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Design interventions to repair migrants' mental well-being: The 'Culture in Mind' healing space

ABSTRACT

The intention of this article is to present the transformation of a space that houses a migrant-oriented community service with a focus on mental health and well-being (Culture in Mind) into an inviting milieu, which fosters healing processes, inter-cultural understanding and community empowerment in Brisbane, Australia. This project, which was formed as a case study, is described through its ideation phase, the installation methods, the sourcing and use of reclaimed materials as well as the methods employed for the collection of data, including interviews conducted for the evaluation of the design interventions. In like manner, the outcomes of the data analysis are discussed in conjunction with evidence provided by relevant studies and photos collected through the documentation process. The final part of the article is dedicated to arguing the necessity of different understandings of mental health according to non-western cultural backgrounds so as to inform the design of mental health services and physical settings and enhance sentiments of privacy, safety and dignity for migrant patients.

Background: Understanding the relationship between mental health care and the built environment

The connection of mental health to the built environment usually leads people to think of clinical settings with bars, white walls and metal beds. That is how mental institutions have been, notoriously, depicted in films, songs and literature but also in explorations of mental illness coming from philosophy and psychology. In *Madness and Civilization* Michel Foucault ([1964] 2001) negotiated the birth of the asylum and described built environments defined by cultural and religious preconceptions of insanity. Along with Foucault, a number of theorists (Szasz 1997; Guattari 1995; Illich 1976) have stressed the role societal structures play in defining mental health and its opposite. With this in mind, what can be drawn from the historical retrospect of the physical structures of mental health facilities is the reality of an ever-changing context according to the Zeitgeist.

The exploration of how these particular settings affect behaviour, the healing process or deterioration of the patient's condition did not fully arrive until the 1970s when human geographers, psychologists and architects became interested in these research questions. Since then, studies, especially in the field of environmental psychology, have produced a body of knowledge examining the interaction between the physical environment and human psyche in many different settings.

Despite growing attention regarding the design of mental health services, existing studies have not yet emphasized the need for healing environments created for migrants. The distinction between the general and migrant population is based on the fact that newcomers carry different cultural backgrounds and perceptions of their psychological states. As defined by Sarah Lischer 'refugee mental health refers to the specific psychological health concerns of those who have been forcibly displaced from their country of origin', and in many cases have lived through 'torture' (Lischer cited in Slewa-Younan et al. 2014: 320) and 'deprivation of necessities such as adequate food and clean water and experiences of civil war' (Cronin et al. cited in Slewa-Younan et al. 2014: 320). Furthermore, resettled populations are reluctant to employ western mental health services notwithstanding an increased possibility of a significant proportion suffering from 'trauma' and 'post-traumatic stress disorder (PTSD)' (Slewa-Younan et al. 2014: 321). The latter should be considered whilst bearing in mind that migrants' mental states are defined and classified according to western standards and diagnostic tools, like the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V). To highlight the necessity for a culturally informed and appropriate approach to migrant mental health, the following sections present design's role in generating a positive effect through mental health settings on patients and healthcare practitioners as well as the existing physical, social and diagnostic framework supporting migrant psychology.

Design's contribution to improving the experience of health and mental health settings

Findings from studies conducted within the past few decades offer insights concerning how health and mental health settings could accommodate healing conditions and enable faster recovery. Roger Ulrich's (1991) theory of supportive design underlined the importance of considering physical features in order to improve the stress levels of patients within hospitals. Unwanted or unpredictable environmental circumstances can lead to elevated stress levels (Evans

1982; Evans and Cohen 1987), which could be minimized through design features able to give more control over the ambient environment (e.g. individual thermostats, dimmer switches), and nature functioning as an indirect feature of design that could battle staff's mental fatigue (Kaplan 1995; Kaplan and Kaplan 1989) and meliorate stressful conditions (Ulrich 1981). Donald McKahan (1997) also highlighted the humanistic and therapeutic perspectives that can be created through design in hospital settings by enhancing properties such as views and access to nature, ceiling design, acoustic properties, artwork and colour.

Other research outcomes have indicated that a quiet healthcare setting is achieved primarily through the appropriate design of the physical environment, and not through changes in organizational culture and staff management (Ulrich 2006). In fact, interior design features (colours, finishes, artwork and the layout of furnishings in healthcare settings) have been related to the comfort or discomfort of patients and practitioners (Shumaker and Reizenstein 1982; Carpman and Grant 1993; Fottler et al. 2000; Zimring et al. 1987) and there are statements from healthcare professionals supporting the belief that aesthetically pleasing decor and artwork can improve the patient experience (Behrman 1997; Fottler et al. 2000; Friedrich 1999).

Finally, Sally Shumaker and Janet Reizenstein (1982; see also Carpman and Grant 1993; Shumaker and Pequegnat 1989; Zimring et al. 1987) summarized four important factors to consider in relation to healthcare settings, patient satisfaction and staff performance and well-being, these being: (1) way-finding or features that assist orientation around the healthcare facility; (2) physical comfort or features (ambient, architectural, interior design); (3) privacy and territoriality and (4) symbolic meaning or environmental messages (figure, atmosphere).

Besides the general context of health settings and their impact on patients and staff, research has been conducted on mental health facilities so as to enhance the experience of visitation or residency and facilitate the healing process. Neomi Kronish and Tiiu Poldma (2013), when assigned the redesigning of a psychiatric ward located in a community hospital in Canada, discovered that the spatial configuration of the ward was disrupting the provision of services and consequently the patients' treatment. From the data collected via a spatial analysis and the feedback received from patients and caregivers, they determined certain elements of design that facilitate (such as colour, lighting and spatial organization) and hinder (such as distractive sounds, spatial disorientation due to poor design, and institutional interiors) the healing process. Additionally, the researchers pointed out the importance of acknowledging the psychosocial factors affecting the space, an element also underlined by Gabriela Novotná et al. (2011) who emphasized the importance of exterior and interior design in lessening stigma and fear concerning mental health facilities. According to their findings, attractive exterior and interior spaces make the mental health environment as well as the patient's condition appear less threatening to patients, family and community. Home-like settings, privacy and supporting practitioner–patient interaction by limiting physical barriers were found to improve the experience of the space too.

The themes detected in the aforementioned studies have been identified in numerous other research articles, papers and theses, as shown by a literature review on mental health and architectural features realized by Kathleen Connellan et al. (2013). In detail, the review revealed that environmental aspects such as light and gardens could improve patients' level of stress,

interior details (e.g. colour, potted plants and new furniture) help create a therapeutic environment and spatial configuration enables security and privacy. 'Post-occupancy evaluation, and user engagement in the design process' could also lead to a sense of well-being and an improvement of psychopathological manifestations (Connellan et al. 2013:128–29).

Connections (or lack thereof) between mental health faculties and migrant populations

Taking the exploration of the connection between the built environment and mental health a step further, there has been a growing research interest in the link connecting migrants and mental health facilities. The emotional well-being of people from diverse cultural and ethnic backgrounds, especially those that had to flee their homelands due to a massive disaster, war or political upheaval, is a subject matter emphasized in several studies and publications nonetheless, there has not been sufficient evidence on mental health facilities oriented towards migrants. Another issue to take into consideration is the fact that mental health is a concept based on western cultural and habitual characteristics and framed by predominately Caucasian male psychologists situated in Europe and the United States. Using the western mental health structure to evaluate and support the psychological state of people who have been shaped by different 'lifeways, worldviews and value systems […] and concepts of well-being' (Paredes-Canilao and Babaran-Diaz 2013: 770) demonstrates a lack of intercultural understanding and acknowledgment of a different way of living. For instance, Virgilio Enriquez (1994) argues that the colonial psychology framework imposed on the Filipino societal context is irrelevant to the indigenous psychology where 'the babaylan/katalonan […] medicinal priests/priestesses […] administered over the harmonious relationship between the different dimensions of a person' (Enriquez cited in Paredes-Canilao and Babaran-Diaz 2013: 770). These people, mostly women, 'were central personalities in' (Paredes-Canilao and Babaran-Diaz 2013: 771) 'the fields of culture, religion and medicine and all kinds of theoretical knowledge about the phenomenon of nature' (Salazar cited in Paredes-Canilao and Babaran-Diaz 2013: 771).

The above is supported by Kenneth Miller and Lisa Rasco (2004), who pointed out the urgency for designing national strategies able to provide services tailored to the needs of non-western populations, the importance of family and community in mental recovery and adaptation and the recognition of alternatives to psychiatry and psychotherapy models of mental healing. A study conducted by Erminia Colucci et al. (2015) in multiethnic Melbourne, demonstrated the difficulties that young people experience when it comes to accessing mental health services due to cultural misconceptions and the system's insufficiency to successfully engage them so as to receive proper counselling and treatment. In this context, the study underlined the significance of making available to migrant populations a comprehensible framework regarding mental health and creating psychosocial structures involving family, community and a network of culturally trained practitioners and facilitators.

Notwithstanding research findings recognizing the importance of exploring further the role of cultural transition and acknowledgement of cultural difference in relation to mental health, there is not much evidence about the design of facilities that house multiculturally oriented healthcare services. This

was discovered while conducting the preliminary research for the realization of design interventions in a well-being community clinic located in Brisbane, Australia. As a case in point, the study presented in this article emerged from an invitation to the author to assist Culture in Mind, a 'community-based service that supports the social, emotional and mental wellbeing of migrants, refugees and asylum seekers in the greater Brisbane area'[1]; the objective was to improve the 'clients' (as the patients were referred to by the staff members) and employees, volunteers and students' experience of the space. Culture in Mind is a joint initiative by Multicultural Queensland (MDA), an independent multicultural agency providing settlement services to newcomers (refugees, asylum seekers and immigrants) and World Wellness Group, a social enterprise that provides western and alternative health care services via a Brisbane-based community clinic. The clients of the World Wellness Group and Culture in Mind are migrants that have limited access to health and especially mental care and they mostly come from Iran, Iraq, Afghanistan, Sri Lanka as well as Burma and African countries. These people usually seek treatment for conditions such as PTSD, depression and anxiety, and occasionally for more severe psychopathological conditions. Both facilities offer services to 20–50 persons per day.

The incentive to partially renovate the Culture in Mind facility was created by descriptions of the practitioners in regard to the meeting and group spaces as well as the open plan office area; the concerns raised were about the space limiting their ability to perform and clients not receiving the best possible support. For the purpose of enhancing the Culture in Mind facility's healing intentions by design, interventions were implemented in order to create a therapeutic environment with the use of reclaimed materials and low budget design solutions so as to improve the experience of the space for both practitioners and clients. At the same time a framework including participatory design and post-occupancy evaluation was created, which was structured and documented in the form of a case study. In brief, the aim of this project was to compliment the efforts of an intercultural community-based facility to produce a healing space via minor design interventions and make present the necessity of designing interculturally and sustainably for well-being.

Methods

The ideation phase and realization of the design interventions took place between May and September 2015. A qualitative approach was adopted for the collection of data involving group consultations, literature reviews, documentation of the spatial characteristics of the space, interviews and their analysis. The research process did not commence before ethical approval was granted by Griffith University's Human Ethics Research Office (Protocol Number 2015/829). The study and interventions were conducted by a design team that consisted of the author, who acted as the chief investigator, and a group of third-year undergraduate design students who worked voluntarily on the project.

Selection of renovation materials and installation

The materials and furnishing used came mostly from op-shops, second-hand shops, salvage yards and curbside collection. New materials were used too but only when there were no other options available. The office cabinet that replaced the old one was salvaged from a curbside, the curtains, which were

adjusted to fit the windows, were second-hand and donated by a lady working at an op-shop, and the portable community garden as well as the storage system were designed and constructed by the students. The creation of the community garden involved the use of a salvaged crate, a homemade worm tower, recycled Styrofoam void filler and donated herb seedlings.

One of the interventions' aims was to minimize the office items so as to de-clutter the space and allow for easier movement and improve environmental comfort; this was achieved by replacing a bulky dark brown cabinet with a white slimmer one salvaged from a curbside and creating additional storage solutions such as shelving units over the working stations.

Creative interventions such as the art-piece (coloured map), the card-holder system and the handmade artistic instruction labels for the plants, were crafted and installed by the design team. Some of the plants were donated by nurseries and most of them were potted in second-hand pots. Most of the items were created at the Culture in Mind facility and the whole operation, including the fitting of the curtains, the installation of the storage system and shelves and the rearrangement of office and kitchenette items (the addition of hooks for the mugs and the blackboard) was realized by the students under the author's supervision and instructions.

Data collection

Consultations

The consultations took place throughout the indicated period with representative members from Culture in Mind who actively participated in the process via recommendations and feedback, providing a list of features to be changed, improved or added concerning the mental health facility. The course of action was grounded in recognition of the importance of the staff members' participation in the design conceptualization and planning process. The Culture in Mind members expressed their desire for the improvement of the open plan office's spatial configuration including the kitchenette, the replacement of the furniture where the printer was located, the addition of greenery and curtains, the creation of a home-like environment ('worry about dull painting in office space') and a connection to the local community by beautifying the entrance. There were also discussions about the lighting and the replacement of the entrance door and more signage being present inside and outside the premises of the facility.

The consultation process entailed the provision of detailed suggestions from the design team based on the staff members' recommendations and a comprehensive budget[2] connected to the design interventions. The design suggestions were informed by a literature review and evaluation of existing mental health/well-being and multicultural environments and the budget created was based on a pro-sustaining approach. The term is related to the selection of pre-loved and up-cycled furniture and objects, reusable and recyclable materials and the adoption of practices such as Do It Yourself (DIY). The author was in direct contact with the staff members during all stages while the students met with them after the completion of the design process and prior to the design applications so as to make sure that both parties shared the same aspirations concerning the space additions and alterations.

Documentation

The space was photographed and analysed prior to the consultation phase. For the purposes of the analysis the layout of the space was documented via drawings, room and windows measurements and floor plan sketches (Figure 1), and notes were taken regarding colours, lighting, materials and furniture. The facility consists of a group room, two meeting rooms, a massage room and an open plan office space.

Interviews

As part of a post-occupancy evaluation process (Blyth et al. 2006) interviews were conducted with the use of a custom-made questionnaire. Five key-members of both World Wellness Group and Culture in Mind were interviewed so as to collect information about the impact the space had on their everyday activities. The interviewees were not selected based on individual attributes (e.g. age, gender, socio-economic background) but on having a before and after experience of the design interventions; they were invited through a letter disseminated via e-mail, which included details about the process and the project's goals. The number was limited due to the nature of the study (case study), the interview questions (open-ended) and the overall number of personnel using the Culture in Mind facility (between ten and fifteen members, including students and casual staff). The case study could be characterized as exploratory because of the intention to identify the elements that contribute to the creation of a multicultural healing space. To do so, the questions asked during the interview were oriented towards pinpointing the sense and problematic aspects of the previous setting, the experience of the space after the design interventions and their impact on healing processes and the well-being of the practitioners and clients. In particular, the survey was divided in two parts. The questions 'how did the previous setting make you feel?' and 'what was wrong with the previous setting?' belonged to the first part, which related to the initial setting. The questions 'have the design interventions changed the way you experience the space?', 'does the new space help you to better connect with the clients?', 'what are the changes that you have noticed in regards to the clients' perception of this space?', 'have the design interventions improved the wellbeing of the practitioners and clients?', 'which are the most important behavioural changes that you have noticed in the space?' and 'which is the most important functional change in the space?' were included in the second section of the survey, which inquired about the experiences obtained after the design interventions took place.

Data analysis

For the analysis of the interviews, which were transcribed verbatim, content analysis was employed, and data were arranged in patterns and themes following a progression model based on Thomas Carney's 'ladder of abstraction' (Carney cited in Miles and Huberman 1994: 91) that allows the compacting, clustering and sorting of information. This method leads to connections and interpretations presented through a descriptive framework (Gherardi and Turner cited in Miles and Huberman 1994). The use of more than one data source (spatial documentation and analysis, literature review, interviews) enabled an exploration of the spatial characteristics that can actually improve

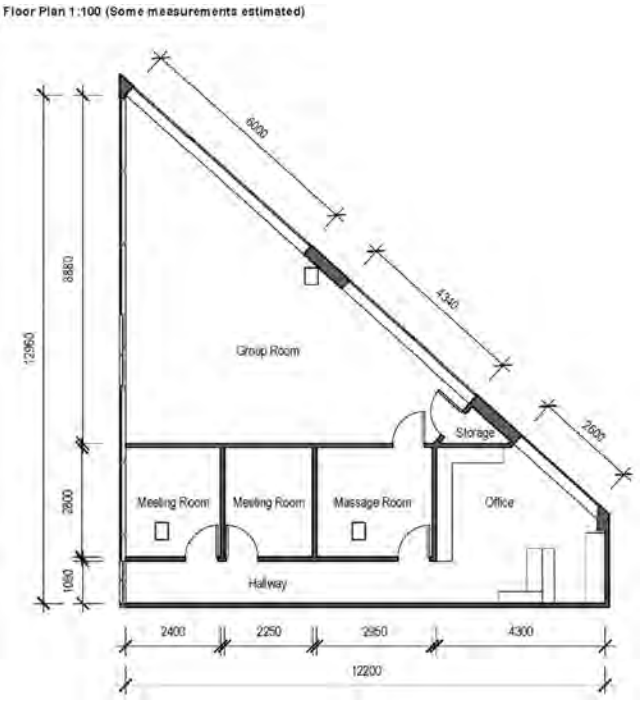

Figure 1: Floor plan. Courtesy of Kara Simpson.

the therapeutic aspects of the investigated built environment and development of proposals for further design interventions. From the patterns identified in the interviews four themes emerged. These findings were triangulated with an analysis of visual data (photos), which enabled certain interpretations of the space (Christmann 2008) and outcomes provided by other studies.

Themes

1. Non-place (placelessness)

Non-place indicates, according to Marc Augé, a space 'without identity', a 'non-relational' space (Augé 1995: 77–78) that people cannot connect to. The original state of the Culture in Mind space was characterized by the interviewees as 'unfriendly', 'unhomely', 'disconnected' and 'not a healing space'. The absence of an inviting atmosphere was mentioned in all answers regarding the feel of the space prior to the design interventions, a fact that can be reinforced by what can be seen in Figures 2–4. Empty white walls, a lack of greenery, an impersonal entrance, temporary lighting control (pieces of paper placed on windows to block direct sunlight) caused a detachment from and a negative sense of the staff members' working environment, which were heightened by its poor spatial organization. As mentioned in studies' findings, the lack of a home-like atmosphere inhibits the nourishment of the healing aspects of a mental health clinic (Connellan et al. 2013) and an unwelcoming environment is 'unsupportive of client needs' (Walsh and Boyle cited in Muskett 2014: 7). Especially in

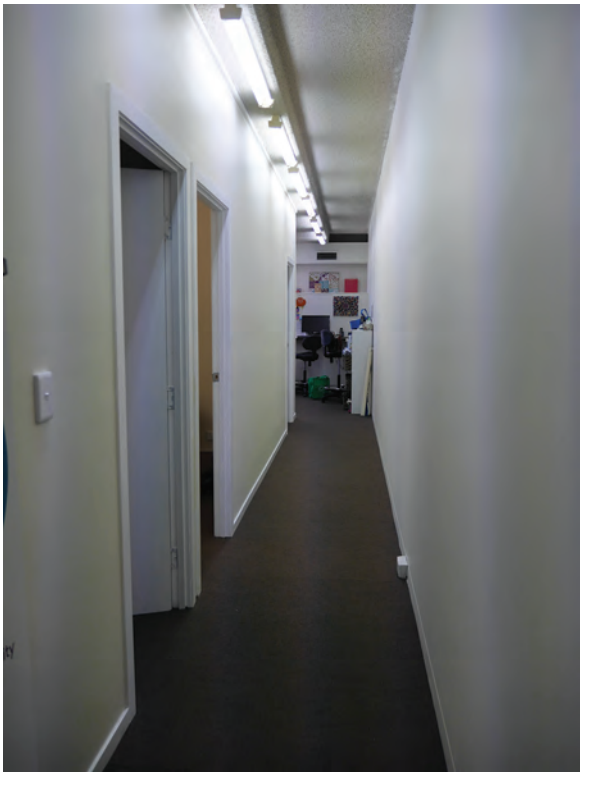

Figure 2: Corridor (before intervention). Courtesy of Eleni Kalantidou.

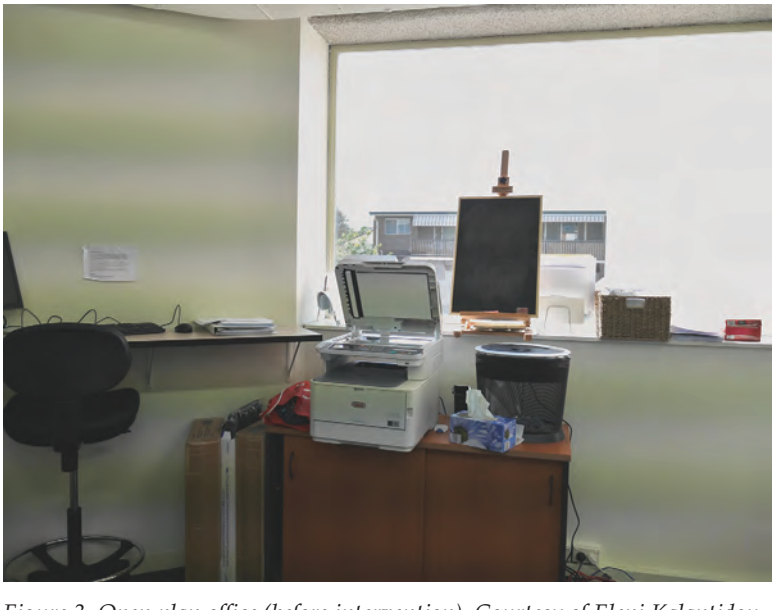

Figure 3: Open plan office (before intervention). Courtesy of Eleni Kalantidou.

Figure 4: Communal activities space (before intervention). Courtesy of Eleni Kalantidou.

Figure 5: Curtains – communal activities space (after intervention). Courtesy of Eleni Kalantidou.

the case of migrant clients, as acknowledged by the Canadian Task Force on Mental Health Issues (Tribe 2002), an 'unwelcoming host community', even in the form of a facility, perpetuates pre-existing conditions mostly related to PTSD and depression.

2. Sense of place (placeness)

In contrast to the evaluation of the initial state of their working environment, the staff members interviewed expressed how the design interventions have helped establish a sense of place at the facility of Culture in Mind. When asked about the most important behavioural change noticed in the space, the responses ('connection to space', 'welcoming', 'happier', 'user-friendly', 'feels warmer') validated the creation of a context that generates attachment and becomes 'the carrier of emotionally charged events' (Tuan 1974: 93), potentially leading to positive therapeutic outcomes. The making of 'place' was boosted by the overall environmental comfort ('comfortable', 'improved use and feeling of the space') produced through modest changes such as the addition of curtains in the group room (Figure 5), the coloured map (Figure 6), the spatial reconfiguration of the office space (Figure 7), the addition of storage space (Figure 8) and plants (Figure 9). For Coral Muskett (2014: 7), the provision of a 'welcoming environment' is achieved through 'art and craft hangings', whereas Susan Lorenz (2007) suggests that a therapeutic environment is created via the element of a 'home-like environment' (Lorenz cited in Connelllan et al. 2013: 160). In terms of the multicultural aspect, a friendly setting allows people to openly seek help and negotiate the best possible approach concerning their mental health or that of their loved ones (Colucci et al. 2015).

3. Spatial organization

The majority of the interviewees identified functionality as the most compromising aspect of the previous state of the space. They perceived it as negatively linked to the therapeutic element of their working environment, on the basis of the spatial limitations affecting their capability to perform. In contrast, they commented positively on the spatial organization that came out of the design interventions when asked about what helps them connect better to their clients; the response 'it maximized the potential of what is on offer' suggests that an efficient spatial configuration enables the staff members to perform better. This feature of the space was additionally mentioned as the most functional change of the space. A point to be highlighted in relation to this is how design interventions effectively assisted the space to be perceived as 'less cluttered' and more aesthetically appealing (Figure 7); in relation to the former, this was brought up more than once in Connellan et al.'s (2013) literature review as a factor that defines environmental comfort and affects patients and staff's spatial satisfaction. Architectural features (the plan or layout of the facility, the size and shape of rooms and the placement of windows) play a significant role in the expression of behavioural mechanisms such as place attachment (Baird and Bell 1995; Verderber and Fine 2000) and crowding (Baum and Paulus 1987), and can reduce patients' psychological distress and recovery time (Ulrich 1984). Given the Culture in Mind professionals' difficult task of facilitating the transition from one culture to another by 'recognizing how the person and his/her family [may] conceptualize the problem [differently] from Western constructs of mental health symptoms and diagnoses' (Colucci et al. 2015: 770), it is important that they retain their mental well-being and are content with their working milieu.

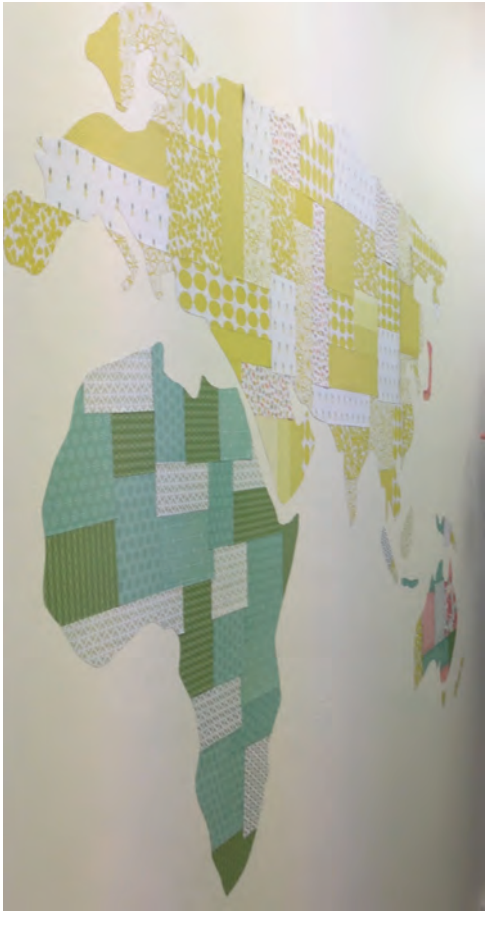

Figure 6: Mural – corridor (after intervention). Courtesy of Eleni Kalantidou.

4. Healing space

The definitions of what is a healing space vary, but what they usually share as a common denominator is the fact that this is a location requiring equilibrium between the 'physical, emotional and mental realms' (Ferrara 2004: 8). Responses such as 'not a healing space' about the feel of the previous setting and 'was not to its potential in terms of making it functional and healing, as a healing space' in regard to what was wrong with it demonstrate a discontent, which shifted, due to alterations by design, to a perception of the space as 'more therapeutic'. Based on the participants' answers, the main element that made this shift possible was the enhancement of a sense of privacy, safety and purpose. As mentioned before, turning the facility into a space where everyone is welcomed has produced, as put by one of the interviewees, 'an indication that it is a therapeutic space and that we are here to help them and support them and that it is safe'. Another feature that enhances the therapeutic character of the space is the creation of a bridge between the community and the facility through the potted plants and the community garden (Figure

Figure 7: Open plan office (after intervention). Courtesy of Eleni Kalantidou.

10) situated at the entrance, a passing-by-spot for locals. In the event that the clients are of a multiethnic background, this fact makes the facility less threatening for the outsiders (minimization of stigma) and brings the community closer to the newcomers.

Besides the atmosphere of a positive environment reinforced by the link to the community, 'renewal/restoration of attention and stress relief' are achieved via the access to plants, which are spread throughout the inside and the outside of the facility (Naderi and Shin in Connellan et al. 2013: 139). At the same time, the curtains in the group room provide a sense of control in terms of environmental comfort (direct sunlight), privacy and safety. Privacy is defined by Irwin Altman (1975) as selective control over access to the self or one's group. Privacy is also the behavioural mechanism most affected by healthcare settings according to research outcomes (Carpman and Grant 1993; Shumaker and Pequegnat 1989; Shumaker and Reizenstein 1982; Zimring et al. 1987) and is related to confidentiality matters between patients and physicians, and to patients' need for personal space and control over social interaction.

Discussion

The preliminary investigation showed that there are specific interior design aspects and environmental characteristics that generate or bolster positive

Figure 8: Communal activities space – storage space (after intervention). Courtesy of Eleni Kalantidou.

Figure 9: Open plan office (after intervention). Courtesy of Eleni Kalantidou.

feelings within healthcare facilities. These findings were no different from the evidence provided in the literature regarding health care environments specialized in mental health services. Through the discussions that took place

Figure 10: Entrance (after intervention). Courtesy of Eleni Kalantidou.

between the design team and the staff members of World Wellness Group and Culture in Mind, the need that stood out the most was for a space that could enhance a production of place and, in that case, a therapeutic place. What was also underlined was the need for the creation of a link between the facility and the local community. The mindset behind the interventions was to alter the space by adding elements such as colour and plants, by improving its spatial organization and enhancing environmental comfort with minimal economic and environmental cost. The aspect of multiculturalism was always present in the consultations and design thinking, but it was only explicitly manifested through a colourful handmade map, which had as a goal removing a negative connotation from divisions and barriers between countries, East and West. Despite the design team's desire to focus on the multicultural element, a subtle approach was adopted due to the complexity of directly involving migrant clients in the design process, the limited possibility of major interventions and budget constraints.

The concept behind the project was to change the space by design, emphasizing characteristics (e.g. plants, colour, spatial organization) that have

been proven, as previously described, to improve the well-being of mental health patients. Despite its limited breadth, it worked as the first step towards confronting the mental circumstances of migrants with behaviour traits that manifest forms of psychopathology. Emphasis was given to creating a welcoming environment connected to the community by greening the entrances and creating a locus of interaction between the inside and the outside via the portable community garden and potted plants.

Most of the Culture in Mind staff members' expectations were met (spatial organization, replacement of furniture, curtains, greenery, art, entrance interventions), but the improvement of ceiling lighting and the replacement of the door required centre management permission, the involvement of professional handymen and a cost way above the provided fund. The process has been characterized as successful by the survey participants but, in the light of the fact that the clients were not interviewed and that the design interventions did not directly strengthen the multicultural character of the space, what will be discussed in the following paragraphs is the connection of 'privacy', 'dignity' and 'connection to community', concepts which have emerged from the 'Culture in Mind' case study and existing research findings, to migrants and healing built environments.

Privacy

Non-westerners' perspectives related to privacy have been indicated in many publications, the most prominent being 'The Hidden Dimension' by Edward Hall ([1914] 1969). According to his writings, there is no word describing privacy in Japanese, not because the notion does not exist in their culture but because it derives from the idea of an open space shelter, which people can share and where life revolves around certain points, in contrast to the western idea of fragmentation that allows individual privacy (corridor, closed-room spaces) (Hall [1914] 1969: 156). In regard to the Arab world, privacy was illustrated by the same author through the following incident: 'if A is standing on a street corner and B wants his spot, B is within his rights if he does what he can to make A uncomfortable enough to move' (Hall [1914] 1969: 156). These are just indicative examples of diverse privacy perceptions according to cultural predispositions to be considered when designing multicultural spaces and particularly for people facing mental challenges.

Within the investigated context, privacy was explored from the employees' and not clients' point of view and with a western definition of privacy in mind. In Zimring et al.'s (1987) study (Zimring et al. cited in Evans 2003: 550) about control and the designed environment, as well as William Ittelson et al. examination of the 'environmental psychology of the psychiatric ward' (Ittelson et al. cited in Evans 2003: 550), privacy is related to having the option of controlling social contact (architectural barriers, single rooms). In the Culture in Mind study, privacy was mentioned as a means to better connect with clients, relating the concept to a sense of safety and comfort. The provision of safety is an absolute prerequisite when considering that most of the clients have experienced some sort of abuse within their previous situation. Karina Landman's survey reported that gated communities flourish in South Africa due to a growing demand for 'the right to safety and security, as well as privacy' (2004: 156), validating the interrelation between these basic human needs in non-western settings.

Dignity

Dignity has been a recurrent theme in the existing literature when it comes to reinstating mental health. The Institute for Innovation and Improvement, which operates under the banner of United Kingdom's National Health System (NHS 1999), issued in 1999 the sourcebook *Privacy and Dignity: The Elimination of Mixed Sex Accommodation-Good Practice Guidance and Self Assessment Check*, which elaborated on the importance of dignity and respect and the role the built milieu should play in the provision of privacy to the patient. Additionally, the Social Institute of Care (SCIE) established eight 'dignity factors' that should always be adopted in contexts of care provision including among others 'privacy' and 'social inclusion'.[3] The available resources do not indicate how privacy and social inclusion can be achieved when migrants are involved, but the frameworks' descriptions indicate good practices for enabling people to express their concerns when given space and time to adjust to the facility and practitioners, and connect to local communities. The importance of social inclusion was also raised by Joseba Achotegui, the secretary of the Transcultural Section of the World Psychiatric Association, through the 'Ulysses Syndrome', a concept framed by Achotegui, which stands for a latent mental condition developed because of the pain experienced due to multifaceted loss (country, family, job, belongings, cultural references) and the 'extreme grief' of not being-at-home. Achotegui recommended this condition to be removed from a psychopathological context and instead become a matter confronted socially rather than medicalizing it (WFMH 2015).

Connection to community

Following on from Achotegui's remark about the society's role in creating preventative structures against ethnic isolation and clustering, local and ethnic communities, clans and families should actively participate in supporting the healing process. The idea of a healing space has already been discussed but with an emphasis on a fixed environment; a different version of a 'healing space' for a migrant could be a person who belongs to the same culture and has a prominent position in it, either as a leader or an elder (Tribe 2002). Furthermore, Colucci et al. (2015) fostered the idea of practitioners understanding that some of their clients belong to tribes that adopt collectivism, in order to promote a different structure for mental health facilities. Kenneth Miller (1999, cited in Tribe 2002) corroborated Achotegui's claim that a bond with the community and an interactive relationship with the society through a service supported by a clinic – not necessarily a mental health one – could meliorate symptoms of mental illness and remove its stigma from migrants.

Conclusion

As shown above, the aforementioned issues cannot be resolved or exhaustively explored in this article, but they beg for a more comprehensive interrogation from future studies. The Culture in Mind case study has been an incentive to identify design not only as an element that can improve treatment and working conditions for migrant patients and staff, respectively, but also as a dynamic force that could help transform the spatial characteristics, capacities and connotations attached to intercultural healing environments. What is yet to be revealed is the multifaceted interrelation between the built environment,

health/mental care and migrants and its manifestation through novel design formats, able to accommodate people's needs from different cultural backgrounds. For this to happen, a systemic approach is required in order to enable a culturally informed interrogation and categorization of mental health, more diverse and versatile treatment options and the involvement of local communities to support migrants' social and cultural adaptation to their new home.

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