

Mental illness and inclusive environments in the community

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Mental illness generally does not compromise our mobility. Mentally ill patients with catatonic conditions might be immobile, yet, even for these cases universal accessibility aids could not make any difference. However, mental illness presents a lot of challenges regarding accessibility. First, it constitutes an umbrella of several, very diverse conditions, presenting very limited diagnostic accuracy as well as limited effectiveness of treatment and intervention. Since the closure of Asylums, mental illness is more likely to be treated inside community settings, varying from several types of community based facilities to ordinary housing. Also, it affects an increasing number of the population: especially in the West where it affects about 1 in 4 people and Europe alone has 9 out of 10 countries with the highest suicide rates. Moreover, there is an increasing number of mentally ill people who present multi-morbidities across the lifespan. Regarding the latter, for a variety of reasons that are beyond the scope of this article to elaborate, there is lack of specialised provision to address their needs in a comprehensive way. Here we could add that the needs of mentally ill people are changing from adolescence to adulthood to their silver years. Finally, there is one very real situation, not yet reflected in any guidance on accessibility: physical and mental health conditions co-exist, and both have to be designed for. In the purely physical domain, some needs and required environmental adjustments have been picked up in BS 8300. Yet, our built environment is very little equipped to alleviate the disabling effects of mental illness both in specialised settings and in the community.

Patients' movement in mental health facilities, both in hospital settings and inside our community, might be frequently compromised for reasons other than real physical incompetence. Accessibility within mental health facilities is a more complex issue than universal accessibility standards generically allow for.

About ten years ago, a research we conducted at the Bartlett, UCL examined the physical environment of accommodation for acute mentally ill people. Community

mental healthcare units were reviewed and analysed while they were occupied and running. Part of the study involved restrictions of movement and the use of universal accessibility devices. The data derived from empirical, comparative and user inclusive methods. That study found that mental health facilities were rarely designed for the model of care and staffing regimes which they would need to accommodate. This discordance between the physical and organizational milieu inevitably compromised accessibility, even though the vast majority of the patients were physically able. Outdoor access, vertical circulation and the accessibility of bathrooms were particularly affected.

In 2016, for the purposes of another study on Mental Health facilities in the community we visited some more acute mental health wards. This study is ongoing, however, from the first set of data we could identify some ways that the physical environment restricts people. For example, some wards might still be located on floors and might result in sectioned patients being deprived of any access to open air. In one case, even for people lucky enough to be on the ground floor and have access to a fully enclosed courtyard, the demolition of a protective canopy in that space “for anti-ligature purposes” prevents them from using that courtyard during rainy or very hot days. This might not be that bad if that were not the only area of free access to fresh air and if the ward was adequately ventilated. Taps and showers were challenging too. Patients complained that they could not achieve a constant water flow or a comfortable water temperature: the fact that they had to press constantly with one hand to keep the water running was adding to this disabling effect. This was a problem for both patients and staff, adding to the lack of motivation to shower for the former and preventing the latter of remaining dry when assisting patients. Additionally, staff complained about the inadequacy of the environment to cater for the needs of frail and older mentally ill patients, which differed considerably from those of younger and more aggressive patients. To this complexity we could add the lack of knowledge and understanding on the neurodiverse needs of mentally ill patients presenting multi-morbidities.

So, there is a clear need to:

- further our understanding on disabling effects of mental illness through research

- continue promoting the secure elements of the environment but from a more enabling perspective, i.e. aim for a therapeutic rather than a confining environment, yet always maintaining the necessary degree of safety.
- educate architects, healthcare planners and stakeholders on medical architecture and its basic principle that our perception and physiology when we are ill is different from our perception and physiology when we are well
- understand the complexity of the subject and address it in an integrated way, creating meaningful links between evidence base, care regime and the physical environment
- bringing together relevant professionals and create the educational programs that would allow them to learn from each other.
- understand the potential of the knowledge that the users already have and use this potential through active user involvement at all stages of decision making.
- realise that mentally ill patients live inside the community, therefore accessibility has to be extended to cater for their needs.



Design for mentally health relies on the fine tuning between protective and enabling elements, yet for that we have still a long way to go.

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