TEXAS TECHNOLOGICAL COLLEGE

A REGIONAL MENTAL HEALTH CLINIC

BY

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PREFACE

The Architect seeking guidance in mental hospital planning finds himself in a field in which there is limited definitive information. Ten years ago this was more or less true of general hospitals but the postwar building program has provided the experience from which a substantial body of detailed information has been made available. In the mental health field due to many reasons we do not have comparatively, similar information in scope or in detail.

Too many of the existing mental hospitals are quite inadequate for modern techniques of mental care. Many of them are badly located, crowded, and, to a large extent, have been unable to offer much more than custodial care. Part of the explanation of this lies in the ever increasing number of mental patients and in the rising costs of mental care. Lack of trained personnel and public apathy have also contributed to this unfortunate situation.

A startling one-third of the budget of every state government in the nation goes for the care of the mentally ill each year, yet even this sum has not been adequate to cope with the evergrowing problem. As a result, pared building budgets, understaffing, overcrowding, and inadequate maintance combine to produce an environment which, by and large, is inadequate for the treatment of the mentally ill.

The need for imporvement has long been recognized, but now, through the use of the "tranquilizing drugs", and better treatment methods, a drastic change is not only necessary but also possible.

Medical authorities have predicted that the next great breakthrough may also have begun with the development and use of the tranquilizing drugs, and with the application of newer knowledge in the care of the mentally ill. If the prediction proves true, a considerable change in mental hospital environment will be required.

Completely adequate statistical information of the effect the new drugs will have on the total mental hsopital population has not yet been compiled and analyzed. But it begins to appear that as a large number of patients become more quiescent and more accessible for treatment, fewer detention rooms will be required. More recreational and occupational therapy area will be necessary. Vocational rehabilitation will become a still more important factor in the treatment of many patients. With more patients attaining outpatient status, greater emphasis will be placed on day-care facilities and out patient treatment areas.[1]

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[1]John W. Cronin, "Environment for Mental Therapy", Nov. 1956, A. R., pp. 201.

The mental patient is more self-centered than the average person. His rehabilitation demands that we change this tendancy and direct his attention outward to other people and to his physical environment. Thus the design of a mental hospital must place maximum emphasis on features which tend to draw and hold numan interest. Ideally the design must be considered from a therapeutic and not merely from an administrative or maintenance standpoint.[1]

Mental hospital patients exhibit certain characteristics which are either different from, or exaggerations of, what we expect in the average person. For this reason, the design of mental hospitals does call for certain features over and above those necessary for other types of building. Some of these characteristics peculiar to mental patients are determined by their own particular needs and attitudes which are essentially a part of their illness; others are determined by the fact that they happen to be living in a mental hospital. With these ideas in mind, we can formulate certain basic principles upon which will depend a satisfactory design for a mental hospital.[2]

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[1] Charles E. Goshen, M.D., "Psychiatric Architecture", (Washington, D.C.), pp. 3.

[2] Ibid., pp. 4.

CHAPTER I. DEFINITION

I. DEFINITION

A psychiatric hospital is a haven for that portion of humanity which is suffering the pangs of mental illness; a home that offers care, comfort, hope and love, and which through the practice of specialized methods of treatment and intensive research, a chance to regain social integration (society) in as short a time as possible.[1]

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[1] K. E. C. Appel, "Humanization of the Mental Hospital", Nov. 1953, A. R.

CHAPTER II. HISTORY

1. THE RECENT PAST

When faced with a massive and daunting problem such as that of the 750,000 or so mentally ill people in North America shut up in nearly 500 fortresses whose patient population run from a few hundred to as many as 15,000, one must look into history.

To understand what has happened and to envisage what may happen again, we have to recognize that we are in an early phase of the second great attempt in the last 200 years to give humane care to the mentally ill. We are emerging shamefully and shaken from a dark era. We are not coming out of a primitive condition that could be excused by ignorance or poverty but something far more distressing - from a lapse into barbarism.[1]

In 1768, Governor Francis Fauquier of Virginia made an appeal to the House of Burgesses on behalf of a "poor, unhappy set of People who are deprived of their Senses". Responding to his plea, the good Burgesses passed an act in that year providing for the support and maintenance of "Ideots, Lunatics and other persons of unsound Minds". Five years later, the first institution in the Colonies devoted exclusively to mental patients opened its doors at Williamsburg.

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[1] Goshen, "Psychiatric Architecture", pp. 7.

During the nineteenth century, state after state built one or more institutions for the care of the mentally ill within their confines. However, in most cases these mental hospitals, or "lunatic asylums" as they were most frequently designated, were forbidding dungeons where chains, wristlets, and iron chairs were the prevalent form of "therapy". These institutions were built in isolated rural areas, cut off by design from the main stream of daily life and activity.

For more than a hundred and fifty years following the erection of the Williamsburg structure, there were heroic individual attempts to bring the plight of the mentally ill to the conscience of America. Dorthea Lynde Dix, one of the most courageous of the nineteenth century reformers, brought about the construction of many state institutions and singlehandedly succeeded in convincing Congress to establish a Federal hospital, the famous St. Elizabeths. In the early part of the twentieth centruy, Clifford Beers, a former mental patient, established the National Committee for Mental Hygiene to foster citizen interest in better care for the mentally ill.[1]

From 1840 to 1880 on this continent and in Europe the principles underlying the care of the mentally ill

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[1] Mike Gorman, "Every Other Bed", New York, 1956, pp. 162--163.

were discovered, codified and practiced extensively. The moral treatment of the insane, as this form of care has been called, was fully developed by about 1850, and continued in some places until 1900 and even later. It produced, at its best, a standard of care rarely excelled and seldom equalled in public hospitals either before or since.

Its silent collapse was not followed by any general return to the utter foulness of the 18th century madhouse. This was not due to any special effort to avoid an added disaster, but because public health medicine had developed greatly during the latter period of the 19th century.[1]

But there was a discouraging rise and fall cycle in the attempts at reform. There was temporary public arousement, a crescendo of righteous citizen indignation, and then a falling back into the slough of despond.

Following the advent of World War II, with its dramatic demonstration of the crippling effects of mental illness upon our armed forces, there came a powerful demand for a new approach. Many returning veterans were in need of hospitalization for serious emotional illnesses, yet the Veterans' Administration mental hospitals were, for the most part, custodial snake pits. In a brilliant series of exposés in newspapers and magazines, the deficiencies of these mental

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[1] Goshen, "Psychiatric Architecture", pp.7.

hospitals were laid bare. The Veterans' Administration mental hospitals were then pulled into the community of American medicine, tying their programs into the medical schools.[1]

Centuries of beating, straitjackets, obstracism, dispossession, and neglect of emotionally disturbed persons have not solved the riddle of mental illness, diminished man's fear of insanity, or allayed his troubled concience. In our time we vacillate between trusting mental illness completely out of sight and out of mind, and yielding to humanistic inner promptings to cure these "sick souls". Today our state hospitals represent a crude and unfortunate compromise between such conflicting trends.[2]

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[1]Gorman, "Every Other Bed", pp. 162-163.

[2]Greenblatt, York, and Brown, "From Custodial to Therapeutic Care in Mental Hospitals", New York, 1955, pp. 37.

2. New Ideas

Within the past decade, several major advances in treatment have emerged and have been incorporated into psychiatric practice. One is the intorduction of new drugs for the treatment of mental disorders. Another is the recognition of the effect of the social envirnment of the hospital upon patients and its usefulness as a definite treatment measure.

These developments have already given evidence that the treatment of psychiatric patients is entering a new era. There is evidence, too, that these treatment methods are leading to a need for different types of physical facilities than have been traditional in the past.

(a) New Drugs

In 1953 reserpine, the first of the new drugs, was used to treat psychiatric patients in a New York State Hospital. About the same time, chlorpromazine, a second drug with a similar quieting effect on mental functioning, was intorduced into this country from France. Reserpine and chlorpromazine have been the major tranquilizing drugs which have been used in psychiatry during the past three years. A series of related drugs have also come into clinical use and have been found effective for various psychiatric illnesses and symptoms. It is likely that additional and perhaps more effective drugs will be found

and used in the future.

Writing of the effects of drug therapy, Dr. B. Pollock of the Rochester (New York) State Hospital reported:

> From June 1954 to August 1955, 900 patients were treated with these drugs at his hospital, of whom 66 per cent improved significantly. He listed the following as results of drug treatment:
>
> 1. The use of electric shock therapy decreased by 60 to 90 per cent.
> 2. Insulin shock therapy and psychosurgery are rarely used.
> 3. More patients participate in activities. In 1954, only 15 of 54 patients on a disturbed ward were able to attend a picnic. In 1955, 49 of 51 patients on the same ward went to a picnic.
> 4. The need for seclusion and restraint were reduced markedly. There were 87 patients at the hospital who had been in almost constant seclusion or restraint for 5 to 20 years. After drug treatment, 43 were out of restraint completely, and 11 more required no restraint much of the time. Most restraint in use at the hospital now is for physically ill psychotic patients who are restrained for such reasons as to prevent them from tearing off bandages, or because they will not remain in bed when their illness so required.
> 5. Patients do not need to be transferred from ward to ward. If they are on a quiet ward and become disturbed, they can be treated rapidly with drugs. Before drugs were available, such patients would be transferred to a disturbed ward.
> 6. The wards can be furnished more comfortably and tastefully.
> 7. The outpatient department is much more active and important now, since many patients who leave the hospital are maintained on drugs and supervised by the medical staff during the period of trial visit.

Thousands of patients in hospitals and clinics, and those under the care of private physicans have been treated with the new drugs. While three years is a relatively brief time to fully evaluate a new therapy,

the evidence is impressive that the new drug therapies are affecting many aspects of psychiatric treatment.

(b) Social Treatment

Social treatment is a term used by Greenblatt, York and Brown in their book "From Custodial to Therapeutic Care in Mental Hospitals" to describe an organized and systematic utilization of the hospital environment as a treatment measure.

That hospital environment affects patients markedly has been recognized since the days of moral treatment 150 years ago. Moral treatment was an effort to create a favorable environment in which recovery could take place. It was a group experience in which patients could share and learn.

(c) The Architectural Implications

The developments of the past 10 years have changed considerably the practice of psychiatry. Psychiatric wards, even those which were once the most disturbed, are becoming quiet tranquil places. By means of drugs, it is now possible to quiet rapidly even the most disturbed patients. The influence of the ward atmosphere helps the patient further in remaining in control of himself.

The use of shock therapies has decreased, hydrotherapy in many hospitals is no longer used. The danger of patients damaging attractive furnishings is greatly

reduced and the opportunity to create attractive surroundings is greatly increased. The needs of patients for social exchange is much less hampered by the symptoms of mental disturbance and the capacity of the patient again to find himself in a social world is enhanced.

Recently the staff of the Architectural Study Project spent two weeks studying the 400-bed admission building of a large mental hospital. Practically all the patients were psychotic. In each of three wards, observers were stationed for 10 eight-hour periods. During this time, not a single major disturbance occurred and restraint or seclusion was never used. More than 60 per cent of the patients on these wards were receiving the tranquilizing drugs. The patients were also in a new building which was comfortable and pleasant. The situation was helped further by the availability of a large group of student nurses in addition to the nurses and aides, who spent most of their time in direct contact with patients.

By use of drugs and social treatment as well as older tried-and-proven psychiatric treatment methods, security requirements for mental patients have decreased sharply. Few seclusion rooms are required and the construction and design of the hospital wards have few special requirements, though many psychiatrists still prefer to place newly admitted patients on closed wards until there has been adequate opportunity for observation and diagnosis.

There is now no excuse from a psychiatric standpoint to fail to provide most patients with confortable rooms, suitably furnished, well-lighted, and affording privacy or opportunity for group social life as desired or needed.[1]

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[1] Ozarin, M. P., "New Horizons in Psychiatry", pp. 202-204, A.R., Nov. 1956.

CHAPTER III. REQUIREMENTS FOR A REGIONAL MENTAL HEALTH CLINIC.

1. THE MENTAL HEALTH CLINIC AS A WHOLE

The mental health clinic is divided into three main parts: 1. Receiving and diagnostic, 2. Intensive treatment, 3. Continued treatment.

The three parts may be treated as separate units and may be designed as such, but the three are separated by facilities that are common to each.

All patient buildings should be one or two stories arranged to insure convenient and immediate access to easily supervised outdoor areas. Where patients must be supervised and where restraint may be necessary, outdoor areas should be designed as courts enclosed by structures in most cases. Small buildings and small groups of patients, not to exceed twenty-two patients on any ward, provides for more satisfactory treatment.

Facilities that are common to each of the three main parts are, administration, medical, rehabilitation, and service.

The recreation and occupational therapy buildings should be grouped together to provide for as much variety in programs, including both men and women, as possible.

The receiving and intensive treatment building will include, separate treatment area for various types of treatments, large living room with an enclosed court,

and private bedrooms. This unit will provide for ten to fourteen patients.

The convalescent building will be set apart from the treatment building by visual means such as screens and courts, but will be in the same area as the treatment building.

Continued care and geriatric service will not be included in this program because this type of patient could not be housed at the clinic and would not be within the range of treatment offered here. Continued care and geriatrics would be afforded the services of the out-patient clinic only. The clinic may accept special cases under certain conditions.

2. PATIENTS' PROGRAMS

The patients' programs are varied and various resources are required to cope with them. The major program for the mentally ill will be the out-patient program. This program includes services that are usually not offered in a state institution. The program would provide the following services:

1. Professional interviews with the patients and family of persons needing psychiatric care.
2. Guidance to children and teenage persons needing assistance with mental problems.
3. Prevention of illness through public education.
4. Continued care administered in the form of appointments for private interviews and chemotherapy perscribed by the psychiatrist to be taken by the patient at home.
5. Testing and counceling by a psychologist.
6. Social activities to be scheduled by the clinic for patients returning from the various institutions in the state.
7. Occupational placement service.
8. Day care programs, by special arrangements only, for those requiring all of the facilities of the clinic except its safety and security.

The intensive and convalescent patient programs, because of the small number of each admitted for treatment, will be on a more individual basis. Some of the patients will be given complete freedom of the grounds and areas and others will be required to follow strict programs of the therapist's choice. The patients under intensive treatment programs will be under strict observation of the nurses and attendants. The patients who respond to treatment and then are considered convalescent patients do not always stop treatment, only the more severe treatments. A convalescent patient may be under mild treatment such as chemotherapy until his release.

All patients in the convalescent and treatment units will have access to the living rooms and enclosed courts for their own activities as well as those prescribed by the therapist. The centrally located occupational therapy areas provide for more organized group and individual activities.

It will be the policy of the clinic that the nervous and mental patient can do much for himself if given the opportunity, the proper invironment and necessary assistance.

3. ORGANIZATION

In any institution, hospital or clinic, organization is a very important element. The treatments, therapies, and diagnostic facilities are all a part of a whole and cannot be handled as separate functions of a clinic with expectations of an effective organization. It is recommended that a psychiatrist head the organization. The basic policies of the clinic will be prescribed by the psychiatrist and his staff. This eliminates a major portion of confusion. Special attention should be given to securing a qualified staff which is an important factor in maintaining high standards for the clinic.

The clinic team plays a most important part in the organization. A clinic team is composed of a psychiatrist, a psychologist and one or two psychiatric social workers. With a clinic team, the psychiatrist makes the medical diagnosis and assumes responsibility for therapy. Psychological testing for such purposes as aptitude, vocational interest, intellectual assessment, and other psychological testing, not related to medical diagnosis, is supervised by the psychologist who could also conduct group therapy and individual psychotherapy. The psychiatric social workers give casework services to the families of patients and do counseling not involving psychiatric diagnosis or psychotherapy.

4. VARIOUS ELEMENTS OF A MENTAL HEALTH CLINIC

(a) The Out-Patient Building

The out-patient building houses the administration and diagnostic facilities.

The administration area is located near and convenient to the main entrance lobby and waiting area, information counter, public toilets and telephones, business office, record room, library and conference room, social workers office, secretaries and admitting, and personnel lounge and toilets.

The main entrance and lobby is convenient to the corridors leading to the diagnostic facilities and administration area. Two control points are needed. One for the administration area for business and visiting purposes and the other in the main entrance lobby for information and assistance to the diagnostic teams. The diagnostic teams consist of one psychiatrist, one psychologist and one or two psychiatric social workers. There should be an estimated three teams of this type in the clinic. The three groups of offices are arranged to provide access to the medical diagnostic facilities.

The medical diagnosis area affords one office for the medical doctor and his equipment for examination purposes. A lab for use by the doctor is also adjacent

to the examination room. A secretary has control over the waiting room and the doctor's office.

The basic reason for this particular arrangement of space is due to the traffic pattern set by the proceedure of a person being admitted to the clinic. To understand this procedure in relation to the proposed design, one could assume the traffic moving in a counter-clockwise motion. The first step is the interview by the teams, the second is the medical diagnosis and examination, and the third is the admission and business arrangements. This completes the out-patient department functions concerning the admittance of a patient.

The conference room may be used by the staff or by the social worker, according to scheduling. The conference room, used by the medical staff, should have access to records and administration area. This area may well be used for group meetings between the staff and personnel of the clinic. The lounge for the personnel is adjacent to the conference room. Coffee and light refreshments may be provided for in the lounge. The personnel toilets are located adjacent to the lounge. Lockers for the nurses and doctors are located near the medical diagnosis area. An exterior court is enxompassed by a main corridor, which is enclosed to the weather, but may be entered from several locations which connects all of the above mentioned facilities.

(b) Intensive Treatment and Convalescent Facilities

In receiving a patient, an active program of therapy is gegun with each individual, and diagnosis is continually being made during the course of his treatment. Areas for programs, in work, in recreation, in socialization, and, at times, for uncontrolled self-expression in activity are required. Conveniently or therapeutically, these programs cannot be accomplished within the general hospital setting where the bed is the place of treatment.

In planning new facilities there is sufficient evidence to support the program of intensive treatment of new patients separate from other services. In order to accomplish this initial facilities for the treatments should be included in the intensive treatment areas.

There should be facilities for shock treatment in the building. This would include a waiting room for the patient that would be controlled by a nurse in the area. An examination room is necessary to examine patients for shock treatment and routine check-ups of all patients. Other spaces in the treatment area are shock treatment room and a recovery room. The patient will be examined first, given a shock treatment, and then moved to the recovery room. Ample storage for blankets and lined should be provided for in the treatment area.

The waiting space should provide good observation from the nurses' station. Patients waiting should not be able to hear or observe others being treated. Patients should be conducted to the treatment area in small groups. The electric shock treatment may be used for the out-patients and convalescent patients as well as those in intensive treatment. The necessary recovery period from electric shock treatment is as prescribed by the doctor giving the treatment.

Convalescent facilities include a less strenuous program. The convalescent patient, according to the individual patient, will be more active in social functions and will have more social and recreational facilities than the intensive treatment patient. A lounge and canteen will be provided for his use as well as living room area and occupational therapy facilities. The canteen and lounge should provide facilities for such activities as card games, ping pong, parties, a small snack area for refreshment and other social functions.

(c) Occupational and Recreational Therapy

Recreational and occupational programs are not new in mental hospitals. Today's programs of activities are, however, more scientific; they are no longer used solely for the amusement of the patient. All human beings and

particularly those with emotional or mental illness need to achieve something in the way of balanced activties. Doctors have long urged the development of work-play, exercise-rest relationships in a day's living program.

Occupational and recreational therapy programs will be organized activities on the nursing units, and in the central facilities. Additional occupational activities may be provided in useful work in the clinic, on the grounds, and in the dining and kitchen areas.

In the occupational and recreational building spaces for activities such as occupational shops with office spaces for activities such as occupational shops with office space for the therapist and equipment storage room, exercise space, a canteen and a reading room. The exercise space should be smaller than one-half of a basketball court. Tumbling mats, parallel bars, exercise pulleys, barbells, are some of the equipment to be used. The space for exercise should be designed to provide space for motion pictures, plays and dances. The exercise area should open to the outdoors so that the storage for outside games may be scheduled without duplication of storage space.

Therapist office should be located in an area so that observation of the patient can be carried out with ease.

The canteen, equiped to supply soft drinks, coffee and light refreshments is preferably located in an area convenient to the shop and exercise rooms.

The shops will be organized in the general activity areas for bench work, equipment work, table work, loom work and painting space. Bench work will include carpentry, sewing, typing, painting, modeling and ceramics.

The occupational therapist office should be near the instruments of the shop areas to maintain good observation of the various activities. The office should include a des, work table, bookcase and filing cabinet.

(d) Dietary and Service Facilities

A central kitchen is desirable for the preparation and cooking of food for the total clinic. A central kitchen simplifies the patient feeding program. The dining room should be located for convenience to traffic flow of patients, staff, and prepared food that will be served to the nursing units in food carts that are insulated and heated.

The atmosphere of a dining area should be that of a nice restaurant. The patient should have a view to make his meal nourishing and digestible. Separate dining rooms are preferred for men, women and staff so that they may all be used at one time.

Food service ot the non-ambulatory patients will be prepared and placed in a mobile food card for delivery and serving to the nursing units.

The ambulant patient will be scheduled for occupational therapy in the occupational therapy building, which is adjacent to the dining area.

Service in the kitchen should be convenient for deliveries and garbage pick-up. The latter area should be separated from the dining area.

(e) Nurses' Stations

The nurses' stations should be located to provide good observation of corridors and activity areas and have complete control of each. Privacy is necessary for the nurse in medical preparations, record making, telephone conversation, etc. A private toilet should be located in the area. The nurses' desk may be placed according to the best location for control. It may be located outside of what is termed a nurses station. A visiting room may be in the area of the station. The nurse should have control of the coming and going of all patients.

(f) Bed Rooms

The patients' rooms, since they will spend a major portion of their time here, should be planned to be living spaces rather than traditional bedrooms.[1]

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[1]Goshen, "Psychiatric Architecture", pp. 14.

It is most desirable for each patient to have a single room or an area which they can consider their own. As Dr. Leslie A. Osborn puts it:

> Psychiatric patients generally have been non-assertive, sensitive people who have difficulty in finding a life and place in group living. As they have much difficulty in relating to a group, and even trouble in individual relationship, it is advantageous to have single sleeping units where they can have privacy and a place they can consider their own.[1]

The bedroom of the patient will include a single bed, writing desk with chair, easy chair, reading lamp and book storage at the headboard of the bed, clothes closet shelf and toilet with wash basin.

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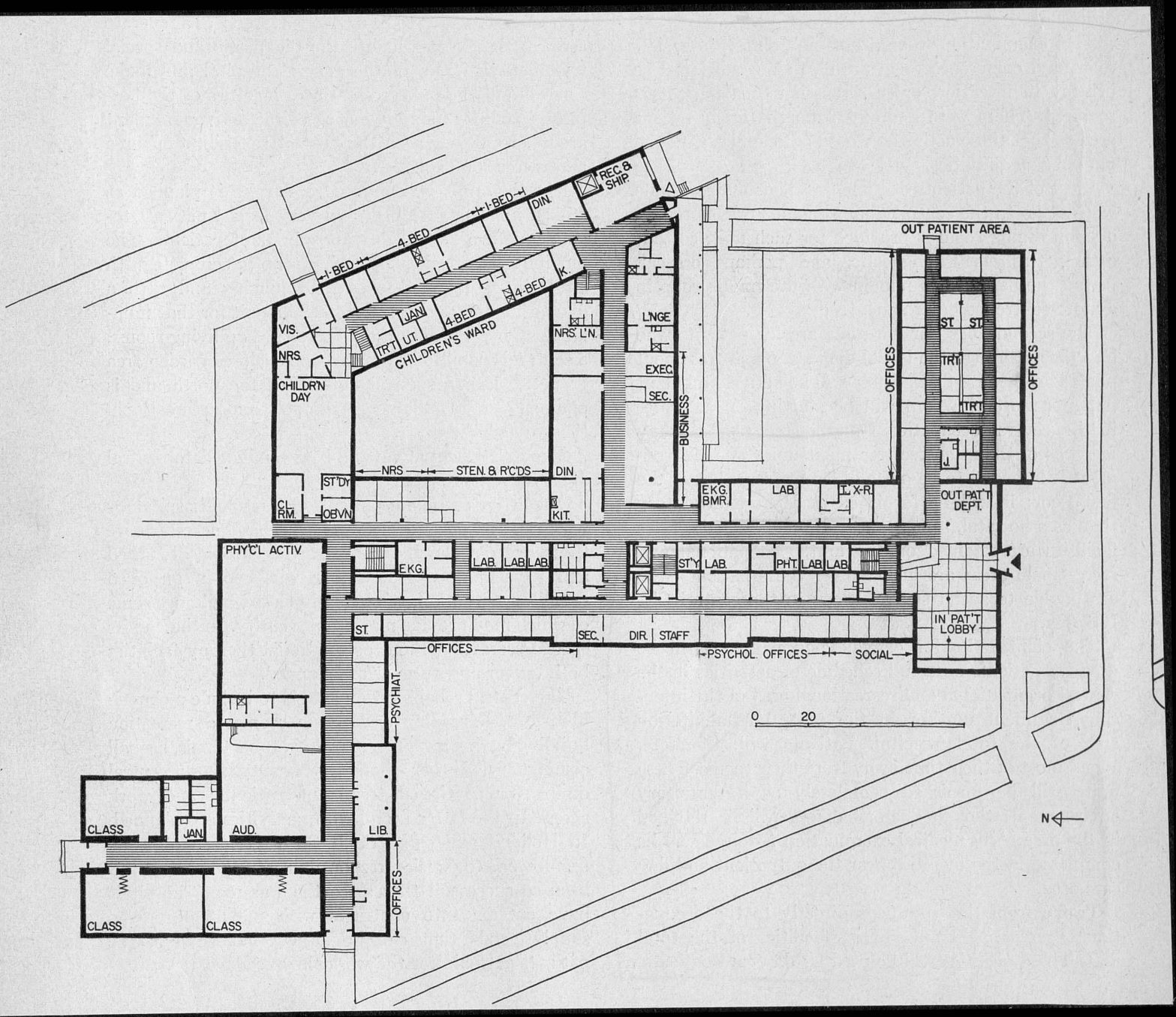
[1] Leslie A. Osborn, M.D., "Functional Designs of Psychiatric Hospitals", Vol. 109, No. 2, American Journal of Psychiatry, Aug. 1953.

5. EXAMPLES

(a) A Clinic and Training Center for A University.

Planned as part of the Wayne University College of Medicine, the Institute is primarily a training center for psychiatric workers and nurses, but will also engage in research. Secondarily, it is to serve directly the in-patient and out-patient therapy, administration of convalescent care supervision, family care placements and pre-admission services. For in-patients, the building is planned for approximately 36 adult psychotics, 50 adult psychoneurotics, 24 adolescents and 40 children. All in all, the institute should prove a valuable link in the chain of mental health facilities designed to keep patients out of the strictly mental hospital and to catch and cure disturbances in early stages.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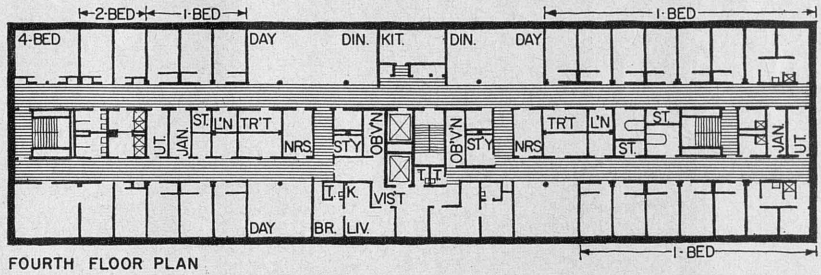
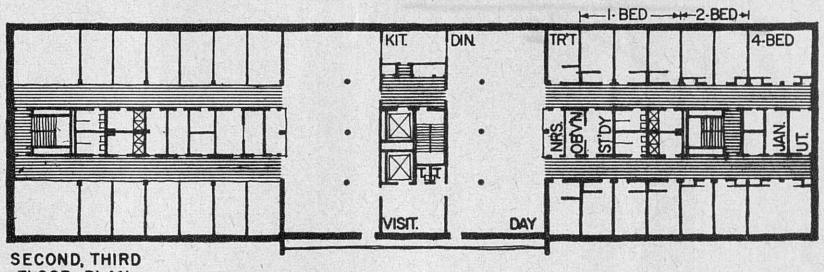
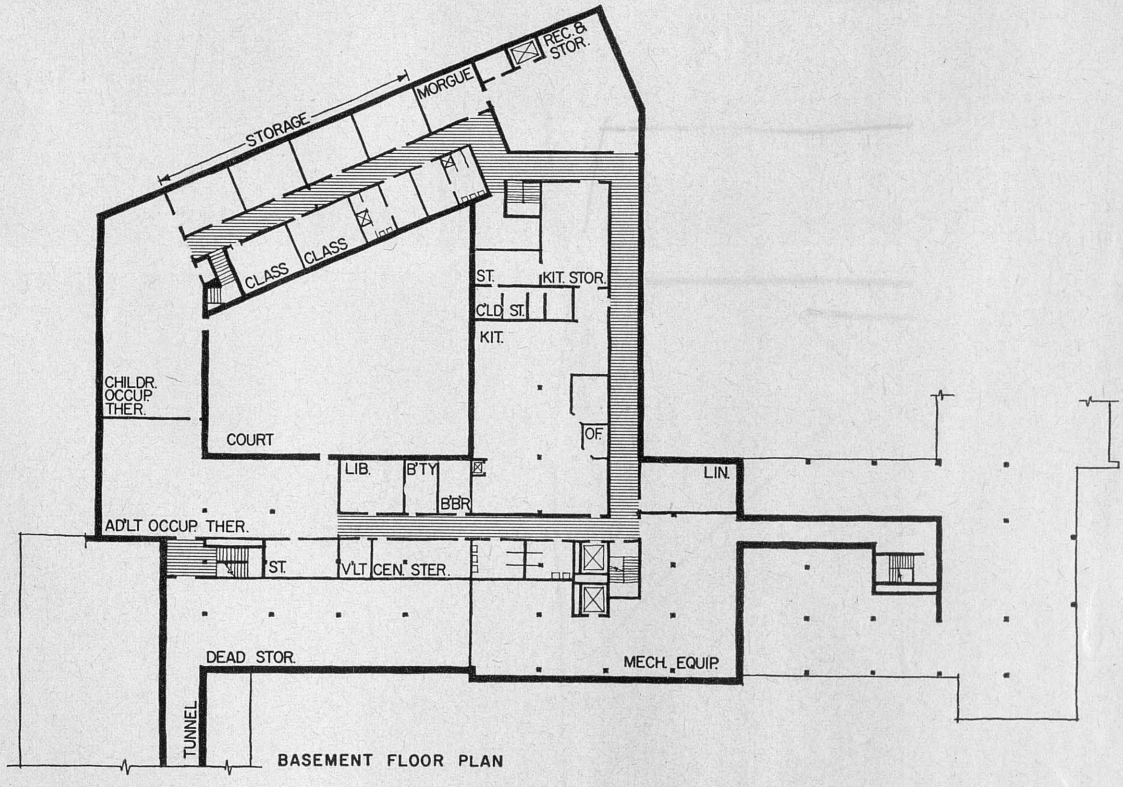


FOURTH FLOOR PLAN



SECOND, THIRD
FLOOR PLAN



BASEMENT FLOOR PLAN

Julius Shulman

The Administration Building sets a note of spaciousness with a wide entrance plaza and planting beds

Lobby of Administration Building brings the outdoors inside and presents a very cheerful aspect

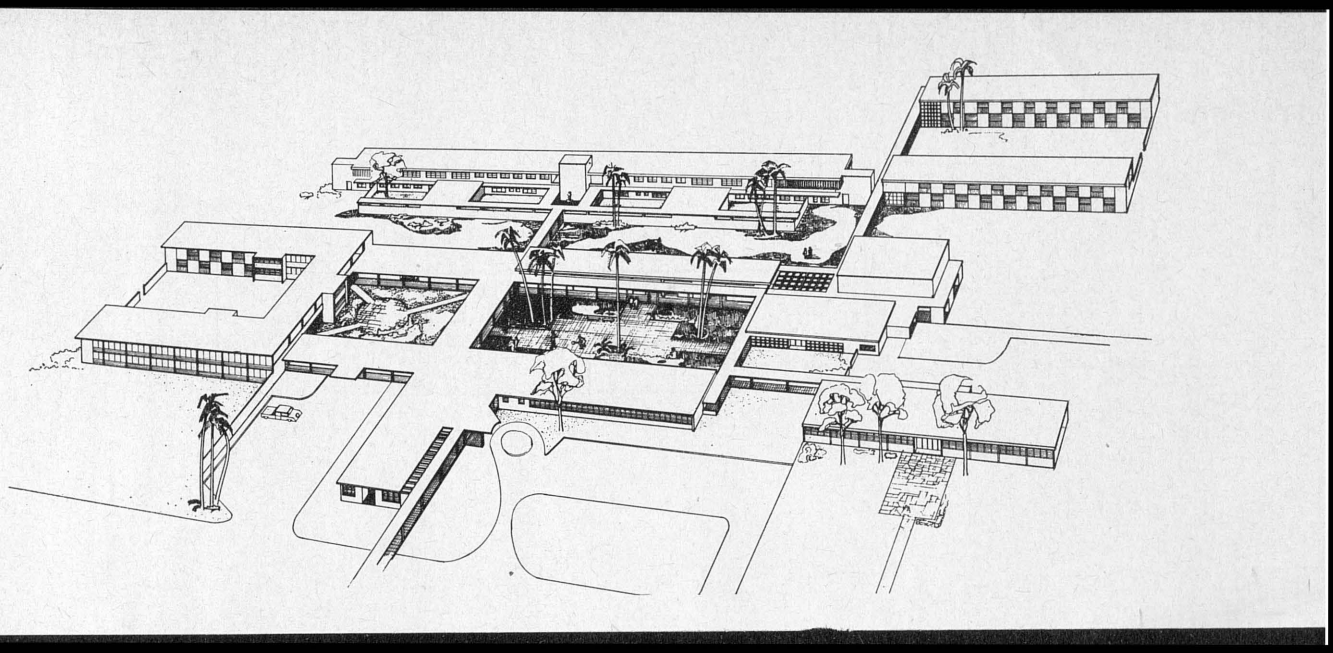
(b) A Psychiatric Hospital and Medical Center

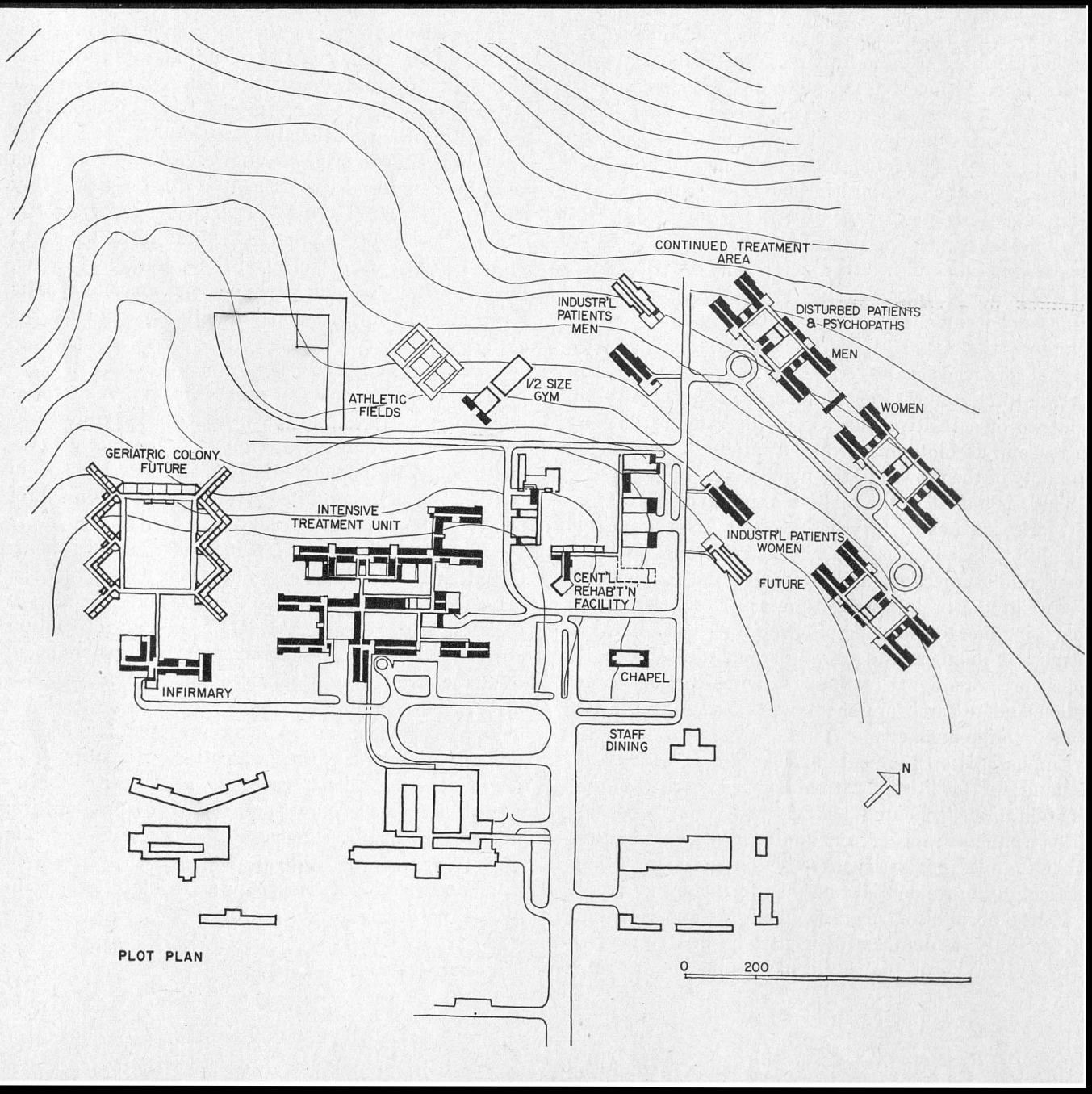
Early plans for this hospital reflect, probably as do no other current plans, two major developments in therapeutic procedures in the mental hospital. These are (1) the new drug therapies, and (2) the so-called "activity program", by which mental hospitals in Europe have been able largely to eliminate security features and maintain an "open hospital".

The out-patient department is to include offices for psychiatrists as part of the regular out-patient diagnostic and treatment services, and the in-patient area of the general hospital was programmed to include a 22-bed nursing unit for acutely ill psychiatric patients.

The psychiatric hospital is planned as a base unit to serve the entire region. General hospitals of the region are scheduled to have in-patient and out-patient services where they will be large enough to support such a service. The smaller general hospitals are programmed to have rooms for the receiving and emergency care of any patient until he can be transferred to a psychiatric service.

The intent is to provide at the base unit all services required in a community intensive treatment unit. Thus, the services provided are an out-patient service, this unit also to serve as the facility from which ambulant psychiatric teams are to serve other communities.

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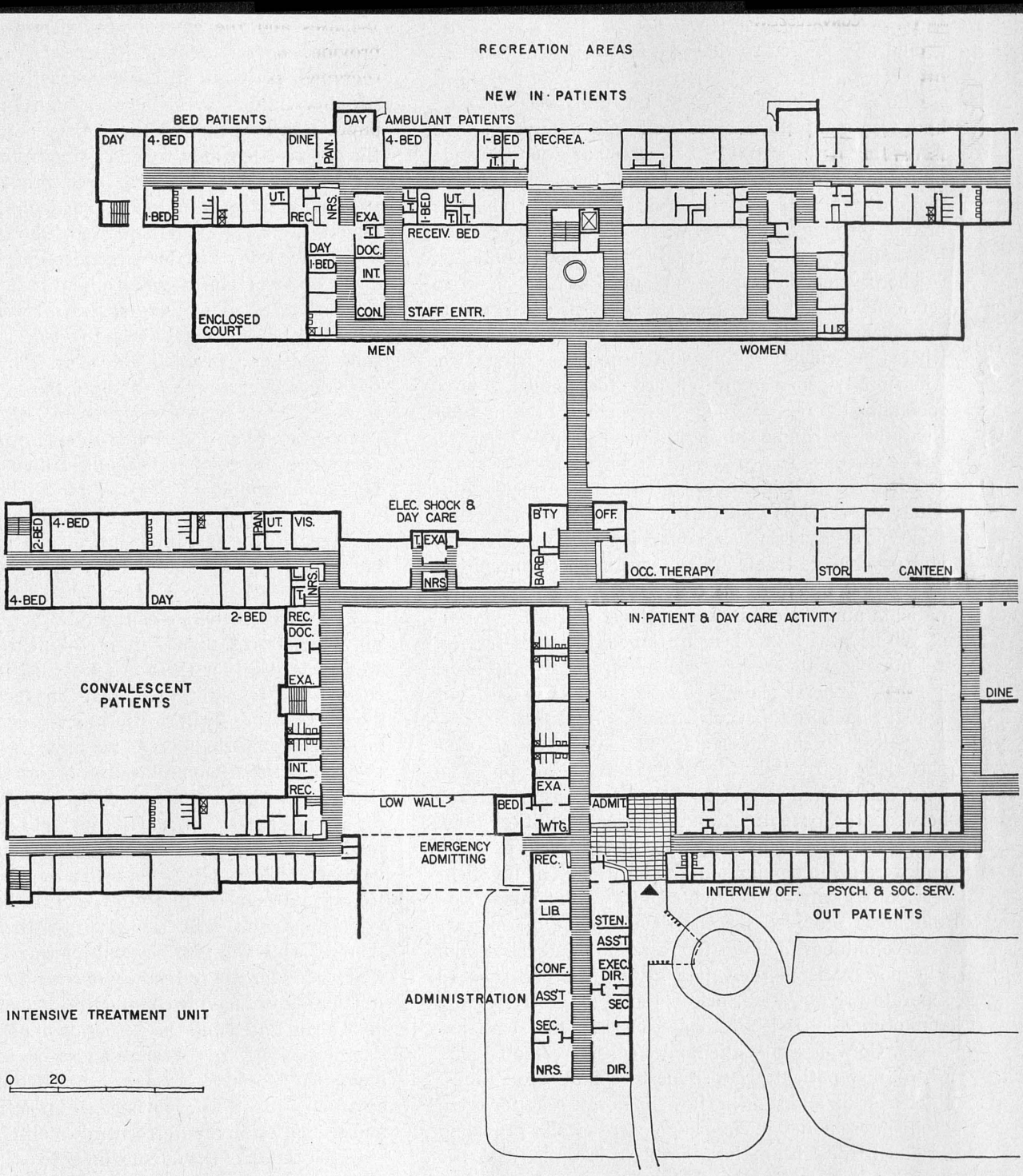
200

PLOT PLAN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BED PATIENTS
DAY
AMBULANT PATIENTS
DAY
4-BED
DINE
PAN.
4-BED
1-BED
RECREA.
1-BED
UT.
REC.
NRS.
EXA.
T.
1-BED
UT.
T.
RECEIV. BED
DAY
1-BED
DOC.
INT.
CON.
STAFF ENTR.
ENCLOSED COURT
MEN
WOMEN
ELEC. SHOCK & DAY CARE
2-BED
4-BED
PAN.
UT.
VIS.
T.
EXA.
NRS.
B'TY
OFF.
BARB.
OCC. THERAPY
STOR.
CANTEEN
4-BED
DAY
2-BED
NRS.
T.
REC.
DOC.
IN-PATIENT & DAY CARE ACTIVITY
CONVALESCENT PATIENTS
EXA.
DINE
INT.
REC.
EXA.
LOW WALL
BED
ADMIT
WTG.
EMERGENCY ADMITTING
REC.
INTERVIEW OFF.
PSYCH. & SOC. SERV.
OUT PATIENTS
LIB.
STEN.
ASS'T
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INTENSIVE TREATMENT UNIT
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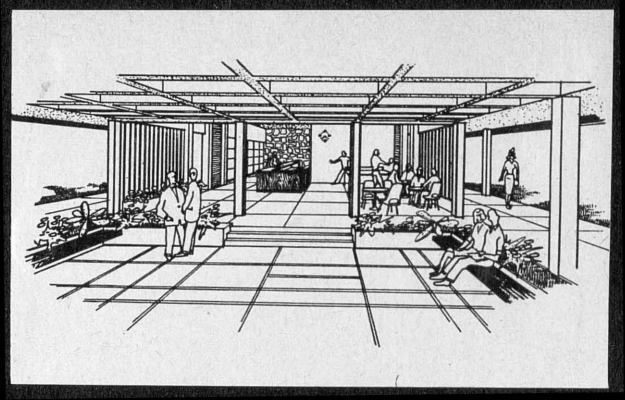

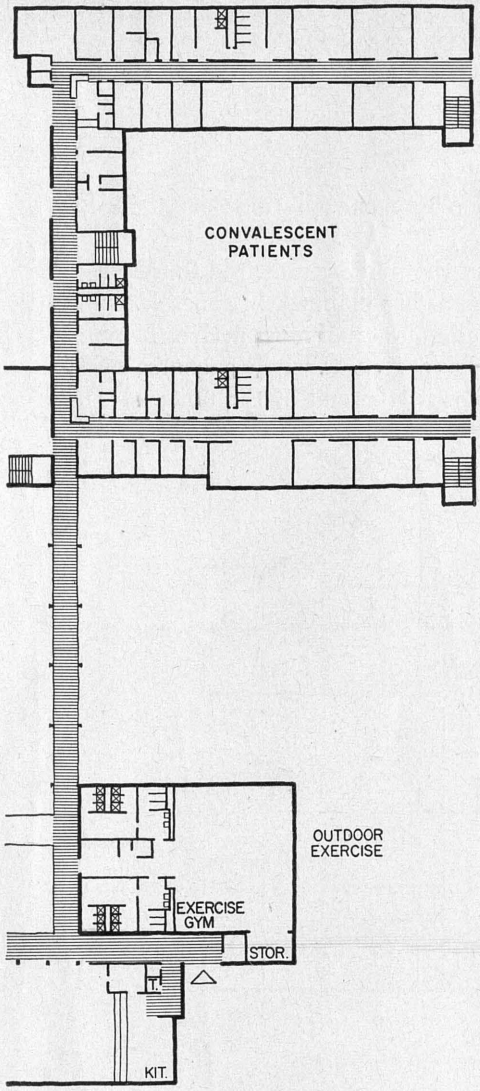
CONVALESCENT
PATIENTS
OUTDOOR
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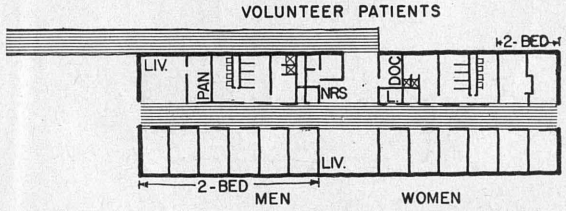
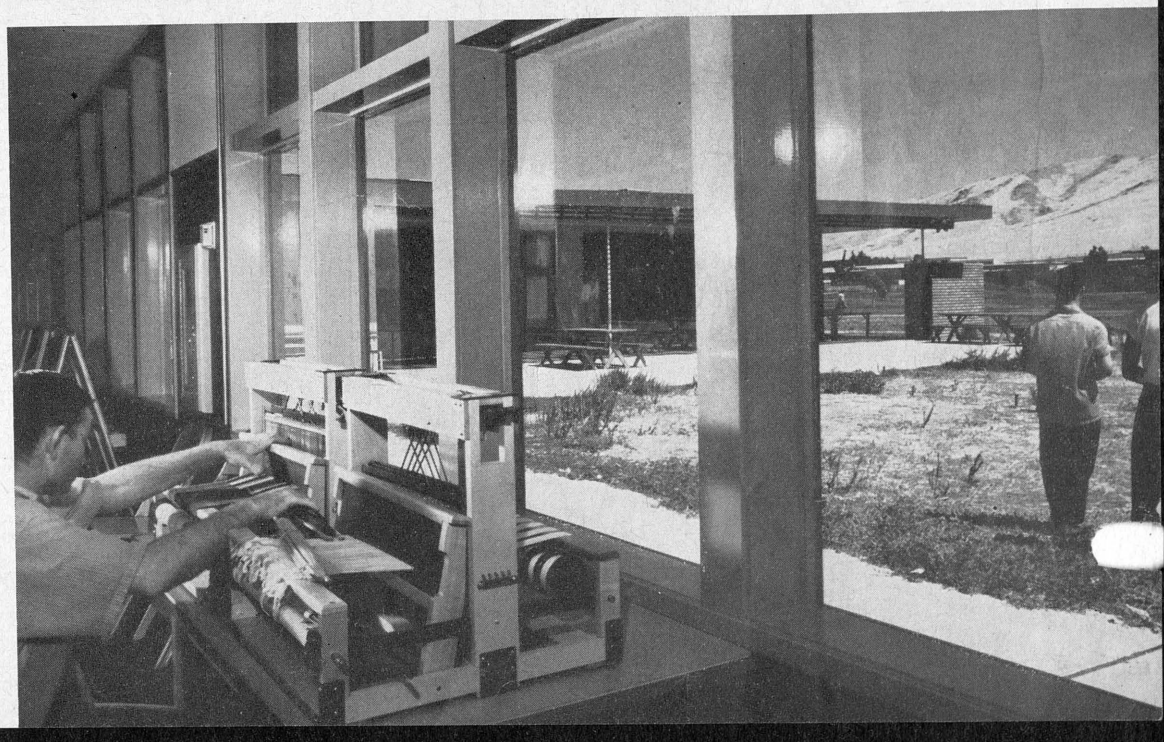
STOR.
T.
KIT.


VOLUNTEER PATIENTS
2-BED
LIV.
PAN
NRS
DOC
LIV.
2-BED
MEN
WOMEN

The activity area outside the music and activities therapy room, Rehabilitation Therapies Building

The occupational therapy suite in the same building; use of hand tools is especially good training



View from the same room; the boy operating the loom looks out on covered picnic area and mountains

CHAPTER IV. PROGRAM FOR A REGIONAL MENTAL HEALTH CENTER

1. THE LUBBOCK MENTAL HEALTH SITUATION

National statistics indicate that one of every sixteen persons is suffering from a mental or emotional disorder. If Lubbock is typical, this would mean that there are 8,004 persons in the city needing mental health services of some kind.

The number of admissions to State mental hospitals from Lubbock is not high in comparison with other counties. The most recent comparative figures available are shown on Table 1.

TABLE I
PATIENTS IN STATE MENTAL HOSPITALS
September 1, 1957, to August 31, 1958

County	Number of Patients
Dallas	1309
Galveston	223
Harris	1145
McLennan	269
Potter	136
Smith	337
Tarrant	741
Travis	448
Wichita	361
LUBBOCK	113

These statistics do not include Lubbock patients in private mental hospitals, and it is not possible to secure this information. Acute short-term cases are hospitalized at local hospitals, and 455 mental patients were treated at Methodist Hospital in 1959. Methodist Hospital has 26 beds for such cases; and when the present expansion is

completed, there will be 52 beds which can be used for cases of this type. Other local hospitals admit mental patients under some circumstances but do not designate certain areas of the hospital for these cases. In a study made in Long Beach, California, the standard of one-half bed per 1,000 population for acute short-term care for mental patients in general hospitals was recommended by State and Federal health authorities. This would mean 64 beds for Lubbock with no consideration for the number of patients who came from the surrounding area.

An analysis of the Lubbock patients admitted last year to Big Spring State Hospital, the State mental hospital at which most Lubbock patients receive treatment, reveals that approximately 53 per cent of those admitted from Lubbock were for "sociopathic personality disturbance". This is an unusually high percentage.

Homicides and sucides are generally considered as indications of mental health problems. The last full year for which statistics have been compiled for Lubbock was 1958, and during that year 17 homicides and 10 suicides were recorded. The Lubbock rates per 100,000 estimated population were 9.9 for homicides and 5.8 for suicides as compared with the Texas rates of 7.6 for homicides and 9.2 for suicides.

Extensive study by the Hogg Foundation for Mental Hygiene of the University of Texas has resulted in this statement: "Delinquency is quite obviously a mental health problem because it involves the emotional and social adjustment of youth". While other phases of the delinquency problem are also recognized, this view of the relationship between delinquency and mental health is generally accepted by authorities in the field.

A study made in Austin, Texas, in 1958, revealed that 34 per cent of the 148 patients admitted to the State hospital there for the first time during 1958 had been known to the health and welfare agencies in Austin during the three years preceding hospital admission. Discussion with personnel from the various health and welfare agencies in Lubbock substantiated this as they stated that mental health problems are involved to some degree in most of their cases.

School personnel emphasized the large number of school children who have emotional problems. In a report prepared last year by the Guidance Study Committee of the Lubbock Public Schools "a central guidance clinic headed by a clinical psychologist to work with students with severe maladjustment problems" was listed as needed to assist classroom teachers in "discharging their guidance responsibilities". A conservative estimate by school personnel indicates that 583 children would be referred to such a clinic annually.

Based on an examination of case records, agency staff personnel made the following estimates of the number of referrals that would be made to a mental health center per year:

Vocational Rehabilitation Agency	205
City-County Health Department Nurses	64
Juvenile Probation Department	150
Out-Patient Clinic	40
City-County Welfare Department	30
Children's Training Center	30
Child Welfare Department	20
Family Service Association	18
Adult Parole Officer	6

Combining the estimates of school personnel, agency personnel, ministers, and physicans, a total of 1451 referrals per year is anticipated. This number is recognized as only an estimate, but no more definite information can be secured. This does not include those returning from State mental hospitals and needing follow-up care.

2. THE PROPOSED MENTAL HEALTH FACILITIES

There are four psychiatrists and three psychologists serving Lubbock on a private practice basis. Also working in the mental health field are the Guidance Department of the Lubbock Public Schools, Texas Tech Testing and Counseling Center, Vocational Rehabilitation Agency, Family Service Association, and the Mental Health Association.

The services of the Guidance Department of the public schools are, of course, limited to school children. The Tech Testing and Counseling Center serves Tech students and a limited number of others at a fee of $35 for persons not enrolled as Tech students. Eligible for assistance from the Vocational Rehabilitation Agency are persons who desire employment and who could be employable after rehabilitation. The Family Service Association provides counseling service for those with personal or family problems. The Mental Health Association has a limited program of public education, and the office serves as a referral center for those seeking information concerning mental health problems.

None of these agencies include a clinic team which allows for diagnosis and treatment of mental health problems. The only psychiatric and psychological services available are on a fee basis. Many persons who can take care of other family needs cannot pay for this care since continued treatment over a period of time is frequently required.

The Texas Governor's Committee on the White House Conference on Children and Youth, which met earlier this year, recommended that "regional mental health centers be set up as quickly as local initiative can plan for them" and that "guidance clinics be made available to every community for the prevention, analysis, and treatment of emotionally disturbed children". On the national level, reports of the White House Conference itself point out the great need for these services.

The Lubbock Mental Health Committee has recommended that action be taken to effect the establishment of a mental health center in Lubbock. The proposed Mental Health Clinic would offer the following facilities:

1. Diagnosis of mental health problems for children and adults.
2. Prevention of mental illnesses through education and guidance programs
3. Treatment of acute short-term patients only. Chronic and continued care patients are to be treated at other state and local facilities.
4. Follow-up care and rehabilitation of those recovering from intensive treatment.
5. Professional services for patients from various mental hospitals returning to the community.

It appears obvious that the cost of mental health problems and mental illness to the community is quite high, even though the exact cost cannot be computed. To the cost for maintaining State mental hospitals should be added the

loss of productivity of those individuals affected and the assistance provided to some of them by the various community agencies. Early diagnosis and treatment should reduce total cost.

In financing the proposed Mental Health Clinic the "State-Federal" funds are made available by the National Mental Health Act which was passed in 1946 and are administered by the Texas Department of Health and by the Texas Legislature. It is possible to secure up to 50 per cent of the operating budget from this source for the first three years of its operation, if it meets the standards set by the Department of Health. There is no definite rule, but the Department usually anticipates that a community should assume full financial responsibility within seven years after establishment with the amount from State and Federal funds being gradually reduced each year.

Lubbock can expect to receive this financial assistance. Since appropriations for this purpose are limited each year, whether or not Lubbock should secure it immediately depends on plans and requests of other cities as well as the total amount available.[1]

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[1] Community Planning Council, "Report of the Mental Health Committee", June, 1960.

CHAPTER V. PROGRAM FOR A REGIONAL MENTAL HEALTH CLINIC

CHAPTER V. PROGRAM FOR A REGIONAL MENTAL HEALTH CLINIC

1. DESCRIPTION OF SITE

The site is located approximately five miles west of downtown Lubbock on State Highway 116. The plot lies north of the highway which forms the southern boundry. The western boundry is formed by Milwaulkee Street. There are no other streets in that area. There are about fifty acres that could be developed. There is a gradual slope to the south to provide sufficient drainage. The ground is other-wise level.

The climate is mild but has extremes in any season. The average year round temperature is 59.5 degrees. The prevailing winds are from the south to the southwest with an average velocity of 12 M.P.H. The average rainfall is 18.89 inches. The average snowfall is 4 to 5 inches per year.

The location of the site was determined by the medical needs of the clinic. The adjoining medical services offered by the proposed Medical Center, located three miles east of the site chosen, would be accessible to both doctor and patient. The Medical Center would provide all medical services not offered by the clinic.

2. SPACE REQUIREMENTS

The space requirements for a Mental Health Clinic are somewhat standard but under the proposed program which would provide for the development of the clinic in separate stages according to the needs of the community and their ability to finance each stage. The stages are outlined as follows:

1. A large out-patient clinic which would house the administrative staff and their needs.
2. Nursing and intensive care wards with rehabilitation facilities.
3. Medical diagnostic facilities.
4. Social activities building located on the site, but separated from the clinic for those people needing follow-up care in the community. This facility would also provide additional office space, for social workers, etc.

The space requirements are as follows.

A. Out-Patient Department.

1. Administration Areas.
    a. Main entrance and lobby.
    b. Reception area.
    c. Public toilets.
    d. Business office.
    e. Record room.
2. Diagnostic Facilities.
    a. Interview offices for three teams, each team consisting of a psychiatrist,

psychologist and one or two social workers.

b. A library and conference room for review of patients records.

c. Doctors office and waiting room.

d. Medical examination room.

e. Laboratory and speciman room.

f. Treatment space for one or two patients.

3. Lounge with facilities for coffee and light refreshments for the staff.

4. Toilets and locker rooms for doctors and nurses in the out-patient department.

B. Nursing Units.

1. In-Patient Units.

a. Two intensive treatment units of approximately twelve patients each.

b. Nurses station for each unit.

c. Large living rooms for each unit.

d. Interview rooms for each unit.

e. Single rooms with and without toilet facilities.

f. Shower and bath facilities.

2. Convalescent Patient Units.

a. Same as nursing units with the exception of the treatment area, which will be used

for a lounge in the convalscent units.

C. Recreation and Occupational Therapy.
   1. Occupational therapy shops.
   2. Exercise and rumpus rooms.
   3. Therapists office with shower and toilet facilities.
   4. Canteen.
   5. Ample storage in all areas to be provided.
   6. Outdoor area to be developed for games, etc.

D. Dietary Facilities.
   1. Dining areas for patients of each sex.
   2. Staff dining area.
   3. Central kitchen with storage area.
   4. Service entrance and garage facilities.

E. Mechanical Equipment Space.

3. SOLUTION

The mistakes of the past make gloomy reading - yet they had to be isolated and faced before we could more ahead to formulate principles which can lead to good constructive design. The melancholy list which follows were the practices which led to the construction of the "human warehouses" whose atmosphere was in direct contradiction to the purpose of the mental hospital:

1. The location of the hospital in a remote area with a "cordon saitaire" of grounds about it, to keep patients in and community out.

2. The construction of large, multi-story, unadorned brick buildings within extensive grounds; conspicuous features were window screens or bars, "sunporches" heavily grilled, and high fences.

3. The housing of large numbers of patients in single buildings and in large wards; by virtue of numbers alone the occupants were deprived of any opportunity to express themselves as individuals.

4. The use of obvious security devices, which not only depressed the patients, but also had an adverse effect on staff and community attitudes.

5. The use of uniformly drab furniture and colors, the almost complete absence of accessories commonly recognized as being expressions of individuality - pictures,

draperies, floor coverings, potted plants,a canary singing in a cage, and the absence of attention-getting and interest-holding design features such as picture windows and so on.

6. The widespread use of building material designed primarily for easy maintenance, such as tile walls, terrazzo floors, and so on.

7. The absence of facilities where patients might store their personal possessions, and the lack of opportunity for displaying such personal items as pictures, family photographs and other personal trivia.

8. The use of uniform clothing for patients, somewhat resembling prison garb.

9. Mass feeding practices, with no choice of food, and the lack of a full set of tableware.

10. The mass transportation - "herding" - of patients from place to place.

11. The lack of privacy for bathing and toilet facilities.

12. The scarcity of means for the identification of time, place and persons - such as clocks, calendars, newspapers, photographs, telephones, and other "normal" means of keeping in touch with reality.

13. The creation of construction features, such as a "secure" nursing station, which tend to limit personal contact with patients.

14. The use of materials and engineering features which allow "institutional odors" to accumulate.

15. The absence of objects which can becoma a matter of local pride for individuals and groups of patients, such as pictures, tropical fish tanks, plants and so on.

16. The absence of facilities which would make it possible for a patient to offer elementary hospitality - such as a snack, privacy, conversation, etc. - to his visitors.[1]

With these ideas in mind, we can formulate certain basic principles upon which will depend a satisfactory design for a mental hospital.

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[1]Goshen, "Psychiatric Architecture", pp. 2-3.

4. Drawings

CHAPTER VI. CONCLUSIONS

VI. CONCLUSIONS

The primary objective of this thesis has been to lower the number of mental health problems of the Lubbock region and those of the state. The state institutions have been overburdened with the care of mental patients and cannot properly care for those they already have. The present day problem of mental health, on a national scale, is outstanding and the number of mental patients is growing and will continue to grow higher each year.

The solution of the problem lies in the prevention of mental illness in its early stages, which could be accomplished by having mental health clinics throughout the state. The Lubbock Regional Clinic has been designed to provide for this type of patient.

The architect who has a love for people and who would like to contribute to the welfare of his fellow man, should certainly investigate the field of mental health. The Architecture of a Mental Hospital, since the introduction of the new drugs, is virtually a new field in which much can be learned. It can actually be a part of the therapy for mental patients. The field of mental hospital planning is a rewarding one in which the architect can make a contribution to the well-being of his fellow man unequalled in any other area of architecture.

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