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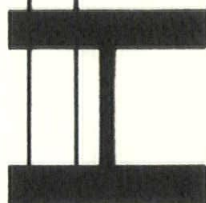
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# SKYLINES

THE OFFICIAL MONTHLY JOURNAL  
OF THE KANSAS CITY CHAPTER OF THE  
AMERICAN INSTITUTE OF ARCHITECTS

306 DAVIDSON BUILDING

KANSAS CITY 8, MO.

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AUGUST, 1961

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## TEN YEARS OF SKYLINES

In July, 1951, a 16-page magazine with a bright green cover made its debut in the field of AIA Chapter publications. Initial circulation was 250. Under the name SKYLINES, the baby has grown into a healthy 10-year-old recognized by the AIA as one of the outstanding Chapter publications in the country.

You may have noticed that we've put on a little weight over the years, reaching 40 pages in this issue and a circulation of more than 1000.

But to get back to that July of 10 years ago, page one carried this letter from Joseph B. Shaughnessy, Chapter president:

Dear Readers,

With this issue is realized a long standing hope of the Kansas City Chapter of the American Institute of Architects.

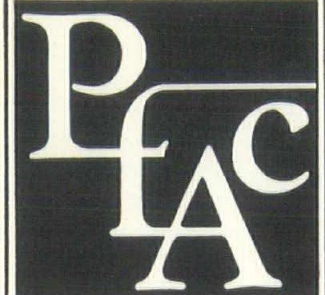
Kansas City has recently begun to acquire a national prestige in the field of building and design. As a result of this recognition, the need for some means to acquaint local and national groups with the activities of the architects in this area has become increasingly apparent. It is hoped that this publication, the official voice of the architectural profession in the Kansas City territory, will satisfy such a need.

We wish to congratulate the younger members of the chapter who have undertaken this literary record of our architectural achievements. However, since one aim of SKYLINES is to stimulate interest among members who have heretofore remained inactive, we trust that the responsibility for future issues will not entirely devolve upon these same men, but that all members will support this publication by contribution of material and constructive criticism.

Yours sincerely,

Joseph B. Shaughnessy

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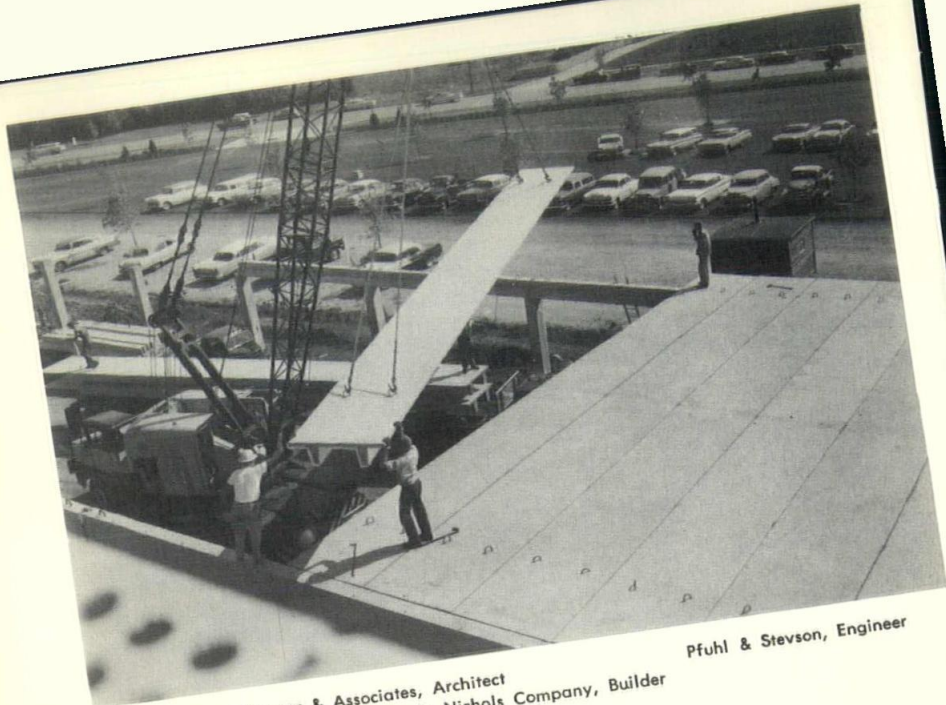


## SKYLINES' EDITORS

The first SKYLINES editor was Frank Grimaldi, now vice-president of the Chapter. Frank's editorship continued until October, 1955, when the woman's touch was given SKYLINES by Betty Brooker, of Voskamp & Slezak. Betty served as editor until March, 1957. Dave Miller, of Hollis & Miller, was tapped for the next editorial stint, serving until March, 1959.

From April, 1959 up to the present, a publication committee has been in charge of SKYLINES. Chris P. Ramos, of Geis-Hunter-Ramos, is the current chairman of the committee.

At left, top to bottom, are Frank Grimaldi, Editor 1951-55; Miss Betty Brooker, Editor 1955-57; J. David Miller, Editor 1957-59 and Chris P. Ramos, present chairman of the SKYLINES publication committee.



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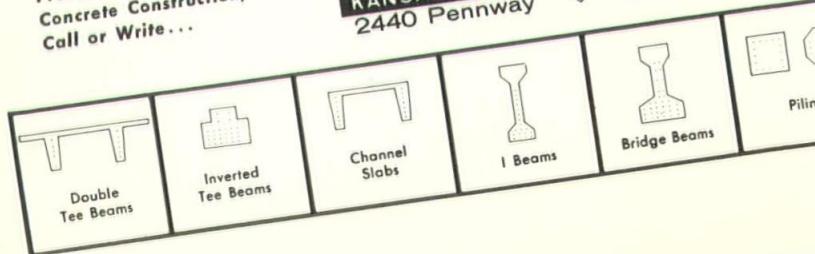
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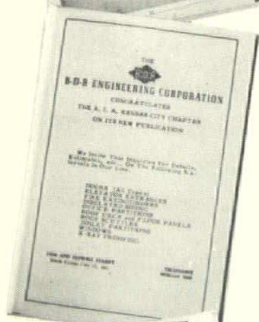
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## SKYLINES' ADVERTISERS

While we are looking backward for a moment it would be a great oversight if we did not give credit to the SKYLINES advertisers who have made it possible to publish some 120 issues. Several of the advertisers in this issue have appeared in SKYLINES since Volume 1, Number 1. The real old timers include B-D-R Engineering Corporation, Western Blue Print Company, the Carter-Waters Corporation, Sterling Ronai (Devoe), and Kansas City Natural Slate Co. Ronai's ad, incidentally, has appeared in the same spot (inside back cover) of every issue since July of 1954. See page 40 for a complete list of advertisers in this 10-year issue.



Three of the earliest ads from SKYLINES appear on the left. The Carter-Waters ad was in the form of a letter, signed by Mr. A. R. Waters, congratulating the K.C. Chapter for launching the new magazine. The last paragraph read, "The 1951 skyline of Kansas City is largely due to the skill and knowledge of the architects who have designed these many structures. May your good work continue toward the building of yet a greater skyline in Kansas City."

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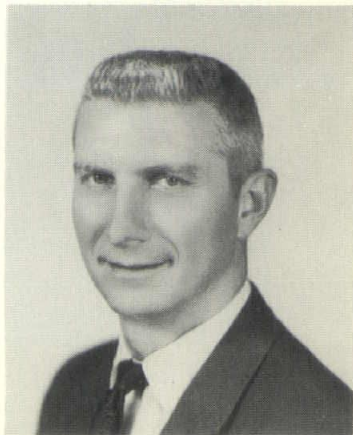
## NEW MEMBERS

CURRY WARD MILES, new JUNIOR ASSOCIATE member, is a native Kansas Citian. After graduation from Southeast High, Curry attended the school of engineering and architecture at the University of Kansas. He is an architectural draftsman with Tanner-Linscott & Associates and lives at 8247 Virginia, Kansas City, Mo.



BILLY DEAN WUNSCH is another new JUNIOR ASSOCIATE member of the Chapter. Bill, originally from Goddard, Kansas, obtained his B.S. in Architecture from Kansas State University in January of this year and is with Voskamp & Slezak. He was active in the K.S.U. Student Chapter, AIA.

KENNETH R. BOYLE is our newest CORPORATE member. Ken is a partner in the firm of Boyle & Wilson with offices in Overland Park, Kansas. He earned his B.S. in Architecture at Kansas State University and is registered in Missouri and Kansas. In addition to his practice, Ken teaches courses at Finlay Engineering College.



# The Architect's Role in Milieu Therapy

by ROBERT W. JACKSON

MILIEU THERAPY has been defined as a psychiatric treatment program that emphasizes environmental factors. In addition to shock and drug therapies and psychotherapy, environmental factor such as the general psychological atmosphere of the unit, relations with the community and the personnel who work with the patients are considered in the total planning program.

Milieu therapy is part and parcel of the philosophy of the so-called "open hospital" as opposed to the closed hospital where patients are closely confined, custodial care is the prime objective and isolation from the community is the watchword. The "open hospital" concept stems mainly from Thomas Kirkbride's "moral treatment" philosophy of the 1850's. He was the first to recognize the psychiatric hospital as a separate field of architectural design. The hospital was to be (in present day semantics) a "therapeutic community" in which the dignity and the individuality of the patient was to be preserved and the patient's freedom to be used for constructive activity.

Unfortunately, the architectural maxim of "form follows function" is laid aside too many times today in psychiatric design; a layout is compromised to fit the pattern of the medical-surgical nursing units. True, a uniformity in structural and mechanical systems and interior finishes may be

achieved, but the atmosphere of the "institution" also is ingeniously preserved inviolate!

With the acceptance of milieu therapy, it would seem that a re-appraisal of the architect's approach to this design problem should be made. Traditional "rules of design" and preconceived ideas should be examined in the light of psychiatric philosophy and practice evolving today.

The design of a psychiatric unit in a general hospital that would incorporate this philosophy and practice requires a positive "team" approach by the professional hospital staff, the hospital consultant and the architect if the results desired of such a treatment program are to be achieved. A thorough understanding of the philosophy by all the members of the design team is essential for the incorporation of a dynamic treatment program.

The architect, in approaching this design problem, should know at least four important facts:

1. Patients admitted to a psychiatric service may have lost contact, temporarily, with their usual environment which may result in behavior that is considered unacceptable within society's frame of reference; however, their prognosis is such that a short term, intensive treatment program should result in their being returned to society.

(Continued on page 12)

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2. Milieu therapy is designed to bring the patient back into contact with his environment through exposure to various "social situations" which he is expected to manage successfully.

3. The family is the usual social unit to which the patient will return.

4. The functional layout and atmosphere or feeling of the psychiatric unit is an integral part of the treatment program.

The architect's task, then, is quite clear—the creation of a therapeutic environment to which the patient can easily relate in terms of his experience,

one that encourages social groupings comparable to the home and friends left behind. With this new concept of design and treatment, both space and spatial relations become effective means of therapy.

Ideally, what kind of a home would you and I like to have? It would be one designed with a series of environments to fit our ever-changing moods, complete with facilities for performing various social functions as desired. It would probably include such areas as a living room in which the entire family could enjoy each other's company, a family dining room, a kitchen and breakfast room for "coffee breaks" and preparing between-meals snacks, a laundry for washing and ironing personal effects, a hobby room as an outlet for the creative mood, a place for a quiet card game, a library for reading or writing, a den in which to watch television undisturbed, a garden for taking leisurely strolls and enjoying nature, a recreation room where the rug may be rolled back for dancing or games, a quiet room where one may entertain guests and serve refreshments, and a private room in which to withdraw from the group when complete privacy is desired. A neigh-

borhood barber and beauty shop, as well as an outdoor recreation area, would be available. Nearby would be the family church for worship, prayer and meditation.

These are some of the various social environments that the patient has left behind and we should provide them in the psychiatric unit if our treatment philosophy is valid. The creation of each of these areas of activity will encourage the patient to enter into

social relationships with those about him: fellow patients, nurses, doctors, other therapists, visitors, etc.

Careful attention should be given to the location of the psychiatric unit in relation to the main hospital and to the community in terms of patient care and public relations. Of course supporting services such as laboratory, x-ray, laundry, administration, dietary, etc., should be as available to this unit as to any other clinical area of the hospital. Community acceptance and support of the psychiatric service may be enhanced by the proper physical location coupled with a positive program of community education. The public's acceptance of a psychiatric unit seems to be directly related to its accessibility. In short, it must become an integral part of the community so that the public can easily understand the activities and treatment programs. The unit located on the ground floor and adjacent to the outpatient department would promote just such an understanding in addition to other benefits.

First, such an arrangement would enable psychiatric treatment to be given in the regular outpatient department, thereby erasing some of the stigma usually connected with mental disease because of separate outpatient departments for psychiatric treatment.

By bringing together in one place all the diagnostic and treatment facilities of the hospital not only would the public's fear in this area be alleviated, but such an arrangement would actually concentrate medical and paramedical personnel for use in a total inpatient and outpatient program. In addition, this ground floor location adjacent to the outpatient department would encourage the development of day-care and outpatient psychiatric programs, thereby relieving some of the patient load through early diagnosis and treatment. Then, too, future developments in drug therapy may lead to a majority of psychiatric patients treated as outpatients.

Secondly, the increasing use of community facilities for recreational and occupational therapy indicates that patient transportation could be simplified by having the patients on the ground floor. This would also encourage better relations with the community.

Outdoor recreational areas, patios, gardens and lawns should be readily available from the nursing unit. Obviously, these can be reached more easily if the unit is located on the ground floor where no vertical transportation problem exists and visual supervision may be simplified. The design of these exterior areas can then be coordinated with the interior rooms. If handled properly, nature is not abruptly set apart by the exterior walls in the patient's visual perspective, but becomes an extension of the interior space. Interior space may be made to seem to flow outward; exterior and interior space become one; the patient is invited to look beyond the four walls to another part of the world he knew; the "confinement" aspects of his treatment are nullified. Many delightful spatial relationships may be evolved by

considering the exterior and the interior together in the design.

The matter of visual perspective of the outside world from the ground floor location should be examined. Most patients do not live in a penthouse but in a one or two-story house. Why, then, should they be put on the top story of the hospital and have to adjust to an entirely new visual concept of their surrounding community? The many adjustments necessary before they again face reality are difficult and we should avoid adding to their confusion.

The last point for consideration might be that, placed on the upper floors, the room layout is fairly well dictated by the mechanical and structural systems of the nursing units below. Great care has been exercised in designing the typical nursing units for medical, surgical and maternity patients; column spacing and vertical shafts for air ducts and piping is dictated by the space requirements of these room layouts. But it does not necessarily follow that the therapy and patient room requirements for a psychiatric unit can be adjusted to fit into these predetermined physical limitations. Too often the psychiatric unit is just another typical nursing unit with a different name on the door—the institutional layout and feeling has not been allayed.

Orientation of the unit as to sun, view and prevailing breezes must be considered. All rooms should have sun at some time during the day, if only for psychological reasons. Sunlight can add cheer to any room. This should preclude an east-west axis for the unit. While sunlight is very desirable, too much can be a detriment, especially in southern climates. Exterior sun-control devices, such as roof overhangs or vertical louvers, should be consid-

ered if sunlight is a problem, particularly on western exposures. Sun-control devices will also reduce air conditioning costs.

In selecting the means of any sun-control, care should be taken that desirable views will not be obstructed or that a closed-in feeling results from too much protection from the direct rays of the sun. The patient should be able to maintain visual contact with the outside world.

With the advent of year-around air conditioning, many buildings are being designed and operated with no thought of ever opening the windows. However, it would seem that in areas where there are no odor or dust problems, there is a distinct psychological advantage to be gained, during certain times in the spring and fall, if the patients' windows can be opened just enough to admit the stimulating fresh air and the myriad of noises associated with the outside world. It might help the patient in maintaining contact with the outside and be a welcome change from the artificial atmosphere provided by mechanical means. It would seem more natural and closely akin to that found in the home. This could be another small movement away from the "institutional" feeling. With this in mind, prevailing breezes should be studied in designing the unit. To complete the architectural expression of milieu therapy, careful attention should be given to seemingly minor details in the interior design and furnishing of the unit. For instance, in the matter of dimensional perspective, why should patients adjust to 9'6" high ceilings and 3'8" wide doors? In our homes we have 8'0" high ceilings and a maximum of 3'0" wide doors. An exception to this proposed door width would seem to be indicated only for those rooms where non-ambulatory patients

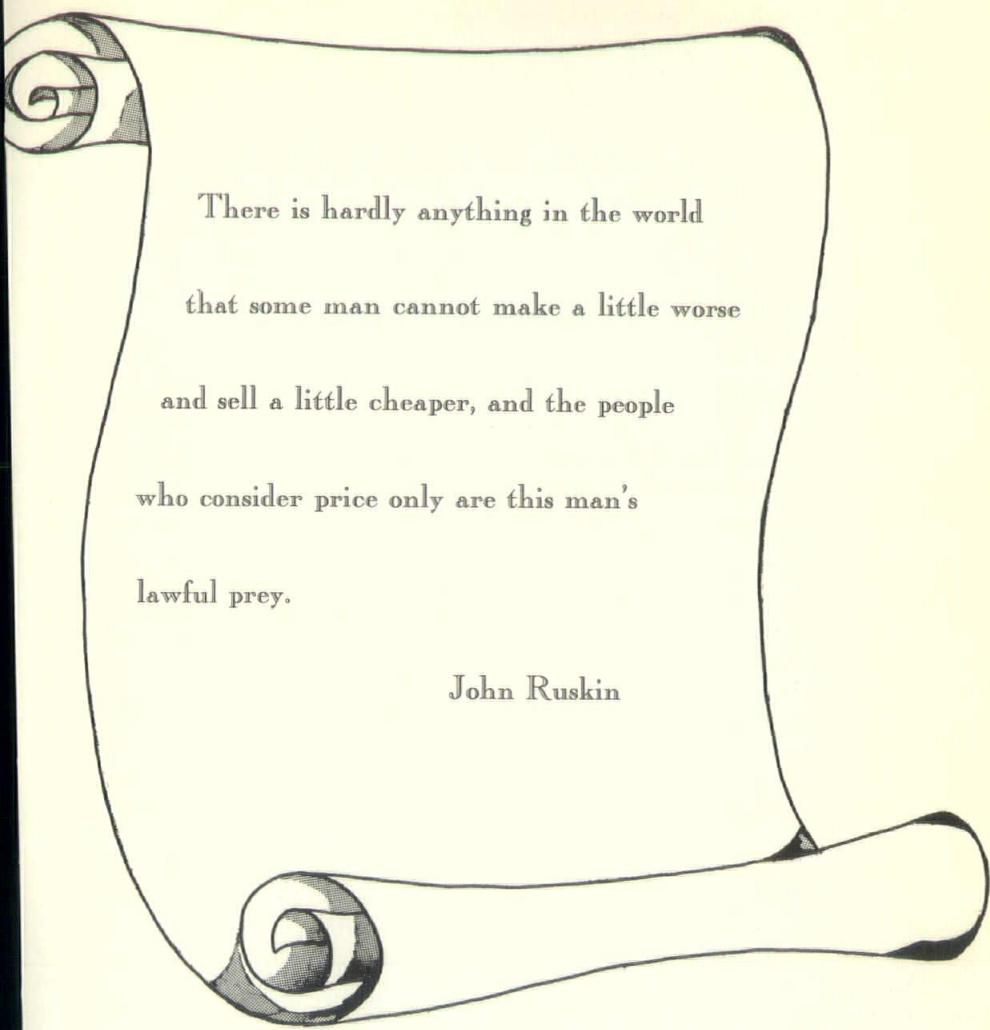
might be expected. However, the medical and surgical units in the general hospital could have combination isolation-psychiatric patient rooms. This would then eliminate the need for any wide doors in the psychiatric unit.

Windows, also, must be carefully selected to avoid the institutional characteristics so often seen today. The residential feeling, dimensions and placement in the wall should be as nearly like residential design as possible. A ground floor unit may not even need the forbidding security devices since the suicide risk would be much less. Some means of controlling the maximum opening of the window would be indicated, however.

Sound control, lighting, color and mechanical ventilation are other details to be studied within the total framework of milieu therapy. Sound may pass through a wall if it is not properly designed; it may also pass through the ceiling, over the top of the partition and down through the ceiling of the adjacent room if care is not taken. Patients should be given as much sound isolation as is possible in their private rooms.

The corridor is a source of noise emanation as well as transmission. Proper control here would be to provide acoustical ceilings, carpeted floors (just like home, perhaps?) and an occasional change of wall material to help break up sound reflections. Tiled corridor walls are definitely not acceptable for sound control and tend to preserve the institutional atmosphere. A floor carpet will help to soften the harsh, sterile lines of the hospital unit. A judicious mixing of corridor wall materials can help to foreshorten, visually, a long and sometimes bleak corridor.

(Continued on page 34)



There is hardly anything in the world  
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and sell a little cheaper, and the people  
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John Ruskin

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## 1961 PROFESSION OF ARCHITECTURE AWARDS



A proposal from Conrad Curtis, of Curtis & Cowling, to prepare a publication explaining an architect's service to his client was selected for the 1961 Producers' Council Profession of Architecture Award.

The award, in the amount of \$1000, was made at the June Chapter meeting by Lee Dalgleish, outgoing P.C. president. In the picture above, Curtis explains his booklet idea to John Hewitt, left, president of the K.C. Chapter, AIA, and Dalgleish, standing. Merit Award certificates were presented to John Daw of Roark, Daw & See, for an advanced construction seminar proposal, and to Elpidio Rocha for a community recreation plan.

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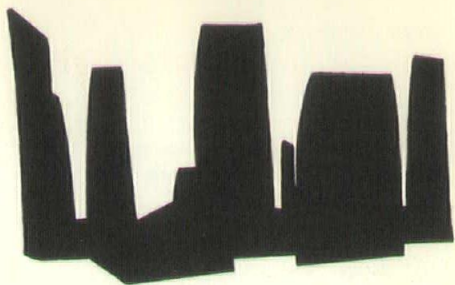
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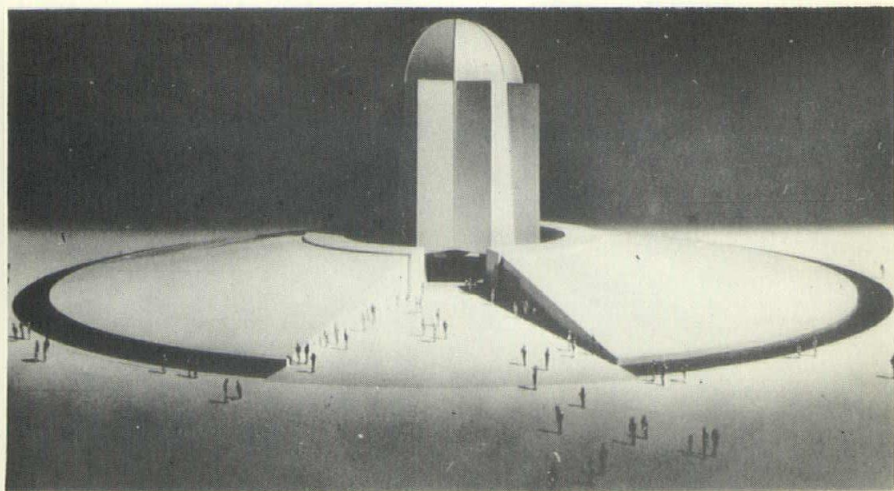
FT. SMITH

# FDR MEMORIAL



The May Chapter meeting program was a presentation of FDR Memorial Competition entries, featuring four from this area. Two Kansas City firms, Marshall & Brown and Kivett & Myers & McCallum, entered the competition. Gene Brown of M & B and Ted Seligson of K & M & McC handled the presentation of their firms' entries and led a critique of other entries.

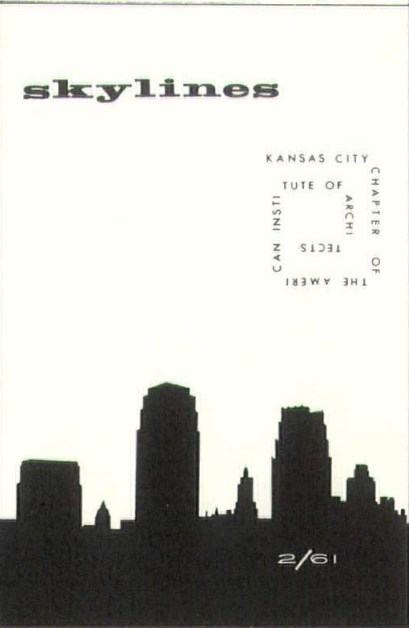
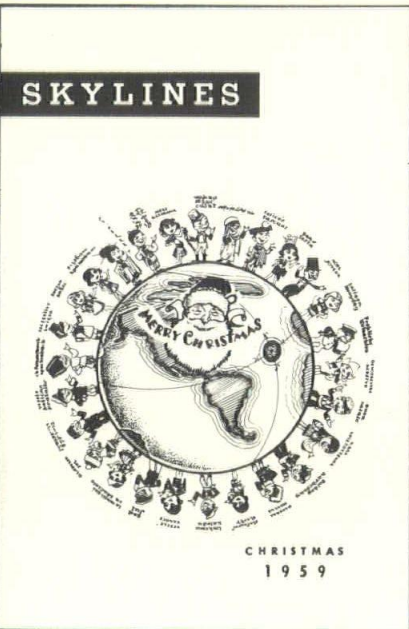
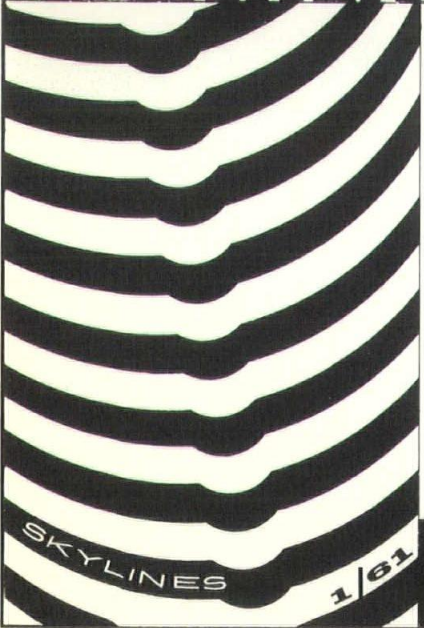
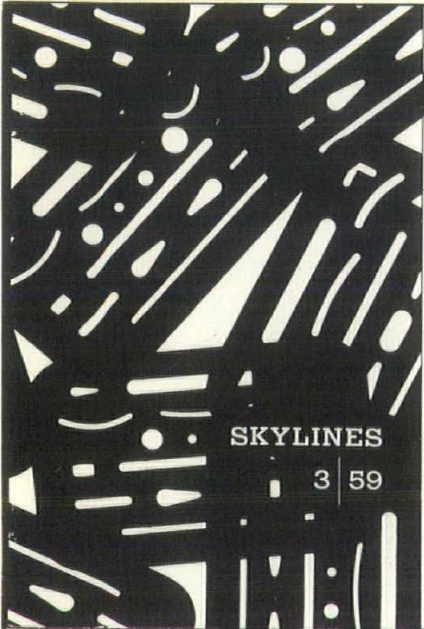
The winning design has already received considerable publicity (much of it controversial) so this article will be concerned with some of the non-finalists. Murphy & Mackey of St. Louis, winners of the 1961 Reynolds award for their Climatron, won an honorable mention for their design, shown on page 22.

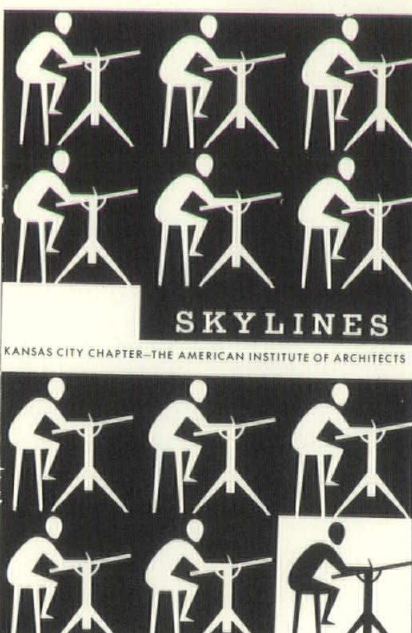


ENTRY OF PHILIP JOHNSON

# SKYLINES' COVERS

A point of pride with all SKYLINES editors, past and present, is that no two successive covers have ever been alike. A few from recent years appear below.



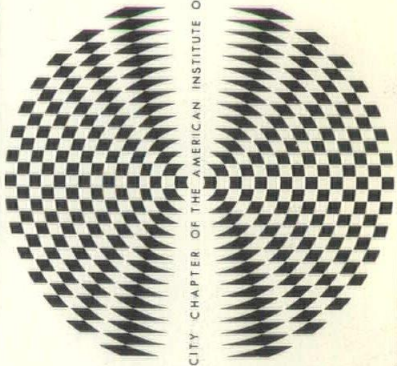


# SKYLINES

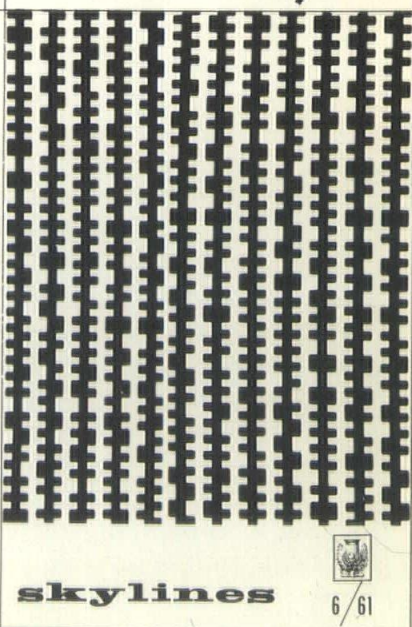
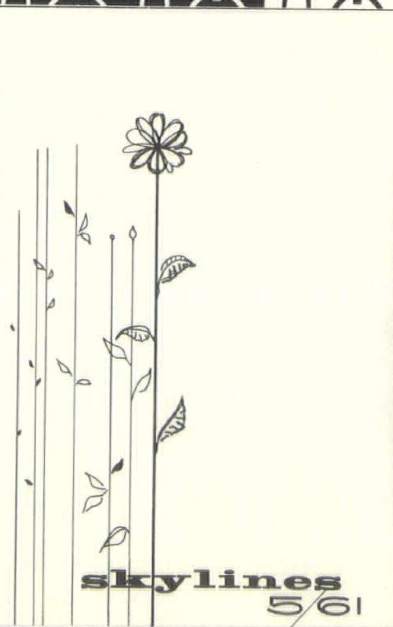
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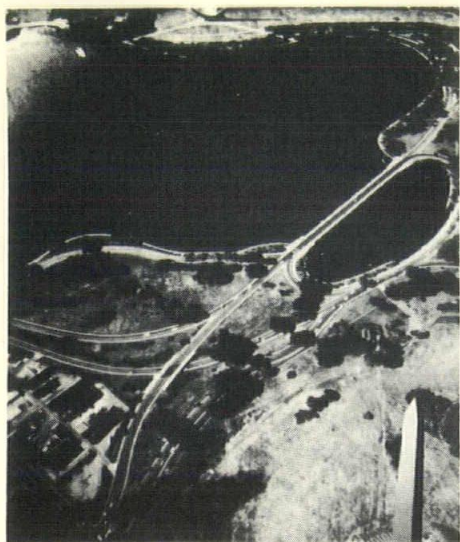
# skylines

KANSAS CITY CHAPTER OF THE AMERICAN INSTITUTE OF ARCHITECTS



12/60





Murphy & Mackey's design is a soaring sculpture, barely visible at the top center of the picture, almost at water's edge. This view gives a good perspective of the Tidal Basin area in Washington, D.C. and the future location of the memorial. The top of the Washington Monument is at the lower right.

The following report, by Gene Norton, gives a fairly complete picture of the competition itself, some idea of the work involved in preparing an entry for a major architectural competition and the design considerations in M & B's solution:

On August 11, 1955, the Congress of the United States authorized the appointment of a Commission to consider and formulate plans for the design, construction, and location of a permanent memorial to Franklin Delano Roosevelt in the City of Washington. The Congress, by joint resolution of September 1, 1959, reserved a site for the memorial in that portion of West Potomac Park in the District of Columbia, which lies between Independence Avenue and the Inlet Bridge; and authorized the Commission to hold a competition for the memorial. The resolution further provided that the proposed memorial should be carried out so as to insure that it will be harmonious as to location, design and land use with the Washington Monument, the Jefferson Memorial, and the Lincoln Memorial.

The competition consisted of two stages. The first stage was open to all registered architects licensed to practice in the United States or to associations of landscape architects, sculptors, painters, or others providing that each association included a registered architect. Six competitors were selected in the first stage by the jury to compete in the second stage. Awards consisted of a ten thousand dollar stipend to each of the six competitors selected to compete in the second stage; and a fifty thousand dollar prize to the winner of the second stage. Honorable mention designs were also to be selected from competitors in the first stage.

(Continued on page 25)



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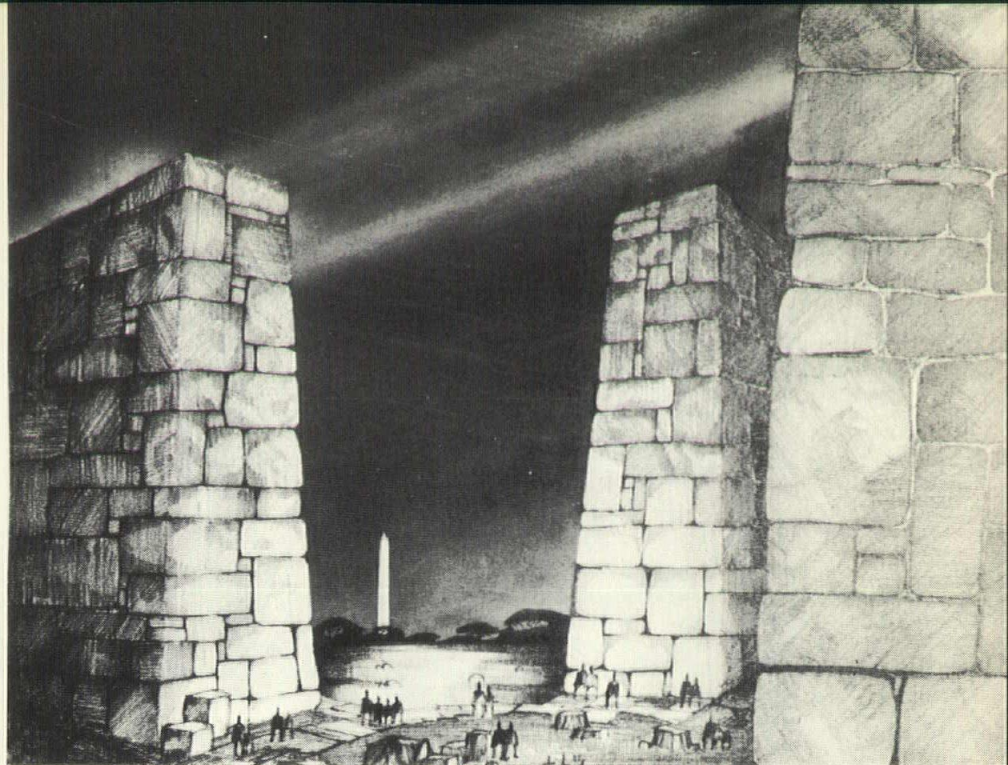
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Delineation of the Kivett & Myers & McCallum entry. Three of the four massive wall structures are shown, with the Washington Monument visible between two of the walls at left center.

In June, 1960, the 5 partners of Marshall & Brown held a conference and decided that the firm should enter the FDR Memorial competition. A design team consisting of Gene Norton and Mel Solomon was selected with Dwight Brown and James Marshall, two of the firms' partners, as advisors.

It was decided that the first step was to spend several weeks in research alone before formulating any ideas regarding solution of the problem. The design team read about a dozen books, collectively, ranging in subject matter from FDR's family life to his policy making and transcripts of his speeches. It was felt that in order to design a fitting memorial to any man the designers must try to learn as much as possible about him.



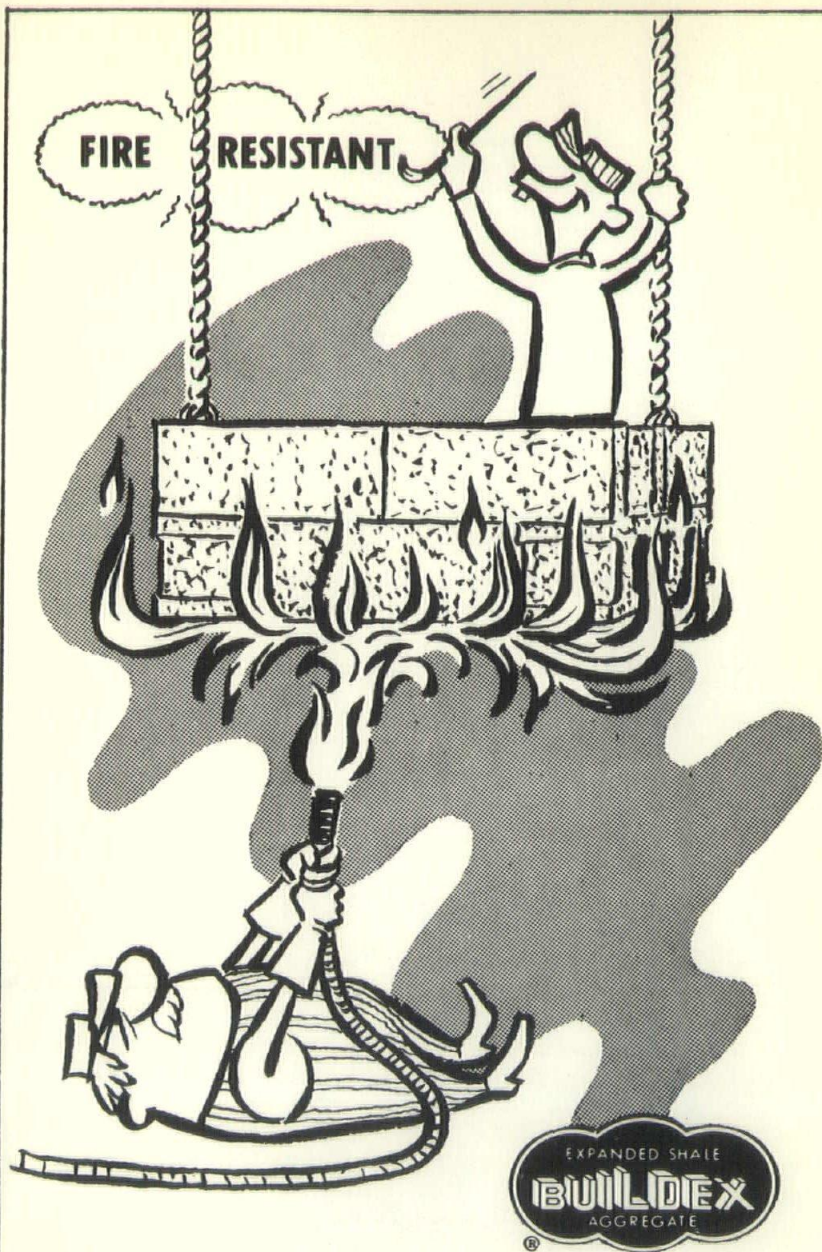
Bird's-eye view of Marshall & Brown's entry. A series of flat-topped concrete umbrellas on a single point suspension cover the walkway leading up to a large sculpture of Roosevelt. Cover for the sculpture is provided by larger-scale versions of the concrete structures. A pool surrounds and mirrors the statuary.

We also felt that a trip to the site before beginning any drawing was of prime importance. We flew to Washington in early July for a two-day stay, most of which time we spent on the site and visiting the surrounding monuments. The purpose of our trip was to analyze the site of the FDR Memorial and to study the Washington Monument, Lincoln and Jefferson Memorials. We felt that a study of these structures, finding out how they were successful and unsuccessful was essential in designing a fourth memorial that would be harmonious to the other three.

After the trip, statements of intent were prepared to establish in writing all of the thoughts and ideas we had gained from our research and the visit to the site.

After about 6000 sq. ft. of yellow sketch paper, and only three weeks before the competition deadline, we felt we had the answer. Then, in developing sketches during the next week, we decided everything was all wrong and so the weekend was spent making major revisions in the design. We then decided to build a 1/8" scale model which could be photographed for our presentation. We felt that drawings alone could not sufficiently convey the design to the jury.

(Continued on page 29)



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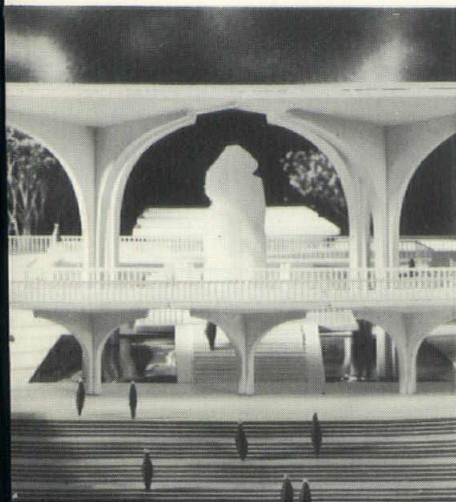
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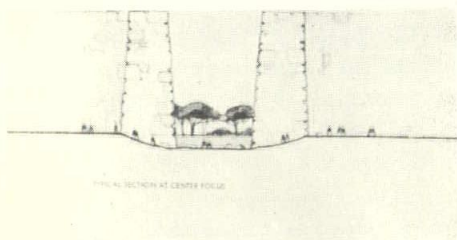
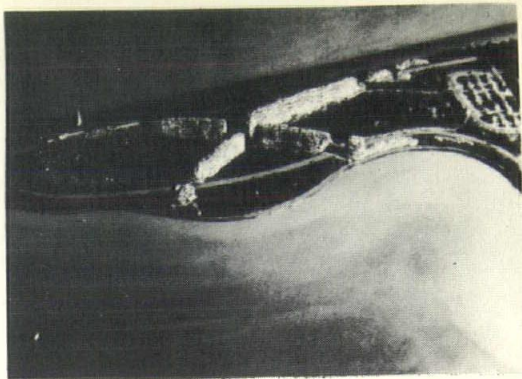
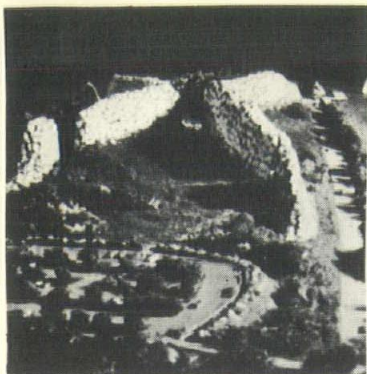


So, in six days, with the devoted help of other members of the firm — Joe Morrotto, Bob Moore, Ed Kinney, Gary Jarvis, Pat Harriman, and some of the wives — we completed the model. Wayne Wright then spent about eight hours shooting seven photographs (during which time his automobile was stolen). Wayne's photography was superb and was a major contribution to our presentation. The remaining week was spent preparing three 30"x40" boards which completed the presentation. Two of the boards were site plans and the third board contained the photographs and supplementary drawings explaining the concept.

## DESIGN CONSIDERATIONS

After our research on Roosevelt's life and our visit to the site, we were able to make several conclusions about the solution of the problem. First, we felt that whatever the design consisted of, it must be a multiple experience idea — we felt that the three existing memorials, especially the Washington Monument, were of a "singular experience" type and that they failed to provide the intimacy between the viewer and the memory of the person to whom the memorial was dedicated. Intimate participation, we felt, was a prime requirement of a memorial to FDR. Scale, as in any element of architecture, was also considered one of the most important elements. We felt that the memorial, both in whole and in part, must be human in scale so as to not dwarf the participant but to introduce him to FDR more nearly as an equal. This would further emphasize Roosevelt's image to his constituents as "friend of the common man", etc. We had also determined by the visit to the site that the location of the memorial could only be in one place, nestled among the cherry trees around the basin at a point where the peninsula protruded slightly into the Tidal Basin. This enabled the memorial to take full advantage of the reflective qualities of the basin, and its relationship to the





Details of the entry from Kivett & Myers & McCallum in the FDR Memorial Competition. Four massive simulated stone walls radiate out from an open center. The walls or arms of the model symbolize Roosevelt's Four Freedoms, and as carried out to the site's perimeter, they serve to tie the natural features into an integrated mass.

Jefferson Memorial was more natural at this point than any place else on the site. These, then, were the important conclusions regarding function, scale and location. Our concept was based on the above assumptions.

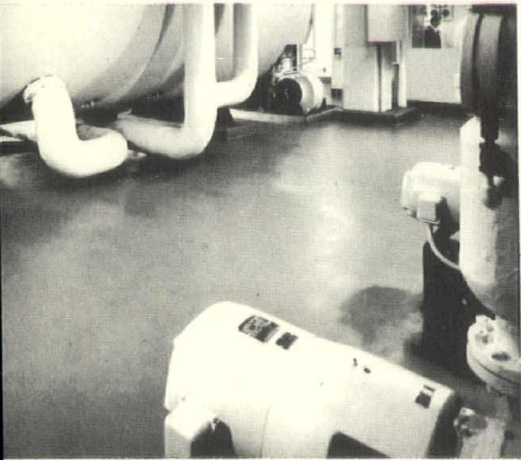
Two Kansas City sculptors, Richard Hollander and Dale Eldred participated in the preparation of the Kivett & Myers & McCallum entry. The FDR Jury of Award was made up of Pietro Belluschi, Dean of the School of Architecture, M.I.T.; Thomas D. Church, Landscape Architect, San Francisco:

(Concluded on page 33)

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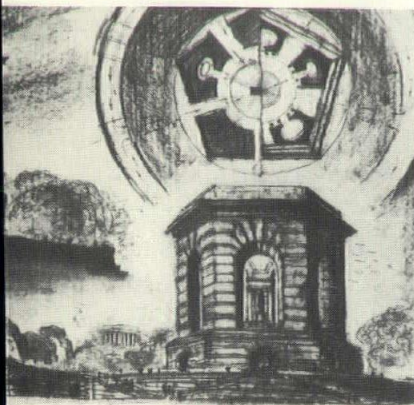
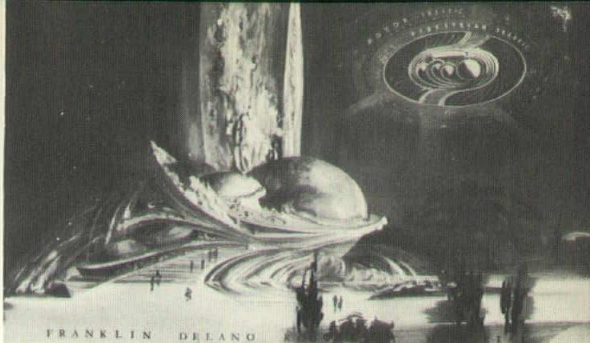
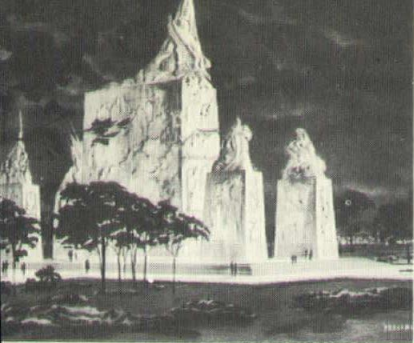
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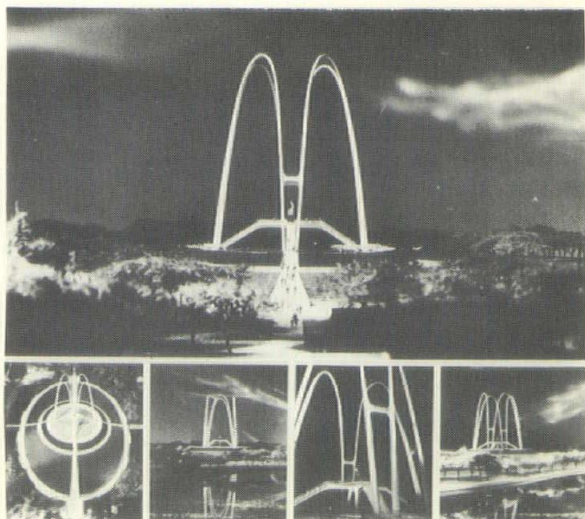
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These are a few of the remaining 574 entries received in the FDR Memorial Competition. While many were not identified, Minoru Yamasaki's design is below. The winner of the \$50,000 first place design was Pedersen & Tilney, in association with Joseph Wasserman, David Beer and Norman Hoberman. Estimated cost of the eight free-standing tablets of reinforced concrete is \$4,254,366.

Burtlett Hayes, Jr., Director of the Addison Gallery, Andover, Mass.; Joseph Hudnut, Professor of Architecture Emeritus, Harvard University and Paul Marvin Rudolph, Chairman, Department of Architecture, Yale University. A traveling exhibit on the winning memorial entry is now available from AIA headquarters at the Octagon in Washington, D.C.



## A Combined Effect

The lighting can contribute much to the achievement of this goal. Lighting is needed that will accent and complete the theme—warm, intimate and friendly; not large, impersonal and uniform, such as is found in commercial establishments. The use of fixtures of institutional character should be avoided. Corridor lighting should not march down the center in a monotonous regularity that accepts the length, but it should be subdued, indirect or even emanate from invisible recessed spotlights or a cove. This type has been used to illuminate patient artwork hung on the corridor walls and, at the same time, helps break up the long corridor length.

The selection of paint colors and fabrics should be in the hands of an expert who understands color dynamics and the problems of color perception in psychiatric patients. Color creates moods; therefore, the colors, wall materials and fabrics for each social area must be selected to compliment the intended function, lighting and exposure. Each social area should be considered separately, but it must also be designed in conjunction with the overall pattern of the unit so as to attain continuity throughout. Room perspectives may be materially altered by the use of colors that appear to recede or come forward. Color contrasts and textures in fabrics and wall materials can add immeasurably to the delight of any room.

The design of individual patient rooms is too often neglected, being considered as fairly standard with little need for improvement. But this private room must perform many functions and should be studied carefully. The room must be versatile since it must serve as a bedroom, a study, a

place to entertain guests, write letters, read, listen to the radio, etc. Adequate storage for clothing should be available; space for books, a radio and the display of pictures and other personal effects should also be provided to encourage a continuing interest in the home and society.

Individual tastes in furniture arrangement should be encouraged for ambulatory patients. This implies that the design should have several possible arrangements. The room should be more like a residential bedroom in terms of physical layout, dimensions and feelings. It might possibly have a convertible couch-bed, a rug, an easy chair, reading lamp, private toilet with lavatory, a closet and drawer space.

The matter of proper ventilation should not be overlooked. Odors emanating from the main hospital, as well as those from within the unit, can be eliminated by proper design. The sterile "hospital" smell has no place in this area. The exhausts from the main kitchen, laundry and hospital should be placed after considering the fresh air intake for the psychiatric unit and the prevailing breezes. All interior rooms, toilets and "wet" rooms, require ventilation, as do all patient areas. Proper housekeeping and the judicious selection of materials will also aid in the control of odors.

A final consideration should be the nurses' station. The traditional enclosed and somewhat forbidding station seems to speak of separation instead of integration of staff and patients. A low, open, desk-like station would seem to encourage contacts between nurse and patient and thereby strengthen the total therapy program.

(Continued on page 37)

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Separate rooms behind the open station could take care of medicine preparation, charting and conferences.

### Team Investigates Details

Many of these concepts of an open psychiatric unit are being incorporated into the treatment facility for the new St. John's Hospital, St. Louis, Mo., which is now under construction. Architect for the project is Bernard McMahon, with Gordon A. Friesen Associates as the consultants. Of special interest is the hobby room located directly across from the nurses' station. Patients will be encouraged to use the art and craft materials in this room at any time. This means that the patients' creative moods will not be limited by a rigid time schedule.

In summation, the architect's role in milieu therapy design should be that of a member of the design team that investigates the meaning, intent and physical requirements of the proposed treatment program. Every aspect of

the nursing unit's environment and its effect upon the patient and staff must be examined in minute detail. The written architectural program that results from this careful study should interpret the treatment program in terms of the space and social environment needed to enable the medical and paramedical personnel to carry out the intended therapy.

This approach is truly based upon the total needs of the staff and patients and should result in a functional and socially significant structure. ★

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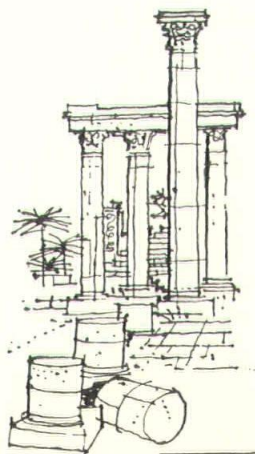
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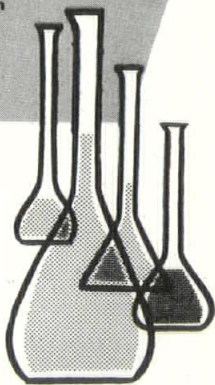
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