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Residential Facilities for Psychosocial Rehabilitation: Planning Permit Regulations and Social Inclusion

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Abstract

Mental illness affects one in four people at some point in their lives, and the incidence is increasing. 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 the consequent characterisation of accommodation as 'special buildings'. However, change in mental health accommodation planning and licensing legislation could be more enabling for people's social integration. This paper explores the planning legislation of Greece, a country with an extensive network of community-based mental health facilities, the consequences of planning legislation for the actual integration of its mentally ill people and how alterations to 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 favoured segregated institutions. The uses of land framework promoted the development of mental health accommodation in buildings designed for other purposes (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 mechanisms – a set of fit-for-purpose guidelines incorporated into national legislation.

Keywords: healthcare facilities; architecture; mental health; social inclusion; psychosocial rehabilitation

Introduction

According to the WHO, in Europe almost 20 per cent of the burden of disease relates to mental illness, which affects one in four people at some point in their lives. 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 limited evidence for their therapeutic effectiveness.² Europe is a pioneer in the treatment and care of mental illness. However, several European countries are still at the early stages of deinstitutionalisation, with most mentally ill people treated in institutions rather than in the community.³

The fact that mental illness is treated in closed spaces, even if they are small in scale, often segregated from urban grid institutions, is contradictory to advances in social psychiatry. These started to happen as early as 1932, with the establishment of what are now called day hospitals.⁴ Soon after the war, the Foyer Elan Retrouve was developed in Paris by Sivadon, and in the US the Movement for Mental Health in the Community was formed, laying the ground for deinstitutionalisation.⁵ Since then, the WHO⁶ has directed that mentally ill people should primarily be treated as close to their home as possible, with hospital admission being the last resort.

The allocation of closed institutions as places for 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 within broader discussions around accessibility and its implications.⁷ This paper will focus on the building use that could host specialised accommodation for mental illness and how legislation towards greater flexibility could affect the whole deinstitutionalisation prospect. It will also include a case study of national mental health facilities planning legislation and how alterations to legislation for psychiatric facilities could affect their integration outcomes.

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 health-care facilities.⁸ Moreover, design requirements for people with mobility, visual or other sense-related impairments have already been included in the generic building guidelines,⁹ as well as in strategies and provisions for older people.¹⁰ This shift in architectural thinking, and its effect on the built environment, will hopefully eventually lead to a more integrated society, involving broader parts of our everyday lives, such as accessible education, employment and tourism.¹¹

However, mental illness is still dealt with as a problem that society cannot manage in an integrated way. The involvement of the police as a first point of contact for mental health care emergencies is a clear demonstration of this. This translates into people still being transported to services by a police vehicle – as opposed to an ambulance – the existence of, and discussion around, mental health facilities in police stations, and the existence of mental health tribunals and obligatory hospitalisations.

Although for people with physical disabilities, society tries to improve their mobility at home and make the public domain accessible, the majority of people in acute mental health wards are not allowed to visit the garden of their ward, if it is not secure enough.¹² The arguments for this 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. For the latter, society explores ways for management, with accessibility policies being among those. This emphasis on accessibility should, ideally, lead 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 from fully accepting the integrative principles of care in the community.¹³ Mentally ill people need to be deemed well enough for social reintegration. This is a lengthy and uneven process. It is also a non-linear one, as progress can be reversed at any time during the process by a revolving-door syndrome and the possibility of relapse. In short, the integration of mentally ill people is not a given, but something to be assessed and achieved.

The authors argue 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 result from

lack of knowledge and understanding.¹⁴ According to scientists, mental illnesses are among the diseases of which we have very limited knowledge and understanding.¹⁵ Changing our perspective about mental illness, and incorporating what is already there as a theoretical model, could be a first step for the better integration of mentally ill people. Yet, how do we achieve that when people are still spatially segregated and out of sight?

This paper argues that strategic planning, legislation and broader built environment interventions could play an important role in the social integration of mentally ill people. The paper also argues that the segregated view that mental illness affects only a limited number of the population, compared, for example, to mobility issues or old age, needs to be addressed as a myth. The paper addresses both points.

Regarding the first point, we refer to theories that explore the relationship between society and space. Hillier and Hanson support the interconnection between the two.¹⁶ Marcus, influenced by Foucault on the power of systems and Goffman in his work on total institutions, investigated the ways that architectural typologies reproduce social norms to support institutional power, including in health care.¹⁷

To address the segregative approaches towards mental illness as something that should be addressed only in specialised settings, we need to reassess the view that it affects only those in care. On the contrary, it is key to consider mental illness as a subject affecting society as a whole.¹⁸ Then we will demonstrate how these principles were put into place to support the reintegration of mentally ill people in a real context that required urgent policy intervention. Finally, we will demonstrate new strategies that would help include mentally ill people in society. The latter will be argued using the case of an 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 of Greece, the place where the somatic basis of mental illness originated,¹⁹ and then the place where psychiatry was born.²⁰ However, modern Greece is a European country that started its ‘psychiatric revolution’ in the mid-1980s, and until the time of the project it had a low placement in the Mental Health Integration Index, being 28th out of 30 countries;²¹ it has now moved two places up.²² The prolonged economic crisis and high rates of unemployment are among the reasons for Greece’s position in the Index. Other reasons include poor access to health services, stigma and lack of a stable residential environment.

As a case study, Greece sheds light on a model of deinstitutionalisation that has already been applied in a European Union country with limited resources, and the lessons learned could have great value to many European countries that are starting their deinstitutionalisation now, such as Bulgaria and other Balkan and Eastern European countries. However, aspects of this shift towards integration can also be relevant even in more advanced countries on the subject, such as the UK, as several of their so-called ‘community-based wards’ are still in hospital campuses.²³

With the support of the European Commission, Greece was exploring and employing a series of strategies to improve the provision of care under the Psychargos Programme, a national plan that began 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 was the identification of problems in the licensing of all types of community mental health facilities and, as a next step, the alteration of the licensing procedures, and updating the building and technical equipment requirements. This attempt was based on two main objectives: (1) the design of a simpler and fairer licensing procedure; and (2) the redesign of a set of national guidelines for each facility type that would promote the integration of mentally ill people in the community.

Methodology

As this was a policymaking programme, the time frames were significantly constrained compared to an academic project. The duration of the research part was four months at the beginning of 2015, which is still generous time in terms of policymaking. This was extended for another two months for the writing up of the report and its presentation to key stakeholders. Additional support from the researcher to the

Support Mechanism for Mental Health Services and the Ministry of Health was provided until the end of the Psychargos Programme on 31 December 2015.

The methodology designed and used was in two main parts. The first part involved a high-level identification of problems regarding the issue of licences to operate not-for-profit mental health service providers. These organisations provide the majority of non-hospital psychiatric care in Greece. This was conducted by the Support Mechanism for Mental Health Services and their networking and cooperation activities at a sectoral and peripheral level. The experts also went through the available reports of the inspection committees and the fire brigade, and reviewed Greek legislation on the subject of planning and licensing mental health facilities in the community.

The second part of the project focused on two separate streams. One comprised the end-user perspective and the other explored international state of the art and best practice. Service providers were approached by the researchers and were interviewed on their input. Initially, the researchers approached selected service providers to provide feedback on a qualitative, exploratory level. The response rate was low, and was focused mainly in inner-city metropolitan areas and on very specific parts of the provision, such as psychogeriatrics. The fact that time was limited contributed to this: for trusts to respond to independent researchers would require considerably more time. This was not feasible in a four-month time frame. The plan had to be revised and the methodology adapted. This involved two major changes: change of contact point with the service providers and change of method employed, so that the researchers would have direct contact. This methodology aimed at the evaluation of the situation in Greece, and the provision of an understanding of how the facilities perceive the problems they face and what they perceive as potential solutions.

To facilitate the process, and to increase the response rate, the involvement of the established operating body of Psychargos, the Support Mechanism for Mental Health Services, was deemed necessary. They had already established strong communication channels with all trusts, and had been in close contact with them for years and coordinators of the entire programme. Being in place and interacting with the NGOs since the beginning of Psychargos was essential: they managed to cultivate trust and were considered to be part of the establishment. By supporting the coordination of the programme, irrespective of changes in central government and the Ministry of Health over the years, they were regarded as the systemic point of reference for service providers.

The interviews with selected trust representatives were replaced by a questionnaire. The researchers designed a purpose-built questionnaire on the procedure concerning the issuing of planning permits and operations permits for mental health facilities. This was distributed via emails sent from the Support Mechanism to all 116 facilities of the Psychargos programme, to be completed within 26 days (9 April–5 May).

The questionnaire comprised 29 questions. These were subdivided into eight sections. Seven sections concentrated on problems encountered by the service providers and their planning teams during:

1. The checks required to approve the site plan, at the planning permit department.
2. The checks required to approve the architectural plans at the planning permit department, or any other relevant public sector departments required to give approval at this stage. These included questions related to parking spaces provided, facade changes, accessibility, collaboration with other residents of the same building, difficulties with the brief, fenestration, natural light and ventilation requirements, special materials, balconies and green spaces.
3. The checks required for the structure of the buildings.
4. The checks of the mechanical and electrical plans.
5. The checks required for passive and active fire protection. This concentrated on problems related to the approval of the fire protection plans and changes required that could not be implemented.
6. The choice of property for the units, including issues related to the floor hosting the facilities, the property selection criteria and possible compromises regarding choice of property.
7. The choice of equipment. This investigated the problems encountered during the selection, problems deriving from lack of space for required equipment and special requirements (such as sound insulation).

The eighth section included general questions on the experience of acquiring paperwork, any permits that were pending, factors that would prevent completion, the involvement of architects and engineers in the choice of property, the time frames, and any steps/means during the process that caused major problems or provided support to the service providers. Finally, respondents were asked to provide suggestions for improving the process.

Findings

The strategy to utilise the existing and effective communication path with the service providers (that is, utilising the Support Mechanism as the contact point) changed the response rate dramatically. The return within the proposed time frame consisted of 103 completed questionnaires, deriving from 112 mental health units. These comprised 53 care homes, 28 day centres, 3 mobile units, 23 protected apartments and 5 hostels.

The completed questionnaires were forwarded to the research team, who gathered and analysed the findings. The main findings of the first part were incorporated to produce a report and a set of actions that would set the basis for producing new national guidelines. It involved questions regarding the process of acquiring building permits and operational licences. Even though some facilities had been operating for more than twenty years at the time of the research, 10 per cent had their operating licences still pending. The psychiatric departments of the general hospitals, or other types of facilities inside hospital campuses, have been excluded, as they were not part of community care and were not part of the Psychargos programme.

A key finding of the questionnaire was that people involved in the running of facilities expressed the need to simplify planning permit procedures. As building permits did not have implications for the mobile units (outreach teams of staff only working with patients in their own settings) and the independent-living apartments (one of the final stages of rehabilitation, where up to three service users whose condition is considered stable and who have reached an advanced level of psychiatric rehabilitation live on their own), in this research, we focused on care homes, day centres and hostels, the facilities that host service users and where service users require staff presence. For care homes and hostels, this could be either because they are not well enough to lead an independent life in the community and at the same time receive some in-house therapies or treatment. For day centres, this was because service users attend these places to participate in therapies. Regarding permits, 47 per cent of the facilities that replied encountered a series of problems with strong financial implications, and an additional 8 per cent did not specify the source of difficulties; 36 per cent replied that the planning permit procedures negatively affected their timescale and added to overall costs, with an additional 10 per cent mentioning significant delays with financial implications to their budget; 14 per cent encountered problems with site plans and permitted uses. Additionally, 57 per cent of the total sample proposed additional support measures, including the creation of a support service for the planning and licensing of psychiatric rehabilitation services, or insisted on the need to reduce the time required for acquiring licences. This last point was in agreement with earlier findings of the Support Mechanism. Therefore, the research indicated that one of the main reasons for the lack of an adequate number of community mental health facilities in Greece was the complexity and length of licensing procedures. This was either preventing trusts from opening new facilities or led them to operate with an obscure status by not being fully compliant with existing licensing. The latter would have very serious implications when the Psychargos programme closed, less than half a year after the end of the research, because the transitional 'testing' period ended. During the transitional period a degree of flexibility was expected, as it was considered a time for tuning the new system. This was necessary as it was introducing a whole new experimental set of health-care provision structures, and replacing the entire asylum era, which was very institutional with practices that were resistant to change. Once this transitional period was over, any unlicensed facility would not continue to receive funding for services from the national insurance or any other health-care insurance. This would result in a large number of patients being without proper treatment and a considerable number becoming homeless. This was mostly the case for the hostel population, as they tended to be what the system refers to as the 'long-term' mentally ill, that is, people with a long history of institutionalisation and with very little hope for reintegration into the

community, who still require a place to live and also to receive care, as the old asylums closed decades ago. As a result, the main aim of the project became the establishment of a realistic platform that could enable the facilities to operate in a legitimate way.

One of the biggest problems identified in the existing facilities was the process of change-of-use, in terms of planning permit: it proved too lengthy, costly and complex to be achieved as a procedure. Plus, there were several facilities located in areas where change-of-use could not be granted at all. For example, a hostel for the mentally ill could not be located in a residential-only area. This creates a care-in-the-community paradox. In essence, a psychiatric hostel for long-term mentally ill people is their home for life: we rarely expect this population to move to more independent accommodation, as they experience significant dependency as a result of institutionalisation. So, hostels are in fact their main residence. Yet, when planned as health-care facilities, these buildings cannot be located in residential-only areas, even though they are in fact residences with staff to support people living within them. This fosters the phenomenon of Nimbyism, rather than promoting social inclusion. As a result, 67 per cent of the participating facilities would have to compromise, either by paying expensive rents, which would threaten their sustainability and the quality of provision they could afford as budgets for mental health provision tend to be limited, and/or by looking for property outside their catchment area, compromising care-in-the-community principles. Alternatively, the facilities would have to come to terms with the fact that they were not able to get their licence yet and, until the use requirements changed, could not get it at all. This would translate into many facilities having to cease operations.

As it would be practically impossible to change overnight the dysfunctional and highly bureaucratic system of planning permissions,²⁴ the alternative of simplifying use requirements was examined. Thus, an initial solution was proposed by the Support Mechanism and 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 requirements in terms of structural engineering. Although this change of requirements for use provided some solutions, problems remained. The most significant in terms of licensing was the lack of local fire brigade departments that recognised the adequacy of residential requirements for the function of psychiatric premises; 33 per cent had to make changes and 21 per cent of the total sample found it difficult to comply, resulting in considerable delays. This was reasonable, considering the issues related to the function of these facilities, as they accommodate a larger number of people than an ordinary family home, there is increased danger due to the pathologies involved, and there would be greater difficulties regarding evacuation in emergencies.

From all of 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-care-related use would incorporate. Neither the typologies of residence and office, nor their materiality, could be fit for those purposes, being over-simplistic. This agreed with prior research findings²⁵ on the inadequacy of domestic typologies to fully cater for the needs of mentally ill people at an acute stage or in the early stages of rehabilitation. Basic needs, such as safety and security, were compromised, but so was service users' ability to function independently, as well as their opportunities for personalisation and choice. Once more, the oversimplification of requirements as expressed in residential typologies could by no means prevent institutionalisation. The built environment of these services could still be institutional. 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. Contrary to the intentions of community care, a consequence in practice of deinstitutionalisation attempts was the creation of small-scale asylums inside the community that operated as care-in-the-community premises.

The introduction of detailed guidelines referring to the specific typologies was proposed as the solution to the problems deriving from oversimplification of uses and from the lack of an adequate framework for mental health facilities.

Guidelines for physical attributes of these spaces and their equipment already existed. They were, however, limited in terms of requirements. Regarding architectural features, they mostly focused on the general dimensions of spaces. The pre-existing requirements hardly covered what the space should include and what should be the key features. This resulted in the selection of properties that, after all the required changes, could hardly be characterised as therapeutic or fit for purpose. For example, as visits by the Support Mechanism revealed, there were examples of staircases that were difficult for the regular population to negotiate, let alone severely mentally ill people under medication with possible sedative effects, in an environment of increased danger and chances of arson or fire caused by neglect.²⁶ There was one bedroom with three beds in it, and three bedside tables (obligatory by the equipment requirements), one per patient, but all three were stacked on top of each other, with patients sleeping in the institutional arrangement, having nothing in which to store their personal belongings within easy reach when in bed. Similar cases of facility managers compromising normal (in the sense of complying with normalisation principles)²⁷ place-making to comply with complex requirements can occur in mental health settings. The researchers' approach was that these cases could be indicators of conflict between the different priorities of planning and real-space options. The approach of the Support Mechanism was that the researchers had to provide a list of minimum dimensions for each type of room, in each facility type, so that these compromises would not occur. The research team suggested a different, more descriptive approach, as they had evidence from site visits in several case studies across Europe (and in Greece specifically) where they had conducted work of hypothetical design scenarios wherein specifying general dimensions would increase the difficulty of finding fit-for-purpose properties, but would not necessarily improve the domestic or normal feel of these spaces. For example, a bedroom that might be a few centimetres short in one dimension could have qualities such as good lighting and views, and still have room for furniture if carefully designed, rather than a bedroom that complied with general dimensions but had odd features, as in the case of the three-bed room, which was big enough, but had a free-standing column that resulted in a very institutional arrangement, with beds placed directly next to each other to fit. In a general dimension scenario, the first room would be described as unfit for use as a bedroom and would end up as a staff office. Patients could potentially end up in a worst-case scenario with compromised qualitative characteristics, as in the case of an institutional solution of two patients/strangers sleeping unwillingly in practically a double-bed arrangement.

The proposed solution was one involving providing very detailed guidelines that focused on functional dimensions, such as the least distance between beds, with reference to books concerning general dimensions, such as Neufert,²⁸ in case of doubt, or to health-care guides used in other countries' services, such as the UK health building notes.²⁹ That way, the emphasis would be on fit-for-purpose elements and more normative environments, such as situations that occur in real-life residential accommodation – as where bedrooms of 2.95 m clear dimensions instead of 3.00 m would still be used as bedrooms – instead of placing two strangers in a larger room, possibly originally designed for a living room and situated by the entrance, with common areas then being grouped deeper within the core in spaces designed for private areas, resulting in what Hillier and Hanson describe as inverse buildings with institutional indicators.³⁰

To avoid the abuse of this system, with scenarios where facility owners hire places with a residency permit and then ignore these suggestions and provide substandard accommodation, the guidelines should be embedded in legislation. This constituted a health-care planning innovation. The planning permits were becoming much simpler, as there was no need for change of use, but the requirements for the acquisition of operation licences was becoming more detailed and fit for purpose. The key difference from what happens in other contexts that maintain the change-of-use approach and still have detailed guidelines that are mostly suggestions (such as in the UK, with Health Building Notes) is that in that case, because of the deregulation of planning permits, the guidelines had to become more regulated so as to avoid abuse of the system – with them being omitted against the quality of life of patients and staff or, even worse, real-life dangerous scenarios. An addition to this system was the inclusion of suggestions for best practice in guidelines, to support the evaluation of facilities according to an evidence base:³¹ guidelines included obligatory lines, highly commented suggestions, and suggestions to be included if facilities wished to aim for therapeutic environment excellence. The latter provided a framework of possible solutions that

would give designers and facility managers the opportunity to make a difference in a way that complied with safety, service-user competence and therapeutic aims. This latter approach was based on the SCP model, an evidence-based tool for the design of mental health services.³² The SCP model is a tool created specifically for the evaluation of psychiatric facilities by researchers at UCL. The initials correspond to three variables: Safety and Security (S), Competence (C) and Personalisation and Choice (P), which form a three-dimensional space within which each mental health facility could be placed (Chrysikou, 2012; 2014; 2019).³³

As a result, all problems deriving from the selection of land would be prevented, allowing more choice of potential properties and saving time and costs. Even then, adaptations would be necessary according to purpose. This way, the limitations could be eliminated but quality safeguarded by fit-for-purpose guidelines that facilities would have to meet prior to operation. It is beyond the scope of this 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 facilities within the community. As already explained, this was not the main motive for this change of use, but it was certainly an integrating element that happened 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 facilities to be located even in purely residential areas would be a considerable step towards their integration by enabling access to normal neighbourhoods.

Finally, another topic that arose in the legislation was again related to the location of facilities. According to rehabilitation theories, community mental health facilities have to be located within the community they serve. Greek legislation enabled the facilities to operate in close proximity to the community,³⁴ rather than 'within' the community only. This resulted in existing facilities being located outside the population they served, and they were sometimes segregated from the urban grid. In rural settings, such as the case of one project in central Greece, the facility was located outside the urban grid but still within walking distance from its edge, surrounded by fields. This was a clear case of segregation, with references to the old asylums that were located in rural settings away from the urban grid. This research enabled us to alter the requirement from 'close proximity' to 'within' the catchment area served. This signified increased impact in terms of accessibility, breaking the barriers of Nimbyism and allowing mentally ill people to live and be treated within the community to which they belong.

The research findings produced a final report³⁵ that was presented for the scrutiny of a stakeholder committee comprising members of the Support Mechanism and the Department of Health, and representatives of clinicians and facility managers. It was adopted to enable the successful closure of the Psychargos programme and, in essence, the end of the transition period for the psychiatric reform programme.

Conclusions

The project proposed a way of rethinking the planning and licensing of facilities for mental illness at a national level. This was the result of the inability of the old, change-of-use led system to comply with the complex and inclusive needs of the mentally ill deriving from community psychiatry and psychiatric reforms. It demonstrated that deinstitutionalisation cannot be complete when distinctions between mental health, or even health uses and normative uses, occur in planning permits, as these result in employing institutional buildings or locations that are on the fringes of communities. At the same time, complete deregulation of mental health facilities would result in compromises to their therapeutic purpose, with serious consequences for safety and security, as well as for the facilitation of therapeutic activities. Through the proposed path of planning permits deregulation and increased regulation of licensing, by including detailed guidelines linked to evidence and the current state of the art in psychiatric design, this balance could be achieved. This approach could also enable us to move from the experimentation phase, the mere provision of community spaces as opposed to people living in asylums, to a more evolved model of buildings for care that could facilitate compliance with the therapeutic regime.

The increasing numbers of mentally ill people will eventually increase the pressure for the existing need of caring for these people in the community. The ultimate enabler of this acceptance will be architecture accommodating the elements necessary for the universal accessibility of mental illness in

generic guidelines, very similar to other forms of disability and the needs of older people. This is a future goal rather than a current reality, as we might not yet be of sufficient clinical or societal maturity to achieve it.

Therefore, a whole range of strategies, as well as products, will be needed, from low- and high-tech and from specialised to generic architectural guidelines, software applications, workplace and accommodation solutions, referring to all ranges of spaces, from physical to virtual, including even sectors such as gaming, entertainment and tourism, to cater for the whole spectrum of a person's needs. This will mean a paradigm shift in design for mental illness, improving primarily the quality of life of those experiencing it, as well as their families and carers, who can also experience fatigue, distress and burnout. The broadest impact will be on our entire society, as it will mean that one of the most characteristic types of total and confining institutions will become more and more obsolete. This reality is linked to a more adaptive and a more responsible society that does not need the walls of asylums (small or big) to contain its 'risks'.

Declarations and Conflict of Interests

The authors declare no conflict of interests with this work.

Notes

¹ WHO, 'Prevention of Mental Disorders and Suicide'.

² Priebe et al., 'Reinstitutionalisation in Mental Health Care'; Chrysikou, *Architecture for Psychiatric Environments*, 11–27; Gilbert et al., *Service Transformation*, 4–10.

³ EIU, *Mental Health and Integration*.

⁴ Madianos, 'Social Psychiatry'; Vostanis, 'Re-Establishment of the Mentally Ill', 97–1984.

⁵ Diebolt, *De la quarantaine au quarantaine*; Chartokolis, *Introduction in Psychiatry*, 51–60.

⁶ WHO, *Mental Health: New Understanding, New Hope*, 85–91; WHO, *Mental Health: Facing the Challenges, Building Solutions*, 93–105.

⁷ Chrysikou and Cornel, 'Accessibility for Fully Mobile Patients'.

⁸ Langdon et al., *Inclusive Designing*.

⁹ Gomez et al., 'Designing Accessible Workplaces for Visually Impaired People'.

¹⁰ Glasgow, 'Transportation Transitions and Social Integration of Nonmetropolitan Older Persons'; Dementia Friendly Hampshire Toolkit, 'Making Hampshire a Dementia-Friendly County'; Chrysikou et al., 'Home Environment Design and Frailty'.

¹¹ Riley, 'Schools as Centres of Community'; Darcy and Dickson, 'A Whole-of-Life Approach to Tourism'; Maisel, *The State of the Science in Universal Design*, 31–57.

¹² Chrysikou, 'Accessibility for Mental Healthcare'.

¹³ Muijen, 'Mental Health Services'; Letovancová et al., 'Attitude of Society Towards People with Mental Illness'.

¹⁴ Tobias and Tobias, 'In-Patient Bedroom Design'.

¹⁵ Christensen et al., *The Innovator's Prescription*.

¹⁶ Hillier and Hanson, *The Social Logic of Space*.

¹⁷ Markus, *Buildings and Power*, 41–91

¹⁸ Lindert et al., 'Public Mental Health'.

¹⁹ Christodoulou et al., *Anthology of Greek Psychiatric Texts*, xv–xxix.

²⁰ Christodoulou et al., *Anthology of Greek Psychiatric Texts*, xv–xxix.

²¹ Diebolt, *De la quarantaine au quarantaine*; Chartokolis, *Introduction in Psychiatry*, 51–60.

²² Diebolt, *De la quarantaine au quarantaine*; Chartokolis, *Introduction in Psychiatry*, 51–60.

²³ Priebe et al., 'Reinstitutionalisation in Mental Health Care'; Chrysikou, *Architecture for Psychiatric Environments*, 11–27; Gilbert et al., *Service Transformation*, 4–10.

²⁴ Economou et al., 'National Urban Policy in Greece'; Manolopoulos, *The Looting of the Hellenic Republic by the Euro, the Political Elite and the Investment Community*, 94–103.

²⁵ Christensen et al., *The Innovator's Prescription*.

- ²⁶ Hollin et al., ‘Patients with a History of Arson Admitted to Medium Security’.
- ²⁷ Wolfensberger and Glenn, *Program Analysis of Service Systems (PASS)*.
- ²⁸ Neufert, *Architects’ Data*.
- ²⁹ Health Building Note 08-02, *Dementia-Friendly Health and Social Care Environments*; Health Building Note 35, *Accommodation for People with Mental Illness, Part 1: The Acute Unit*; Health Building Note 35, *Accommodation for People with Mental Illness: Case Studies, Vol. 3*.
- ³⁰ Hillier and Hanson, *The Social Logic of Space*.
- ³¹ Chrysikou, ‘From Normalization Theory to a “Fit for Purpose” Architecture for the Mentally Ill’.
- ³² Chrysikou, ‘The Ecopsychosocial Complexities of Acute Psychiatric Wards’.
- ³³ Chrysikou, ‘Psychiatric Institutions and the Physical environment’; Chrysikou, *Architecture for Psychiatric Environments and Therapeutic Spaces*; Chrysikou, ‘From Normalization Theory to a “Fit for Purpose” Architecture for the Mentally Ill’.
- ³⁴ FEK, ‘YA No Y5v/1962/21-9-2000 FEK B 1268/19-10-2000’, Article 7, Paragraph 5.
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