Dr Evangelia Chrysikou

Evangelia is a registered architect (ARB) and medical planner. She is amongst the few architects globally holding a PhD on healthcare architecture.

She is a Lecturer at the Bartlett Real Estate Institute, UCL, where she is the Program Leader for the MSc Healthcare Facilities. Her research involves mental health, accessibility, autism, welfare, medical architecture, and medical tourism facilities. Books include 'Architecture for psychiatric environments and therapeutic spaces' (IOS Press, 2014).

How did you develop your interest in therapeutic architecture?

My initial interest started when I read Foucault's *History of Madness* when I was a studying for my masters in Architecture. I came across that book by accident. My sister was a psychology student and Foucault was a part of their curriculum. I literally devoured that book. Next semester, I attended a theory module on architecture for psychiatric facilities, by Prof Fani Vavyli a well-known professor for her involvement in the international community of hospital architects. Influenced by Foucault, I felt the module was not about architectural typologies but about people who lived in the past and suffered in those buildings and that architecture was playing a significant role not only as the physical context but as a mechanism of power and control. I wanted to do investigate the matter further and approached the psychiatrist involved in moving the people from the asylum of Leros back to the community. This helped me realise that the architectural knowledge on this transition was very limited: there was no literature on buildings to help these people transition back to the community. In short, what would be the new "home" for life after the asylum? Would it be a flat? Would it be a centre? How many people per dwelling or room? How people who had not seen trees drop their leaves for decades, as Leros asylum had no trees but the odd Eucalyptus, would go back to "normality" and this with a gap of few decades in between? We did not know.

Fani suggested that I should go to the Medical Architecture Research Unit to study hospital design. This is how I went on to learn Medical Architecture where I did my MSc there and later continued for my PhD at the Bartlett School of Graduate Studies at UCL, with Prof Julianne Hanson. Yet, medical architecture focused more on regulations and constraints but the seeds for patient focused care were also there thanks to my tutor Susan Francis who was very passionate on the subject. The therapeutic qualities of space as a topic was then starting to develop it slowly, several individual academics in several parts of the world. Yet, we did not use the term "therapeutic architecture" as such. We could refer to therapeutic qualities of space. We might use terms such as patient focused/centred design and some used the term salutogenic (as this was developed by Alan Dilani referring to the work of Antonovsky) meaning the same thing. Others might even use the term evidence based, when we would refer to evidence that space could support the therapeutic team. However, at a period where alternative treatments were on the rise, as a discipline we were cautious to refer to the term therapeutic architecture. My PhD supervisor coming from Architecture would edit the term "holistic" to "integrated" when I used it as "holistic" was perceived too risky to use. Yet, holistic was a term that people in the school of psychiatry used as part of the care in the community but for architecture these appeared very much associated with

concepts such as Feng Shui that as a concept was very far from what we were doing or supporting as it lacked scientific backing. Interdisciplinary work was not so common twenty years ago so we were very careful not to jeopardise the integrity of our work, especially since we were a niche field.

Later, when I was teaching at a postgraduate program at a medical school and came closer to the clinical community I realised that the medical community perceived the value of space more than we, built environment professionals and academics. Perhaps because they lived and worked in these spaces every day and could understand the limitations better than us but they did not have the time and maybe the tools or the priority to study these spaces (although some of them actually do and we have brilliant research on the field coming from teams involving clinicians). Then, I realised that maybe we (medical architects) should consider that area from the direction of supportive design to the patients and the medical professionals. This was the first time that I used the term therapeutic architecture (which was not a term my discipline used back then) and I wrote my description of it in the opening paragraph of my first book. This has been a term that we do use it now but ten years ago this was not straightforward.

Now, twenty something years after my first reading of Foucault's book I realise that it was not the hospital environment that attracted me in the field but the inequality and injustice that vulnerable people in such establishments would face. I realised that when we finished the research project comparing mental vs healthcare facilities in a central London area.

Tell us about one of the projects you have been involved with.

Can I use the word "sweet" to describe a project? This is the feeling that I have for a UCL Grand Challenge on Justice and Equality pilot project that we worked not long time ago where with little money and a great idea we entered into something much bigger. It was a research project on the comparison of mental health vs healthcare facilities in the catchment area of Camden and Islington NHS Foundation Trust. I had been doing research on psychiatric facilities form the inside in several contexts, from Europe to New Zealand but was concentrating on the space as experienced by patients and staff. One day I asked the head of the Division of Psychiatry at UCL if there could be something that I could do as a medical architect that would be of help. He asked for a photographic exhibition that would showcase pictures of the mental health facilities next to healthcare facilities. We won funding through UCL Grand Challenges Scheme and started this small but very flexible collaboration between the Bartlett, the Division of Psychiatry and the Slade School of Art, all UCL. The project was small in scale and it involved only a small area compare to London or the UK but it was a great pilot, involved thinking outside the box and to me it came with a revelation. I have been visiting hundreds of psychiatric facilities and never realised the extend they differed. The project had two elements: one was the location of the facilities in relation to the London Underground network. The second was the facades. We must do the same project in a larger scale but from the pilot we found a tool to investigate special inequalities and stigma. This is very timely as the land where the mental health facilities are sitting becomes a great asset. So, the services tend to be relocated in the periphery to capitalise on that real estate gain. But then access might be compromise and this has implications to staff and carers who visit. The aesthetics have an implication to everybody as it is a means to

generate stigma against mental illness. Everybody can be influenced by that: passer-by's, families, neighbours and patients.

In what ways can staff and service users be involved in the design of a psychiatric or therapeutic space?

In every possible way, from the very beginning and throughout. For my PhD I asked residents of psychiatric facilities in France and the UK to give feedback on the environment of the wards they were staying. At the time this was very innovative as we were also historically at a time where the rights of the mentally ill people were very limited. In some cases, this is still the case. I had visited the London Club House and their self-government model impressed me. Asking for feedback was practically a bit easier than today, as getting ethical approvals was much easier but the concept that we need to consult the patients was not established in medical architecture. I got great feedback. It enabled me to remove my own bias coming from an architectural background. It also contradicted many of the theories and assumptions I was reading in the literature back then or some of the things said on presentations by architects who designed mental health facilities. Until getting that feedback, I shared the same opinions as I had been formatted by people creating some these frameworks. The gap between staff and service users –as I interviewed both groups—was not big but the gap between the architects and the service users/staff groups was. The most successful case studies were two that involved staff and current patients throughout the design process from day one. Involving patients and staff in the pre-brief consultations and keep that dialogue open through-out is the way forward. It is also important that their voice remains clear and is not dominated by other stakeholders during these consultations. Vulnerable people might be easily silenced and intimidated so it is important for the facilitators to be aware of that. The project will be more meaningful and fit for purpose at the end.

What are some of the ways in which architectural design interacts with the therapeutic milleu?

Architecture is about space and place. These two comprise the physical context of our lives. When we are well and active any obstacle in our environment requires extra energy from us. The fact that we have our health is a great internal resource that turns potential obstacles to be mostly manageable. When we are ill or have some short of disability it is more difficult to overcome such obstacles as we need to draw on resources that are scarce or unavailable, even internally. Same applies to staff when they are tired or close to burnout: obstacles from the environment require extra effort. Architecture that is compatible to our physiology and perception mechanisms at a given time allows to concentrate where is important and in this case to get well sooner and at the same time allows staff to operate according to what they consider as best practice instead of compromising their movement because of spatial restrictions. This knowhow, to design spaces according to people's perception and physiology and according to therapeutic best practice is the essence of therapeutic architecture. This knowhow also involves ways that environments can be restorative and support health and wellbeing. This can have an effect to both patients and staff. There is research for example on the value of nature for faster recovery and for supporting staff. At

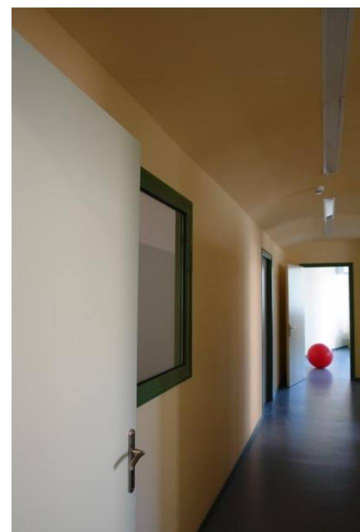
the same time have to be aware of the need in certain wards, for example haematology wards, to avoid plants for infection control purposes.

What are the therapeutic benefits of good architectural design?

Good architectural design is not necessarily therapeutic design. Also, design that might be therapeutic might not be considered Avant-guard by architects. It depends how you define good architectural design. I can only talk about therapeutic design. In that sense, I would say restorative and eco-psychosocially supportive. For example, urban design that provides public toilets at regular distance might enable older people to walk longer distances. Absence of those might restrict them in short walks very close to home. That could affect their mental health as they get housebound and contribute to frailty due to limited mobility. Similar staircases hidden, too narrow, uncomfortable and badly lit might discourage people from using them. Certain luminaires have been associated with the disruption of our melatonin. On the contrary, design could enable safe movement, natural daylight and utilises positive and negative distractions and therefore support healthier lifestyle.

At some point, we designed a facility for children in autism. It was a very low budget building as it happened during a long recession and finance was very limited. We had to be resourceful with money and invest in good design. I worked closely with a neuroscientist and staff. We looked at the lighting very carefully to have spectrums as close to natural light as possible, to avoid a visual noise from flickering that we cannot detect but our brains can. We chose the colours very carefully, we worked closely to the therapeutic team to create the spaces that were compatible with their treatments. We introduced elements of positive and negative distraction. We avoided areas that would trap dust such as cornices, as we were cautious of respiratory multi-morbidities. Children when they first came to the new building they had less symptomatology the time they were in the building compared to the old one (which was not bad at all). This was a great surprise, as we expected that they might need time to adjust. Staff mentioned that the days they worked in that building they even “forgot” that time passed.

Please, find below some photos from the project in Faliro:



How do you see the field of therapeutic architecture developing in the future?

I think this is a great time for therapeutic architecture. From niche and institutionalised it becomes more and more relevant to real people as they understand the value and benefits for themselves. When our dean asked me to create a Master's programme on therapeutic architecture at the Bartlett, the largest and one of the most prestigious faculties of built environment in the world, I realised that health was becoming the new green! As twenty years ago, when I was doing my case studies in psychiatric facilities at the same school (and I assume at any school might have been the same) I could feel a stigma around my topic. I was the odd PhD student choosing to do a non-inspiring topic such as psychiatric buildings. Now, I see many young people wanting to study and work in that area, several young and aspiring PhD students in several universities around the world. There is also tremendous need to change our practices. Baby boomers entering old age, challenging demographics, people demanding better healthcare, better experience, with less money for infrastructure, disruptive technologies, new medtech, better diagnostics, healthcare spreading across the community are all very important developments. Therapeutic architecture can play a pivotal role in supporting services and people's experiences. Especially on areas where diagnostic and interventional tools are still limited, such as mental health and dementia, our human resources and our space could be crucial. In the new MSc we involve clinicians and healthcare professionals to present and/or attend. The complexities of healthcare are such that we need to work together to identify the right questions. This is our only hope for eventually coming up with some valid answers.

Do you have any advice for psychologists who want to improve the setting in which they work?

When I think of healthcare professionals I remember the aviation staff. We can learn a lot by their commitment to reducing error. In case of emergencies or increased danger they advise to put your mask first before help others. Taking care of their needs in their environment is

crucial for professionals. Having a workspace with access to daylight is essential. In the Netherlands, all hospital offices must have direct or indirect access to daylight. In this country, there is staff working from offices sitting deep in the buildings or in basements. This needs to change. Views to nature, adjustable temperature for thermal comfort, especially for women, clean air are very important. Then it is very important to establish a place that enables good communication with their clients: acoustics for privacy, suitable seating and with optimal space for the chairs. One of the most critical parts of the NHS now is the difficulty to recruit and retain staff. Unfortunately, taking care of staff spaces is still a taboo. There is a lot of space for improvement. And staff need to be involved, together with patients, in the decisions about their built environment.

Link to the Architecture for mental health event in May:

https://www.ucl.ac.uk/bartlett/real-estate/events/2019/may/architecture-mental-health