

HOPE & BEYOND FOR THE MENTALLY ILL

A THESIS

Submitted in partial fulfillment of the requirements for the award of
Bachelor of Architecture degree

By

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**DEPARTMENT OF ARCHITECTURE
SCHOOL OF BUILDING AND ENVIRONMENT**

SATHYABAMA

**INSTITUTE OF SCIENCE AND TECHNOLOGY
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NOVEMBER 2021



DEPARTMENT OF ARCHITECTURE

BONAFIDE CERTIFICATE

This is to certify that this Thesis Report is the bonafide work of **SAI TEJA T N (37210041)** who carried out the Thesis entitled “**Hope & Beyond for the mentally ill**” under our supervision from July 2021 to November 2021.

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DECLARATION

I, **SAI TEJA TN** declare that the Thesis Report entitled "**Hope & Beyond for the mentally ill** " done by me under the guidance of **Ar.Selvendiran SG**(Internal Guide), **Ar. Vijendranath .R**(Internal Review Member) and **Ar. Sarath Chandrakanth**(External Guide) Sathyabama Institute of Science and Technology is submitted in partial fulfilment of the requirements for the award of Bachelor of Architecture Degree.



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ACKNOWLEDGEMENT

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I convey my thanks to **Dr. Devyani Gangopadhyay**, Dean and Head of the Department, School of Building and Environment, Our Design Chair **Dr. Suresh Kuppuswamy**, Thesis Coordinator **Ar. Surya Rajkumar** for providing me necessary support and details at the right time during the progressive reviews.

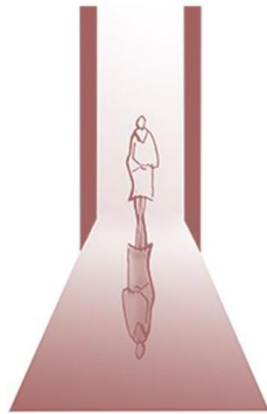
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Sai Teja TN



H O P E BEY & ND

*for the mentally ill
at Ervadi*

THESIS SYNOPSIS

We are persuaded that architecture impacts individuals and that individuals impact architecture as well. We are keen on the interaction between planned architecture, built space, and the people who actually use them. This relationship is critical, particularly in the field of psychiatry. A mentally disturbed person perceives his environment differently than a healthy person. In the event that the space that encompasses us can influence our discernment, our sense of well-being, and our mood, what is then the best environment for a mentally ill person?

In this work, we might want to discover the particular necessities that the mentally ill need from their architectural; environment. On troublesome occasions, patients are especially delicate to their current circumstances, which can add to their well-being. Might the architecture even affect the mending system of the insane? We think of it as a commendable challenge to design that meets these individuals.

The proposal will accumulate and examine known information on the components that make architectural space alleviating for the minds, with a lot of thought to people working there as well. Some are eventual self-destructive, some are frightened, some in elevated nervousness that isn't much influenced quite a bit by control. The solitary solace they can find would be on people who help them and the environment they are in. Subsequently, the emphasis will be on the architectural details that make up this environment.

Keywords: *Mentally ill, Psychiatry, architectural environment, Mentally disturbed, patients, insane*

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CHAPTER 1: INTRODUCTION

1.1 TOPIC INTRODUCTION

The current model of community mental health care doesn't give sufficient therapeutic settings to numerous mentally ill patients to completely recuperate. Because of this inadequacy, patients are falling into an unsafe cycle where they are conceded to the hospital, balanced out at the acute care setting, and released inside merely days into the bigger community where they have restricted admittance to assets and encouraging groups of people. Now, patients become overpowered, have another occasion, and return round trip to the emergency division. Thus, there is a radical requirement for new sorts of privacy settings that give a middle condition between the organization and freedom where there is both asylum and admittance to therapeutic services, just as associations with the world on the loose.

Currently, mental health patients when initially conceded for care, or submitted by a court, are isolated from society in institutional settings that give prompt, settling treatment. These settings are horrendous, now and then unpleasant conditions that are centered around intense therapy and infrequently address the more extended term therapeutic necessities of the patient, not to mention give a safe space. When released from the hospital, patients are delivered into the world everywhere with practically no setting anchors and restricted admittance to the services they need.

Group homes, or halfway houses, offer patients insignificant consideration and inconsistent services with more autonomy than numerous patients are prepared to expect. Not at all like the settings for hospitals and group homes, a more extensive therapeutic community, one which is situated inside the community everywhere and has quick admittance to help and services, can give a more steady framework to progressing patients from systematized disengagement and isolation to an incorporated type of care that improves patient and community communication.

This thesis concentrates on how architecture can assist with making a setting that shows up in a harmony between supervision, medical treatment, and patient freedom while giving the two combinations into the community and shelter from the world on the loose. It is designed to meet the particular residential and treatment needs of patients that are released from the hospital yet are not prepared for autonomous living all alone or in a gathering home.

1.2 NARRATIVE

This thesis investigates the fact that architecture will have a very positive effect on the common attitude toward mentally challenged sufferers by means of imparting them with an environment suitable for improvement and initiative. The venture analyses the scenario of such a discussion board in the process, that of a psychiatric and rehabilitation facility functioning to trade mindsets on either side of the fence by taking patients via a healthy improvement software designed specifically to resource them within the actual world.

The center gives a space complete with natural surroundings and power, a place that is self-contained and bureaucracy a corresponding dating with the environment. The assignment attempts the use of an architectural language reflecting the significance of development and evolution in intellectual fitness for the kingdom. It allows social interactions between human beings from one-of-a-kind cultures, creating treasured connections among communities whilst reducing social isolation and prejudices, lowering the stigma that surrounds such people.

The center will be imagined as a structure of progress, a gateway to a higher destiny.

1.3 NEED OF THE PROJECT

Mental illness has proven to be both a prevalent health and economic burden worldwide. The World Health organization found that neuropsychiatric disorders cause the highest percentage of life years lost out of 22 disease categories. The WHO also estimates that the global cost of mental illness will reach \$6 trillion by the year 2030.

Thus economic loss is much less due to the cost of care, but more so because of unemployment of people with mental illnesses, expenses for social supports, and additional costs for resulting chronic disabilities. Outlooks developed by the World Economic Fund find that mental illnesses will account for 35% of the global lost economic output. This figure can become even higher when it is taken into consideration that those with mental illnesses are at higher risk of cardiovascular disease, respiratory disease, and diabetes.

Understanding the social and economic need for attention to mental health is vital in the coming years and decades of population growth.

1.4 AIM

The aim of this thesis is to design the infrastructure of mental health institutions to make them more humanized and habitable, simultaneously endeavoring to reintegrate the infrastructure into society.

1.5 OBJECTIVES

01. To study the evolution of hospital infrastructure in India and the establishment of the Mental Health Act, 2017.
02. To Understand the present working of mental health institutions and derive user sets from the same.
03. To understand the current psychiatry, Psychiatric Treatment approaches and relate them to architectural Treatment facilities.
04. To design an infrastructure that supports community interaction and educational spaces for better patient integration into society.
05. To design various therapies that could make the patients obtain skills and be a part of reintegrating into society.

1.6 METHODOLOGY

This thesis is to a great extent dependent on the secondary data gathered from different optional sources of information assortment like websites, newspapers, magazines, various research papers, and auxiliary studies. The study uses a qualitative process, where conclusions and inferences are drawn dependent on translations of the exploration material reviewed.

Few buildings were all around investigated in the type of architectural drawings, photograph representations, and psychologically. Architectural elements and spaces were recognized as healing elements that were analyzed in detail for their role in architectural development. The ultimate result is in the type of proposals and ideas that will be helpful for planning an architectural environment providing hope to the users of this project.

1.7 MOTIVATION

01. National Institute of Mental Health and Neurosciences have revealed that at least 13% of the Indian population are suffering from mental health conditions with 10% i.e. approximately 150 million Indians in need of on-the-spot interest.
02. India was one of the first countries to develop a national mental health program in the 1980s but no concrete measures were implemented to understand and estimate the spread of mental illness in the country.
03. The Parliament passes the Mental healthcare bill 2016 providing comprehensive legislation for state healthcare facilities, spelling out rules, and protecting the rights of persons with mental illness in India.
04. Several calls have been made to invoke political will, enhance advocacy, and for galvanizing community participation.
05. With rising awareness in Indian society, it can be expected that early recognition and access to treatment will follow, as will the adoption of preventative measures.

1.8 GOALS

The goal of this proposed psychiatric rehabilitation center is to help patients to develop the emotional, social, vocational, and intellectual skills needed to live, learn and work in the community with the least amount of professional help

This Mental health care feature will be at two levels, institutional care and community mental health care popularly known as community psychiatry. Institutional care takes place in psychiatric hospitals whereas community psychiatry occurs in the community in which patients reside. Psychiatrists and nurses offer treatment at the institutional care level and community psychiatry nurses administer care at the community psychiatry level.

The psychiatric rehabilitation center will serve as a transitional zone between the hospital and the community where patients are taught the requisite skills needed to be reintegrated into the community. The rehabilitation center will seek to accomplish two main purposes.

They are 1) to help train recovered patients in skills acquisition for gainful employment and 2) to help provide the opportunity for patients to gradually acquire socialization skills through their supervised contact with some members of the community. The idea of trying to include the public into this proposed design is to help patients learn how to live with people upon getting back into the community and also to help break down the wall of prejudice the public has concerning mental illness, and to make sure that the patients are treated well as the public eyes would be on the institution.

1.9 SCOPE

A design that appropriately addresses the issues mentioned in the study.

A design that enables and empowers the mentally ill to live in a community within the facility as well as the right to the confidentiality of treatment.

A design that will be imagined as an architecture of progress, a gateway to a better future.

1.10 RESEARCH CONTRIBUTION

An architectural design model of psychiatric rehabilitation centers with the focus on reintegrating mental patients into society is proposed. Patients will consequently acquire skills and furthermore contribute to economic development. It will also assist in reducing stigmatization associated with mental illness as a result of the education human beings will receive even as playing a role within the recuperation technique.

CHAPTER 3: LITERATURE REVIEW

Given the research-based nature of this project, performing a literature review was essential to synthesize existing research into a set of conclusions. A series of scholarly articles, historic documents, lectures, and interviews are compiled on the topics of both design and psychiatric care. While these reviews provided a wealth of information, they were distilled to the development of the design process which is a key step. Conclusions are drawn that ensure the composition of qualitative and quantitative information-based decisions.

3.1 MENTAL ILLNESS

The meaning of mental illness or mental disorder is an extremely emotional matter since it relies upon esteem decisions including what is ordinary and what isn't inside a social setting. However ambiguous as the meaning of mental issues seems to be, the meaning of mental health is similarly so. The World Health Organization (WHO) characterizes mental health as a being of prosperity in which the individual understands their own capacities, can adapt to the typical burdens of life, can work beneficially and productively, and can make a commitment to their local area.

Mental health can in this manner be viewed as a deep-rooted process. In each period of life, we need to confront various difficulties, which we could possibly feel fit for surviving.

However, mental health isn't just a statement of solidarity, prosperity, and great mental limits. It is additionally the capacity to acknowledge our own shortcomings and limits and to adequately manage them.

3.1.1 Mentally ill

The WHO portrays mental health because of dynamic associations between natural, mental, financial, socio-social, and institutional variables. Hence mental health is a perplexing interaction that is, other than individual perspectives, intensely impacted by the previously mentioned outer variables.

The weakness of an individual to a mental problem relies upon many factors like his hereditary demeanor, his mental condition, and the climate where he resides. Everybody could be moved by a mental problem, and truth be told, it is exceptionally normal in our general public. Public and worldwide examinations from the seventies to the nineties showed that pretty much consistently individual meets the rules of a mental problem once during his lifetime.

Individuals who are defied with an adjustment of their life circumstances or who face a troublesome test have an especially high danger of being impacted by a mental issue. Significant life changes, for example, the beginning of young, immaturity, section to proficient life, retirement, separate, proficient disappointment, or encounters of savagery would all be able to create mental issues. The danger of turning out to be sick ascents assuming a few variables are available.

For what reason accomplish more individuals currently experience the ill effects of a mental illness than before :

There are different conclusions on the purposes behind the developing number who looking for psychiatric treatment. Certain individuals accept that the wellsprings of the issue are new environmental stressors, for example, fast changes, strain to succeed, and unhealthy workplaces. Then again, thoughts regarding mental health and illness are changing, with more practices presently falling under the class of mental illness. What before was viewed as the particularity of somebody's character is today viewed as a problem that ought to be dealt with. Notwithstanding this turn of events, the tremendous advancement that is being made in the areas of neuroscience and hereditary qualities presently makes the treatment of an ever-increasing number of problems conceivable. For those determinations, the quantity of cases has not really developed. Rather, practices that were once viewed as unchangeable pieces of their characters are presently perceived as a mental illness and accordingly taken care of with treatment. As a result, the quantity of dealt with cases has expanded. We can say that the developing mental strain, the improvement in assessments, and the greater levels of popularity on health have all added to the rapidly developing number of psychiatric medicines.

3.2 CAUSES OF MENTAL ILLNESS

Mental illness is a condition, wherein an individual experiences issues in taking care of circumstances and sensations of a regular nature (Regier et al., 1999). In specific

cases, conditions are portrayed by the disability of scholarly capacities, the experience of shallow and temperamental feelings, and trouble in adjusting to one's current circumstances (Bayes, 2000). Mental illness is a term that alludes to every one of the various kinds of mental problems, including issues of thought, state of mind, or conduct. To be delegated a mental illness, the condition should make trouble and result in a decreased capacity to work mentally, socially, occupationally, or relationally (Regier et al., 1999).

This implies that somebody experiencing mental illness might experience difficulty adapting to feelings, stress, and outrage, for example, the difficulty of taking care of such things as everyday exercises, family obligations, connections, or work, and school liabilities. This surmises that an individual can encounter more than one sort of mental illness simultaneously. Albeit the specific reason for most mental illnesses isn't known, it is turning out to be clear through research that a significant number of these conditions are brought about by a mix of organic, mental, and environmental elements (Butler, 1985).

3.2.1. Biological factors responsible for Mental Illness

Some mental illnesses have been connected to a strange equilibrium of uncommon synthetic compounds in the cerebrum called synapses. Synapses assist with nerving cells in the mind to speak with one another (Edam and Koon, 2000). Assuming these synthetic substances are out of equilibrium or are not working as expected, messages may not endure the mind accurately, prompting manifestations of mental illness. Instances of the indications are; confounded reasoning; dependable bitterness or crabbiness; outrageous highs and lows in disposition; inordinate dread, stress, or tension; social withdrawal; emotional changes in eating or dozing propensities; overwhelming inclinations of outrage; dreams or pipedreams (seeing or hearing things that are not actually there); expanding failure to adapt to day by day issues and exercises; musings of self-destruction; forswearing of clear issues; numerous unexplained actual issues; maltreatment of medications as well as liquor. What's more, surrenders in or injury to specific pieces of the cerebrum have likewise been connected to some mental conditions (Regier et al., 1999). Other natural factors that might be engaged with the improvement of mental illness incorporate hereditary qualities, diseases, mind imperfections, and possible harm.

A. Genetics

Numerous mental illnesses run in families, proposing that individuals who have a relative with mental illness are bound to foster mental illness. Powerlessness is passed on in families through qualities. Specialists accept numerous mental illnesses are connected to irregularities in numerous qualities and not only one. An individual might acquire helplessness to a mental illness and may not really foster the illness. Mental illness itself happens from the connection of different qualities and different factors like pressure, misuse, or an awful accident which can impact or trigger an illness in an acquired individual defenselessness to it (Regier et al., 1999)

B. Infections

Certain diseases have been connected to cerebrum harm and the improvement of mental illness or the deteriorating of its manifestations. For instance, a condition is known as pediatric immune system neuropsychiatric confusion (PANDA) related to the Streptococcus microscopic organisms has been connected to the improvement of the fanatical enthusiastic problem and other mental illnesses in youngsters (Regier et al., 1999).

C. Brain Defects

Defects in or injury to certain areas of the brain can also cause mental illnesses (Argyle, 1970)

D. Prenatal Damage

Some evidence suggests that a disruption of early fetal brain development or trauma that occurs at the time of birth, for example, the loss of oxygen to the brain may be a factor in the development of certain conditions, such as autism (Regier et al., 1999)

E. Substance abuse

Long-term substance abuse, in particular, has been linked to anxiety, depression, and paranoia (Regier et al., 1999).

F. Other factors

Poor nutrition and exposure to toxins, such as lead, may play a role in the development of mental illnesses (Reiger et al., 1999).

3.2.2. Psychological factors responsible for Mental Illness

Mental variables which add to mental illness incorporate 1) extreme actual injury endured as a youngster, for example, enthusiastic, physical, or sexual maltreatment 2) a significant early misfortune like the departure of a parent, 3) disregard when one feels deserted or dismissed 4) powerlessness to identify with others (Madison, 2003)

3.2.3. Social factors responsible for Mental Illness

Certain stressors can trigger the illness in a helpless individual to mental illness. These stressors incorporate demise or separation, a broken everyday life, living in destitution, sensations of deficiency, low confidence, nervousness, outrage, or depression, changing positions or schools, social or social assumptions (for instance, a general public that partners magnificence with slimness can be an element in the improvement of dietary issues) and substance maltreatment by the individual or the individual's folks (Regier et al., 1999). Mental illness doesn't ordinarily begin of the blue yet typically grows gradually (Morgan and Cheadle, 1981). Notwithstanding, certain individuals may unexpectedly get a mental illness, like the advancement of insane illness (Argyle, 1970). Epidemiological information proposes that around one out of four individuals experience mental health issues (Regier et al., 1999).

3.3 HISTORY

The historical backdrop of psychiatry centers around the treatment of mental illness throughout the ages. It means to build up the logical, social, and clinical perspectives in this mind-boggling matter. The space can be organized into three ages.

The historical backdrop of psychiatry in the severe sense starts with the illumination in the eighteenth century, when endeavors to methodically focus on the mentally poorly started. Since the finish of the nineteenth-century psychiatry has turned into a scholastic sense.

PHASES of Development of Mental Institutions

First Phase



First hospital established in Bombay

1745

Dr. William Dick, a surgeon, established a private hospital, which was recognized and rented to East India Company (EIC).

Another lunatic asylum in Monghyr, Bihar, about 400-500 miles north of Calcutta, established by the British rules.

Another lunatic asylum was opened at Patna, Bihar.



18th Century:

- Care for those people began

19th Century :

- Psychiatry came into academic sense

Middle Ages :

- Considered as God's punishment, locked in prisons.

Renaissance to French revolution :

- The moral treatment with Asylums(18th Century)
- Asylum built by Ar. Hyppolyte Lebas (19th Century)

The Early 20th Century :

- Decline of the asylum
- Revolving Door effect

1787

1795

1821

1784

1794

1817

The next hospital established in Calcutta both under the direct authority of East India Company. (IEC)

Surgeon Valentine Connolly established the first hospital in South India at Kilpauk, Madras, for twenty patients

Surgeon Beardsmore had opened a private hospital at Bhowanipore, Calcutta. This hospital housed around 50-60 European patients with clean surroundings and a garden.

Indian Mental Health Condition

MENTAL HEALTH: THE NUMBERS ARE TROUBLING

15 CRORE
People across India are in need of mental health care interventions

0.3 Psychiatrists per 1,00,000 people in India compared to 6.6 psychiatrists per 100,000 people in developed countries

1 IN 20 suffers from depression alone

0.07 Psychologists per 1,00,000 people in India

70-92% Fail to receive any treatment

*\$500-1,000 Consultation fee at private clinics

\$1.24 TRILLION
ECONOMIC LOSS ESTIMATED BETWEEN 2012 AND 2030 DUE TO MENTAL ILLNESSES

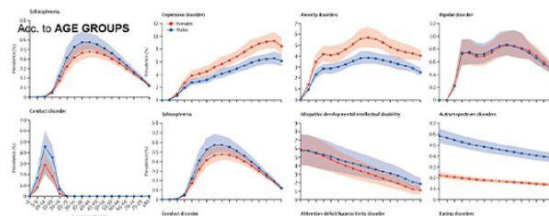
*Per visit fee in metros
Source: News reports

DEPRESSION, ANXIETY COMMON

INDIA
2016: National Mental Health Survey studied 40,000 individuals in 12 states
Finding: 11% Indians over 18 years had a mental disorder
This means, 110m need mental health intervention

WHAT THE NEW STUDY ADDS
India State Level Disease Burden Initiative
Mental Disorders Study 2017 findings
In 2017, 101m people had mental disorders in India
4.7 lakh disability-adjusted life years or measure of overall disease burden in terms of years lost due to ill health, disability or death

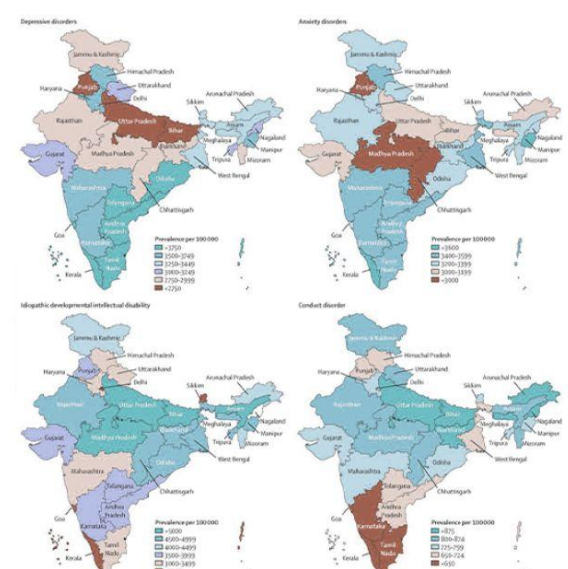
Mental issues in India (2017)
All mental disorders
Developmental disability
Depressive disorders
Anxiety disorders
Bipolar disorder
ADHD
Schizophrenia



- NHRC Report stating one among every seven people has mental disorder.

- Only 37 Indian Mental Health Institutions, as if the time had stood still.

- 57% Jail like structure, Open drains, Inadequate water, lighting, open urinated systems, high enclosures



Second Phase



The first Lunacy Act (act no 36) was established

1858

Second Phase (mid 19th - late 19th century)

India Lunacy Act established : Led to establishment of Central Lunatic Asylum, Behrampur

1912

Third Phase (1st quarter 20th cen.)

Col. Berkeley Hill called for a change of name of the Institutions from 'Mental Asylums' to 'Mental Hospitals'

1920

Fourth Phase (1920 - 1947)

Not many new hospitals were established. More emphasis was on creating and developing general hospital psychiatry wards.

post 1947

Fifth Phase (post 1947)

1840

1860

1880

1900

1918

1940

1960

1872

During this period, new asylums were built at Patna, Dacca, Calcutta, Berhampur, Cuttack, Waltair, Trichinapally, Colaha, Poona, Dharwar, Ahmedabad, Ratangiri, Hyderabad (sind), Jabalpur, Banaras, Agra, Bareilly and Lahore.

Colaba was mainly meant for Europeans with over 285 beds and Ahmedabad had 180 beds.

1918

Colaba was mainly meant for Europeans with over 285 beds and Ahmedabad had 180 beds.

1946

Establishment of the "Bhore Committee" for surveying mental hospitals.

2050

Only 40% of India's population predicted to move to urban areas.

15,890

28% Involuntary admissions out of 56,777 inpatients. (Mental Health ATLAS : Member state profile, 2017)

6.1%

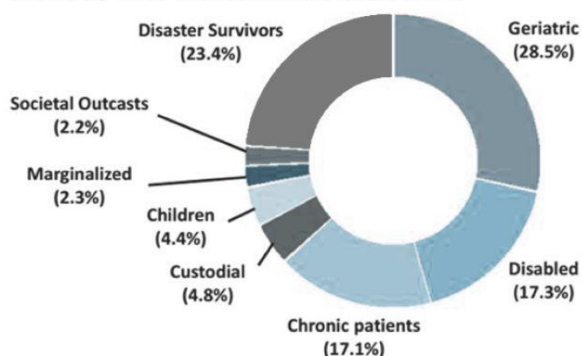
Inpatients stay for more than 5 years.

(Mental Health ATLAS : Member state profile, 2017)

1951 lakh

Out of approximately 156 crore Indian population is susceptible to some form of mental health issue.

(Study by Bada Math & Srinivasaraju, 2010)



NEED FOR REIMAGINATION

Factors



No evolution



Custodial Architecture



No Uniformity



Spatial Quality



Workforce



Overcrowdness

Importance

- 01 Emotional Balance
- 02 Symptoms Management
- 03 Faster Recovery
- 04 Necessary Life skills
- 05 Opportunities
- 06 Social Awareness
- 07 Expectation of care
- 08 Natural Analogues
- 09 Safe therapeutic healing space



ARCHITECTURE THESIS Hope & Beyond for the mentally ill



Plate no :02

3.3.1. Middle ages

In the early medieval times, mental issues are seen inside a philosophical and moral system. Middle age society accepts that people have through and through freedom and are liable for their activities, however, that illness comes from wrongdoing and results in discipline from God or ownership by Satan. In this line of contention mental illness is viewed as either the aftereffect of transgression or a trial of confidence, and strict movement turns into a regularly utilized fix. Cloisters begin to design a significant job in the caretaking of needy individuals' illnesses, however many mentally sick live by and by with their families and are treated at home.

The social place that maniacs are involved in middle age society is difficult to distinguish. On one side there is a specific level of comprehension towards the experience that mental illness brings, then again, a course of the social guidelines is slowly evolved. Everyone that is strange is contained, minimized, and avoided.

A specific number of mentally shaky and risky ones have secured up penitentiaries. This imprisonment is viewed as important to have the option to keep everything under control. There is a sure dread that the perilous neurotics could hurt the local area and that their frantiness could some way or another spread. Jails and different spots of disconnected constraintment are the most widely recognized arrangements that archaic culture needs to manage forceful, mentally unstable individuals.

3.3.2. From the renaissance to the french revolution

A renaissance clinic is a spot where various exercises are joined: strict rituals, help, care, exchange, and creative work. Those many capacities make the emergency clinic a little city inside the city. The engineers set up a wide range of components to imagine and support the public person of those structures. Arcades, loggias, pronaos, groups, porches, and yards, make change zones between the roads, the squares, and the emergency clinic. When discussing those medical clinics and their significant job in the metropolitan texture of Florence, one could get the feeling that the general public of the Renaissance period took excellent consideration of their frail individuals.

3.3.3. The End of the 18th Century - The moral Treatment

Early reflections on the connection among design and caretaking of the mentally sick date back to the late eighteenth century that marks the rise of the refuge, a spot devoted to treating the mentally sick and it is just consistent that it is in this period,

interestingly, that a restorative worth is allocated to engineering. The ethical treatment perceived that frantiness is certifiably not a straightforward loss of the brain, but a confusion of the psyche. This suggests that inside every persistent's brain the explanation is to be viewed and as worked with. The structures for the mentally sick have consequently advanced from basic jails, with the main objective to close away from the perilous, to refuges, committed only to the mentally shaky and equipped for giving some sort of treatment.

3.3.4. The 19th Century - Construction of the asylum

The making of refuges depends on two suppositions: separation, which builds up as a helpful system the expulsion of the patient from his environment, and moral treatment, which enables the alienist to practice his impact over the upset psyche.

Since the primary reflections on structures explicitly for the mentally sick, numerous hypothetical works were distributed, and regularly the evil was moved out of jail. By the by, the day-to-day environments of the mentally sick have scarcely changed. Here, the refuge is changed into a restorative local area where specialists and patients live respectively. They accepted that the patients should be isolated from the rest of the world to set up quieting distance from the interruptions brought about by their infection. The refuges ought to be worked outside of the city on an incline, to profit from the virtue of air and water and permit the mentally sick admittance to nature, which should have a restorative impact in itself.

The model arrangement comprises of two balanced parts: the ideal for the men and the left for the ladies, isolated by an organization building. Each part included two arrangements of three living quarters organized on the two sides of three structure administrations. The quarters are U-molded, coordinated around a yard, and restricted to a solitary story.

These haven structures are by and large those which are built on the ground floor wherein the displays are remained open, the crazy is less unattractive, and can go outside as they wish.

Every division has its own restricted nursery, which permits patients to get natural air and move around, without upsetting the patients with different levels of unsettling. The various administrations are additionally organized progressively.

3.3.5. The early 20th Century - Decline of the asylum

By the mid-1900s, the previously well-known shelter had lost its glory. Because of the distant geographical area, a universe of its own has been created where the shelter chief is the director of a major foundation, rather than a clinical scientist. Patients are not really ready to leave the havens, and thus, the structures are stuffed.

Dealing with the mentally sick outside of huge establishments and in this way staying away from a too-long division from their environment initially became famous during the 1920s. The conviction is that if treating inside the refuge isn't working, maybe treatment outside would. One of the principal organizations that offered administration was the medical clinic Henri-Rousselle in Paris. Made in 1922 by the mental cleanliness association, the medical clinic housed an intense day ward, just as friendly help and the examination research centers. The insane person havens have changed names, yet actually as yet unchanged.

3.3.6. Deinstitutionalization

The arrangement of deinstitutionalization started after World War II. The essential idea is to relax the intertwined and tight connection between psychiatric treatment and the enormous organizations and to empower treatment, not in a separated environment but rather near the patient. Clearly, the new energizer and antipsychotic drugs, which were acquainted with the market during the 1950s, impact this advancement since they permit decreasing the occasionally weighty manifestations and make patients' treatment inside society conceivable. The medications abbreviated the normal stay in the clinic, however since most places are missing after treatment and recovery, numerous patients return to the center. This cycle is basically named the spinning entryway impact. It is currently clear that for a really long time the specialists focused uniquely on fixed and move around treatment, however, that there is a requirement for middle constructions like day emergency clinics, which build up an interface between the ongoing and short term care.

3.4 INDIAN MENTAL HEALTH CONDITION

From the reports issued by NHRC and Supreme Court of India, 2017

01. "This report uncovers that in 2017, one among every seven individuals in India had a mental problem, going from gentle to extreme. The corresponding

commitment of mental issues to the all-out illness trouble in India nearly multiplied from 1990 to 2017. Among the mental problems that show overwhelmingly during adulthood, the most elevated illness trouble in India was brought about by sadness and nervousness issues, trailed by schizophrenia and bipolar issue. The most noteworthy illness trouble was brought about by IDID, (Dissociative personality issue) trailed by lead issue and mental imbalance range issues.

02. The higher commonness of burdensome and nervousness problems in southern states could be identified with the more elevated levels of modernization and urbanization in these states, We tracked down a positive, however humble, connection between burdensome issues and self-destruction passing rates at the state level, with self-destruction demise rates, additionally being higher in the southern states than in the northern ones.
03. The Supreme Court, stunned by the conditions and thinking of them as a gross infringement of the fundamental freedoms ensured under Article 21 of the Constitution of India, asked the National Human Rights Commission (NHRC) to review all the 37 government mental medical clinics (joined bed strength of 18,918) in the country.
04. The finishes of the very much archived NHRC Report of 1996 reverberated in only one sentence: "Maybe the time had stopped."
05. Two surveys of mental medical clinics were attempted in 1998 and 2008 to recognize the lacunae in these foundations and the progressions that happened more than 10 years. These assessments outline the difficulties these foundations present to mental health care.
06. The circumstance of mental clinics at the hour of the primary audit was profoundly inadmissible – "38% of the clinics actually hold the prison-like design that they had at the hour of commencement, nine of the emergency clinics developed before 1900 have a custodial sort of architecture, contrasted with 4 worked during pre-and one post-freedom, 57% have high dividers, patients are alluded to as 'detainees' and people in whose care the patients stay through a large portion of the day are alluded to as 'corrections officers' and their chiefs as 'supervisors' and the various wards are alluded to as 'nooks'."

07. Stuffing in enormous clinics was clear with the general proportion of beds: patients being 1:14, showing that floor beds are a typical event in numerous mental emergency clinics as found in India. Patients are relied upon to pee and poo into an open channel. In general visibility, numerous medical clinics dislike running water. Storerooms are likewise poor in 70% of emergency clinics, lighting is lacking in 38% of the emergency clinics, 89% had shut wards while 51% had solely shut wards, and 43% had cells for segregation of patients.
08. Releasing rooftops, spilling over latrines, dissolved floors, broken entryways, and windows are normal sights; security for patients was available in under portion of the emergency clinics, withdrawal rooms were available in 76% of clinics and utilized in most of these clinics, and just 14% of the staff felt that their emergency clinics' ongoing office was sufficient.
09. The current type of treatment in most mental emergency clinics is fundamentally custodial rather than remedial. There is a need to create and develop short-term administrations with the accessibility of advising, psychotherapy, youngster direction, and psycho-instructive administrations.
10. "There is a need for rebuilding and revamping the existing infrastructure in these hospitals."
11. The Mental Hospital should be termed as the Institute of mental health.

3.4.1. Need for Reimagination of Mental Health Institutes

"The latest things show us that close to half of the patients keep on vegetating in a dehumanized way with the emergency clinic as family members frequently don't have any desire to take patients home. Many extended stay patients are being deserted by their families in the mental emergency clinics. Mental medical clinics fill in as unloading grounds which are advantageous for family members of undesirable mentally sick patients. There is likewise a lopsided conveyance of the psychiatric administrations. Huge segments of the populace and huge geological regions in many states come up short on even simple mental health care. There is a requirement for remaking and redoing the current framework in these medical clinics. The mental clinic of the past should be changed over to a cutting edge tertiary psychiatry community with different subspecialty psychiatry centers being accessible for the utilization of the everyday person." Jacob et al., 2007

3.4.2. Factors

01. NO EVOLUTION

No evolution in terms of physical infrastructure since its inception in 1745.

02. PRISON LIKE INFRASTRUCTURE

The hospitals still reflect the jail-like confinement spaces & are almost inhabitable.

03. NO UNIFORM INSTITUTE

Facilities like - halfway homes, rehabilitation centers, OPD stations are not always present under one umbrella.

04. SPATIAL QUALITY

The spatial construct mimics that of inmates in prison being looked over by a prison warden, consisting of isolated dormitories, large-scale overwhelming common spaces, and an imposing 'guard-tower' to keep the patients in check. The buildings are texturally uniform and covered in an institutional color palette (dull, pastel colors like - sandstone, reds, blues, whites, etc.) The wards/dorms themselves are in appalling conditions, almost inhumane and inhabitable, with patients being restrained to their beds indefinitely.

05. LACK OF WORKFORCE

6.5% of the Indian population suffers from some sort of mental disorder. Mental illness contributes to nearly one-sixth of all health-related disorders. A study in 2014-15 predicted that about 20% of India's population would suffer from some form of mental illness by the year 2020. There are 0.3 psychiatrists, 0.12 nurses, 0.07 psychologists, and 0.07 social workers per 100,000 population (WHO,2018) International standard ratio of mental health professionals to patients is 1 psychiatrist, 1 psychiatrist nurse, 1 psychiatrist social worker, and 1 clinical psychologist per 10,000 persons or 3:1,00,000 (Bada Math et al., 2019)

06. MONETARY ISSUES

In 2019 the budget allocated to National Mental Health Programme (NMHP) was brought down from Rs.50 crore to Rs.40 Crore. Increased by 7% but there has been no change in the mental health care budget. The budget for Mental Health is 0.05% of the total budget. The total cost for human resources development over a period of 10 years (Section 31(3) of the MHCA, 2017) dictates that the government should

achieve internationally accepted standards for the number of mental health professionals per lakh population within 10 years.

07. OVERCROWDING

In India, around, 56,600 public psychiatric beds (35,000 psychiatric beds in mental clinics, 10 beds each in 723 region medical clinics, and 30 beds each in 479 clinical universities) exist for a 130 crore populace. The assessed prerequisite would be 50 beds for each 1,00,000 populace. It is suggested that the bed strength of the existing emergency clinics will be limited to 400, psychiatric preparing units (25-50 beds) be set up at the region level. Two audits of mental clinics were attempted in 1998 and 2008. "Stuffing in huge medical clinics was apparent with the general proportion of beds: patients being 1:14, demonstrating that floor beds are a typical event in numerous mental emergency clinics as found in India." (Patel and Kleiman, 2003).

3.5 STIGMA

Stigma is something about an individual that causes him/her to have a profoundly compromised social standing, a characteristic of disgrace or dishonor. Many individuals with genuine mental problems give off an impression of being diverse on account of their indications or the results of their medicine. Others might see the distinctions, neglect to get them, feel awkward around those impacted and act in a negative manner towards them. This compounds the two indications and handicaps in people with mental problems. Individuals with mental problems are regularly thought to be languid, unintelligent, useless, inept, perilous to be with, vicious, crazy, consistently needing management, moved by evil presences, the beneficiary of heavenly discipline, unusual, questionable, flippant, untreatable, without heart, clumsy to the wedding and bring up kids, unfit to work, progressively unwell all through life and needing hospitalization (WHO, 2001)

3.5.1. Effects of stigma

01. The reluctance of an individual with mental issues to look for help. Because of the shame related to this illness, patients are hesitant to look for clinical assistance and therefore, around 65% of individuals with mental illness abstain from looking for clinical assistance (Davis et al., 2003).

02. Detachment and trouble in making companions. When an individual encounters mental illness, he/she is seen as a perilous individual fit for causing hurt. Consequently, 'ordinary individuals' isolate themselves from them with the dread of getting injured.
03. Harm to confidence and fearlessness. Patients feel so discouraged that they lose their feeling of worth and balance. Losing their feeling of worth makes it hard for them to blend with individuals even after recuperation and even take part in any significant thing (Regier et al., 1999).
04. Families are all the more socially disengaged and have expanded degrees of stress. Groups of the patients are peered downward on and no family needs to have one thing or another to do with them. They become socially outsiders and the family name is disparaged (Regier et al, 1999).
05. Fewer assets are accommodated mental health than for different spaces of health. Since there is a social conviction that individuals don't actually recuperate from this illness, the public authority is hesitant to enter more assets into this area. Pretty much 5% of the public authority financial plan is apportioned to mental health (Laugharine and Burns, 1999)

3.5.2. Strategies to combat stigma

Below are proposed strategies which when adopted will help eliminate stigmatization in the society

01. Local area schooling of mental issues. Mindfulness ought to be made on the reasons for the illness, counteraction of the illness, what to be done on account of mental illness, and a consolation that the illness is treatable. Psycho-instruction should be coordinated for buyers and families on the best way to live with people who have or have once experienced mental issues. Such individuals need unique guiding (psychotherapy), word-related preparation, bountiful love, and care (Davis et al., 2003).
02. Improvement of mental health administrations (quality, access, deinstitutionalization, local area care). Mental health offices ought to be improved, significantly more specialists are prepared and better states of administration are proposed to health laborers in this area.

03. Enactment on the freedoms of people with mental issues. It will be moved when the Mental Health Act is passed (MHP, 2006).
04. Schooling of people working in the broad communications pointed toward changing misinterpretations about mental problems. Individuals in the media ought to be taught the best way to deal with cases related to mental patients particularly when writing about them to keep the general population from replicating what they see and hear (Davis et al., 2003).
05. Improvement of local area care and social incorporation habitats for people with a mental problem or has once experienced mental illness (Davis et al., 2003)

3.6 THE PATIENT

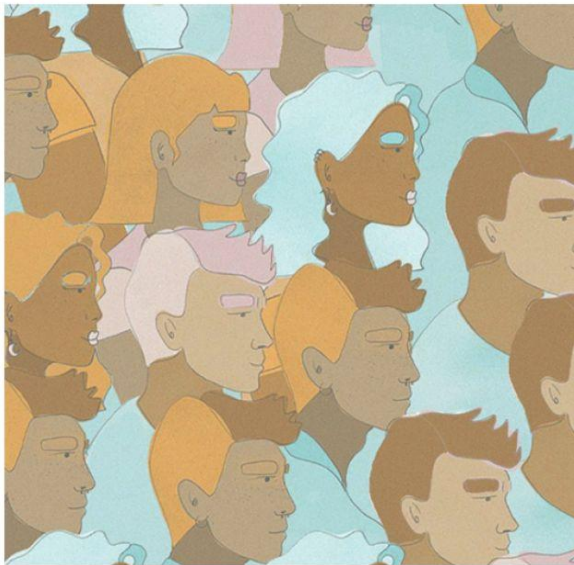
What's the significance here for a patient to be in a fixed psychiatric clinic?

The stay in a fixed psychiatric center is certainly not a simple matter for a patient or his family members. The patient is pulled out of his environment and his interpersonal organization and he loses the various jobs he played inside society. He ends up in a few embarrassing circumstances because of the departure of a piece of his own uprightness, which is brought about by debilitation and the deficiency of security. For somebody who has never been moved by such a circumstance, it is not really imaginable to envision what patients and their family members need to go through.

Thus, I might want to close with a citation from Rae Unzicker. She was a backer that supported mental health patients' freedoms. She portrays what patients experience once they are in the plants of psychiatric clinics. Regardless of whether these days a major exertion has been made to advance the circumstance, these assertions actually have a great deal of truth and they assist us with understanding the patient's circumstance.

01. *To be a mental patient is to be trashed, segregated, mingled, disparaged, psychiatrized.*
02. *To be a mental patient is to have everybody controlling your life yet you. You're watched by your psychologist, your social specialist, your companions, your family. And afterward, you're analyzed as suspicious.*

03. *To be a mental patient is to live with the steady danger and probability of being secured whenever, for practically any explanation.*
04. *To be a mental patient is to live on \$82 every month in food stamps, which won't allow you to purchase Kleenex to dry your tears. What's more to watch your psychologist return to his office from lunch, driving a Mercedes Benz.*
05. *To be a mental patient is to ingest medications that dull your psyche, stifle your faculties, make you jitter and slobber, and afterward, you consume more medications to decrease the aftereffects.*
06. *To be a mental patient is to go after positions and lie about the most recent couple of months or a long time, since you've been in the emergency clinic, and afterward you don't land the position at any rate since you're a mental patient. To be a mental patient isn't to issue.*
07. *To be a mental patient is never to be approached in a serious way.*
08. *To be a mental patient is to be an occupant of a ghetto, encircled by other mental patients who are as frightened and ravenous and exhausted and broke as you are.*
09. *To be a mental patient is to sit in front of the TV and perceive how vicious and hazardous and imbecilic and bumbling and insane you are.*
10. *To be a mental patient is to be a measurement.*
11. *To be a mental patient is to wear a name, and that mark never disappears, a name that says little regarding what you are and surprisingly less with regards to what your identity is.*
12. *To be a mental patient is to never express what you mean, however, to seem like you mean what you say.*
13. *To be a mental patient is to tell your therapist he's aiding you, regardless of whether he isn't.*
14. *To be a mental patient is to go about as when you're tragic and quiet when you're distraught, and to consistently be suitable.*
15. *To be a mental patient is to act as when you're sad and calm when you're mad, and to always be appropriate.*
16. *To be a mental patient is to take part in moronic gatherings that call themselves treatment. Music isn't music, it's treatment, volleyball isn't a game, it's treatment, sewing is treatment, washing dishes is treatment.*
17. *To be a mental patient isn't to pass on, regardless of whether you need to, and not cry, and not hurt, and not be terrified, and not be irate, and not be helpless, and not to snicker excessively clearly - in light of the fact that, in case you do, you possibly demonstrate that you are a mental patient regardless of whether you are not.*



thoughts anxiety mind SUICIDE HOPELESSNESS
STIGMA Doctor Pandemic Disor-ns panic
MENTAL HEALTH
medicine Stress TABOO psychotherapy
uncertainty brain depression

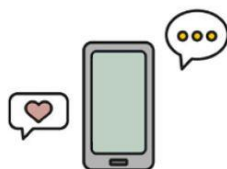
“
It's a disorder, not a decision
It is just a longing for something unable to explain

What is mental illness ?

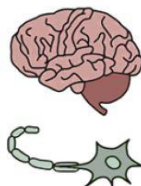
A mental disorder or mental illness is a psychological or behavioral pattern generally associated with subjective distress or disability that occurs in an individual, and which is not a part of normal development or culture.

What causes mental illness ?

Psychological & Social Factors



Brain Chemistry



Genetics & Biological Factors



Sai Teja

ARCHITECTURE THESIS

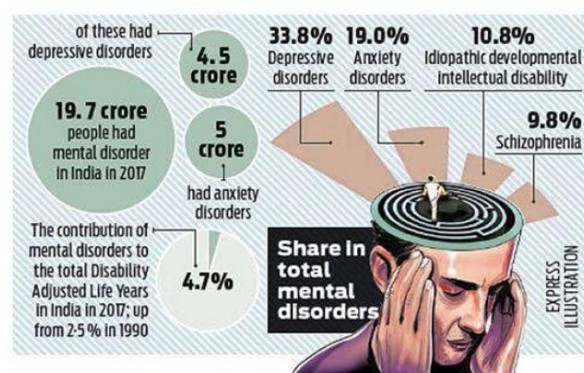
Hope & Beyond for the mentally ill

H OPE
BEY O ND

WHO's classification

- F0** | Organic, including symptomatic, mental disorders (Alzheimer)
- F1** | Mental & Behavioural disorders due to psychoactive substances.
- F2** | Schizophrenia and Delusional Disorders
- F3** | Mood / Affective Disorders (depression)
- F4** | Neurotic, stress-related, somatoform disorders (OCD, Phobias)
- F5** | Behavioral syndromes associated with psychological, physical factors
- F6** | Disorders of personality and behavior in adult persons (Schizoid, paranoid)
- F7** | Mental retardation
- F8** | Disorders of psychological development (Expressive language disorder, autism)
- F9** | Behavioural, emotional disorders with onset usually occurring in childhood

Depression, Anxiety on the Rise



RESEARCH

Psychiatric

Treatment approaches

A. The Psychotherapeutic approach :

Relationship of Patient and Physician

B. The Physical approach :

Physical exposure, sports, gymnastic halls

C. The Pharmaceutical approach :

Usage of antipsychotics, antidepressants drugs to carry out therapies

D. Ergotherapy :

The patient learns or relearns activities by improving his motoric-functional, psycho-functional, activities.

Facilities

A. Stationary Clinic :

24hrs care

High security due to suicidal risks.

Two different categories :

1. Hospitalization for acute care
2. Hospitalization for rehabilitation.

B. Intermediate Structures :

Daycare hospital

Therapeutic programs get socialized the whole day.

Various activities.

C. Ambulatory :

Clinical treatment

Consultations with psychiatrist, psychologist

D. Long term structures :

Autism, Mental retardation

Several years

Residential homes, wherein patients will not be able to lead a totally independent life anymore.



The Patient

These statements will have a lot of truth and they helped to understand the patients' situation.

01

To be a mental patient is to be stigmatized, ostracized, socialized, patronized, psychiatrised.

02

To be a mental patient is to have everyone controlling your life but you.

03

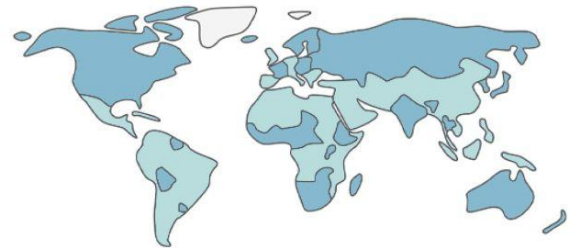
To be mental patient is to live with the constant threat and possibility of being locked up at any time, for almost any reason.

04

To be mental patient is never to be taken seriously.

05

To be a mental patient is to never to say what you mean, but to sound like you mean what you say.

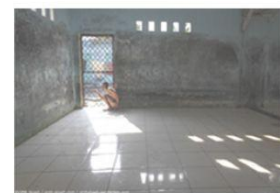


<9.9

Suicide rates per 100,000 population,

>10.0

due to patient problems



3.7 RECOVERY FROM MENTAL ILLNESS

By far most in Ghana really acknowledge that when an individual is checked mentally wiped out, the individual can never totally recover. To be sure, even most recuperation specialists acknowledge that mental illness is a durable condition (Laugharine and Burns, 1999). It is acknowledged that fear is a tremendous variable in supporting the legend of no recovery. Research completed at the National Empowerment Center has shown that individuals can recuperate completely from even the most serious types of mental illness. Top-to-bottom meetings of individuals determined to have schizophrenia have shown that these individuals are fit for recapturing a critical job in the public eye and running their own lives. However they have recuperated from their mental illness they, similar to every other person, keep on mending inwardly. Much of the time, they presently don't require a prescription and utilize comprehensive health, friends and family keep on supporting their recuperating. These specialists have shown that for more than a 20 – long term period a larger part of individuals recuperates from even the most serious types of mental illness. As per the World Health Organization (WHO), the pace of recuperation from serious mental illness is greatly improved in underdeveloped nations than in western industrialized nations (Fisher, 2005). This fantasy won't proceed in case individuals named with mental illness completely recuperate and presently don't require drugs.

3.7.1. Strategies to recovery

There are four main strategies of recovery in mental illness. These are, hope, empowerment, self-responsibility, and establishment of a meaningful life mental illnesses (Argyle, 1970)

A. Hope

Recuperation gives the fundamental and persuading message of a superior future that individuals can and do defeat the hindrances and deterrents that face them. Trust is disguised however can be encouraged by peers, families, companions, and suppliers. Trust is the impetus of the recuperation interaction. Mental health recuperation not just advantages people with mental health disabilities by zeroing in on their capacities to live, work, learn, and completely take an interest in our general public, yet additionally advances the surface of society (Fisher, 2005)

B. Empowerment

Patients have the position to browse a scope of choices and to partake in all choices including the assignment of assets that will influence their lives and are taught and upheld in doing as such. They can get together with different patients to all things considered and viably represent themselves about their necessities, needs wants, and yearnings. Through strengthening, a singular oversees their own predetermination and impacts the authoritative and cultural constructions in their day-to-day existence (Fisher, 2005).

C. Self Responsibility

Patients have individual responsibilities regarding their own taking care of themselves and excursions of recuperation. Making strides towards their objectives might require extraordinary boldness. Patients should endeavor to comprehend and give significance to their encounters and recognize adapting methodologies and mending cycles to advance their own health (Fisher, 2005).

D. Establishment of a meaningful role in life

Patients lead, control, practice decision over and decide their own way of recuperation by streamlining independence, autonomy, and control of assets to accomplish not set in stone life. By definition, the recuperation cycle should be self-coordinated by the person, who characterizes their own life objectives and plans a novel way towards those objectives (Fisher, 2005).

3.8 REHABILITATION

Many individuals comprehend restoration to mean the exercises which get ready patients to have their spot locally after clinical treatment has been finished (Davis et al., 2003). Then again, certain individuals see recovery as a solitary proceeding with the process and don't make any qualification between clinical medicines and the preparation exercises which follow (Greenblatt and Simon, 1999). They pronounce that recovery begins the exact second a patient enters the clinic and may proceed even after he has been released from the emergency clinic (Hector, 2001). Instances of this persistent cycle can be found in local area nursing. Medical attendants might be occupied with normal visits to a patient's home long after his release from the clinic. The reason for the visits by the local area nurture is to oversee to a patient his standard drug, offer directing, screen conduct, and report all perceptions to the proper individual from the group.

Restoration is a structure action that reestablishes an individual's physical and mental limits and works on the nature of their life to a level that is pretty much as close as conceivable to that which existed before his illness (Greenblatt and Simon, 1999). The method for accomplishing this is called treatment, which implies treatment to recuperate. The point is to help 'arrange the patient fully intent on reestablishing them back to health. Recovery includes trust and trust in the treatment. This surmises that the reason for restoration includes ingraining or the compensation of positive abilities or perspectives in an individual to give him/her a more contributive and satisfying job in the public eye (Butler, 1985).

3.9 DESIGN CONSIDERATIONS FOR TODAY'S PSYCHIATRIC INSTITUTION

01. Deinstitutionalized and homelike settings:

Giving a feeling of being at home assists patients with feeling loose, safe, and welcome. Psychiatric emergency clinics need to turn into a mending span among homes and society.

02. Sprawling shape with one to two stories:

This construction permits the requests for normal lighting, a breezy environment, and admittance to the outside, which are significant components in the recuperation interaction.

03. Enhancing privacy:

Private rooms and restrooms are liked by practically every one of the patients. Private living spaces augment the mental fulfillment and solace of patients.

04. Well organized and maintained environments:

From one viewpoint, an efficient and kept up with the environment passes on a feeling of regard for patients (Shepley et al., 2016).

05. Access to nature:

Outside environments decidedly influence the physical and mental health results of patients and can fill in as an asset for recuperation and recovery (Bengtsson and Grahn, 2014).

06. Attractive furnishings:

Outfitting configuration diminishes the sentiments related to institutional climates, which is thus connected with upgrading passionate and scholarly prosperity working on patients' conduct (Karlin and Zeiss, 2006).

07. Enhancing social interaction:

Feeling associated with others is significant in the recuperation interaction. Social exercises assist patients with breaking the sensation of disconnection and patients adjust to society all the more rapidly after their visit.

08. Providing certain freedom and control:

The absence of control is one of the inescapable worries among patients. A feeling of opportunity and control is essential for the recuperation, further developing the mental health results of patients.

09. Maximizing lighting:

Daylighting and electrical lighting are significant components in psychiatric offices. Daylighting is related to working on great rest, diminishing animosity, and lessening the length of stay of patients (Shepley et al., 2017). Electrical lighting is related to improving the solace and wellbeing of clients.

10. Strengthening safety and security:

Well-being and security are the absolute greatest worries among staff. An all-around planned psychiatric environment ought to diminish the pressure of staff because of the expected danger of some viciousness from patients.

11. Noise control:

Commotion is a stressor and adversely affects the prosperity of patients. Limiting commotion will improve the treatment and mending of patients.

12. Improving hygiene:

Cleanliness issues are one of the principal worries among patients. An awful condition of cleanliness will to a great extent compromise the nature of their lives.

13. Increasing entertainment amenities:

Numerous patients grumble in an absence of diversion conveniences inside psychiatric medical clinics. Amusement is important for the treatment and can improve rest quality and assist patients with adjusting to society rapidly after their medical clinic stay.

14. Nurse station:

Nurse station configuration should adjust the management of patients and the security of staff. The choice regularly centers around open versus shutting stations.⁵⁶

15. Preventing suicide:

Self-destruction obstruction is basic in psychiatric emergency clinic plans as psychiatric patients have a higher pace of self-destruction. Furniture and goods should limit or dispense with the chance of self-destruction.

The design considerations listed above reflect the inadequacies of today's psychiatric hospital design around the world.

CHAPTER 3: DATA COLLECTION AND STANDARDS

Sai Teja TN | 37210041 | Sathyabama Institute of Science and Technology

STANDARDS

Present trend away from isolated sites for psychiatric hospitals in favour of places allowing easy access for day patients and visitors and enabling inpatients maintain close ties with their community. Community involvement often encouraged in USA both by making appropriate parts of centre available to public, eg gymnasium, children's play rm or craft studio, and by incorporating such amenities as art gallery or public lib.

Association with med centre desirable but important psychologically psychiatric centre maintain own identity and character. Environment contributes essentially to therapeutic process. Centre should be non-institutional as possible consistent with type of patient, need for security, protection from self-injury and vandalism; range from 'open door' to forensic institution for criminally insane.

Great size to be avoided; patients should be grouped into units (max 30 P), small enough facilitate development of community spirit (atmosphere nearer college dormitory than hospital).

Where climate allows common practice provide residential units in form of cottages in landscaped grounds. Even where restricted site imposes compact bldg form essential individual units be identifiable as separate entities.

Bedr should afford opportunity retreat and privacy: if 2-B, plan so that each patient has clearly defined individual area.

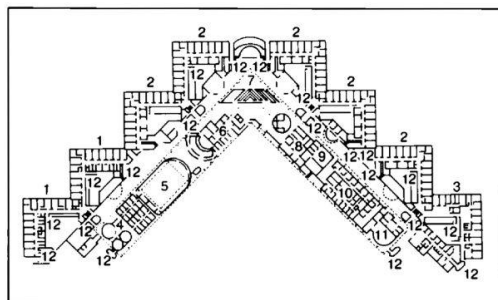
Conversely design and furnishing of public areas should encourage sociability, supplementing formal treatment with therapeutically beneficial, informal patient/patient and patient/staff meetings. Place nurse/security stations so that staff engaged in routine activities can observe patients casually. Unobstructive nature of such surveillance important psychologically in alleviating persecution complex.

Hierarchical arrangement of staff and patients in group therapy rm inhibits patient involvement. Square or circular seating space affording min distraction, with circular seating arrangement, probably ideal.

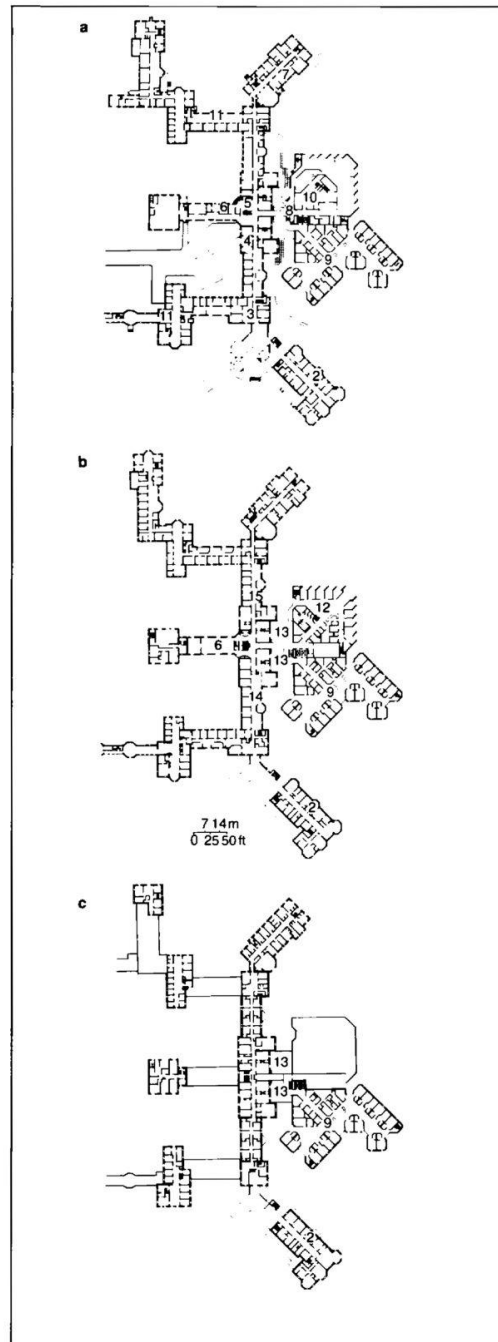
Mentally disturbed persons commonly show symptoms disorientation with regard to time and space. Views and contacts with outdoors and living plants aid patient's comprehension of time and season; direct and clearly defined circulation patterns, supported by such aids as graphics and colour coding, inculcate sense of security. Colour plays important role in therapeutic process: eg yellow and orange help dispel lethargy among geriatric patients.

Hospital psychiatric units

Similar considerations apply psychiatric units within general hospitals. Since patients generally ambulatory, day rm and therapeutic activity rm assume special significance. Although exigencies of hospital planning seldom allow direct access outdoor areas at ground level from psychiatric unit sunny outdoor roof terrace should form integral part, particularly for geriatric patients.



1 Capital District Psychiatric Center Albany New York USA accommodates 400 inpatients in 16 residential units each of which also serves 25 day patients: upper of 2 superimposed units set back from lower creates outdoor terrace while lower has direct access to landscaped site; treatment, educational, recreational, admin, research & service dept housed in 4-storey chevron-shaped structure, joined to residential units by sky-lighted, brick-paved, indoor mall which has colourful banners, informal seating groups, beauty & barber shop, chapel, music & games rm, laundromat; plan at mall level 1 geriatric unit 2 adult unit 3 pediatric units 4 psychiatric outpatient clinics 5 consult 6 volunteers 7 dining 8 admissions 9 med records 10 emergency clinics 11 business 12 free-standing colour-coded stairs in mall each serve 4 residential units, supplemented by elevators for

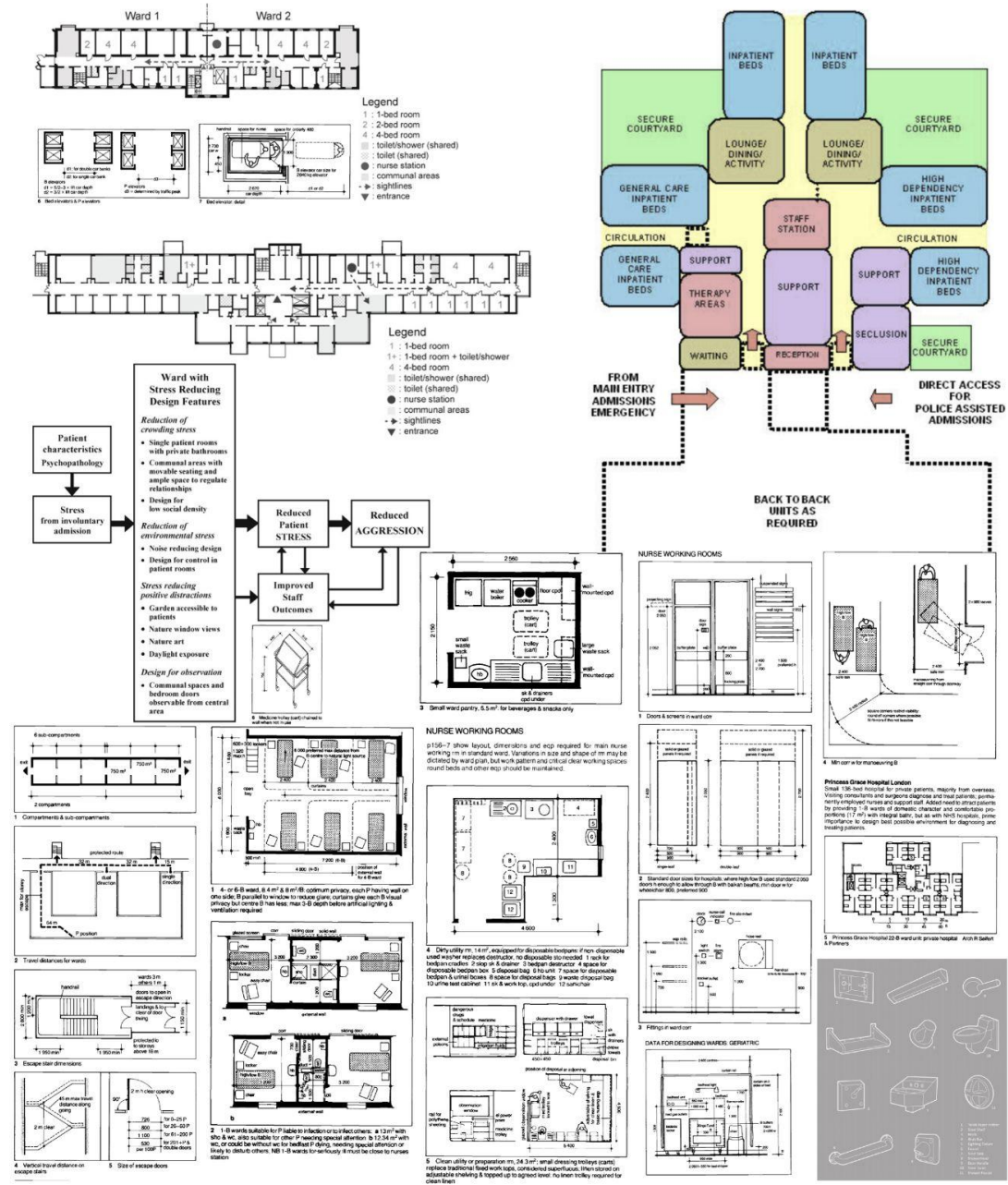


2 Hospital for mentally disturbed patients founded 1844 in Providence RI USA, which has been upgraded and expanded, stands in beautiful grounds by Seekonk river a first level b second level c third level
key 1 lob 2 admin 3 admission & testing 4 emergency 5 med records 6 activity therapy 7 day hospital 8 interior courtyard 9 inpatient units 10 food services & cafeteria 11 existing 12 intensive treatment unit 13 interior garden below 14 professional off 15 diagnostic/treatment

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BEYOND

Plate no :05



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CHAPTER 4 - CASE STUDIES

Sai Teja TN | 37210041 | Sathyabama Institute of Science and Technology LITERATURE CASE STUDY

VIDYA SAGAR INSTITUTE OF MENTAL HEALTH

ABOUT

Location	Year	Site Area
Amritsar	2004	45 Acres
Designer	Beds	No of floors
Sarbjit Singh Bahga	746	G+2

PHILOSOPHY

• Planned on a site of 45 acres, the master plan comprises primarily two zones: the **Outer Circle** and the **Inner Circle**.

• All the building blocks in the campus have been laid out on a strict **Cartesian pattern** with **symmetrical juxtaposition** reminiscent of traditional Indian campuses. The built-up masses and the open spaces are ingeniously interwoven to create a **building-in-the-garden effect**. The entire hospital complex has been linked by **vaulted corridor** running independently through open spaces with greenery on both the sides.

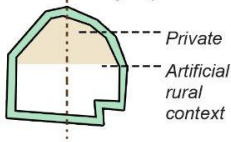
QUANTITATIVE DATA

Unit Name	Area (sqm)	Beds
Intermediate / Improved Patients Unit	5400	100 +100
Acute Care Units	1580	40 +40
Forensic Ward	2660	20 +20
Chronic Stay Units	1180	50 +50
Voluntary Unit		50

CONTEXT



Situated on a busy **urban context**, yet a peaceful environment is setup for the mentally ill patients.

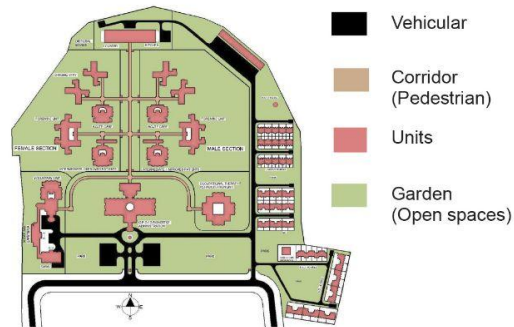


ZONING



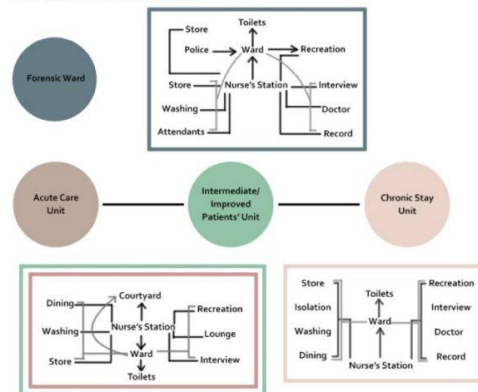
- Landscape
 - Units
 - Defined pathways
1. Cartesian pattern
 2. Symmetrical
 3. Garden effect
 4. Connecting corridors

ACCESS

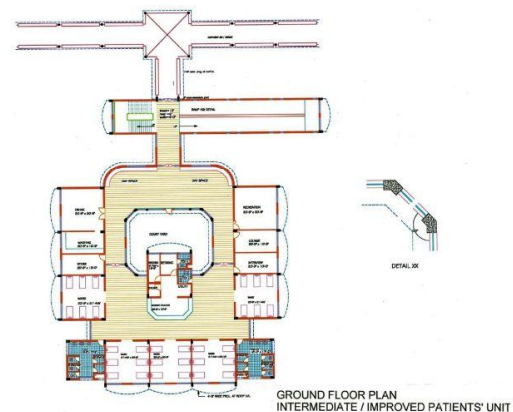


SPATIAL ORGANIZATION

Programme Chart



The Intermediate / Improved Patients unit

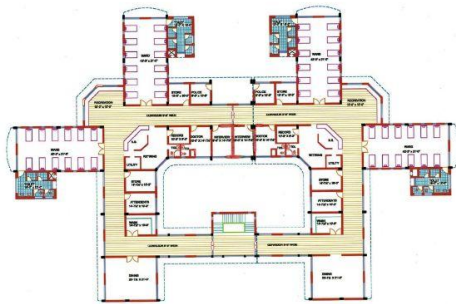


- Since the condition of this category of patients is comparatively better their Wards are designed to be **two-and three-storey**.

- Each floor of these blocks has an **identical plan**, accommodates six-bed dormitories, a recreation-room, lounge, interview-room, dining-room, wash-room, store, toilets, and nursing station.

- To provide **security to the nursing staff**, it is warded off from the patients' area by a **mild steel grill**. The nurses can keep direct eye on each dormitory.

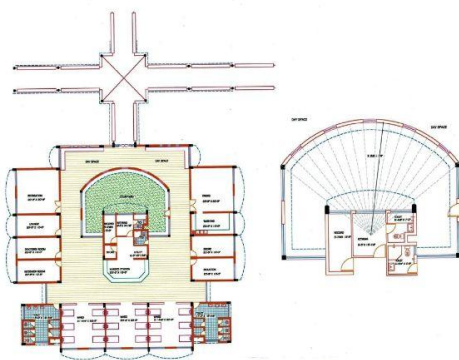
The Forensic ward



FIRST FLOOR PLAN
FORENSIC UNIT

- **Adequate security** provided by the police.
- **Police attendants rooms** and provision for direct watch by the nursing staff, besides other requirements like dining hall, recreation space, doctor's rooms, interview-rooms, attendants' rooms, etc.
- The units are **highly-disciplined symmetrical structure**.

The Acute Care units

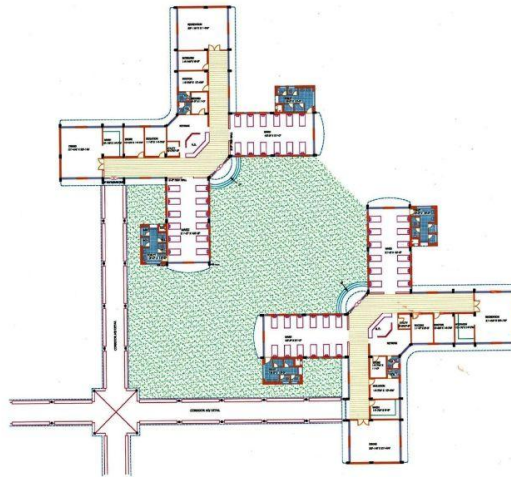


GROUND FLOOR PLAN
ACUTE CARE UNIT

- Accommodate those mentally-ill patients who are acutely serious, and **need longer stay and special care** in the hospitals.

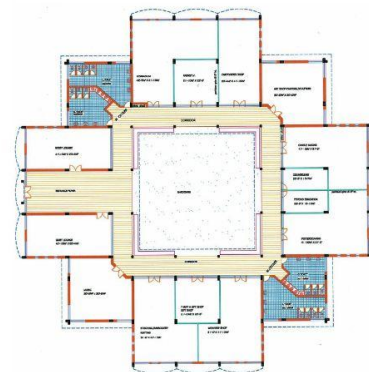
- Since these patients are not expected to move upstairs, their Wards are designed as **single-storey**.

The Chronic Stay unit



- Patients who are **unable to sustain lifestyle** on their own, and, therefore, **need external help to perform** their daily chores.
- Majority of these **patients are unlikely to be recovered** and hence **need hospitalisation throughout the remaining part of their life**.
- The patients were provided with **exclusive open space/court for outdoor activities**.

Occupational Therapy / Rehabilitation unit



GROUND FLOOR PLAN
OCCUPATIONAL THERAPY / REHABILITATION UNIT

HELSINGOR PSYCHIATRIC HOSPITAL

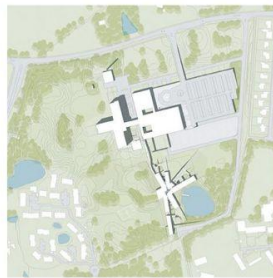
ABOUT

Location	Year	Site Area
Denmark	2006	6000 sqm
Designer	Beds	No of floors
BIG Architects	54	G+2

PHILOSOPHY

- The hospital needs to **allow control** and **protection** while maintaining a **free and open atmosphere**.
- A **safe and calm environment**.
- In the design concept for Psychiatric Clinic they have avoided all clinical stereotypes: the traditional hospital hallway without windows and rooms on both sides; artificial easy-cleaning materials like plastic paint, linoleum floors or ceilings made of gypsum, etc.
- All materials have their **natural surfaces**. Cast floors in concrete or **lively colours** and **walls made of glass**, wood and concrete. Functionally the hospital is **tailor-made to modern psychiatric treatment and therapy**. Experientially the hospital appears as anything but a hospital.

CONTEXT

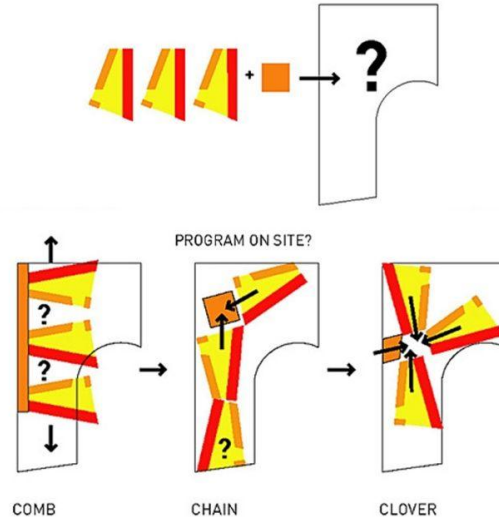


- Surrounded by residential area on the east and southern sides.
- Hilly landscape
- The main hospital is connected towards the north side

- The circulation towards residential units is limited with the help of trees
- An **isolated environment is created**.

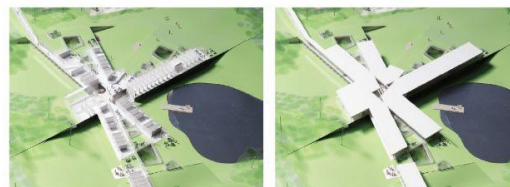
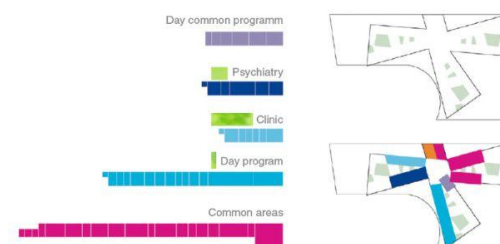
ACCESS AT SITE AND BUILTUP LEVELS

- **Minimised circulation** time.
- **Divided units (3)**, helps in dealing with patients, unites at the central unit.
- Each unit is supported with an atrium, a kitchen and a dining space, with its own staff space.
- The staff spaces are planned at the centre of each unit, with good **visual access** to the patient units, and receptions are also provided in the **central core**. Which results in **proper supervision**.

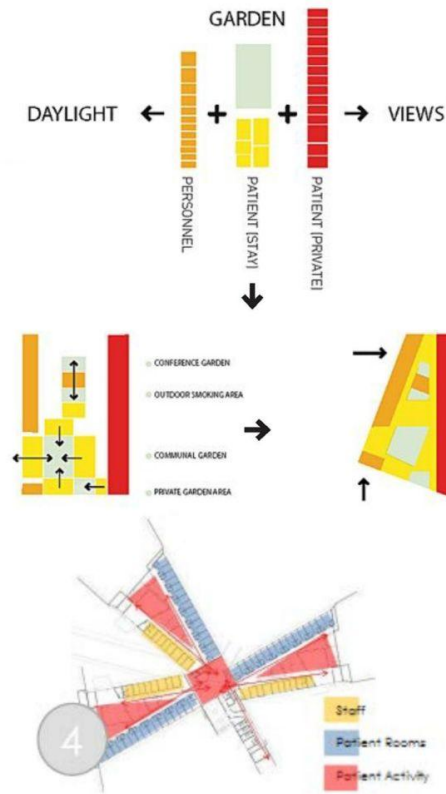


- **Walking distances** are effectively and logically minimized.
- **Sense of home**.
- Limited freedom to move but **without feeling trapped**.
- The day-and-night sections are spatially-open, and offers overall views to the staff, & avoids patients **feeling of being watched**.

ZONING



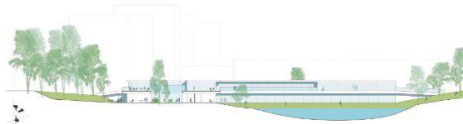
SPATIAL ORGANIZATION



● Psychiatric Clinic on 2 different levels makes the building literally grow into the **green and hilly landscape**.

● Half hidden in nature the clinic thus avoids spoiling the view from the existing somatic hospital and at the same time provides its users with a multitude of experiences of the lake and woods.

● In Helsingor, all materials are natural textures. Cast floors in concrete and lively colors and walls are made of glass, wood and concrete. The functions are designed to fit modern treatment and Helsingor Psychiatric Hospital's 29 therapy.



Ward unit structure

14 single rooms
2 double rooms

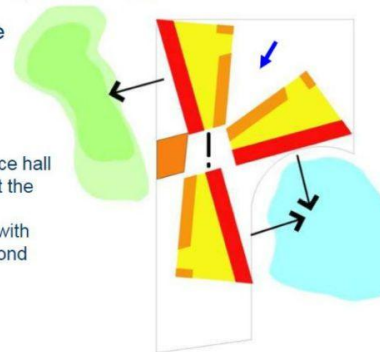
Staff base

■ Patient rooms
■ Staff/ treatment
■ Common rooms
■ Courtyards



Unit structure

• cloverleaf
• central entrance hall
• gym/ physio at the central hall
• patient areas with views to the pond and the fields



● The public treatment program is placed on a level with the existing hospital and is organized as 5 individual pavilions, combined into a snowflake structure by the central space. Day sections, out-patient's clinic and department of district psychiatry gather around the arrival areas.

● All parts of the building are fused at one single point, right above the center of the clover structure.

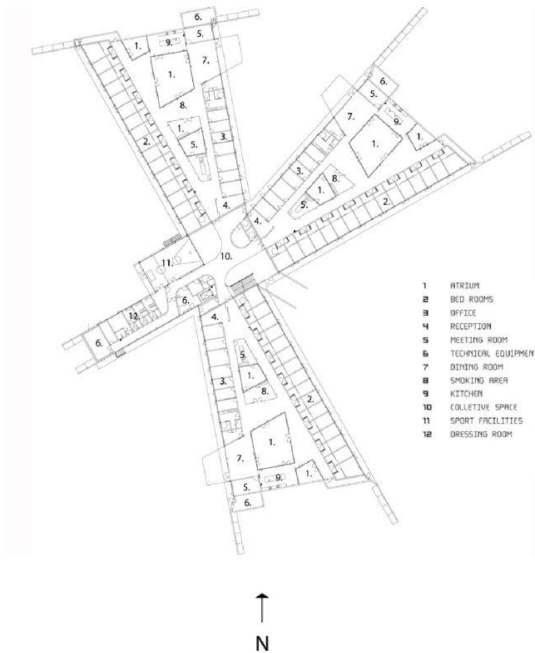
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Plate no :10

Ground Floor



- The living program includes a collective space, six small sunken gardens and several offices, populated by small patios. On the other hand, the treatment program is organized into five single or double story individual pavilions, radiating from the center of the clover structure. All parts of the building are fused at one single point, resembling a **snowflake structure**.

- Individual **pavilions** including treatment spaces and offices are placed to one side and waiting areas to the other side. The galleries of the treatment program grow along the individual pavilions, varying in lengths according to the size of individual pavilion.

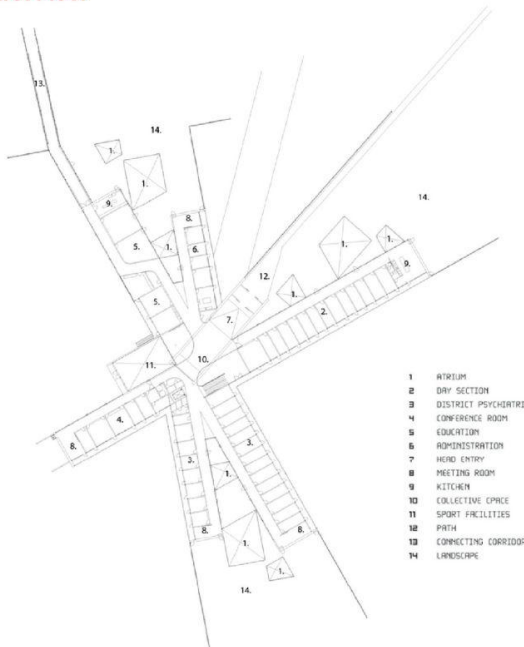
PATIENT ROOM

- The room is flushed with natural lighting and ventilation, & is also engaging patients with the views around.

- Two sets of the rooms view the **water body** and one set of them view the **hilly landscape**.

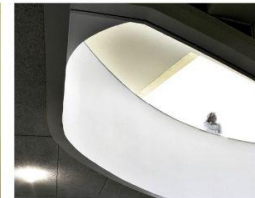


First Floor



LIGHTING & VENTILATION

- **Transparent walls, window, courtyards** and **skylights** draw light into the structure.



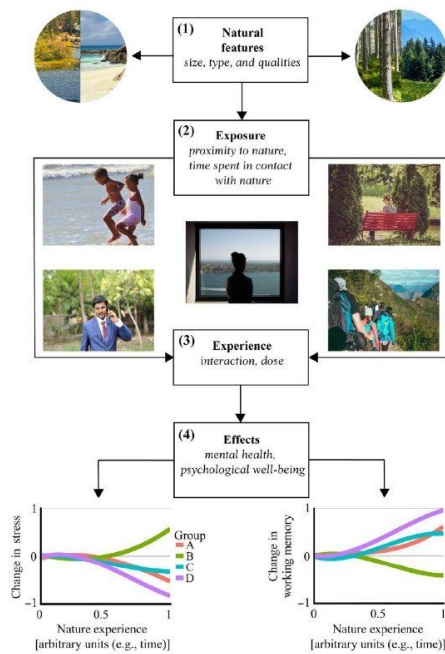
- The interior **color palette** is marked such a way that it boosts the natural light and becomes a part in the healing process to the patients.

- The system it is arranged proves to be successful in the **patient's recovery rate**.

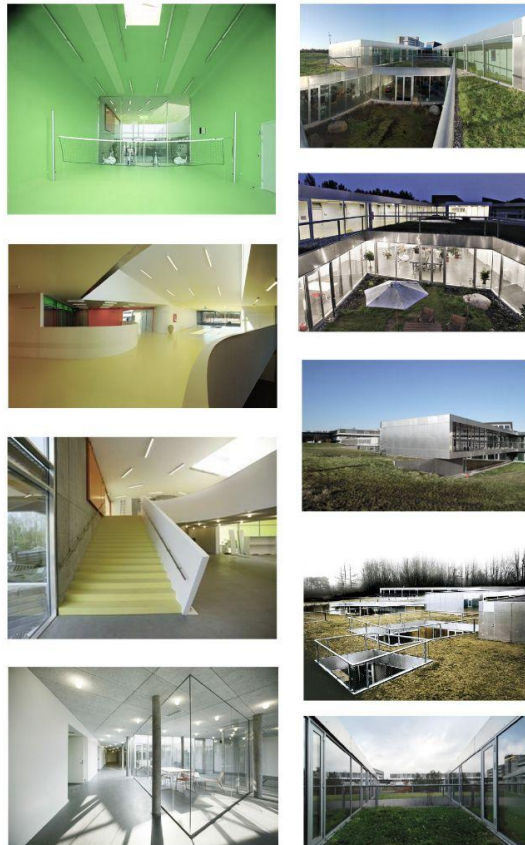
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H O P E
&
B E Y O N D



INDOOR & OUTDOOR SPACES



FORM

- The form was designed such a way that the clinic setup integrates with the natural environment for the cure of mental illness.
- A clover-shaped organizing structure is applied to the living program so that each inpatient unit has its own connection to the landscape.



CHILDREN'S CENTER FOR PSYCHIATRIC REHABILITATION

ABOUT

Location	Year	Site Area
Japan	2007	14590 sqm
Designer	Beds	No of floors
Ms/ Sou Fujimoto	50	G+1

PHILOSOPHY

- This is the treatment center for mentally disturbed children where they *live together* to get regaining their mental health. It may be thought that it is a very special building when I write so, but it is truly rich life space that requested in origin like a *large house* and also like a *small city*, the intimacy of a house and also the variety of the city. This is a proposal of a *loose method*.

- The *method of being random*
- A *precise planning / Accidental landscape*

CONTEXT



- Present in the *small mount* that is away from the residential settlements as they wanted the rehabilitation center to be *more private and isolated from a busy environment*.

ACCESS AT SITE AND BUILTUP LEVELS



- The building is designed with the care for of *children suffering in depression*. It avoids long corridors which may be trying to minimize mental stress when trying to find way around the building.
- There is also the *freedom to choose* which type of space one wants to inhabit that is common with other case studies.
- Two access points were made, one for the children & the other for staff.



1. The vehicular access to the center.
2. The staff and outpatient access to the center.
3. The children access to the center.
4. Parking

ZONING



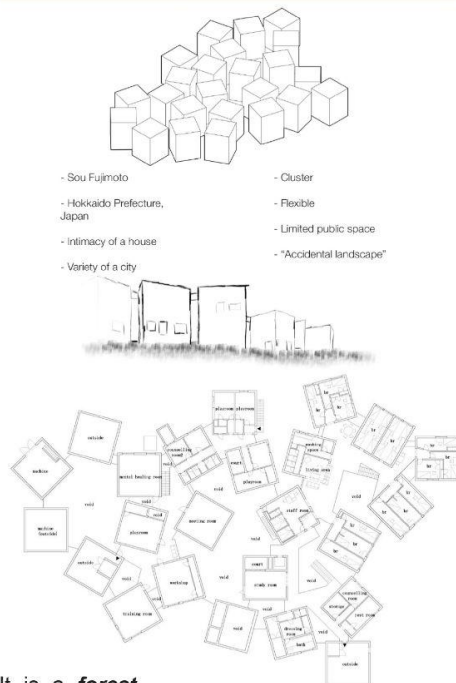
- The plan design is from the concept of "*calculated randomness*" where the programmed elements seems to be randomly shuffled.

- It shows the experience of A precise planning / Accidental landscape and also Selectivity and contingency / *freedom and inconvenient*.

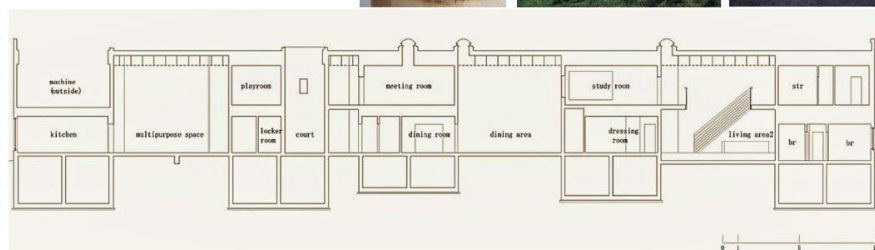
- Although, this space is created as a result of an infinite, strict and artificial design process, it stands as a place which is not planned at all, or which has been made automatically with no intention.



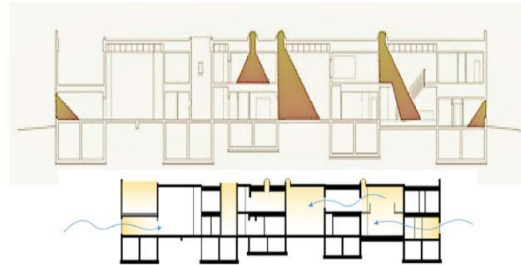
SPATIAL ORGANIZATION



It is a **forest** where every-one can find a place for one-self, where one can feel **sheltered** among the trees, while at the same time there are **no walls dividing them**.



LIGHTING AND VENTILATION



INDOOR AND OUTDOOR SPACES



CPNVD, Yverdon-les-Bains

ABOUT

Location	Year	Floor Area
Yverdon-les-Bains	2003	7200 sqm
Designer	Beds	No of floors
HES Architects	56	G+1

PHILOSOPHY

"Let the patient feel that he is in hospital, where he gets professional treatment, and that he has to leave as soon as his condition allows him to."

SYSTEMATIC APPROACH

Emphasizes the *integration of the patient's environment* in therapy.

RELATION TO SOCIETY

- The Building finds itself in a rather difficult environment where no one would expect a psychiatric institution. It was not an easy task to find a good architectural solution to make it **blend in with the surroundings**, while at the same time claiming its specific role.

- The Institution integrates itself to some extent into its surroundings by means of **proportions, rhythm** of the facade and alignments with the nearby industrial buildings. But at the same time, it **marks its autonomy** by its strong shell of red tinted concrete and by its freestanding form.

- Through its shell and rather small openings, the building expresses a **protective character**. The institution's strong appearance fulfils two important roles : firstly, it shows to the public that **mental illness is part of our society** and that **people with mental disorders are not to be excluded** from the same.

- It has **shared outdoor space** that invites patients as well as the public.



ACCESS

- The freestanding building is situated on a plot that is accessible from three sides. There are four entrances : the main entrance via the forecourt, the access for emergencies which is directly reachable from the road, the access to the ambulatory which is located in the north-western side, and the delivery on the south-east. The employees have an additional entrance through the parking garage.

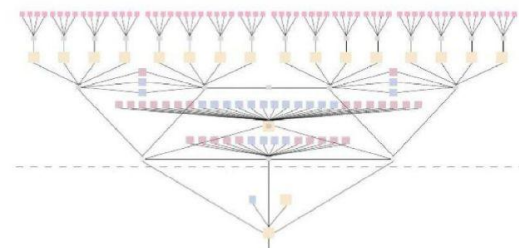


■ public accessible space

- When approaching the building, the **expressive character** and the form are distinguishable from afar. The main entrance's access is not head-on; one has to go along the smaller part of the two wings. The forecourt, which the patients and visitors use to sit outside, reveals itself at the last moment.

- The red-coloured concrete walls and the red floor penetrate the building's interior and form a fluid transition from the outside to the inside. This makes the entrance hall appear as an exterior space. The generous glazing also allows for good visual contact between two areas.

SPATIAL ORGANIZATION



- In the CPNVD the ramifications and the gradual transitions stand out most. There is something more happening to the private part. The floor with offices in between the patient rooms and the exterior spaces act as a buffer zone and strengthens the feeling of retreat in the stationary units.

■ common space
■ room for therapeutic purpose
■ office
■ patient room
■ horizontal circulation
■ vertical circulation
■ entrance

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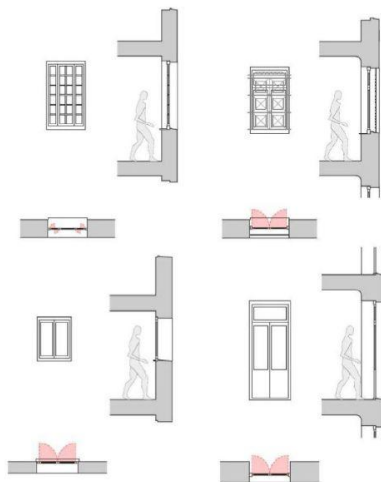
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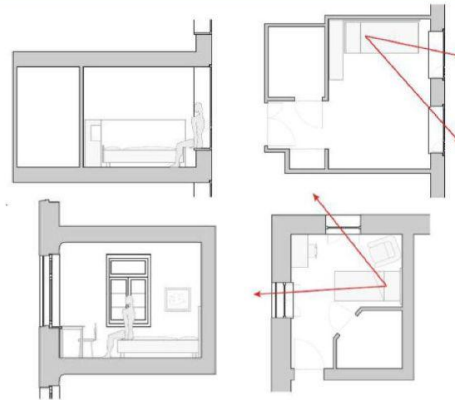


- The building offers the patients a **series of re-treat possibilities** that become gradually more public toward the outside. This is important because the patient arrives in a very poor health condition and must feel strongly protected during the first phase. Because of the central location within the city and the limited outdoor areas available to the patients, the internal common areas become even more important for gathering & socializing.

WINDOW ANALYSIS

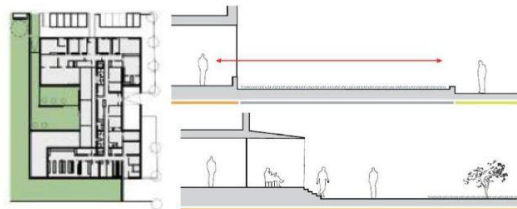


PATIENT ROOM

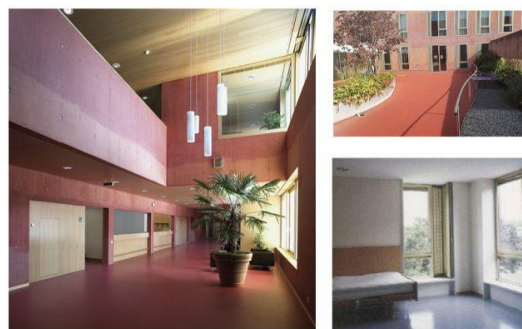


- The opening in the CPNVD is more than a simple window. It is the **connection to the world** out there. This feeling is reinforced by the fact that the golden window frames are the only elements that are visible on the red facade, as well as in the white room.
- When the patient looks out of the window, he sees the clinic's park. As opposed to the view from the CPNVD, nothing in his range of **vision can remind him of society** there. The window therefore does not form a threshold between the hospital world and the outside world.

OUTDOOR SPACES



INDOOR SPACES



INSTITUTE OF MENTAL HEALTH

ABOUT

Location	Year	Site Area
Kilupak, Chennai	1871	70 sqm
Designer	Beds	No of floors
East India Company	2000	G+1

DEVELOPMENT

- The asylum started functioning in the new premises on **May 15, 1871 with 145 patients**, and Surgeon John Murray, as superintendent with residential quarters inside the premises.
- The buildings were put up on the cottage or pavilion system with blocks for **12–15 persons in each block** fairly close by.
- The year **1892** saw the transfer in of all **“criminal lunatics”** from the districts and increase in staff strength was made with additional buildings including cottages for paying patients.
- Although a small number of those admitted could be sent back to their homes as “recovered,” the vast majority had to stay on in the asylum for the rest of their lives, and consequently, the word **“Asylum”** came to have a bad association.
- It was then, the year **1922** witnessed the change in name of the institution from **“Government Lunatic Asylum”** to **“The Government Mental Hospital.”** However, it was rechristened in **1977** as **“IMH,”** by the then Hon’ble Chief Minister of Tamil Nadu Dr. M.G. Ramachandran.



PLANNING

Specialized care for general medical problems

- It had patients with general medical problems and they are treated with Entamoeba histolytica were also common. Before the advent of **modern drugs**, carbon tetrachloride, oleum chena podium, and tetrachloroethylene were the drugs used for deworming.

The “Diarrhea Block”

- Minor epidemics are not uncommon in closed communities. However, when patients required more **energetic and specialized treatment**, they were transferred to the infectious diseases hospital.

The “Leprosy Block”

The “Tuberculosis Block”

Care of the Mentally Retarded Children

- Among the long-stay patients of the hospital, usually numbering around **1000**, about **25%** of them belonged to the various categories of mental retardation. The severely retarded (IQ <50) patients formed about 67% and the rest mildly retarded. About half of these patients had epilepsy and other concomitant disorders.

- Care of these children and adolescents is particularly difficult, many of them requiring **“total” care**. A **“School”** opened during Dr. Venkatasubba Rao's time for defective children was functioning regularly in the campus of the hospital.

“Criminal” Ward

- The patients did not have the privileges of their civil counterparts. With a few exceptions, they were **not allowed access to other parts** of the hospital.

- It occupied almost a tenth of the hospital area, with a number of airy blocks, **single rooms**, and cultivable lands to grow good quality of vegetables and fruits that were supplied to the hospital kitchen.

- A number of sports such as **football, ring tennis, and kabaddi and indoor games** such as caroms and chess were encouraged.



“Vigilance” block

- Patients who had expressed **suicidal intentions** by words or deeds and those with suicidal risk were segregated in this ward, which was intensely monitored by the nursing and other staff day and night.

- During night, one or **two recovered patients** were also included in the group, who could request help during emergencies.

- **Psychotherapy and electroconvulsive therapy (ECT)** were the only modes of treatment for these patients until the advent of **antidepressants** and other drugs.

- However, also considering other emergencies, an “Intensive Psychiatric Care Unit” was established in 2003.

DIL block

Staff and administrative



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REHABILITATION

Recreation therapy

- The whole compound was converted into a **garden**, and some playgrounds were created for the patients to play tennis, volleyball, badminton, tennikoit, etc. **Group activities and games** were introduced.
- **Dramas** were organized in the **recreation hall** where both the patients and staff participated. Radio sets were provided in the recreation hall and in some of the wards also.
- Facility in the recreation **hall for worship** was provided for patients of all religions. Every year Pongal day celebrations, Christmas day function, etc., were organized.



Occupation therapy

- Occupations introduced were **gardening, Weaving, tailoring, carpentry, toy making, smithy, embroidery, cotton and coir rope making, mat making, bookbinding, poultry farm, washing clothes, general cleaning of premises, and kitchen works.**
- Books were bound for other hospitals also. Mats and the like were sent to other hospitals as per demand. About **150 patients** were attending this occupation therapy every day.

Garden therapy

Culivation therapy



Industrial therapy

- This was a non-profitable and therapy-oriented center, primarily focusing on **psychosocial rehabilitation**.
- Over the years, the center was developed and has a **soft toys manufacturing unit, wire bag unit, agarbatti unit, paper cover making unit, chalk piece making unit, soap preparing section, a flour mill** for grinding the essential day to day of the kitchen of IMH, and a **candle making section**.
- There is also a **bakery unit** that caters to the daily requirement of bread for the Mental Hospital, besides supplying biscuits, cakes, and other confectionaries to the hospital canteen.

IN PATIENT ZONE



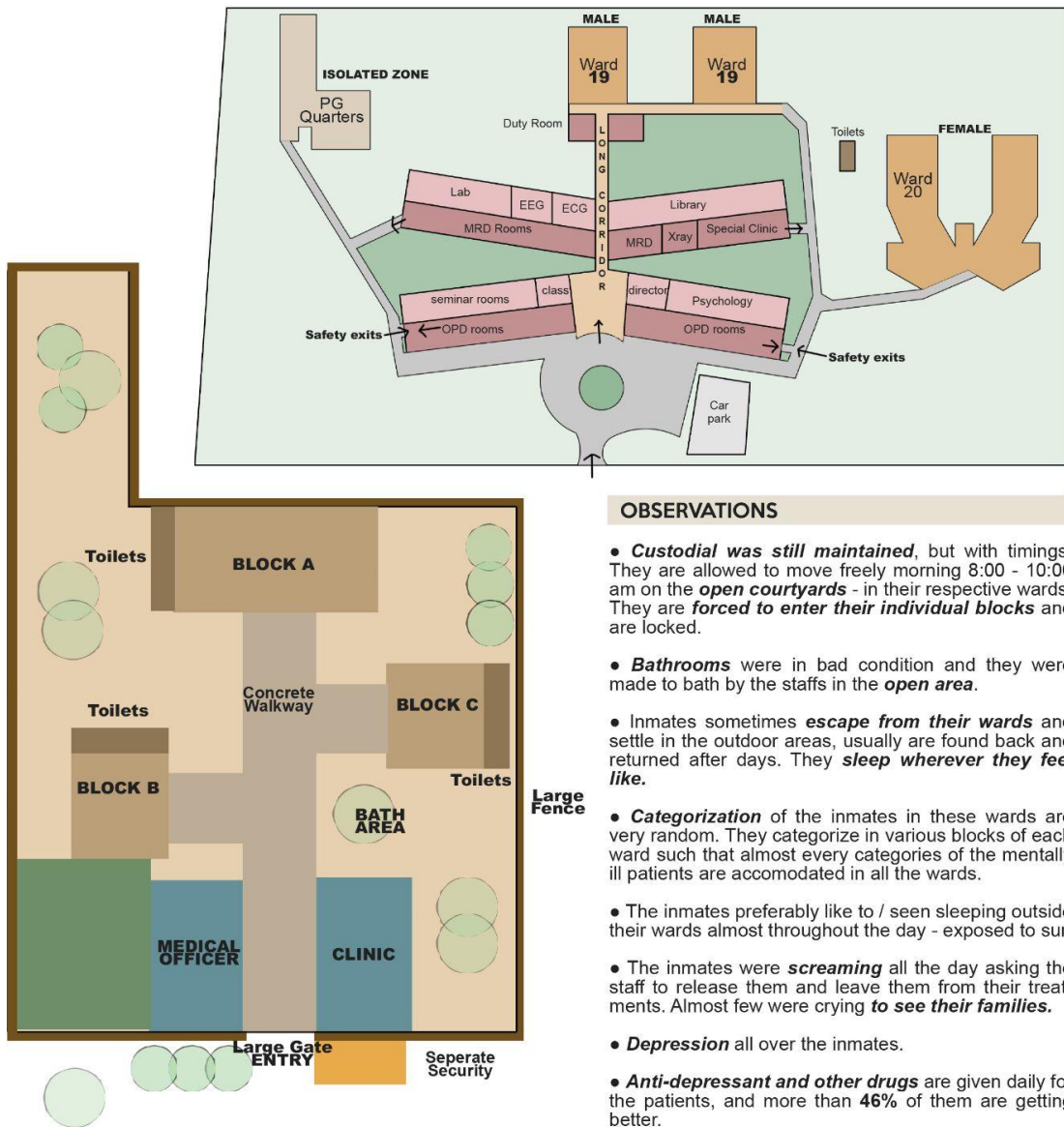
OUT PATIENT ZONE



SPATIAL CONFIGURATION



Out patient department



OBSERVATIONS

- **Custodial was still maintained**, but with timings. They are allowed to move freely morning 8:00 - 10:00 am on the **open courtyards** - in their respective wards. They are **forced to enter their individual blocks** and are locked.
- **Bathrooms** were in bad condition and they were made to bath by the staffs in the **open area**.
- Inmates sometimes **escape from their wards** and settle in the outdoor areas, usually are found back and returned after days. They **sleep wherever they feel like**.
- **Categorization** of the inmates in these wards are very random. They categorize in various blocks of each ward such that almost every categories of the mentally ill patients are accommodated in all the wards.
- The inmates preferably like to / seen sleeping outside their wards almost throughout the day - exposed to sun.
- The inmates were **screaming** all the day asking the staff to release them and leave them from their treatments. Almost few were crying **to see their families**.
- **Depression** all over the inmates.
- **Anti-depressant and other drugs** are given daily for the patients, and more than **46%** of them are getting better.
- **Occupational therapies, Gardening therapies** are very much supportive in their healing process.

Sai Teja

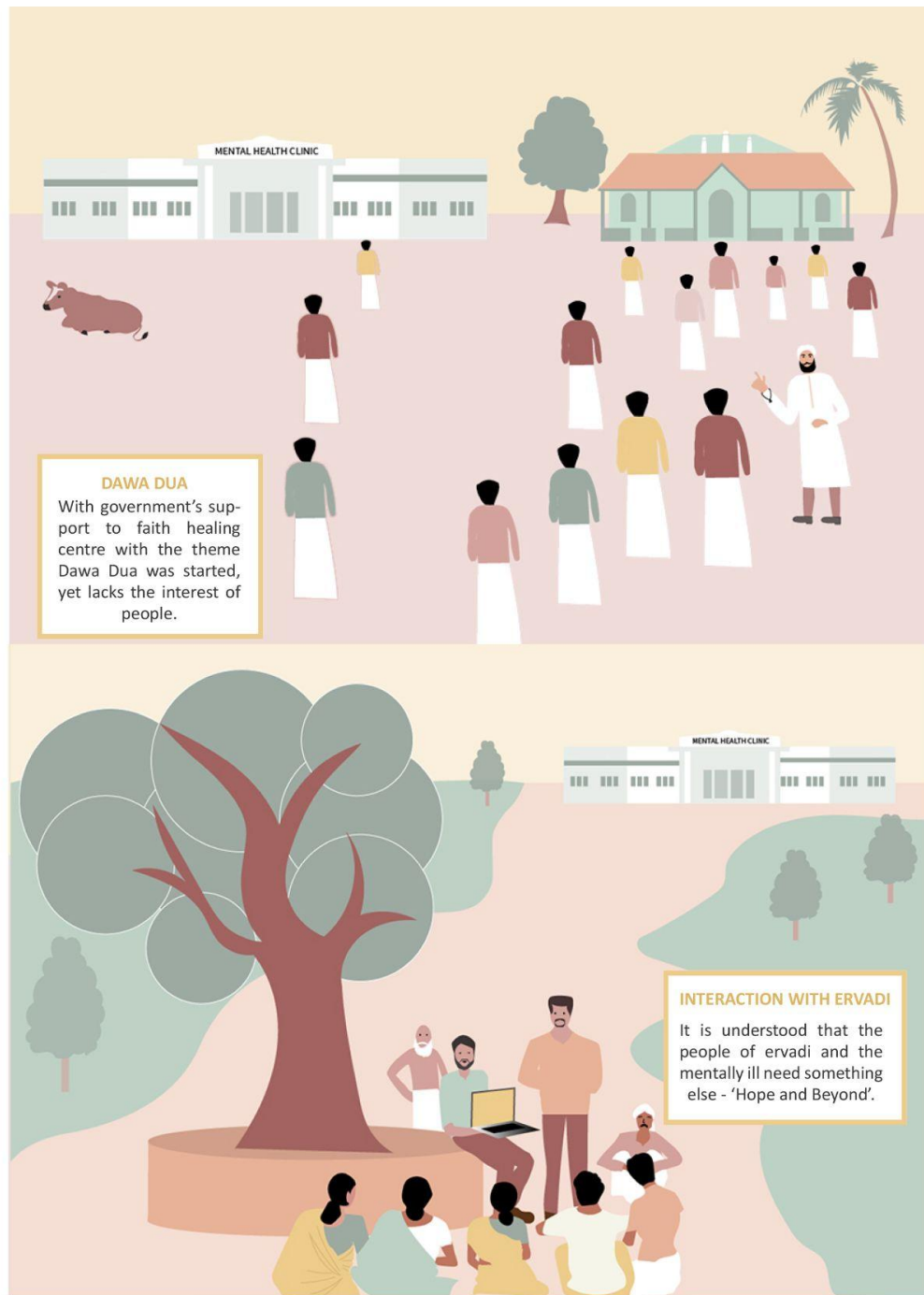
ARCHITECTURE THESIS Hope & Beyond for the mentally ill

HOPE
&
BEYOND

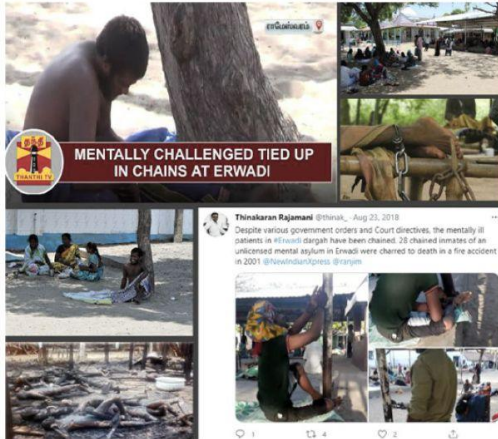
CHAPTER 5 - SITE STUDY AND ANALYSIS

Sai Teja TN | 37210041 | Sathyabama Institute of Science and Technology **SITE INTRODUCTION**





journey with ervadi begins...



Current situation at Ervadi

1. People still believe their religious practices.
2. 40 bed hospital is not in use by the mentally ill.
3. Almost 50 people daily visit dargah (mentally ill).
4. They are not chained but are left free in front of the dargah.
5. No proper treatment facilities is being carried out.



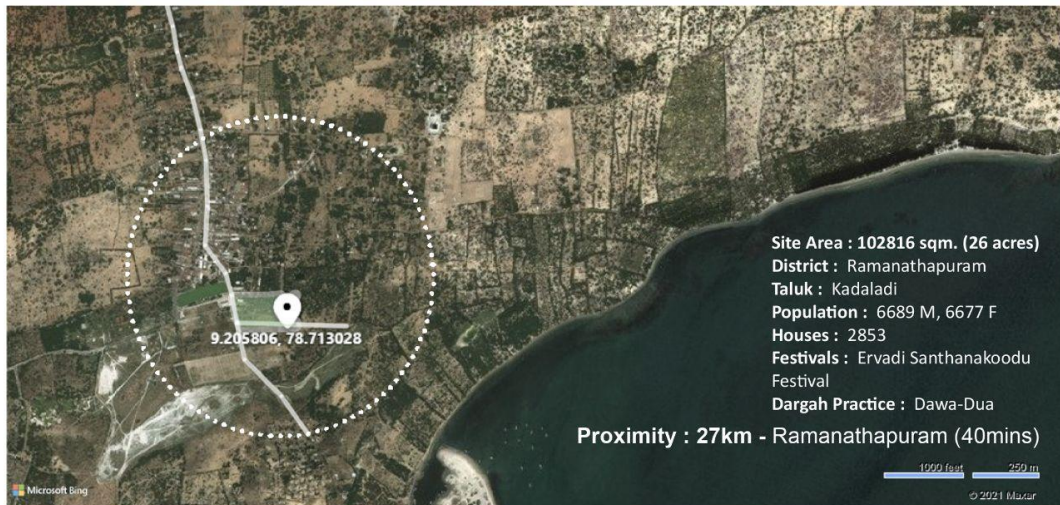
Why Ervadi

1. With respect to present mental health conditions.
2. With respect to cultural and religious factors towards Mental Healing.
3. With respect to a place that is far away from urbanisation.
4. 2001 Fire Accident Incident.
5. History of mental disorder and connection to the site - asylums, faith healing centres & hospitals.
6. Can be potential enough in acting as an alternate solution towards the integrated planning and design system of mental health institutions.

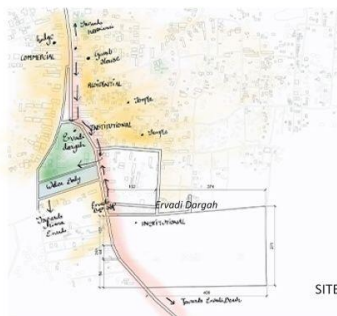


Site Photographs

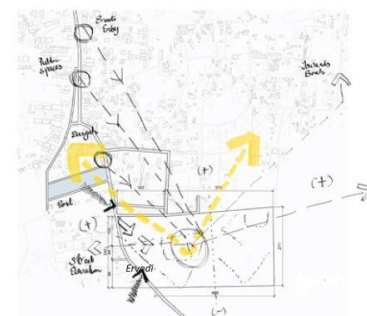




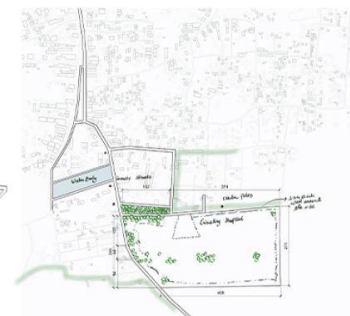
Site Context



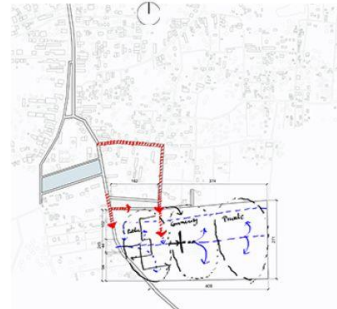
Sensory



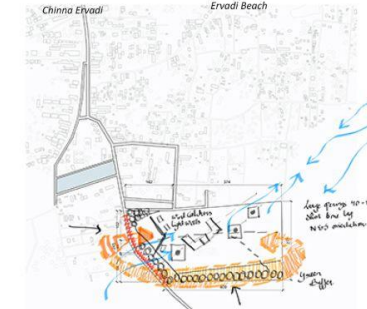
On Site and Off Site features



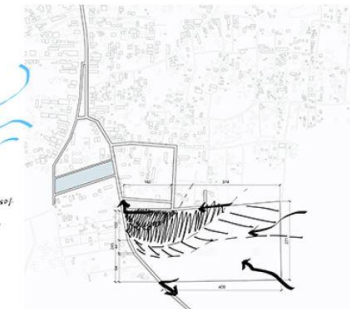
Circulation



Climate



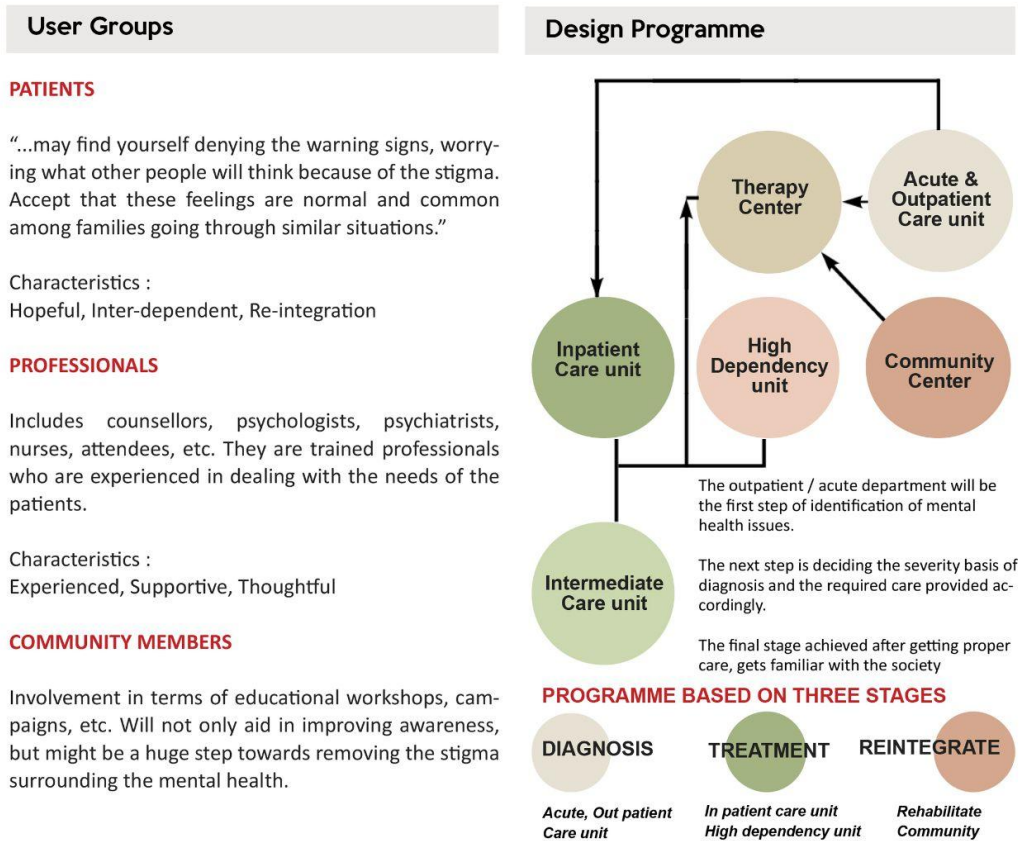
Contour



CHAPTER 6: ARCHITECTURAL DESIGN

6.1 Spatial Requirements

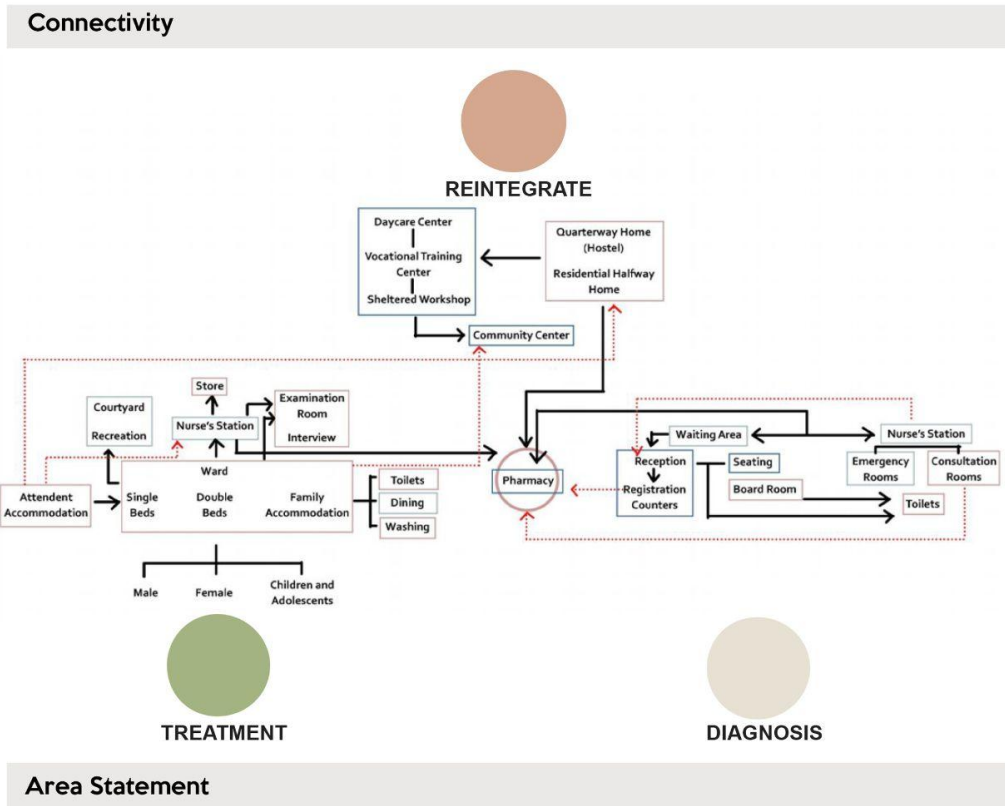
Sai Teja TN | 37210041 | Sathyabama Institute of Science and Technology **SPATIAL REQUIREMENTS**



The Patient

	ACUTE	GERIATRIC	REHAB	OUTPATIENT	ADOLESCENT	PEDIATRICS	ADDICTION	INFIRM-ARY
Illness	Depression Anxiety Bipolar	Dementia Alzheimer	Schizophrenia PTSD	Depression Anxiety	Autism Epilepsy Depression	Autism Epilepsy	Alcoholism Drug use	Co-morbid Mental Physical
Lenght of stay	0-28 days	>28 days	>28 days	1 day	>28 days	>28 days	1 week	1 week
Age	18-45	>45	18-45	All	10-18	6-10	18+	18+
Stimulation	High	Low	Low	Low	Moderate	Moderate	High	Moderate

6.2 Area Statement



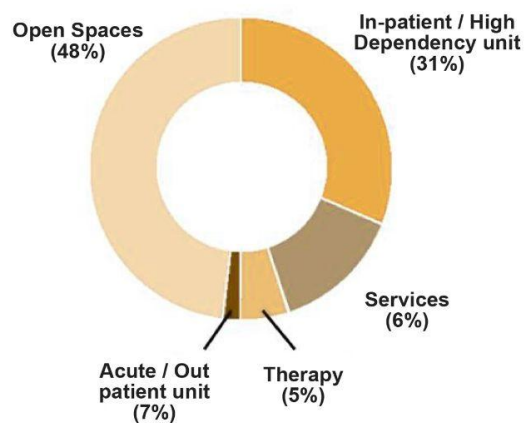
SITE DETAILS

01. Site Area	1,02,816sqm
02. Maximum permissible FAR	1.5
03. Maximum permissible Built-up	1,54,224 sqm

BED DISTRIBUTION

01. Intermediate (Male)	32
02. Intermediate (Female)	32
04. Emergency room / ICU	21
05. In patient care unit - Acute (Male)	38
06. In patient care unit - Acute (Female)	38
08. High dependency unit (Male)	70
09. High dependency unit (Female)	70
Total Beds	376

AREA DISTRIBUTION



6.3 Concept and Design Program Development

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DESIGN DEVELOPMENT

Architectural space and environment that could enhance the mental health, and even a psychological treatment.

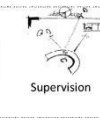
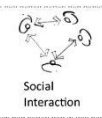
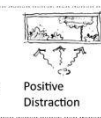
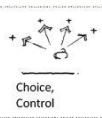
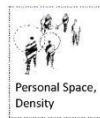
GOAL



METHODOLOGY FOR DESIGN FORMULATION



EXPLORATION OF CREATING AN ARCHITECTURAL ENVIRONMENT FOR THE MENTALLY ILL



Hope

- A. To Define
- B. To Treat
- C. To Reintegrate



Water as purification
CREATION OF WATER AS A SIGNIFICANT ELEMENT



Water as subconscious



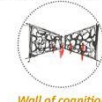
Water as psychic power



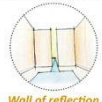
Wall of compassion
DEFINING WALL



Wall of freedom



Wall of cognition



Wall of reflection



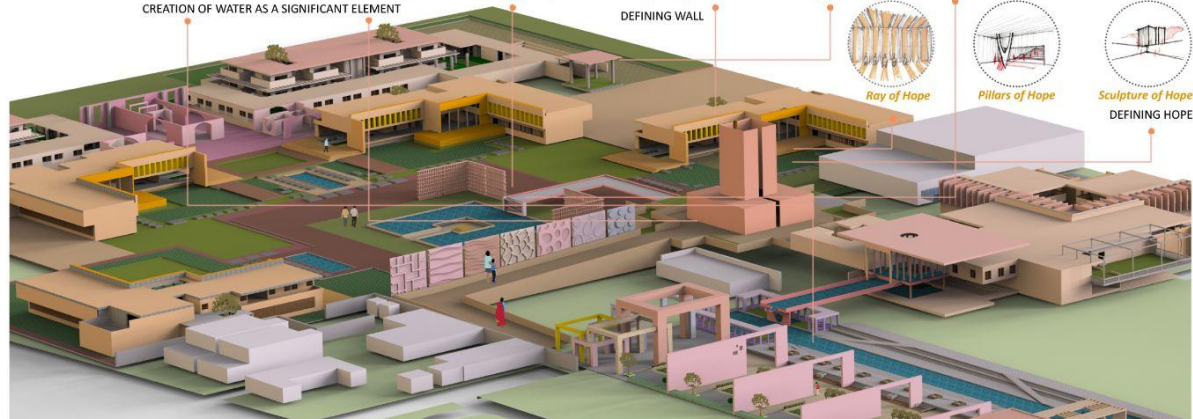
Ray of Hope



Pillars of Hope



Sculpture of Hope
DEFINING HOPE



Front Elevation (West)



Dargah Elevation (North)



Ariel View of the Proposal

Sai Teja ARCHITECTURE THESIS Hope & Beyond for the mentally ill

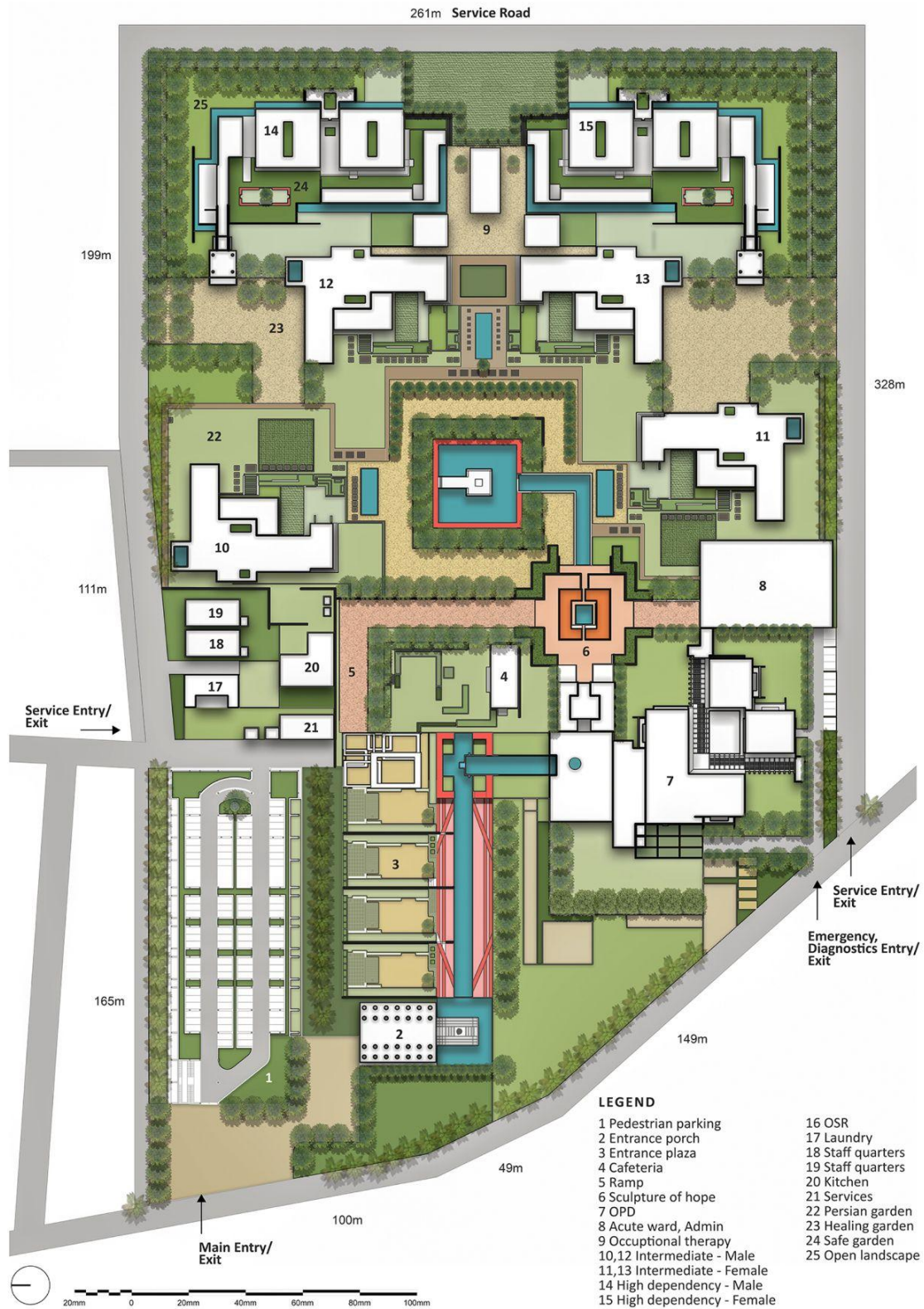
Plate no :27

H & PE
BEYOND

6.4 Zoning and Master plan

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MASTER PLAN



Sai Teja ARCHITECTURE THESIS Hope & Beyond for the mentally ill

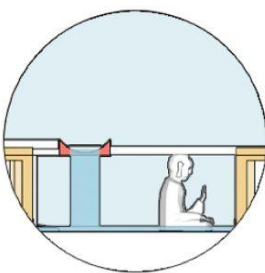
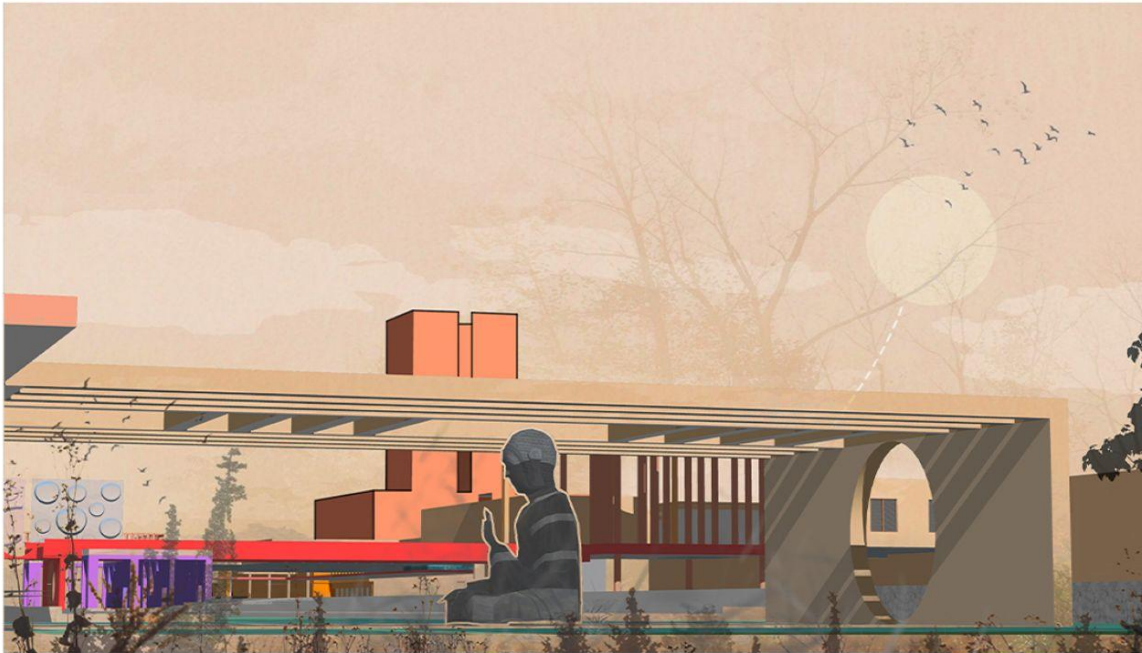
Plate no :28

H OPE
BEY & ND

6.5 Detailed Drawings

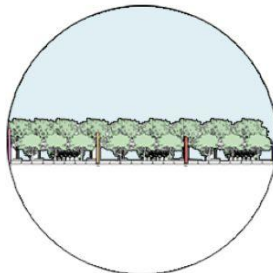
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ENTRANCE PLAZA



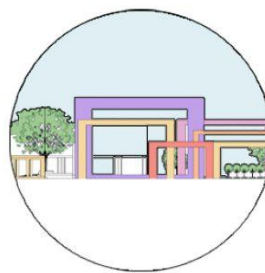
1. Sense of Calmness

Cascading water through the gutter systems on three sides.



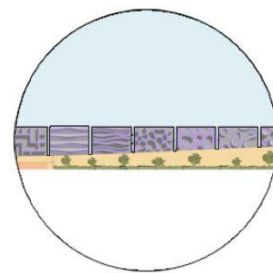
2. Sense of Serenity

Ascending free walls with landscape serving as sense of mysticness.



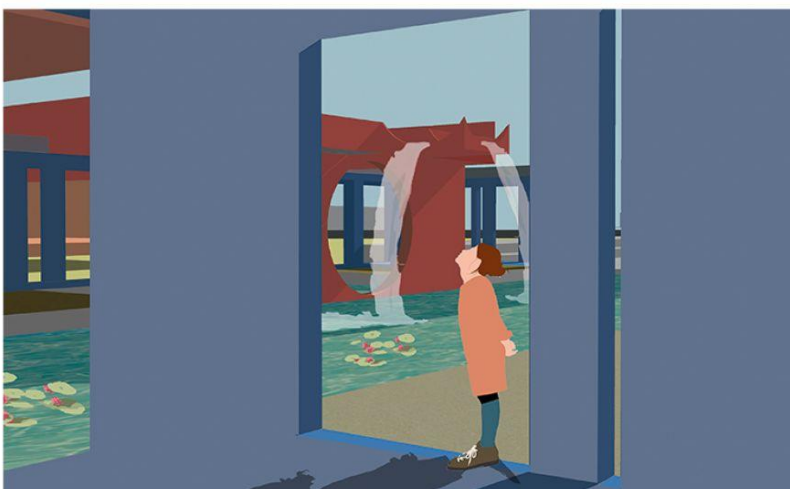
3. Sense of Puzzle

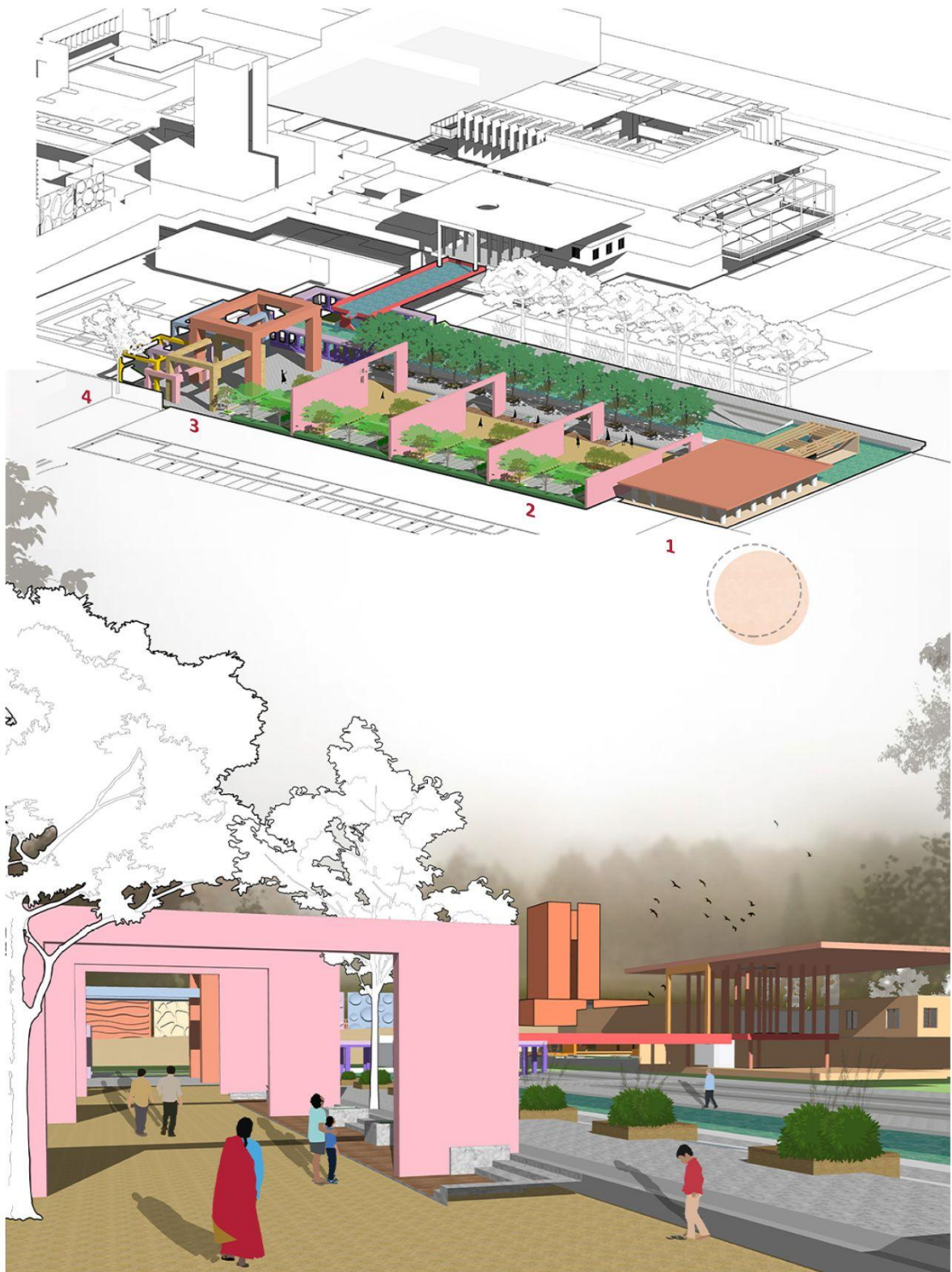
Visual stimulation in order to boost the cognitive mind.

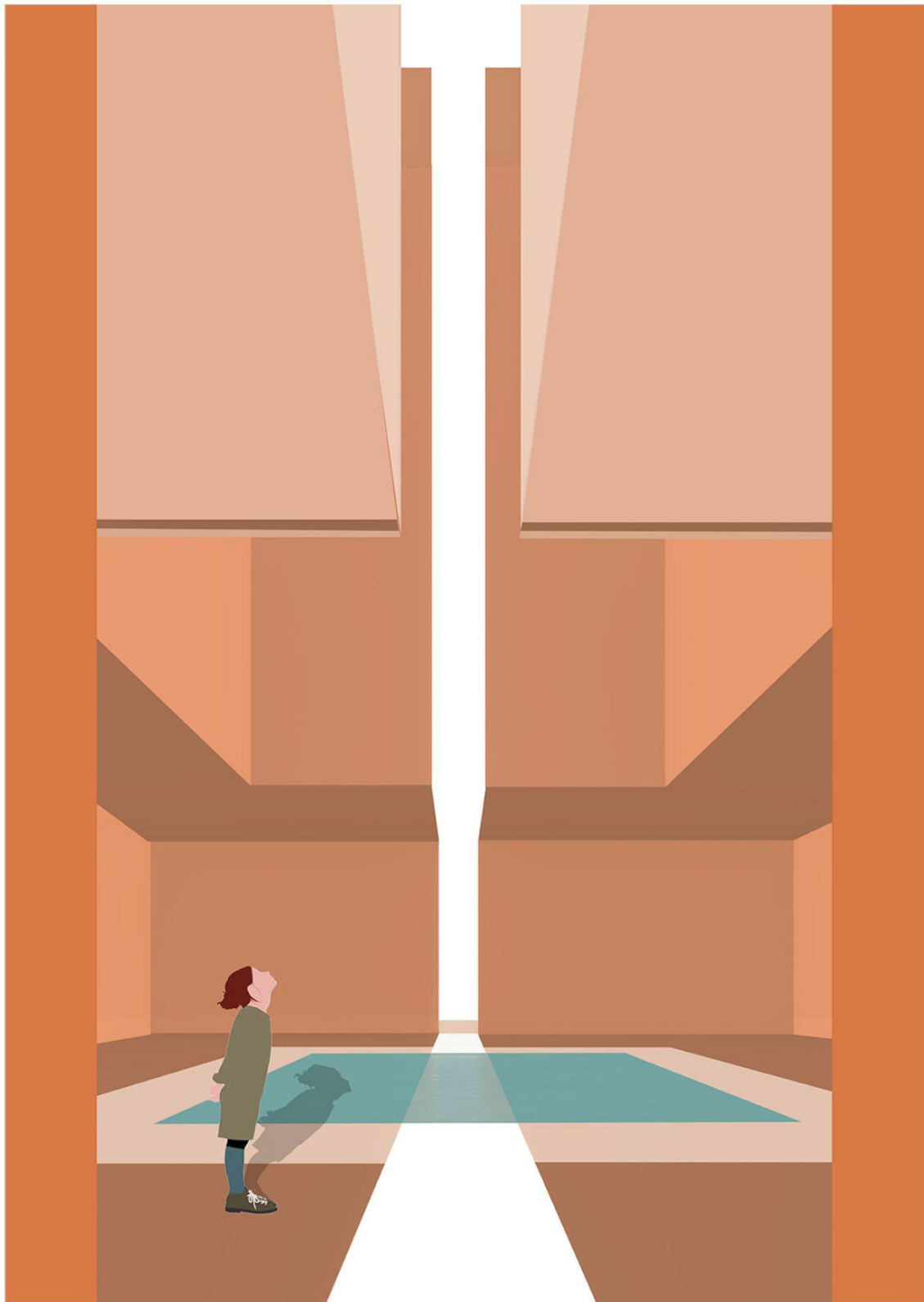


4. Sense of Direction

Mural wall serves as a visual stimuli that evolves from lines to patterns.



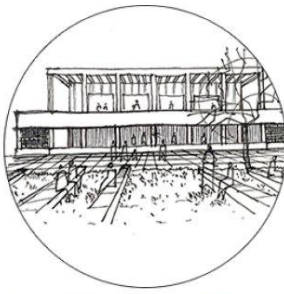




DESIGN THEME / TRANSLATION PROCESS



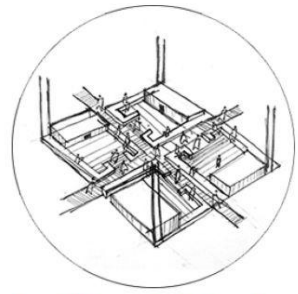
Deinstitutionalized and homelike settings



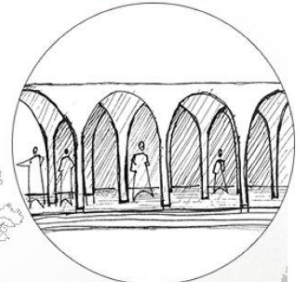
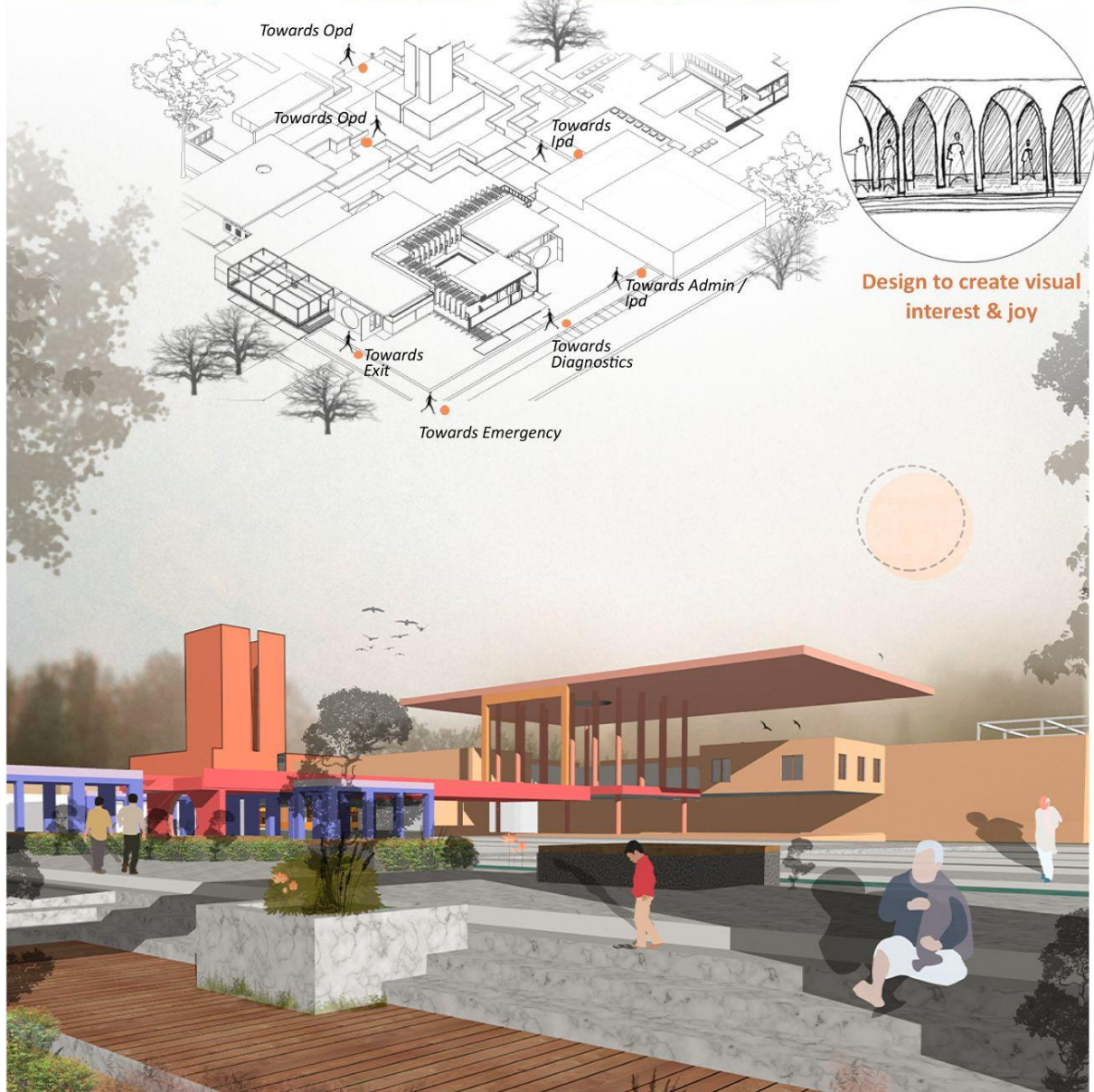
Sprawling shape with one to two stories



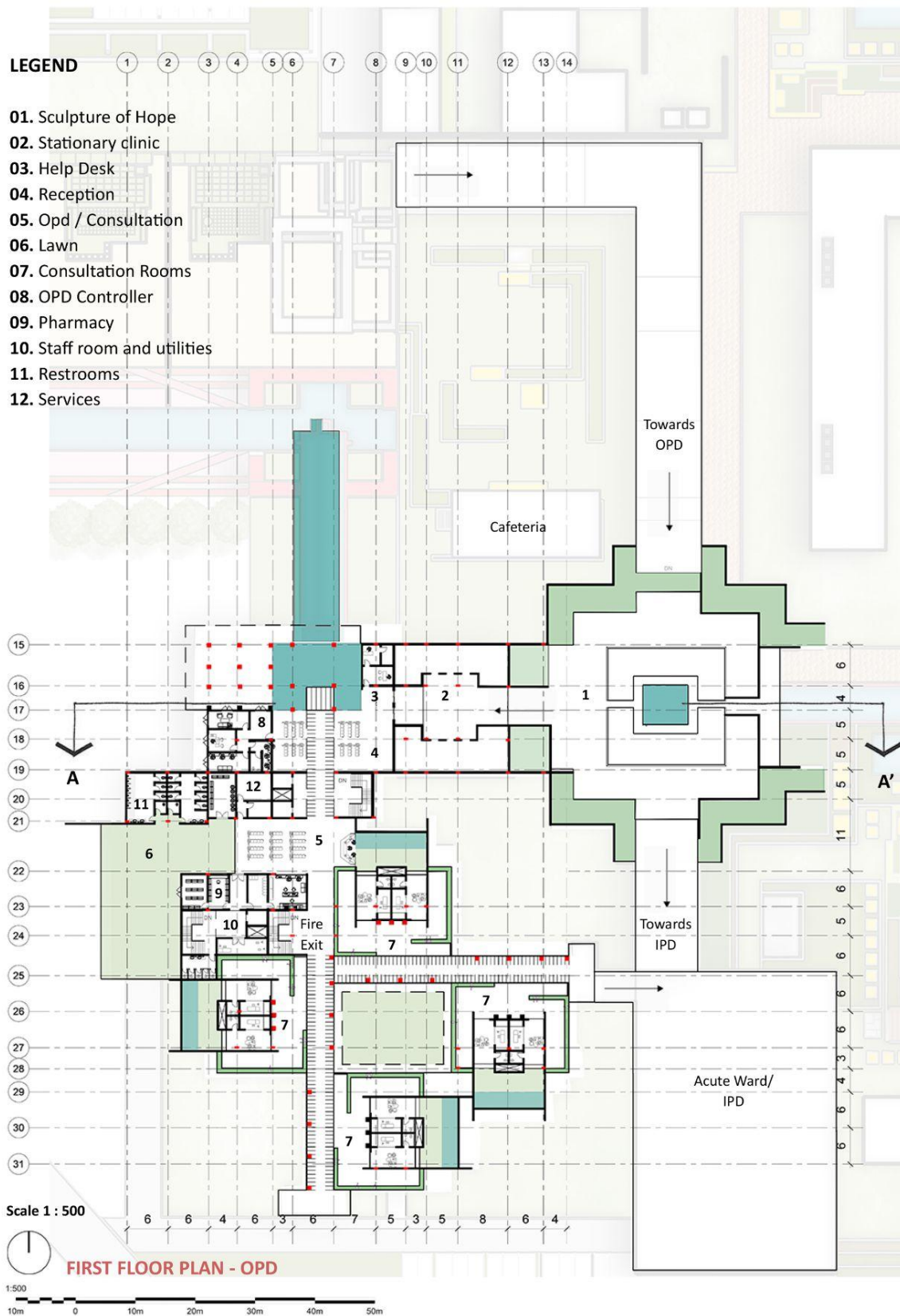
Access to nature, and enhancing social interaction

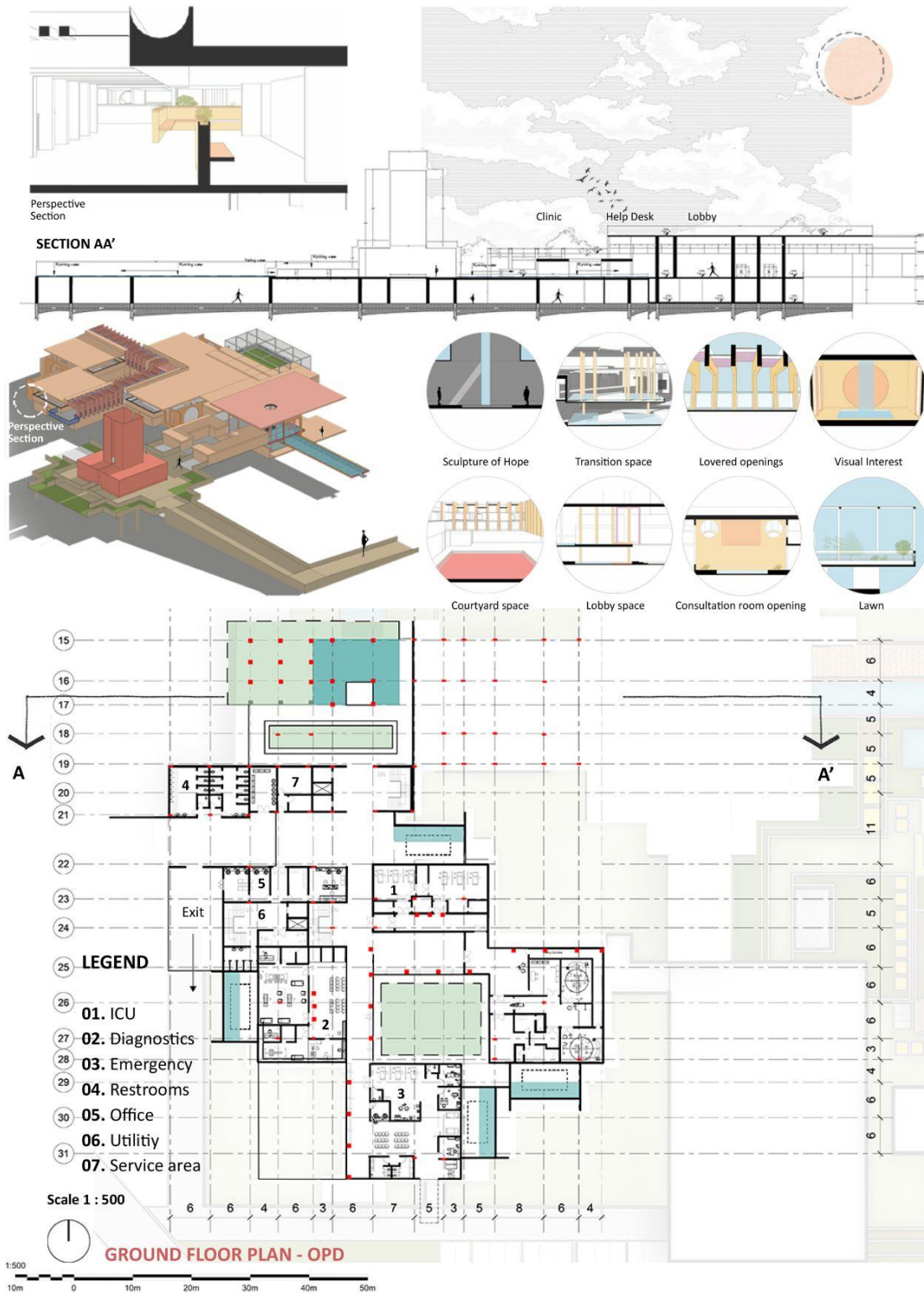


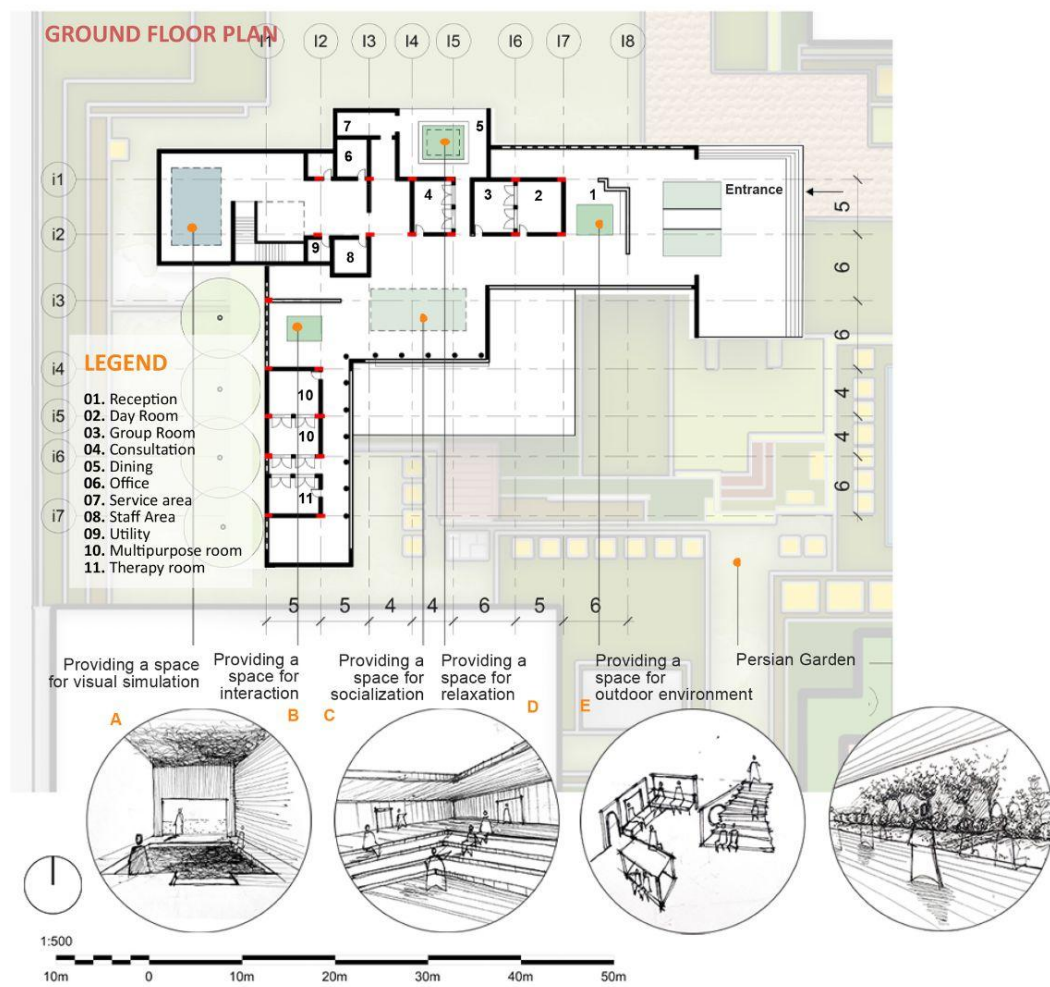
Providing certain freedom and control



Design to create visual interest & joy

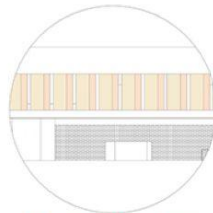




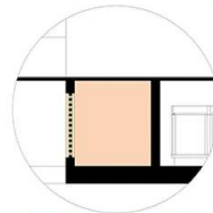




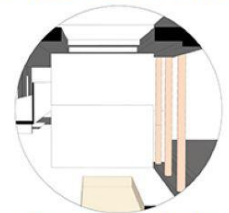
WARD THAT IS VISUALLY AND PHYSICALLY ACCESSIBLE TO THE CENTRAL THERAPY UNIT, OCCUPATIONAL THERAPY UNIT



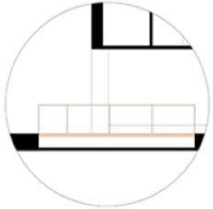
Louvered openings



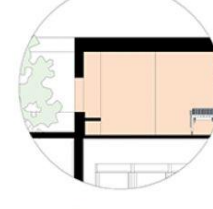
Interactive corridor



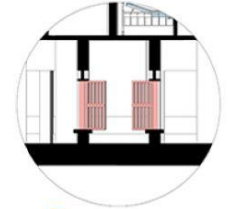
Space for socialization



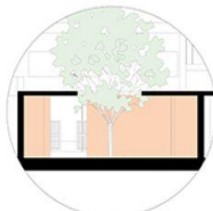
Space for outdoor environment



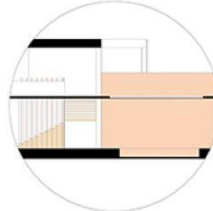
Patient room



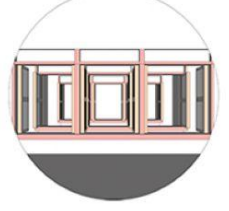
Therapy rooms



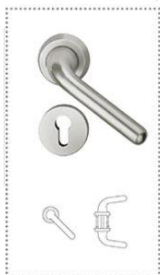
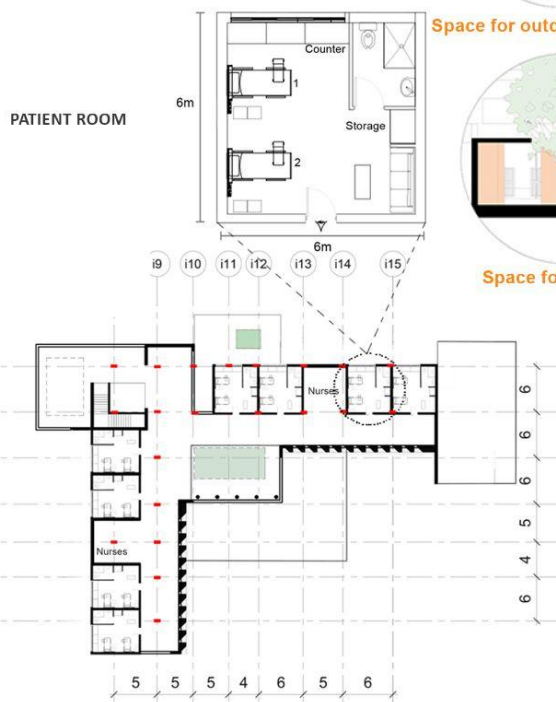
Space for relaxation



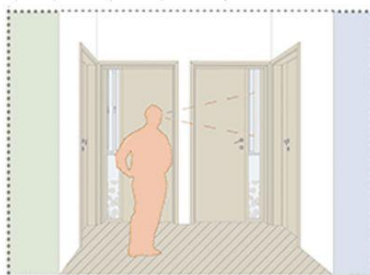
Space for visual stimuli



Level of concern - eye level



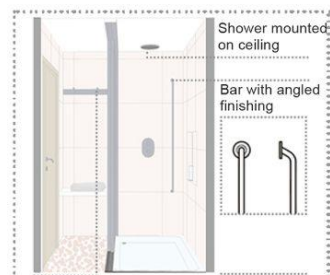
Design of door knob that prevents clamping of choke straps



Doors with a side glass panel - When opened they allow passage and when closed they still remain the monitoring of the rooms.



Windows allow the autonomy of patients to control ventilation (safe dimension of 15cm of free opening) and rolling shutter.



Towel hooks : breakage with a load above 20kg.

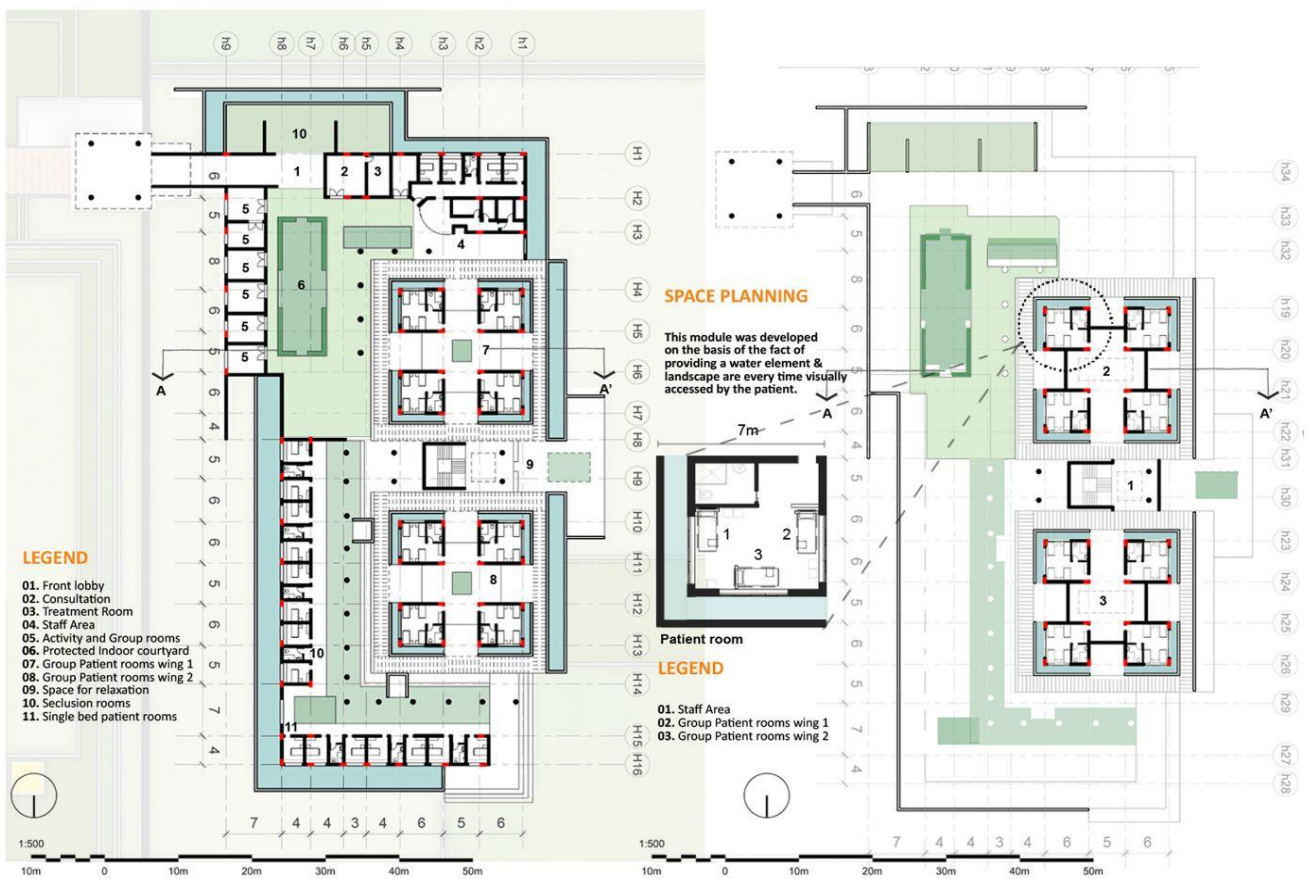
Sai Teja

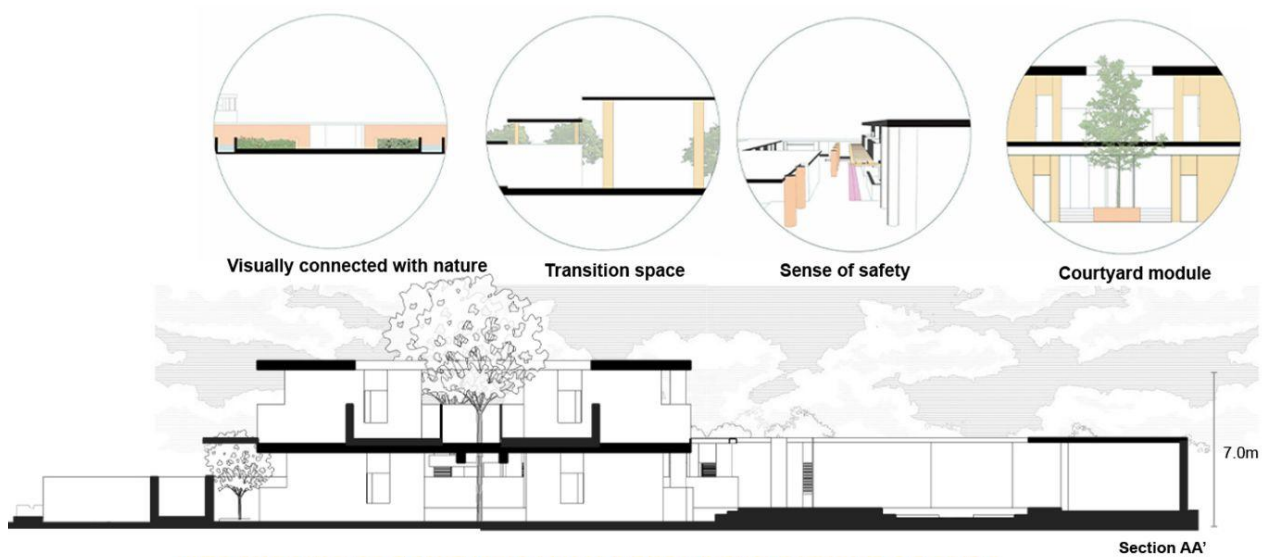
ARCHITECTURE THESIS

Hope & Beyond for the mentally ill

H O P E
B E Y O N D

Plate no :36





STRATEGIES FOR VARIOUS HIGH DEPENDENT PATIENT GROUPS



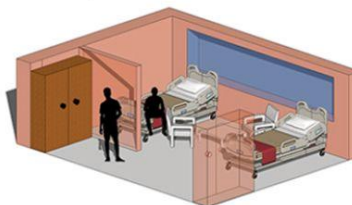
Physically disorder room

Have a transition space between private space and communal space for the adaptation needs of patients to different environments.



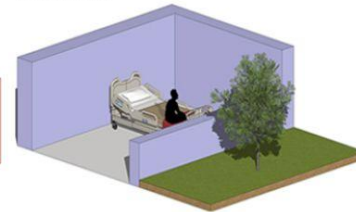
Identity disorder room

Have an open space and providing opportunities for patients to explore themselves.



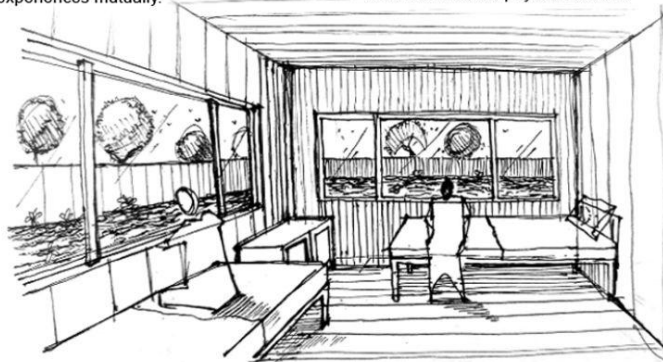
Psychic disorder room

The bed is propped against the wall to give a sense of security in each room occupied by 2 patients. The concept of spatial planning like this can create an atmosphere of mutual ownership, and also has a common space where patients can share their experiences mutually.



Reality disorder room

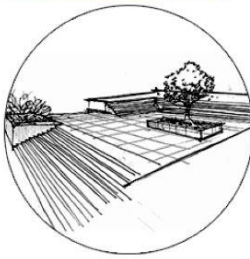
The room that can limit the movement of patients for safety reasons, but still provide a media that connect to the outside world or the reality that can support their healing process. The room is very protected wherein he has visual access instead of physical access.





DESIGN THEME

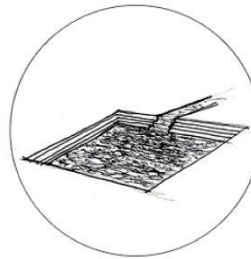
A. Architecture as art



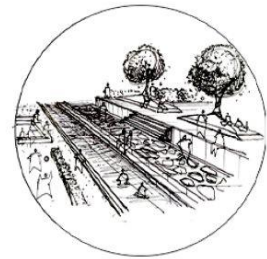
Pathway pattern, Plaza, Garden, Sculpture



B. To Support Mental Health



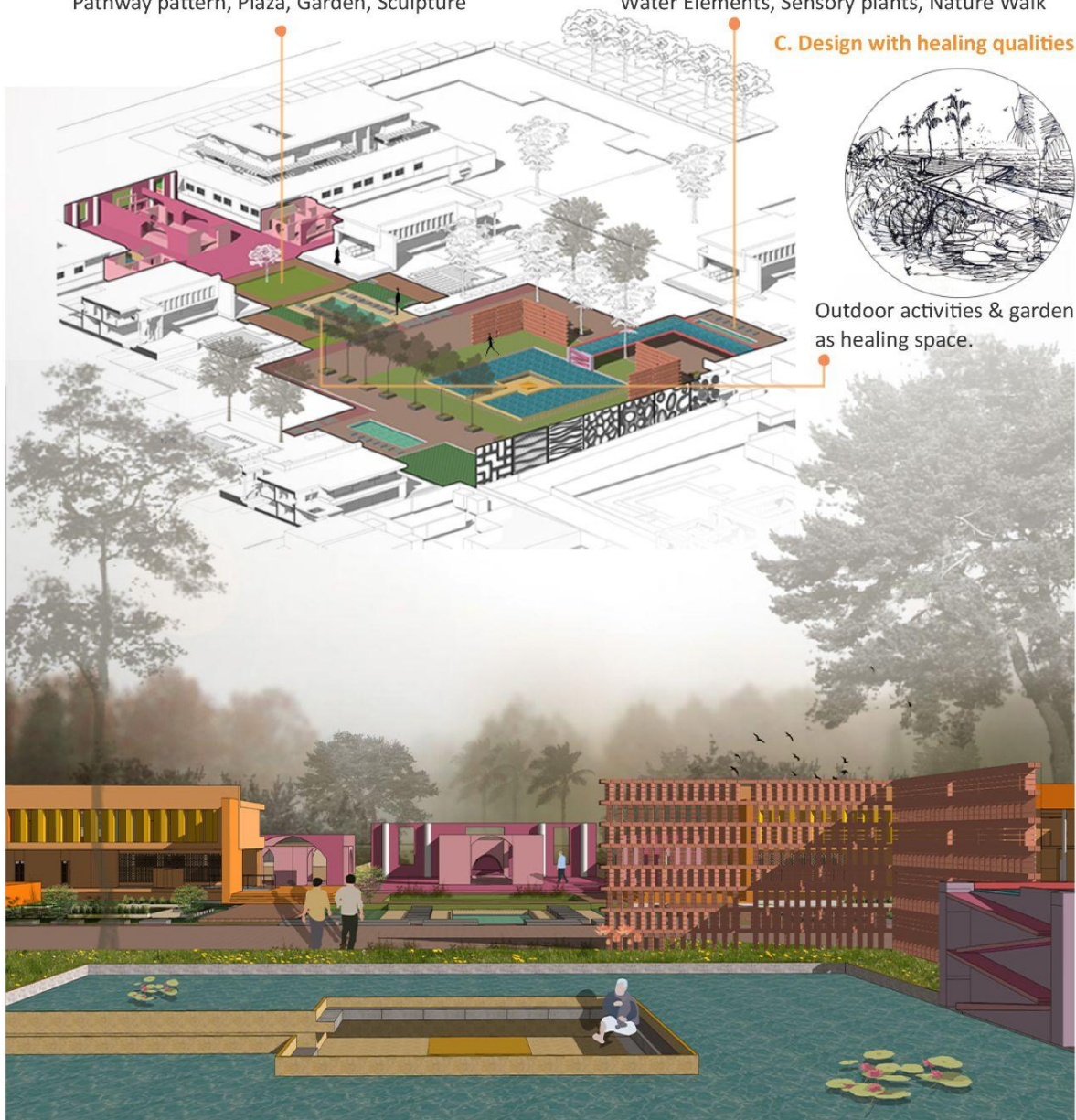
Water Elements, Sensory plants, Nature Walk

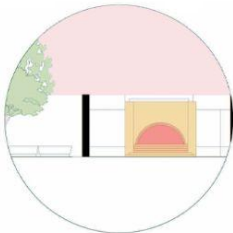
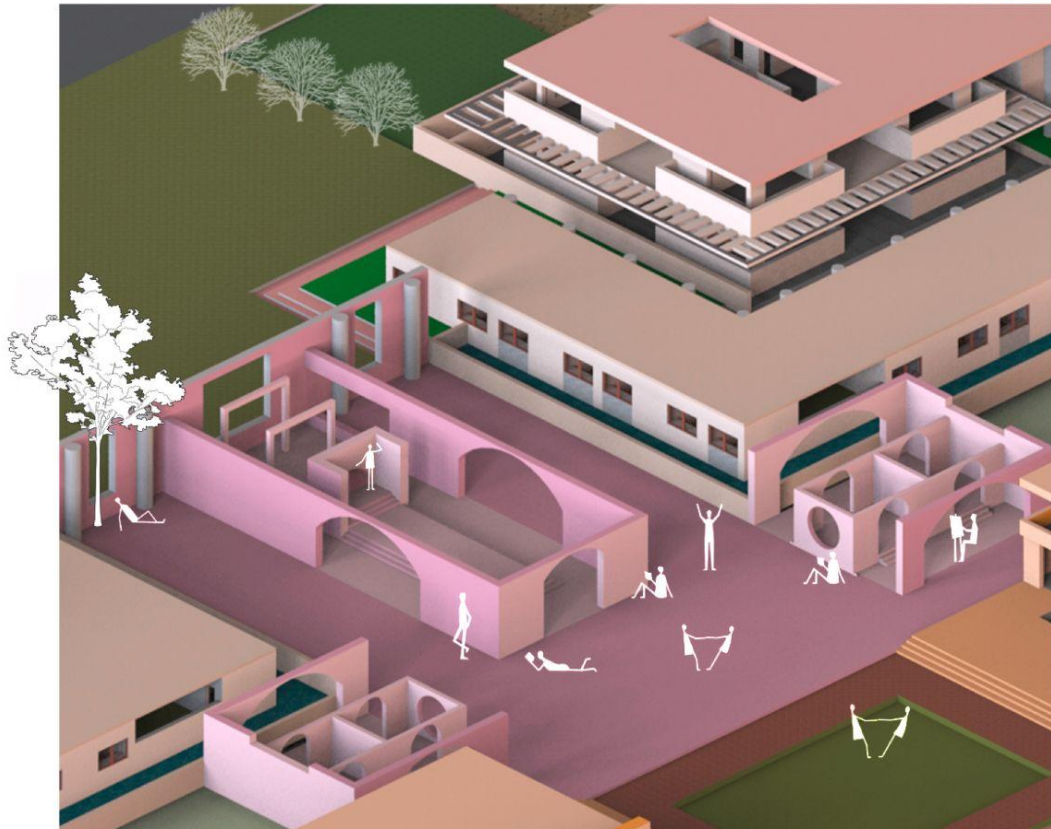


C. Design with healing qualities

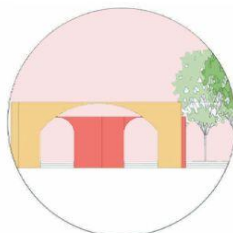


Outdoor activities & garden as healing space.

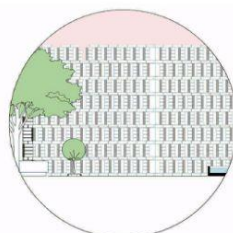




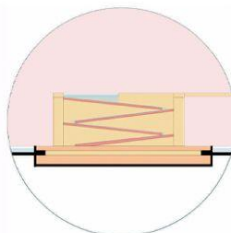
Wall of Interaction



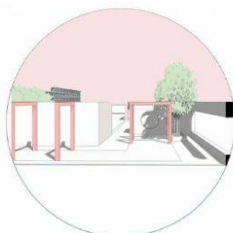
Wall of Escape



Wall of Art



Wall of Serenity



Wall of Direction



Temple Tree



Trumpet tree



China Gold



Giant Bamboo



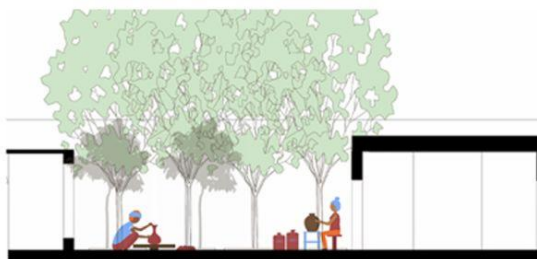
Chinese Fringe Flower



Kadok



Jasmine



The Sensory Softscape

The Sensory plant is a plant selection that is appealing to the five senses which are sight, smell, sound, taste and touch. It is a strategy to create positive emotions and to enhance mental well being.

Sight	Trumpet Tree, Chinese Fringe Flower, Jasmine
Smell	Kenanga, Cempaka, temple Tree
Sound	China Gold and Giant Bamboo
Touch	Tea Tree
Taste	Asam Gelugor, Kadok

CHAPTER 6: REFERENCES

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