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**Space, the final frontier: outdoor access for people living with dementia**

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## **Space, the final frontier: outdoor access for people living with dementia**

### **Introduction**

Studies have consistently found that access to outdoor space has a positive impact on the mental and physical wellbeing of people with dementia (Mapes, 2010; Rappe & Topo, 2007). Benefits are often linked to an affinity with nature (Hendriks, van Vliet, Gerritsen & Dröes, 2016) and outdoor settings (Olsson, Lampic, Skovdahl & Engström, 2013) with a government White Paper expressing the commitment to reconnect people with this natural environment (HM Government, 2011). The benefits of outdoor access can also arise from engagement in specific activities (Noone, Innes, Kelly & Mayers, 2015), helping to promote inclusion and occupation, with the Joseph Rowntree Foundation (2005) finding that older people regarded the ability to get out and keep active as being an important aspect of their life. Specific benefits of going outside expressed by people with dementia include interaction with others, aesthetic appreciation, exercise and a sense of freedom (Duggan, Blackman, Martyr & Van Schaik, 2008). For those living in care homes, where privacy tends to be lacking, additional benefits of outdoor access can also potentially include the experience of being alone and in a peaceful place. Of course, these benefits are unlikely to be unique to people with dementia who just want to maintain an ordinary way of life (Fukushima, Nagahata, Ishibashi, Takahashi & Moriyama, 2005), nor are benefits confined to the promotion of individual wellbeing. As such, this editorial will suggest that access to the outdoors is central to the promotion of the human rights and social inclusion of people with dementia. It will also explore the barriers and facilitators to the achievement of this access.

### **Barriers to outdoor access**

In spite of the evident benefits of outdoor access, in practice, this access is often denied to people with dementia (Natural England, 2016), who either have limited means of getting out of their own homes or else, if they live in a care home, find that the doors are locked and they are de facto detained (Griffith, 2016). This perpetuates the social exclusion and isolation that have long existed for older people. In the past this has been attributed to the personal characteristics of older people themselves with the theory of social disengagement suggesting that declining health, increasing disability and limited life expectancy led to 'an inevitable' social withdrawal (Cumming and Henry, 1961, p. 14). However, this simplistic view has been criticised since we know that social processes

operate in maintaining this exclusion (Phillipson, 1982). Furthermore, critical gerontology highlights the diversity and active social involvement of older people rather than their role as passive victims (Gilleard and Higgs, 2000). However, despite the promotion of inclusive and human rights based approaches aiming to help older people ‘to live as full lives as possible’ (Department of Health, 2005, p. 27), social exclusion persists. For people with dementia, this can be exacerbated by a combination of physical and cognitive impairments (Harada et al., 2016) forming a barrier to outdoor access with declining memory and confidence as well as disorientation in unfamiliar settings potentially restricting this access (Duggan et al., 2008).

While these narrowing horizons seem to suggest the ‘inevitability’ of social withdrawal, as postulated by social disengagement theory, contextual issues are also important. These include negative attitudes towards people with dementia such as the belief that nothing can be done to help them or even that they are ‘effectively dead’ (Clarke, Heyam, Pearson, & Watson, 1993) and the corresponding belief that those with dementia need to be confined indoors (Duggan et al., 2008). These beliefs are reflected and reinforced by a lack of appropriate support to access outdoor spaces, as well as in professional cultures that focus on minimising levels of risk (Bantry, White & Montgomery, 2015; Furumiya & Hashimoto, 2015). With regard to the wider social and policy context, the closure of local facilities, progressive cuts in public transport provision and other resource limitations (such as the lack of a ‘mobility component’ in the UK Attendance Allowance for older people with a disability), reinforce isolation. In addition, while care home standards for Scotland and Northern Ireland do clearly suggest the need for outdoor access for residents, there appears to be no comparable requirement for England and Wales. Similarly, Council of Europe standards stipulate the need for daily outdoor access for patients in psychiatric facilities (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (hereinafter CPT), Psychiatric Facilities, para 37, 2002). Prisoners too have the recognised right to ‘outdoor exercise everyday’ in settings which are ‘reasonably spacious’ (European CPT, Prisons, Para 48, 2002). The CPT has not yet published standards for care homes, when it does, it seems likely it will include a similar right of access to the outdoors.

### **Promoting outdoor access**

Guaranteeing access to the outdoors is not only, therefore, a matter of good practice in dementia care but it is also a matter of rights and social justice. If offenders have rights to fresh air, then so too do older people whose only transgression is to have developed dementia. The UN Convention on the Rights of Persons with Disabilities (United Nations, 2006) is more specific. Article 9, on Accessibility, aims ‘to enable persons with disabilities to live independently and participate fully in all aspects of life’. Towards this end, parties should identify and eliminate all barriers and obstacles to ‘inter alia, buildings, roads, transportation and other indoor and *outdoor facilities*, including schools, housing, medical facilities and workplaces’ (our emphasis). Article 19 on living independently and being included in the community, emphasises ‘community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community’. Dementia groups, such as Dementia Alliance International, are urging that Article 19 is applied more forcefully to dementia (Mittler, 2016), and it is difficult not to agree with this perspective. While the Alzheimer’s Society (2016) observes that in spite of the introduction of the Equality Act in 2010, people with dementia continue to experience contraventions to their human rights and call for a more robust enforcement of the Mental Capacity Act (2005) which requires those with reduced capacity to be supported in making their own decisions.

What else should be done to transcend this final frontier? At an individual level, any care plan should consider the person’s rights and wishes regarding access to the outdoors and incorporate the use of facilitators to this access such as assistive technology and carer support. On a wider level, service providers and commissioners should fulfil their obligations by taking active steps to ensure that people with dementia can get outdoors as and when they desire. This requires more than a simple assumption that wheeling someone outside is sufficient but consideration as to how this fits in with the social engagement of that person. Appropriate measures also need to adopt a proportionate balance between rights and risks and incorporate context, community and collaborative working, enabling the sharing and development of innovative practice. For example, Natural England (2016) recommend the further expansion of dementia friendly open spaces, the creation of local directories providing details of these spaces as well as the greater consultation with people with dementia on their own needs and aspirations. Aligned with these recommendations are the development of Dementia Friendly

Communities which is now an international movement (Alzheimer's Disease International, 2016). Finally and importantly, social prejudice and stigma towards people with dementia should be addressed for this not only legitimises their social exclusion, it also influences the process of resource allocation which helps to reinforce this.

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