Transcript

Inclusive Spaces: Environments for Mental Health

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Speakers *(order of appearance)*:

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**DR EVANGELIA CHRYSIKOU:**

Welcome to the Inclusive Spaces seminar series at The Bartlett, the Faculty of the Built Environment here at UCL. I am Dr. Evangelia Chrysikou, Associate Professor, The Bartlett School of Sustainable Construction, here at University College London, UCL, and I'll be hosting this Inclusive Spaces session. Inclusive Spaces is a monthly online event series led by The Bartlett - eh – Equality, Diversity and Inclusion EDI group where we explore disability, race, gender, LGBTQI+ and many other dimensions of diversity and discover how they intersect with the built environment around the world.

Today, you have joined the May edition of Inclusive Spaces, Environments for Mental Health. So for the introduction today it’s my pleasure to welcome Prof Helen Killaspy who is a Professor and Honorary Consultant in Rehabilitation Psychiatry at UCL and Camden and Islington NHS Foundation Trust. And Katherine Barrett, mental health service user and since 2009 co-chair with Prof Helen Killaspy of the Service User Research For a at UCL. Now, about the session today, we will explore the architecture of psychiatric buildings with a focus on involving end-users in the design and planning of mental health care services and built environments.

So as I said empowerment and architecture for mental health. So how architecture can empowerment, what I have found out from my research which spans since the nineties actually, on psychiatric built environments. So Professor Christiansen, sometime a while ago, so , things might have changed but not dramatically, did this amazing work at the Harvard business group. Where he classified all the pathologies according to how easy it is to diagnose them, how accurate and how accurate we can offer a solution.

So here you can see several diseases like the only mental health but also anything from fractures and cancers. What we see is that two of the most common mental health conditions, depression and schizophrenia, they are very close to zero. To the beginning of the access. That means we have a difficulty to establish a very accurate diagnosis. Like for example we have an x-ray for fractures.

And at the same time a very, it’s a bit more tricky to give a permanent solution. Again like plaster for fractures. So for this reason these conditions are normally long-term. And people spend quite some time in psychiatric facilities. For that purpose and going back to Christiansen's diagram, medication, since we don't have certain accurate diagnosis we cannot have certain accurate intervention. Like as I said with if you broke something, there is a plaster involved and the doctor puts the plaster and after a few weeks that is gone forever. So we don't have that level of accuracy of intervention will with dementia.

But we need to give some important to the other elements that are part of the therapeutic environment. So and actually that happens in every, in every healthcare condition. It’s not only in mental health that we do have these elements. So we have the medical intervention. We have the therapeutic interaction with staff and then also the space that this therapy takes place. But because here, the first element cannot give all the accuracies so you go to the hospital, you get the pill and you go back home and you forget about what happened.

Here, we need to place more emphasis in the other two elements. Like staff and the Built Environment. Because they cannot cure the built – at least the built environment cannot cure any body but the person will stay longer in these facilities. And also they can support or hinder the treatment. Therefore their role, especially because of this long-term element, is very important.

I will talk to you about three recent projects that I have done. One is in the nineties. The other is like 2010 and the other is somewhere between 2010 and 2020. And the third is more recent. The pictures that you see from like surrounded by blue and grey. They belong in the earlier part. And these pictures healthcare facilities in France, psychiatric facilities in France. In the pictures and grey are psychiatric facilities in the UK and I did a lot of research in these buildings, like involved with patients, staff but also some independent research involving the plans and the space along how I could evaluate. And then I repeated the research and some other facilities in London this time. These are the pinkish one. And recently we have done some work in New Zealand where there was some novelty there there, because New Zealand is not only the Western medicine but we have also the modern medicine and also the modern population that are kind of different culturally.

Through this work I have developed a theory. The SCP Model, where every facility can be evaluated and the main axis that I believe is important are the safety and security of the environment. What competence allows for people to gain or retain. In the personalisation and choice of the end-users.

But what I have found in this research is some of the most, the buildings that I would expect to perform better and I mean in some of the facilities that were quite famous when I conducted the research and actually I came as an architectural researcher to admire those buildings in their architectural qualities. And these are the two buildings on the top they performed very bad. Both from the perspective of what the end-users and the staff said. But also from my methodology that was completely independent from what people said and suggested. And actually, they had – one of them – the same exact score with a facility in France. Which was not therapeutic at all. People reported many social problems and here we see, for example, a typical bedroom. And this was a three bed facility most of them where it was a women’s facility and you can see here one bedroom but there are another two beds – sorry one bed but there are another two beds in the room. And hidden behind the curtain is the toilet. So, no privacy, humiliating conditions but the scores and the responses of the people were kind of similar. And if I go and show you all of the facilities that I have seen, that I have used the same methodologies throughout the years, the two buildings that I mentioned that were also the buildings that had received a lot of awards. They are were ward number two and ward six. Ward A and ward B belong in a different time zone. So Ward One to the ones that have the Latin numbers are the ones from the experiments in France and the UK – the original research in 2000. So these two projects, the awarded ones, one was among the second worse in the sample. Ward One was the worst. It was, it had equal score and how institutional it is. Like the highest the score shows how institutional the facility is. The building is. So it was equal institutional with the ward with a toilet in the middle of the rooms. And in that facility also, the one with the toilet, there were many other social problems. And also, yes, and some facilities that were kind of typical were between the 47 and 41 and one was 56, extremely poor. But as I said, the two wards were alarming. And there were two facilities that did exceptionally well. Ward nine and ward 10. These 2 facilities, they were designed from the beginning with the contribution of the service users. From the first stages of planning the service users had strong say in these facilities. And that actually reflected both in the how less institutional they look, more domestic looking. But also these facilities were the facilities that staff and service users were happy with the building.

Now and here, this is something. The two that you see with a yellow. These are recent facilities. So it’s a recent research project but one of them is actually more modern than the rest. And they are very institutional. And on that, I was surprised. I thought I did something wrong. But then I found research from Helen Killaspy that says actually that mental health facilities in the community can be quite institutional. And, actually, we don't necessarily solve or make things better as we progress.

At some point after this research, we did another project where we compared mental-health facilities with the health facilities in the community. And we found a lot of comparisons. And a lot of analogies. But the mental health was always the poor narrative and here you see part of the St. Pancreas hospital and part of the children's hospital in the same catchment area. And that is also very obvious and how not only the buildings look but where they are located. And psychiatric facilities they tend to be away from transportation, and kind of in the very very hidden away. Which requires a lot of time also for staff to get there. And that led to a project that we did for St Pancreas Hospital, where they wanted, they realized that in the new buildings that they were building they had to involve the patient. And they had to empower the people. So we prepared a consultation with the hospital the briefing stage of the planning. Of the new hospital were we needed to empower the patients.

We try to give examples, international examples to the patient's that say the facilities are not forgotten and actually they are designed. Maybe we don't agree with all of them but I want to show the approach of something else, something different happening somewhere else in the world. And these facilities are bit controversial from outside you can see how intense the treatment is inside, I wouldn't say I would agree. It reminds me more of… But it is an interesting example. This is something that I found by researching in the facility again abroad. That the service users before leaving the room to go back, they actually prepared a small gift for the next person that would use their room. And that was like another type of involvement from the service users to say I am here, I was here, like you are coming here. And I prepared something for you. For you to remember that you will get out like I got out and something that I believe will help you. So, and that was a nice practise. That I like.

Something that I liked in this psychiatric facility is that there was a theme, sorry for the presentation somehow has a mind of its own. But, and this is that the service users actually wanted when it was asking them “what you need in your ward?” because they spend a lot of time indoors. So I like that someone actually did it. And finally, that is another project that I really liked, that is in Libriana, in and I was therefore a public health event and spotted a shop in the most expensive area in Libriana in the most expensive spot where normally would expect luxurious jewelry store for example. But, that was a project run by end-users. And actually that was products created by artist and products created by service users. And it was run by service users. And actually there was a support line for people to call or to come and sit and engage. And for me that was very important. Not only because it was a very beautiful and successful gift store but also because it was in the heart of the city. In the prime location where you don't normally find something related to mental health. Because mental health as we saw in the other project pushes towards the very, but here it was a joined project with the service users and the artists and obviously the health service of Libriana is truly a unqiue example and makes a great example to be repeated everywhere.

And finally something else out of the box, in Paris there is a day centre that they travel around the river. And in the past like many, many centuries ago, the boats were associated with until illness as they carried patients across the rivers of Europe. But here and such a beautiful day centre and the biggest attraction of Paris which is the river, I would say is something very destigmatizing and give us hope on what we can achieve. So that is all for me. Thank you. I will stop sharing and I will welcome Helen and then Katherine.

**PROF HELEN KILLASPY:**

Hello there.

**KATHERINE BARRETT:**

Hello everyone!

**PROF HELEN KILLASPY:**

So, Leah, thanks very much for your introduction to this whole area. My name is Helen Killaspy I’m, as Leah said, I’m a professor in rehabilitation psychiatry at University College London. I’m also a clinician - I work half time for a mental health rehabilitation team in North London. And Leah’s asked Katherine and I to talk to you about our service user research forum, so I’m going to say a bit about how that forum came about and then Katherine’s going to talk about her experiences of being a member and for many years now the co-chair of the forum. And then after that we’ll have time for any of your questions that you’ve posted into the Q&A. So we started the server users research forum, I will call it S.U.R.F the from now on because that’s quicker, we founded the S.U.R.F in 2005. And the reason we did that is because up until that point the process of involving service users in the development of research protocols, research funding applications was really very tokenistic. Funders would expect us to be able to write something about patient and public involvement of PPI, but it was often just a very small line in a funding application and a tick box and had to be signed by a lead service user. So that the process basically was incredibly tokenistic. And there was a particular service user who is very involved with the local mental health organisation who tended to just sort of lend his signature to these forms. So did not feel like authentic service user involvement or consultation user at all. And so we set up without any, really an awful lot of thought. This idea of a server research forum. We put an advert out for service users who might be interested in coming to hear about it. And we held a meeting or two to tell people what we were thinking. And about 30 or so people came along to the initial meetings.

And over the time that the forum has been running, that initial group of 20 to 30 people has really established a core membership of more like 12 to 15 people. And we meet every three months or so at University College London before the pandemic and since the pandemic online.

And the format is consultation. So the meetings usually involve two sometimes three, but more commonly two presentations from researchers who want to talk about their project and get feedback from service user experts.

The kinds of projects that are discussed is quite broad. And often is the focus on health service research obviously for our population, mental health services research. So applied clinical research, neuroscience applied, clinical neuroscience. Sometimes people are presenting studies that are evaluating new interventions, psychosocial interventions. But sometimes they are wanting to talk about new technologies, apps and other kinds of technologies. So it’s quite a broad range of topics that might be brought to the S.U.R.F.

I guess over the time we have been running – now it’s 18 years – it’s something like 150 projects that the S.U.R.F. has consulted on. We give a little bit of guidance to people who are presenting their projects to suggest that, you know, they might want to send a brief summary ahead of the meeting so that the member of the S.U.R.F. have time to sort of think about the project before the meeting and if the researcher wants to give a specific feedback on any particular aspect, then obviously they should focus on that when they are talking to the S.U.R.F. They usually have about half and hour to 40 minutes for the discussion.

So you know it gives enough time for people to hopefully get whatever feedback they need. The other part of the S.U.R.F. is as well as providing this consultation function, what we also do is to provide the opportunity for researchers to invite if they would like. A service user or more than one service user to join the project for example on the project management group or steering group, or as part of their service user reference group. Sometimes S.U.R.F. members have been employed on projects as researchers collecting data, interviewing, co-facilitating focus groups. And then they might also be involved in analysing data and interpreting results and giving advice on recruitment. Also helping with the writing of papers, presenting at conferences.

So basically, the sort S.U.R.F. experience is also building research capacity for S.U.R.F. members. And that was a process that evolved over time. When we first set up the forum some of the members really wanted us to sort of train them to be researchers. And the S.U.R.F. when it was first funded had no funding we had a very very small amount of funding from our mental health organisation and the University to pay the S.U.R.F. members a little for their time. And so this process by which people actually then link into studies that have been presented at the S.U.R.F. provided a much better model for service user to gain hands-on research experience if they want to. And that has been really successful and I think pretty much all of our S.U.R.F. members have had at least one of those roles over the years and many of them have many roles and take these sorts of positions on with specific research projects very frequently.

Um, I mentioned all the S.U.R.F. the members are paid, of course, they are paid for attending the meeting. We used to fund that through asking researchers to pay a consultation fee if their project was funded. Often people would come to talk about the project before they have submitted it for funding. So we don't charge them at that point. But if they are successful and their project is funded, then we asked them to potentially payback a fee for their consultation that they’ve had with the S.U.R.F. and quite often people will build in further consultations as part of the PPI for their project and of course those also need to be funded. That was quite a precarious funding model. Because we see a lot of researchers that come to the S.U.R.F. and talk about projects and of course they all don't get funded. And also it’s kind of embarrassing going around and having to contact people and ask for money after the event.

So I'm very pleased to say that for the last nine years we've been funded in a much more robust way through the Biomedical Research Centre at UCL's mental health's theme and so that has really, really helped so that we have a much more secure footing.

I guess the other sort of USP of about this model is that most PPI in research studies in other fields, not just mental health, will invite people to give their perspective on a project because they are service users, absolutely right. That's what researchers want, they want to have service user perspectives on the research idea. The rationale for the research and then the specific methodology and other aspects.

But what S.U.R.F. allows is for us to have built the expertise amongst the members of the group. So yes they definitely give their views based on their own personal experiences of having mental health problems and using mental health services. But they have also over time of course gained this expertise around research methodology. And so you are getting kind of two for one of and so they understand the potential tensions and difficulties and the different sort of payoffs that researchers have to make when designing a project to fit into a certain timeframe and a certain budget.

So it has felt as though it has been a rather sort of organic development of this model that and has been successful and we never have a shortage of people to present at the S.U.R.F. We often have to organise additional meanings because we are too much demand for our quarterly meetings. And I guess the fact that has been running all of this time, 18 years, is also some evidence that it seems to be providing some useful service. I'm going to stop talking now to give Katherine the opportunity to say a few words so I’ll hand over to you Katherine if it that is okay.

**KATHERINE BARRETT:**

Thanks Helen. Thank you. Hello everyone! Yeah, so I am a mental health service user. And I will tell you a little bit about the process of the Server User Research Forum. It runs as often as we need it really, but usually about four or five times a year. We meet online for one and half hours and as Helen said the participants are paid which is great.

There is usually two to three presentations per meeting. And they are usually UCL researchers but sometimes the researchers are from other organisations. Each presenter has about half and hour to present and get feedback from the service users present. They often present on PowerPoint and then there is plenty of time for questions and answers. This involvement is great for service users as we hear about research being conducted. And how the S.U.R.F. helps research refine their studies and gain successful applications. It also helps service users gain confidence and then about the relevance of mental health research.

I feel that this format is just right for the group. Allows plenty of time for question and answers. Both from the presenters and the participants and what works well online. Sometimes the researchers want more involvement from the participants or extra involvement is arranged. Coproduction of research proposals is highly valued by researchers at UCL and S.U.R.F. find their role highly stimulating and rewarding. The fact that S.U.R.F. has been running for so many years is evident of how much it is valued and used.

We had strong views on one presentation we had recently. Videos on the ward. And the participants don't want to see this on Camden and Islington ward. They didn't like the subject, it’s not often there’s such strong views about a study in this presentation so it's important for the researcher to hear. It was all about cameras on wards. The participants didn't like this idea at all and had strong views but that is not usually the case. Usually there is equal participation from the presenter and the participants.

Everyone has a voice and it’s important for everyone to have the opportunity to share their perspective and views in the S.U.R.F. meeting. And we are a friendly bunch who are polite in allowing everyone to speak. Everyone is encouraged to participate. Researchers have good comments about S.U.R.F. and we are often very positive about the projects realise all of the hard work that has gone into the presentation and realise all the hard work that has gone into the presentation.

As cochair of the group with Helen it is a great experience for me and has helped to learn about the relevance of mental health research and the processes involved in delivering good quality studies that can help improve people's lives. I look forward to S.U.R.F. meetings. They not only provide simulation but are also helpful researchers so it is a win-win situation. Thank you.

**PROF HELEN KILLASPY:**

It certainly feels like that doesn't Katherine?

**KATHERINE BARRETT:**

Yeah, yeah, yeah. It really does.

**PROF HELEN KILLASPY:**

The study that Katherine just mentioned I don't know if this is happening in other countries, Lia, you may be aware, but increasingly in the UK, and the inpatient mental health wards, staff are potentially having body cams on their uniforms or there are cameras within patient’s rooms and communal areas. And this is sort of sold as a way of trying to improve safety in these settings. And as Katherine has said, actually, of course it’s a huge human rights infringement issue here. So that was a particularly lively S.U.R.F. meeting and the researchers were wanting to evaluate the impact including service users experiences and views on it. But it was very clear, and it almost got to the point where people were saying we don't need research, we just don't want this at all. Just, you know, let’s just not evaluated. It is just a bad idea. But unfortunately, these things have already been implement. So as Katherine says quite often you know the topic of the research isn’t as contentious as that. But we do have a really lively discussion and there is sometimes quite a robust exchange of views. About different aspects of the research or even whether the members feel that the research is worthwhile is the actual main objective of it worthwhile?

More commonly though it will be a discussion about a specific aspect of the research, the researchers might bring a topic guide for qualitative interviews and ask for more precise and specific detailed feedback about the areas that are going to be covered or they might be asking about strategies through recruitment into the study.

So it covers the whole range really of research thinking, right from the design stage right through to dissemination and all of that can be covered in these forum.

So I think we are at a point we would be very happy to answer any queries or questions or just have a broader discussion Lia.

**DR EVANGELIA CHRYSIKOU:**

Yes, thank you Helen and Katherine for the presentation. Indeed, the group does a wonderful job. I’m looking at the… We have a couple of questions in the chat. The first is from Shmuel, it is addressed to me but I will address it to both of you actually. That is about the role of the government and public medicine system and empowerment and improving mental health. Which if I can mention here because for me actually this session is about the opposite. It doesn't matter what the government of the central systems do. But what we can do as people and as end-users and giving power for the service user even for the buildings or the research, for me that is the ultimate act of empowerment, leaving a strong voice and giving it in a way that a way that should be heard. Like structuring their voice in a way that is not as you said one service user that is involved in all of the project but making a collective voice important and clear. So yes it is about the opposite because I think this is what is missing.

**PROF HELEN KILLASPY:**

Yes.

**DR EVANGELIA CHRYSIKOU:**

Your opinion on that as well please?

**PROF HELEN KILLASPY:**

Well, I think you 're absolutely right Lia. The purpose of the S.U.R.F. the was to really try set up a structure that would have a collaborative culture and that would really empower and enable a group of people who have many of whom, all of whom have experienced mental health problems and many of whom have experienced severe mental health problems to have their voices heard. In this particular focus of it of course it is on research and research design. Mental health research. But that is a culture, this kind of trying to create collaborative forums to enable service users to give their perspective is a culture which really has improved in the UK at least over the time that I have worked in mental health which is about 30 years. We never used to talk about this term coproduction, but that’s very much the term these days that people use. I would say coproduction is one end of the production of service user involvement. Consultation is at the other end. And the S.U.R.F. is more on the consultation end of that spectrum than the co-productive. But is the very collaborative style that we foster.

I mean, my personal view is that all mental health services should foster and provide a collaborative culture. At every aspect of the service-level. And certainly in the individual interactions with service users between staff and service users. But also at the team level, at the management level, at the organisational level and actually, collaborative discussions is you know, it can be quite a skilled thing to facilitate a collaborative discussion. Particularly if they are very strong opinions in the room. Also if someone is not very well and so they might be you know taking a lot of the time or repeating the same point. Because they are not currently and less able to be aware of other people's needs.

So you know those sort of aspects of making this work in the mental health setting have to be considered as well. And I think we have managed to do that. I mean, Katherine and I won't go into detail but over the years there has been one or two times where we've had to sort of ourselves have a separate conversation to think about how to manage difficult situations. And we have managed all of them well without people becoming you know, annoyed or alienated or anything like that. But sometimes we do have to tweak the way that we are managing some of the forums.

But I think basically the sort of idea of a collaborative culture in a way in which we provide opportunities for people to be heard, that actually is what changes the quality of care. And you know, of course, you've given lots of examples of where the built environment lets us down terribly, and it really does. And is also true that we can do excellent work in dreadful buildings. You know, it’s not – we want both ideally. But you know it is possible to run an excellent service even when you're running out of a shabby building that has very, very poor facilities.

So you know more investment means that we can improve quality. But just throwing money at things does not work unless you also are also clear what you are going to spend that money on.

We did a study across Europe, some years ago looking at longer-term mental health facilities across 10 European countries. At different stages in their development of community mental health services. So some of them were countries that still had most of the mental health services in large, inpatient, institutions, and others had more community-based smaller facilities.

And we developed a measure to look at the quality of care that included the aspect around the Built Environment but also all sorts of other aspects of quality of care. And we did some modelling around the investment that the government makes in mental health. And it is, it's poorly sure-- and correlation between that proportion of the total health budget and the quality of care in longer-term facilities. And there was a very clear association. The higher the investment in mental health by the government the better the quality of longer term mental health facilities. So in a way, the quality of the mental health facilities gives you a sort of benchmark as to how much the government cares about mental health. And we also found that there was a sort of sweet spot and it was around 10 percent. If the government invested 10 percent or more of its health budget in mental health, then the quality of longer-term mental health facilities was above the European average. So we kind of know how much they should be investing for us to have adequate facilities for those with the most complex and longer-term needs. That was quite a long answer, sorry. [Laughter].

**DR EVANGELIA CHRYSIKOU:**

Thank you Helen. I mean, for us, we have obviously, I mean funding is important. For us, the interesting project comparison between mental health and healthcare services was that the budget at that time was quite high for mental health facilities. But so but still... I guess maybe the ratio of the funding for the building compared to a health facility might be different or the attitude. So I still believe that money is important. But it is not necessarily going in the right direction. I mean that is what the research that involved the awarded facilities showed, that the expensive facilities that were awarded where in the wrong direction. Because for example they had a garden that the service users could not access because it was not safe enough for them and there was drug trafficking in those gardens and so people spend time, and so there were bad design decisions. And also in mental health facilities. The building is the only equipment that you have. In the hospital you have a lot of machines and diagnostics and very, very complex technologies that occupy the budget and also they have a direct impact.

But in the psychiatric architecture, that’s – there is no equipment. So it’s the building and the people who stay there for months. So if you get it right they will be in a place that they need to be, if you get it wrong, they will be like in a prison for months and it’s bad for them. So, but as I said the impact is quite different. But yes. As I said the end user involvement I believe it is still very, very important. Even when the funding is there. As a show from my research.

Someone is asking, Eunice is asking what does S.U.R.F. stand for?

**KATHERINE BARRETT:**

Service User Research Forum.

**DR EVANGELIA CHRYSIKOU:**

Yes, thank you. And, so, and people are asking if you are involved in the development of architectural projects not research project?

**PROF HELEN KILLASPY:**

Well Lia, you’ve brought your consultation to the S.U.R.F. for consultation, so you’ve had the direct S.U.R.F. experience yourself a couple of times.

**DR EVANGELIA CHRYSIKOU:**

Architectural research projects yes.

**PROF HELEN KILLASPY:**

Indeed. I think, I mean Katherine you might want to speak to this about your involvement when there were new designs within the mental health estates within the trust.

**KATHERINE BARRETT:**

Yes we have been fully involved. There’s a new hospital being built at Archway. Near the Whittington. And the St. Pancreas site wards are all moving there shortly and we have been very involved in coproducing the development with the architects so that has been great and that’s been on for a few years. There’s also a there is a big in Holloway of the CMHT, um, they’ve flattened it and they’re rebuilding it. So there is a lot of work going on in Camden and Islington, with new buildings and this will all be being used within the next 2 years. I think the aim is to move the wards from St Pancreas the end of this year so, yeah, it has been great to be involved with the architects and they really did listen and change some of their thinking with our input.

**PROF HELEN KILLASPY:**

That is good to hear. I can see there is also a question about feeding into things like the colors and the specific design that is chosen. Did you feel that those-

**KATHERINE BARRETT:**

Yes we did talk about the colors in the design definitely. Yes.

**DR EVANGELIA CHRYSIKOU:**

My experience from that consultation, because we were involved, at some point at the beginning – because this was a massive consultation for the St Pancreas hospital – I mean, it was very successful by the amount of how many staff that were involved. And how many patients were involved. And it was a very, very active space.

Initially it was at the planning stage, somehow the planners and the architects were not familiar on how to listen to the end-users. And because I was there and all of the meetings, like for the new hospital, it was, so… I guess also the fact that there was people experienced in giving feedback from the end-users, but also we had the project that we did to prepare everybody who was not familiar with such processes in order to gain their voice. And this is a recent work that we have on how you need to prime the end user.

In general, not only mental health, in dementia, in other healthcare projects. Especially, but mental health is very important because there is a history of institutionalisation and everyone is proud of their opinion for many, many centuries, not years. So it is difficult to have that voice. So I guess, I mean you are doing that with S.U.R.F. and that is the purpose of S.U.R.F. of and the success, but… It’s not easy for somebody who is not well in general, to give feedback and it is not easy out of the blue, it is intimidating in the beginning. You see people that have studied those things, have a strong opinion and that you feel you cannot raise your voice and say you disagree or things might be different.

And this work of priming and preparing the ground for the voice to be first raised and then shared. I think that is an important contribution of S.U.R.F. of because there has been worked there on how.

**PROF HELEN KILLASPY:**

I think that is right Lia and I think, as I was talking about before when we first began, the first meetings, researchers might come to a project and it will be hard for people to have many comments to make. Because you know they did not necessarily feel that they had the expertise to say what I don't think that is the right approach here. But over time of course people have got much more familiar with how research projects are designed. And it’s the same if you are thing about you know what is the process for a redesign of a building or a building of a totally new facility? That you know you need to be empowered to know what you can comment on.

So if you raise a point in somebody sort of you know shuts you down and say well no, that’s not really negotiable kind of response then of course you feel you can say anything again. So giving people the opportunity to understand and that is one of the reasons that we ask researchers to send a brief summary of the project before the meeting. People often need time to process, to read and to have a think and there are cognitive sequalae of severe mental health problems and people sometimes need some adaptations to be able to take information in. So if a researcher comes with a large number of PowerPoint slides and very technical data got you just lose the audience very quickly. And you know I think we have done that now, I think we do know how to do this in the S.U.R.F. format well. But pictures are much better, in fact, we generally discourage people from using PowerPoint in our S.U.R.F. meetings and some people do. [Laughter].

We just make sure that it is as minimal as possible because it tends to be a distraction, and tends not to help but what tends to help is is explaining it in words. And it’s also good practise for researchers to explain their research project simply in a way that a member of the public can understand it.

I see that there is a couple other questions in the Q&A.

**DR EVANGELIA CHRYSIKOU:**

There are questions about mostly if your work would be extended outside the institutions to the city level, to public mental health?

**PROF HELEN KILLASPY:**

I have not done that myself. I mean I work in the community so my research is on, you know the services and interventions that go on within those services. To help people live as independently with as high a quality of life as possible in the community. I must say that we have little research in my experience on the outside space in mental health facilities. I think there is a bit more focus on that for inpatient facilities. For things like mental health supported accommodation or community base units. I think people don't think about enough. They tend to get very focused on the building and the rooms in the building and the office space with the staff and the consultation rooms. And they think a bit less about the outside space. And actually the outside space is very important because if people are attending a centre for appointments then it is very common they would want to have a bit of time outside before they come in for their appointment or after they have had their appointment. So we should think about it more. But I am not aware of any specific research on that.

**DR EVANGELIA CHRYSIKOU:**

Yes it is the project that we had about the comparison of mental health. We didn’t look inside the buildings, we only looked on the facades, what people do on the outside. We did not think of it, like, as you say, but we thought what community is because it's what people say about the psychiatric buildings and how they are predisposed. And how they can be regenerated. But there is the space just before you enter and must have as we prime for the consultation, technically we prime the people in the way it is perceived is very important.

**PROF HELEN KILLASPY:**

It is.

**DR EVANGELIA CHRYSIKOU:**

I see there is a question about interaquality. There are is data, I had a lot of great data that I did not have time to publish. About how people felt et cetera. So if you want we can discuss it at one point but I guess it is very important topic especially the windows don't open in most facilities.

**PROF HELEN KILLASPY:**

Yes.

**DR EVANGELIA CHRYSIKOU:**

And not so much of the thermal control, I mean, there is if you have ever been in a psychiatric facility during a heat wave and I have happened to do research, it is very difficult, for the patients it is very difficult, even for me, so I think it’s a very important topic.

**PROF HELEN KILLASPY:**

Absolutely, it’s horrific is the truth. The last few summers have been awful the windows in our newest mental health facility in North London, as you say of course they don't open for safety reasons, they have vents, it doesn't allow any throughput of air. You know it feels very suffocating and of course that cannot be good for people's well-being. [Laughter].

So I think there is a research question and their actually about that budget control.

**DR EVANGELIA CHRYSIKOU:**

The temperature, the air quality and also, I would connected it to the axis of exterior space. Like the exterior, the internal exterior like from my experience and also personal experience that was a very, very big problem. There are many aspects there of safety and security, it is actually when I show the model, that says about safety and security, and the other axis that says about control. These two axis, they have a very strong argument between themselves to solve. That.

**PROF HELEN KILLASPY:**

Yes.

**DR EVANGELIA CHRYSIKOU:**

Yes and I think we are a little bit close to the end. We only have one minute. It was wonderful having your questions and unfortunately what we have a live audience, we didn't have time to refer to all of your questions. Which is a pity. But I mean a researcher is always easy to find. Both myself and Helen and the S.U.R.F. group is very, very easy to find our emails from the UCL website. And in that sense we would be very happy to discuss it with you.

**PROF HELEN KILLASPY:**

Just to add Lia, I think there was a query about whether the S.U.R.F. has open for UCL people. We tend to work with anyone who is working across North London but we are not actually that closed to working with anyone. So if you know someone who wants to use the S.U.R.F. to consult that doesn't happen to be working in North London I'm sure we would be open to that as well, if we can help we will.

**DR EVANGELIA CHRYSIKOU:**

Yes, we have done… I have done a S.U.R.F. group with researchers from Germany.

**PROF HELEN KILLASPY:**

[Laughter] right.

**DR EVANGELIA CHRYSIKOU:**

Okay so to wrap up the session. I would like to thank everybody for joining us today. And a big thank you to our panel. For your time and contributions to the discussion.

Thank you.

Thank you.