Briefing –
Buildings Speak to Us: The need for Trauma informed environments

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This briefing is relevant to anyone who wishes to make a positive contribution to the recovery and care outcomes of people impacted by trauma, and to the wellbeing of the staff who support them.

Key points:
Buildings which are trauma informed are healthier to work in and can be seen as part of the health offer for service users. Environments can be hostile to healing and wellbeing – this can impact negatively and be costly to recovery, staff wellbeing and the operational delivery of care. This briefing calls for more consideration of how environments and their design are part of the landscape of healing and recovery.

You are invited to consider the following questions within your service:

- What is the experience of your estates by staff and service users?
- If you don't know, how can you find out?
- How do trauma informed values translate into the way the estate is designed, shaped and co-produced?
- Are your estates team meaningfully involved in your organisation's Trauma Informed Strategy, and are they trained in trauma informed principles?
- Do your physical spaces help service users to feel psychologically and physically safe and reimagine their circumstances and recovery in positive ways?

We hope that reflecting on some of these questions may open up a *space for change*.

1. Drivers for considering care environments

The NHS Long Term Plan highlights the importance of trauma informed services and providers will now be revisiting their estates in a way that perhaps only happens once every 10-20 years. It is a critical time to be thinking about how to use environments in ways that facilitate healing and wellbeing.
https://www.england.nhs.uk/mental-health/adults/cmhs/

People who have suffered childhood or adult trauma, can be re-triggered into distress by environments that are not adapted to their needs around trust, boundaries, safety and grounding.
See Sweeney et al 2018 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6088388/

There is evidence that placemaking can have important and positive health outcomes.
See Russell, C. March 2020
https://www.ryderarchitecture.com/insight/spatial-inequalities-in-health-and-wellbeing/

Environments affect how we feel and behave. They can be part of a therapeutic offer.
See Maggie's centre examples:
https://www.maggies.org/about-us/how-maggies-works/evidence-and-research/

http://maggies-staging.s3.amazonaws.com/media/filer_public/37/b9/37b933c0-5ed6-4761-9a1b-ba48dbd516c1/silent_carers_-_architecture_and_gardens.pdf
The converse is true – environments can be hostile.
https://www.nytimes.com/2019/11/08/nyregion/hostile-architecture-nyc.html

https://www.theguardian.com/society/2015/feb/18/defensive-architecture-keeps-poverty-undeen-and-makes-us-more-hostile

It is possible to design spaces which can improve our mental wellbeing. See Channon, B. (February 2019) Designing Buildings to improve mental health. The Planning BIM and Construction Today website, DOI:https://www.pbctoday.co.uk/news/building-control-news/buildings-improve-mental-health/51625/

Designing wellbeing into buildings includes the impact of light, ventilation and bringing the outdoors in or 'greening' spaces. See Howard, B.C. (2017) 5 Surprising Ways Buildings Can Improve Our Health, *National Geographic,* DOI: 5 Surprising Ways Buildings Can Improve Our Health

2. Beliefs into decision making

Within mental health, there may be unvoiced or voiced beliefs which shape decisions about buildings. These may variously concern respect and empowerment; security and risk; freedom and choice; integration.
For an example see: *Curtis, S. et al. (2007) Therapeutic landscapes in hospital design: A qualitative assessment by staff and service users of the design of a new mental health inpatient unit. Environment and Planning C, 25, 591-610.*

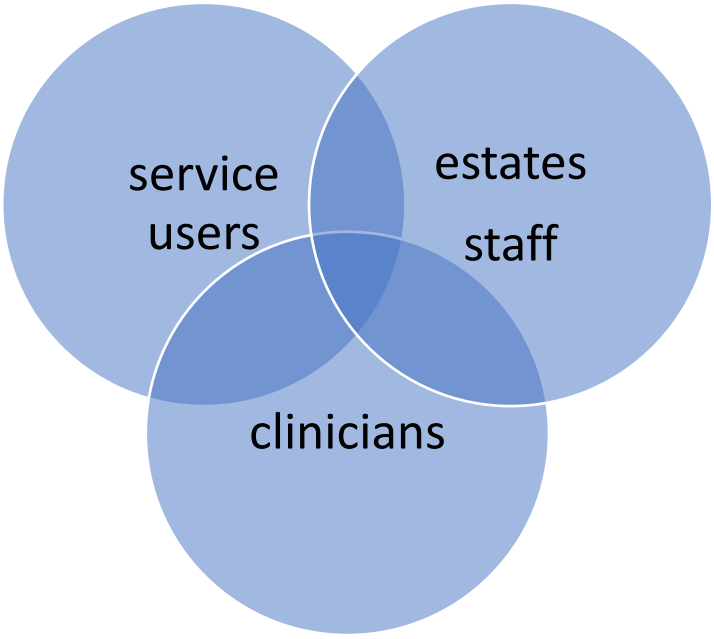
Historically, mental health spaces have been more medical, sometimes more custodial and regimented in feel. This functionality can feel bleak and sterile to service users, and reflects a standardised 'one size fits all' approach which can inadvertently be dehumanising and signal that difference is not welcome in the space. Research into the location, access, condition and status of mental health buildings in one London borough found that, in comparison to physical health buildings, they tend to reinforce social exclusion including through deprived, underfunded and isolated facilities (Chrysikou et al 2019: Conference poster available at: https://discovery.ucl.ac.uk/id/eprint/10071249/).
Investment into settings can make service users and staff feel more valued and hopeful about recovery.

Trauma informed practice toolkits and NHS co-production tools, emphasise the need to involve service users and clinicians wherever possible (see Sweeney, forthcoming). As Transformation Plans go forward – co-designed services involving the partnering of Estates expertise, with the expertise of those with lived experience and clinicians, will ensure that the best design decisions can be made.
https://www.england.nhs.uk/participation/resources/co-production-resources/

See for example, Chrysikou et al (2020) Rethinking inner city psychiatric building provision. Conference proceedings available at:
https://discovery.ucl.ac.uk/id/eprint/10101807/3/Chrysikou_1042-2196-1-DR%20_updated.pdf

Larkin, Boden and Newton (2015) cite steps in co-designing services with experts by experience. These steps include gathering experiences from staff, service-users and carers via observation and interviews; identifying "touchpoints" or critical moments of service encounter; iteratively using thematic feedback to identify key areas for service improvement and group collaboration to co-design positive changes. Importantly, any positive changes are marked and celebrated, allowing transparent feedback and the sharing of success around what has been achieved.
See: Larkin, M., Boden, Z.V.R., and Newton, E. (2015) On the Brink of Genuinely Collaborative Care: Experience-Based Co-Design in Mental Health. *Qualitative Health Research.*
PMID: 25829467 DOI: https://pubmed.ncbi.nlm.nih.gov/25829467/

It is suggested that the best decision making for recovery is likely to occur if there is a diversity of perspectives, involving services users, clinicians/staff and estates staff. The best shared decisions can be achieved through respectful and equitable dialogue.



3. Principles of Trauma informed spaces

The following principles have been developed from clinical practice, service user feedback and emerging evidence. Considering these issues can lead to design decisions which make spaces less institutional, more welcoming and more humanising (Rhodes, pers.comm).

Building and location-

- Buildings should be located in well - lit areas, with good access to parking or public transport.
- Buildings should also be physically safe and spatially welcoming (e.g. staff photo boards, easy to find reception).
- Bases should not be 'sterile' (e.g. they should be more informal, homely and using soothing colours and furnishings).

- Bases should be accessible and with good signage, also taking account of literacy/different languages.
- It is important to include diverse artwork, which also helps people to know where they are in the building.
- There needs to be sufficient security to protect vulnerable service users.
- Be supported by a helpful website with resources, such as information leaflets; videos and animations; video or photo tours of the building so service users can see where they are coming to before they visit.

Waiting areas

- Should not feel lonely or isolated, but also don't feel overcrowded or overlooked.
- Timely – people should not have to wait in the waiting rooms for long periods of time
- Waiting areas should be staffed.
- The use of CCTV may be anti-therapeutic in waiting areas.
- It should be easy to find the way in and out of - traumatised people can feel trapped easily or may feel threatened by badge controlled/locked doors.
- Have quiet spaces or sheltered areas so people can compose themselves before and/or after appointments.
- Have gender neutral toilets (single occupancy), as well as a choice of other toilets – obviously taking account of health and safety issues like reducing ligature points.
- Waiting areas should feel comfortable and welcoming e.g. through considering plants, soothing lighting, seating and potentially music. Televisions as background are not recommended. There should be somewhere for people to get a drink of water.

Clinic rooms-

- Chairs should be wide and solid, without arms to help bigger people, and they should not be too low. There should also be furniture which can accommodate children and young people.
- Rooms should have the ability to have furniture moved around and rearranged, opening windows, dimmable lights, blinds that can be raised and lowered and so on.
- Multiple sensory aspects of clinic rooms should be considered e.g. the area should be quiet enough to be calming, using sound in creative and meaningful ways. For example, low levels of noise; use of soothing colours, like pale green (rather than clinical white), and enlivening colour combinations; good ventilation; clear and accessible exits; use of plants and greenery; have access to sensory grounding objects (e.g. aromatherapy oils, strong mints, pebbles to hold); use of pictures and posters; and access to drinking water
- Have adequate soundproofing to ensure confidentiality.
- Be spacious enough not to feel cramped yet not so large people feel that they are in a large team meeting room.
- Use light to create spaces with different atmospheres.
- Have enough space for people with disabilities to manoeuvre through doorways properly.
- Have access to natural light.
- Have access to grounding / soothing areas.
- Spaces should not be overwhelming (e.g. narrow corridors, poor ability to see what is ahead).

4. **Staff wellbeing**

Of course, there is also an interface with staff wellbeing, and also staff who may have lived experience of personal or occupational trauma as well.
Staff working in trauma settings can face a high degree of emotional pressure, and so attention needs to be paid to supervision, compassionate and relational culture and the physical working environment.
An example of an attempt to ensure that an agreed wellbeing standard has been attained can be viewed here:
https://www.wellcertified.com/

5. **Planning a way forward**

There are beautiful examples of creative design and artwork being used in health and hospital settings, such as the Nightingale Project see https://artuk.org/visit/collection/the-nightingale-project-2374

Such spaces are likely to help people feel less frightened, socialise and connect, and allow the kind of perspective shift that can help people to reimagine their circumstances with more hope of change (Nick Rhodes, pers.comm, June 2021). As well as communicating a sense of worth to staff and service users, well planned and designed spaces can create a sense of community that can counteract the isolation that can be a consequence of significant trauma (Sweeney, forthcoming). This can be achieved through, for instance, shared kitchens where service users can get a hot or cold drink before or after a therapy session.

Questions to ask:
In moving towards trauma-informed spaces through co-design, consider these questions.

- Does the organisation have a Trauma Informed Strategy which includes estates, green spaces and therapy / therapeutic spaces?
- Can service users/ experts by experience be involved in the evaluation and redesign of existing bases and therapy spaces? This could involve photo-journaling, visiting spaces and taking qualitative feedback individually and via focus groups.
- Can the parameters of what is possible within budget be clearly defined?
- Can the costs of not being trauma informed be estimated?
- Can the project be evaluated – and are you measuring what matters for trauma survivors in their recovery, e.g. trust, safety, connection, kindness, being heard and included?
- Will the project be written up and are experts by experience co-authors or recognised appropriately in the work?
- What are the lessons learned from introducing this method, and how will they feed back into ongoing continuous improvement?

Such service improvements need to be evaluated – there is good anecdotal evidence that service users and staff respond very positively to well designed and creative spaces – that these spaces are pleasant, soothing and engaging – and so help in recovery.
However, the evidence base needs to be developed; it appears that this is a largely ‘unmapped zone’ of service user and staff experience which deserves closer attention.

6. A space for change:

Buildings speak to us – they affect how we think, feel and behave. Yet, we often miss how significant they are to us, and to the public being served. Environments become associated with history and community stories, for instance, the meaning of old asylums may affect whether people feel afraid of 'the old psychiatric hospital'. The meaning of mental health spaces can also become entwined with personal history, as those who have suffered trauma and mental health difficulties can experience *further trauma* during treatment from services.

How we offer care must also closely consider what the buildings are communicating to our service users about their safety and worth, and also how they impact upon staff.

We invite you to think about this briefing within your service context.
We hope that reflecting on some of these questions may create a *space for change*.

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This briefing is based on clinical experience and the following resources:

Sweeney et al (forthcoming) Evidence-Based Guidelines for Conducting Trauma-Informed Talking Therapy Assessments. Trauma Informed Community of Action and St George's University of London

Tees Esk and Wear valleys NHS Foundation Trust (2011). Standards for Psychological Therapy Rooms.

Trauma Informed Practice Guide 2013:
https://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

Trauma-Informed Practice: A Toolkit for Scotland 2021:
https://www.gov.scot/publications/trauma-informed-practice-toolkit-scotland/