HEALTH: THE DESIGN, PLANNING AND POLITICS OF HOW AND WHERE WE LIVE
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RESIDENTIAL FACILITIES FOR PSYCHOSOCIAL REHABILITATION: PLANNING PERMIT REGULATIONS AND SOCIAL INCLUSION

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ABSTRACT

Mental illness presents significant increase affecting a quarter of the population. Yet, institutions are still responsible for preventing mentally ill people from having integrated lives in the community. Existing planning legislation might contribute to this. A potential mechanism is the requirement for non-residential use of land for mental health accommodation and their subsequent characterization as 'special buildings'. However, change of mental health accommodation planning and licensing legislation could be more enabling for people's social integration. The paper explores the planning legislation of a country with an extensive network of community-based mental health facilities, the consequences of planning legislation to the actual integration of its mentally ill people and how alterations on the change of use legislation for accommodation for mental health affected the national integration outcome.

The research was top down, led by the European Commission and the Ministry of Health. The sample comprised 112 out of 116 community-based facilities. The research highlighted those elements in the existing planning legislation that favored segregated institutions. The uses of land framework promoted the development of mental health accommodation in buildings designed for other purposes (i.e., industrial, logistics or offices) or in segregated areas. The research identified planning legislation as a key disabler of social inclusion. Then, alternatives were tested, including the redefinition of uses; a change that initially generated functional complications. The condition of altering uses alone proved inadequate, so new design guidelines were introduced to act as quality control mechanism. A set of fit-for-purpose-guidelines incorporated in national legislation.

BACKGROUND

According to WHO, in Europe almost 20% of the burden of disease relates to mental illness that affects one in four people at some time in life. Moreover, 9 out of 10 countries with the highest suicide rates in the world are in Europe[1]. Yet, society still accepts the concept of treating mental illness inside closed institutions, despite the limited evidence on their therapeutic effectiveness[2] [3] [4]. Europe is pioneer in the treatment and care of mental illness, but several European countries are still at the early stages of deinstitutionalization, with the majority of the mentally ill people treated in institutions rather than in the community[5]. The fact that mental illness is treated in closed and often segregated from the urban grid institutions, even if they are small in scale, is contradictory to advancements in Social Psychiatry. These started to happened as early as 1932 by establishing an equivalent of what nowadays is called day hospital [6] [7]. Soon after the war, the Foyer Elan Retrouve was developed by Sivadon and in the US the Movement for Mental Health in the Community was formed, setting the ground for de-

institutionalisation[8 9]. Since then, WHO[10 11] directs that mentally ill people should be primarily treated as close to home as possible with hospital admissions being the last resort.

The allocation of closed institutions as the places of treating and caring for mental illness, prevents architecture from seeing mental health issues as part of a community integrated design concept and incorporating the needs of mentally ill people in the broader discussion of accessibility and its implications[20]. This paper will focus on the building use that could host specialized accommodation for mental illness and how legislation towards more flexibility could affect the whole deinstitutionalization prospect. It will also include a case study of national mental health facilities planning legislation and how alterations on the change of legislation for psychiatric facilities could affect their integration outcome.

THE NEED TO INCORPORATE MENTAL HEALTH IN THE ACCESSIBILITY DISCUSSION

Design for people with disabilities tends to be incorporated into generic architectural guidelines, starting to influence broader architectural typologies, as opposed to specialised healthcare facilities[12]. Moreover, design requirements for people with mobility, visual or other sense-related impairments have already been included in the generic building guidelines[13], as well as strategies and provisions for older people.[14 15 16]. This shift in architectural thinking and its effect on the built environment, eventually leads to a more integrated society, involving broader parts of our everyday life, such as accessible education, employment, tourism etc.[17 18 19].

However, mental illness is still dealt as a problem that society cannot manage in an integrated way. Although for people with disabilities society tries to improve their mobility at home and make the public domain accessible for them, at the same time the majority of people in acute mental health wards are not allowed to visit the garden of their ward if that is not secure enough[20]. The arguments for that concentrate on anti-ligature but this practice might at the same time be seen as stigmatising. .

In short, here lies an important difference between mental illness and other disabilities regarding inclusive design. In the latter, society explores ways for its management, with accessibility policies being one of those which leads eventually to integration. In mental illness however, the closed mental health structures such as hospitals and the fear of harm and self-harm still prevent society fully accepting the integrative principles of Care in the Community[21 22].

The author supports that knowledge and understanding of mental illness would promote the integration of mentally ill people in our societies. According to a service user, stigma and segregation results from lack of knowledge and understanding[23]. According to scientists, mental illness is among the diseases where we have very limited knowledge and understanding[24 5]. Changing our perspective about it, and incorporating what it is already there as a theoretical model could be a first step for the better integration of mentally ill people.

This paper argues that strategic planning, legislation and broader built environment interventions could play an important role towards the social integration of mentally ill people. Also, the segregative aspect that mental illness affects only a limited number of the population, compared for example to mobility or old age, needs to be addressed as a myth. The paper addresses both points. First, the importance of considering mental illness as a subject affecting society as a whole[25]. Secondly, it will demonstrate new strategies that would help include mentally ill people in the society. The latter will be argued with a case of EU led, Greek policy on the subject and how it challenges the existing broader framework of building permits.

THE CASE STUDY

An interesting case will be explored as an example of a shift of policy from segregative to integrative. That is the example of Greece, the country who first accepted and protected the mentally ill as a valid part of society. However, modern Greece is a European Country that started its “Psychiatric Revolution” in the mid-80s and till the time of the project presented a low placement according to the Mental Health Integration Index, being 28th out of 30 countries[5] and currently moved two places up[5]. The prolonged economic crisis is amongst the reasons for this placement. Yet, despite the fact that

employment is having a great influence on that Index and Greek unemployment tends to be one of the highest in Europe, the poor access to health services, stigma and access to a stable residential environment prevent the country from achieving a better position. As a case study, Greece sheds light in a model of de-institutionalisation that has been already applied in a European Union country with limited resources and the lessons learned could have great values to many European that start their de-institutionalisation now, such as Bulgaria and other Balkan countries. However, aspects of this shift towards integration can be also relevant even in the most advanced countries on the subject such as the UK, as several of their so called 'community-based wards' are still in hospital campi[3].

Greece with the support of the European Commission was exploring and employing a series of strategies to improve the provision of care under the Psychargos Program, i.e., a national plan that started in 2000 for the closure of the big institutions and the provision of a network of services in the community. One of the interventions of Psychargos had been the identification of problems in the licensing of all types of community mental health facilities and as a next step altering the licensing procedures, updating the building and technical equipment requirements. This attempt was based on two main objectives: a) the design of a simpler and fairer licensing procedure and b) the redesign of a set of national guidelines for each facility type that would promote the integration of mentally ill people in the community. As this was a policy-making program the timeframes were significantly constrained compared to any academic project. The duration of the research-part was four months at the beginning of 2015 and it was extended for another two months for the writing up of the report. Additional support to the Mechanism and the Ministry of Health was provided until the end of the Psychargos Program, which was the 31/12/15.

The methodology designed and used constituted two main parts. Initially, it involved a first identification of problems regarding the issue of licenses to operate for non-for-profit mental health service providers, who provide the majority of non-hospital care. This was conducted by the Support Mechanism for the Mental Health Services and their Networking and Cooperation at a Sectoral and Peripheral level. The expertise also took into account the available reports of the Inspection Committees, the Fire Brigade and the Greek Legislation.

The second part comprised approaching service providers and asking their input as well as literature review on international best practice. Initially, the researchers approached individual trusts to provide feedback on a qualitative, exploratory level. The response rate remained low but this was not the case when the feedback was asked from the Support Mechanism, on a detailed questionnaire, designed from the research team but distributed by the Mechanism. The main findings of the first part were incorporated in order to produce a report and a set of actions that would set the basis of producing new national guidelines. That stage involved the design and administering of a 29-questions questionnaire regarding the process of acquiring building permits and operational licenses. This was then distributed by the Support Mechanism to all 116 facilities to fill. These comprise 53 care homes, 28 day centres, 3 mobile units, 23 protected apartments and 5 hostels. Even though some facilities have been operating for more than 20 years at the time of the research, a 10% of those had their operating licences still pending. The psychiatric departments of the general hospitals or other types of facilities inside hospital campuses have been excluded. The Support Mechanism sent the completed 103 questionnaires back to the researchers for evaluation. This methodology aimed at the evaluation of the situation in Greece, the provision of an understanding on how the facilities perceive the problems they face and what they perceive as potential solutions.

FINDINGS

A key finding of the questionnaire was that people involved in the running of the facilities expressed the need to simplify the planning permit procedures. As building permits did not have implications for the mobile units and the apartments, here we will focus on the care homes, the day centres and the hostels. Regarding permits, 47% encountered a series of problems with strong financial implications and an additional 8% did not specify the source of difficulties. 36% replied that the planning permit

procedures affected negatively their timescale and added to their total costs, with an additional 10% mentioning significant delays with financial implications to their budget. 14% encountered problems with the site plan and the permitted uses. Additionally, 57% of the total sample proposed support measures, including the creation of a support service for the planning and the licencing or insisted on the need to reduce the time required for acquiring the licenses, something that was in agreement with earlier findings of the Mechanism. Therefore, the expertise indicated as one of the main reasons for the lack of adequate number of community mental health facilities in Greece, the complexity and the length of licensing procedures. This was either preventing trusts to open new facilities or led them to operate in an obscure status by not being fully compliant with the licensing procedures. As a result, the main aim of the project became the establishment of a realistic platform that would enable the facilities to operate in a legitimate way.

One of the biggest problems that was identified in the existing facilities was the change of use: it proved too lengthy, costly and complex to be achieved as a procedure. Plus, there were a number of facilities located in areas where the change of use could not be granted at all. In that case, 67% of the facilities would have to compromise either with expensive rents and property outside their catchment area, or with the fact that they did not get their license yet and until the use requirements changed, could not get it at all.

As it would be practically impossible to change overnight the dysfunctional and highly beaurocratic system of planning permissions,[26] [27] the alternative of simplifying the use requirements was examined. Thus, an initial solution was proposed by the Support Mechanism and was implemented with the decrees of Protocol Number 107931/22-11-2013 and 107933/22-11-2013. Under these two decrees, community mental health facilities that served as accommodation, could be facilitated in residential areas and day centres could be hosted in any property characterised as offices. Compared to the health or welfare uses that existed before, these uses were much simpler as they allowed flexibility, increased the choice of available premises and decreased the requirements in terms of structural engineering. Although this change of requirements for use provided some solutions, some problems remained. The most significant in terms of licensing, was the lack of the local Fire Brigade departments to recognize the adequacy of residential requirements for the function of psychiatric premises. 33% had to make changes and 21% of the total sample found it difficult to comply, resulting in considerable delays. This was reasonable taking into account issues related to the particular function of these facilities, as they accommodate larger number of people than an ordinary family home, there is an increased dangerousness due to pathologies involved and there is a greater difficulty regarding evacuation in cases of emergencies.

From all the above, it became clear that there was a need to retain the simplified licensing procedure, without losing the qualitative and therapeutically necessary attributes of space that a health related use would incorporate. The typologies of residence and office could not be fit for those purposes, as over simplistic. This was in agreement with predeceasing research findings[25] on the inadequacy of domestic typologies to fully cater for the needs of mentally ill people at acute stage or at the early stages of rehabilitation. Basic needs, such as safety were compromised but the same could be said for the ability to function independently as well as users' personalisation and choice. Also, once more the oversimplifying of requirements as it were expressed in residential typologies could by no means prevent institutionalisation. The research also indicated substantial problems in evacuation plans, increased wear and tear due to tough use, increased needs for security and institutional environments that provided very limited stimuli to users, by resulting once more in the creation of small scale asylums in the community.

The introduction of guidelines referring to the specific typologies was proposed as the solution to the problems deriving from oversimplification of uses and the lack of an adequate framework for mental health facilities. Thus, all the problems deriving from the selection of land would be prevented allowing more choice of potential properties, saving time and costs, yet even then adaptations would be necessary according to purpose. That way, the limitations could be still eliminated but the quality would be safeguarded by fit for purpose guidelines that facilities would have to meet prior to operation. It is beyond the scope of the paper to go into more detail, however, it is important to state

that the guidelines contained all the building traits and other specs and at the same time the flexibility of uses (residences and offices) in terms of planning permits enabled a higher degree of integration of the facilities in the community. As already explained, this was not the main motive for this change of use but it was certainly an integrating element that came as a result. In that sense, even in countries where planning permits are easy to get, the flexibility in uses relating to mental health and the ability of the facilities to be located even in purely residential areas, would be a considerable step towards their integration by enabling access to normal neighborhoods again.

Finally, another topic that rose in the legislation was again related to the location of the facilities. According to rehabilitation theories, community mental health facilities have to be located in the community they serve. Greek legislation enabled the facilities to operate in close proximity to the community[28]. This resulted in existing facilities being located outside the population they served and sometimes segregated from the urban grid. This was altered changing the requirement from close proximity to within the catchment area they serve, as obligatory, meaning a lot in terms of accessibility, breaking the barriers of NIMBYism and allowing mentally ill people to live and be treated within the community they belong to.

CONCLUSIONS

The increasing numbers of mentally ill people will eventually create the pressure for the existing need of caring for these people in the community. The ultimate way of this acceptance is architecture accommodating elements necessary for the universal accessibility of mental illness in generic guidelines, very similarly to other forms of disability and the needs of older people. Right now, this is a future goal rather than a current reality.

Therefore, a whole range of strategies as well as a range of products, from low or high-tech and from specialised to generic architectural guidelines, software applications, workplace and accommodation solutions, referring to all range of spaces, from physical to virtual, including even sectors such as gaming, entertainment or tourism to cater for the whole spectrum of a persons' needs. This means a paradigm shift for the design for mental illness improving primarily the quality of life of the people living with the illness but also of their families and carers, who also suffer of high burnout rates. The broadest impact will be, however, for our entire society as it means that one of the most characteristic types of total institutions, i.e. the mental institutions, will become more and more obsolete. This reality is linked to a more adaptive and a more responsible society that does not need walls of asylums (small or big) to contain its risks.

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