A Recovery-Oriented Care Approach
Weighing the Pros and Cons of a Newly Built Mental Health Facility
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ABSTRACT
The current study adopted a recovery-oriented care approach by emphasizing patients’ perspectives and experiences regarding changes to a newly built mental health facility. The inpatient entrance, or “portal,” intended to balance the aims of recovery-oriented care with minimizing risk. A mixed-methods study of the portal’s pros and cons was conducted, according to four themes: (a) autonomy versus inconvenience; (b) safety and security versus stigma; (c) unit door versus portal operating costs; and (d) privacy versus community integration. Focus groups engaging with patients (N = 39) indicated that the design effectively supported recovery-oriented care. Patients did not find the portal to be stigmatizing or triggering and valued the safety and privacy it created, and visitors also generally had a positive experience. Survey responses (N = 101) from portal users were also positive about the new design. The study findings suggest that the pros outweighed the cons of the new design. [Journal of Psychosocial Nursing and Mental Health Services, 54(2), 39-48.]
However, the best way to act on this type of directive remains unknown (Grol & Wensing, 2004), particularly in inpatient settings (Kidd, McKenzie, & Virdee, 2014). One possibility for implementing this standard of care is by engaging patients as co-creators of health care through their engagement in mental health services decision making (Calaminus, 2013; Schwartz et al., 2013).

The purpose of the current study was to adopt a recovery-oriented care approach by emphasizing patients’ perspectives and experiences to study and manage the change to a newly built mental health facility. Engaging patients for their contributions is particularly important when, as in the case of the current facility, the novel and unique design features have generated debate among hospital administrators, care providers, and other building users.

**BACKGROUND**

The somewhat controversial issue arose in the context of St. Joseph’s Healthcare Hamilton’s (SJHH) newly built West 5th facility—a 305-bed, tertiary-care, inpatient mental health hospital that is integrated with outpatient mental health, diagnostic, and medical services. The newly built environment was developed using a clinically informed, patient-centered design to improve the quality and safety of care (Karlin & Zeiss, 2006), stemming from the best evidence and a participatory approach that included many stakeholder groups (e.g., staff, patients, community members, funders) (Karlin & Zeiss, 2006; Perkins, 2013). Among the most innovative, but also potentially controversial, features of the new facility are the interdependent inpatient entrance, or “portal” (Figure 1), and a unique transitional security zone, or “galleria,” where many amenities for patients are located (Figure 2). The portal restricts movement between a fully publicly accessible outpatient area and an inpatient area that includes both the galleria and 14 inpatient units (Figure 3). These design features were intended to balance the aims of supporting patients’ autonomy (e.g., by having unlocked inpatient unit doors) and integration with the community while minimizing risk and protecting patients’ privacy (Dvoskin et al., 2002; Eggert et al., 2014). By contrast, the original 1950’s-era facility was readily publicly accessible, except for the inpatient units, which

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**Figure 1. Blueprint of the inpatient entrance (i.e., the portal).**

**Figure 2. Photograph of the transition zone (i.e., the galleria).**
were universally and consistently locked. These novel and unique design features added significant expense and had far-reaching design implications for the entire hospital. For example, access to outdoor spaces by patients residing on the second floor requires leaving the unit, and access to some allied and medical health services (e.g., dentist) requires all patients to be able to leave their units. Although the stakeholder groups who participated in the hospital's design were hopeful about the transformative potential of these innovative features, their newness created unanticipated challenges.

Soon after opening in 2014, the hospital's leadership received feedback that users were having difficulty adjusting to this significant change in design. Visitors to inpatient units now had to identify themselves at the portal before going to the specific units to see a loved one, and security personnel were now participating in the decision to let a patient in or out through the portal. As a result, many options were considered to manage the change in design, including removing the portal and effectively returning to the security design of the old facility. However, before any option was selected, a decision was made to gather feedback from users and evidence of the impact of the design features in an effort to maintain a recovery-oriented approach at all levels of care (Livingston, Nijdam-Jones, Lapsley, Calderwood, & Brink, 2013). Consequently, an ongoing existing pre- and post-occupancy evaluation of the West 5th facility was expanded to include a specific sub-study of the portal and galleria (Ahern, McKinnon, Bieling, McNeely, & Langstaff, 2015).

This smaller study, outlined herein, compares the pros and cons of the portal and galleria based on four themes developed in collaboration with key stakeholders, particularly unit managers (Figure 4) and draws on a mixed-methods approach. The first theme is autonomy versus inconvenience, where patients’ autonomy is enhanced by the inpatient zone yet creates an inconvenient process for visitors to access the inpatient units. The second theme is safety and security versus stigma, where the more obvious security presence might increase stigma by further associating criminality with mental illness. The third theme is unit door versus portal operating costs, where the costs of locking all inpatient unit doors are compared to the cost of operating the portal. The fourth theme is privacy versus community integration, where patients are integrated with the community to enhance transitions out of the inpatient setting.

**METHOD**

A mixed-methods approach was taken to gain both users’ perspectives and experiences of the design features and their impact on the quality of care. Methods included six focus groups (N= 39 participants), a survey (N = 101 respondents), interviews (N = 14), observations (72 hours), and a review of hospital records, which emphasized patients’ perspectives and experiences to better inform the decision-making process (Van Tosh, 2013). This approach was selected because the novelty of the facility design meant that there was no baseline comparator and because of the complexity of the related issues and implications for care. Ethics approval was obtained from the Hamilton Integrated Research Ethics Board.

**Focus Groups**

Six groups were conducted with patients from the Forensic Psychiatry Program (n =2), Schizophrenia and Community Integration Service (n = 2), Acute Psychiatry (n = 1), and Concurrent Disorders Program (n = 1), as this approach has been proven helpful for gaining perspectives of other redevelopment projects (Malagon-Maldonado, 2016).
A focus group was conducted with family members of patients in the Seniors Mental Health Program because many patients in this program are non-verbal. Patient participants were offered a $5 coffee gift card for participating and were asked to complete a consent form, assuring the anonymity of their responses. Every effort was made to support meaningful engagement to ensure patients’ perspectives were faithfully represented. This representation included having a skilled facilitator lead the group, inviting unit staff to remain and offer support, and taking notes instead of using a recording device. The facilitator (C.C.A.) described the consent process, explained the reasons for the design features, and summarized the criticisms of the portal and galleria. This approach seemed to be successful, as patients engaged with the topic, and consensus or near consensus was reached at each session. At the end of each session, an informal poll was taken about whether the portal should remain or be removed.

**Survey**

Individuals who stopped at the security desk between July 7 and July 19, 2014 (N = 101), were invited to complete an anonymous survey about their experiences and were offered a $5 coffee gift card, following quality improvement methodologies (Ortiz, 2014). The survey was developed for visitors, but no one wanting to participate was refused. Reasons identified for using the portal were used to group respondents into patients (coming to receive care) and visitors (e.g., family members, friends, community workers) (Table). Regular West 5th staff did not complete the survey as they rarely use this entrance.

**Interviews**

Key informant interviews were conducted with directors and managers to obtain a clear understanding of the original vision and purpose behind the design, following qualitative methods that have been used by others (Wood et al., 2013). In their unique roles, directors and managers had received formal and informal feedback about the portal and galleria and were well versed with the issues. They were able to review and confirm the pros and cons identified in the current study as being the most relevant issues relating to the impact of the portal. Interviews were audiorecorded and transcribed, but given the unique position of each participant, no guarantee of anonymity could be provided (i.e., there is only one manager for each unit and four directors across all of SJHH’s Mental Health and Addictions Program).

**Naturalistic Observations**

Observations were performed to compare the quality and nature of the interactions of individuals talking to the inpatient entrance security staff against the interactions of individuals talking to Public Affairs staff at the welcome desk, following the methodology of other facility evaluations (Edgerton, Ritchie, & McKechnie, 2010; Tyson, Lambert, & Beattie, 2002). A trained observer spent 20 hours at three locations (i.e., public side of the inpatient entrance, inpatient side of the inpatient entrance, and information desk). For each interaction, the observer recorded the duration, types of participants, number of participants, and nature of the interaction. The nature of the interaction was scored as positive, negative, or neutral on a digital scoring sheet. Each category had a clear set of descriptions that had to be met so as little as possible was left up to the observer’s subjective judgement. The observer also...
made subjective field notes immediately after each observation period.

To measure the amount of time it takes individuals to pass through the portal, 8 hours of security footage were reviewed over a single, arbitrarily selected day (i.e., May 28, 2014, 8:00 a.m. to 4:00 p.m.). Time for each observation was recorded from arriving at the portal on the outpatient side to completing the transit to the inpatient side. Observations included 225 stops at the security desk (112 used the turnstile, 88 used the sally port, and 25 remained on the public side).

Observations of the amount of time staff spent managing the locked door of a unit took place over 1 week (i.e., September 22-26, 2014). Over the week, 12 hours of observations were made during 2- or 3-hour intervals that timed how long it took staff to let patients in and out of the unit. For patients who were arriving, the time taken from the sound of the buzzer to the time the nurse had resumed his/her previous activity was recorded. For patients who were leaving, the time taken from when the nurse left the care desk to the time he/she returned and resumed the previous activity was recorded.

Hospital Records

Patients’ access to the various security zones is determined by their clinical care team. Each patient is given a therapeutic pass level (TPL), which corresponds to a specific security zone (Figure 3). A snapshot of all pass levels was taken from the whole hospital on October 2, 2014, from each unit’s communication boards to determine the number of individuals with each TPL, as well as to capture all of the qualifiers (e.g., time limits, accompaniment requirements). These data were drawn directly from the units, so the data were in real-time, reliable, and detailed. Data from the hospital’s Observation, Seclusion, Restraint and Application (OSRA) database for the duration of the study were also reviewed. These data are less detailed because the OSRA database only records pass level (not qualifiers) and is not as reliable (i.e., it is an imperfect system of entry and upkeep).

At the conclusion of the study, a summary of the findings (Figure 4) was presented at the Mental Health and Addictions Leadership Forum, which not only included inpatient managers and directors, but a wider group of participants, including hospital executives and outpatient and community-based managers (approximately 40 attendees). Participants at that presentation were invited to provide written comments and complete an informal survey at the end of the forum.

RESULTS AND DISCUSSION BY THEME

Overall, results from the various methods generally support keeping the portal operating as intended (Figure 4). All but two of 39 patients agreed it should be kept based on the informal polls taken at the end of each focus group. The overall experience reported on the survey was positive (Table). Managers and directors were supportive of the vision for the space that requires the portal, which is understandable because many had sat on committees responsible for reviewing and selecting architectural designs, as noted by one manager: “The building was built so that the sickest of the sick would have more freedom, and I don’t think we can lose sight of that.” They believed in the vision but also understood why, now that the new facility was operational, there were concerns about how to manage this novel design. Of 14 interviews with managers and directors of the West 5th campus, one was undecided, one was opposed,
and the remaining 12 participants favored keeping the portal. Their impressions were consistent with the findings, described below, that weigh the pros and cons of the novel and unique design features according to the four themes.

**Theme 1: Autonomy Versus Inconvenience**

The creation of the three security zones by the portal was intended to safely advance patients’ self-determination in keeping with a recovery-oriented approach to care (Gilbert et al., 2013). As one manager explained:

People who were previously confined to a unit that ended at the front door can now go out and have a space they can walk in, which is still behind a secure perimeter. I think that has greatly enhanced the client experience.

This statement is particularly true for those who are at risk for leaving without authorization. In the old facility, such individuals would never have been able to leave their units, even accompanied by staff because they were too great a flight risk.

The increased autonomy for patients created by the three security zones emerged in the key informant interview as being an improved quality of care for those individuals who would otherwise be confined to their units. As one manager explained, “It [Zone 2] creates a safe yet normalized environment to help patients prepare for community integration.” For example, one long-term patient is, for the first time since coming to the hospital, able to get a can of soda for himself. This task increases his independence and physical activity, thereby supporting his recovery and improving his quality of life.

TPLs allow patients various degrees of independence, making it possible to quantify this increased autonomy. Use of different TPLs varies widely by program and two data sources were used to explore this issue (i.e., OSRA database and communication boards snapshot). The OSRA data do not capture any of the ways that TPLs are used as a therapeutic tool, which allows for conditions and exceptions. The database only captures patients’ maximum TPLs (1 = not allowed off unit; 2 = unit and galleria; 3 = unit, galleria, and public side; 4 = off-site). The OSRA data show only an average of 15% of patients with TPL 2 between April and October 2014. Conversely, the data garnered from the unit communication boards snapshot capture a range of TPL exceptions and conditions, including individuals who have:

- accompanied Level 2 (i.e., likely flight risk and would not be able to leave the unit without the portal);
- escorted (1:1) or accompanied (3:1) Level 3 (i.e., allowed past the portal, but only when a staff member has the time to go as well);
- Levels 3 and 4, but with time restrictions (ranging from 30 minutes to several hours).

By capturing some of the complexity of how the TPLs are used, 25% of the patient population is shown to benefit from the portal and galleria.

The most persuasive results come from the focus groups. Patients admitted to the hospital were encouraged to freely express their thoughts about the physical surroundings. Although they acknowledged the inconvenience of going through the portal, they valued being able to access the galleria and having the autonomy of leaving the units without having to wait for a staff member to unlock the unit doors. As one patient explained:

It’s [the portal] one of the best features of the hospital. It’s annoying to wait and takes longer than you want, but really it takes only 45 seconds to 1 minute and means you can leave. At [another site], you’re locked on the unit. Here, you can go in the in-between space…that’s huge.

Being able to access the galleria (Figure 2) was valued by many participants. Patients enjoyed being able to leave the unit to go for walks, socialize, use the computers, visit the clothing store, and get coffee and snacks at the cafe. One patient especially appreciated the proximity of the gymnasium, saying, “I love the gym; I love being able to do something physical…. It’s an amazing feature.” Patients’ only criticism was that the hours for many of the amenities are not long enough, making some unavailable at certain times.

Surprisingly, even patients who could freely cross to the public side valued the portal and galleria, empathizing with fellow patients who were not yet able to do so, with one patient stating, “It’s kind of like having a really big unit.” The qualitative findings are supported by the survey results.

The additional process of going through the portal may be an inconvenience to visitors, such as family members, community-based service providers, and external professionals (e.g., lawyers, social workers), who have to go through one or two additional steps to gain entry into the units. At the portal’s security desk, visitors are asked for their name and are registered as visitors. Based on the key informant interviews, some
viewed this process as an onerous, unnecessary step that seems like social control, even stigma. For others, being asked your name seems like a sensible and expected step for someone visiting a loved one in a controlled environment, especially in an increasingly security-conscious world. The latter position was supported by the survey results, as most individuals were comfortable giving their names at the security desk (Table).

The family members from the Seniors Mental Health Behavioural Unit felt the least favorably about the portal because it makes it more difficult for them to visit. In addition, their family members do not benefit from the portal because their unit doors must remain locked because of some patients’ symptoms (e.g., wandering due to dementia). However, family members noted that they enjoy bringing their loved ones to the gallery and expressed appreciation of the portal from a safety perspective, in terms of keeping out individuals who and exit the inpatient side through a number of access points, not just the portal.

Field notes from the naturalistic observations indicate that certain security staff members provided better customer service, such as smiling, using a warm tone of voice, and apologizing for wait times. This variability depended largely on the personality of the individual, not whether he or she was hospital staff or a contracted security guard. However, with the exception of one or two individuals, most guards provided professional, courteous service, suggesting no particularly adverse consequence of having to speak to a security staff member before accessing the inpatient area.

Findings suggest that having to go through the portal is only a minor inconvenience for visitors and patients who are able to leave the inpatient side. Observations showed that it takes an average of 1 minute, from the moment a visitor approaches the portal, to getting on the other side. The majority of visitors responded positively about the wait time (Table).

**Theme 2: Safety and Security Versus Stigma**

The portal was intended to manage safety and security without compromising autonomy (Eggert et al., 2014). One of the most important goals of the new design was to protect patients who were vulnerable to individuals participating in illegal activity (e.g., dealing drugs). The portal was envisioned as a deterrent by having a security guard ask for names before issuing a visitor pass. The portal also acted as a second safety net for patients leaving their units without authorization. If patients leave their units without permission, they can more easily be found and brought back, without requiring a report to the police, as is the case of patients in the forensics program or involuntary patients. Finally, having visitors check in at the portal serves to generate a record of who has entered the building in case of an emergency (e.g., a fire).

As one key informant explained, the drawback to these safety and security measures is that they may be seen to increase the stigma of mental illness by further associating mental illness with criminality. Another concern is that the experience of going through the sally-port of the portal could be unpleasant or even triggering for patients who have been incarcerated or otherwise traumatized from being enclosed.

It is difficult to quantify the benefits of the facility design to safety and security because these are largely preventative measures, and measuring them would depend on estimating adverse events that were prevented. Security staff at the portal have a list of individuals who would be turned away if they requested access to the inpatient side.

Patients, managers, and visitors are generally positive about the increased levels of safety and security made possible by the portal. In focus group discussions, most patients expressed feeling safer with the restricted access into the facility. As one patient stated, “I would prefer the [portal] doors remain for safety reasons.” Another patient commented, “I like seeing visitor badges and knowing that the visitor belongs here, as opposed to someone who has just wandered in and shouldn’t be here.” Another patient noted, “Security makes me feel safe; I like that they know what’s going on.” The portal also provides patients with a sense of ownership of the

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KEYPOINTS

1. The recovery-oriented care model, emphasizing hope, empowerment, self-determination, and responsibility in care provided by mental health service practices, is being used to inform mental health facility design.

2. One of the newest recovery-oriented mental health facility designs is a secure transition zone between the inpatient and public areas created by a secure entryway (or portal).

3. Four principle pros and cons of these new features were identified:
   (a) autonomy versus inconvenience; (b) safety and security versus stigma; (c) unit door versus portal operating costs; and (d) privacy versus community integration.

4. Results showed that the pros outweighed the cons for each theme, except for the privacy versus community integration, where neither position was more supported.

5. By using a recovery-oriented model of care to guide the facility design and evaluation of that design, the hospital leadership chose to keep the portal operating as intended.

Responses to the survey question about providing personal information to security staff reinforced that most individuals are generally accepting of modern security measures. They also rated the security personnel’s friendliness above average (Table), indicating that the security staff’s roles are important and professionally executed and not particularly stigmatizing.

Theme 3: Unit Door Versus Portal Operating Costs
As a publicly funded institution, SJHH’s leadership have a responsibility to ensure the public receives good value for health care dollars. There are always financial considerations for any decision, and this holds true to the role and value of the portal. The design is complete and the portal built, so setting these capital and start-up costs aside, the study researchers compared the different costs of operating or not operating the portal. In an interview, security supervisors estimated that it requires one additional full-time staff member to operate the portal (i.e., provide visitor passes and answer questions).

However, the portal also creates costs savings because many units can now have their doors unlocked, or even open, resulting in clinical staff spending less time opening unit doors for patients and visitors (of 13 operating units, four are routinely and two are occasionally left unlocked). On these units, patients and visitors can come and go as they please. On units that remain locked, individuals who do not have an activated SJHH identification badge (e.g., patients, visitors, staff from other hospital sites) must be allowed on or off the unit by a unit staff member. Observations showed that approximately 2.5 hours of nursing time per day are used to manage the door on a locked unit. Not only is this labor-intensive, there is the additional adverse effect of being disrupted (e.g., interruptions in conversations with patients).

Overall, the cost of an additional security staff member is minimal compared with the cost savings of un-
locked units. As a general estimate (based on interviews with security managers and observation data), the dollar costs associated with both options are approximately equal: $100,000 each (5,827 hours of security staff = ~$104,832; 1,820 hours of provider time = ~$91,100). Therefore, keeping the portal is justified from a financial perspective.

Theme 4: Privacy Versus Community Integration

The facility was designed to support patients’ privacy and sense of ownership and control over the spaces they are using. However, the facility was also intended to support integration with the surrounding community to foster patients’ independence and re-engagement in the community. Both of these priorities are in keeping with recovery-oriented care (Ballard, 2008). These priorities were managed by building a flexible perimeter that would allow a large section of the galleria to be opened to the public. As of yet, this system has not been used, and the findings suggest that it may not be necessary.

Patients value the galleria and the amenities it offers. They are not against it being more accessible to the public; however, some patients expressed a preference for increased privacy. As one patient explained, “It is a checkpoint for us to get out, but it’s a checkpoint for them to come in as well, and people can’t roam the hospital.” On the other hand, according to another key informant, there has been much demand to have community partners use this space. Ultimately, if the demand for access to the inpatient side increases, it would be possible to address this issue. For the time being, priority is being placed on keeping access to the inpatient side more restricted to protect patients’ privacy and sense of ownership over the space.

Leadership Forum Feedback

Attendees who provided feedback on the study at the Leadership Forum included directors and managers, as well as others in leadership positions, such as nurse educators and program evaluators from the Mental Health and Addictions Program. The response at the Leadership Forum was one of generally pleasant surprise that patients were enthusiastic about the impact of the portal on their experiences, based on the informal survey (n = 21) taken at the end of the forum. As one attendee noted, “The responses from patients were most moving...that they understood the vision and were prepared to live with the portal to improve their peers’ lives.” Most attendees preferred to keep the portal and galleria, and those who did not were persuaded by the results shown above presented at the time. Of the nine individuals whose opinions were changed by the presentation, all changed to either yes or not sure from not wanting to keep it. One individual remained unconvinced of the value, even after viewing the findings, stating, “Good idea for now but depends on value for money.” The remaining 11 individuals came to the meeting being convinced of keeping the portal and remained so, as captured by this comment: “Thanks, really helpful to have data. Always felt it was needed; however, appreciate now having data for rationale to keep it [the portal].”

CONCLUSION AND IMPLICATIONS FOR NURSING PRACTICE

The various methods presented combine to inform an overall picture of the impact of the portal and galleria on the four themes that capture the most salient controversies about the design. Results suggested that the pros of keeping the portal outweigh the cons (Figure 4) for each of these themes despite the unexpected challenges associated with the novel and unique facility design. As a result of the findings, SJHH leadership was guided by patients’ perspectives and experiences to continue operating the portal as designed, albeit with minor adjustments.

REFERENCES


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