Transformative Landscapes: Deinstitutionalizing Mental Healthcare Through the Urban Park

by

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Dalhousie University is located in Mi'kmaq'i,
the ancestral and unceded territory of the Mi'kmaq.
We are all Treaty people.

To Danielle, may the memory of you last a lifetime.

Contents

Abstract

People are a product of their environment; the psychological and physical well-being of individuals are continually shaped by life experiences, relationships, community culture, and environmental conditions. Historical paradigms around mental health continue to influence healthcare architecture, subsequently affecting patient services and healthcare models. Institutional facilities are designed to treat individuals in private settings, furthering an ocularcentric culture driven by stigmatization. These spatial and systemic qualities limit mental healthcare affordances, communal cohesion, and preventative measures to aid in mental resilience. We can redirect and transform psychological services into community-based amenities by weaving these systems into the urban fabric.

Deinstitutionalization, through applying concepts of visibilism, proxemics, and environmental inhabitation, will foster a sense of place while stimulating community interaction. An urban wellness park that employs an architectural language of inhabitation through the figure ground will bridge the treatment gap by advocating and devoting a new place in the city for mental well-being.

Acknowledgements

My sincerest gratitude to each and every person who has supported me throughout this journey. I would like to thank my committee, Niall Savage and Michael Faciejew for your guidance and pushing this thesis to its true potential.

To my friends, I could not imagine anyone else by my side in moments of adversity and celebration together.

Finally, to my parents, thank you for your unwavering support, love, and compassion along every step, your dedication and passion for life inspire me everyday and I would not be here without you both.

Chapter 1: Introduction

Life's journey is not of linear progression; it involves unpredictable experiences and undulating moments of success and hardship. Existing in tandem; one's physical being and psychological state require constant adaptation to the trials and tribulations of everyday life. Interactions with oneself, relationship and social dynamics, environmental conditions, and resource access both consciously and subconsciously affect an individual's psychological status. Consequently, these idiosyncratic experiences and factors prevent a comprehensive definition and universal remedy to attain mental health. Questions of accessibility and adaptiveness emerge when analyzing the current healthcare system and the services provided to those with neurodiversities and mental health challenges. Given the ranging needs of each individual and their psychological health, does a "one system fits all" approach suffice?

The journey towards mental health should not be one that is walked alone

Paradigms surrounding mental health and treatment approaches have contributed to an enduring stigma that impacts individuals who are perceived as mentally ill. These historical preconceptions towards mental illness are rooted in misunderstanding and lack of empathy which continue to be perpetuated by contemporary culture due to a lack of healthcare reform and societal re-education. Present healthcare systems reinforce this pattern of stigmatization through isolative facilities, prescriptive methods, and authoritative treatment (Rössler 2016, 1251). By fostering a culture of visible compassion and informed empathetic understanding, this ingrained stigma around mental illness and systems of mental healthcare can be redefined. The social and systematic transformation requires prioritizing

inclusivity and adopting community-based mental healthcare models emphasizing support rather than marginalization.

This thesis addresses the spatial and systemic qualities of institutional mental healthcare and communal resources that aim to provide support to those with psychological challenges. Through recognizing the individualized needs for mental well-being and the current lack of accessible community resources, this thesis proposes implementing an urban wellness park as a public health amenity. In the context of Halifax, Nova Scotia, this wellness park integrates architectural and programmatic systems woven throughout and into the landscape that respond to the needs of neurodiverse individuals and psychologically vulnerable populations. Individuals identified as military personnel, Indigenous, and descendants of Africville residents are subject to a higher risk of mental illness due to a history of traumatic subjections (Waldron 2018). As many of these identifying individuals reside within Halifax, it is paramount to provide accessible mental healthcare through offering supportive community networks. The architectural application of visibilism and proxemics of mental health resources investigates how a sense of place is cultivated and driven through the inhabitation of the urban landscape. By weaving psychological services and advocacy systems into the community, therapeutic programs and support spaces aim to afford individuals a space of refuge, release, and reengagement that is reinforced through transparent healing and rooted in the communal landscape.

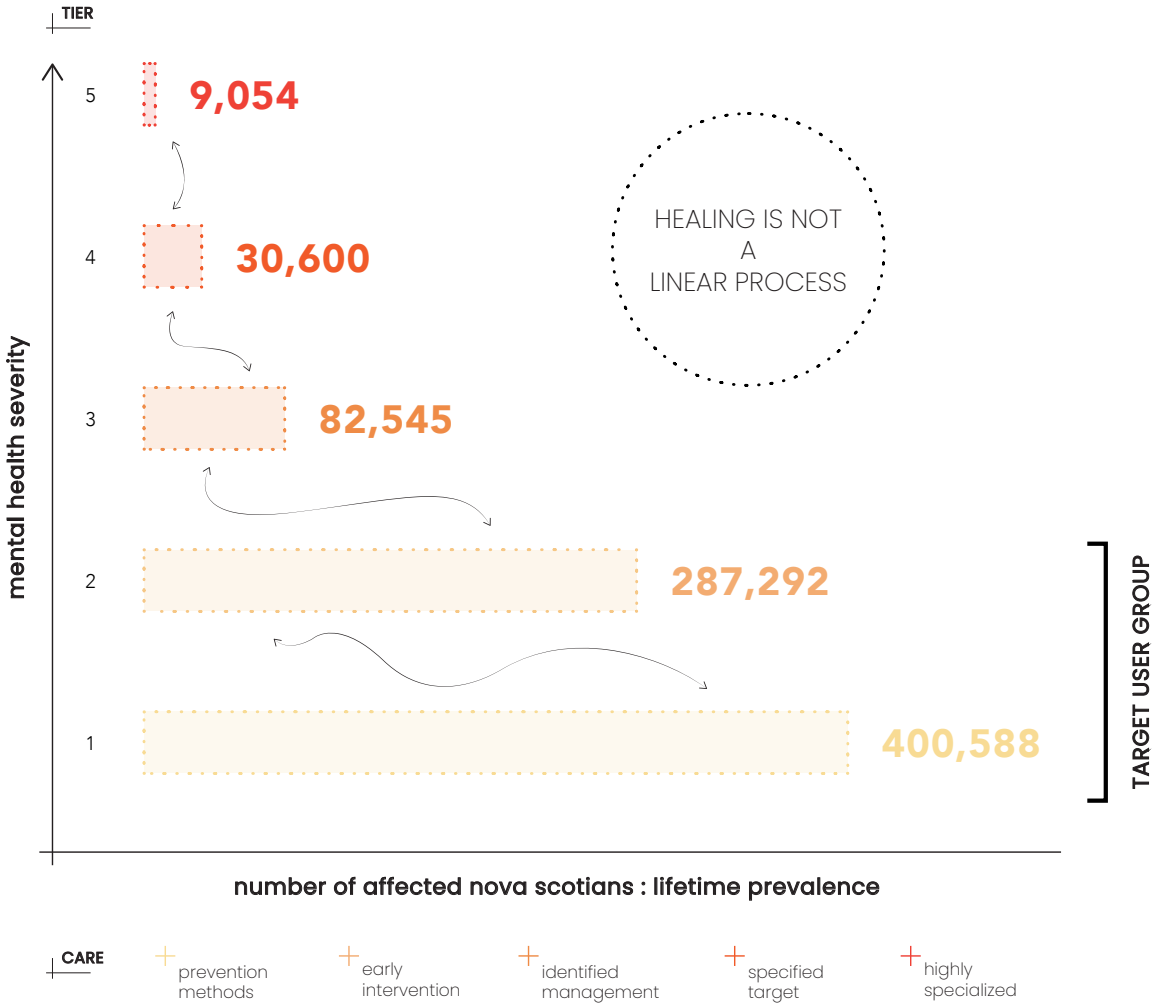
Chapter 2: Establishing the Head Space

Mental health has become a more frequent topic in today's global conversation particularly in the wake of the recent pandemic. A greater understanding of mental health challenges and the diverse impacts they can have on individuals, calls for the advancement of healthcare services, as well as a built environment that reflects the psychological needs of the community. This chapter suggests redefining mental illness through the lens of neurodivergence and provides an analysis of environmental, spatial, and systemic factors that contribute to communal mental well-being.

Neurodivergence

Gifford's theory of environmental psychology examines the interconnection and symbiotic relationship between the environment and human behaviour. This theory suggests that the composition of space impacts an individual's behaviour, yet it is also human behavior that impacts spatial development (Gifford 1987, 2). Analyzing the realm of architecture through environmental psychology reveals that an individual's mental well-being can be influenced and affected by their physical surroundings. Unique to each person, those who experience neurodiversities can be affected by various environmental factors which impede their ability and comfort when utilizing spaces and integrating within social programs.

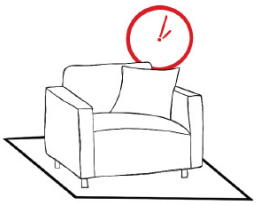
It is vital to recognize that mental health is more than the absence of mental illness; it exists on a complex scale with varying degrees of impact and challenges.



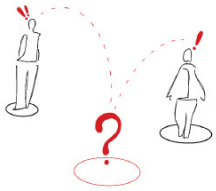
Mental health severity and care framework
(data source: Nova Scotia Department of Health and Wellness 2013)

In Nova Scotia, 66% of those struggling with mental health are not engaged or cannot access the proper care (Jacobs and Forsyth 2017). This treatment gap further expands for marginalized and disadvantaged individuals, in addition to the cascading impacts that psychological challenges can have on one's family and social network. Despite considerable progressions toward mental health awareness and services offered, accessibility, participation, and stigmatization continue to be a barrier throughout the province and nation.

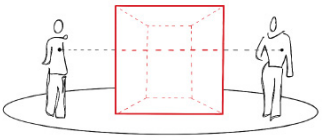
urgent care



professional care



group care



community care

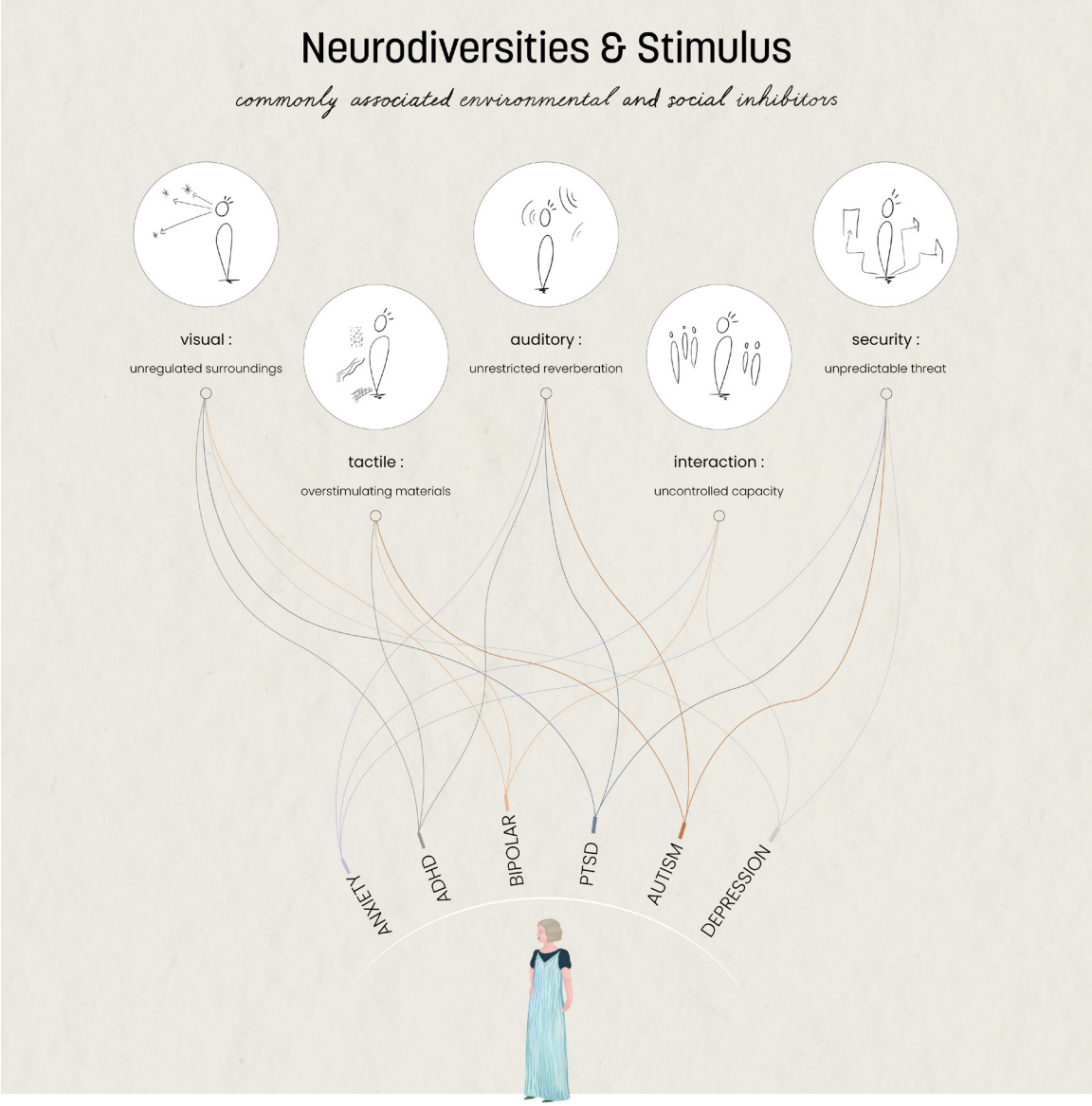
Current service structure for mental healthcare

The current framework of mental health care consists of urgent hospital care, professional care through therapists and social workers, and group programs supported by private organizations. However, accessible mental healthcare that is adaptive to various neurodiverse individuals has yet to be established and integrated at the community level.

Neurodiversity proposes the notion that individuals who identify as having psychological differences are like any other person, as opposed to being stigmatized as abnormal or mentally ill. Neurodiverse individuals are considered as those who are diagnosed or experience, yet not limited to, attention deficit hyperactivity disorder, anxiety, depression, post-traumatic stress disorder, schizophrenia, and autism (Cleveland Clinic 2022). These neurodiversities and affected individuals can present as various behavioral and psychological challenges, unregulated thoughts and emotions, as well as a range of sensitivities to their environmental conditions. Existing on a complex and fluid continuum, neurodiversity challenges can manifest over a short period of time and last for a few hours, yet also develop and endure over the course of several months or years (WHO 2023).

> At any one time, a diverse set of individual, social and structural factors may combine to protect or undermine our mental health and shift our position on the mental health continuum (WHO 2023, 14).

Recognizing the variance of psychological differences through social awareness and mental healthcare systems perpetuate the demand for inclusive architecture that is sensitive and adaptive to the challenges that these people face.



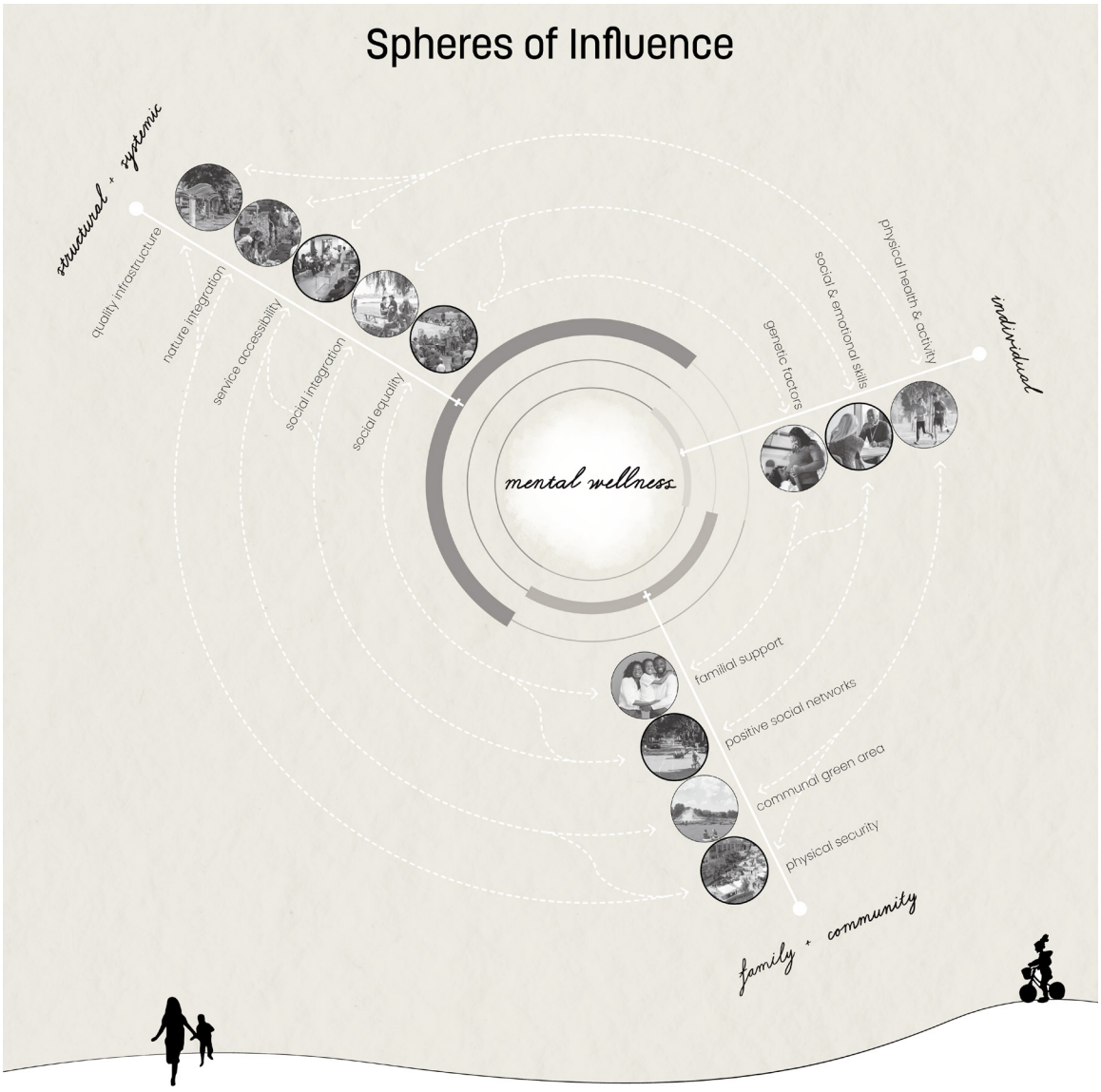
Commonly associated environmental and social stimuli for the neurodiverse

Although each neurodiverse individual may encounter different challenges and barriers when accessing mental health care and interacting with the built environment, five elements have been identified by Kelty Mental Health Resource Center (2023) as imperative design considerations to provide psychologically accessible mental healthcare. These architectural features include visual connectivity, tactility, acoustics, interaction capacity, and spatial security. Visual stimuli considers sightlines throughout an interior

or exterior space and connection to other spaces and activities, in addition to potential visual stimulants, such as materiality and lighting. Tactility of a space and associated materiality can affect the physical and psychological comfort of neurodiverse individuals as highly tactile environments may be over stimulating, while conscious minimal material selection can provide a more tranquil environment. Acoustic design considers spatial and material attributes that limit acoustic reverberation and potential over stimulation for neurodiverse individuals. Spatial capacity for user interaction ensures that the size of the space correlates with the intended program and the proximity between active and non-active programs is consciously organized. Lastly, perceived security of a space or landscape is vital for those with neurodiversities which combines design elements of clear sightlines, controlled user capacity, as well as the organization of a space to provide areas of refuge, as well as visible circulation routes and access points. Ensuring care programs dedicated to providing mental health services are inclusive, regardless of one's physical or psychological position, affords equitable access and agency for those in need of support. A built environment which embraces and supports those with neurodiversities provides an imperative foundation when fostering a collective community that prioritizes mental health and well-being.

Mental Wellness

A progressive shift towards communal mental well-being involves diverse factors and collective involvement at the individual, community, and strategic level. Spheres of influence on an individual's mental health and well-being involve psychological and biological factors; structural factors, such as sociocultural and environmental surroundings; and family and community networks (WHO 2023, 20). The World Health Organization states that addressing mental well-being



Spheres of influence on an individuals mental wellness

and healthcare disparities requires a transformation of social and structural exclusions to those with neurodiversities, who are often denied many social and civil rights. Furthermore, ensuring that services are accessible to all members of society through evidence-based social contact strategies to engage those with lived experiences, reduce community stigmatization, and promote systemic and self-advocacy (2023, 94). Prioritizing mental well-being by offering programs and tools to strengthen mental resilience is imperative at the public community level. The multisectorial nature of mental wellness stipulates that interventions and healthcare should also be provided across multiple sectors which extend beyond clinical and institutional care (WHO 2023, 19).

Current mental healthcare systems and programs focus on downstream solutions and treatments that cater to those who require immediate assistance or have previously accessed services. This downstream approach has subsequently neglected to consider public community care as an imperative infrastructure for communal mental well-being. Issues of inaccessibility are exacerbated by federal budget cutbacks for community-based programs, proliferating unreasonable wait times for those requiring mental health support in non-urgent capacities (Sloan 2023). This thesis argues for shifting the systematic and development efforts towards community-based, upstream preventative solutions, and awareness programs to alleviate the issues of accessibility, overcapacity facilities, and stigma associations. The WHO Comprehensive Mental Health Action Plan of 2013–2030 emphasizes community centered initiatives through a recovery-based approach involving promotion, prevention, treatment, and rehabilitation found within a communal sense of place: “Care should be coordinated across different levels and sites within and beyond the health sector, according to people’s needs throughout the life-course” (WHO 2023, 190).

Chapter 3: Historical Paradigm

Recognizing the present spatial and systemic structure of mental healthcare transitioning towards community-based care initiatives, this chapter investigates the historical recognition of mental health challenges and development of the institution. In the context of the historical evidence, the language used within this chapter is reminiscent of the time period to emphasize the treatment and societal views of those with mental health challenges and neurodiversities. Analyzing the historical implications of institutional facilities, stigmatization, issues of societal visual fixation, and the current treatment gap within mental healthcare will be defined.

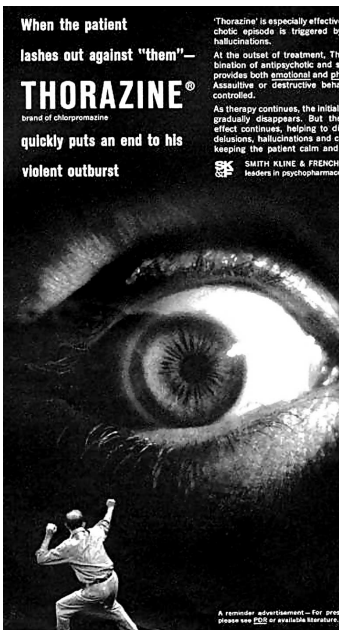
> There is no country, society or culture where people with mental illness have the same societal value as people without a mental illness (Rössler 2016, 1251).

Caricature of Bethlem Hospital from the 1700s satirises politicians as ‘lunatics’ chained to the wall in the ward (Rowlandson 1789)

The Institution

William Norris, a patient at the Bethlem Hospital, sketched from primary perspective (Arnald 1814)

The global phenomenon of mental illness and stigmatization can be traced to times of Ancient Greece when those who were viewed as mentally ill were shunned and locked away from society (Corrigan 2002). Hippocrates, a physician of the classical period, later theorized that the brain was the epicenter of thoughts, producing intelligence, emotions, and cause of mental illness (Ahonen 2014). The development of mental asylums and institutions in the eighteenth century began to shed light on the presence of psychological differences, however, these facilities perpetuated patient stigmatization and societal alienation. Michel Foucault details that “madness under the effect of confinement had really vanished from the classical horizon that it was ultimately stigmatized as non-being?” (1988, 57). The complete isolation of these individuals in treatment facilities, coupled with the inhumane corrective treatments and public display as caged spectacles, engrained societal views with lasting “powers of terror” (1988, 94). The Bicetre asylum located in Paris, France under the direction of Philippe Pinel was the first mental institution to implement new approaches of patient care and treatment reform through the removal of shackles and permissions to engage with the outdoor environment (Ahonen 2014). However, authoritative impositions, coercive methods, and victim-blaming ideologies remained steadfast with lingering similarities still present in today’s healthcare institutions.

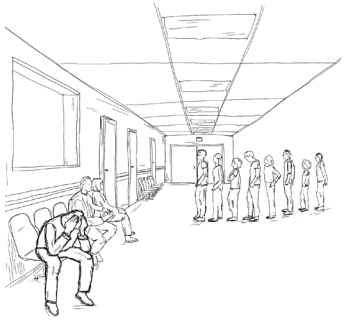


Thorazine advertisement for antipsychotic sedative drugs (Kline 1962)

> Structural discrimination of the mentally ill is still pervasive, whether in legislation or in rehabilitation efforts (Rössler 2016, 1250).

Stigmatization

Stigmatization continues to be one of the most apparent obstacles when accessing mental healthcare services and participating in support programs. Shame and fear of being labeled as someone with mental health challenges or addiction problems, prevents two in three individuals from getting the help they seek (Jacobs and Forsyth 2017). Prejudice against those with mental health challenges or neurodiversities can display in a variety of ways from subtilties to clear judgements or discriminatory actions. The American Psychiatric Association (2023) outlines three types of stigma including, public stigma, institutional stigma, and self-stigma. These three stigma typologies are further classified as the macro level, involving societal and media views, the intermediate level regarding healthcare professionals, and the micro level which include individuals with mental health challenges (Rössler 2016, 1251). Stereotypes and stigma in the case of neurodiversities have introduced and normalized harmful language and terms, such as “a mentally ill person” opposed to “someone with mental health challenges”. This prejudicial stereotyping diminishes all other qualities, as it characterizes a whole person as their psychological difference or perceived illness.

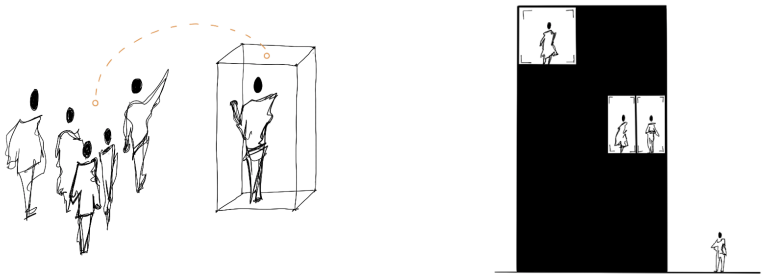


Institutional stigma that is associated with hospital patient care

Public stigma associated with digitally focused mental healthcare services

Self-stigma associated with macro and micro impacts of daily life

Lay concepts introduce conceptual models within society which attempt to provide an explanation for psychological differences. In relation to the cause of neurodiversities, lay concepts present a dichotomy between biological and psycho-social factors (Rössler 2016, 1252). Anxiety can be viewed as a psycho-social cause, where schizophrenia or bi-polar disorder is often regarded as a biological implication. These societal assumptions and lay concepts propagate the public desire to distance and isolate those with mental health challenges (Rössler 2016, 1252). Medical institutions and the pharmaceutical industry model further contribute to these lay concepts as they emphasize issues, behavior, and health remediation at the individual level. Thus, neglecting social and organizational context issues by promoting a 'victim-blaming' ideology (McLeroy et al. as cited in Baum 2008, 430).



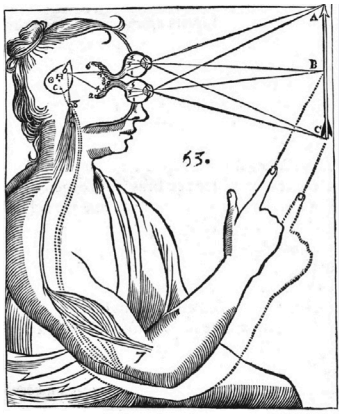
Patient stigmatization perpetuated by societal norms and spatial isolation within the mental healthcare systems

The spatial and systematic composition of hospitals, professional care offices, and support facilities embody isolation and stigmatization through a "closed door" approach and sterile environment. Goffman (1963) was a particular critic of the institutional healthcare system and facilities as he believed they advanced patient self-stigmatization and marginalization, rather than enabling

and integrating these individuals back into the community. Similar views were shared by Foucault (1988) who claimed that stigma associated with mental illness is a consequence of the institution and psychiatric organization, opposed to the actual implications of mental health challenges. A holistic wellness park that integrates and inhabits mental health services and advocacy programs into the public landscape, challenges the systematic and isolated organization of current institutional care. Fostering empathetic communities through visible support spaces, allows neurodiverse individuals to access the care they need in an environment and communal landscape absent of stigma.

Ocularcentric Era

Comparatively to prejudicial stigmatization, Western society currently exists in an era of ocularcentrism, where visual perception is regarded as priority, influencing and dictating cultural views and development. Cartesian theories of perception versus reality serve as an introduction to ocularcentrism, which is defined as privileging sight over other senses.



Cartesian diagram of sight
(Descartes 1644)

A Cultural Fixation

The twenty-first century introduction of social media and digital marketing has significantly contributed to this visual paradigm by influencing the ideology of how someone or something looks, directly correlates to its value. Cultural desires to present as a model citizen has furthered the avoidance of emotional factors and internalization of mental health issues due to fear of stigmatization (Ryff and Singer

1998, 3). Individuals and healthcare professionals often resort to prescribing medication as a quick and effective treatment, however, this encourages “false expectations in the population, wrong beliefs on the etiology and [mis] treatment of common psychological problems” (Migone 2017, 136). Subsequently, the popularization of prescription drugs dismisses the potential long-term health impacts and detrimental dependency issues, while also neglecting psychotherapy as a viable treatment alternative. This paradox remains a challenge due to the immense influence on the medical discipline from pharmaceutical industries who profit greatly from prescribed drug treatments (Migone 2017, 137). The line of responsibility between social order and the medical profession becomes blurred, as there are strong tendencies to define all psychosocial problems and medical problems (Ryff and Singer 1998, 81).

Individualization

Preferential treatment of form over function, driven by ocularcentric priorities and the pharmaceutical industry is also evident within the discourse of healthcare architecture. Confining hospital environments, psychological services isolated in buildings, and promotion of support programs online, indicate that health issues should be treated and regarded as private matters. Encapsulating the ocularcentric ideals of mental health treatment, Morrisseau states that “We valued this secrecy as though it were our protection from forces that could ultimately destroy us, yet it was that very secrecy which would, in fact, be our destruction” (1998, 58). The seclusive and sterile nature of healthcare facilities disregards the healing potential of empathic communal

environments and the necessity of personal support systems. Pallasmaa (2012) critiques contemporary architecture as it is curated around visual appearance, but does not consider the emotional or phenomenological engagement. Thus, it limits the impacts of the built environment to a surface level interaction being “one of distance and exteriority” (2012, 33). The commodification of visual experiences has skewed cultural values and influenced developments that lack true meaning and the desensitization of reality. Spatial design profoundly influences human behaviour, interactions, and development. Therefore, contriving architecture based upon the conscious and unconscious desires of the occupants affords emotional and communal engagement that extends beyond the eye (Pallasmaa 2012, 29).

The Lovers: in heightened emotional states and deep thought, vision is repressed as other sense overtake (Magritte 1928)

In continuum with the historic paradigm, neurodiverse individuals face numerous barriers when accessing support and adequate services due to stigmatization and isolation. The current mental healthcare model lacks empathetic and socially responsive infrastructure, as treatment approaches emphasize remediation at the individual level, neglecting the importance of community support measures. It is paramount to recognize that the mind and body do not exist as separate entities. Spatial qualities and perceived atmospheres must harmonize with the human scale in order to produce a sense of place through emotional communication and closeness (Gehl 2010). The design and organization of space and landscape can both promote and restrict communal utilization and psychological engagement. Shifting away from this ocularcentric era that currently dominates cultural and spatial development allows the mental, emotional, and physical needs of users to be equally prioritized. The predominant individualization of institutional mental healthcare within current society has established a treatment gap when providing accessible and responsive community care and support networks.

Chapter 4: Theoretical Basis

In contrast to institutional driven stigma, the identified correlation between mental well-being and communal support networks allows Urie Bronfenbrenner's ecological systems theory and the social determinants of health to serve as a theoretical foundation when recognizing the impacts of one's environment. Ecological perspectives offer a simultaneous emphasis on the individual, the surrounding contextual systems, and the dynamic interplay between both entities. This chapter examines the concepts of environmental psychology, the social determinants of health, and the role of community in supporting those with neurodiversities.

Environmental Psychology

Aligning with Gifford's theory of environmental influence on human behaviour, Urie Bronfenbrenner's theory and informed interventions aim to go beyond targeting the individual to the broader social environment (Eriksson, Ghazinour, and Hammarström 2018, 424). The Process-Person-Context-Time model was revealed in phase three of Bronfenbrenner's theory, which was developed between 1993 and 2006. This model involves proximal processes, which are defined as the reciprocal interaction between the individual, other people, surrounding objects, and the immediate environment (Eriksson, Ghazinour, and Hammarström 2018, 420). Proximal processes were highly regarded as a powerful predictor of human development, as Bronfenbrenner intended to demonstrate how individual characteristics, when paired with environmental aspects, influence proximal

processes. Studies applying concepts of Bronfenbrenner's theory conducted by Liem, Cavell, and Lustig (2010) and Williams and Nelson-Gardell (2012) revealed that peer and family support, when in tandem with an individual's capacity to recognize and access resources, is critical in combating declines in psychological health. Bronfenbrenner emphasized the importance of reciprocal face-to-face interactions when supporting those with mental health challenges. Williams and Nelson-Gardell's (2012) research further reinforces that when promoting mental resilience, interventions that focus on support, proximal processes, education, and financial affordability are most effective for neurodiverse individuals. The complexities of mental health challenges and the ecological system needs of the public require recognizing social inequalities of the healthcare system and the effects of space and place on psychological and physical health (McLaren and Hawe 2005, 429). Both Gifford's and Bronfenbrenner's theories of environmental and reciprocal interactions are further supported when analyzing the correlations between the social determinants of health and mental well-being.

Social Determinants of Health

The social determinants of health involves a framework that is derived from the concept of "social gradient", in which those with an identified lower social and economical status are at greater risk of health challenges and reduced life expectancy (Alegria et al. 2018, 3). This is in comparison to those with a higher social and economic status, in which their position will have a more positive outcome on their physical and mental health that is compounded over time.

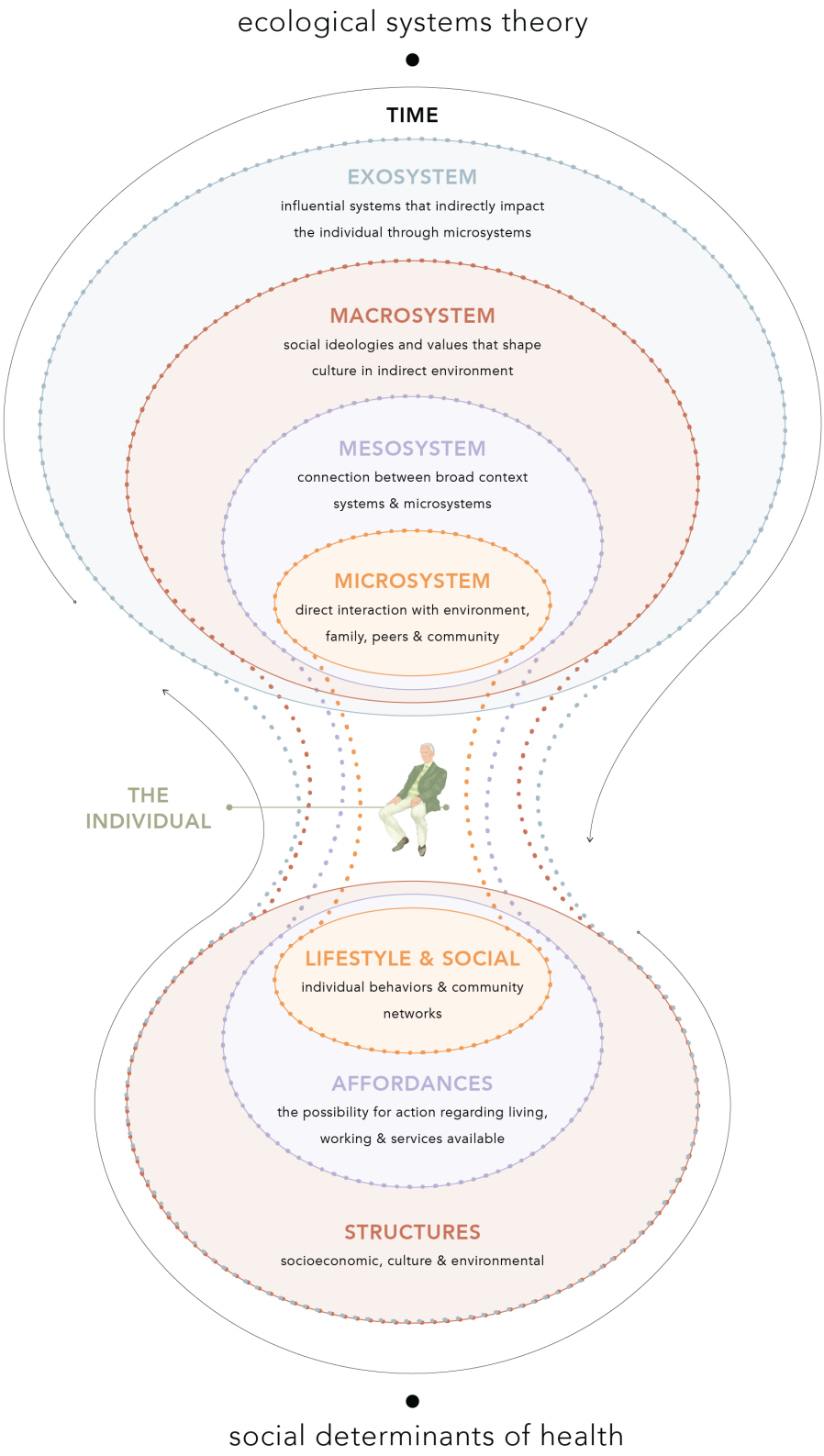


Diagram illustrating the overlapping concepts of Bronfenbrenner's theory and the Social Determinants of Health, both placing the individual at the center

The social determinant framework is imperative to assess when considering mental health, as the social gradient can influence risk of neurodiversity development and one's ability to access services and proper care. Consisting of a three-tier framework, the social determinants of health include structural factors, communal affordances, and lifestyle and social contributors. Structures include socio-economic and political position of one's country and or community, as well as cultural and environmental factors which can influence the physical and psychological well-being of an individual. Affordances include the possibility for action regarding if an individual's living conditions are adequate, education opportunity, the ability to work, and engage with and access proper health services. Lastly, lifestyle and social factors such as if an individual's behavior and community network provide a basis for social, physical, and mental well-being. Mental health challenges and social determinants can fluctuate in tandem, as poor living conditions, political turmoil, and or lifestyle habits can all affect the psychological position of an individual (Alegria et al. 2018, 56). Therefore, when assessing the systemic and structural role of institutional and communal mental healthcare, it is paramount to also consider external factors which contribute to social determinants. Approaching mental health care and treatment from a holistic perspective will ensure that the whole person is being treated, rather than just the illness. The role of community and environment not only contributes in supporting and aiding the mental well-being of an individual, but also builds awareness, resilience, and collective mental health care reform.

The Role of Community

Despite the historical paradigms of isolative psychological treatment, community networks are instrumental when assisting and supporting those with mental health challenges. Maintaining personal autonomy is a frequent obstacle for neurodiverse individuals, particularly when engaged in institutionalized care and authoritative treatment methods (Landeweer 2018, 148). Community integration through group programs and peer-to-peer interactions stimulates social skills, strengthens social networks, and offers personal identity and independence. However, if professionals assume the expected presence or empathetic support of personal networks, this may allocate care responsibilities to unstable or non-existent networks. Elleke Landeweer argues that personal and community networks are taken for granted by professional healthcare systems when transitioning roles and obligations away from the institution (2018, 148).

Although individuals with psychological challenges greatly benefit from social and familial network interactions, if these support systems are not adequately educated or prepared to take on responsibilities, a cascading impact cycle may develop. Assumed care for those with mental health challenges and responsibilities of personal networks continue to remain in the private domain due to societal constructs derived from prejudicial role assumptions (Landeweer 2018, 152). Neo-traditionalist views of care stem from the archival role of a parent, such as declaring that a mother's moral obligation is to take care of the child (Tronto 2013, 152). However, a democratic approach to sharing responsibilities through communal involvement

provides a more sustainable approach that fosters clarity and efficiency for those needing support.

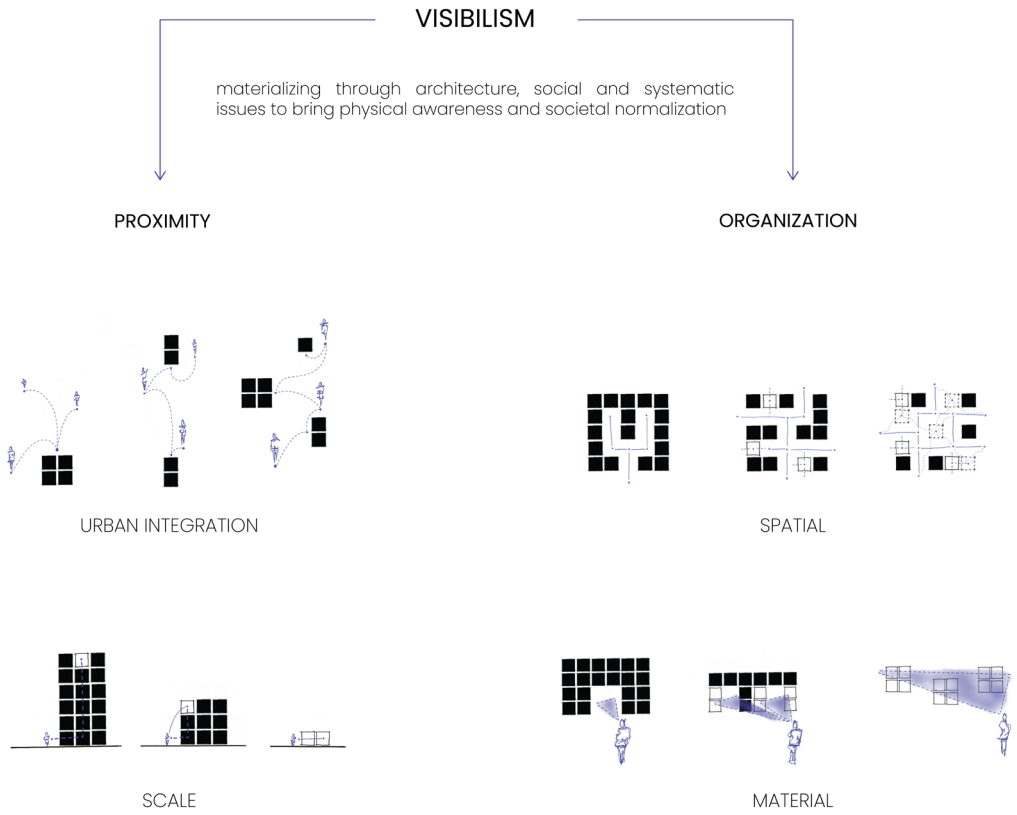
> I speak of community as if it were a living entity, and rightly so, for a community has a life of its own. It is made up of many individuals tied together through a collective desire to live in a type of harmony (Morrisseau and Trinkaus 2000, 48).

Marian Barnes (2015) proposes networked care, which suggests an interdependent support system and equitable care responsibilities to alleviate the pressures of presumed onus (Landeweer 2018, 151). A five-step process for care and corresponding moral values identified by Joan Tronto suggests a path forward when developing effective communal support systems. This process includes caring about; identifying needs, caring for; requiring action, caregiving; requires moral competence, care receiving; involves responsiveness, and caring with; requires solidarity and involvement (Tronto 2013, 22). Recognizing Tronto's proposed care system subsequently brings to question the role of the built environment when providing adequate public space and communal landscapes to facilitate these network interactions.

Chapter 5: Deinstitutionalization

Affordances

Intersecting the role of community and environmental psychology, communal mental health systems and architectural affordances will be investigated through the applications of deinstitutionalization. Building upon Gibson's definition of affordances, the opportunity for mental health and support networks will be afforded by structured social and environmental landscaped systems (1979, 3). The architectural translation of affordances will provide self-determined healing by integrating varied levels of visibilism and porosity from the public urban environment scale to the personal scale. Derived from the mental wellness research and theories outlined in the previous chapters, this thesis proposes a mental wellness network of architectural and programmatic spaces implemented within the language of the figure ground landscape. Utilizing the primary form language of the environment and topography, this urban park will offer diverse resources and mental wellness spaces, in which individuals have the agency to choose which programmed element caters best to their current psychological needs. This chapter explores how communal mental wellness and deinstitutionalization can manifest through urban visibilism, program proxemics, and self-agency.



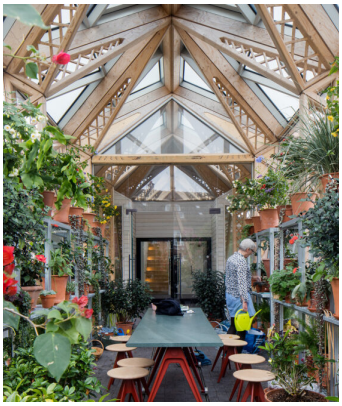
Diagrammatic types of visibilism within an urban environment and architectural intervention

Visibilism

The isolative systems of patient treatment and confining spatial attributes of institutional healthcare have been identified to promote stigmatization and ocularcentrism. However, the theory of visibilism offers tools to counteract these present issues. Derived from Dr. Peter Rudiak-Gould's proposition of constructive visibilism in relation to climate change, he states that "Climate change is neither inherently invisible nor inherently visible; it is, like all other objects, made visible" (2013, 128). This thesis suggests a parallel application of Rudiak-Gould's climate change visibilism to mental healthcare visibilism. Although mental health awareness and neurodiversities are present within our communities, segregating these individuals from the public realm undermines their personal value and diminishes the opportunity for community involvement.

Maggie's Care Centre in Manchester, United Kingdom (Maggie's Centre 2023)

Maggie's Care Centre community kitchen (Maggie's Centre 2023)



Maggie's Care Centre greenhouse (Maggie's Centre 2023)

Implementing a holistic wellness park situated within the urban landscape provides visible recognition, awareness of mental health, and welcomed support to re-engage those experiencing challenges. As the stigmatization of mental illness deters individuals from seeking assistance, establishing services that are visible and engaged within the urban landscape and community promotes acceptance, empathy, and normalization of the neurodiverse. The architectural application of mental health care visibilism can materialize through situating resources in appropriate locations and physically ingraining wellness programs into the fabric of the urban environment. Ensuring access from public transportation routes, close proximity to current institutional facilities, and evident indications of services through spatial design will stimulate community involvement and societal acceptance.

The Maggie's Cancer Support Centre in Manchester, England demonstrates successful applications of communal re-engagement and visibilism through a spatial design that embodies accessible and comfortable healing driven through communal support and environmental integration. Situated just outside of the city center, the Maggie's Centre is within walking distance to two major hospitals and public transportation routes. The design of the Centre intends to provide a place of physical and affective sanctuary where the "environment assumes a form of agency, acting as a calm presence or 'silent carer' in the individual's encounter with a cancer diagnosis" (Maggie's Centre 2023). The deliberate domestic scale and informal design of the building integrate principles of visibilism to provide relief and support without the pressures of institutional dominance.

> We need to think of all the aspects about a hospital layout which are so demoralizing: the closed doors implying secrets withheld, the endless corridors, the signposting, the artificial light, and then unpick and unravel these (Maggie's Centre 2023).

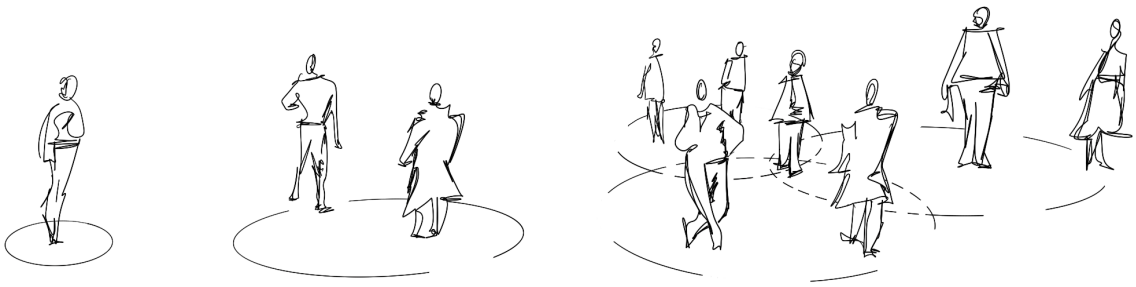
Emerging as the antithesis of the hospital, services provided at Maggie's do not require referrals or appointments. The organization focuses on accessibility and supporting the individual in all capacities, as opposed to emphasizing their specific diagnosis. Aiming to eliminate emotional and physical isolation, the design and spatial organization integrate diverse levels of visibilism that "think about the degree to which people want to be private, to offer them corners to tuck up in with a book, but also places where they can sit and watch, but not necessarily join in" (Maggie's Centre 2023). The empathetic nature of the programs offered allows individuals to engage in an environment that is cognisant of health challenges and recovery needs. Derived from Maggie's blueprint, design methods that apply spatial visibilism and conscious programs embedded into the public realm can strengthen community networks, support those with neurodiversities, and re-engage those who feel isolated and neglected by current mental healthcare systems.

Proxemics

Principles of proxemics contribute to the physical application of mental health visibilism through designing empathetic environments that are conscious of the varied needs of neurodiverse individuals. Proxemics involves the study of how occupants utilize and perceive space, dependent on individualized needs and socio-cultural contexts

(Hall 1973). Accommodating for diverse levels of social interaction and stimulus through design, provides spatial opportunities based on the level of comfort and engagement desired. Affording neurodiverse individuals and vulnerable populations space to re-engage and interact with large groups, as well as intimate areas of refuge, promotes self-agency and autonomy over one's healing journey.

Anthropologist Edward Hall (1973) proposes a proxemics framework detailing various zones of personal space. Public zones engage distances beyond twelve feet, appropriate for public interactions where physical distancing is desired. Social zones range from a four- to twelve-foot separation, suitable for gathering and interacting with acquaintances. Personal zones involve distances between eighteen inches and four feet, commonly recognized as personal interactions between friends and relatives. Intimate zones range from zero to eighteen inches, typically encountered with partners or close family members. Identifying and applying the principles of proxemics within spatial landscapes and social system design is valuable when providing users accessibility and affordances, in addition to fostering familiarity among individuals. Proxemics suggests the concept of nonverbal communication among unfamiliar people, known community members, and close friends and family. Offering a public



Intertwining proxemic networks from the individual, to the community, and the collective

space to interact and engage within support programs where the user does not feel pressured to participate, fosters willing interaction and self-determination.

The Trusted Strangers project concept proposed by Atelier de Lyon exemplifies proxemic zoning throughout twelve connected barges docked at the New Amsterdam Park in the Netherlands. These repurposed barges serve as a new type of landscape that individuals can inhabit and reclaim as an extension of the community. The design engages a range of activated programs aimed at gathering various socio-cultural groups through mixed spatial configuration and fluid circulation. The intention is to establish an individual sense of place through personal refuge zones on each barge, yet encourage exploration and spontaneous interactions throughout social and public program zones. Integrating varied levels of visibilism, porosity, and conscious barge zoning, allows users to interact dependent on their degree

Trusted Strangers proposal render of the barges dock in New Amsterdam Park
(Atelier de Lyon 2010)

of comfort, while also prompting intrigue to participate through spatial visibilism. Trusted Strangers offers insight, methodologies, and design principles when developing community networks and landscape support systems based on the needs of the individual and the collective.

The application of visibilism and proxemics establishes the fundamental aspects of personal agency. Essential to human development and independence, agency supports self-efficacy and empowerment of an individual to pursue their own desires and needs. Alegria et al. suggest that interventions designed with “Heterogeneous social networks consisting of individuals with varying degrees of susceptibility and awareness—increase network resilience” and demonstrate mental health improvements (2018, 85). Affordances of psychological support and deinstitutionalized systems within the urban landscape serve as the catalyst to redirect and transform mental healthcare into a public amenity.

Fostering Sense of Place

Belonging and emotional connection to places and people are rudimentary elements of human needs. A sense of place found within a physical environment provides tangible refuge for those who seek comfort. For neurodiverse individuals and those experiencing psychological challenges, support systems and mental health services provided in a familiar community setting are imperative to their healing journey (WHO 2023). The significance of elemental thresholds and spatial domestication will be the focus of this section to inform how a fostered sense of place can provide refuge and release for those who seek psychological and communal support.

Elemental Thresholds

Elemental thresholds serve as a preface to spatial perception, as they organize and choreograph the boundaries of landscape, space, and human expectation (Boettger 2014, 10). Thresholds can offer definition to expansive environments and diverse programs through a combination of signifying stereotomic, tectonic, and landscaped features to form a new place in the city. Designed by Mies van der Rohe, the Neue Nationalgalerie located in Berlin exemplifies the guiding principles of blurred thresholds, as the limits between interior and exterior space have become negligible. However, thresholds possess “complex spatial sequences and spatial structures” that provide control and user security, contributing to a signified sense of place (Boettger 2014, 10). As users are guided throughout an environment, thresholds orient an individual in space, as well as recontextualize programmatic shifts. In the scope of mental well-being, an array of thresholds limits a continuum of space, which is often overwhelming and evokes placelessness for neurodiverse individuals (Boettger 2014).

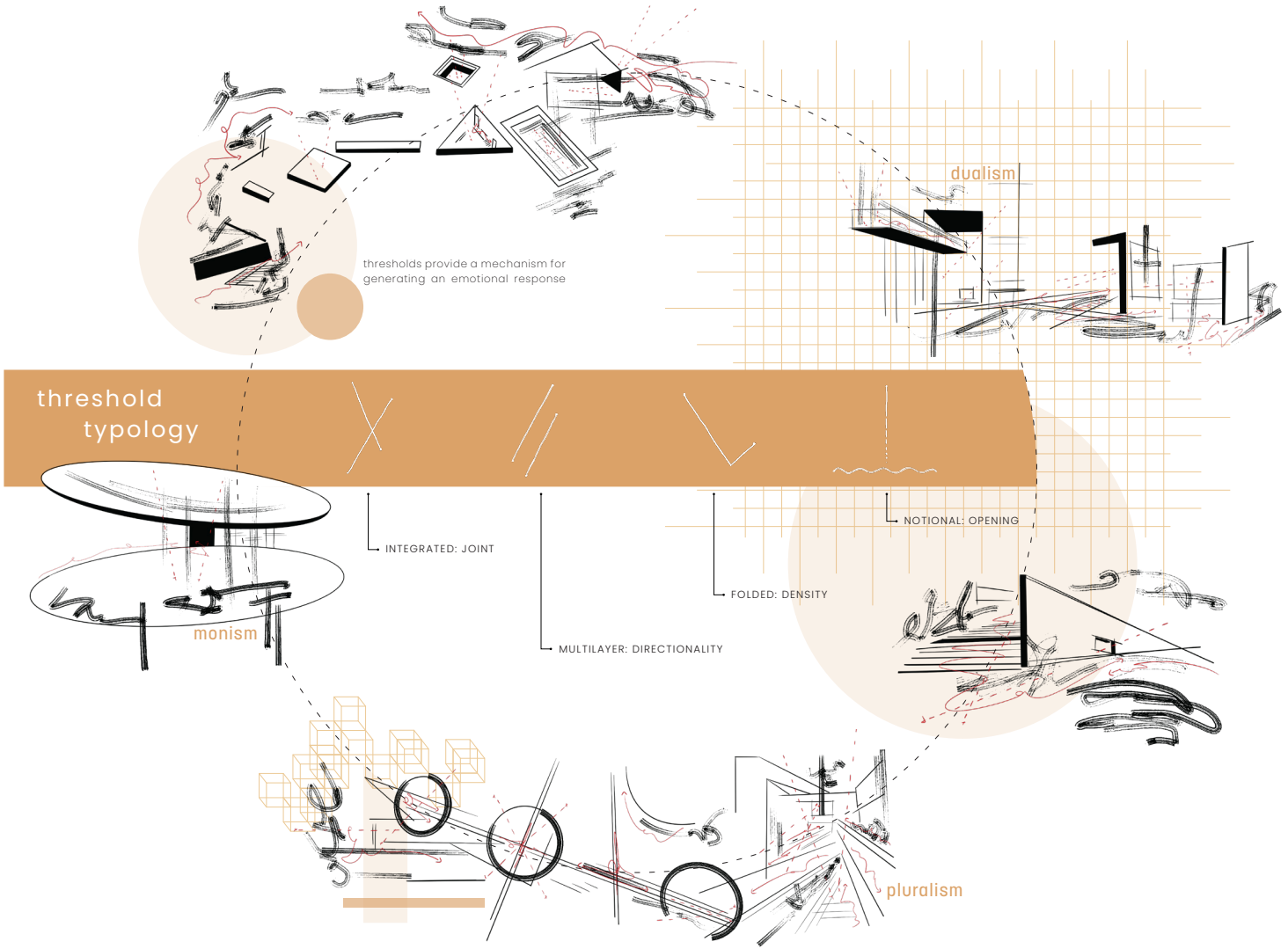
Thresholds provide a mechanism for generating emotional responses, and depending on the level of privacy, transparency, and or security, a threshold can serve as an invitation to engage. Tadao Ando’s principles of thresholds suggest three architectural typologies: monism, dualism, and pluralism (Farhady and Nam 2011, 31). In parallel with the type of threshold, as the opportunity to interact through spatial or landscaped openings increases, the circulation throughout an environment also intensifies. Contributing to mental healthcare visibilism and proxemics, prominent thresholds within the public realm can signify and serve as

a beacon of psychological support and communal systems. When designing mental wellness services, spaces, and landscapes that engage community interaction, ensuring that thresholds are not intimidating from exterior perspectives or isolative from the interior promotes ease of use to vulnerable populations (Maggie's Centre 2023). The dialogue between thresholds and circulation paths is imperative in the public realm to connect passerbyers, programmatic networks and cross-cultural engagement. Contributing to the design development of a holistic wellness park, integrating elemental thresholds within a primary figure form and inhabited landscape clearly identifies areas for re-engagement, release, and refuge to afford a dynamic support system for those with mental health challenges. The continuous language of an inhabited form also further emphasizes elemental thresholds within the landscape and provides recognition of a new place in the city for those who seek mental health support.

> In other words, here, the thresholds are transitional points where surfaces interface with each other, or the place where the forms open up to the surrounding context. Therefore, the threshold is not static. On the contrary, it has dynamic movement in its spatial composition (Farhady and Nam 2011, 32).

Spatial Domestication

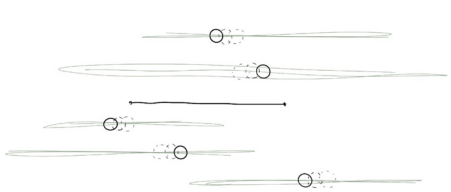
Spatial domestication suggests an architectural design concept which resonates as familiar and comfortable to the engaged individual. Physical environments have the capacity to extend beyond the preliminary function as refuge, through connecting with users in an emotional and phenomenological sense. Contrary to the imposing and authoritative nature of institutional care facilities, when

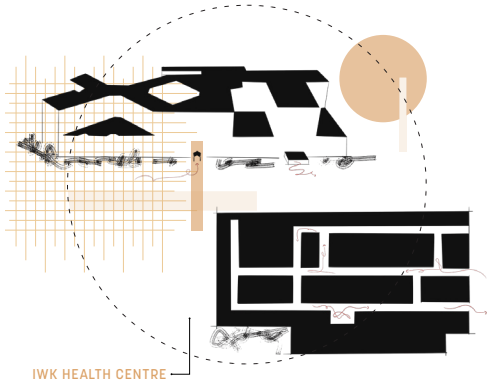


Illustrated diagram of Tadao Ando's threshold principals and case study analysis of thresholds and circulation patterns

monism

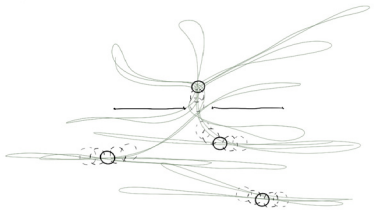
private : directed circulation

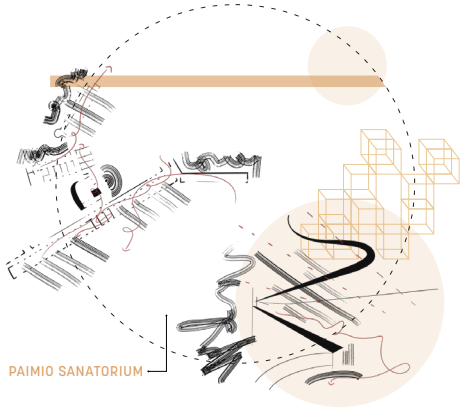




dualism

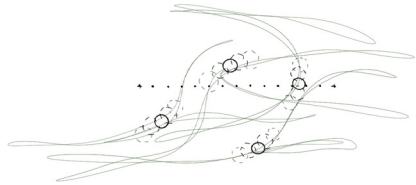
semiprivate : dense circulation

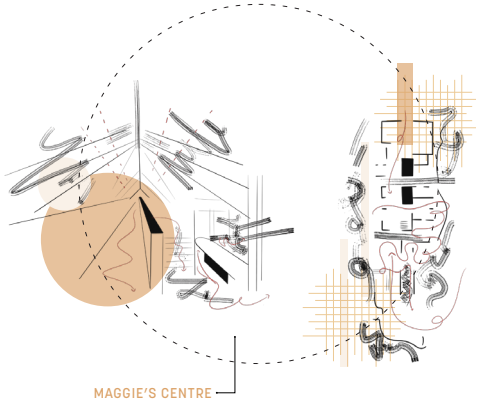




pluralism

public : fluid circulation





Analysis of the IWK in Halifax, Paimio Sanatorium, and Maggie's Manchester, applying Ando's threshold principals

space and landscape are domesticated and resemble features similar to a home, this promotes users to feel more welcomed and positively affects their mental well-being (Maggie's Centre 2023). As neurodiverse and vulnerable individuals can experience challenges of self-efficacy, domestication encourages ownership and a sense of control, particularly in public environments (Landeweer 2018, 148). A sense of place cultivated through a figure ground landscape, approachable building scale, materiality conscious of neurodiverse stimuli, thresholds, and proximal support networks fosters community cohesion and individual identity. When people are connected to a landscape and space naturally, the likelihood of participation and success of programmatic intentions are increased (Kellert 2005, 123).

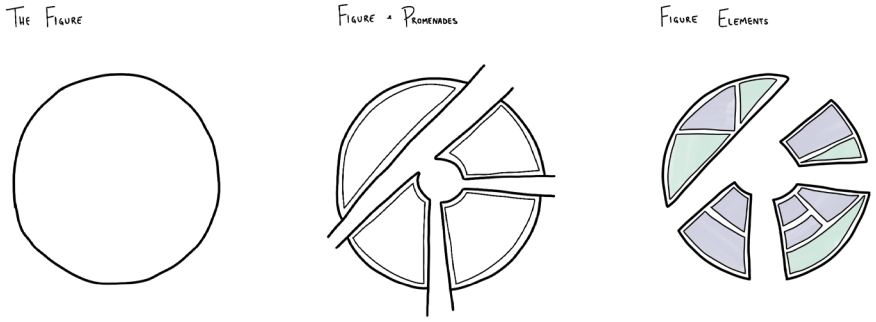
Pallasmaa suggests that humans innately have the psychological desire to "grasp that we are rooted in the continuity of time, and it is the task of architecture to facilitate that" (2012, 32). Criteria of spatial domestication within public wellness amenities and landscapes include adaptive environments that integrate cultural sensitivity and a found sense of place that is informed by community context. Connectivity to the natural environment through designing architecture that is integrated both on and within the landscape deinstitutionalizes the typical qualities of mental healthcare facilities. Emotional resonance through evoked familiarity, such as community kitchens and social areas resembling living rooms and backyards, offer the potential association with nostalgic memories (Pallasmaa 2012, 40). The accumulation of these design elements contributes to a succinct connection and sense of place found between the anchors of the program elements and flows of the users

and natural landscape. The design of Maggie's Centres illustrates this idea of spatial domestication by proposing a kind of non-type: "It is like a house which is not a home, a collective hospital which is not an institution, a church which is not religious, and an art gallery which is not a museum" (Heathcote and Jencks 2010, 14). An inhabited figure ground landscape composed of elements for refuge, release, and re-engagement choreographs a natural urban environment that eliminates spatial disconnection and overcomes the sense of individual isolation. Domestication and deinstitutionalization within a community wellness park affords a place of belonging that removes the barriers of spatial intimidation for those seeking refuge, mental reprieve, and support services.

> Freed from the formality of reporting to a reception desk, people walk into Maggie's as individuals in their own right, rather than patients to be processed - It removes the boundaries of 'care-giver' and 'care-receiver' and becomes an exchange between equals (Heathcote and Jencks 2010, 48).

Chapter 6: Healing Landscapes

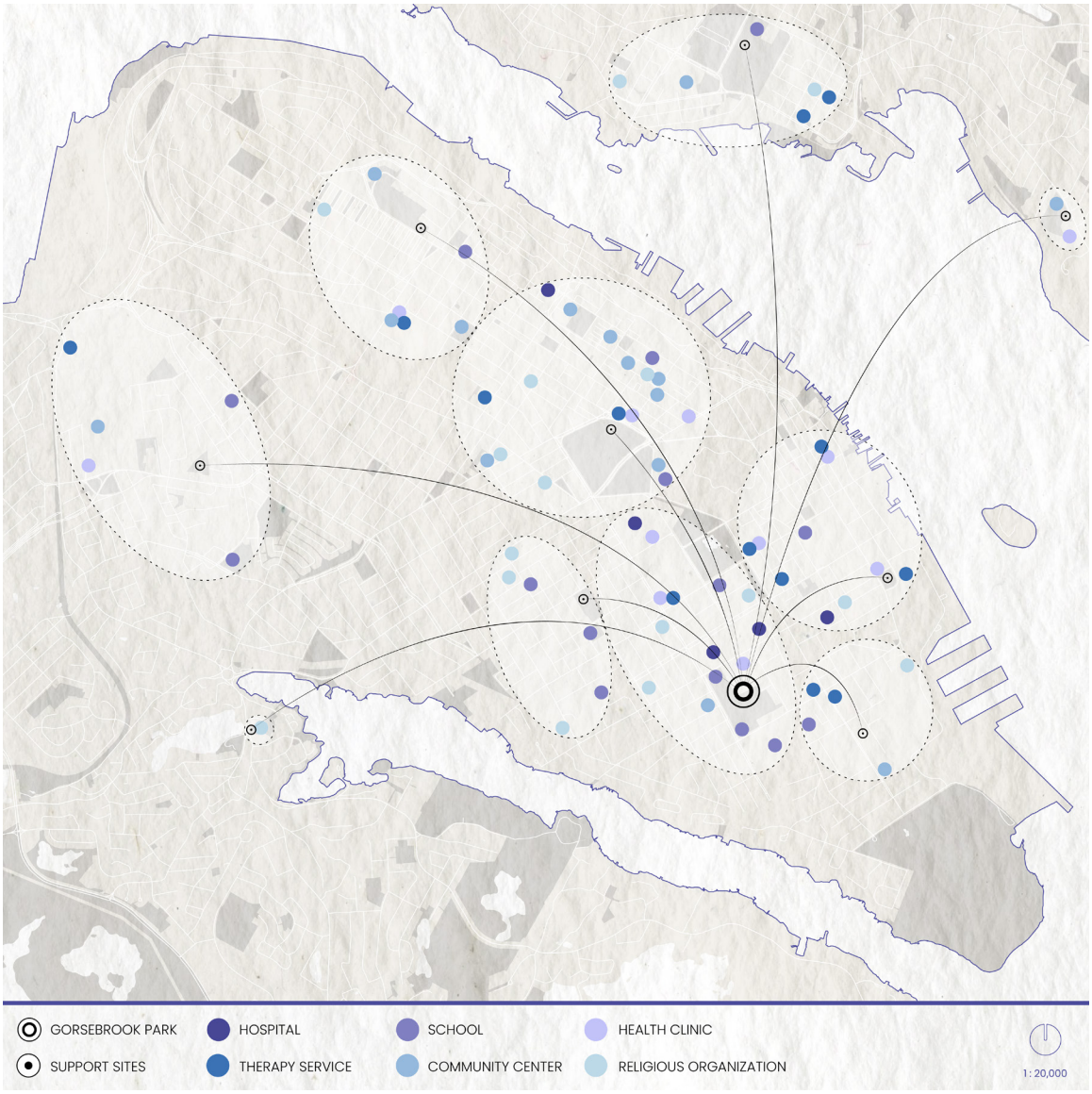
Combating the paradigms of stigmatization and isolation incurred by individuals who experience mental health challenges, this thesis proposes reform of societal and systematic norms through an architectural language of inhabitationintegrated within the natural environment. The application of a mental wellness park immersed into the urban landscape will serve as a public amenity for mental health and community wellness. Established through the theoretical and conceptual frameworks, this design proposes methods of deinstitutionalization through an inhabited landscape form that offers communal visibilism, engagement, and proxemic organization. The intent of the design is to provide the community a collective spatial landscape to refuge from the mental challenges of daily life, release their psychological burdens, and re-engage within a community that prioritizes the mental health of all. This design offers various programmed elements that inhabit the figure ground landscape to provide users agency and a self-determined healing journey. Orchestrated throughout Gorsebrook Park, this thesis will serve as a beacon of accessible and community-driven mental health care, amongst the institutionally dense surrounding environment.



Diagrammatic exploration of the figure, promenades, and elements of the figure

Site

Gorsebrook Park located in Halifax, Nova Scotia, has been chosen as the design application site for this holistic wellness park. Spanning an entire city block, this park is situated at the intersections of South and Robie street, and Wellington and Inglis street. This site provides a diverse environmental and social demographic landscape, as it is surrounded by institutions, residential homes, and commercial businesses.



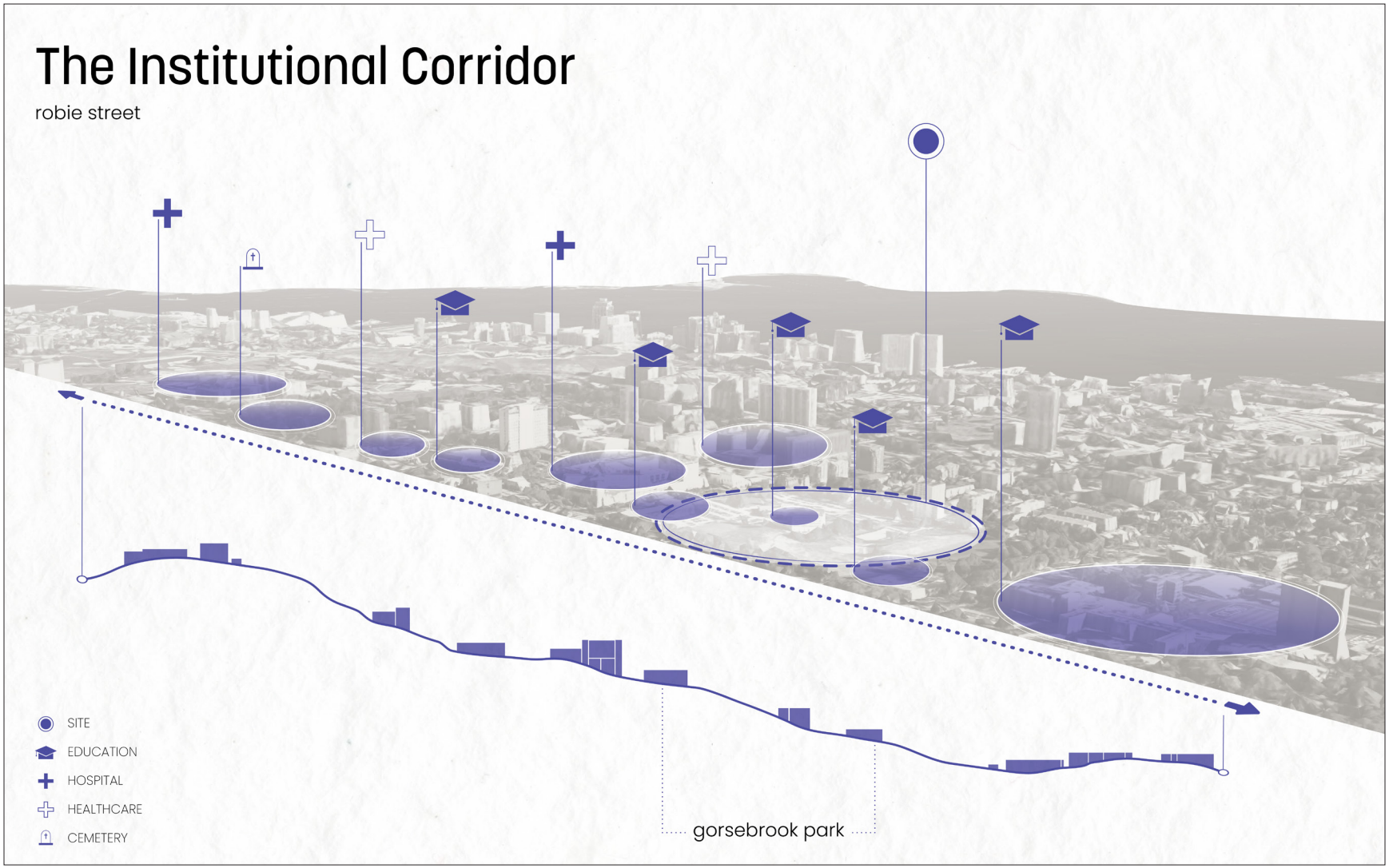
Context map identifying Gorsebrook Park, institutions, and alternate design applications in Halifax

Institutional Corridor

The institutionally condensed corridor along Robie street links multiple hospitals, medical facilities, schools, universities, and Gorsebrook Park together. However, the architectural composition, attributes, and scale of these institutional facilities impose greatly on the urban landscape and neglect the rudimentary and psychological needs of the individuals and community utilizing these services. As Gorsebrook Park offers ample greenspace, in combination with the design proposal's focus on communal mental health, this site provides a succinct juxtaposition and setting for urban deinstitutionalization.

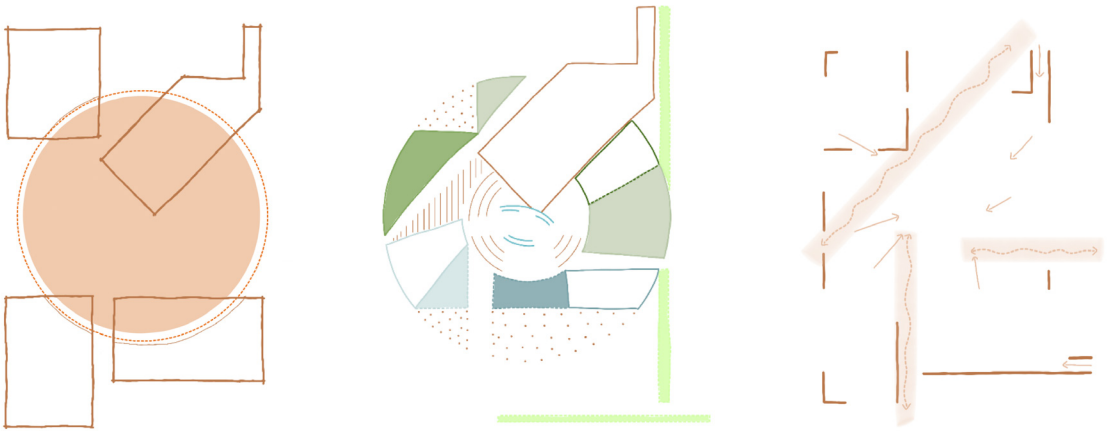
Figure-Ground Inhabitation

This thesis proposes a modified topography of Gorsebrook Park as an organizational tool to identify a new room in the city through the inhabitation of the figure-ground landscape. A circular figure emphasized through the topography is utilized as the primary form language to inform the conditions of the architectural elements. Embracing the surrounding context, the figure integrates the existing programs within the site, while also introducing new architectural and landscape elements to complete the notion of a new place for mental health within the community. A paramount design consideration was to ensure that this site was not foreign to the community and that individuals can feel comfortable to utilize the landscape and programs that are previously known to them. Therefore, identifying familiar elements such as the school, the house, and the playground within the site, in tandem with the addition of the citadel and the architectural and landscape elements allow individuals to find psychological solace in a deinstitutionalized environment.

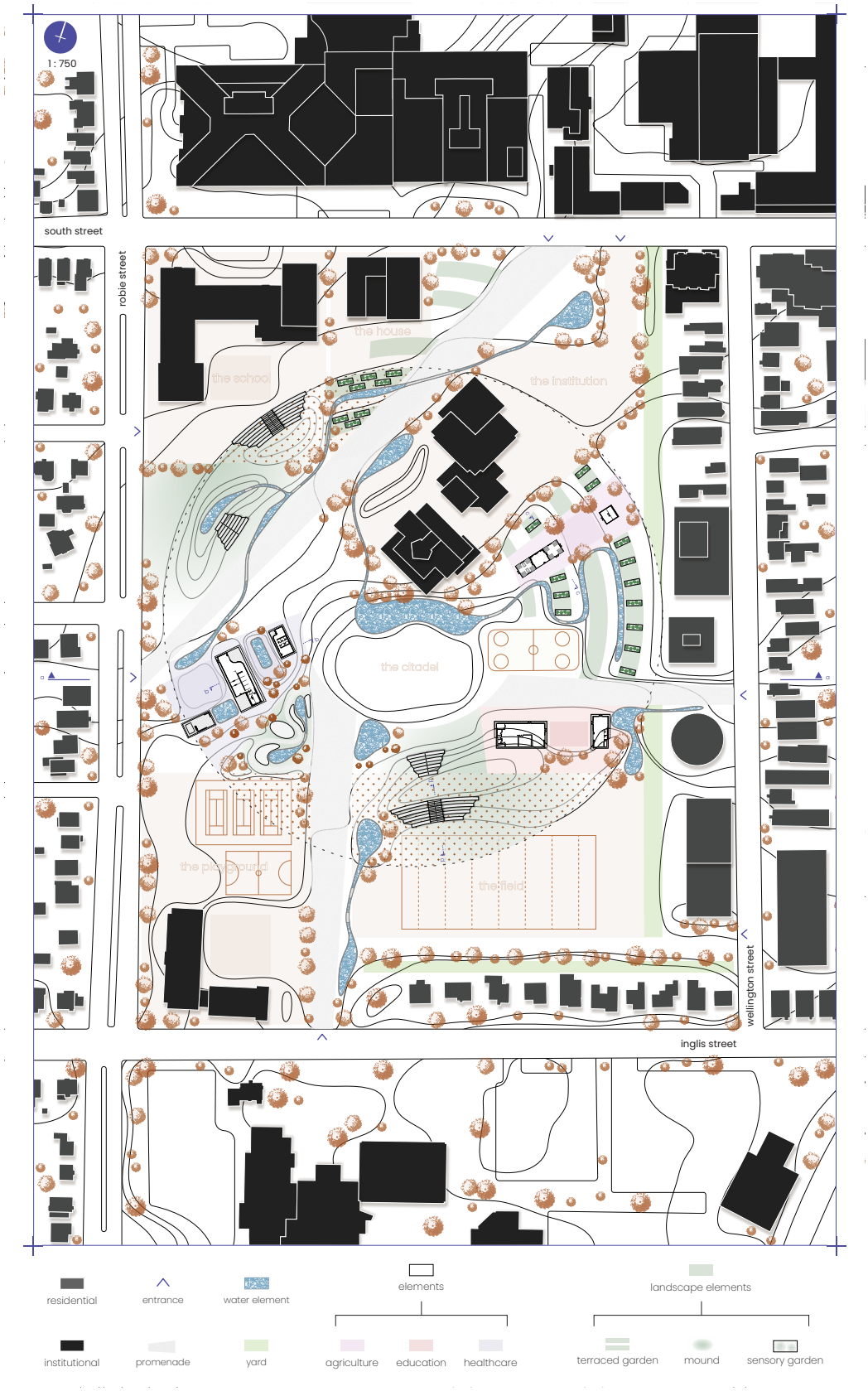


Identified institutional facilities along the Robie Street corridor and interruption of Gorsebrook Park

The figure-ground landscape has been inhabited in a manner that is not imposing on the community or individuals utilizing the space, as the intention is for people to explore and engage at their leisure and comfort level dependent on their psychological health status. Located within the site is Gorsebrook Junior High School, Inglis Street Elementary School, the Atlantic Provinces Special Education Authority, the Canadian Cancer Society Lodge that Gives, the new Ronald McDonald House, and multiple residential homes and large apartments. The proposed design forms a topographical figure that intends to contrast the existing site that is currently severed into disconnected quadrants of parking lots, greenspace, and unorganized activity zones, as well as oppose the linear and confining spatial nature of the institution. By figuratively opening up, organizing, and connecting the entire site through the circular form, this allows Gorsebrook Park to establish itself as a new room in the city. Through integrating both on and within the natural landscape, the existing buildings, proposed support-based programs, and surrounding context form a cohesive figure, revealing an architectural language that prioritizes communal mental wellness.



Primary illustration of the figure zones, elements of the figure, and site boundaries

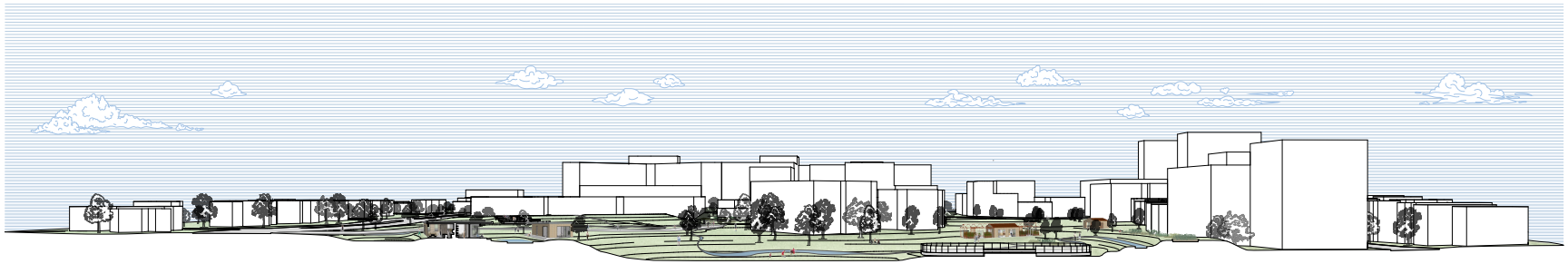


Master Plan: The inhabited figure ground landscape of Gorsebrook Park

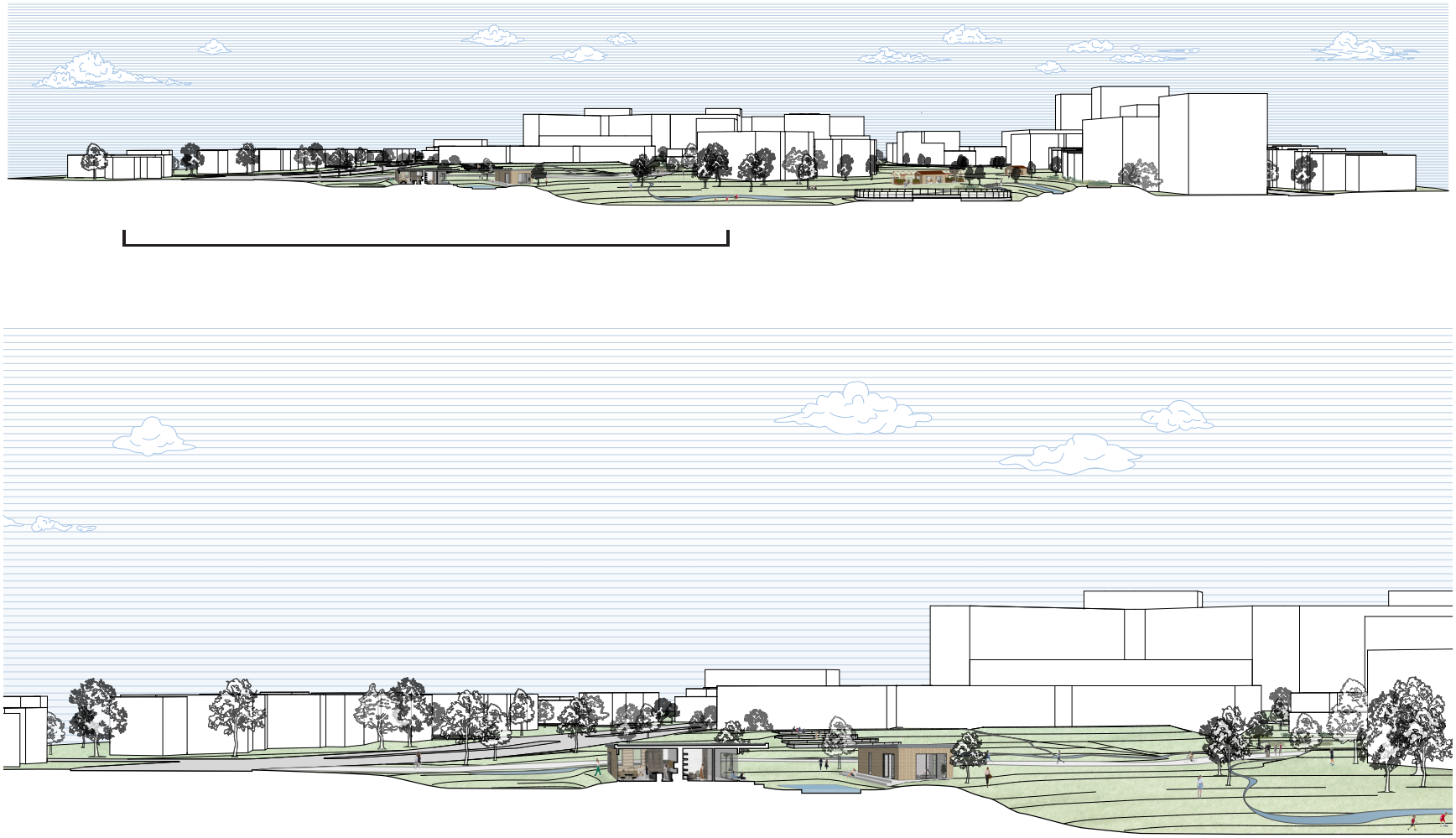
Figure Elements

As the circular shape of the figure-ground organizes and informs the various architectural and landscape elements, this provides an identifiable sense of place and structures user orientation when navigating the outdoor environment. The elements of the figure include the three primary promenades, a community healthcare centre, an agricultural centre, and an education centre, terraced gardens, observation mounds with terraced seating, a sensory garden, and the existing institutional buildings and sport court. The visual connectivity and proximity of these program elements across the landscape offers users agency to choose which service or space caters best to their physical and psychological needs. The topographical condition of each figure element has informed the architectural attributes of the program and established adjacencies between existing context and other implemented support programs. The radiating lines of the circular figure not only informs the type of architectural inhabitation, but also deinstitutionalize the structural grid by distorting and contrasting the imposition and authority as experienced in a typical institutional corridor.

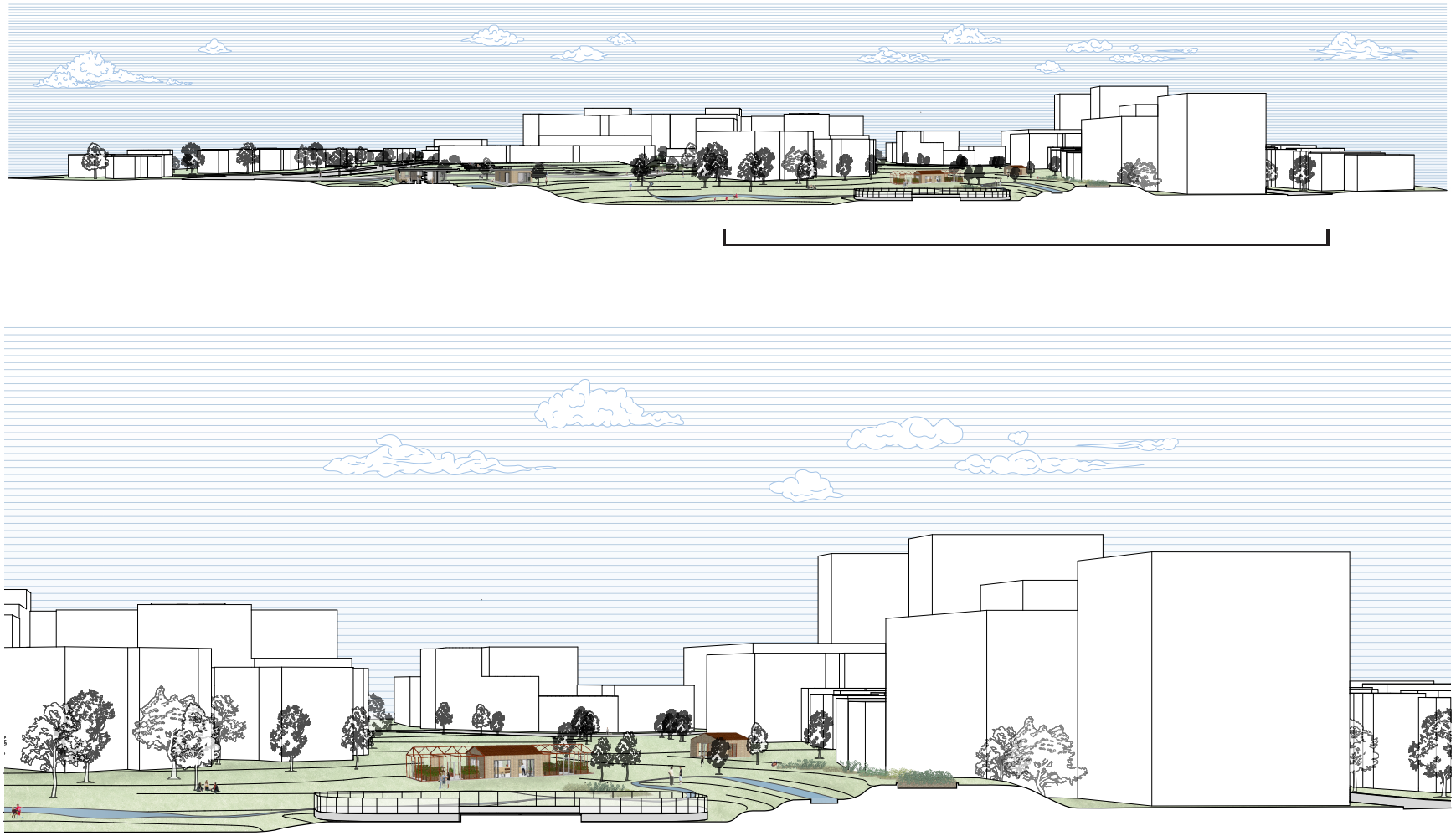
The promenades serve as the primary threshold and extensions of the figure to welcome and guide users from the street and throughout the park, while interacting with the various elements and programs for refuge, release, and re-engagement. The circulation routes are emphasized by water elements that meander in parallel, providing the opportunity to actively engage the surrounding community, while also being a natural resource for therapeutic recovery. Embracing the fluid landscape topography, the pathways also afford users the agency to roam freely, explore the programs that resonate with their current psychological needs, and spontaneously encounter and interact with other users.



Section a-a: An inhabited landscape for mental well-being



Enlarged section a-a: Robie Street entrance, Community Care Centre, and the Citadel



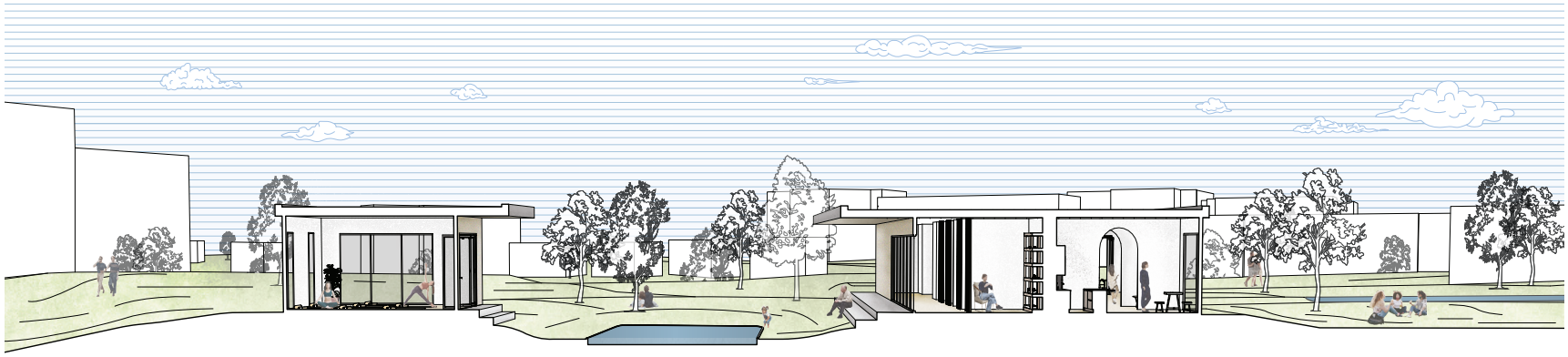
Enlarged section a-a: The Citadel, Agricultural Centre, sports court, and terraced gardens

Language of Form

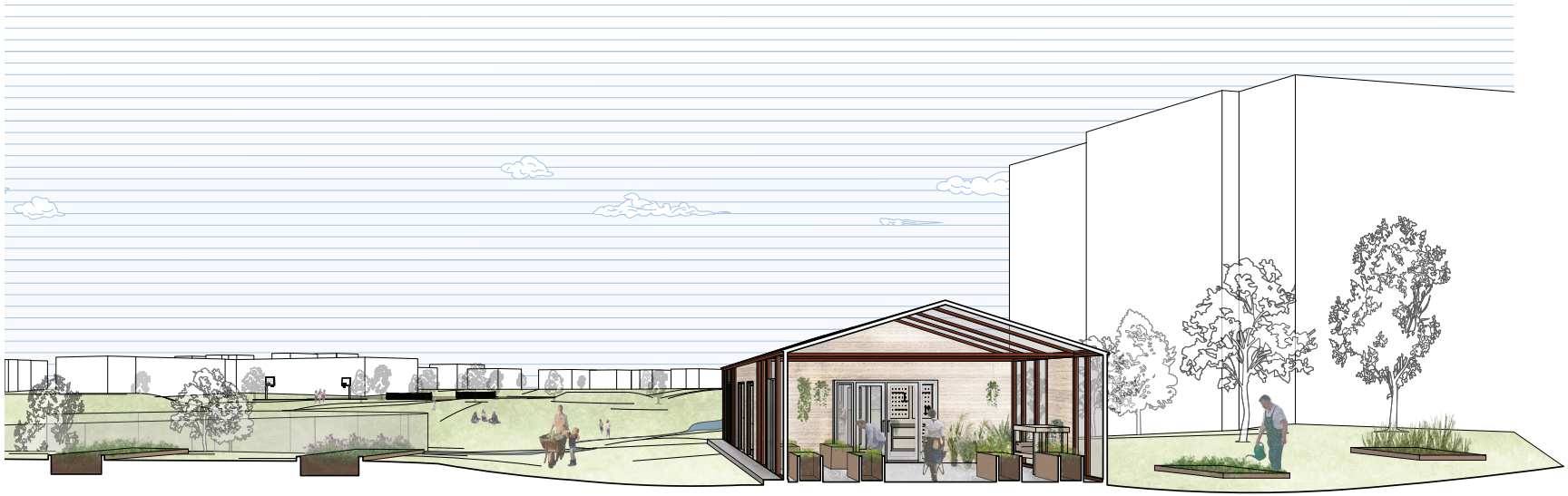
Refuge, release, and re-engage propose a form making language that is revealed in the architectural and landscape elements, intending to provide mental healthcare amenities that are accessible and tailored to a diverse spectrum of those with neurodiversities.

The spatial composition of the agricultural, education, and healthcare centers intend to integrate the cycle of refuge, release, and re-engage within each of these figure elements. Amalgamating the programmatic requirements of each of these individual centres with refuge areas expressed through stereotomic elements and dynamic release areas in the outdoor courtyards provide a complete care cycle regardless of which figure element a user chooses to engage with.

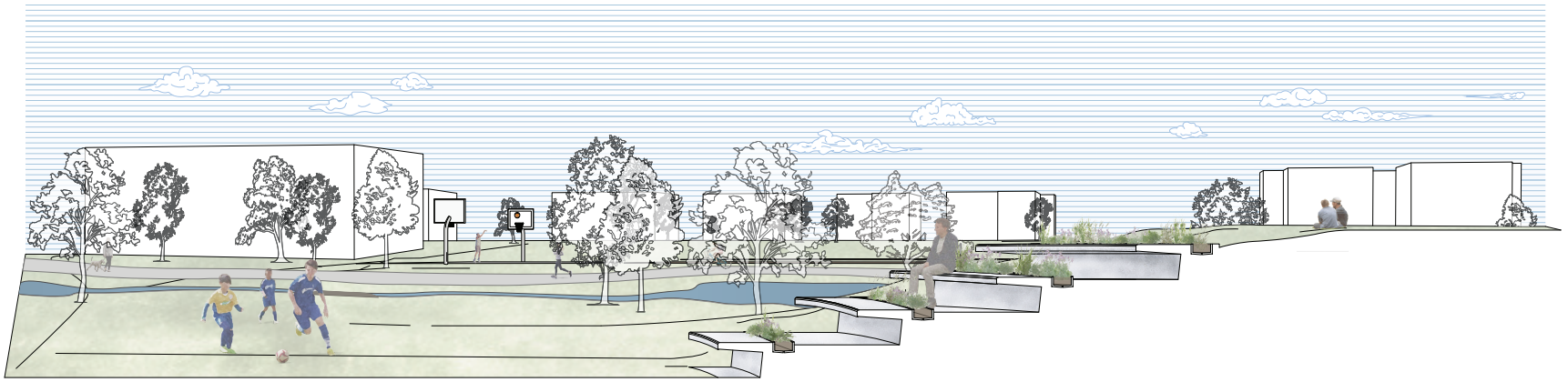
Fostering a sense of connection and community; each programmed figure element among the collective inhabited landscape provides a space and place for individuals to support one another and normalize visible empathy. By implementing and prioritizing accessible spaces of refuge, release, and re-engagement, communities can acknowledge the importance of mental well-being and affirm the commitment to nurturing environments that support the psychological recovery and health of all individuals.



Section b-b: The Community Care Centre and gathering courtyards



Section c-c: The Agricultural Centre and terraced gardens



Section d-d: Integrated terraced seating and activity field

Chapter 7: Conclusion

Humans cannot exist in isolation; we are all a part of an intricate system built upon connections and relationships. As a result, to function as a collective society we must ensure that the physical and mental wellbeing of all individuals is prioritized and those in need have continuous access to the support systems required.

It is the unfortunate and evident reality that the current systematic structure of institutional mental healthcare does not suffice in providing accessible or adaptable services for neurodiverse individuals. This identified service gap in communal-based support brings to question the adequacy of standardized approaches.

Through integrating and inhabiting mental healthcare into the urban landscape, this thesis offers a tangible manifestation of cultivated communal awareness and empowers individuals to reclaim agency over their wellbeing. Departing from the status quo, this deinstitutionalized approach guided by an organizational form and language of the figure-ground, provides individuals encountering psychological challenges a beacon of hope. Gorsebrook wellness park offers visitors and community members a place to reflect, a place to express, and a place to gather and support one another.

This thesis underscores the imperative purpose of reimagining mental healthcare as a communal endeavor, transcending beyond physical boundaries of the institution to embrace the interconnectedness of the psychological and physical landscapes we inhabit. By implementing the vision of an urban wellness park, as a collective population we can embark on a journey towards compassionate and inclusive communities – one where mental health is not merely treated, but fostered, nurtured, and woven into the very fabric of urban inhabitation.

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