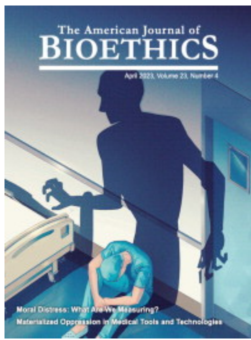

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OPEN PEER COMMENTARIES

Materialized Oppression in Inpatient Psychiatric Unit Design

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INTRODUCTION

Liao and Carbonell argue that medical devices are often not merely biased, but rather materialize oppression through the perpetuation of oppression into the present and future (Liao and Carbonell 2023). In order to address this oppression, they propose that solutions must take a systems approach through layering solutions in response to the aggregation of harms. This article will extend their theoretical approach to the setting of care delivery, using inpatient psychiatric architecture as a case study to explore racial injustice in the care of seriously mentally ill persons. From asylums to modern inpatient psychiatric units, the architecture of facilities that treat patients with mental illness is often overlooked, yet has a significant role in creating an environment that encourages or discourages healing. Current inpatient psychiatric design often creates an atmosphere of detention rather than rehabilitation, reinforcing the oppression of those it aims to serve.

Inpatient psychiatric units are designed to maximize safety as many patients will be at an elevated risk of self-harm and suicidality. For example, the Mental Health Environment of Care Checklist which provides guidelines on assessing such hazards has been shown to substantially reduce the risk of suicide in inpatient units (Watts et al. 2012). Such checklists, however, focus on promoting safety often at the expense of promoting humanity. For example, many inpatient units immediately confront patients with double doors, a wall-mounted card reader, thick glass, and monotonous shades of white or light blue stretching down blank hallways. The nursing station and medication room are locked, sometimes with the appearance of being barricaded. If the patient's risk is too high, they may have no privacy; allowing staff to see directly into their room and bathroom. In the common space, maybe there is a TV, maybe a phone, but always protected or kept in a closet. The space is devoid of plant life, with limited colors. How could someone ever feel good in a place like this?

In an effort to treat patients in the least restrictive setting possible, psychiatrists often evaluate patients for different potential levels of care, including partial hospitalization or intensive outpatient programs. However, there are times that inpatient hospitalization is necessary for safety and more acute management of illness. Within the inpatient setting, there are a variety of design decisions that shape the experience of the unit as a place—evoking an atmosphere that may or may not encourage optimal healing. We argue that an unwelcoming setting of care is, in fact, more restrict-

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ive than a welcoming setting of care from an architecture and design perspective. Indeed, it is the materialized oppression of inpatient psychiatric units that directly contributes to the degree of restrictiveness.

MATERIALIZED OPPRESSION AND THE HISTORY OF PSYCHIATRY

Psychiatry is a relatively new medical specialty, with multiple points of origin and an evolution that is both troubling and hopeful. There are ways in which those historical developments led to the current materialized oppression of aspects of the modern psychiatric inpatient unit. During the 19th century, diagnoses emerged such as "negritude," which was conceptualized as a form of leprosy caused by dark skin that could only be cured through the skin becoming white (Washington, 2006). This diagnosis came from Dr. Benjamin Rush, considered by many to be the father of American psychiatry, who was the face of the American Psychiatric Association logo from 1921 to 2015. Through racist diagnoses and beliefs, social differences can be essentialized into biological differences whose legacy persists.

Today, individuals with bipolar disorder and schizophrenia are ten times more likely to be in a correctional setting than in a hospital bed (Fuller et al. 2010). This effect is further compounded for Black patients who are overrepresented in psychiatric emergency rooms or inpatient psychiatric units but are underserved in voluntary, community-based mental health facilities (Alegría et al. 2002; Snowden, Hastings, and Alvidrez 2009). Distrust and fear of services delays service utilization which leads to Black patients receiving more aggressive treatment due to the worsened severity of untreated symptoms (Keating and Robertson 2004).

As a Black woman psychiatrist, Dr. Sampson-Mills prides herself on being able to give good information to her community with how to engage mental healthcare. In the case of one needing emergency psychiatric care, she often finds herself in a bind about how to be most helpful for families, friend and acquaintances when they reach out. For example, she's received calls requesting advice on how to get a manic family member who is engaging in risky behavior seen urgently. Whenever safety is concerned the recommendation is to call the police, however, she also recognizes the hesitation of many Black people with engaging the police for help with psychiatric emergencies. Knowing the realities of the intersection between race, mental illness, and police violence puts her in a difficult position. She champions proactivity with her community in addressing mental health and encourages skilled and trained mental health providers to be a part of these crisis intervention teams. Perhaps police armed with deadly force is not the best way to manage these crises. In the end, we need to collaborate with law enforcement find a better solution to manage mental health crises with the potential for violence among Black Americans that do not disproportionately end in fatalities.

INPATIENT PSYCHIATRIC DESIGN AND MATERIALIZED OPPRESSION

Liao and Carbonell contend materialized oppression manifests contingently through the perpetuation of imbalanced power relations. Therefore, oppression can occur without discriminatory attitudes, beliefs, or behaviors because the discrimination results from inattention rather than intention. To address this oppression, Liao and Carbonell utilize Katrina Hutchinson's framework of moral aggregation problems which are composed of invisibility, expediency, and structural factors (2019).

Invisibility accounts for the covert nature of aggregated oppression as it is able to hide in a world that is predominantly oppressive. As with many specialties in American medicine, psychiatry needs to take full ownership of its contribution to pathology of Black American's lived experiences. It would be our hope that racism as a systemic issue is addressed and taught to all psychiatry residents as a social determinant of health. Most mental health conditions are borne out of multifactorial issues that draw on the biopsychosocial formulation. Within that framework, we would advocate for the explicit inclusion of cultural, political, and other factors that are part of the effects of systemic racism in the United States. We recommend in addition to ownership of these sordid pasts we develop new ways of understanding the experiences of Black Americans with earnest curiosity of understanding instead of pathologizing everyday experiences.

Expediency refers to the existing incentives and norms that guide behavior as well as the motivation to be efficient due to the scarcity of resources. This factor encapsulates much of the resistance to addressing harms. Hospital directors and unit designers will argue that balancing safety regulations with limited funding doesn't leave room for inpatient psychiatric architecture to be utilized as a therapeutic tool that addresses oppression. This, however, is the exact

argument that perpetuates oppression and, therefore, is not a sufficient argument.

Structural factors, finally, are composed of the accumulation of smaller acts as well as larger social, political, and geographical factors. In the United States, the regulatory structure governing inpatient psychiatric units typically includes the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards, which dictate specific safety regulations that impact how space is designed. These standards were developed to ensure safe and effective care, ostensibly meant to protect patients and staff. However, these regulations perpetuate aspects of design in inpatient psychiatric units that result in easy comparison to prisons, often stripping patients of privacy, liberty, and dignity in the name of safety. The question to ask is whether we are now in a system that under-emphasizes or over-emphasizes safety, and what the implication is for patient rights. Importantly, we are not advocating for a universal approach to inpatient psychiatric unit design. We recognize that there may be a diverse set of structural factors that may vary with geographic challenges and differences, in addition to the regulatory landscape described. For example, ensuring access to outdoor space and fresh air may mean something very different for an urban inpatient psychiatric unit as compared to a unit in a more rural or less population-dense area. This also may have considerable variation between public, private, and Veterans Affairs units.

In order to address the aggregated harms of materialized oppression, solutions must address invisibility, expediency, and structural factors in the architecture of inpatient psychiatric units. This is critical to improve and optimize the care being provided, particularly given the issues of racial justice that have been discussed. The voices of patients, providers, patient advocacy groups, and other nonpartizan groups will all be necessary to ensure that structural factors of materialized oppression are addressed. It is imperative that aspects on inpatient psychiatric architecture be examined from the lens of materialized oppression, then justified and reconfigured when possible, to preserve the privacy, liberty, and dignity of patients while they are receiving care.

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