THE HISTORIC PRESERVATION AND
ADAPTIVE REUSE OF
ELGIN STATE MENTAL HEALTH CENTER:
CENTER BUILDING

An Architectural Thesis Proposal by:
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July 15, 1981

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HISTORY OF ELGIN STATE MENTAL HEALTH CENTER

The 'Northern Illinois Hospital and Asylum for the Insane' was established by an act of the Illinois legislature on April 16, 1869. Its first patients were received on April 3, 1872. Between 1878 and the late 1920's, much growth occurred. A farm was established and patient participation was viewed as very therapeutic. The Social Service Department was opened, as was the Occupational Therapy Program.

By 1929, there were 3,172 patients. Ten E-shaped buildings were built to provide an additional 300 beds for the facility. By 1935, the patient population exceeded 4,000. The economic difficulties of the Depression years made it both difficult to discharge patients and to avoid becoming a "poor farm." During this same period, however, treatment was improved through the addition of professional staff, particularly physicians. In 1936, the Elgin Papers were published. These papers contained numerous research studies conducted at the facility and were read worldwide by mental health professionals.

Patients were entertained with 'talking' motion pictures and with radio. Dances were held weekly and the present Assembly Hall opened. The name of the facility had been changed to the 'Elgin State Hospital' and the facility was a self-sufficient community.

By 1941, there were 4,000 patients. A new 200 bed Veterans Diagnostic Center had opened. Early evidence of the community mental health movement could be seen in the late 1940's when the new Facility Director, Louis Steinburn, argued for more public education regarding the return of patients to the community. In 1956, Fox Valley Mental Health Clinic opened.
By that time, there were more than 7,000 patients at the facility. Eighty percent of the employees lived on the grounds.

In the 1960's, the L.B. Mendel Research Laboratory was established. Research concerning the cause of mental illness, including possible relationships to dietary deficiencies, was carried out. Also, a new class of "middle staff" who participated in the everyday activities of patients was trained. Known as the Generalists, they bridged the gap between the aides and the professionals at a time when professionals were in demand throughout the mental health system.

By the end of the 1960's, services which would allow patients to return to the community were being emphasized. With the help of psychotropic medications, the population was now decreasing from its 1950's population. Also at this time, employee residence on the grounds was terminated, bringing a close to an era in which the institution had been home to both staff and patients. During the 1970's, the population continued to decrease as sub-region staff helped to develop community services and agencies. In 1972, the facility officially celebrated its centennial.

In 1984, a decision was made to close the facility. This decision was later reversed. It is said that the determining factor was the spirit of the staff and its determination to provide the best possible service patients given available resources. Whatever the reason, other old facilities were closed and Elgin State assumed responsibility for many of their long term patients.
MENTAL HEALTH ATTITUDES

We have an innate instinct to protect ourselves from danger. By nature, therefore, we avoid those who are unpredictable by behavior, or by group identity. We are taught as children to avoid those who are different, and, unquestionably, the behavior of mental patients is different.

Prejudice and discrimination toward people who appear different are facts of life. People who are identified as mentally ill are ill in a way that many people do not understand and also fear. With much unsureness about the causes, cures, and consequences of an array of disorders, it is no wonder that negative or questionable views toward mental illness are common.

A mental health center derives its characteristics from being an identifiable place: somewhere where people go to receive mental therapy. In other words, its very separateness enables it to provide the facilities deemed necessary. Yet, from the perspective of the setting as therapeutic, it can be readily argued that settings which are separate, isolated, or distinct will not be so readily therapeutic. The argument here is essentially that in order to make people 'normal' or more like others in the community, it is essential to provide an environment which is part of the community and as similar to other 'normal' environments as possible.
ENVIRONMENTAL SETTINGS

Fear, isolation, and a sense of helplessness characterize hospital experiences for the majority of patients. To enter a hospital, especially a mental hospital, either as a visitor or a patient, is to encounter an environment which has no equal barrenness anywhere in our culture save for the prisoner's cell.

These environments may be described as disintegrated or empty because they lack wholeness—they are incomplete. Because settings are missing, they cannot adequately support the great range of human behaviors associated with the recovery process. More important, typical hospital environments may impair the patient's confidence in their own competence to take care of themselves and live normal, independent lives. What is missing from these hospital environments, from the patient's perspective, is richness and meaning.

Ordinarily, we live in a world of great visual complexity. We manage to not be confused by it all because of our ability to focus on only those parts of the environment that are of particular interest. We spend a small but continuous amount of energy filtering out the irrelevant information. Even though we sift through it, the richness of the environment is important to us, and without this array of stimuli, sensory deprivation occurs and we can lose our mental balance.
Consider how the environment takes on meaning. Obviously, no two individuals will derive the same meaning from any aspect of the environment. The process by which we identify and select our meaningful points of attachment (my place at the table, my plot in the garden) is determined by our association patterns and our cultural conditioning.
Meaningful Richness is complexity with which we have previous associations or experience...
All the small objects and furniture in the world will not add up to a sensible and useful setting if it is selected and organized in a way which reflects the day-to-day life needs of the users. Hospital institutions always have order, but many times the wrong order. Obviously, the order is designed around janitorial routines and patient management—the chairs side by side along the walls, card tables in irrelevant places, and large lounge chairs in rows like theater seats. No one lives like that at home; not the janitors, the nurses, or the patients.

Significant steps have been made by researchers concerned with the physical environment of psychiatric hospitals in relation to patient behavior. Although psychiatric patients spend considerable time in day room settings, there is evidence to indicate that these settings tend to inhibit social and functional behavior while coercing isolation. Some researchers have distinguished between spaces which facilitate social interaction and spaces which inhibit social interaction. Osmond (1957, 1959) defined 'sociopetal', spaces which encourage or foster the growth of stable relationships. Osmond lists as examples of sociopetal spaces, tepees, igloos, and Zulu kraals, while railway stations, jails, hotels, and hospitals are typically sociofugal spaces. Hall (1969) has indicated that sociopetal space is not universally good. He contends that the most desirable space is flexible space where individuals may or may not be socially involved, depending on the occasion.
The following system of 'Archetypal Places', as written by Mayer Spivack, illustrates the fundamental range of functional places used by man. They intend to denote space with highly specific sets of specifications. This is regarded as the smallest set of all possible spaces associated with needs, drives, and their realization, social life, psychological life motifs, biological existence, and maintenance of species population levels. They are seen as the minimum group of settings which together are necessary for support of the healthy life of human family and the larger community. The separate functional places or archetypes may not be divided by walls, but the routes between parts is most apparent.

The behavioral counterpart of archetypal place, what people do in these settings, constitutes meaning in our environment. It is what makes a place out of a space.

In order to comprehend an organization and take advantage of it, it is necessary to understand how it is arranged in space. The clarity of organization is especially critical for places designed for short term visits or places designed to encourage interaction. A patient in any hospital requires some idea as to where nurses or attendants are likely to be found and the likelihood of a doctor being present on the ward itself. Also, the patient is likely to gain some understanding of his changing state through his changing experience of the setting, whether it be the locations he is moved to or the places he becomes able to seek out. The patient who understands how the organization operates and where people can be found is likely to have a greater potential for active search to find help and care than one who can only wait in hope that such facilities will be brought to him.
The possession of personal territory, a claim to a piece of the physical environment, is important to a person's health. It has been observed many times that patients in a hospital setting will claim a piece of the hospital corridor or day room, or sit in a particular chair, and place a kind of imaginary chalk line around it.

To use these ideas as a framework for design requires a good understanding of just what kinds of activities are expected to take place in the new setting. It also requires that the settings be programmed to accommodate such activities in as specific a manner as possible.
Preservation is a great big old word, but a simple concept: saving architecturally & historically distinguished places, caring for them, and putting them to good uses that will enrich the lives of all who experience them.

Buildings, like people, grow old. The repair or deferred maintenance of an old building is usually expensive. The uses for which a structure was originally designed can become obsolete. Fashions change. Urgent needs compete for limited amounts of land. In addition, there are the factors of ignorance, indifference and inertia to be faced. Many people know little about architecture or history. Of these who do something, most are preoccupied with other concerns. Of the few who both know and are concerned, a great number, unfortunately, feel that circumstances are so unfavorable for preservation that the loss of old buildings is inevitable.

With these inexorable obstacles in mind, historic preservation is still viewed as one of the best hopes for managing the constant change in our built environment. The force behind this emerging industry is the philosophical transition away from a throwaway society, based on an illusion that resources are unlimited, toward a new kind of civilization grounded in permanence, balance and order.
Old buildings.
1. Are physical links to the past
2. Give a sense of national and personal identity
3. Provide environmental diversity
4. Have intrinsic value as art
5. Continue to be useful
6. Contribute to urban revitalization
7. Represent scarce resources
8. Stimulate education and moral improvement
9. Lend psychological stability
10. Fulfill nostalgic instincts

The basic purpose of historic preservation is not to arrest time, but to understand the present as a product of the past and a modifier of the future.
GOALS & OBJECTIVES

- Re-establish the center building as the service center of the campus by providing an atmosphere that is community oriented.
- Restore the historic architecture and preserve its image of stability and security.
- Embrace the current needs of the mentally ill through modern therapeutic services.
- Reduce the stigma applied to the mental health center and its patients by providing meaningful richness to an environment shared by both mentally handicapped and well visitors.
The buildings on the campus of Elgin State Mental Health Center were sensitively built through time to provide a variety of needs for a sensitive client. Today, through modern medication & therapy, the emphasis on specific needs has been reevaluated and redirected, reducing many of the original provisions of these buildings. At this point, we cannot simply discard the domains that once housed old, antiquated techniques and call them outdated and useless. We must preserve those elements that led us to our present achievements and build upon them.

**LEGEND**

- vacant, to be removed
- occupied

**LOCATION ANALYSIS**

Elgin State Mental Health Center is strategically located at the southwest corner of the city of Elgin, Illinois, at the intersection of Illinois Route 21 and U.S. Highway 20. The site itself encompasses 220 rolling acres of grandiose landscape. Although it has a beautiful, campus-like atmosphere, it lacks coherence between buildings and an overall sense of direction. Ironically, the most captivating, impressive building, located at the center of the main drive, is abandoned. One is left redirecting their attention toward any one of the smaller, less dominant buildings.
The primary function of the center building is to serve as a nuclei for therapeutic, occupational & recreational services provided by the health center. Pedestrian circulation is thoroughly addressed providing direct access to auxiliary buildings frequented by patients, staff and visitors. Patients and staff will primarily be travelling between buildings by foot, therefore ample walkways will be provided at strategic locations. Travelling routes are clearly defined and directly accessible for the convenience of all users while simultaneously providing stopping points and viewing points for the casual stroller.

- Walkways provide the pedestrian link for social contact between all who enter the health center.
The original building was symmetrically designed in the classic 'Kirkbride' style of architecture. Its plan is strongly Palladian with a dominant center bay and identical stepped wings to either side. Any subsequent design concepts must be similarly enriched by this powerful classic symmetry.

The central axis is emphasized by the access drive circle in front of the building, giving a clear sense of direction to any newcomer. This strong axis must reach out past the edge of the campus into the normal community to visually and symbolically link the two. Attempts must be made towards reducing the scale of the existing facade, so it becomes more humane and less overwhelming. The presence of architectural features such as exterior seating areas, balconies, awnings, porticos, etc. would symbolically convey an attitude of personal comfort or humanitarian concern. If the building is to be read as multifunctional, its mass must be broken down in order to convey its separate functions and address the human scale.
BUILDING PROGRAM  TOTAL 251,050 S.F.

ADMINISTRATION  41,400 S.F.

Superintendent
  Personnel
  Security
  Community Services
  Chapel

Asst. Supervisor - Admin.
  Business Admin.
  Dietary Services
  Business Offices
  Physical Plant
  Receptionist
  Housekeeping
  Inventory Control

Asst. Supervisor - Medical
  Program Director
  Medical Staff
  Dental Staff
  Medical Records
  Pharmacy
  Research

PATIENT WARPS  138,900 S.F.

Recreation Room
  Dining Room
  Bathroom
  Circulation
  Nurses office
  Kitchenette
  Laundry
  Meeting Room
  Conference Room
  Attendant Station
  Single Rooms
  Double Rooms
  Quiet Lounge
  Public Lounge

MAINTENANCE  22,025 S.F.

Inventory Control
  Repair Shop
  Supply Shop

KITCHEN  20,425 S.F.

Hot Food Prep.
  Cold Food Prep.
  Cold Storage
  Dry Storage
  Dietary Offices
  Employee Dining

VISITOR/STAFF LODGING  17,300

Rooms w/bath
  Public bathroom
  Lobby/Reception Office
  Dayroom/Meeting
  Circulation
  Maintenance
SCHEDULE OF ACTIVITIES
(Schematic)

Schedule

Monday - Friday
7:00  Get up
7:00-8:15  Make Bed
    Clean up
    Breakfast
8:30-12:00  Classes
12:00-1:00  Lunch
1:00-2:00  Occupational Therapy
    Recreational Therapy
    or in Ward
2:00-4:00  Classes
4:00-5:00  Free Time
    Spent in Ward or
    on grounds, library,
    music, swimming, etc.
5:00-6:00  Supper
6:00-7:00  Quiet Time
7:00-9:00  Activity
9:00-9:30  Go to bed

Weekends
Patients can go home for the
weekend but must be back
by Monday morning.

Visitas
Visitors can come anytime, but
visits are usually preplanned.
A member of the treatment
team often sees parents or
family during the visits.

Descriptive Activities

Dining
Each ward has its own dining
room, served by the main
kitchen facility.

Occupational Therapy
Sensory Integrated Exercises
Crafts
Cooking
Sewing
Painting

Recreational Therapy
Swimming
Fishing
Bicycling
Cooking
Team Sports
Table Games

Music Therapy
Singing
Playing Instruments
Dance
Theatre
The following is a list of items found in a university dormitory room shared by two female occupants. The length of their stay is 4 days.

**Supplied by university:**
- 2 beds (twin)
- 2 pillows
- 2 sets of sheets
- 2 dressers
- 2 mirrors
- 2 desks
- 2 lamps
- 1 waste basket
- 1 telephone
- 1 closet
- 2 chairs

**Personal Items:**
- 1 set of markers
- 1 bag of chips
- 10 bottles of fruit juice
- 4 boxes of crackers
- 1 set colored sheets
- 4 towels
- 3 cosmetic bags
- 3 pairs of earrings
- 1 pair eyeglasses
- 2 cans deodorant
- 2 brushes
- 2 shampoo
- 2 toothbrush & toothpaste
- 1 clock radio
- 1 cassette player
- 1 fan
- 1 camera
- 1 bottle of Tylenol
- 1 video game
- 2 magazines
- 1 deck of cards
- 2 paperback books

*Note: Dorm rooms are not equipped with private bathe, therefore, personal care items must be kept in room.*
The following is a list of items found in a hospital patient room shared by two female occupants.

Supplied by hospital:
1. 2 beds (twin)
2. 2 pillows
3. 2 sets of sheets
4. 2 comforters
5. 1 desk
6. 1 lamp
7. 2 bedside lamps
8. 1 waste basket
9. 1 closet
10. 2 chairs

Personal Items:
1. Newspaper
2. 2 Plants
3. 1 Photo
4. 5 Clay models
5. 1 set of jacks
6. 1 box of envelopes
7. 1 box of stamps
8. 1 frisbee

*Note: Hospital patients have private bathrooms, therefore, personal care items such as towels, deodorant, shampoo, toothbrush & toothpaste would not be found in a patient room.
THE CORRIDOR

The interactive connector

2 PATIENTS

- Classical Motif
- Homely Environment
- Complexity: Not long monotonous
- Meaning: Each room is unique in content and form
- Softlight: Spaces encourage interaction

FLOORS: low profile carpet - quiet space

WALLS: painted the color.

CEILINGS: all low - low ceiling, close to covered equipment with no ventilation.
Sociofugal activities are separated and isolation is encouraged.
SOCIOPETAL

This type of setting encourages intertwining of activities and acceptance, multipurpose uses.
LODGING FACILITY FOR VISITORS & STAFF
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