

COMPREHENSIVE COMMUNITY MENTAL HEALTH  
CENTER CONCEPTS FOR THE STATE OF KANSAS

BY

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## INTRODUCTION

With new concepts of what mental health is, and how it should be treated, new health facilities will soon be planned throughout the United States.

It is the conceptual architectural planning solution for these new health facilities, that I have chosen as a thesis project.

The State of Kansas will soon build a series of "Comprehensive Community Mental Health Centers". What the goals of these facilities are, and how they should fit into the planning of the community is an important problem.

The author, therefore, feels that a research study of this kind would promote the community-based program for treating the mentally ill and thereby benefiting Kansas and the nation.

Through the correlation of information gathered mainly from Dr. H. G. Wittington, Director of the Bureau of Community Mental Health Services of Kansas and his distinguished staff, a direction as to the character of this project has been established.

This study is to be considered as an approach about translating the comprehensive community mental health center concept into an architectural design problem and not as an end in itself. It is to be used in establishing the requirements of the buildings to be created.

## STATEMENT OF THE PROBLEM

For many years, the mental hospital in our society has had its primary functions, the protection of the community from unwanted members and the provision of custodial care for them. Some trends are emerging clearly recently. The one that gained the widest support is that services for persons mentally ill should be located in the community in which they live. Thus, an attempt has been made to remove the prison-like atmosphere of many existing mental hospitals, and instead create an environment emphasizing a home-like atmosphere within a community. The trend stems from marked evidence that most mentally ill persons can be successfully treated in their own community and will need to stay less and less time in mental hospitals, and they will do better if they are treated nearer home. They need to be treated in the environment in which they became ill, and more and more patients are being handled by a variety of treatment programs which were formerly not even considered.

In addition, the major function of these mental hospitals in the past, was to give psychiatric diagnosis and treatments. There is a change in function as they are becoming community mental health centers. These centers give consultation to other agencies such as the social work

agencies, schools and the communities. They have come to a much broader function than that of merely diagnosis and treatments. The Community Mental Health Center is a place for people in a community that need help from the community and individuals.

With many communities already moving ahead in developing a variety of mental health facilities, the United States 87th Congress made a grant of \$4.2 million to the United States Public Health Service and its National Institute of Mental Health for evaluation and planning of mental health services at the community level.

On October 31, 1963, the Community Mental Health Center Act of 1963 (Title II, Public Law 88-164) was signed into law by the late President John F. Kennedy, under the new law, \$150 million was authorized for a three-year program of aiding the construction of community mental health centers. Federal construction grants will provide from one-third to two-thirds of the cost of a center, and it is estimated that the \$150 million will assist in the construction of approximately 144 community mental health centers throughout the nation.

Since funds have been made available to state departments of public health, the establishment of mental health centers at the community level has been made possible. As the United States Department of Health, Education, and Welfare has developed and extended its programs, the need for more adequate mental health services at the local level becomes apparent. Thus, the demands for community mental health centers increase.

The question of how to meet these demands with adequate services in the community is the goal of this problem.

Above all, a community mental health center is not only to prevent hospitalization, but to discover mental disturbances and promote earlier hospitalization. It will increase human health and will save human energy.

It is with this aim in mind that this study is being made, so as to create a favorable environment for effective community mental health services.

## MENTAL ILLNESS IN MODERN SOCIETY

Mental illness is one of the leading health problems of modern society. Approximately one in every ten persons in the United States has some form of mental or emotional disorder requiring treatment. On any day of the year there are as many patients under treatment in mental hospital as in all other hospitals combined. Mental and emotional illness cost the nation three billion dollars annually<sup>1</sup>. Furthermore, there is the incidence of crime, suicide, alcoholism, and juvenile delinquency. All of these have made the magnitude and importance of the problem very clear.

For many years, treatment of mental illness consisted mainly of institutional care. It was not enough to bring about any great changes from the earlier methods of imprisonment. But since World War II, there has been a great awakening to this problem.

In 1946, the National Mental Health Act was passed which established the National Institute of Mental Health. It has functioned to increase research and training and to provide the states with technical and financial assistance in the development of community mental health facilities.

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1. National Association for Mental Health, 1959.

Twenty years ago, one psychiatric clinic for every 100,000 people was widely accepted. More recently, two such clinics for the same number of people were recommended by the Joint Commission on Mental Illness and Health. One clinic team for every 25,000 people may be a goal that is more realistic.

## THE HISTORY OF MENTAL HEALTH SERVICES IN THE COMMUNITY

The first organized psychiatric research program, the Pathological Institute of the New York State Hospital was one of the originators and developers of present-day community mental health services. In 1902, Adolf Meyer became the head of this institute. In 1903, he succeeded in changing its name to the Psychiatric Institute. From his observations of mental patients, Meyer developed his concept of mental disorders as maladjustment of the whole personality, a concept that led inevitably to community-based services.

Some fifty years later, the coming together of social work and Psychiatry influenced the development of the aftercare movement in America. Aftercare is a transitional step of medical and social support for those who no longer require hospitalization. It was one of the first forms of community mental health services. New York's State Charities Aid Association established the first aftercare program in the nation in 1906.

The first neuropathological research unit connected with a state hospital was organized in New York City in 1929, in connection with the New York State Psychiatric Institute

which is affiliated with the College of Physicians and Surgeons of Columbia University and is operated by the New York State Department of Mental Hygiene. In World War I, awareness of the needs of the insane was heightened by the large number of cases of Psychoneuroses, public and professional were made aware of mental disorders not necessarily confined to the hospitals. Since then, communities have been ready to accept the practice of psychiatrists outside the hospitals and private office practice of psychiatry developed rapidly. However, in the period between World War I and World War II, the general public and the government were preoccupied with other problems. Mental health services in the community developed slowly and almost under voluntary auspices. The only development was in the field of child guidance and resulted in the organization of almost three hundred clinics for children, although, most of these operated only on a part-time basis.

In 1946, Congress passed the National Mental Health Act, thus recognizing mental health as a major public health program. The Act provided a method for federal financing of research and training programs and assistance to the states to develop community mental health services. The National Institute of Mental Health was formed in the United States Public Health Service and charged with administration of the program.

In 1954, New York State passed the first community Mental Health Services Act for the great concern and interest in Mental Health problems and demands for more mental hospital beds. It gave the control of mental disorders beyond the institutional care. It established a permanent system of state aid for community Mental Health purposes. Two important principles were made from the Act.

1. Comprehensive programming in mental health requires the total efforts of health, education, welfare, and corrective agencies both public and private.
2. Treatment is a responsibility of the medical specialty, psychiatry and the related clinical professions, and promotion of mental health is the responsibility of the total community.

Since 1954, the following states have also passed community mental health legislation, varying in scope, but generally patterned after the New York Act; Indiana, California, Minnesota, New Jersey, Vermont, Connecticut, Wisconsin, Maine, South Carolina, Oregon, Utah, Wyoming, and South Dakota. A number of other States have appropriated funds and have passed laws or adopted regulations to stimulate the development of community mental health services. Among them are Kansas, Iowa, Georgia, Massachusetts, Nevada, and New Hampshire.

The community mental health services act provide for support of all or some of the following:

1. Outpatient diagnostic and treatment services
2. Inpatient care in general hospital
3. Rehabilitation services
4. Consultatives services to schools, courts, health and welfare agencies, and public and private
5. Educational services to professional and lay groups
6. Collaborative and cooperative services with other public or voluntary agencies to prevent mental disorders and to rehabilitate those handicapped by mental disorders

DIFFERENT KINDS OF COMMUNITY MENTAL HEALTH  
SERVICES IN THE UNITED STATES

1. The outpatient psychiatric clinic:

Numerically, this is the largest of community mental health services. It is defined by the United States Public Service as an unit that provides outpatient mental health services and has a position for a psychiatrist who has regularly scheduled hours in the clinic and who assumes medical responsibility for all patients. A majority of the clinics are independent, non-hospital-connected units.

The chief function is to provide services that make it possible for the patient to remain in the community while receiving care on outpatient basis. Clinic treatment is most often individual psychotherapy, group therapy, drug therapy and shock therapy. Clinics that are highly specialized are usually found in large metropolitan areas. The use of home visiting and treatment by clinic teams in the United States is growing.

2. Inpatient services in General Hospitals

Psychotherapy both individual and group, physical treatment, drug therapy, activity therapy, all are used in well organized psychiatric units of general hospitals.

In the past, most psychiatric services were organized as units so that the psychiatric patients are kept separate from the rest of the patients. Changing attitudes and current trends emphasize dispersing the psychiatric patients throughout the hospital. However, a small number of secure rooms for acute toxic reactions and acute temporary behavioral disturbances are needed.

### 3. The Community Mental Hospital

This is at present a goal rather than an existing community mental health service. This is a relatively small open mental hospital organized as a "therapeutic community" designed to restrain the patient to meet the normal stresses of an ordinary community. It receives patients on a voluntary or compulsory basis, carries on prehospital and posthospital outpatient services. It engages in educational and consultant services and relates to all of the other health and welfare services of the community.

### 4. Community Mental Health Centers

Only a few such centers are in existence, but they represent the type of service most highly recommended by mental health planning groups. They differ from the community mental hospital only in that they do not admit certified patients. When fully developed, the centers provide diagnostic

services, outpatient care, day, night and twenty four hours hospital care, transitional and aftercare services. With variations in size and scope of activities, they represent the probable prototype for the future organizations of comprehensive community mental health services.

#### 5. Day Hospitals and Night Hospitals

In the day hospital, all the activities of a psychiatric hospital are available - psychotherapy, drug therapy, shock therapy, adjunctive therapy, as well as vocational rehabilitation. Patients stay with the total hospital program during most of the day, and for the remaining hours of day and night, they are members of their families and community.

In the night hospitals, the hours of occupancy are reversed. Not all the therapeutic activities are available to night hospital patients, but they may receive psychotherapy, drug therapy and shock therapy, It has been used mainly as separation from full hospitalization or when the patient requires supervision at night or they have family problems.

It is claimed that the total treatment period has been considerably shortened by the use of Day and Night Hospitals, and has relieved the load from the single large state mental institution.

### 6. Community Day Centers

Day centers were developed as a rehabilitation service for former mental hospital patients. They provided a meeting place for clubs composed of released patients, clubs of former patients, filled an important need for mutual aid, and to engage in the regular social life of the community.

### 7. Halfway House

This service was designed originally as a transitional step for persons no longer requiring hospitalization, but not yet ready to resume independent living. It provides an opportunity for gradually reestablishing work, family and social relationship.

### 8. Day Treatment or Training Centers for Children

There are many children who are too emotionally disturbed or mentally ill to be treated in outpatient clinics. They present problems that cannot be coped with in the school. Day treatment centers combine schooling and clinical treatment for such children. For severely retarded children, day training centers provide socialization, habit training, special education and in combination with psychiatric and medical supervision.

## ANALYSIS OF KANSAS

Total area : 32264 sq.mi.

Population (1960) : 2,178,611

Topography :

The state's physical features are attributable largely to its location between the Missouri River and the Rocky Mountains. Altitude varies from 4135 feet near the Colorado line to 734 feet above sea level in the Verdigris River Valley in southeastern Kansas. Rolling hills, creeks, valleys, and a good deal of woodland are characteristic of the eastern sections, while the western third is relatively level and treeless. There are no mountains, swamps, or natural lakes of permanent character. There are sinks and buttes, badlands, chalks bluffs, and glaciated areas. There are no deserts in Kansas, and only a very small part of the state is considered to be in the "dust-bowl" area. Kansas is exceeded only by Nebraska and Iowa in the percentage of total area used as farmland.

Climate :

Two factors combine to produce in Kansas a climate of extreme variability: the differences in altitude and the location of the state far from any large body of water.

There are no mountains to ward off southward-moving storms from the arctic and northward-moving storms from the tropics. The winds are of high velocity, averaging in the western third a rate of 12 to 14 mph. The yearly mean temperature varies from 53°F. in northern counties to 57°F. in southern counties, sunshine is a characteristic feature of the state, there being, on the average, more days of sunshine than in any other part of the nation having as much rain. The rainfall in Kansas in terms of annual averages diminishes from east to west. The average rainfall for the state is 26 inches a year, varying from 40 inches in the southeast to 15 inches along the western border. The greater part of the rainfall comes during the growing season.

#### Economic Activities:

Kansas is usually thought of an agricultural state, though since 1940, it has been gradually converted to an economy based on manufacturing as well as farming. Current trends are toward an even greater emphasis on manufacturing, though Kansas will continue to rank as one of the top food-producing states. The value of manufactures increased rapidly and reaching an estimated \$1,170,000,000 by 1958. Kansas now has a larger percentage of its population employed

in manufacturing than any of the surrounding states except Missouri.

The rolling fertile prairies of Kansas have been the determining factor in the state's development. With nearly 50,000,000 acres devoted to farming, Kansas has more land in farms than any other state, with the exception of Texas.

Kansas ranks among the top ten states in the nation in mineral production. Petroleum, which is produced commercially in seventy counties of the state, is the most valuable mineral.

#### Population:

In 1960, Kansas had a population of 2,178,611, an increase over of 273,312 over the 1950 population of 1,905,299. The most populous counties were Sedgwick, including Kansas city; Shawnee, including Topeka, and Johnson, including suburbs of Kansas City. Analysis of the 1960 census showed that 95.4 per cent of the Kansas population belonged to the white race, 4.2 per cent to the negro race, and 0.4 per cent to other races.

**Government:**

Kansas has 105 counties, 1552 townships and 2976 election precincts. The counties and townships are governed by elected officials. Kansas has 613 incorporated cities, 35 are governed by a city manager and 38 are operated under a commission form of government. A city must have 15,000 population to become a first-class city.

## COMMUNITY MENTAL HEALTH SERVICES IN KANSAS

Kansas has made a good beginning toward the development of community mental health services. The Bureau of Community Mental Health Services has the responsibility for helping to establish and develop the community mental health services. As the program has developed, it is apparent that the amount of professional time spent in all Kansas outpatient psychiatric clinics is among the highest in the nation, and is increasing.

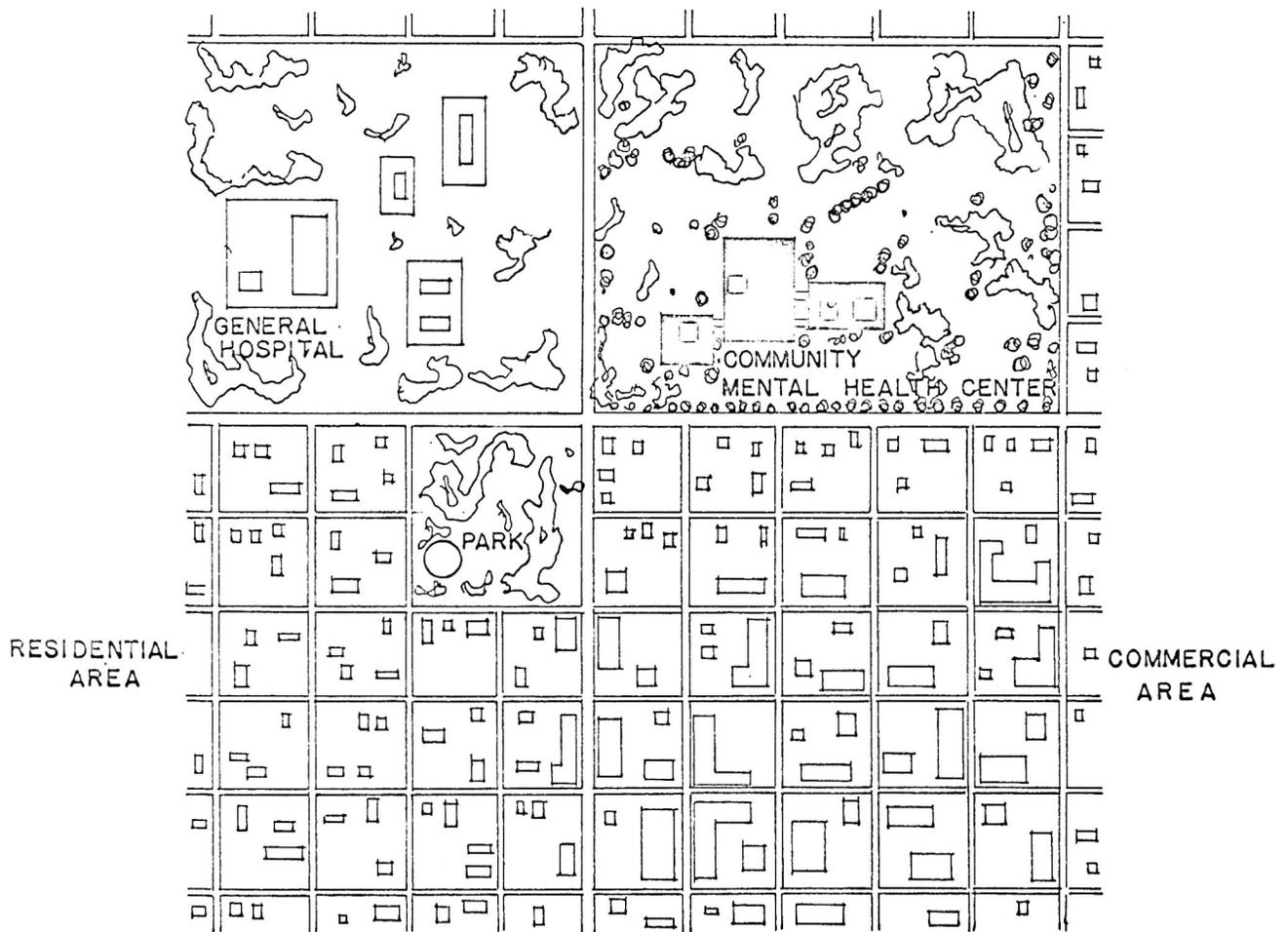
At June 1963, there are 16 community mental health centers serving 23 counties in the State of Kansas. These counties contain 56 per cent of the state's population. (Appendix C). Though, Mental health facilities in Kansas are unevenly distributed, most are concentrated in the northeastern part of the state. The western portion is almost completely without psychiatric services. It seems that communities which desire immediate and local services, should consider to establishing community mental health centers in that portion of the state.

Kansas has made much progress since the National Mental Health Act was passed and is well known as high ranking, with regard to mental health at the state level.

SCHEMATIC RELATIONS

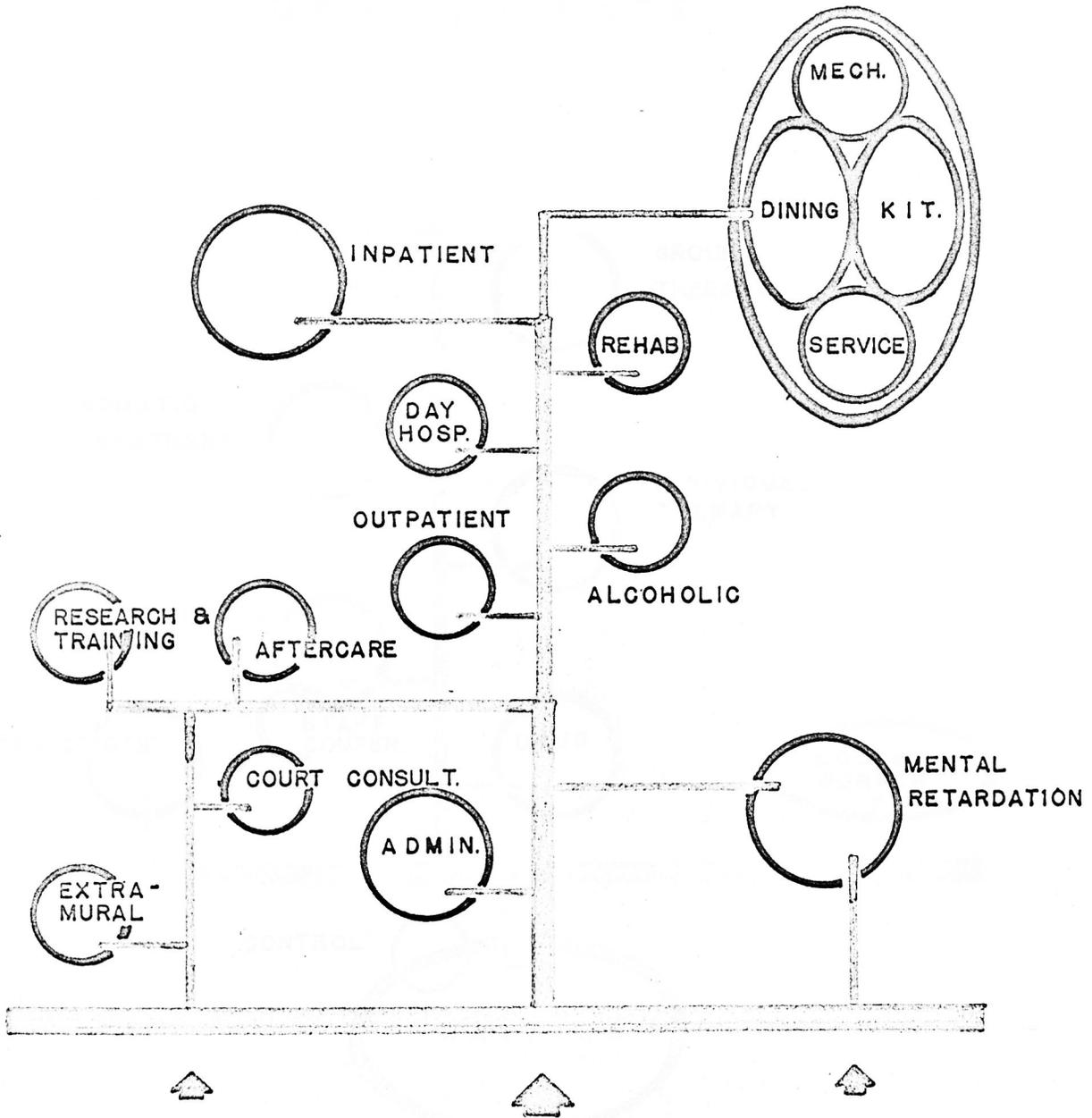
RELATIONSHIPS FOR A COMMUNITY

MENTAL HEALTH CENTER

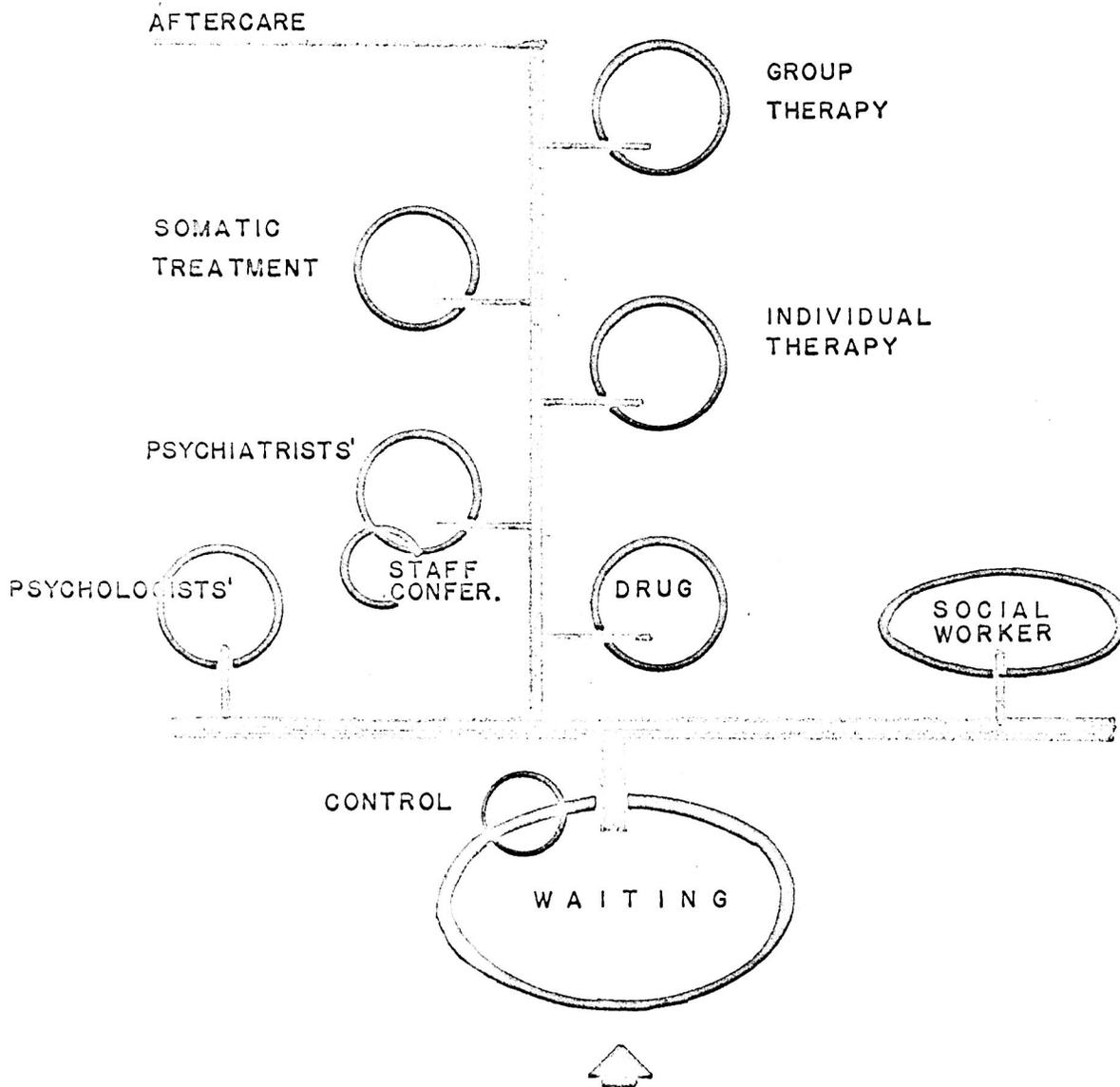


IDEAL SITE 1" = 600'

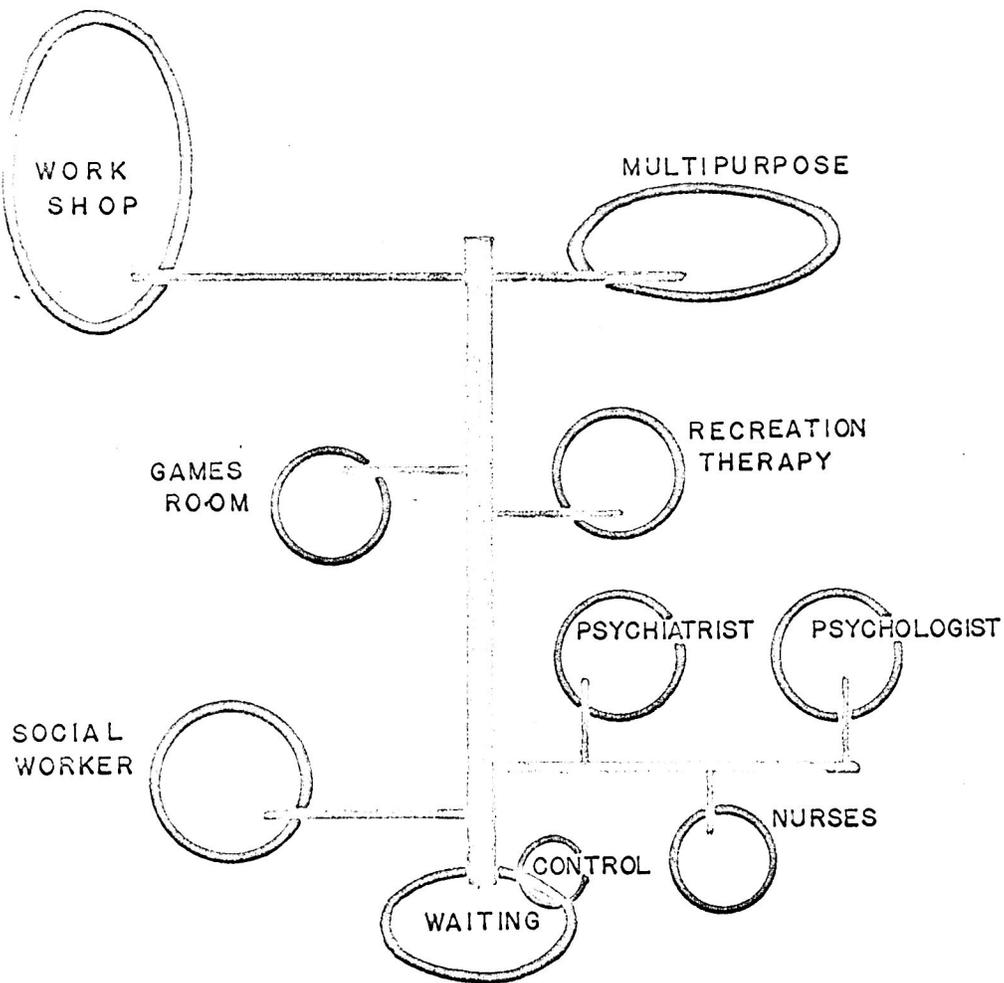
# INTERRELATIONS OF MAIN ELEMENTS



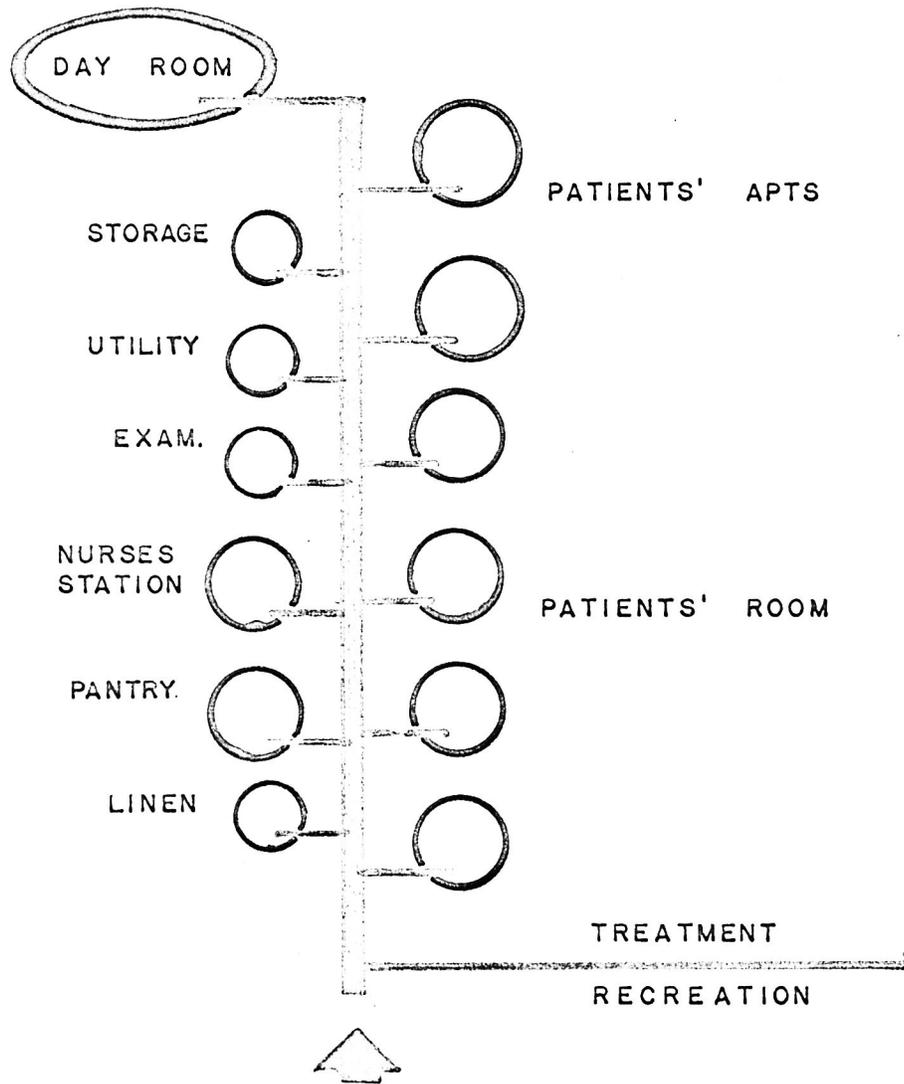
# OUT - PATIENTS



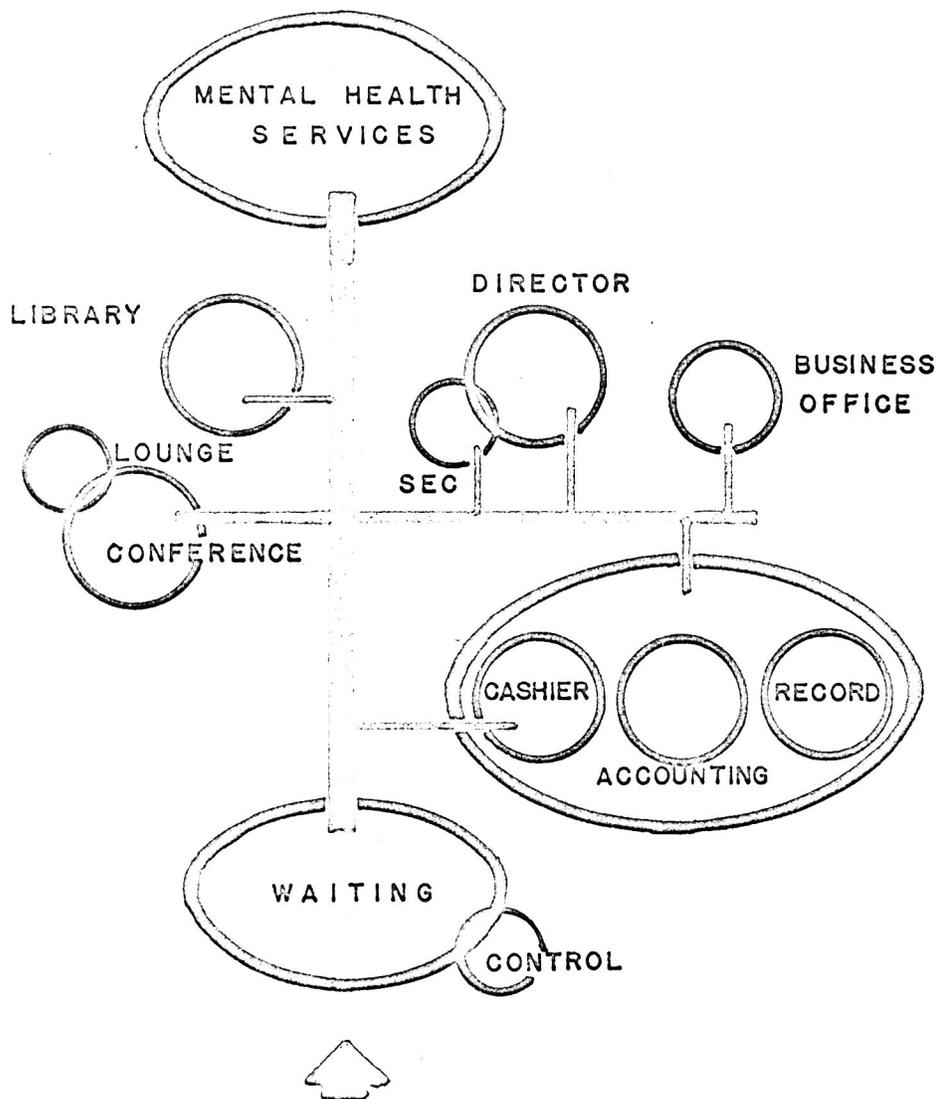
# DAY HOSPITAL



# IN - PATIENTS

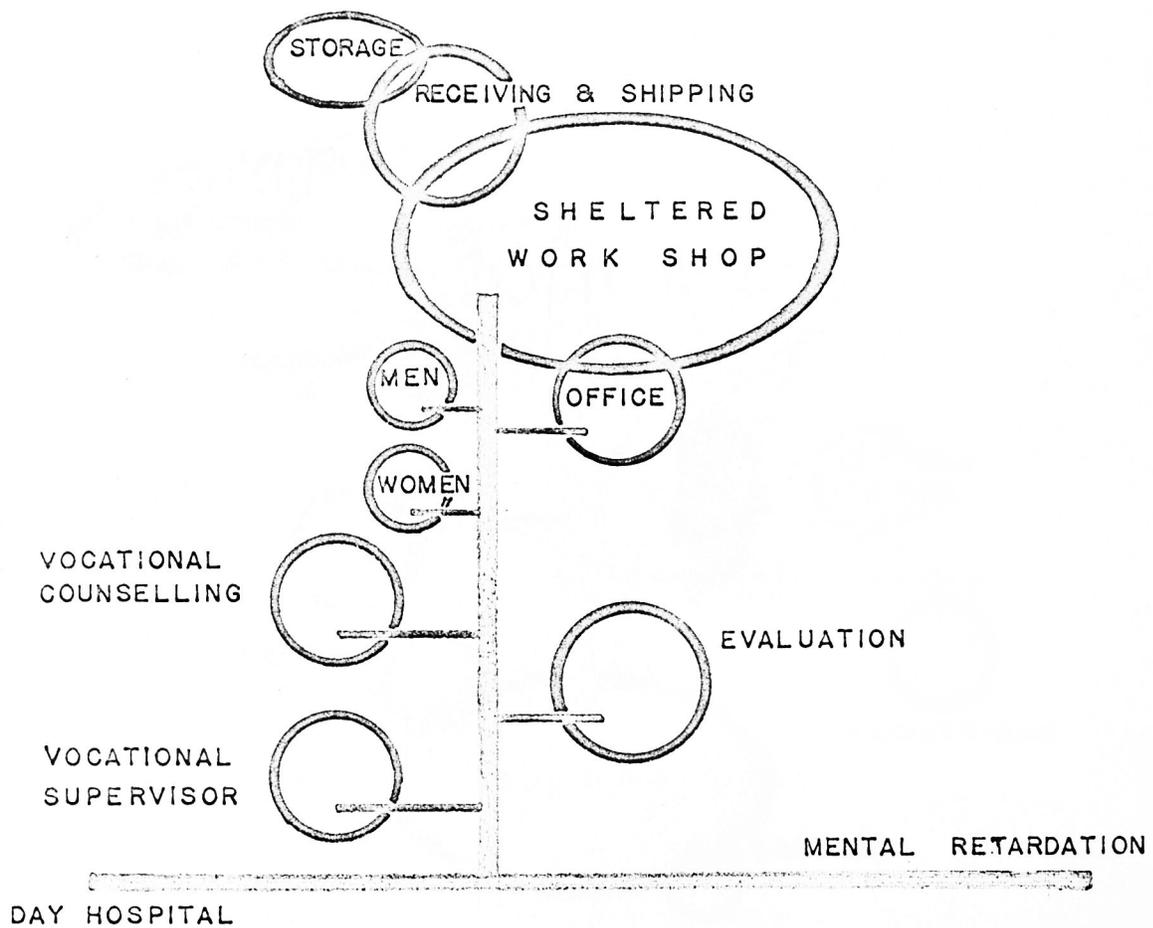


# ADMINISTRATION

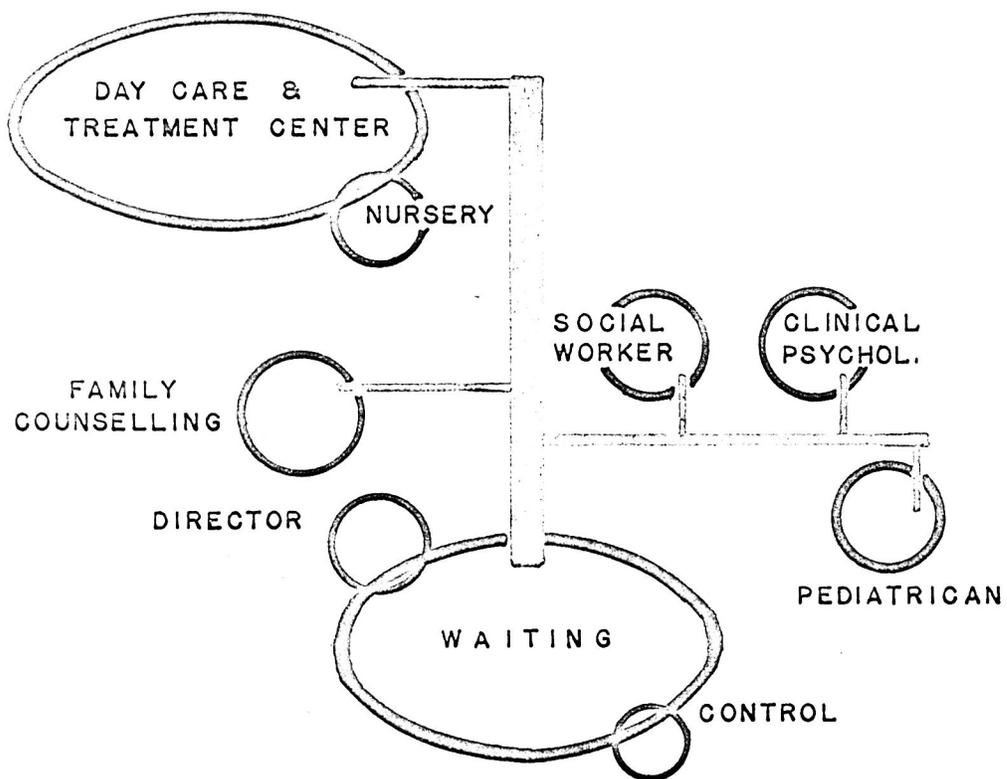


# REHABILITATION SERVICES

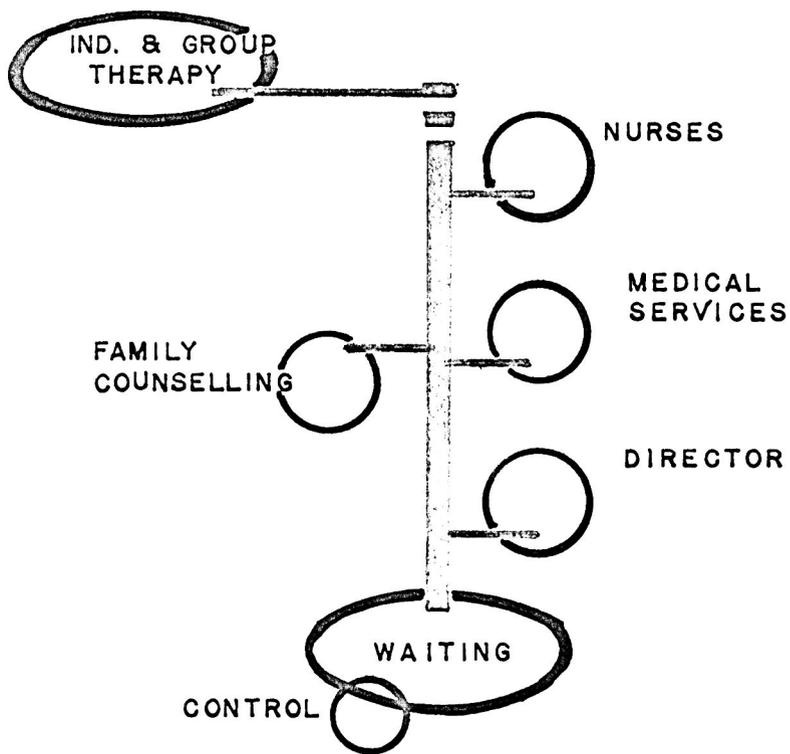
SERVICE



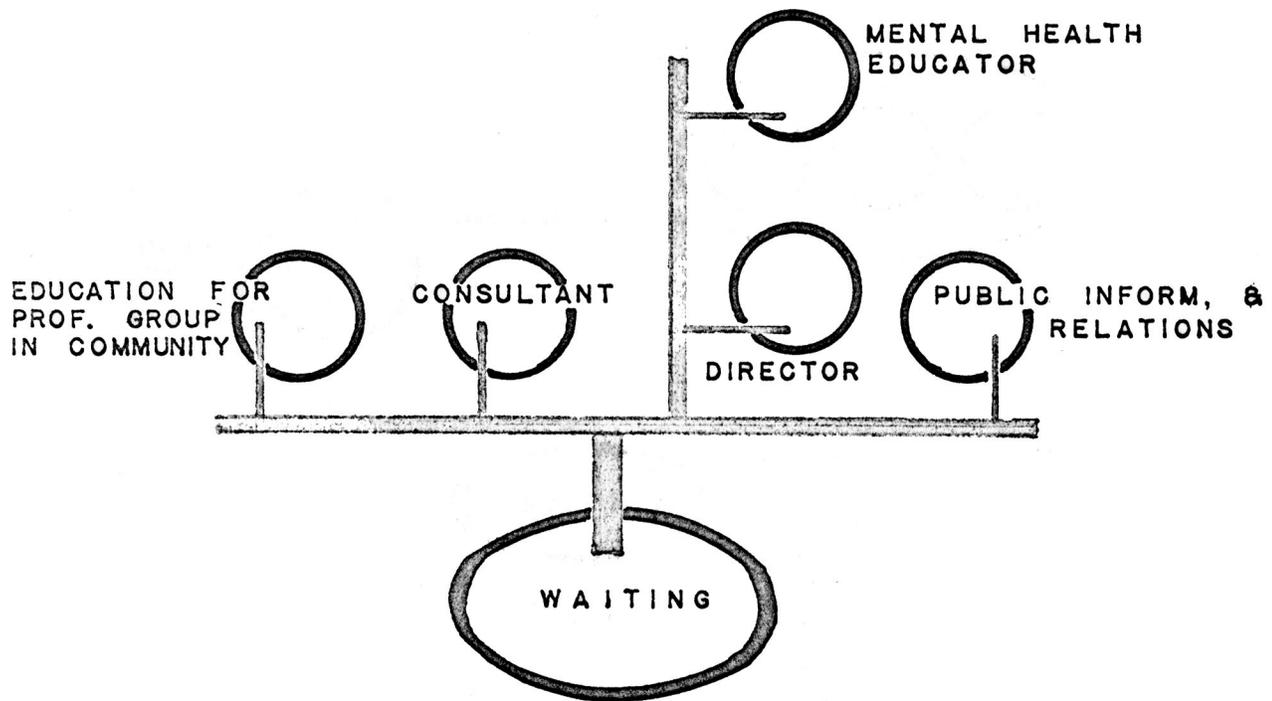
# MENTAL RETARDATION



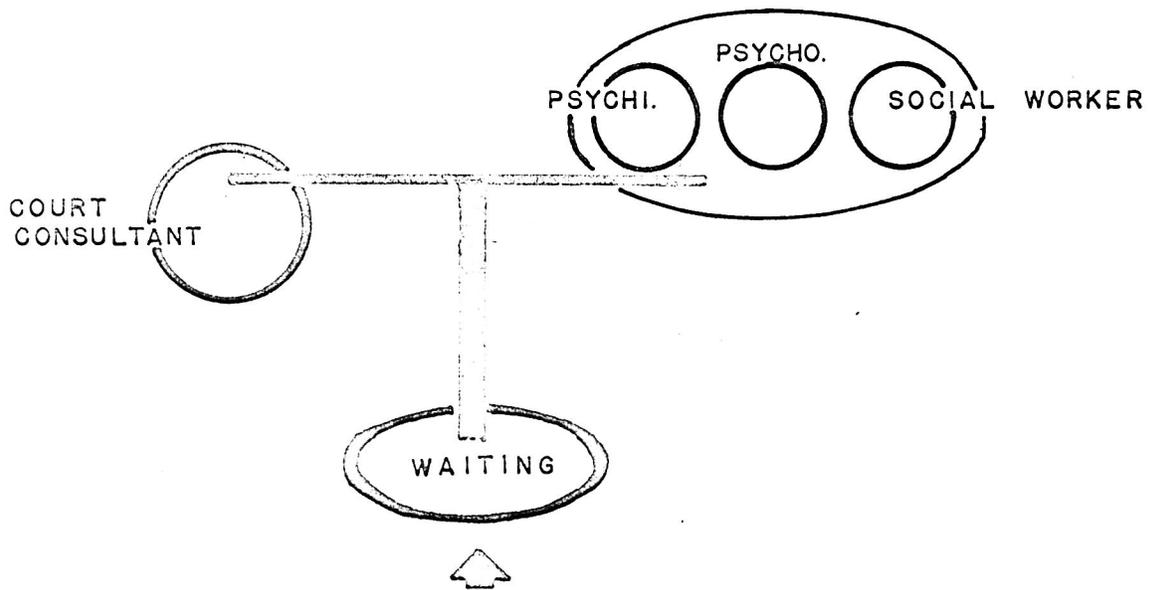
# A F T E R C A R E                      S E R V I C E S



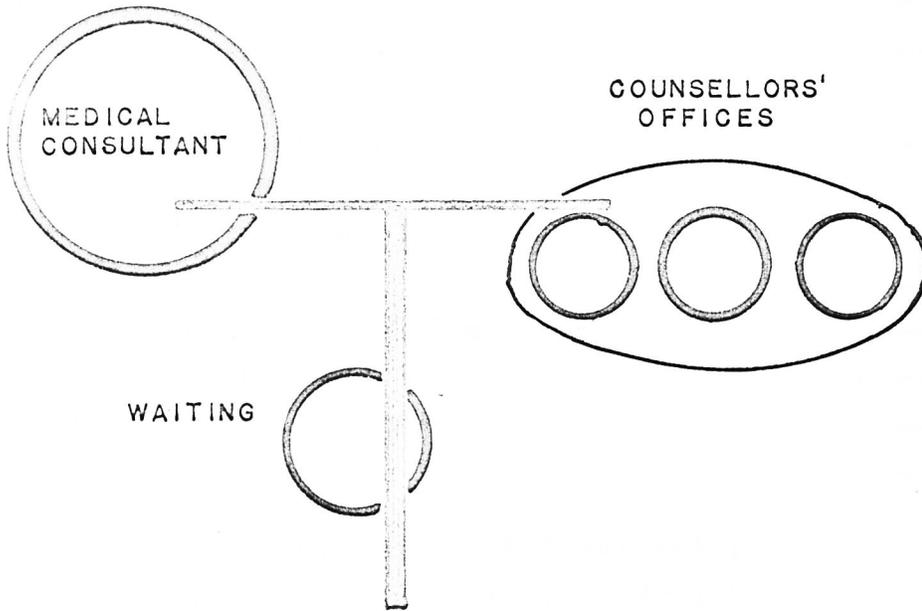
# EXTRAMURAL SERVICES



# COURT CONSULTATION



ALCOHOLISM SERVICES



## AREA OF ACTIVITY

A possible program of requirements for A Comprehensive Community Mental Health Center in Kansas, actual sizes and areas would of course vary considerably from community to community.

## (A) Mental Health Services :-

a) Day Hospital Services:	(Area - sq. ft.)
1. Psychiatrists' offices - 2@ 150	----- 300
2. Psychologist office	----- 120
3. Social workers' offices - 2@ 120	----- 240
4. Nurses' office	----- 150
5. Adjunctive therapists' office - 2@ 120	----- 240
6. Department office	----- 300
7. Offices - 2@ 150	----- 300
8. Examining	----- 200
9. Group therapy - 2@ 300	----- 600
10. Lounge	----- 400
11. Music room	----- 500
12. Library	-----1000
13. Multipurpose room	-----1500
14. Games rooms	-----1800
15. Arts and crafts	-----1600
16. Storages	----- 300
 b) Outpatient Evaluation & Treatment :	
1. Psychiatrists' offices - 3@ 150	----- 450
2. Psychologists' offices - 3@ 120	----- 360
3. Social workers' offices - 4@ 120	----- 480
4. Department office	----- 300
5. Offices - 2@ 150	----- 300
6. Staff conference room	----- 400
7. Staff lounge	----- 400
8. Psychotherapy	----- 500
9. Somatic treatment	----- 300
10. Pharmacy	-----1500
11. Cashier & office	----- 500

c) Inpatient Services (60 beds) :	(Area - sq.ft.)
1. Waiting space for visitors	---- 400
2. Doctors' office	---- 300
3. Examination room	---- 400
4. Offices for Psychiatrist & Psychologist	---- 360
5. Nurses' stations	---- 1200
6. Conference rooms	---- 500
7. Day rooms	---- 3600
8. Utility rooms	---- 400
9. Pantries	---- 700
10. Dining room	---- 1200
11. Group therapy	---- 1600
12. Patients' rooms & apartments	---- 12000
13. Patients showers, bathrooms & toilets	---- 700
14. Drug storages	---- 200
15. Storages	---- 300
16. Supply & linen storages	---- 120
17. Personnel clothing spaces	---- 240
18. Stretcher alcoves	---- 200

(B) Rehabilitation Services :

1. Rehabilitation supervisor office	---- 150
2. Counsellors' offices - 4 @ 120	---- 480
3. Department office	---- 300
4. General office	---- 200
5. Evaluation office	---- 150
6. Sheltered workshop (space for small woodworking, tools & benches for carpentry, metal work, printing, weaving, etc.)	---- 2500
7. Storage	---- 200

(C) Mental Retardation Services :		(Area - sq.ft.)
1. Director's office	----	150
2. Department office	----	300
3. Activity aides' office	----	150
4. Training assistants' offices		
- 2 @ 200	----	400
5. Counsellors' offices - 3 @ 120	----	360
6. Pediatrician's offices- 2 @ 150	----	300
7. Social worker's offices- 2 @120	----	240
8. Clinical Psychologist's office	----	120
9. Offices - 2 @ 150	----	300
10. Treatment space	----	300
11. Staff lounge & conference	----	400
12. Hobbies	----	600
13. Arts & crafts	----	1000
14. Classrooms - 2 @ 400	----	800
15. Children's play & nurse's	----	1200
(D) Administration :		
1. Director's office	----	150
2. Assistant director's office	-----	120
3. Nursing director's office	----	120
4. Secretarial pool	----	800
5. Business office	----	500
6. Offices - 2 @ 150	----	300
7. Record room	----	800
8. Conference room	----	300
9. Staff lounge	----	400
10. Library	----	800
11. Snack bar	----	1000

(E) Aftercare Services :		(Area - sq.ft.)
1. Director's office	----	150
2. Department office	----	250
3. Mental health nurses' office	----	200
4. Medical consultant's office	----	150
5. Casework aides - 2 @ 120	----	240
6. Offices - 2 @ 120	----	240
 (F) Extramural Services :		
1. Director's office	----	150
2. General office	----	150
3. Public information & public relations	----	120
4. Mental health consultant's office	----	120
5. Office space for education for professional groups in community	----	300
 (G) Court consultation services :		
1. Psychiatrist's office	----	150
2. Psychologist's office	----	150
3. Psychiatric social worker office	----	120
4. Court consultant	----	120
5. Office	----	150
 (H) Alcoholism Services :		
1. Department office	----	200
2. Alcoholism counsellor's offices - 4 @ 120	----	480
3. Medical consultant's office	----	150
4. Treatment room	----	200
5. Offices - 2 @ 120	----	240

(I) Research, Training & Program Analysis	(Area - sq.ft.)
1. Director office	---- 150
2. Program analyst office	---- 120
3. Statistician office	---- 120
4. Research assistants	---- 300
5. Offices	---- 200
(J) Service Department	
1. Main kitchen	---- 2600
2. Dietitians' offices - 2 @ 120	---- 240
3. Garbage collecting & disposal facilities	---- 100
4. Cafeteria	---- 4000
5. Personnel lockers	---- 500
6. Laundry	---- 600
7. Separate clean & soil linen room	---- 400
8. Central Sterilizing	---- 1600
9. Housekeeper's office	---- 150
10. Mechanical room	---- 4000
11. Maintenance & storage	---- 1000
12. Receiving office	---- 120

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Adequate circulation, corridors, lobbies, waiting spaces, stairs, exits, elevators, toilet facilities, etc. to be provided. ----- 30,000

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Total area - 107,470 sq.ft.

## SUMMARY AND CONCLUSION

## General consideration:

Mental patients differ from general hospital patients in many ways, one of the most important being that most mental patients spend very little time in their beds or bedrooms. Generally speaking, unless they are confined, the greater amount of the mental patient's time should be spent in public areas with other patients and in involvement with various forms of treatments and activities.

In the past, public mental hospitals tended to be large, multistoried buildings, massive in appearance and depressing in their general effect on the patients. Large dormitories with a hundred or more patients were common.

The recent movement has been to place patients in small groups. Small buildings or small cottages holding up to a hundred patients are used, and broken down into smaller units of 20 or 30. A greatest change is, with a great deal of sun light and color, and a better organized arrangement of space to permit the circulation of patients.

from bedroom to dining room, to activity and recreational centers and the outside. This implies that considerable attention would be paid to the attractiveness and hominess of the environment. Within this environment the patients receive responsibilities as in any home, and achieve a sense of being a part of the whole.

Thus this design will eliminate the traditional "locked up" atmosphere of mental hospitals by giving the patients more freedom within the grounds. Security features are kept to a minimum.

**Assumptions:**

It is felt that the community Mental Health Center should have a close working relationship with the general hospital, permitting maximum interchange of professional staff and personnel and cooperative use of facilities. The site should be convenient to transportation, have good fire and police protection, and, of course, should be closed to the community center. It should also be generous, and must allow for attractive, landscaped grounds adequate parking facilities, accesses, and expansion programs. A site of about twenty city blocks

in area was assumed; since conditions of topography, view, access, and architectural environment were not established adaptability of the scheme was essential.

As communities vary in size, density, organization, styles of life, value systems and needs, possible expansion in the future should be considered. The stages represent an attempt at a long range view of the growth and diversification of the community mental health center.

Certain basic functions have been found to be deserving of consideration as essential to the community mental health center. They include the administration, outpatient, Day hospital, Rehabilitation, aftercare, alcoholic and extramural services. The need for secondary facilities in the later development of this center would be the mental retardation services. The in-patient services will be treated in a later section.

These facilities recommended and their relationships are presented on the schematic relationship diagrams.

It is also recommended a flexible initial unit, allowing for both vertical and horizontal expansion as quantity and types of services increase in later stages.

### Site Development:

One of the major problems in site development is approaches. These should include two avenues of approach; public and services.

The public approach will serve visitors and staff. It should be a direct approach to the main entrance door.

The service approach should be from one point and serve all delivery of the center supplies and removal of waste. The employees' entrance and parking should be served from this approach. It should be considered primarily as a connection between street and storage area of the center.

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## APPENDIX A

### THE COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTER: WHAT IS IT?

By Staff of Community Mental Health Services\*

Because of our strong belief in and emphasis upon local autonomy and the development of local programs in congruence with locally perceived needs and wishes, we in Community Mental Health Services have been somewhat reluctant to set forth grand schemes, or designs for comprehensive community mental health centers. However, with the impetus of the new federal legislation, and the increased involvement in the planning process by many citizens, we have finally decided that it is time that we spell out, for review and consideration, our underlying convictions about what a model comprehensive community mental health center is.

Our belief that local people should evolve their own programs has, we are afraid, at times been perceived as passivity, secrecy, or indecision on our part. As one of our colleagues so aptly put it, "you're laying low in the grass while we stick our necks out, and not telling us what you really think." This study paper, then, arises out of our determination to let interested persons know some of the thinking of the staff of Community Mental Health Services about the organization, administration, financing, and program of the optimum or "ideal" comprehensive community mental health center, as we believe it should evolve in Kansas.

#### ADMINISTRATIVE ORGANIZATION

In the accompanying Figure I, we have drawn up a functional diagram, to indicate the proposed administrative organization of such a center. At the present time, most of the community mental health centers provide some of the extramural services, and outpatient mental health services, as well as some limited aftercare services. In this comprehensive and optimum mental health center, we would propose an expansion of extramural services to include more formal mental health education, as well as specialized education for professional groups; the addition of day hospital and in-hospital services to the mental health services section; a considerable extension of aftercare services; and the addition of rehabilitation services, mental retardation services, alcoholism services, court consultation services; and a training, research and program analysis section.

In actuality, we would anticipate that only approximately 10 of the existing mental health centers would develop the full range of services that we have outlined in the functional diagram. Also, even if the center carries on all of these services it does not necessarily mean that there is an entirely separate staff for all of the different activities.

In Figures II through X, we have outlined the proposed staffing for a population base of 200,000 persons, in order to provide the comprehensive facilities that we refer to as "third echelon facilities."\*\*

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\*The views presented in this paper do not represent official policy of the State board of Social Welfare or the Division of Institutional Management, but are those of the staff of Community Mental Health Services, are designed to provoke thought and discussion.

\*\*The reader is referred to other study papers entitled "Echelons of Mental Health Service, and various proposals for financing other various types of activities for further details.

For example, Figure II is a recap of the range of expenditures for the various types of services that are proposed. If we multiply these figures by 10, and subtract from the totals the local tax levy (approximately ½ of the \$2,000,000 that can be raised if all counties levy ½ mill tax; this is assuming that another 10 to 15 centers would not develop these third echelon services, but would use their tax levy to provide second echelon services in their communities) and the estimated fee income, we will see that a yearly state support for salaries for personnel, would range from \$3,860,500 to \$6,325,000 per year.

If we say that another 15 centers will function as second echelon centers, The local tax levy and fee income would allow for each of these 15 centers to have a budget of \$80,000.00 a year, entirely out of local funds.

#### DESCRIPTION OF ACTIVITIES

In this section, the author will attempt to spell out in a narrative form some preliminary thoughts concerning the activities of the various sections.

#### EXTRAMURAL SERVICES FOR 200,000 Population

The extramural services program would be directed by a professional person with a degree and/or experience in journalism, health education, public relations, or education. In this section there would also be working one mental health that would have a degree and experience in one of the mental health disciplines. The mental health consultant would be responsible primarily for providing consultee-centered consultation for other care-giving agencies and individuals within the community. He would be responsible for helping existing agencies to do a more effective job in meeting the mental health needs of their clients, and to assist community planning groups in coordination and integrating, as well as planning for future development, of the full spectrum of preventive and therapeutic mental health services. The mental health educator and the director of the program would be responsible for maintaining public information program, and for working with the mental health association, public schools, and other lay and professional groups to provide an ongoing program of education and information about mental health and mental illness. In addition, the staff in the other sections of the comprehensive mental health center would be involved in special training programs, set up by the staff of extramural services, for other professional groups in the community – such ongoing seminars or classes for general practitioners, county welfare workers, ministers, and so forth.

#### ADMINISTRATIVE SERVICES

This section would assist the psychiatrist-director of the mental health center in handling the administrative details involved in an operation with a large annual budget. The expenditures estimated in Figure IV for some of the overhead items are equipment available.

## MENTAL HEALTH SERVICES

In Figure V, the schema shows the various staff personnel that would be necessary to conduct the full spectrum of outpatient services. We have purposely not made a distinction into child and adult services, since we feel that this dichotomy is, by and large, undesirable; and that attention should be focused on the total needs of the family unit rather than differentiating along the traditional child and adult services lines.

The outpatient evaluation and treatment team would function very much in the present mode of mental health centers. However, we would hope that in expanding the base of the services, that mental health center would begin to differentiate some of their staff to have responsibility for home visitation and setting up home treatment programs for severely ill individual in the community.

The day-hospital program, which here is set up for 20 spaces (which would probably be inadequate for a population of 200,000) would envisage that the comprehensive community mental health center would provide the facilities and the basic staff for the day-hospital. However, it should be stressed that staff privileges would be open, and that any qualified physician and psychiatrist in the community would be allowed to place his patients in the day hospital and participate in their treatment.

Likewise, we would anticipate that the psychiatric unit in the general hospital, again proposed as a 20-bed unit, would be staffed with personnel under the supervision of the psychiatric staff of the community mental health center. However, it would be anticipated that the staff selection, financing, and operation of the clinical facility would be jointly administered by the governing board of the hospital and the governing board of the community mental health center. It would be very advantageous to have certain key employees have double appointments, since it will be necessary to insure free movement of patients from one setting to another. That is, it would be desirable to have the outpatient department unable to have a patient admitted for hospital care, or the hospital be unable to discharge a patient for aftercare or outpatient treatment following hospitalization. As with the day hospital, it is to be hoped that the staff of the community mental health center would provide the basic professional staff, charged with administration and in-service training responsibilities in the hospital unit; but that the hospital unit would have open staff privileges, with all qualified physicians hospitalizing their patients on the unit and personally directing and prescribing their treatment.

## AFTERCARE SERVICES

The proposal here would be to utilize the skills of nurses and case work aides, both of whom have had appropriate inservice training, in providing some visitation and supportive services for seriously ill individuals in the community. In addition, it would be proposed that private practitioners in the area be employed on a part-time basis to assist in periodically evaluating, in special aftercare clinics, the adequacy of the medication program for the patient. In addition to this specialized service, those patients able to use and needing psychotherapy, either individual or group, or case-work services, would be referred to the staff of the mental health section for appropriate service. However, we do not have sufficient manpower resources in the judgement of Community Mental Health Services, to have the treatment of every patient in the community personally conducted by a psychiatrist, psychologist, or fully trained psychiatric social worker. This proposal, then, is an attempt to come to grips

with the professional manpower limitations, to utilize the experience of other states in using nurses and ancillary personnel effectively in aftercare programs, and to provide a public health approach to the needs of seriously ill patients in the community.

### MENTAL RETARDATION SERVICES

Diagnostic and appraisal services, one of the services outlined in Figure VII, are already being provided by all the centers to some extent. For example, 7% of the male children and 12% of the female children evaluated in mental health centers are seen because of problems of mental retardation. However, the proposal as set forth here is to establish 10 mental retardation regional centers, which can provide back-up consultation services for the second echelon centers, as well as direct diagnostic and appraisal services for their area of the state.

Because of the large numbers of the retarded, and the desirability that has been demonstrated in other states of maintaining some kind of ongoing contact with the families of retarded individuals over the years, and to help them work through the problems in education, social adjustment, and vocational training that arise at various stages in the life course of the individual, we propose the establishment of a non-professional person who would be called a mental retardation counselor, and would receive appropriate inservice training from the Division of Institutional Management. In addition, we are proposing that each mental health center establish a day care and treatment center for mentally retarded children, to begin to partially meet the needs of those children who are not suitable for the program presently being offered in the schools; as well as to provide specialized day care programs for the emotionally disturbed retarded child.

### REHABILITATION SERVICES

We propose that special psychiatric rehabilitation counselors would be trained by the Division of Institutional Management, and would work under the direction of comprehensive community mental health center. In addition, we are proposing that a sheltered workshop be established, to provide structured work activities for 40 to 80 patients. We would suggest that patients not be segregated on the basis of age, diagnosis, and so forth. That is, we think it would be better to have an integrated workshop, rather than having a workshop for the retarded, workshop for the emotionally ill, workshop for the physically handicapped, etc. In our judgment there are definite advantages in integrating all of these different kinds of problems, allowing not only for a richer experience for the patients but probably for a smoother operation of the sheltered workshop itself.

### ALCOHOLISM SERVICES

The most recent survey indicated at least 24,000 chronic severe alcoholics exist in Kansas. If their wives and children are included, we have a problem which involves directly on an almost daily basis the lives of about 100,000 individuals in the States of Kansas.

Because of the epidemic proportions of this problem, the total lack of a coordinated program to deal with it, and the seriousness of the need, we would propose that special alcoholism counselors be trained with the assistance of the Division of Institutional Management to work in the comprehensive community mental health center. These persons would have the responsibility for assisting the families of alcoholics to make the many adjustments that are necessary in their lives from time to time; to try in so far as possible to support them through these crisis periods; and to provide counseling services to the alcoholics themselves, as well as assisting in the procurement of adequate treatment services both in the community and in institutional settings for the alcoholics. In addition, we would propose the employment of a part-time local physician, who would be responsible for prescribing and supervising various medications, such as tranquilizers, "Antabuse," and so forth.

### COURT CONSULTATION SERVICES

The courts of Kansas have shown an increasing desire to have available expert opinion concerning motivation, personality organization, and rehabilitative potential or various kinds of offenders. It is anticipated that this perceived need and demand adequate services for probation and parole, for pre-sentence investigations, and in general develop as truly rehabilitative units of society. We have proposed, then, that the 10 third echelon mental health centers begin to differentiate specialized services for the courts, utilizing some of their clinical staff to provide the diagnosis and evaluation services necessary, and employ at least one person with psychiatric social work training who would be designated as the court consultant and would work full time in close collaboration with the probation and parole officers, with juvenile authorities in the police and sheriff's departments, and with district and juvenile judges.

### RESEARCH, TRAINING, AND PROGRAM ANALYSIS SECTION

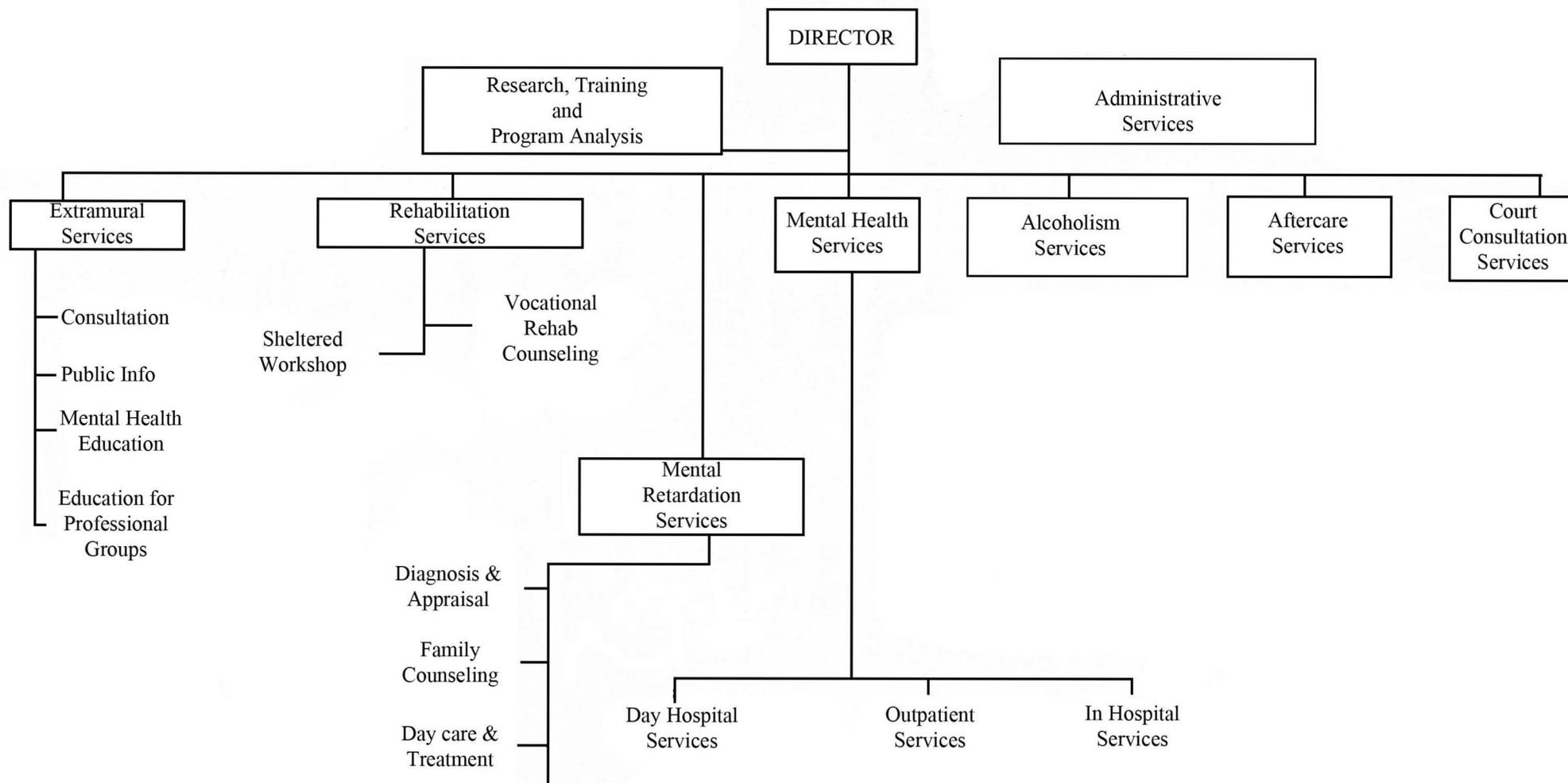
This section would have responsibility for two kinds of activities. First of all, for conducting the traditional kind of basic and/or applied research in the genesis and treatment of mental and emotional disorder. In addition, it would have an equality important function in analysis the program of the center of an ongoing basis. This kind of programmatic inquiry would attempt to assess the impact of various kind of programs and services, their usefulness, methods to improve them, etc.

### SUMMARY

We have attempted to outline here, in a very sketchy way, some of our thinking concerning the evolution of comprehensive community mental health centers at ten locations in Kansas. The acceptance or rejection of this plan, and the priority for implementing various parts of it, will and must rest largely with the local communities. The key words are **COMPREHENSIVE; COORDINATED; PLANNED; AND INTEGRATED.**

We want to see the communities sit down together, with our assistance if they wish, and look at the entire spectrum of services for the prevention, treatment and rehabilitation of the mentally ill and emotionally disturbed. We would then like to see some division of responsibility in the assignment of certain roles to the comprehensive community mental health center, as the nidus in the network that must be provided by state, local governmental and local private individuals and agencies, if we are to indeed develop truly adequate mental health services for all of our citizens.

FIGURE I  
 FUNCTIONAL DIAGRAM  
 IDEAL COMPREHENSIVE COMMUNITY  
 MENTAL HEALTH CENTER\*



\* 200,000 persons given 3rd Echelon services  
 100,000 persons given 2nd Echelon services as well

FIGURE II

Cost per 200,000 Population

THIRD ECHELON FACILITIES

Service	MINIMAL	MAXIMUM	EST. FEE INCOME
Administrative	71,800	97,300	0
Extramural	21,500	37,000	0
Mental Health	267,500	321,000	80,000
Aftercare	37,000	57,000	5,000
Mental Retardation	81,800	120,000	30,000
Rehabilitation Services	63,600	96,500	5,000
Alcoholism	28,400	47,000	5,000
Court Consultation	35,500	35,500	0
Research, Etc.	41,400	45,250	0
	<u>611,050</u>	<u>857,550</u>	<u>125,000</u>
Total Yearly State-Wide Cost	\$ 6,110,500	\$ 8,575,000	
Local Tax Levy	1,000,000	1,000,000	
Fee Income (est.)	1,250,000	1,250,000	
State Tax Support	\$ 3,860,500	\$ 6,325,000	
Cost of SECOND ECHELON FACILITIES	1,200,000	1,200,000	
Local Tax	1,000,000	1,000,000	
Fee	200,000	200,000	

FIGURE III

For Third Echelon  
 Facility Service 200,000 People

EXTRAMURAL SERVICES

Activity	Staff	No. of Staff	Training Required	Salary, Etc.
Mental Health Education	1) Director of Extramural Services	1	Degree and/or experience in Journalism, health education	\$5000-8000
	2) Mental Health Educator	1	Public relations, teaching	\$4000-6000
Public Information and Public Relations	Same staff as above	0	-----	-----
Consultation Services	Mental Health Consultant	1	Degree in Clinical Psychology, psychiatric social work, or psychiatry plus appropriate experience	\$9500-20,000
Education for Professional Groups in Community	Same staff as above	0	-----	-----
			Travel & Supplies	\$18,500-\$34,000 <u>3,000- 3,000</u> \$21,500-\$37,000

FIGURE IV

ADMINISTRATIVE SERVICES

Activity	Staff	No. positions	Training	Salary
Director of Mental Health Center	Psycyiatrist	1	MD + Residency + experience	\$20,000-25,000
Administrative Assistant	Assistant	1	Administrative Training, experience & ability	\$4,800-8,500
Accounting	1) Accountant	1	Variable	\$4,000-7,000
	2) Clerk	1	Variable	\$2,400-3,600
Secretarial Services	1) Chief of Sec. Services	1	Variable	\$4,000-5,000
	2) Stenographers	4	Variable	\$14,400-16,000
	3) Clerk-typists	6	Variable	\$14,400-18,000
				\$64,000-83,000
			Supplies	\$3,000-5,000
			Travel	\$1,800-3,000
			Bldg. Maintenance	\$1,800-3,000
			Utilities	\$1,200-3,000
				<u>\$71,800-\$97,300</u>

FIGURE V

MENTAL HEALTH SERVICES

Activity	Staff	No. persons	Training	Salary		
Inpatient Evaluation Treatment	Psychiatrist	3	3 year residency	\$45,000	\$60,000	
	Psychologist	3	1 PhD, 2 M.A.	24,000	30,000	
	Social Worker	4	M.S.W.	30,000	36,000	
Day Hospital (10 spaces)	Psychiatrist	1	3 year residency	\$16,000	\$20,000	
	Psychologist	1/2	PhD	4,500	6,000	
	Social Worker	2	M.S.W.	15,000	18,000	
	Nurse	2	1 RN, 1 LPN	9,000	11,000	
	Adjunctive Therapist	2	Degree in OT, RT, MT	8,000	11,000	
	Aides	2	I.S.T.	6,500	8,000	
Psychiatric Unit in a General Hospital (10 beds)	Psychiatrist	1	3 year residency	\$16,000	20,000	
	Psychologist	1/2	PhD	4,500	6,000	
	Social Worker	2	M.S.W.	15,000	18,000	
	Adjunctive Therapist	1	Degree in OT, RT, MT, etc.	5,000	6,500	
	Patient care personnel	Head Nurse	1	Psychiatric Nurse	5,000	6,500
		Assistant	1	Psychiatric Nurse	4,500	5,500
		Staff RN	8	RN + I.S.T.	36,000	36,000
		L.P.N.	6	LPN + I.S.T.	20,000	20,000
		Aides	3		9,500	9,500
					\$267,500	321,500

AFTERCARE SERVICES

Activity	Staff	Number of Personnel	Training	Salary	
Nursing Services	1) Director of Aftercare Services	1	RN with public health psychiatric training or experience	\$6,000	8,000
	2) Mental Health	3	RN or LPN with	12,000	18,000
Family Counseling	Casework Aides	2	BA + IST	8,000	11,000
Medical	Part-time Medical Consultant	1/2	MD + IST	6,000	10,000
			Medication	\$32,000 5,000	47,000 10,000
				\$37,000	57,000

FIGURE VII

MENTAL RETARDATION SERVICES

Activity	Staff	No. of Staff	Training Required	Salary	
Diagnostic & appraisal Service	Pediatrician	1	MD+trn.+experience MR	\$12,000	20,000
	Clinical Psychol.	1	Ph.D. with MR emphasis	9,500	12,000
	Social Worker	1	Medical or Psycho. MSW	7,500	11,000
Family Counseling Service	Counsellor	3	B.A. + IST	\$10,800	18,000
Day Care & Treatment Center (40 spaces)	Director	1	Special Education	6,000	8,500
	Activity Aide	2	IST	6,000	9,000
	Training Assistants	8	IST	24,000	36,000
				\$75,800	114,500
			Supplies	6,000	6,000
				\$81,800	\$120,500

FIGURE VIII  
REHABILITATION SERVICES

Activity	Staff	No. of positions	Training	Salary	
Director of Service	Vocational Rehab. Supervisor	1	Voc. Rehab. training or counseling psychologist	\$ 5,000	10,000
Rehabilitation Counseling	Voc. Rehab. Counselors (psychiatric)	4	B.A. + IST	\$14,000	25,000
Sheltered Workshop (40-80 spaces)	Supervisor	1	Variable	4,800	7,000
	Voc. Teachers	4	Variable	16,000	20,000
	Rehab. Aides	4	Variable	14,400	18,000
	Industrial Representative	1	Variable	4,000	6,500
				\$58,600	86,500
			Supplies	5,000	10,000
				\$63,600	96,500

FIGURE IX

ALCOHOLISM SERVICES

Activity	Staff	No. of positions	Training	Salary	
Family Counseling	Alcoholism Counsellors	4	BA + IST	\$14,400	22,000
Medical Service Counseling	Part-time Medical Consultant	1 full time equivalent	MD + IST	\$12,000	20,000
			Medication	2,000	5,000
				\$28,400	47,000

FIGURE X

COURT CONSULTANT SERVICES

Activity	Staff	Positions	Training	Salary
Diagnostic & Appraisal Services	Psychiatrist	1/2	MD + Special Trng.	\$ 11,000
	Psychologist	1/2	Ph.D. + Special Trng.	6,000
	Psychiatric	1	M.S.W.	8,500
	Social Worker			
Consultation Services for Probation & Parole Officers	Court Consultant	1	MSW & Special Training	10,000
				\$ 35,000

FIGURE XI

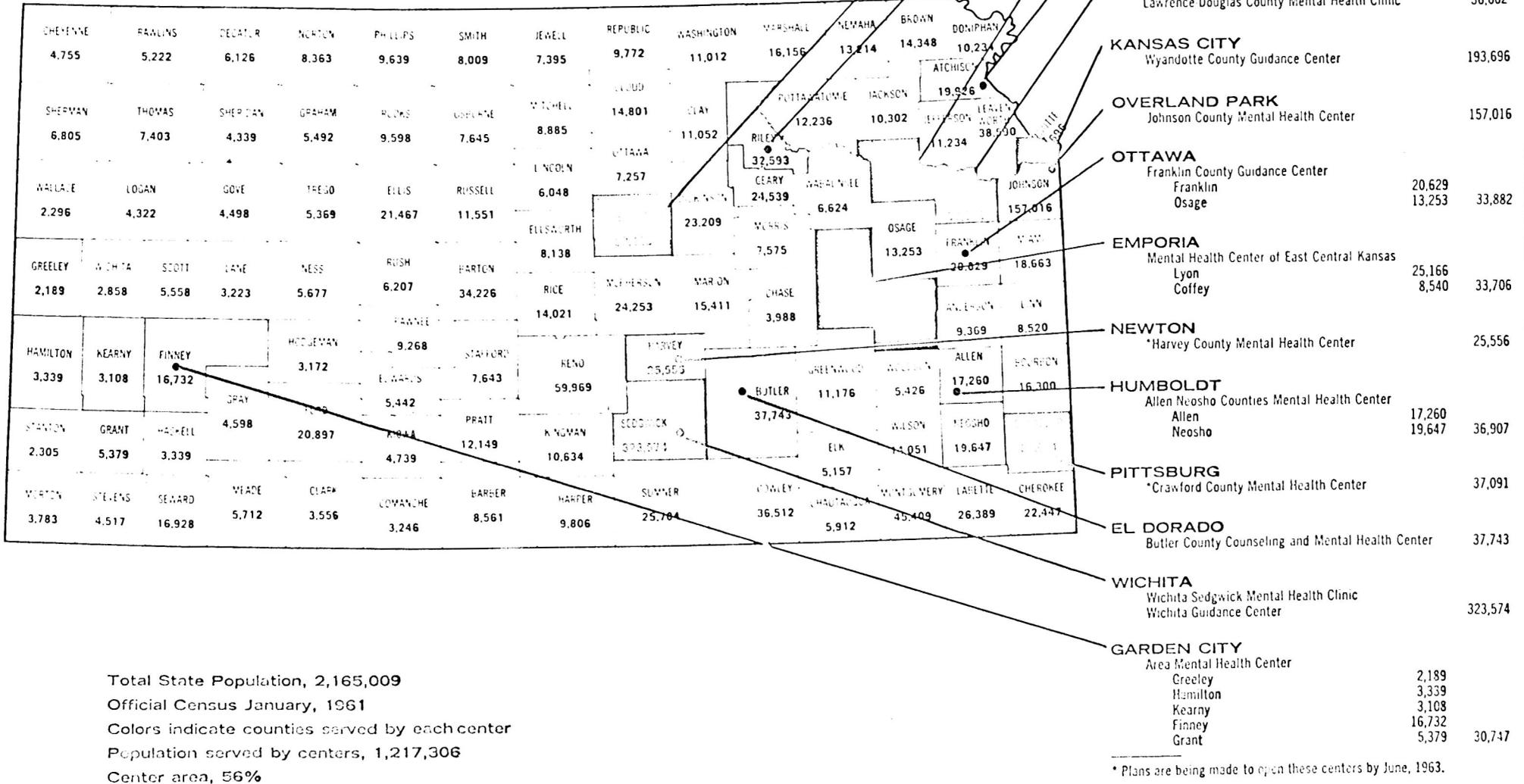
RESEARCH, TRAINING AND PROGRAM ANALYSIS SECTION

Activity	Staff	Positions	Training	Salary	
Director	Behavioral Scientist	1	Ph.D.	\$ 8,500	11,000
Program Analysis	Program Analyst	1	Variable	6,000	8,500
Biostatistics	Statistician	1	Variable	4,000	8,000
Research	Research	3	Variable	12,000	15,000
				\$40,500	\$42,500
			Statistical	500	2,000
			Operational Supplies	300	750
				\$41,400	45,250

# KANSAS COMMUNITY MENTAL HEALTH CENTERS

LOCATION, AREA, AND POPULATION SERVED

JANUARY 1, 1963



APPENDIX B

**APPENDIX C**  
**MINUTES OF MEETING**

MEETING WITH MR. GEORGE S. MANN, KANSAS STATE UNIVERSITY  
AGRICULTURAL DEPARTMENT, DECEMBER 20, 1963

Location: Social Welfare Conferences Room

Present: Prof. George S. Mann, Kansas State University  
Mr. Mg, Graduate Student, Kansas State University  
Dr. Reidel, Stats Department of Health  
Mr. R. Johnston, States Department of Health  
Miss Hazel Kendler, Regional Office, Kansas City  
Mr. Schuler, Regional Office, Kansas City  
Mr. Rix Shanline, Director, Geary-Riley Guidance Clinic, Manhattan  
Mr. Marion Graney, Exec., Director Kansas Assoc. for Mental Health  
Dr. Art Hoyt, Family Service and Guidance Clinic  
Mrs. Anthony Iovine, Pres. Kansas Association for Retarded Children  
Dr. H. G. Whittington, Community Mental Health Services, Division of Institutional Management.

Meeting opened with Dr. Whittington explaining that the purpose of the meeting was to discuss architecture for community mental health centers and some of the implications thereof—such as: What are architectural needs, etc., to assist Mr. Ng and Mr. Mann in developing a concept of an "ideal" mental health center.

Professor Mann introduced Mr. Mg as a graduate student using this material as his thesis and asked the participants to discuss what type of space might be needed, where it might be located in the community, and what functional relationships spectrum with hypothetical results to suit many needs—that the final result in June would not apply to any specific center such as Wichita or Kansas City, Etc., but would be purely hypothetical.

The question was raised as to what kind of center might be eligible. Eligibility was defined by the Director of Community Mental Health Services who also assured the group that regulations would be forthcoming.

Discussion on what types of space might be required. One participant remarked that in general more "office-type" space would be required.

Discussion on ever changing trends in service was brought out and it was generally agreed that a great deal of flexibility would be required for the plan.

Discussion on the aims of trying to get away from an institutional atmosphere and provide an informal atmosphere for local communities that was unlike that of an institution. One participant commented upon the merits of not allowing depersonalization, although such a service would not necessarily have to be under one roof, it should guarantee continuity of care. Another commented that communities do want integrated services and that a concept of administrative integration has lots of merit, instead of getting "stuck" on putting all services under one roof.

Question was raised if this would be a duplication of already existing services. One participant commented that final results would be utilized only after consideration

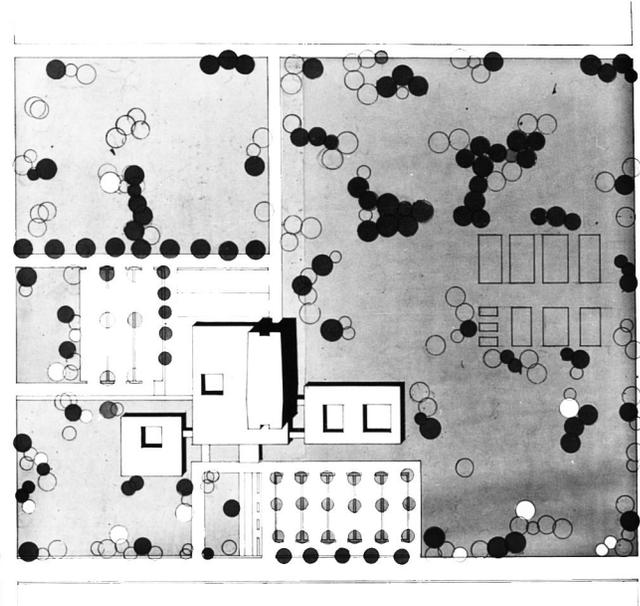
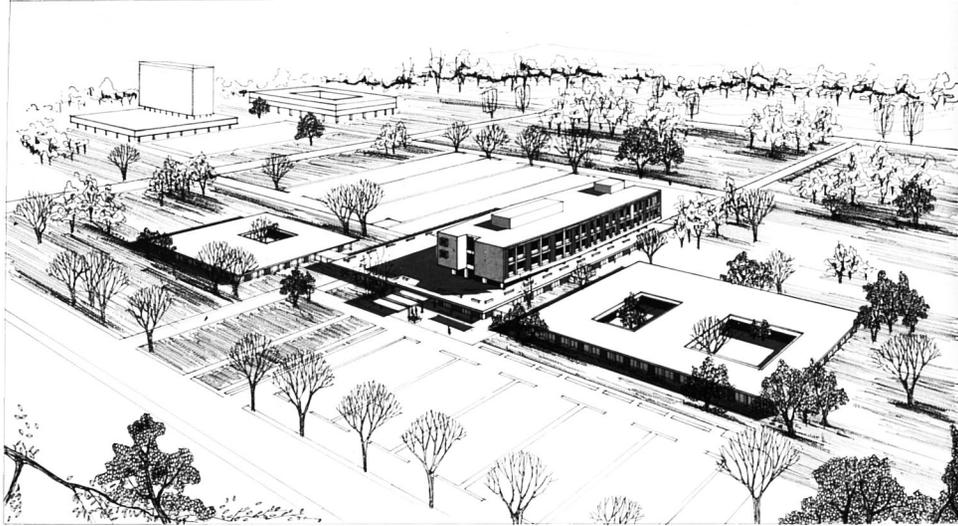
Of any and all local needs, money, and resources. Other suggestions made by Group: Landscaping should be relaxing. Acoustics must be good.

Professor Mann thanked the group for many concrete suggestions he had received.

Meeting adjourned.

APPENDIX D

P R E S E N T A T I O N

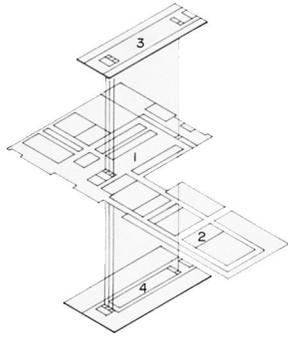


SITE PLAN

0 50 100 200 300'

# COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTER CONCEPTS FOR THE STATE OF KANSAS

NAME VINCENT K. NG, MASTER'S THESIS, JUNE, 1964  
 COLLEGE OF ARCHITECTURE & DESIGN, K.S.U.  
 PROFESSOR GEORGE J. MANN  
 CONSULTANT DR. H. G. WHITTINGTON  
 DIRECTOR, COMMUNITY MENTAL HEALTH SERVICE,  
 STATE OF KANSAS



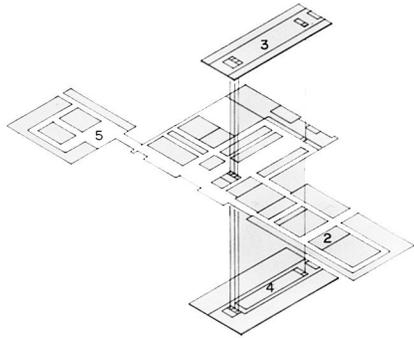
STAGE ONE

**STAGE ONE**

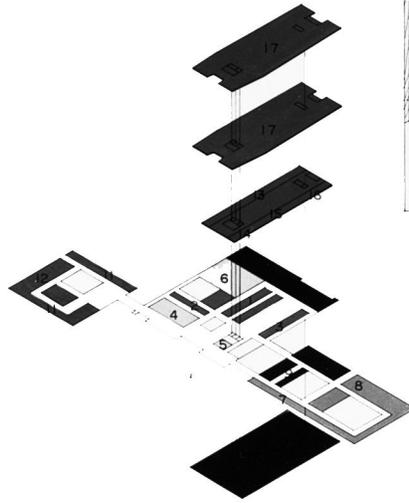
- 1 OUTPATIENT
- 2 DAY HOSPITAL & REHABILITATION
- 3 ADMINISTRATIVE
- 4 SERVICES

**STAGE TWO**

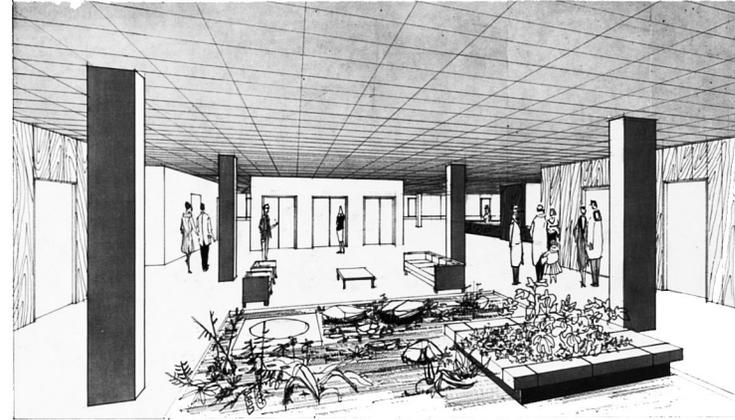
- 1 OUTPATIENT
- 2 DAY HOSPITAL & REHABILITATION
- 3 ADMINISTRATIVE
- 4 SERVICE
- 5 MENTAL RETARDATION



STAGE TWO

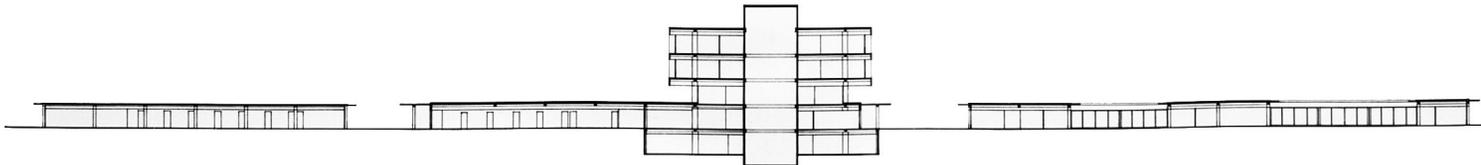


STAGE THREE

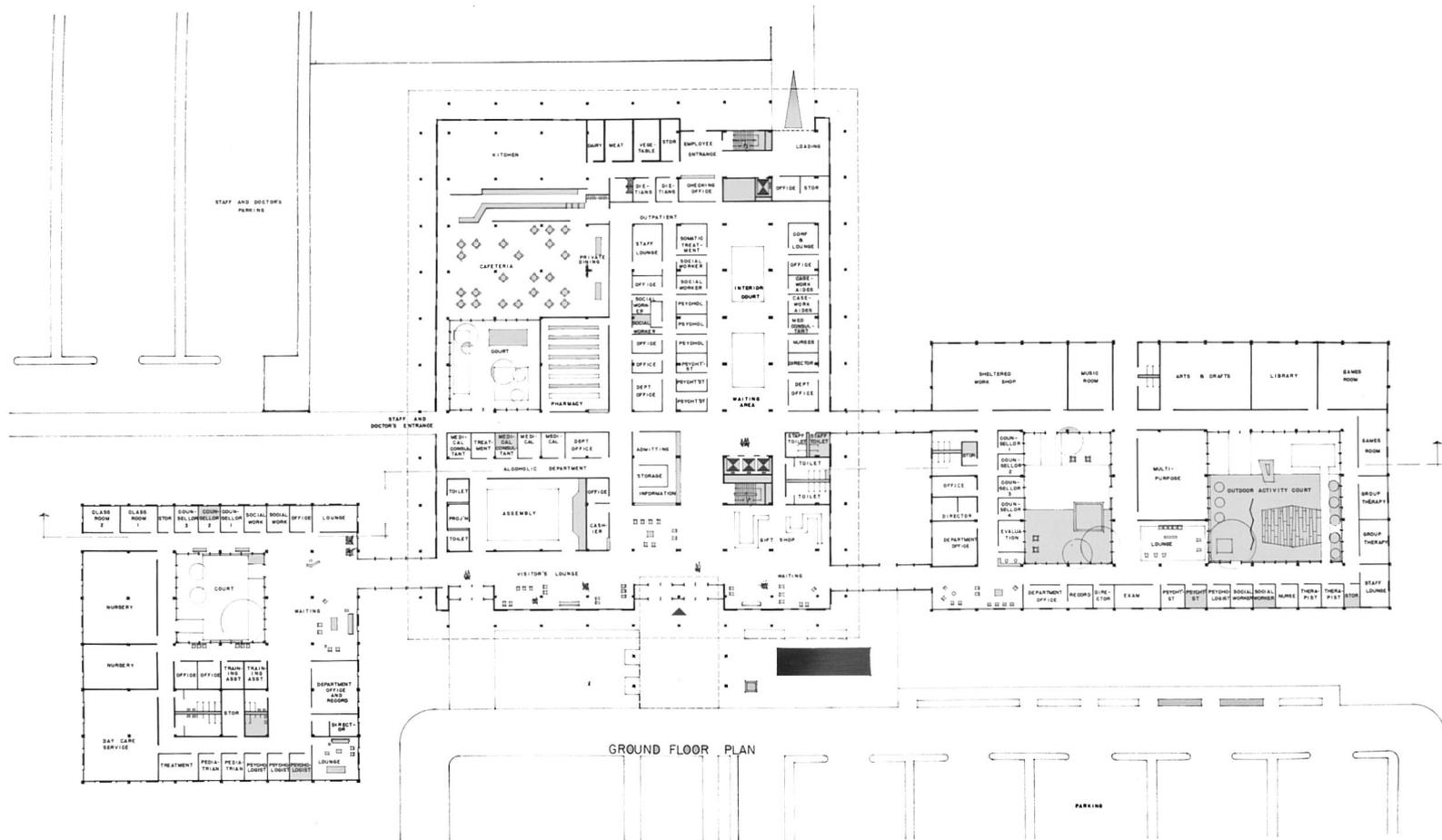


**STAGE THREE**

- |                         |  |
|-------------------------|--|
| ■ OUTPATIENT DEPARTMENT | ■ MENTAL RETARDATION                     |
| 1 OUTPATIENT            | 11 OFFICES                               |
| 2 ALCOHOLIC             | 12 DAY CARE CENTER                       |
| 3 AFTERCARE             | ■ ADMINISTRATIVE                         |
| PUBLIC AREA             | 13 OFFICES                               |
| 4 ASSEMBLY              | 14 COURT CONSULTATION                    |
| 5 GIFT SHOP             | 15 EXTRAMURAL                            |
| 6 CAFETERIA             | 16 RESEARCH, TRAINING & PROGRAM ANALYSIS |
| ■ DAY HOSPITAL          | ■ 17 INPATIENT                           |
| 7 OFFICES               | ■ 18 SERVICES                            |
| 8 ACTIVITIES            |  |
| ■ REHABILITATION        |  |
| 9 OFFICES               |  |
| 10 SHELTERED WORKSHOP   |  |



SECTION



GROUND FLOOR PLAN



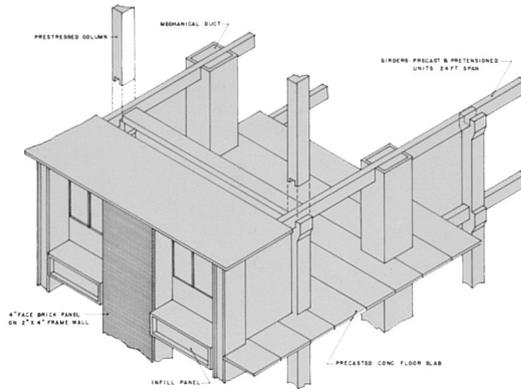
SOUTH ELEVATION



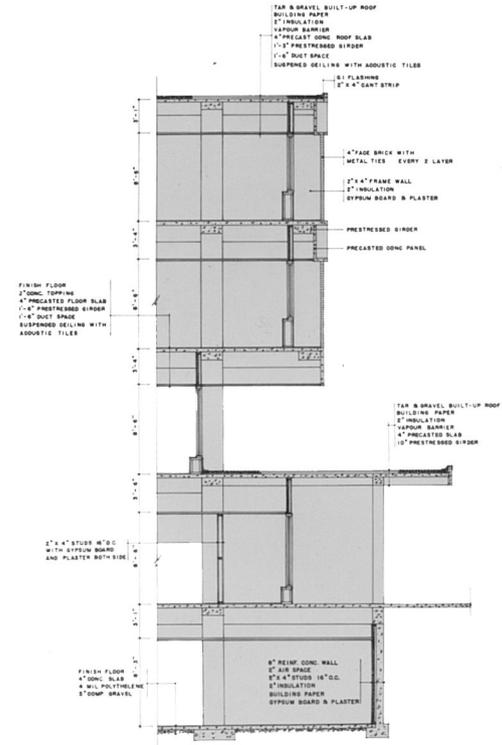




MAIN ENTRANCE PERSPECTIVE



PRECAST CONCRETE STRUCTURAL-MECHANICAL DIAGRAM



TYPICAL EXTERIOR WALL DETAIL

A COMPREHENSIVE COMMUNITY MENTAL HEALTH  
CENTER FOR THE STATE OF KANSAS

BY

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AN ABSTRACT OF A THESIS

submitted in partial fulfillment of the

requirements for the degree

MASTER OF ARCHITECTURE

College of Architecture and Design

KANSAS STATE UNIVERSITY  
Manhattan, Kansas

A COMPREHENSIVE COMMUNITY MENTAL HEALTH  
CENTER FOR THE STATE OF KANSAS

The objective of this study was the design of a Comprehensive Community Mental Health Center to implement the new concepts of mental health facilities which will be able to handle all the requirements for all types of mental health problems within a community in Kansas. The center will include diagnosis evaluation and treatment for patients as well as research, education and consultation for the community. Particular attention was given to a clear definition of departments, straight forward circulation, and provision for orderly expansion.

The center was assumed to be built on a large site, about twenty blocks in area and adjacent to a general hospital.

It is the main factor, through preliminary design studies, to place the patient facilities as close as possible to the ground so as to provide an atmosphere of freedom. In this pleasant environment, with views, water and trees, it is believed that it would help in early recovery.

Another factor in this design was the use of open courts which serves as centers for visual relaxation, recreation and activity as well as to relieve the center of institutional atmosphere.

The center will have three buildings: one houses receptions, outpatient department, administration and services to the community as well as the living units for inpatients immediately above; one day hospital where most of the activities will be housed; and the mental retardation building. Corridors connecting these three buildings and will permit patients, staff and visitors to circulate from building to building. The main entrance to the center is centrally placed, where reception services and admitting is located. The public lobby provides a convenient point for directing the public to various departments. The admitting office also functions as a control point to the living units above. On ground level of this main building are the outpatient department, aftercare services, alcoholic, a cafeteria for staff and visitors and a lecture room for the staff and for the use of community education. The central pharmacy is also placed on this level. Staff offices will

be arranged in group with conference rooms and secretarial space for each department. The Day Hospital will be placed in a rectangular arrangement around courtyards for patients activity. It includes a sheltered work shop for rehabilitation services. It is divided into an office area with interviews, and consultation rooms; and a complete occupational and recreational therapy unit. Connecting the two is a corridor containing spaces for lounge and the all-purpose room which is useful for lectures, demonstrations or group therapy. These facilities is used by both day care patients and inpatients and offering patients a better chance to socialize.

The second floor will contain the administratives offices, court consultation, extramural and research and training services. The third and fourth floor is devoted for inpatients. Each nursing floor is designed to serve 30 patients with all necessary facilities. The design of the inpatient floors are so designed to aid them in returning to their normal living environment. Where possible, they will be assisting in housekeeping and the like. From the living units, the patient can go to join

activities either inside or outside the buildings. However, it depends on the patient's condition and needs. A double door system for security and noise-control was provided for disturbance.

The inpatient unit was designed of precast concrete elements to offer as little disturbance as possible and would shorten the time for required construction.