How do the people we care for live?

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In march 2020, the "Village Landais Henri Emmanuelli" opened in France, a facility many consider to be innovative. Inspired by a similar project founded in 2009 in the Netherlands, the project accommodates 120 residents, all suffering from Alzheimer's disease, in 4 neighbourhoods, each divided into 4 households, spread over several hundred hectares. While the Village project is undoubtedly the one that has received the most media coverage, it is not the only one in France experimenting with new approaches to support people with Alzheimer's disease, such as the "Maisons de Crolles" (Crolles Houses), located in the Isère department. These two houses accommodate 32 "young" people, whose main characteristic is that they were diagnosed with Alzheimer's or a related disease before the age of 60.

These "innovative" projects share a common goal: improving the living conditions by offering new forms of support, with a focus on social rather than medical approaches. This stems from two key factors. First, the lack of a specific medical treatment for Alzheimer's disease has highlighted the need for social and paramedical support [1]. Second, there is growing criticism of the dominant model of residential care homes for dependent elderly people. These facilities are often seen as places of care rather than homes. Their closed nature, collective care system, and highly medicalised environment reinforce this perception [2]. Designed primarily for health professionals and caregivers, they often fail to prioritise residents' needs. This paradox is striking, given that for most, these institutions are also their "last home."

The development of innovative projects is therefore based on the personalisation of support, respect for individual tastes and life rhythms, maintaining close bonds with family and friends, and openness to the outside environment. Another feature of these projects is the attention paid to architecture and the living environment, described, in the case of the Village for example, as "benevolent".

But what is "benevolent" architecture for a person with Alzheimer's disease, and are there architectures that could be described as "malevolent"? While several studies have already identified specific features that are beneficial to the care of people with Alzheimer's disease, the results are mainly focused on a behavioural or even therapeutic approach to architecture, aimed exclusively at reducing disorders [3]. The design of the space is never questioned from a broader perspective of creating a housing offer that reflects the living conditions and the hospitality we are prepared to offer to a vulnerable population. What is the influence of spatial characteristics on people's daily lives, social integration, and stigmatisation, and what is the link between architectural design and the conditions of reception?

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To answer these questions, we carried out a comparative study of 8 case studies, divided into the following categories: dedicated units (n=2), specialised nursing homes (n=2) and innovative projects (n=4). Based on semi-structured interviews (n=42) with different categories of stakeholders (project leaders [n=14], construction stakeholders [n=7], and caregivers [n=21]), and observations (200 hours), we aimed to understand both the social characteristics (support philosophy, representations of illness, organisation of life within the facility, rules and regulations, etc.), and the architectural features (urban integration, references used, organisation of space, ways of using the space, limits, etc.) of these projects, in order to grasp and qualify the hospitality at work.

In this way, we identified various "hospitality configurations" that provide a framework for interpreting the conditions under which individuals are received and help us understand the logic behind the design of spaces [4].

Dedicated units

Dedicated units represent a pragmatic answer to the need for institutional care for individuals with disabilities and have quickly become a benchmark because they are easy to set up. They are part of a process of adaptation of the institutional model.

The architecture of these units is designed to control the manifestations of the disease by securing, delimiting and organising the environment. Security means isolating the unit from the rest of the establishment and restricting access through a code or badge to limit residents' movements. Security also involves the almost constant surveillance of residents using spatial elements such as glass walls or patios, to ensure that care staff can always monitor them. Delimitation relates to the boundaries within the unit itself, creating a clear and precise spatial division of functions, which allows the identification of the uses and stakeholders associated with each area. Organisation highlights a schematic design of the unit's space based on an organisational approach that considers the behavioural disorders of individuals with disabilities. Residents' bedrooms, technical and care areas surround the more collective indoor and outdoor spaces. The circulation paths are designed to create a walking loop that always brings residents back to the same point. The organisation of collective spaces is divided into "corners": music corner, dining corner, lounge corner, TV corner, which restricts the space and its possible uses.

The result is a controlled form of hospitality, aimed at limiting the consequences of the disease and its manifestations, but also reducing freedom of movement and connection with the outside world [5].

Specialised nursing homes

Specialised nursing homes represent a new stage in the alignment between the specificity of a population and the spatial characteristics

employed. Developed in response to concerns about dedicated units, the architectural design of these buildings is based on a desire to offer sufficient interior space to residents, particularly for walking. Corridors make up a large part of the building's surface area.
These establishments attempt to recreate, as closely as possible, the life that residents may have experienced at home, thereby helping the institutional model evolve. They offer a more community-based form of accommodation, combining varying levels of collectivity, access to a range of different on-site services (e.g., hairdresser, restaurant, place of worship), and the preservation of intimate space. The architectural design of these buildings is based on a desire for enclosure, favouring the creation of a dense, low-porosity building front, that protects the life within the structures while also limiting visibility of the outside world. The facades of the buildings are not very welcoming, and all look a bit the same.
This results in a self-sufficient form of hospitality within these specialised residential care institutions. While the general aim is to improve residents' quality of life, the perverse effect is to accentuate their isolation from the rest of society. Autarky is a phenomenon designed to satisfy all residents' needs, meaning that facilities are not very open to outside activities.

Innovative projects

Innovative projects seek to go beyond the normative and regulatory framework typical of institutional care for the elderly, promoting "ordinary life" and the "home life" values of the projects.
The architecture of these projects is designed to integrate, share and conceal the institutional dimension and healthcare aspects. Integration involves mobilising more generic urban forms such as the house or village, which are less stigmatising and more deeply rooted in local architecture. Representation is also based on domestic and urban references, distinct from the image of the hospital that most establishments have today.
The neighbourhood is always considered as a resource for projects based on two principles. In one case, the aim is to involve residents in the life of the neighbourhood by providing them with free access to local amenities, while in the other, the goal is to integrate the neighbourhood into the facility by offering on-site services that are open to all. Invisibilisation refers to the process of rendering the disease less visible, thereby reducing the stigmatising dimensions of collective care. This involves not only the organisation of space and the blending of different functions and stakeholders within the establishments, but also the creation of secondary walkways to reduce the visibility of staff movements and the density of space occupancy.
These projects offer a more integrated form of residential life, as close as possible to the domestic environment of reference that is home, resulting in an inclusive form of hospitality that attempts to integrate both residents and establishments into their surroundings.

Conclusion

In conclusion, it appears that architecture plays an essential role in the design of care facilities for people with Alzheimer's disease, not only in reducing behavioural disorders, but also in transforming basic care structures into living spaces. Innovative projects, in particular, demonstrate that the architectural approach, when inspired by familiar domestic and urban references, can serve as a lever to destigmatise the disease and promote the social integration of those affected.
However, architecture alone cannot guarantee the quality of reception conditions. For these spaces to fully fulfil their purpose, the institutional organisation must evolve in alignment with the goals set by the built environment. The support methods, training of care staff, as well as internal regulations, must adapt to transform these institutional places into living environments, as close as possible to "ordinary life," regardless of the pathology of the residents or their length of stay.
In fact, the hospitality configurations observed in our study - controlled, self-sufficient or inclusive - also have their equivalent in the field of rehabilitation, where the same tension exists between security, technical functionality, and openness to the environment. Whether we're referring to dependent elderly individuals or individuals with temporary disabilities, the fundamental question remains the same: What quality of life and living environment can we offer them that goes beyond medical support?

Key-words

Ageing, Residence Characteristics, Home Environment, Alzheimer Disease, Housing Quality

Competing Interest

The author declare to have no competing interests regarding the content of the editorial

Author contribution

ML designed and wrote the entire article

References

[1] Isabelle Mallon. La maladie d'alzheimer: les fluctuations de la médicalisation. *Retraite et société*, 67(1):169–180, 2014.

[2] Kévin Charras and Fany Cérèse. Être «chez-soi» en ehpad: domestiquer l'institution. *Gérontologie et société*, 39152(1):169–183, 2017.

[3] Gesine Marquardt, Kathrin Bueter, and Tom Motzek. Impact of the design of the built environment on people with dementia: An evidence-based review. *HERD: Health Environments Research & Design Journal*, 8(1):127–157, 2014.

[4] Jacques T Godbout. Recevoir, c'est donner. *Communications*, 65(1): 35–48, 1997.

[5] Liesl Van Hecke, Iris Van Steenwinkel, and Ann Heylighen. How enclosure and spatial organization affect residents' use and experience of a dementia special care unit: A case study. *HERD: Health Environments Research & Design Journal*, 12(1):145–159, 2019.