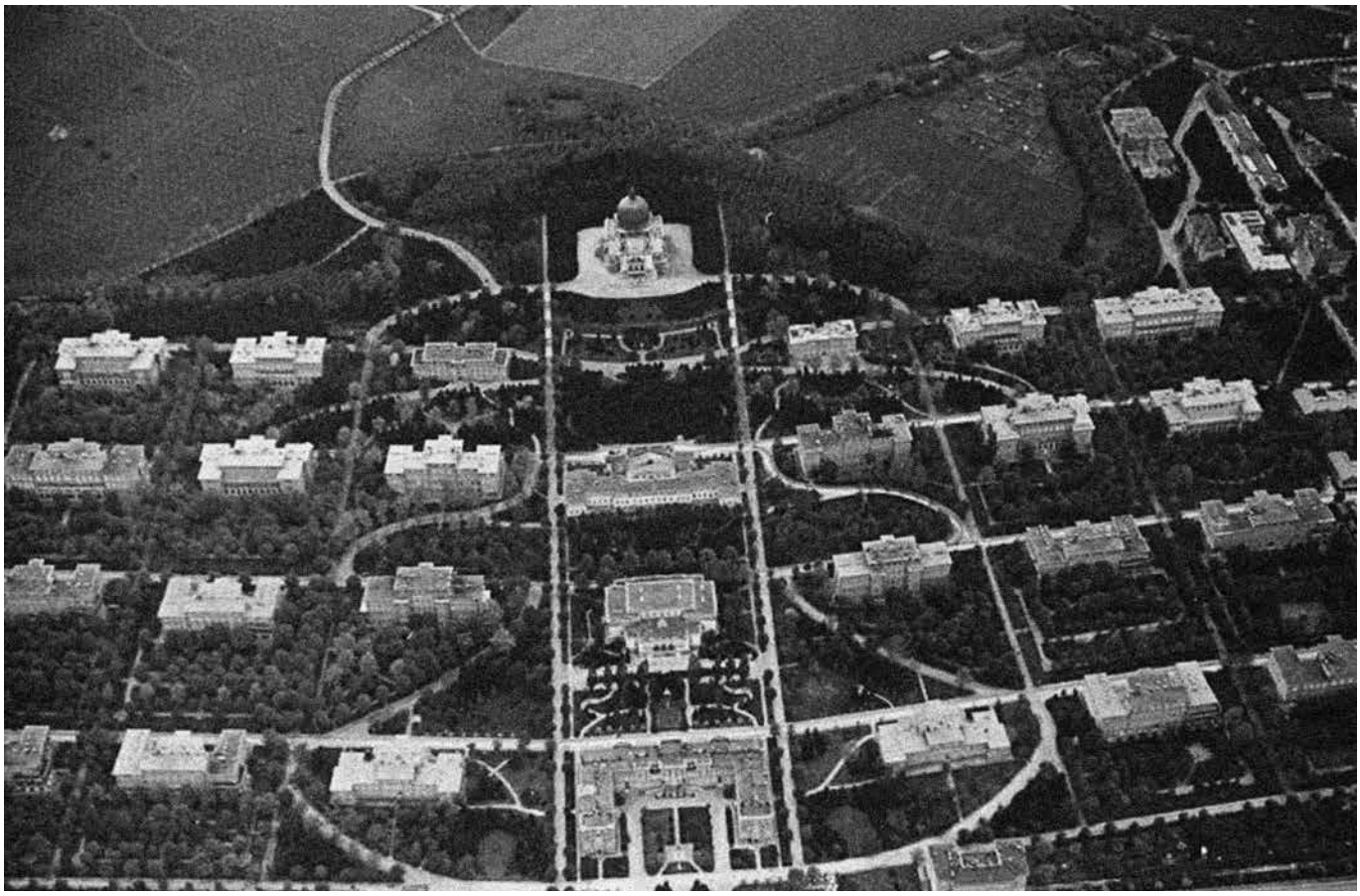


**THE LOWER AUSTRIAN PROVINCIAL INSTITUTION FOR THE CURE AND CARE OF THE PATIENTS WITH MENTAL DISORDERS, "AM STEINHOF", 1907**

DOLNORAKÚSKY KRAJSKÝ ÚSTAV PRE LIEČBU A STAROSTLIVOSŤ O PACIENTOV S MENTÁLNYMI PORUCHAMI „AM STEINHOF", 1907

**Source** Zdroj: https://www.publicbooks.org/top-10-2018-modernism-heal-thyself/

# The City as a Place Prepared for Neurodiversity
## Mesto ako priestor pripravený pre neurodiverzitu

Pavol Mazalán, Peter Mazalán

https://doi.org/10.31577/archandurb.2021.55.1-2.2

Kognitívno-environmentálne urbanistické plánovanie sa začalo uplatňovať v praxi už so štúdiou Kevina Lyncha – *The Image of the City* (1960). Takéto formy plánovania boli zdokonalené vedeckým a technologickým vývojom vrátane vedeckých poznatkov v neurológii a kognitívnej psychológii. Nové vedné odbory, ktoré rozširujú záber architektúry aj urbanizmu, pomáhajú pri priestorových analýzach. Napriek medziodborovým prístupom a vedeckým metódam tvorby optimálneho prostredia vieme však stále iba málo o navrhovaní priestoru, ktorý by mal prispieť k sociálnej inklúzii, destigmatizácii a zvýšeniu právomocí ľudí s duševnými poruchami, ktoré zahŕňajú široké spektrum charakteristík.

Štúdia analyzuje vývoj a úlohu architektúry a urbanizmu vo vzťahu k sociálnej inklúzii v kontexte duševného zdravia v Európe od konca 18. storočia, kedy vznikali prvé komplexné modely starostlivosti o duševne chorých. Cieľom príspevku je analyzovať vzťah architektúry a urbánnej štruktúry k ľudskej neurodiverzite. Prierezová štúdia tiež skúma v kontexte starostlivosti o ľudí s duševnými poruchami, s akcentom na vývinovú poruchu autistického spektra, dynamický vývoj architektonickej typológie takýchto liečebných zariadení. Neurodiverzita vychádza z prítomnosti neurologických odlišností v ľudskej populácii. Je spájaná s presadzovaním občianskych práv pri jedincoch s diagnostikovanými neurologickými alebo neurovývinovými poruchami ako porucha autistického spektra (PAS), porucha pozornosti s hyperaktivitou (ADHD), bipolárna porucha, vývinová koordinačná porucha (dyspraxia), dyslexia, epilepsia a Tourettov syndróm. Koncept PAS s Aspergerovým syndrómom s jemnými prejavmi na jednej strane spektra voči ťažším formám autizmu, v niektorých prípadoch s kombinovaným postihnutím, bol vyvinutý v štúdiách Lorny Wings v deväťdesiatych rokoch. Autizmus je podľa najnovších definícií Svetovej zdravotníckej organizácie (World Health Organization – WHO) charakterizovaný ako špecifikácia duševnej poruchy – vývojová porucha. Vo svojom širšom význame definuje koncept neurodiverzity všetky formy atypického neurologického vývinu ako normálne ľudské odlišnosti, ktoré by mali byť rešpektované a tolerované vzhľadom ku svojej závažnosti ako ostatné ľudské diferenciácie. Neurodiverzita je teda vo svojom najširšom aplikovaní filozofiou spoločenského prijatia a rovnakých príležitostí pre všetkých jednotlivcov bez ohľadu na ich neurologické charakteristiky. Duševné poruchy sú jednou z hlavných tém a výziev WHO v európskom regióne, kde postihujú každý rok až 25 % obyvateľstva.

Pri analýze PAS uvažujeme vzhľadom na jej široké spektrum – od vysoko funkčných jedincov po prípady kombinovaných mentálnych postihnutí – vo vzťahu človeka k architektúre o rôznych úrovniach jej vnímania a užívania. Na jednej strane sa architektúra a urbanizmus dostávajú v diskurze o duševnom zdraví do úzkeho prepojenia so sociálnou oblasťou, kde sa hlavnou témou stáva deinštitucionalizácia – transformácia z inštitucionálnej na komunitnú úroveň poskytovania sociálnych služieb. Na strane druhej prispieva k výskumom súkromný sektor, ktorý má za cieľ poskytnúť aj neuroatypickým vysokofunkčným jedincom optimálne pracovné prostredie.

Dejinná periodizácia starostlivosti a s tým prepojený vývoj liečebných zariadení pre duševné zdravie v Európe sa podľa štúdie Mental Health Policy And Practice Across Europe rozdeľuje do troch období. Prvé obdobie sa datuje od raného 19. storočia do polovice dvadsiatych rokov 20. storočia. Inštitucionalizovaná starostlivosť prebiehala v azylových zariadeniach, kúpeľoch alebo súkromných sanatóriách. Nasledujúce obdobie trvalo do sedemdesiatych rokov a reprezentoval ho model extenzívnej privátnej psychiatrickej praxe. Narastá farmaceutický výskum a s ním medikamentózna liečba. V tomto období sa zavádza ambulantná liečba na psychiatrických klinikách. Posledné obdobie, ktoré pretrváva dodnes, reprezentuje systematická expanzia vertikálnej starostlivosti vo forme sektorizácie, deinštitucionalizácie a komplexnej komunitnej starostlivosti.

Podľa štúdií francúzskeho lekára Jeana Marca Gaspard Itarda (1774 – 1838), prvé popísané charakteristiky autistických tendencií je možné sledovať od počiatku 19. storočia. Autistické prejavy správania s kombinovaným postihnutím neboli v tejto dobe diagnostikované a s vysokou pravdepodobnosťou sa schovávali pod iné diagnózy. Iným prípadom, ktorý skúmali v knihe *Autism in History: The Case of Hugh Blair of Borgue* Uta Frith a Rab Houston, je analýza spoločnosti v kontexte právnych a kultúrnych konvencií narábajúcich s jedincom prejavujúcim znaky, ktoré by sme aj v súčasnosti mohli označiť ako autistické.

O mentálne chorých pacientov, ak to zázemie umožnilo, sa zvykli už aj v období, kedy vznikali prvé zariadenia pre duševne chorých, starať v ich domácom prostredí v odľahlejších periférnych častiach krajiny. V závažných prípadoch končili takéto osoby v chudobincoch alebo väzeniach. Panovala všeobecná obava, že ľudia s duševnými chorobami sú hrozbou pre verejnú bezpečnosť. Táto obava poskytla podnet na vytvorenie verejných

azylov, ktoré mali zadržať a izolovať psychiatrických pacientov. Azyly získali popularitu ako inštitúcie, kde bolo možné vyliečiť duševne chorých „šialencov". Postupne nahrádzali blázince, ktoré predstavovali skôr väzenie a iba málo zohľadňovali kvalitu existencie svojich klientov. Táto perspektíva predpokladala, že duševné ochorenie bolo liečiteľné podobne ako iné fyzické choroby. Napriek tomu, že v Európe sú známe opatrovateľské zariadenia už od stredoveku, história psychiatrie sa významne zmenila vznikom prvých terapeutických azylových zariadení. Pravdepodobne prvé takéto zariadenie vzniklo vo Florencii v osemdesiatych rokoch 18. storočia pod záštitou doktora Vincenza Chiarugiho. O desaťročie neskôr začali podobné zariadenia pod vedením Philippa Pinela vznikať v Paríži. Následne sa trend moderných terapeutických zariadení rozšíril po celej Európe. Z hľadiska systému zdravotnej starostlivosti v kontexte duševného zdravia bolo kľúčovým vytvorenie okresnej siete azylov pre jednotlivé spádové oblasti. Takýto prístup sa inicioval v Anglicku v roku 1808 tzv. County Asylums Act, následne v roku 1838 zákonom vo Francúzsku. Postupne sa pridávali ostatné európske krajiny.

V posledných dvoch desaťročiach 19. storočia vzniklo na území habsburskej monarchie sedem psychiatrických inštitúcií. Veľké plánovanie komplexov v období fin-de-siècle naprieč Európou znamenalo príležitosť pre vedeckú aj architektonicko-urbanistickú aktivitu. Azylové komplexy boli na prelome milénia v stredoeurópskej proveniencii navrhované na princípe vilových objektov. Uzatvorená štruktúra prirovnávaná k menšiemu mestu obsahovala okrem obytných a liečebných pavilónov aj divadlo, kostol či márnicu. Komplexy boli navrhované špecializovaným procesom – azylovým plánovaním (asylum planning), ktorý obvykle riadili osobnosti z psychiatrických kliník. Úloha architekta bola predovšetkým vyriešiť projekt urbanisticky a reprezentatívne architektonicko-esteticky. V stredoeurópskom politickom a geografickom usporiadaní bola reprezentatívnosť národných architektúr dôležitým spoločenským nástrojom. Význam stavieb mal demonštrovať aj záujem spoločnosti na vedecky inovatívnom liečení a následnom socializovaní klientov pre ich ekonomický prínos. V Anglicku, kde je datovaný vznik prvých zariadení, vzniklo v priebehu 19. storočia 120 azylov s viac ako stotisíc ubytovanými.

Ešte v prvej polovici 19. storočia bola považovaná príčina duševného ochorenia za trest z morálneho alebo duchovného zlyhania. Až výrazne narastajúca populácia a zahusťovanie miest v druhej polovici 19. storočia pomohli definovaniu témy mentálneho zdravia. Azylové útulky sa napokon stali nemocnicami pre chudobných, pretože pacienti s lepším postavením sa umiestňovali do súkromných filantropických zariadení. Koncom 19. storočia čelili veľké verejné nemocnice finančným obmedzeniam a rastúcej populácii pacientov, a tak nemohli klientom ponúknuť tento druh starostlivosti. Malé súkromné zariadenia boli podobné nemocniciam z prelomu 18. a 19. storočia. Boli preferované európskymi reformátormi Phillipom Pinelom a Williamom Tukeom. Tí kritizovali dovtedajšie tvrdé nehumánne zaobchádzanie s duševne chorými v Európe. Obhajovali morálnu liečbu, ktorá okrem iného spočívala aj v ponúknutí príjemného a neanonymného architektonického prostredia.

Iným zariadením popri azyloch boli komunitné organizácie pre starostlivosť o prepustených pacientov, ktoré spravovali súkromné charitatívne organizácie a nadácie, keďže pacienti ostávali naďalej neschopní štandardného fungovania v spoločnosti. Tieto zariadenia súvisia už s psychiatrickým vývinom v 20. storočí, keď azylová starostlivosť prechádzala do verejných nemocníc. Podobne ako vo forme súkromných zariadení už koncom 18. storočia, lepší prístup ku starostlivosti pokračuje v súkromnom sektore až do obdobia pred prvou svetovou vojnou, kde integrovaná starostlivosť o pacientov prechádza do sveta sanatórií a kúpeľov.

Kľúčovou témou povojnových rokov je postupné začleňovanie duševného zdravia do plánov sociálneho poistenia a sociálneho štátu. Pokiaľ ide o psychiatrické liečebne, päťdesiate a šesťdesiate roky boli obdobím ich rastu, hoci čoskoro nastal veľký obrat, keď sa v sedemdesiatych rokoch začína presadzovať prístup deinštitucionalizácie. V roku 1959 bol implementovaný do praxe Mental Health Act, ktorý ukotvil deinštitucionalizáciu vo Veľkej Británii s dôrazom na komunitnú starostlivosť. Obdobie od sedemdesiatych rokov sa vyznačuje vertikálnym rozšírením starostlivosti o duševné zdravie, keďže plynulý prechod z psychiatrickej liečebne do spoločnosti sa stáva normou. Starostlivosť o duševné zdravie sa začína demedikalizovať v tom zmysle, že v historickom vývoji služieb v oblasti duševného zdravia začínajú hrať úlohu mnohí nie lekárski profesionáli z príbuzných odborov.

Pokračovaním poslednej charakterizovanej etapy analyzujeme proces inklúzie cez navrhovanie fyzického priestoru architektúry a urbanizmu. Tento proces býva očakávaním na reakciu a odpoveď od jej užívateľa alebo recipienta. Priestor dostáva význam cez svoje interakcie. Tie sú vyvolávané vždy v závislosti od individuálnych skúseností a možností. Odlišný spôsob vnímania u ľudí s PAS spôsobuje, že okolitý svet pre nich znamená rozdielne kódy ako pre neurotypických ľudí. Ich priestorové skúsenosti a interakcia s fyzickým prostredím úzko ovplyvňujú ich charakteristické správanie a osobitný spôsob zmyslového vnímania. Preto má zmysel sa v kontexte neurodiverzity zamýšľať nad konfrontáciou ľudí s PAS a zastavaného prostredia. Skúmať tento vzťah môžeme z perspektívy spôsobu fyzického využívania priestoru a vplyvu na správanie sa vo vzťahu k priestoru. Pri takejto analýze existujú tri aspekty vo vzťahu priestoru k človeku s PAS; dôvera – poznateľnosť, ktorú ponúka fyzický priestor, skrytá logika spojená s priestorom a priamy a vedomý spôsob prežívania sveta. Fyzický priestor znamená pre ľudí s PAS zreteľný a nemenný znak, ktorý je pre nich určujúcim prvkom istoty a stability.

Novým prístupom vo vzťahu k priestoru je vývoj informačno-technologických aplikácií, ktoré ľudom s PAS uľahčia vykonávať ich dennú mobilitu v rámci urbánneho prostredia a zvýšiť ich autonómiu. Dôkladné skúmanie dynamiky medzi architektonickým prostredím – s jeho atribútmi akustiky, vizuálneho charakteru, priestorovej kvality, farebnosti, textúry, geometrie atď. – a správaním ľudí môže viesť k vypracovaniu konkrétnejších a citlivejších usmernení pre dizajnérske návody a pokyny (guidelines). Ďalšou metódou, ako získavať informácie, je analyzovanie autobiografií autistov, tzv. auti-biographies, ktorí

sa vyjadrujú ku vnímaniu priestoru vlastným jazykom a spôsobom. Analyzovaním ich vlastných opisov a charakteristík vzniká sonda do ich autistického premýšľania a správania sa v priestore.

Napriek informovanosti v oblasti povedomia o autizme je v správaní spoločnosti stále prítomné pri konfrontácii s takýmito jedincami prekvapenie. Pri odstraňovaní bariér sa myslí predovšetkým na tie fyzické. Ľudia s PAS musia pre ich znevýhodnenie vyvíjať enormnú snahu, aby vedeli uchopiť a pochopiť prostredie, v ktorom sa ocitajú. Porozumenie priestoru je pre nich proces, ktorý môžeme označiť za úsilie, keďže ich priebeh spracovávania informácie, ktorú získavajú zmyslovým vnímaním, prebieha s problémami. Mnohé elementy prostredia – vizuálny smog plagátov a nápisov, nejasné značenia, hlasné hudobné alebo iné akustické podnety, neónové svietenie s miernym blikaním – to všetko sú reálne bariéry, ktoré stimulujú frustráciu a zvláštne prejavy správania človeka s PAS.

Ak vychádzame v našej štúdii z definície poruchy autistického spektra podľa WHO ako špecifikácie duševnej poruchy, tak v kontexte duševného zdravia je aj téma celého spektra autizmu na Slovensku dlhodobo zanedbávaná. Doposiaľ tu neevidujeme presné štatistiky o ľuďoch s PAS. Podľa odhadov niektorých autistických centier ich však môže byť 30- až 50-tisíc.

Na území Slovenska vznikali, podobne ako v iných európskych oblastiach, zariadenia na opatrovanie ľudí už v priebehu 13. storočia. Takéto charitatívno-sociálne a liečiteľské inštitúcie vznikali pri kláštoroch, neskôr ich vznik podnecovali aj samotné mestá. Významná zmena prichádza v druhej polovici 19. storočia, kedy sa v stredoeurópskej oblasti začína zavádzať a uplatňovať domovské právo ako forma príslušnosti k obci. Toto právo zaručovalo občanovi aj právo na sociálnu starostlivosť v prípade chudoby, núdze alebo iného zdravotného znevýhodnenia. Po druhej svetovej vojne, ktorá znamenala prerušenie alebo zrušenie činnosti špeciálnych zariadení v intenciách rasistického a likvidačného nazerania na slabších a znevýhodnených, prichádza v období päťdesiatych a šesťdesiatych rokov k masívnemu budovaniu veľkokapacitných špeciálnych zariadení na území celej Európy.

Vplyvom znárodnenia sa začali na území Slovenska zriaďovať inštitúcie ústavov v cirkevných budovách a kaštieľoch. Tie svojimi dispozíciami a ani technickým stavom už v čase svojej transformácie takémuto zariadeniu nemohli vyhovovať. Tento prístup k starostlivosti, sčasti stále prevádzkovaný na našom území, kreuje vysokú mieru segregácie. Architektonicko-urbanistické riešenie komplexov je vyčlenené od svojho okolia fyzickými bariérami alebo samotným lokalizovaním mimo komunít. Tak vznikajú recipročné obavy klientov pred vonkajším svetom a okolia pred ľuďmi, ktorých ohraničený priestor deklaruje ako nebezpečných.

Slovensko je aj v súčasnosti stále na začiatku reformného procesu. Deinštitucionalizácia je proces zmeny, ktorej cieľom je odbrzdenie historicky spôsobenej stagnácie vývoja poskytovania sociálnych služieb. V súčasnosti je na Slovensku podľa organizácie SPOSA desať diagnostických centier a zariadení sociálnych služieb pre autistov. Podľa dostupných informácií o počte autistických ľudí by bolo potrebné na Slovensku vytvoriť aspoň 20 zariadení. Na Slovensku prevažuje umiestňovanie klientov do neúčelových budov, čo sa prejavuje na podmienkach bývania. Mnohé zariadenia poskytujú sociálne služby v historických objektoch, ktoré prechádzali zásadnými rekonštrukciami pred päťdesiatimi rokmi. Takéto nevyhovujúce dispozície veľkokapacitných priechodných izieb neposkytujú základný komfort, rovnako ako ani základné princípy v navrhovaní bezbariérového priestoru.

Základné a najdôležitejšie východisko pre potrebu inklúzie a rovnako deinštitucionalizácie a transformácie sociálnych služieb je definované vo Všeobecnej deklarácii ľudských práv a slobôd v článku 1: všetci ľudia sa rodia slobodní a rovní v dôstojnosti i právach. Sloboda, rovnosť a dôstojnosť sú elementárne atribúty ľudského bytia. Odborník v sociálnej oblasti Miroslav Cangár v štúdii *Prechod z inštitucionálnej na komunitnú starostlivosť v Slovenskej republike* píše: „Ak sa hlásime k myšlienkam ľudsko-právneho prístupu definovaného v etike, ale aj v základných medzinárodných dokumentoch, je potom našou morálnou a odbornou povinnosťou meniť systém tak, aby si naozaj všetci ľudia boli rovní v slobode, dôstojnosti a právach.“ Architektúra sa stáva v tomto koncepte nevyhnutným nástrojom na vytváranie fyzických riešení, ktoré prijímajú zodpovednosť za existovanie rôznych komunít.

“Since classical antiquity, the city has had two principal meanings in the West: human relationship (civitas) and built forms (urbs)... How people live together is communality; how they see and treat one another is morality. Considered thus, it is almost tautological to call the city a moral universe. The physical city is a moral document or text.”[1] – so reads the study in the magazine *Geographical Review, The City as a Moral Universe* (1988), authored by the humanistic geographer Yi-Fu Tuan. He is analysing the city as a space shared by everyone with communication and approachability as the functioning principles. The study also describes: “the city is built form as well as human relationship – a material place that visibly and tangibly expresses human needs and aspirations, supporting or hindering their fulfillment.”[2] Cognitive-environmental urban planning and design began a few decades before with Kevin Lynch’s famous *The Image of the City* (1960). Scientific and technological developments, including discoveries in brain physiology and cognitive psychology, the psychosocial determinants of health, and the spread of navigation and information technologies, have increased the pertinence of cognitive-environmental research to planning.[3] New scientific disciplines, which broaden the scope of architecture and urbanism, help with their analyses. Yet in spite of the many past theories and scientific methods of creating optimal spaces, we know very

little about designing environments that contribute positively to social inclusion, de-stigmatisation and empowerment of people with mental deficiencies of different kinds and varying degrees.

The article is addressing a cross-study on the topic of care for people with mental impairments, with a focus on the Autistic Spectrum Disorder (ASD), and on the dynamic development of mental health and psychiatric facilities. It attempts an analysis of the development and role of architecture and urbanism in relation to social interaction and wellbeing, in the context of mental health in Europe since the end of the 18th century. The historical context presents the inevitable realisation of the urgency to contribute to architectural and urbanistic methods which redefine physical and mental accessibility. Partially for this reason, the study is focusing on the 19th century, when the first comprehensive models were established regarding care for people with mental impairments. The aim of the article is to analyse the relation between architecture and urbanism on one hand and human neurodiversity on the other. Even though modern medicine has shifted the social paradigm to the benefit of people with mental disorders, the level of stigmatisation is currently still significant.

The concept of "neurodiversity" originated in the 1990s in the community of high-functioning individuals with ASD. The widespread use of this term is attributed to sociologist Judy Singer and her study *Why Can't You Be Normal for Once in Your Life? (1999)*. Neurodiversity, as defined by Singer, is derived from the presence of neurological differences within the population. It is associated with the assertion of human rights for individuals diagnosed with neurological or neuro-developmental disorders such as ASD, attention deficit-hyperactivity disorder, bipolar disorder, developmental dyspraxia, dyslexia, epilepsy, and Tourette's syndrome.[4]

The concept of the autism spectrum disorder (ASD), Asperger's disorder at the mild end to severe autistic disorder at the other end, was developed in the early 1990s by Lorna Wing. ASD is, according to the World Health Organization (WHO), currently defined as a mental disorder, more specifically a developmental disorder. Symptoms of pervasive developmental disorders such as autism include impaired social behaviour, communication and language, and a narrow range of interests and activities that are both unique to the individual and are carried out repetitively.[5]

Sensory difficulties are also quite common in ASD. These difficulties may be connected to sound and hearing, sight and seeing, touch, taste or general sensory dysphoria. Therefore, the level of affliction within the autistic spectrum (so-called broad and narrow conception) and various kinds of combination disorders are taken into consideration in the discussion on neurodiversity, especially from the legal standpoint. In its broadest sense, the concept of neurodiversity defines all atypical neurological development as a normal human difference that should be tolerated and respected in the same way as other human differences. Proponents of the neurodiversity movement claim their condition is not something to be cured, but rather a human specificity or difference, with different ways of socializing, communicating and sensing that may not necessarily be disadvantageous and that must be equally respected. "Neurodiversity, in its broadest usage, is a philosophy of social acceptance and equal opportunity for all individuals regardless of their nervous system."[6] In the context of our study, neurodiversity defines neurotypical people as those who are not on the autism spectrum or are without mental illnesses. Neuroatypical is an umbrella term inclusive of people with diverse mental and behavioral disorders. "Social inclusion is a process by which efforts are made to ensure equal opportunities for all. The multi-dimensional process aimed at creating conditions which enable full and active participation of every member of the society in all aspects of life, including civic, social, economic, and political activities, as well as participation in decision making processes."[7]

Mental disorders are one of the top public health challenges in the WHO European Region, affecting about 25 % of the population every year. In consequence, the WHO European Region faces diverse challenges affecting both the (mental) well-being of the population and the provision and quality of care for people with mental health problems.[8]

The history of care and the associated development of mental health facilities in Europe recognises three periods, according to the study entitled *Mental Health Policy and Practice Across Europe*. The first period dates from the early 19th century to the mid-1920s, when patients were institutionalised in asylums, spas or private sanatoria. The second period lasted until the 1970s and was characterised by extensive private psychological practice. Pharmaceutical research was on the rise and with it the medication-based treatments. Outpatient treatment in psychiatric clinics similarly took hold during this time. The last period, which persists to this day, is characterised by

a systematic expansion of "vertical care" in the form of sectorisation, de-institutionalisation and complex community care.

## Undefined Autism and the Period of Asylums

The first written records of autistic tendencies date to the early 19th century. One of the best documented cases is Victor of Aveyron, a boy who lived his childhood in social isolation in a forest. According to French physician Jean Marc Gaspard Itard (1774 – 1838), he was extensively studied by several scientists from 1800, and his symptoms were described in the book *An Historical Account of the Discovery and Education of a Savage Man, Or of the First Developments, Physical and Moral, of The Young Savage Caught in the Woods near Aveyron, in the Year 1798*.[9] Another case was analysed by Uta Frith and Rab Houston in the book *Autism in History: The Case of Hugh Blair of Borgue*. It is an analysis of the society with an individual exhibiting signs of what would now classify as pertaining to ASD, in the context of legal and cultural conventions. Autistic behaviour with a combination of conditions went undiagnosed during this period, often likely misdiagnosed as other disorders.[10]

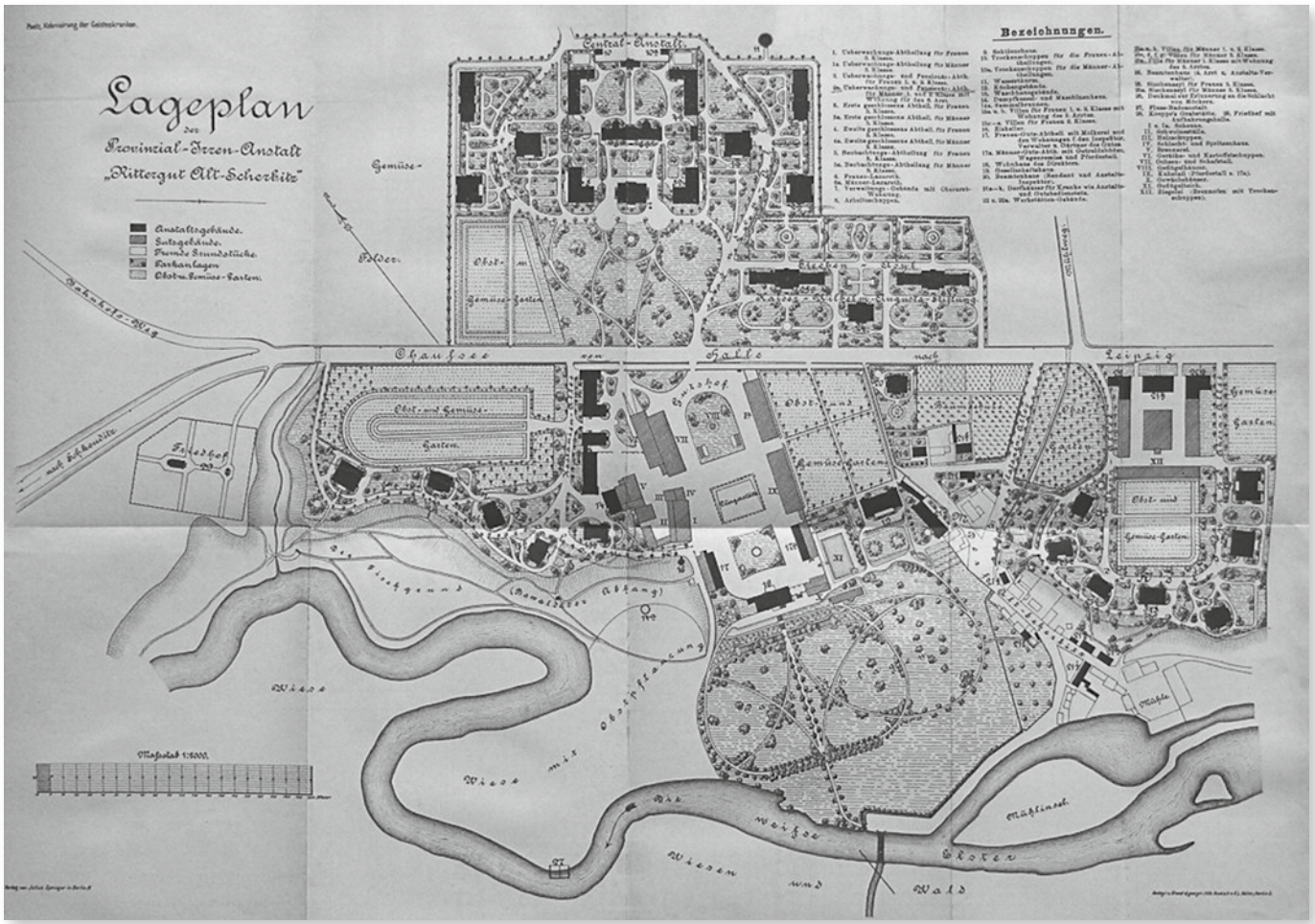
If the means allowed it, and in more remote parts of the country, people were cared for in a home environment, even at the time when first care facilities were starting to open doors to mental health patients. In more serious cases, the afflicted individuals would end up in almshouses or prisons. It was generally accepted that people with mental disorders were a threat to public safety. This fear gave rise to the establishment of public asylums, aimed at detaining and isolating psychiatric patients.[11] Asylums gained popularity as buildings where the "insane" could be nursed back to health and replaced "mad-houses" – institutions that functioned as prisons and showed little regard for patients' quality of life. This perspective assumed that mental illness was something purely physical and, presumably, curable like physical ailments.[12]

Although Europe had known custodial asylums since the Middle Ages, a page in the history of psychiatry was turned with the advent of the first therapeutic asylums. Arguably, the first was formed in the 1780s in Florence under the aegis of Vincenzo Chiarugi, followed by several others in Paris in the 1790s under Philippe Pinel, and then an increasing number in many other countries in the following years.

From the viewpoint of mental health care systems, the crucial event in this first phase was the imposition of a district-level network of asylums, each with its own catchment area. This began in England with the County Asylums Act of 1808, in France with the Law of 1838, and in other countries at successively later dates.[13] Even as recently as the first half of 19th century, mental disability was considered a punishment for moral failures and blasphemy. Not until the population rise and the increase in town density during the second half of the 19th century did the topic of mental health start to emerge. Asylums became hospitals for the poor, because the wealthy were placed into private philanthropic institutions. By the end of the century, large public hospitals were facing financial constraints associated with the rising population and were unable to provide mental health care. Small private facilities akin to hospitals were, from the late 1800s and early 1900s, propagated by European reformists Phillipe Pinel and William Tuke. They criticised the inhumane practices and conditions patients with mental disorders were exposed to in Europe, instead advocating humane treatment, which, among other things, required providing the patient with a pleasant environment. Moral treatment appeared in the 19th century as an approach to treating mental illness influenced by humanistic philosophy and the belief that a rational, caring approach would enable patients to normalize their thoughts and actions. It was based on William Tuke's reatreat model.

Home care was introduced in 1764 by the Engelken family, owners of a private psychiatric clinic in Rockwinkel near Bremen. The second exception to the predominance of the large asylums was the historical development of mental health service urban psychiatric clinics – first proposed by Wilhelm Griesinger (1868), professor of psychiatry in Berlin.[14] He believed in the integration of people with mental disorders into society and their treatment as individuals. Some private madhouses extended their psychiatric services to the support of clients in the community.[15]

The final exception was the emergence of community organisations for post-discharge care, almost always organized by private charities and foundations. "After the Second World War, the shift from asylum to general hospital was to take on positive, progressive overtones..."[16] Only a few years ago, "...before the Second World War, the best example of integrated mental health care was found




**THE ALT-SCHERBITZ PROVINCIAL ASYLUM, 1893**

ÚSTAV PROVINCIE ALT-SCHREIBITZ, 1893

**Source** Zdroj: TOPP, Leslie, 2007. Psychiatric Institutions, Their Architecture, and the Politics of Regional Autonomy in the Austro-Hungarian Monarchy. Studies in History and Philosophy of Biological and Biomedical Sciences. **38**(4), p. 737

not in the public sector but in the private: the whole world of spa therapy and private sanatoria for the middle classes and the wealthy."[17]

In 1910, Paul Eugen Bleuler, a Swiss psychiatrist, used the word 'autism' for the first time when describing specific symptoms of schizophrenic patients where they became withdrawn from others. In the early 20th century, the predominant theories on autism adopted a psychogenic approach, according to which autism is caused by emotional or psychological factors rather than biological or physical ones. In part, this change was grounded in Freudian psychoanalytic theory, which was popular at the time.[18] Additionally, a number of radical physical therapies were developed in Europe between the 1910s and the 1930s.[19]

## The Asylum Pioneers

The notion of the asylum as a microcosm, a miniature world-in-itself, was present throughout 19th and early 20th century literature on asylum planning. Equally, these writings displayed a messianic strain that took the analogy further, presenting the ideal asylum as a utopia in which the chaotic jumble of modern society was replaced by orderly and non-violent co-existence in harmony with nature. By the beginning of the 20th century, asylum planning had its own textbooks and reference works, and significant representation in journals and conferences. As was the case in clinical psychiatry, the German-speaking regions dominated the field and gradually replaced England in dictating trends and best practice in social care.[20]

In the 1880s and 1890s, seven psychiatric institutions were established in the Habsburg Empire. Large-scale planning of complex facilities at the end of the century provided an opportunity for scientific and architectural and urban integration throughout Europe.

At the turn of the millenium in Central Europe, asylums were designed in the form of large villas. Gated developments, not unlike a small town, could contain a theater, a church or a mortuary

**LEAVESDEN HOSPITAL, ABBOTS LANGLEY, HERTFORDSHIRE, 1870**

NEMOCNICA LEAVESDEN, ABBOTS LANGLEY, HERTFORDSHIRE, 1870

**Source** Zdroj: http://www.leavesdenhospital.org/

apart from the treatment and residential pavilions. The specialised process of "asylum planning" was often guided by senior psychiatrists. Here, the role of the architect was primarily to resolve urban issues and architectural aesthetics and representations which, in the political climate of Central Europe, played a significant role in national consciousness. The expression of these buildings would ideally demonstrate a wide-ranging interest in scientifically innovative treatment and the subsequent re-socialisation of patients toward the end of their future economic benefit to the society.

The Italian part of the Habsburg Monarchy tended to draw on their traditions from the Renaissance in the design and building of symmetrical atria and colonnades (the Quattro al Mare asylum, Genoa, 1895) despite the increased influence of progressive German tendencies using open plans, often based on Rittergut Alt-Scherbitz's Provincial Asylum near Leipzig (1893). The modern-looking Am Steinhof asylum, or more precisely the Lower Austrian Provincial Institution for the Cure and Care of the Mentally and Nervously Ill (1907), by Otto Wagner in Vienna, stands in stark contrast to other, mostly eclectic buildings. Wagner adopted a neutral vocabulary to suit a multicultural society with a number of national styles. The establishment was fully integrated into the master plan of the capital city, which sent a strong signal of a more modern approach to patients.

In England, where the institutions originated, 120 asylums housing over 100,000 in-patients were established over the course of the 19th century. Architecturally, these large complexes could be divided into three formats: a mixed type (Suffolk County Asylum), a corridor type, where sections were connected by corridors of several hundred meters (Colney Hatch Lunatic Asylum in Middlesex) and a pavilion type, housing up to 200 in-patients in male and female blocks (Leavesden Hospital, Abbots Langley, Hertfordshire). The gardens, often designed by well known gardeners, contained farms, orchards, workshops, cricket grounds and croquet lawns. Prior to this development, however, the grounds were more akin to those of prisons. The process of designing the older type of asylums in England and Wales is critically described in the book *The Construction and Government of Lunatic Asylums and Hospital for the Insane* from 1847 and compared to the newer tendencies; "in most of the old asylums the architects appear to have had regard solely to the safe keeping of the insane, and the buildings resemble prisons rather than hospitals for the cure of insanity". Urbanistically, an ideal place for an asylum is of "a gentle eminence, of which the soil is naturally dry, and in a fertile and agreeable country, near enough to high roads, a railway, or a canal, and a town".[21] Some complexes had their own railway stations with direct railway lines. The large complex of 5 asylums at Epsom in Surrey had its own light rail system. The complexes also had their own cemeteries.

## Care Centres Revised

The key theme of the post-war years is the gradual inclusion of mental health within social insurance plans and the welfare state. In terms of mental hospitals, the 1950s and 1960s were eras of growth. However, a major reversal was soon in coming. The 1970s saw the beginning of

deinstitutionalization. It remained for the Mental Health Act of 1959 to enshrine deinstitutionalization in the United Kingdom, emphasizing community care. "Deinstitutionalisation is the process of replacing long-stay psychiatric hospitals with less isolated community mental health services for those diagnosed with a mental disorder or developmental disability."[22]

The 1943 study by Austrian-American psychiatrist Lee Kanner marks a milestone in autism research, when the term "autism" was used in diagnostics.[23] The period after the 1970s is characterized by the vertical extension of mental health care, as the smooth passage from the mental hospital to the community becomes the norm; and by the horizontal extension of care, as mental health teams based in non-hospital settings assumed the care duties from isolated community psychiatrists and family doctors. Mental health care started to become de-medicalised, in the sense that numerous non-physician specialists begin to assume a role.

Since the first description of autistic tendencies in the early 1800s, the definition and diagnostic criteria for autism have changed radically. The first Diagnostic Statistical Manual (DSM) according to American Psychiatric Association in 1952 categorized autism as a childhood subtype of schizophrenia. Over time, autism evolved into a diagnostic spectrum by the time the last DSM-5 was published in 2013. Autism is becoming more prevalent, and the diagnostic criteria and definition are likely to continue to change in the future.[24]

## Neurodiversity as a Challenge to Planning

In the final period, as defined above, our subject of analysis is the process of inclusion through the evolving design of architectural and urban environments. This process revolves around the reaction and response from the recipient or user. The environment acquires meaning through its interactions, which are always triggered through personal experiences and possibilities. In the context of this study, we are interested in the interpretative solutions to the perception of the environment experienced by people with ASD. Their different way of perceiving the world reacts to different triggers than does that of neurotypical individuals. Their spatial experiences and interactions with the physical environment closely guide their unique sensory perception and their characteristic reactions and behaviours. For this reason, it remains important to consider the interaction of people with ASD with the built environment in the context of neurodiversity. Studying this interaction can be done from the perspective of space usability and spatial triggers to behaviours. Three aspects of the relations between a person with ASD and physical space can be identified; the confidence offered by the physical space, the hidden logic associated with space, and a direct and conscious way of experiencing the world.

Physical space presents a visible and unchanging feature for people with ASD, which gives them certainty and stability.

A new approach to spatial relations is the development of applications that facilitate daily tasks for people with ASD and their mobility within an urban setting, thereby increasing their autonomy. Their goal is to reduce stress reactions brought on by a disturbed routine or a potential unusual situation. To achieve the project's goals, different methods are used: qualitative interviews, cognitive maps, and participatory design techniques. These methods were chosen to capture the subjective perceptions and understandings of people with autism, in line with the cognitive urbanism approach. One of the currently used software packages, PIUMA (Personalized Interactive Urban Maps for Autism. Principal Investigator: Federica Cena, assistant professor at the Computer Science Department at the University of Turin), "aims to give a technology enhanced orientation support to adolescent/adult individuals with medium (who may present moderate-impaired cognitive ability), or high functioning autism (who present normal mental functioning), or with Asperger's Syndrome (now categorized as a form of ASD in the DSM-52)."[25]

Careful examination of the dynamic between the built environment – with its attributes of acoustics, visual character, spatial quality, color, texture, geometry etc – and human behavior can lead to the development of more specific and sensitive design guidelines. Individuals with special needs have been given particularly close attention in this type of design guideline development. One of the first publications regarding this matter is a series of studies published in the British Journal of Mental Subnormality in the first half of the 1970s with the title "The Physical Environment of the Mentally Handicapped".[26] More actual guidelines and design principles are proposed in "The Autism ASPECTSS™ Design Index" (Author: Magda Mostafa). "The index is based on the Sensory Design Theory, which hypothesizes that by altering the sensory environment using specific design

interventions, as manifested through input from the built environment, autistic behavior can be altered positively."[27] The index summarizes the seven design criteria. "These criteria are acoustics, spatial sequencing, escape space, compartmentalization, transition spaces, sensory zoning and safety."[28] Similar design guidelines are also used in the wellbeing agenda of the well-known commercial certifications WELL, LEED or BREEAM.

Another method of obtaining information is analysing the autobiographies of people with ASD (a.k.a. auti-biographies), who are able to describe, in their own language and expression, their perception of space and built environments. By analysing their own descriptions, we gain insight into an autistic way of thinking and acting in relation to the built environment. A complex outlook on this topic comes from one of the most cited studies on "auti-biographies" in a scientific text by Stijn Baumers and Ann Heylighen, "Harnessing Different Dimensions of Space: The Built Environment in Auti-Biographies" (2010).[29]

Despite the availability of a significant amount of information, the public in general is still largely surprised when faced with instances of unusual behaviour of individuals with autism and when considering accessibility, it is primarily understood as a question of a physical nature. To their disadvantage, they need to make great effort to comprehend and familiarise themselves with the space they find themselves in. During this process of familiarisation and processing of information, visual smog from signs and posters, unclear marking, loud announcements or other acoustic stimuli, neon lights and flashes can all be barriers causing frustration and unusual behaviours.

Persons with autism spectrum disorders continue to face barriers in their participation as equal members of society, and reaffirming that discrimination against any person on the basis of disability is inconsistent with human dignity. Individuals with autism spectrum disorders and their families face major challenges including social stigmatization, isolation and discrimination, while children and families in need, especially in low-resource contexts, often have poor access to appropriate support and services.

Interventions for people with ASD need to be accompanied by broader actions for making physical, social and attitudinal environments more accessible, inclusive and supportive.Worldwide, people with ASD are often subject to stigmatisation, discrimination, and human rights violations. Globally, access to services and support for people with ASD is inadequate.

The city, which comprises mostly persons whom we do not know and will never know, prompts us to reflect that beneath the surface layers of personality everyone is a stranger. Recognition of this kernel of strangeness is not necessarily a defect in a relationship. On the contrary, it can be a virtue; it makes for respect.[30]

"The UN Convention on the Rights of Persons with Disabilities (UNCRPD) is the first international, legally binding instrument setting minimum standards for rights of people with disabilities, and the first human rights convention to which the EU has become a party."[31] The level of effort put into the creation of inclusive spaces currently differs in different European countries, depending on their relevant adopted legislation. Basic health insurance does not, in many cases, cover the wide range of mental illnesses, leading to huge financial difficulties and subsequent social exclusion for families, which spreads from the afflicted individual onto his immediate family and care group. The WHO has made accessible its Mental Health Atlas, a project designed to collect, compile and disseminate data on mental health resources in the world. In Europe 80 % of countries have formulated their legislation after 1990. However, the presence of legislation, even if it has been formulated recently, does not guarantee the protection and promotion of rights of persons with mental disorders.[32]

## The Approach to Autism in Slovakia

If we consider the WHO definition of ASD, seen as a specific mental disorder, the starting point of this study, then the entire topic of autistic spectrum is gravely neglected in Slovakia. The Slovak Ministry of Health has, though, declared a clear intention to address this issue in its latest public outreach announcements on the topic of mental health. One of the most significant of these is the improvement of education about mental disorders in schools, workplaces and communities and the creation of a system of coordination between ministries, that goes beyond their respective fields and within the same agenda.[33]

So far, we do not have sufficient statistical data about people with ASD. The estimated number is about 30 – 50 thousand individuals. (Jozef Šóth, MD, director of the Communal Centre of Autists

Drahuškovo, claims to have researched some 38,000 people within his organisation only).[34]

Considering the large numbers of high-functioning cases and cases of combined mental disorders, neuroatypical people vary in their perception and use of architecture. On one hand, architecture and urbanism can become closely linked with the social aspects of the affliction in mental health discussions where the main topic is deinstitutionalisation – the transformation from institutionalised to community-based provision of social service. On the other hand, there is the contribution of research by the private sector, which looks at providing neuroatypical high-functioning workers with an optimal working environment.

The basic and most important claim for the need for inclusion and deinstitutionalisation and transformation of social services is defined in the Universal Declaration of Human Rights, in article 1: "All human beings are born free and equal in dignity and rights".[35]

"Freedom, equality and dignity are elementary attributes of human beings. If we adopt the thinking of this ethical approach, and in the basic international document, it is our moral and professional obligation to change the system in such a way, that all humans would be equal in freedom, dignity and rights."[36] Within this context, architecture is becoming recognised as an unavoidable tool for the creation of solutions, responsible for the existence of different communities.

In Slovakia, care institutions began to develop, similarly to other European countries, back in the 13th century. These socially charitable and healing institutions were based in monasteries at first; later the towns themselves prompted their creation. The Hospital of St. Anton in Bratislava (1309) and St. Elizabeth in Banska Bystrica (1255) are two of the largest and oldest of these.

A significant change occurred in the second half of the 19th century, when central Europe started implementing home care rights as part of town residency. This right aimed to ensure that a resident would be entitled to social care in cases of poverty, need or health affliction. The oldest establishment for people with mental health issues in Slovakia is the Blum Institution in Plešivec, founded in 1898. A high demand for placement of patients was recorded within the first 10 years of its operations, expanding from 10 to 150 beds and continuing to grow in the following decades.

Some of the care for people with mental health problems was taken on by the Psychiatric Clinic of Comenius University in Bratislava. "It was here that Karol Matulay, MD, who started working here in 1932, became one of the most influential people within 20th century healthcare and social care for people with mental disabilities. During his time at the clinic between 1932 and 1945, he abolished the cell system, net beds, straightjackets and passive care, which he replaced with active therapy and ergotherapy."[37]

After World War 2, when official Nazi policy interrupted some activities and discontinued others of the special establishments in the name of racist and genocidal attitudes toward the weaker and disadvantaged, the 1950s and 1960s witnessed massive construction of high-capacity special institutions throughout Europe.

In Slovakia, nationalisation led to the establishment of care facilities inside former church buildings and monasteries, which were ill-matched for this purpose both spatially and technologically.

This approach to care, still practiced today to a certain extent, creates a high level of segregation. Architecturally, the urbanistic solution for these care facilities was originally a condition of being "carved" into their surroundings by physical barriers or their own locality, away from communities. That is how the setup reciprocated the patients' fears with respect to the outside and towards people who as outsiders, away from this demarcated space, were deemed as dangerous.

"The first signs of deinstitutionalisation, manifested as the need to establish outpatient treatment, are dated to 1982 in Slovakia, when the first outpatient sanatorium (Lipského 13) was established by Doc. PhDr. Slavomír Krupa, PhD. in Bratislava for children with mental afflictions."[38] These first projects implied a significant transformation and deinstitutionalisation after undergoing quality evaluation in the second half of the 1990s. During this period, the final phase of this process is taking place in Western Europe.

The situation from hundreds of years ago, when different diagnoses were housed in the same establishment, making it hard to provide specialist patient care, is also an issue today. Currently, the social establishments care for both people with mental and behavioural issues and people with complex psychiatric diagnoses.

In the present society, it is increasingly clear that the development of the environment is a social construct of the same importance as accessibility or natural resources and finances. Relationships between people as individuals and their varied communities are important factors in the

**COMMUNITY HOUSING DRAHUŠKOVO, KRAJNÉ, SLOVAKIA, 2010**

KOMUNITNÉ BÝVANIE DRAHUŠKOVO, KRAJNÉ, SLOVENSKO, 2010

**Source** Zdroj: https://www.gfi.sk/custom/projects/?id=155

construction of a socially supportive space. The spatial arrangement of towns and villages should create the right conditions for this camaraderie by creating the right living and working conditions and services.

## More Severe Cases of Autism in the Context of Spatial Solutions: Architectural Conversion in Slovakia

Even in 2020, Slovakia can still be considered to be at the beginning of the reformation. Deinstitutionalisation, as the reformation in question, aims to reverse the induced stagnation of the development of social services. "This stagnation comes from the outdated conviction that it is sufficient to fulfil the needs of a person unable to do so for themselves due to physical, mental, or social limitations."[39] Currently there are 10 diagnostic facilities for autism in Slovakia, according to the organisation SPOSA.[40] This number is clearly insufficient.

The only unique case of a modern community-based facility for ASD patients in Slovakia is the Drahuškovo social care facility in the town of Krajné (Myjava district). It was established to cater for adults with complex autism and, similar to other such facilities, is located within an older converted structure. The difference was that it became a place where functionality was enhanced with specific architectural solutions (authors of the reconstruction: GFI). Its operations started in 2010, mostly funded by Norwegian grants and the private sector, in collaboration with the Autism Society Norway and the University of Oslo. The project was created by the parents of people with ASD from the organisation Drahuško. One of the founders is Jozef Šóth, MD, its current director.

The establishment constructs an ideal communal cycle, as it creates work opportunities for former clients from the childcare system and foster families in the position of an assistant carer (a halfway-house program). It cares for ten clients with health afflictions, seven of whom are on a yearly or weekly basis and three on a daily basis as employees of safeguarded workshops. The spatial infrastructure or the workspace is based on three detached objects and a space for husbandry and agriculture in the exterior.

**MUDR. PAVOL MAZALÁN**
FACULTY OF MEDICINE
COMMENIUS UNIVERSITY
BRATISLAVA
Špitálska 24
813 72 Bratislava
Slovak republic

**ING. ARCH., MGR. ART. PETER MAZALÁN, PHD.**
FACULTY OF ARCHITECTURE
AND DESIGN
SLOVAK UNIVERSITY OF
TECHNOLOGY, BRATISLAVA
Námestie slobody 19
812 45 Bratislava
Slovak republic
peter.mazala@stuba.sk

An old converted school is the main assembly building as well as the main centre for creation. A former classroom was turned into a multipurpose hall (gymnasium and event hall). Pottery, kitchen and multi-use workshops can also be found here. The upper floor serves as accommodation for personnel. A new three-storey building was built to provide accommodation for clients, as well as an administrative section and kitchen / dining. The last building houses the DT workshops and livestock / kennel facilities.

Architecturally, the language of the complex is bold. The timber-clad living quarters, the reduced facades and near-achromatic scheme of the converted school, together with the reinforced platforms, work as a harmonic and functional entity. The objects are interconnected by covered walkways. The director describes the project as a result of the needs of parents based on their lives' work for their autistic children. As a space for people with ASD, in this case it is a safe space. At the same time, it is clearly demarcated and organised and offers a variety of stimulation zones.

Even though it may appear to form another large isolated complex outside of the main town centre in a rural setting, similar to the 19th century institutions in Europe, these types of places tend to provide their clients with room for self-realisation, work, social and communal contribution towards a wider audience.

In Slovakia, most of the clients are placed in buildings that were not built for any specific purpose, which is reflected in the living conditions. Many establishments operate in historic buildings, mostly converted some 50 years ago. Their walk-through floor plans with large rooms are not suitable and do not provide basic comforts, nor do they use the basic principles of accessible design.

A mansion in Adamovské Kochanovce, which provides social care for the mentally disabled, is one of the more significant historic buildings, and a piece of national heritage at the same time. This Baroque chateau from the third quarter of the 18th century with an adjacent park was owned by Countess Marguerite de Sizzo Noris (1889 – 1977) prior to being nationalised. The process of its confiscation by the state in the second half of the 1940s is well documented.[41] In 1948, after reconstruction, it became a retirement home followed in 1963 by a social care facility for children with mental disorders. As of 31 December 2019 it housed 60 social patients, although it has naturally turned into an establishment for adults. The social care facility is composed of two accommodation buildings (mansion and operational building), a utility building (laundry and water treatment), garages and parks. The entire complex is fenced off. The mansion has two floors with bedrooms and day rooms. In the adjacent single storey building there are offices, workshops, rehabilitation room, multi-sensory room, event hall and client accommodation in the loft space. "Despite an almost 232,000 euro investment into this facility, in 2016 there were still large capacity rooms with more than 8 beds and a bathtub. One of the negative consequences of this setup is the perception that the term "transformation of social services" only related to capital support and humanisation."[42]

**1** YI-FU, Tuan, 1988. The City as a Moral Universe. *Geographical Review.* **78**(3), pp. 316 – 324. https://doi.org/10.2307/215004

**2** Yi-Fu, T., 1988.

**3** MONDSCHEIN, Andrew – MOGA, Steven, 2018. New Directions in Cognitive-Environmental Research: Applications to Urban Planning and Design. *Journal of the American Planning Association*. **84**(3 – 4), pp. 263 – 275. https://doi.org/10.1080/01944363.2018.1526644

**4** JAARSMA, Pier and WELIN, Stellan. *Autism as a Natural Human Variation: Reflections on the Claims of the Neurodiversity Movement* [online]. Feb. 2011 [Accessed 19. 12. 2019]. Available at: https://www.researchgate.net/publication/49827482_Autism_as_a_Natural_Human_Variation_Reflections_on_the_Claims_of_the_Neurodiversity_Movement

**5** *World Health Organization.* Key facts [online]. Nov. 2019 [Accessed 2. 2. 2020]. Available at: https://www.who.int/news-room/fact-sheets/detail/autism-spectrum-disorders

**6** *Ventura33's.* Neurodiversity. [online]. May. 2006 [Accessed 30. 8. 2020]. Available at: http://www.ventura33.com/ neurodiversity/

**7** *IGI Global.* What is social inclusion [online]. 2020 [Accessed 30. 8. 2020]. Available at: https://www.igi-global.com/dictionary/social-inclusion/27360

**8** *The European Mental Health Action Plan 2013 – 2020* [online]. 2015 [Accessed 2. 4. 2020]. Available at: http://www.euro.who.int/__data/assets/pdf_file/0020/280604/WHO-Europe-Mental-Health-Acion-Plan-2013-2020.pdf

**9** ITARD, E. Marc, *An Historical Account of the Discovery and Education of a Savage Man, Or of the Firts Developments, Physical and Moral, of The Young Savage Caught in the Woods near Aveyron, in the Year 1798* [online]. London, 1802 [Accessed 10. 4. 2020]. Available at: https://archive.org/details/anhistoricalaccooitargoog/page/n7/mode/2up

**10** Admission statistics on 1185 patients between 1883 and 1888 show that 52 % of the clinic's patients had 'neurosis' (neurasthenia, hysteria, hypochondria); 5% had organic CNS conditions such as 'progressive paralysis', a contemporary term for neurosyphilis; 13% were alcoholics, and 9% were 'psychotic', meaning mainly melancholia and obsessive-compulsive disorders. KNAPP, Martin et al., 2006. *Mental health policy and practice across Europe.*Glasgow: Bell & Bain Ltd, p. 19.

**11** The asylum is a form of institution primarily for mentally ill or disabled people which creates a fully segregated entity, built and provided by the state from 1815. CRESSMAN, Abbey et al. Museum of Health Care at Kingston. *Mental Health: Tracing the History of Stigma.* [online]. Jul. 2014 [Accessed 10. 4. 2020]. Available at: https://museumofhealthcare.wordpress.com/2014/07/15/mental-health-tracing-the-history-of-stigma

**12** Cressman, A., 2014.

**13** Knapp. M., 2006, p. 17.

**14** Knapp. M., 2006, p. 17.

**15** The profession of attendant, a 19th and early 20th century term for staff working with patients in asylums and workhouses, could also be provided to live with and look after patients in their own homes or in lodging houses. Such attendants were in many respects the forerunners of modern community psychiatric nurses.

**16** Knapp, M., 2006, p. 18.

**17** SHORTER. Edward, 1990. Private Clinics in Central Europe, 1850–1933, *Social History of Medicine.* (3), pp. 159 – 195.

**18** COOK, Kieran and WILLMENDINGER, Allisa. *The History of Autism* [online]. Sept. 2015 [Accessed 19. 2. 2019]. Available at: https://scholarexchange.furman.edu/schopler-about/1/ https://doi.org/10.1093/shm/3.2.159

**19** Among these we may note the Austrian psychiatrist Julius Wagner-Jauregg's malarial therapy for general paresis of the insane first used in 1917. This treatment heralded the beginning of a radical and experimental era in psychiatric medicine that increasingly broke with an asylum-based culture of therapeutic nihilism in the treatment of chronic psychiatric disorders. TSAY, Cynthia. *Julius Wagner-Jauregg and the Legacy of Malarial Therapy for the Treatment of General Paresis of the Insane* [online]. Jun. 2013 [Accessed 15. 4. 2020]. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3670443/

**20** TOPP, Leslie, 2007. Psychiatric Institutions, Their Architecture, and the Politics of Regional Autonomy in the Austro-Hungarian Monarchy. *Studies in History and Philosophy of Biological and Biomedical Sciences.* **38**(4), pp. 733 – 755. https://doi.org/10.1016/j.shpsc.2007.08.001

**21** CONOLLY, John. *The Construction and Government of Lunatic Asylums and Hospitals for the Insane* [online]. London: John Churchill, 1847, pp. 31 – 55 [Accessed 10. 4. 2020]. Available at: https://books.google.sk/books/about/The_construction_and_government_of_lunat.html?id=jecDAAAAQAAJ&redir_esc=y

**22** "Deinstitutionalisation works in two ways: the first focuses on reducing the population size of mental institutions by releasing patients, shortening stays, and reducing both admissions and readmission rates; the second focuses on reforming mental hospitals' institutional processes so as to reduce or eliminate reinforcement of dependency, hopelessness, learned helplessness, and other maladaptive behaviours." *International Mental Health Collaborating Network.* Deinstitutionalisation [online]. 2020 [Accessed 30. 8. 2020]. Available at: https://imhcn.org/bibliography/deinstitionalisation/

**23** In the article "Autistic Disturbances of Affective Contact", he describes autism as a result of a rigid parenting style. He also defined infantile autism, which also became known as Kanner syndrome.

**24** Cook, K. A., 2015.

**25** CENA, Federica et al. *Personalized Spatial Support for People with Autism Spectrum Disorder* [online]. Jul. 2018 [Accessed 15. 4. 2020]. Available at: https://dl.acm.org/doi/10.1145/3213586.3225229

**26** WILLIAMS, Tim, 2011. *Autism Spectrum Disorders: From Genes to Environment.* Rijeka: InTech, p. 368.

**27** MOSTSAFA, Magda, 2008. An Architecture for Autism: Concepts of Design Intervention for the Autistic User. *The International Journal of Architectural Research.* **2**(1), pp. 189 – 211.

**28** MOSTAFA, Magda, 2015. Architecture for Autism: Built Environment Performance in accordance to the Autism ASPECTSS™ Design Index. In: *An International Journal – Annual Review.* **8**. [online]. Jul. 2015 [Accessed 30. 8. 2020]. Available at: https://www.researchgate.net/publication/283099110_Architecture_for_autism_Built_environment_performance_in_accordance_to_the_autism_ASPECTSS_design_index https://doi.org/10.18848/1833-1874/CGP/v08/38300

**29** BAUMERS, Stijn and HEYLIGHEN, Ann, *2010. Harnessing Different Dimensions of Space: The Built Environment in Auti-biographies.* In: *Designing Inclusive Interactions*. London: Springer, pp. 13 – 23.

**30** Yi-Fu, T., 1988.

**31** *European Commission.* United Nations Convention on the Rights of Persons with Disabilities [online]. 2020 [Accessed 30. 8. 2020]. Available at: https://ec.europa.eu/social/main.jsp?catId=1138&langId=en

**32** *World Health Organization.* Project Atlas [online]. 2019 [Accessed 2. 2. 2020]. Available at: https://www.who.int/mental_health/evidence/atlasmnh/en/

**33** *Ministerstvo zdravotníctva SR.* Duševné zdravie po prvý raz v programovom vyhlásení vlády [online]. July 2020 [Accessed 1. 9. 2020]. Available at: https://www.health.gov.sk/Clanok?minister-dusevne-zdravie-programove

**34** SUDOR, Karol, 2018. Šéf zariadenia pre klientov s ťažkými formami autizmu: Rodičia sú zúfalí, štát tento problém nezaujíma. Denník N [online]. 2018 [Accessed 1. 9. 2020]. Available at: https://www.drahuskovo.sk/db/files/Tlacove-spravy-a-printove-media_6_51_75074.pdf

**35** *United Nations.* Universal Declaration of Human Rights [online]. 2020 [Accessed 2. 9. 2020]. Available at: https://www.un.org/en/universal-declaration-human-rights/

**36** CANGÁR, Miroslav, 2018. *Prechod z inštitucionálnej na komunitnú starostlivosť v Slovenskej republike.* Bratislava: Socia, p. 13.

**37** Cangár, M., 2018, p. 23.

**38** Cangár, M., 2018, p. 37.

**39** *Deinštitucionalizácia zariadení sociálnych služieb.* Deinštitucionalizácia – príležitosť na zmenu [online]. 2020 [Accessed 2. 9. 2020]. Available at: https://npdi.gov.sk/deinstitucionalizacia-rilezitost-na-zmenu/

**40** *Sposa.* Centrá diagnostiky a zariadenia [online]. 2020 [Accessed 2. 9. 2020]. Available at: https://www.sposa.sk/pomoc/kde-najdem-pomoc/

**41** HARŠÁNY, Ľuboš, 2015. Konfiškácia kaštieľa v Adamovciach a činnosť Národnej kultúrnej komisie pre Slovensko. *Monument Revue.* **1**, p. 54.

**42** Cangár, M., 2018, p. 82.