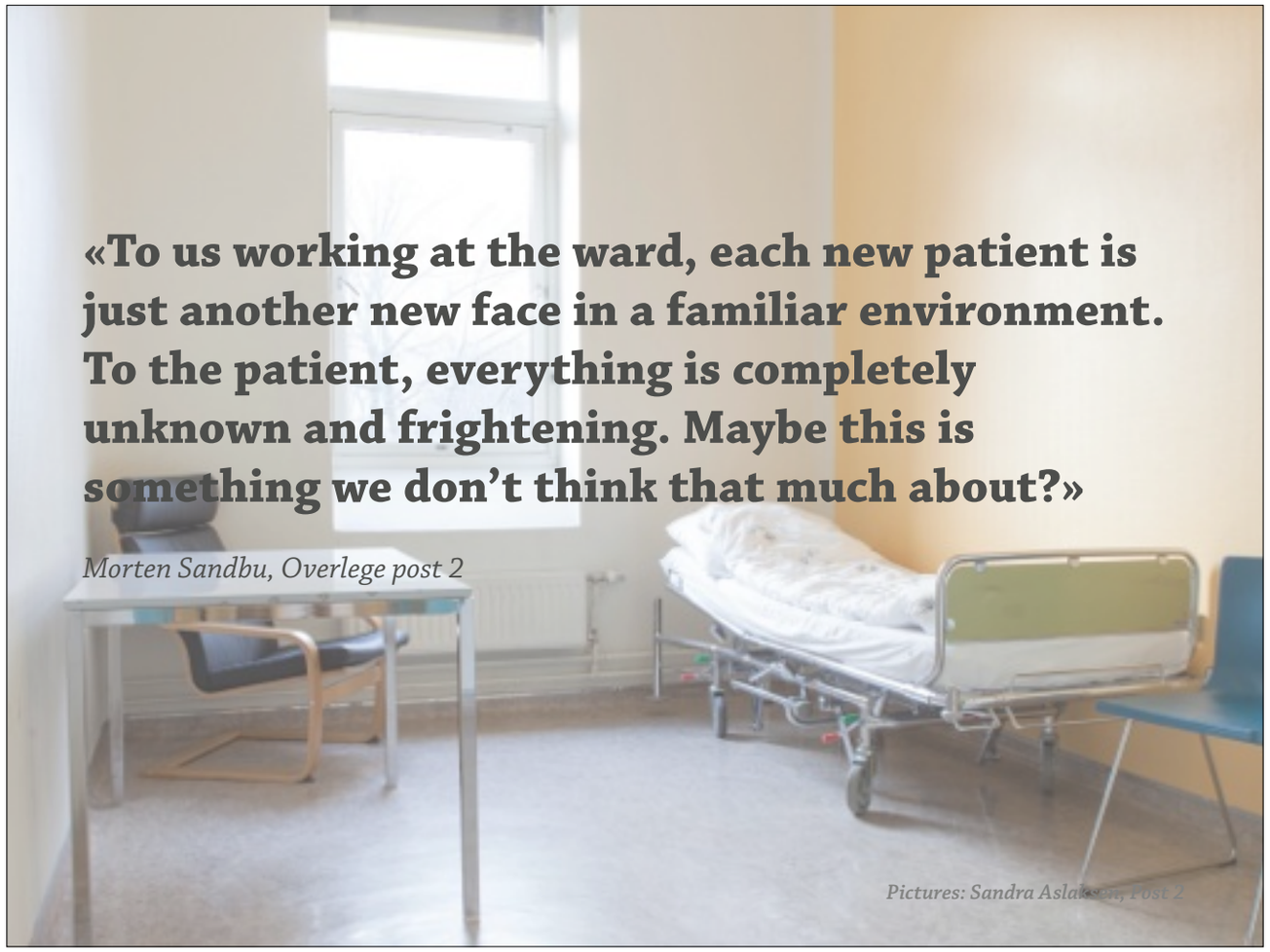
When being **admitted** to a hospital ward you shift from being a **human** to being a **patient** with a diagnose.

And you enter a system that is very much focused on curing the patient of it's diagnose, but it can be hard to be a person with everyday concerns when an organisation such as this, tries to cure you from their perspective. **These** are the **layers** of the **exact** ward I **worked** with, **from** the **direct** patient **contact** to the **top** political and administrational level in Norway.

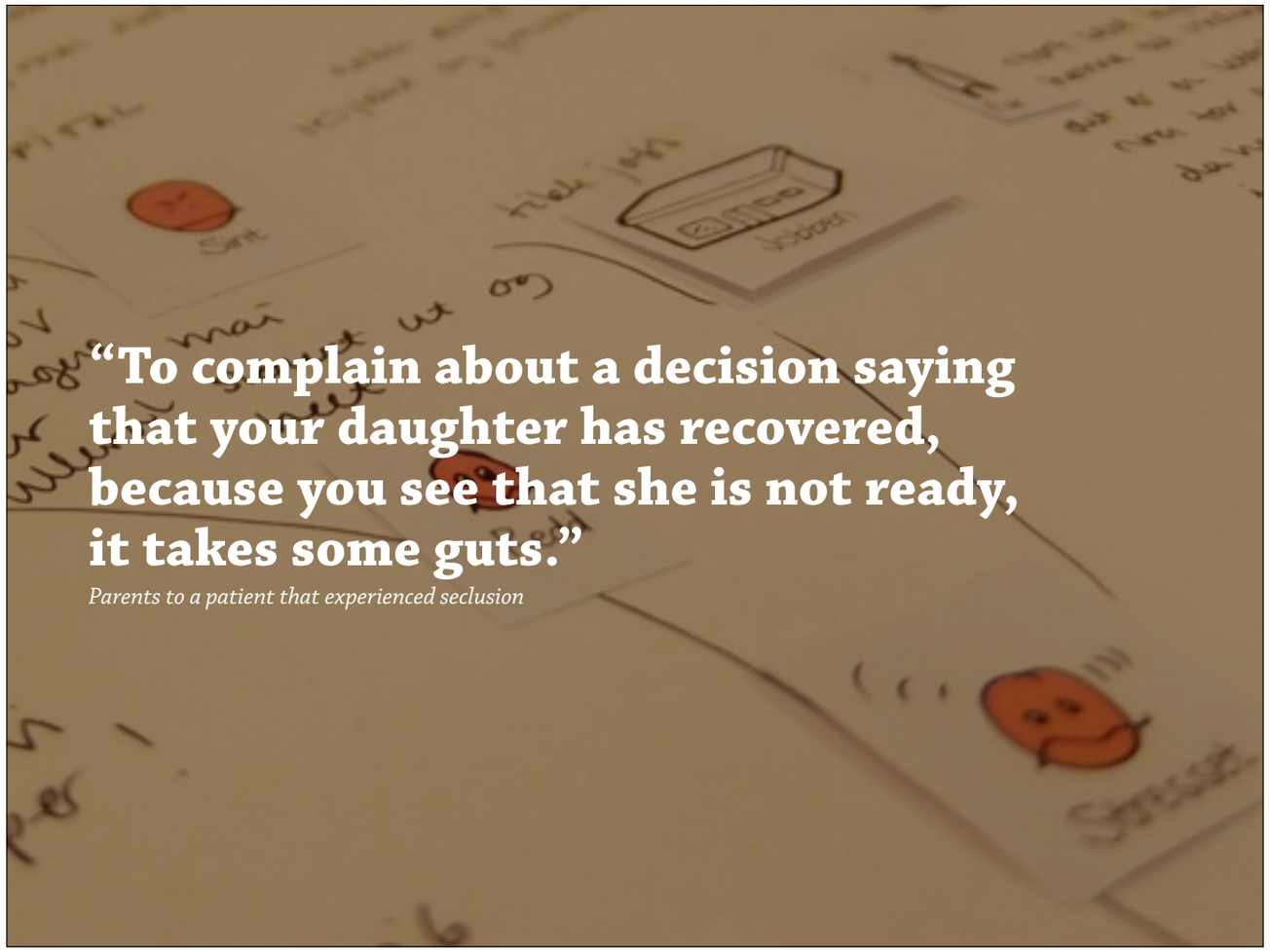
These two diagrams aims to show why patients and staff end up in conflicting relations, by visualising what is important to them, in which order, and what are the boundaries that are around them making some things impossible.



So over to what I call the **conclusion**.



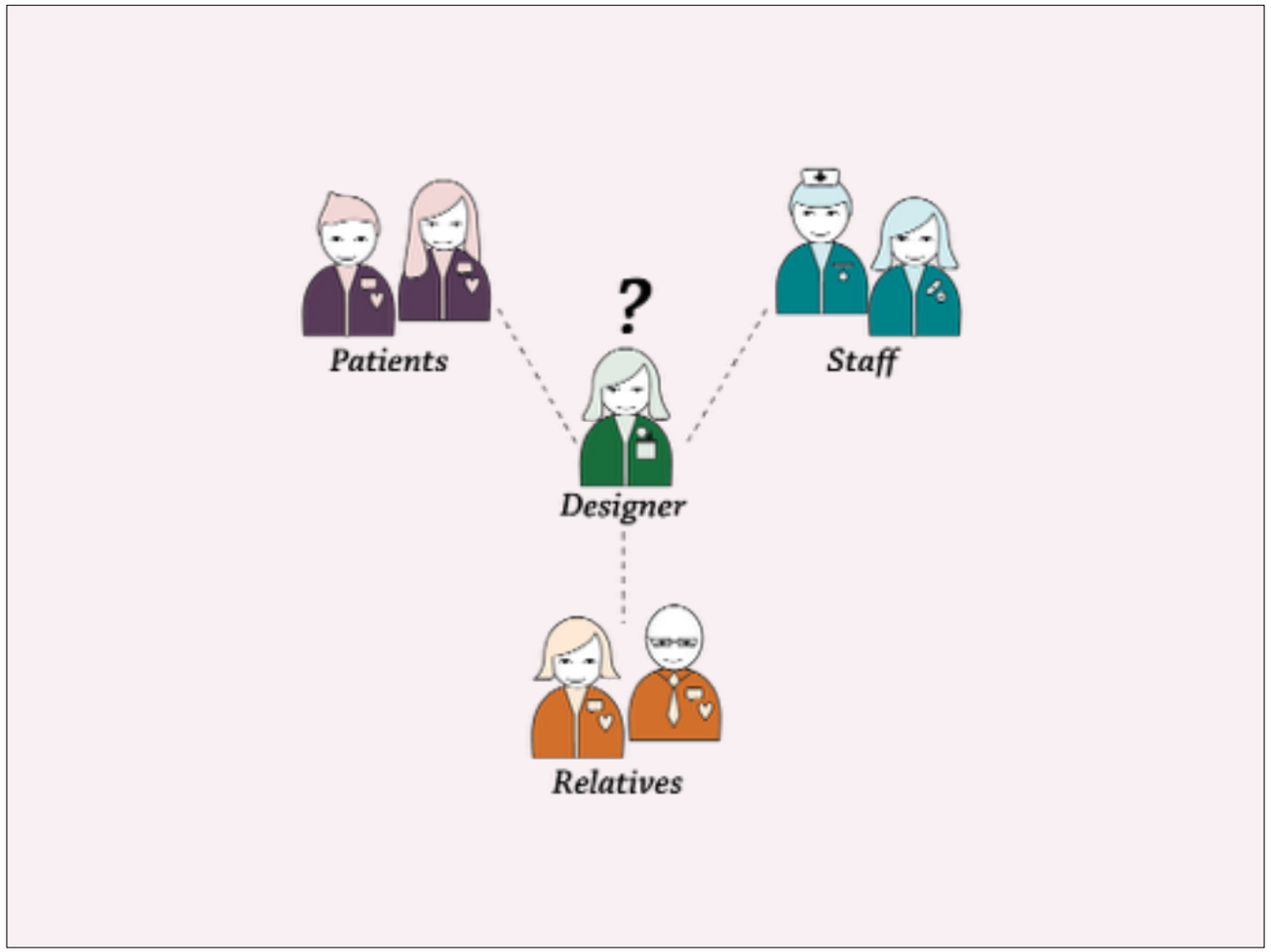
In this project it has been crucial to speak with several different actors in order to understand how the situation really is. If I had spoken only with the staff at the ward, my insights of acute psychiatry would have told a story about staff that struggle to give good care, but despite the situation are able to, day after day, and always with a smile and respectful tone. I might have almost left them, trusting that they don’t really need any change at all.
To illustrate that I have a quote from one of the chief doctors at the ward.
To us working *at the ward, each new patient is just another new face in a familiar environment. To the patient, everything is completely unknown and frightening. Maybe this is something we don’t think that much about?*



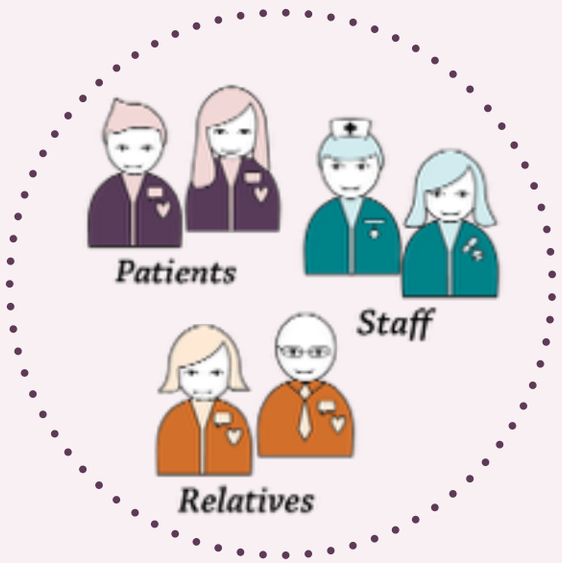
If I had spoken with the relatives or patients alone, my insights would have been more similar, but they would tell a story of some times horrible personnel at the ward, and no respect towards them as human beings. My project would then be circled around revolutionising the system as it is today, and ban it all together!

As this quote clearly puts it:

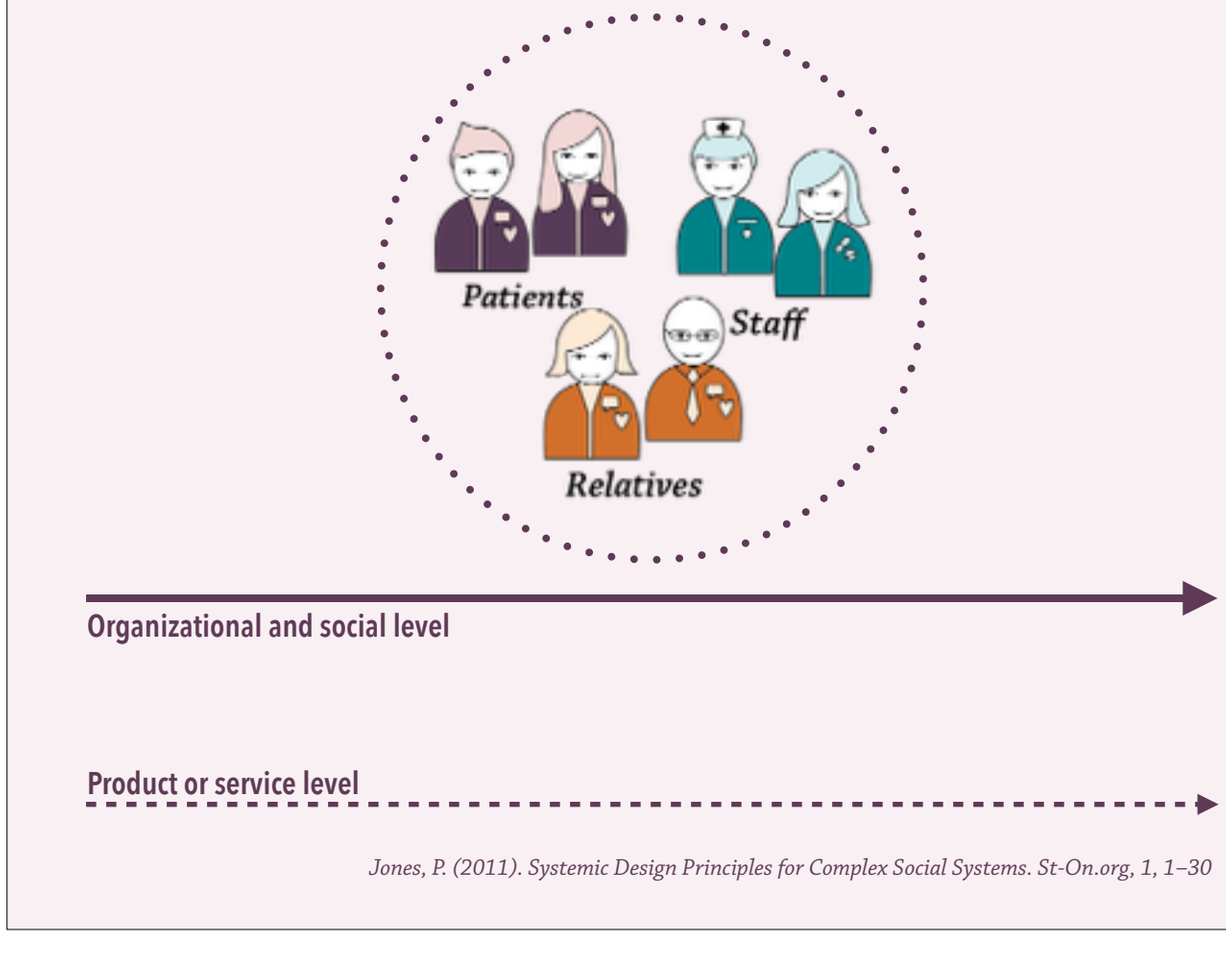
To complain about *a decision saying that your daughter has recovered, because you see that she is not ready, it takes some guts.*



Being put in the center of these three perspectives has been the cause of a rather heavy design process and the main source of confusion. It is very hard to get stories from different actors that are so different in the experience of the situation and through that, to try to find a direction that takes them all into consideration.



Thankfully my insight process with patients, relatives and staff produced an overview of the challenges they all meet, and through this I was able to **see** that the **three** users **all** had to be in the **center** of the design, and be taken into consideration with all aspects of the mental health care practice.



Jones, P. (2011). Systemic Design Principles for Complex Social Systems. St-On.org, 1, 1–30

With this insight at hand it became **obvious** that a design proposal had to be delivered on a **organizational** and social level, rather than on a product or **service** level even though acute psychiatry is a service. Because it is not the service per say that is the problem – it is the system boundaries surrounding the people that causes stress and undignified experiences.

THANK YOU!

Please feel free to comment and ask questions! **Thank** you very much!

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