

THE PHYSICAL ENVIRONMENT OF THE MENTALLY HANDICAPPED

XIV—WHAT CAN A DESIGNER OFFER ?

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The fourteenth article in this series gives some vivid glimpses of the feelings of professionals who, being "outsiders," look at the hospital community with a view to making a contribution to the therapeutic environment. The designer has problems in responding to the wishes of a single client without sacrificing his professional convictions, but the problems become very formidable indeed when he has to satisfy the often conflicting and inadequately thought out wishes of a multidisciplinary team of clients. Most of them are not even aware that standards which they would apply unhesitatingly to their own domestic environment, are also of importance at their place of work—which happens to be the domestic environment of other people.—(The Editor).

Introduction

I doubt whether there would be any disagreement these days that the environment affects us, simply because we have all experienced it doing so. But quite how much it affects us is less measurable because we have different degrees of sensitivity to it and awareness of it. Our minds may well be on higher things—or lower things! Undoubtedly, extremes of any sort, whether of cold or heat, glare or gloom, noise or silence, movement or stillness, which adversely affect our performance, are noticed.

Certainly talk about the environment has become fashionable in proportion to its importance as an indication of the social status or pretensions of individuals, companies and public and private institutions, so much so that designers have made a profession from their particular knowledge and some of them—like many professionals—tend to convince themselves and others of their ability to produce the universal panacea to all human ills. I sometimes wonder whether an all-embracing kindness, compassion and care one for another would obviate the need for so much "expertise" to chart ways through the confusion and complexity our cleverness has created. Ideally kindness, compassion and care are the foundation of the practice of any expertise and the true complement to its practice.

This idealistic view was adopted by the School of Interior Design at Birmingham Polytechnic because as an institute of education it felt it should have ideals, and to ensure the balance of its practice is not overweighted in favour of the privileged and articulate it requires to work for the underprivileged and less articulate. It was fortunate that as this ideal was formulated, an approach by a hospital was made to us, and several of our professional friends designing in the Regional Hospital Boards alerted us to the help that we could give within the Health Service and particularly in the sphere of care for mentally subnormal people.

We agreed to help—uncertain whether we would be of any use, and in awe of the professional prestige of the medical profession, and we agreed to design an environment for boys of both high and low dependency on the assumption that the environment would offer them opportunities for greater happiness, greater learning potential, greater training potential, more effective use of the nursing and care available, and the beginnings of some personal and even private life—to offer them through the contribution of a better environment as much normality of life as they could grasp. We did this design and others, and how we did them and what unfolded as we did them form the subject of this article.

The Client and the Designer

In the approach to a design solution a designer is not unlike a doctor. He has to diagnose the problem by listening to the client give his version of his problem, which will not be given in the language of the professional but in his own words, with a vocabulary which is too limited for accuracy and full of analogies from past experience. It will be emotive and strongly biased in favour of a solution which he may have seen somewhere and which has become, for him, the embodiment of all his hopes. His aspirations for the design solution will nearly always be seen as serving **his** need for greater comfort and convenience which is automatically assumed to be synonymous with that of others. The designer encourages the client to talk (even away from the point), to assess more of his character, temperament, prejudices and practices, for by doing so the designer can balance and fill in that which is unsaid—sometimes deliberately unsaid. The designer also observes with the care of a detective all that can be seen of the problem through a thorough examination of the existing environment and the ways it is used, by its state of maintenance and order, and particularly of the people in it. This is one of the most revealing ways of finding out why the problem exists and what chance there is of an eventually successful solution. It is by talking to all the people who share the use of the environment as well as those who own or administer it, that a designer discovers the breadth and variety of information which bears upon the problem. No two people diagnose the problem similarly. Frequently they are contradictory and at best, though dissimilar, their views on the problem are different facets of the larger problem, and a designer discovers that nobody is more important than another when weighing the value of information given. The cleaning lady is sometimes far more revealing, practical and better informed than the managing director!

While we are talking about people it may be valuable to say something about the value of design. To many clients, the employment of a designer is the equivalent of buying a winning lottery ticket or expecting a miracle. He is called in when all else has failed or nothing has even been tried, and is expected to produce an environment that will solve all their problems—preferably without inconvenience or discomfort or the abandonment of sloth, waste, inefficiency, inaccuracy and inconsideration. No newly designed environment will work or repay what it has cost if the people who are going to use it will not contribute their part to the environment. After all, environments only exist because of people—the people are the human part, the buildings and their equipment are the material complement to them. A new environment is designed like a new tool to give greater potential to those using it, but it does require those using it to learn the principle and practice of it to get the best results from it. I am not writing here about the apocalyptic visionary designs of internationally renowned architects and designers which appear to need a new breed of superman to be worthy of them, but of the design which is one evolutionary step forward into situations which will still have many recognisable features. Thus a designer expects and hopes by the very fact of being commissioned by his client, for a willingness to co-operate in the success of the design by improvements and changes in attitudes and practice.

The Multidisciplinary Team and the Designer

Picture then our students who, having been asked to present a scheme for "upgrading" a building for boys of high and low dependency, find themselves round a large table with day nurses, night nurses, training officers, administrators, therapists, doctors, consultant psychiatrists and psychologists, ward sisters and the hospital engineer (nearly always a dampening pragmatist), who have kindly attended to ensure a balanced and accurate body of information is presented.

(At one of these meetings held in an ordinary medical hospital where a great panoply of the hospital staff were there to contribute their opinions, I innocently enquired whether there were any patients present to give their views. There was a stunned silence. "Patients," came a cry, "it's got nothing to do with them!")

The students have primed themselves by reading information from many sources—the D.H.S.S., this journal, publications of the Kings Fund Centre, the Disabled Living Foundation, newspaper articles, books by parents who have grappled with the task of bringing up a mentally subnormal child, by listening to and looking at programmes on Radio and Television and by consulting with eminent men and women who practise in this field.

As the meeting progresses it is evident the students are rather puzzled. They have a touching innocence in the belief that once a problem has been defined, everyone will work toward the common good, but there seems to be a curious reluctance on the part of some to define **the** problem but only **their** problem, which if only it were understood and solved, would be the salvation of the Health Service. One or two seem to have come to continue a private vendetta, one at least is always extremely sceptical that this is yet another time-wasting exercise in official whimsy about as useful as clairvoyance but nothing like as entertaining. The engineer has just said that there is not a hope in hell of anything being done anyway because the budget is overspent, and may he leave the meeting early because he's got someone coming to look at the boiler. Sister says, "How long are you going to be with the patients?" and we say, "Two days," and she says, "That's no good, you'll need to be here for at least six weeks!" (rather as if one had to sign on as a player to see the match). We retreat rather crushed. The training officer explains the logistics of staff training, which seem to us to be marvellous but curiously self-defeating, since once staff have received the training it means advancement and a better paid post elsewhere, or job enrichment to the point where they no longer actually **do** the job! Work opportunities, schooling and therapy for the patients are described by those responsible and one gets the impression of every patient hour being filled with unconfined joy. Nurses demand larger medical cabinets or even rooms and offices, and vantage points from which to supervise the activities of every patient at every activity. One's mind begins to buckle; but "courage, nothing is impossible." Doctors plead for larger surgeries and better medical facilities redolent of casualty clearing stations. Others, fresh from battle with wheelchairs, warmly advise the need for ramps and lifts in all of a score of places. The idiosyncrasies of the Health Service's policies sometimes formulated years before, together with their implementation, become evident if not comprehensible. The enmeshing of the work of people in different unions which have made agreements at different times that are not primarily consonant with the needs of the patients, seems to add yet more complexity to the problem. Philosophies of care are discussed and generally agreed—but implementation of them—"and that's something else again." "Normalisation is a fine aspiration, but for these patients at their age and with their disabilities we've simply got to be realistic." Everyone is a progressive it seems, and what may seem like reaction is no more than the practice of necessary expedients in these very unique circumstances.

The students listen, noting copiously. One or two venture a question—not too controversial. They are answered politely. More are emboldened to ask questions—some quite controversial. They are taken seriously and answered honestly. They begin to be aware that the framing of a question can sometimes cause the answerer to modify his opinions and thus his answer. They see that discussion can be a way of influencing, even moulding opinion and swaying attitudes and not just a re-assertion of habitual attitudes. And as the meeting progresses, suspicions are put aside, defences are lowered, there is a climate of greater understanding between us and of tolerance, and one finds oneself thinking, “Yes, they care, they really care.” And it is lunchtime and no formula formed and no conclusion drawn.

Eating is punctuated initially by exclamations of the impossibility of our task. How can one reconcile all the contradictions, all the varied and intractable interests? How can one distinguish what is really in the patients’ interest as distinct from the staff? The well-being of each group seems utterly incompatible, and yet as we talk we realise that words themselves can imprison or liberate, so we re-examine our terms. Do the opinions really contradict one another? Or are they complementary? Is not black essential to the appreciation of white, and ugliness to the appreciation of beauty, and cold to the appreciation of warmth? And are not patients necessary to the profession of nursing? Are the opinions not simply different conditions of the same phenomenon or different facets of the same multi-faceted crystal of truth? We realise the pieces are beginning to fit together a little bit better. We also realise that it is our business to sort out the general from the particular, the philosophy from the implementation.

The Environment—as it is—and the Designer

To regain some stability and buoyancy in this turbulence, we clutch at those simple articles of faith which have previously brought clarity out of confusion. Why are we here? To help our fellow-man by using our skill to design environments. Who is your fellow-man in this case? First the patients of this hospital, sometimes unloved and unwanted and sometimes unlovable, all with some mental subnormality and some with physical disabilities, and nearly all unable to define their desires for a lifestyle. Second, the people whose lives are committed to caring for them. How will we achieve this help? By careful and compassionate observation of and listening to our fellow-man, the better to understand him and his needs and to interpret them in an environment.

What will that environment be like? Ah, well, that remains to be seen. We must be among the patients and staff and experience the problem for ourselves. We haven’t looked forward to this. We think it is going to be harrowing.

It is!

First to some of the ladies’ wards where iron cots in serried rows stand each with alternate pink and mauve nylon counterpanes upon the beds, where scarcely a personal possession, photograph or picture is in sight and the ladies in their day rooms sit or stroll aimlessly. Nowhere any privacy, nowhere to call your own. Then to the older men’s ward. Very spartan and drab with no gaiety of coloured counterpanes to relieve the oppressive bleak uniformity. An occasional mural of crude execution gives the place the desperate anonymity of an army hut. There is an air of hopelessness about this place. Each of us is thinking, “God save me from a place like this!” There are so many men there, why aren’t they employed working or at therapy or occupied with games or pastimes—not in the conventional sense but in a way that would stimulate simply curiosity? “There are so many to deal with and so few staff,” we are told. And it seems true. “And they have been institutionalised for so long it is difficult to get them to do new things or arouse their interest.” Again

no privacy, not even in the loos. One wonders whether the vacant stares are the only defence to be had from the all-persuasive community; marking a withdrawal into the only privacy they can get, rather like people who exaggerate their deafness to enjoy freedom from the trivial exchanges of family life. Lights glare, reflecting from glossy painted walls and ceilings and polished lino floors—all eminently cleanable, no softness anywhere—even the chairs are tautly clad in washable vinyl.

Eventually to the building where we will design our new environment. And here we stay for the remainder of that day and all the next. It is easy to be critical of both the people and the place, and because it is easy we are critical. But, to be fair, the very reason we are there is a measure of the concern felt for a much-needed improvement. Furthermore, money for such improvements has not been lavishly disbursed.

The building we have at our disposal is substantially built. Its decoration and furnishing reflect the thinking of a generation ago. All materials and finishes are as nearly indestructible as possible. Grilles and guards about to protect windows and prevent things being "posted" behind radiators. Personal lockers are left unlocked, but everything else is rigorously locked. "Best" clothing is kept locked away from the patients except when going on outings. The dormitory, for that is where they sleep, is supervised from a central nurses' station which also overlooks the toilet accommodation. A similar situation exists on the ground floor where the staff office lies centrally between the recreation room and the dining room. Nothing has prepared us for the smell! Some patients are doubly incontinent we are told, and all surfaces and fittings must be washable and impervious, but very little is impervious—it has joints, it allows chemical to build up in corners and angles, and as for washing down—that is an inexact science resulting more in habit than effectiveness. Few people who undertake cleaning have been trained in its principles and practices. It is assumed that if materials and equipment are provided and staff employed to do the work that is identified, then some miraculous investment of ability will occur in the staff to ensure that the result of their work is cleanliness! Sometimes it seems that so much concern for ensuring cleanability tempts people to be more careless and inconsiderate in their use of environments where it appears that there is nothing to soil irreparably and that someone will soon clear up.

The noise at times is physically painful. Yet every surface reflects and sometimes amplifies sound, hard smooth floors, ceilings, walls and windows, cupboards, tables, and even dining chairs and what few yards of thin fabrics serve as curtains, do little or nothing to absorb the noise. Light from fittings, once considered a satisfactory utilitarian light source, glare cruelly, seeming only to emphasise the bleak hardness of the surfaces and providing no gentle enlivening warmth or brilliance to the scene. Heating is stifling, the radiators are too hot to touch—obviously another reason for the grilles, and the ventilation is governed by long practice of reasons why the windows should not be opened too wide. We photograph nearly everything, we talk to everybody we can, we listen, we look, we begin to get to know one or two of the patients. We get pawed about, which is worrying at first but less so as time goes on, and as time goes on, the ugliness of the environment seems into us. By ugliness I don't mean that it does not equate with fashionable middle class norms of what contemporary environments should look like, for this in itself may well be another recipe for failure. Each culture or social group will produce for itself environments which are comfortable, convivial, colourful, optimistic, convenient and into which they can expand and even become expansive. Whether it is composed of three different patterned wallpapers of great vibrancy with a row of ducks on the wall lit by a brass tulip-shaded centre light, or a Van Dyck glowing on a damask wall lit by a chandelier, matters little: the difference lies only in the way it is done, not the reason for doing it. Our business as designers is to ensure we identify and

maintain the reasons for designing this environment while sensitively divining in what ways it will give the greatest expansion to the people using it.

No, this ugliness is a detached dehumanising ugliness, almost primitive, and reflective of community discipline and order, any visible expressions of individuality are unseen because they would threaten this order. Those with experience of it would recognise a similarity with wartime service accommodation for other ranks.

Such a criticism seems an indictment of the people responsible for it. It isn't simply being wise after the event. Those who were responsible for the environment were undoubtedly concerned to provide the best that they could with the knowledge and resources to hand. Our present position in having more and different knowledge and a greater range of resources, should not give us any feelings of superiority but ensure that we get the answer right, or as right as can be in circumstances which already prejudice the ideal. For our studies and interviews have given us a whole string of apparent anomalies.

The Environment—as it should be—and the Designer

Early in our preparatory study for this design task, we had been told that current thinking in the subject of care of mentally subnormal people was to provide the conditions for their progress towards as normal a life as was possible for them—progress towards normality. Of course, we discussed what normality was and decided that it was the condition which we chose as being the most nourishing and compatible for our individual development and well-being while respecting similar aspirations in others. Each one of us could roughly define what that condition might be. This idea remained with us unshaken throughout our work. Nothing seemed stronger or more persuasive. It seemed rooted in compassion, it had simplicity and purity and a commonsense and an obviousness about it which made it compelling and irrefutable. It respected the dignity of human life which is at the foundation of our concern to help the helpless. Everybody with whom we talked believed this idea in principle, but many had reservations about it in practice, particularly those who had the personal care of the patients literally in their hands. These reservations appeared to us to be due to inherited problems caused by expedient practices. It is a very strong person who will seek to change the situation in order to serve the problem. It is more likely and understandable that one adopts the existing methods of containing the problem and adapts oneself to these as a way of life.

Our solution, therefore, had to be such as supported the belief in the idea of the pursuit of normalisation and gave those who had practical doubts about it a bridge to reach it by way of the physical environment. Not an easy task, since it seemed probable that the new environments would be radically different to the old. After all, the pursuit of normality inevitably assumes a home life within a family within a community, which corporately defends the family and the individuals in it. So it's back to the celebration of the individual within the security of his small family group. How different from a social order without family, excluded from the community and tolerated through prescribed conformity of individuals, whether they be staff or patients.

The refinement of that particular situation would surely result in the efficient processing and servicing of humanity in a way similar to the commercial hen battery. Our society would not countenance that, and if a society emerged that did, it would not be long before it discharged the problem far more peremptorily though doubtless with seductive euphemisms. At this point in our research, the existing anomaly could not appear greater and our assumption of an answer to it to be other than extreme arrogance. But there is considerable hope in two factors. People

cannot resist visual stimuli and the majority of people are fascinated by what might be loosely called "home making." They will trail round giant exhibitions of it, go round shops full of it, spend hours choosing wallpapers, carpets, furniture, curtains, light fittings, and have an insatiable curiosity about how others do it, and this we hope is the denominator that will be common between our proposals for the environment and what they—the users—will find acceptable in it. Where changes in staff routines are involved—routines which for them are tried and proven, our proposals which will occasion different routines, will have to be seen to be carefully considered, apparently possible and, what is perhaps the most important, enhancing their task and the lives of their patients. We hope to add something more, namely a more beautiful environment, no less desirable than their own homes, where incidentally they don't insist on supervisory vantage points to oversee every activity of the family, but where they accept the occasional accidents that occur as their young children and pets grow up and become accustomed to the home through teaching and example. Then the acceptance of this denominator will smooth the way to the acceptance of new methods and practice of care.

If man is partially moulded by his environment, which we believe to be true, then the dehumanised, impersonal environment will degrade all who live in it—the staff no less than the patients. A designer, therefore, must project the ideal environment no matter how much competence he has to apply an attractive cosmetic to that which is basically degrading, but familiar and acceptable. His own integrity demands it.

One by one each student defines his personal approach to the proposed environment. Each shares the common ideal, but how it will work in practice and what it will look like, will differ; but time will show that the differences are not radical.

A very compelling description was given to us in the early days of our research. It was said that one of the most useful environments to learn about surface textures, differences in levels, variations in light, to experience sounds and negotiate spaces, would be an old country hotel, or a rambling Victorian rectory. Such an influence would be anathema to much contemporary architectural thought whose concepts of order and design would reflect neatness and lineal order, directness of access and movement, smoothness of surface, discreetness of services and economy of spatial planning. Much contemporary architecture shows how technology can achieve all service requirements and material finishes with almost complete anonymity and instant boredom. But if one reflects on this most useful descriptive analogy one can remember well the wealth of things there were to touch, to feel, to listen to, to smell. Wonderful things like turned table legs, lace cloths, moulded panelling, flowered wallpapers, chintzy curtains with voluptuous pelmets, fringed lampshades of pleated silk, burning logs collapsing in moulded stone fireplaces, old pictures and candlesticks, eccentric stairs, crooked corridors and myriad views through diamond panels, smells of age, smells of wood, smells of cooking, sound of clocks, sound of doors, sound of wind, sound of silence. Places to be alone and places to be together. What a wonderful world for the senses—and remember what it taught us! For many of us it has been an indelible memory. Why not, then, for the mentally subnormal, whose capacity for absorbing these sensations may be more acute and more telling and more pleasurable by being almost animal in the instinctive response there is to them? Perhaps such a place would be a nightmare to staff in their responsibility to patients, but I have heard that such places have been used for the care of mentally subnormal people with great success. Somehow it seems that all the incipient hazards and imagined inconveniences are conducive to success in learning to be normal. It is inevitable that such an analogy was attractive to students in this context because normal life is made up of hazards and inconveniences which are not necessarily insupportable or unpleasant but quite exciting and very instructive. Were not en-

vironments with plenty of stimuli asked of us? Surely then we should provide as much as we can to enrich those many hours of inactivity that so many patients endure. So great was the impression of inactivity and under-employment, that several students considered providing something equivalent to a Tunnel of Love or the Ghost Train to animate and stimulate!

The Environment—as it could be—Practical Design Proposals

The final designs had much in common. All students designed for smaller groups—never exceeding eight and generally four to six. They converted the building into a number of nearly self-contained “homes” for these smaller groups. It was possible for each to learn and achieve simple skills, to enjoy privacy, to enjoy small community life similar to a family with staff acting “in loco parentis.” Places looked like home. It was assumed that patients would be encouraged to collect and keep personal things to which they were attached and which identified their individuality. The planning of the “homes” within the building was informal, and each home was linked to the others to enable staff to circulate but not to affect the self-containment. Not all the homes were identical, some were positioned to give easier access to outside by virtue of patients’ physical disabilities, some were attuned to be more challenging and give greater learning conditions than others in their similarity to normal family life. All were built to allow the normal task of life support to be carried out by the patients and staff together; things like bed-making, rudimentary housework, simple preparation and cooking of coffee, tea and snacks. All had small group dining areas where eating training could be more private—similar to family life with the staff helping the patients like a mother or father. Colours were gay, patterns were bright, since patient reaction to colour and pattern indicated a preference of this sort to the sophistication of subtle colours and patterns. Furniture was interesting in its use of surface texture, moulding and colour. Some students even suggested the use of “old fashioned” furniture of a robust construction and decoration. Lighting was decorative and various in scale and character with what families have at home. Beds were easy to make, having fitted sheets and “Continental” style down quilts. Most suggestions for heating were designed to be less bulky and the ventilation was more positive and straightforward.

The Response to the Proposals

Much could be said of the specific details of these designs and the ideas that were in them. The test of their acceptance, however, was the presentation of them to the staff and the hope for their acceptance. They would see very radical physical changes and decide whether these presented unacceptable work patterns for them. We at the polytechnic had done our best to present the designs in forms that were easily understood. Plans and elevations were explained with plenty of coloured perspective drawings, and each student was capable of explaining his ideas.

Our test came when at the suggestion of the hospital administrator we hung our work on exhibition in a very pleasant and spacious room made available to us, to which all the hospital staff were invited throughout the day. All the students were present to explain and convince people of the merit of their suggestions.

We recall it as one of the most rewarding and successful events in our experience. A remarkable number of people came to look and discuss, far beyond those who were immediately concerned. The interest in what we had done was searching, professional and appreciative. Many were so genuinely grateful for our spending time in presenting ideas in a comprehensible and attractive manner, that we felt very humble. Absolutely nobody came in a destructively critical spirit, and many who had been rather sceptical about our rôle in the hospital and the theories

we had were won over to some of the ideas within the designs and were prepared to give them a try. Most recognised that their own rôles had been enhanced by the changes which gave the patients a more family life-style and everybody appreciated the betterment in the material and aesthetic quality of the proposed environments.

The remarkable thing about that day was that it provided a bridge or middle ground to many people of different professional persuasions by the designs becoming a new frontier, well mapped and accessible, to which everybody could make their way in their own time. There was gratifying optimism in the way people discussed, not whether they could take up the ideas, but how they could make them work.

Of course, we made many mistakes, and our optimistic zeal to prove our points had given rise to some superficiality on matters of detail, but we were proud of the work we had done and grateful for the opportunity to do it. Our designs were not implemented lock, stock and barrel, we didn't expect them to be. But in as much as they were accepted in principle, any designer would find that satisfactory and be capable of adjusting with different proposals to differences in implementational details. It is salutary to end this article with an example of an ideal designer/client relationship, for in this particular hospital there was set up one of the best working relationships that have been experienced in any sphere of activity. In every level of responsibility people gave freely and willingly of their time, their professional knowledge, their opinions and suggestions and their diagnoses of their problems. We were denied access to nothing and nobody that would have been helpful to us, and there was a genuine interest in what we were trying to do. And finally that interest was sustained in the participation at the critical evaluation of the designs. We think that together with the valuable consultations we held with other professional men and women—psychologists, psychiatrists, designers, architects and others—it enabled us to produce solutions of greater daring than would otherwise have been possible.