

A PSYCHIATRIC CENTER FOR CHILDREN IN ISTANBUL

by 7214

SAHAP CAKIN

Diploma, The Technical University of Istanbul, Turkey, 1969

A MASTER'S THESIS

submitted in partial fulfillment of the

requirements for the degree

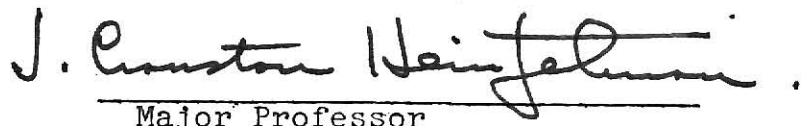
MASTER OF ARCHITECTURE

College of Architecture and Design

KANSAS STATE UNIVERSITY
Manhattan, Kansas

1971

Approved by:


Major Professor

**THIS BOOK
CONTAINS
NUMEROUS PAGES
WITH THE ORIGINAL
PRINTING BEING
SKEWED
DIFFERENTLY FROM
THE TOP OF THE
PAGE TO THE
BOTTOM.**

**THIS IS AS RECEIVED
FROM THE
CUSTOMER.**

LD
2668
14
1971
C345
C.2

TABLE OF CONTENTS

CHAPTER	PAGE
I. INTRODUCTION-THE PROBLEM.....	1
II. DEFINITIONS AND CONCEPTS.....	3
a. Factors Affecting Mental Development in the Child.....	3
b. Children Mental Handicaps.....	4
c. Concept of Community Psychiatry.....	7
III. NEW TRENDS AND VARIOUS MODELS IN CHILD PSYCHIATRY.....	14
IV. BACKGROUND INFORMATION ON TURKEY.....	31
a. Ethnic-Historical Background.....	31
b. Geographical-Economical Background.....	33
c. Cultural Background.....	34
d. Socio-Economical Development in Turkey.....	35
V. A PSYCHIATRIC PROGRAM FOR CHILDREN MENTAL HEALTH CENTER IN GÖZTEPE, ISTANBUL.....	41
a. Essential Elements.....	41
b. Services - Functions.....	44
VI. AN ARCHITECTURAL PROGRAM FOR CHILDREN MENTAL HEALTH CENTER IN GÖZTEPE, ISTANBUL.....	59
a. Site Analysis and Site Selection.....	59
b. Project Content.....	75
VII. ARCHITECTURAL DESIGN CONSIDERATIONS.....	98
a. Landscape Design.....	98
b. Interior Spaces.....	100
c. Structural System.....	102
d. Environmental Control Systems.....	103

CHAPTER	PAGE
VIII. GRAPHIC PRESENTATION.....	107
IX. CONCLUSIVE STATEMENTS ON THE PRESENT AND FUTURE.....	135
X. BIBLIOGRAPHY.....	137
XI. APPENDIX.....	140
XII. ACKNOWLEDGEMENT.....	154

LIST OF TABLES

TABLE	PAGE
I. Number of Beds in Complete Psychiatric Hospitals per Hundred Thousand of the Population in 27 Countries (1959).....	24
II. Number of Psychiatric Outpatient Clinics per One Million Population (1959).....	25
III. Climatological Data of Göztepe, Istanbul, Turkey (1967).....	64

LIST OF PLATES

PLATE	PAGE
I. Topography, Agriculture, Industry and Resources of Turkey.....	38
II. Provinces and Metropolitan Areas of Turkey.....	40
III. Critical Solar Angles, in Göztepe, Istanbul, Turkey.....	66
IV. Major Health Institutions of Istanbul.....	68
V. The Location and the Plan of Site A.....	70
VI. Different Views of Site A.....	72
VII. Different Views of Site B.....	74
VIII. Functional Space Relationships of a Psychiatric Center for Children in Göztepe, Istanbul.....	80
IX. Functional Space Relationships of Administration-Cafeteria-Staff Units-Child Guidance Center.....	82
X. Functional Space Relationships of Day School and Training Center.....	84
XI. Functional Space Relationships of Residential Cottages.....	86
XII. Proposed Functional Space Relationships of Sheltered Workshops.....	88
XIII. Proposed Functional Space Relationships of Youth Club.....	90
XIV. Site Plan of a Psychiatric Center for Children in Göztepe, Istanbul.....	108
XV. Plan of Administration.....	110
XVI. Structural Plans of Administration.....	112
XVII. Sections and N.W. Elevation of Administration.....	114
XVIII. Elevations of Administration.....	116

PLATE	PAGE
XIX. Plans of Day School and Training Center.....	118
XX. Structural Plans of Day School and Training Center.....	120
XXI. Sections and S.W. Elevation of Day School and Training Center.....	122
XXII. Elevations of Day School and Training Center.....	124
XXIII. Plans, Sections and Elevations of a Residential Cottage.....	126
XXIV. North-west View of the Center.....	128
XXV. Birds-eye View of the Center.....	130
XXVI. A Close View of the School, Cottages, and Outdoor Play Areas.....	132
XXVII. A Close View of the School, Plaza, and Outdoor Play Areas.....	134

I. INTRODUCTION - THE PROBLEM

Until recently, little was known about the problems and needs of mentally handicapped children. In many cases no distinction was made between the needs of children and of adult mental patients. Furthermore, children were considered as small adults and were treated as such. Mental handicap covers many different problems and can include conditions such as brain damage, deformation, mental retardation leading to over-slow development, emotional disturbance, and lack of adequate mental capacity. In children, these conditions result in the failure to acquire a normally accepted manner and to develop at the normal rate.

A minority of cases who are unable to move or to co-ordinate movements may hardly develop at all. For these children, very little can be done within the present level of knowledge. Fortunately, most of the mentally handicapped children are capable of development in some way. With the right conditions of care and assistance some can make remarkable progress. They require love, individual care and attention.¹

The failure of mentally handicapped children to communicate forms one of the greatest difficulties in designing the environment for such children. They are difficult to understand. Assessment of the value of a building plan, a room, a feature or a toy can only be determined by the results it gives. Since knowledge is constantly being extended and new ideas are being tried out, one of the greatest needs is for flexibility,

permitting the widest possible range of use. One of the biggest problems is the very wide range of ability and capacity of children to learn, which results in each child needing careful and detailed personal attention.

Social reaction to mental handicap forms another important aspect of the problem. While the public still tends to find adults both embarrassing and difficult, mentally handicapped children are now much more acceptable than they were a few years ago. In recent years the understanding and sympathy towards the mentally handicapped child have increased. Today's disturbed children have a better chance of improving than they have ever had in the past. Particularly in the traditional cultures, all sections of the community still are not convinced that more can and should be done.

The present facilities show that the psychiatric methods cannot operate effectively without good facilities. Good facilities form the most effective total environment. The basic objective of this study is to design such an environment which meets the various psychiatric, functional needs of the children, staff and public in the best way to fit educational aims and to provide the most effective and newest facilities for furthering the children's development towards the fullest possible participation in life and the greatest possible realization of their own potential. The research methodology utilised in this study is based on determining a psychiatric program and the Architectural Response to it.

II. DEFINITIONS AND CONCEPTS

It is difficult to obtain a clear concept of the various kinds of child subnormality. This is due partly to the uncertain state of knowledge on the causes of symptoms or on the relationship between physical and mental disorders and to the lack of an agreed terminology and classification. It is not really known what causes mental disorder. Many complicated and interrelated factors are responsible for the psychopathological resolution, e.g. factors based on early childhood experiences and later socio-cultural and economic pressures.²

a. FACTORS AFFECTING MENTAL DEVELOPMENT IN THE CHILD:

It is known that three basic types of factors affect mental development of the child and child psychiatry:

1. BIOLOGICAL FACTORS:

Food, malnutrition, and city-urban physical structure

2. PSYCHOSOCIAL FACTORS:

Psychological needs and satisfaction which should be met by the other members of the society, e.g. love, play, jealousy.

3. SOCIO-CULTURAL FACTORS:

Socio-economic status of the family, community attitudes, legislations, and policies

b. CHILDREN'S MENTAL HANDICAPS:

In 1964 an International Committee which was formed by the World Health Organization made an attempt to define the terms and concepts with respect to mental health³:

1. MENTALLY SUBNORMAL:

They divided the first main group of mentally subnormal into two sub-groups:

* THE MENTALLY RETARDED:

The problem is caused by socio-cultural factors, or "the educational and social performance is markedly lower than would be expected from what is known of their intellectual abilities.

* THE MENTALLY DEFECTIVE:

The cause is biological or "the mental capacities themselves are diminished as a result of pathological causes, as opposed to environmental causes which may lead to mental retardation". Three degrees of subnormality exist:

* MILDLY SUBNORMAL: feeble-minded in Britain and moron
in America

* MODERATELY SUBNORMAL: Imbecile in Britain and America

* SEVERELY SUBNORMAL: Idiot in Britain and America

There is no clear dividing line between mild subnormality and normality. Mild subnormality is both considered as the lower borderline of intelligence and the upper borderline of mental subnormality. Educationally subnormal children are mostly

within this classification.

2. EMOTIONALLY DISTURBED:

The second main group constitutes the emotionally disturbed children. It includes children with various intelligence levels. They may be found among the mentally deficient; with or without organic disturbance. Their behavior is abnormal, but they show normal or above-normal intelligence. It is not possible to draw a clear-cut line between mental subnormality and emotional disturbance. The emotionally disturbed children may be psychotic, autistic, delinquent, schizophrenic and so on. Emotional disturbance is "the inability to form satisfactory relationships with oneself, with people and with one's environment."⁴ The lack of balance and co-ordination between the various sections of the child's personality leads to the lack of balance among the physical, intellectual, emotional and social development. Some live an inner quiet life, and some behave aggressively. In Britain, "maladjusted" is a synonym for "emotionally disturbed."

There are also some non-medical terms for children which are often used⁵:

3. MONGOLS:

They have distinct physical characteristics which lead them to be thick-necked, and chesty. It is difficult for them to speak, especially to pronounce words. They vary

widely in intelligence and are fully aware of their environment and are anxious to co-operate.

4. AUTISTICS:

They usually look normal and are often very good looking children. They seem to live in a world of their own, do not talk and show no interest in group play.

5. HYPERACTIVE CHILDREN:

Such children show obsessive, repetitive, noisy and violent behavior. Their handicap may be combined with some other disorder. They are very tense and emotionally disturbed.

6. SCHIZOPHRENIA:

It leads to confusion in the mind of what is real and not real. They often have unreasoning fears which the average individual finds difficult to comprehend.

7. CEREBRAL PALSY:

This handicap shows the lack of physical, muscular coordination. Uncontrolled movement causes frustration and emotional problems.

8. OTHER HANDICAPS:

Physical deformity, blindness, partial sight, or deafness often combine with an emotional disturbance or sometimes with severe mental handicap.

c. CONCEPT OF COMMUNITY PSYCHIATRY:

1. COMMUNITY

It usually refers to a specified population which may be contained within geographic boundaries, related by common functional role or activity, or possess some common feature that defines it as a unit.⁶

2. COMMUNITY PSYCHIATRY:

It can be defined as "a subspecialty of psychiatry, focusing on the prevention, diagnosis, treatment and rehabilitation of emotional illness in a given population."⁷ Whereas clinical psychiatry and rehabilitation essentially focus on individuals, community psychiatry focuses on the community.

What lies outside the boundaries of community psychiatry is not well defined. Some would include all human affairs within the borders of community psychiatric practice, since man's activities are relevant to his present and future mental health. With regard to the definition stated above, all social, psychological and biological activity affecting the mental health of the populace is of interest to the community psychiatrist, including programs for fostering social change, resolution of social problems, political involvement, community organization, planning and clinical psychiatric practice. It is still hard to distinguish community psychiatry from some other related

concepts, e.g. social psychiatry, comprehensive psychiatry, community mental health, preventive psychiatry, administrative psychiatry, public health psychiatry, community organization and community planning.

3. SOCIAL PSYCHIATRY:

In the United States the term "social psychiatry" implies preventive community programs, group therapy, and participation of psychiatry in administrative medicine. In England, social psychiatry has been less closely related to general developments in the social sciences. It is a study of psychiatric disorders and psychiatric therapy within a social setting. It is also defined as an exploration of social systems and culture, and their impact on psychiatric process rather than as a type of psychiatric practice. Both social science and psychiatric variables, dependent or independent, are employed in social psychiatry. In parallel to the differences between psychiatry and psychology, social psychiatry is slightly more pragmatic than social psychology.

A useful conceptual model for community psychiatry is the public health model of prevention which Caplan suggests⁸:

4. PRIMARY PREVENTION:

This concept is to lower the rate of occurrence of new cases per unit of population of risk during a designated period of time.

5. SECONDARY PREVENTION:

It is to reduce the rate of occurrence of new and established cases of mental disorder per unit of population of risk at any particular point in time.

6. TERTIARY PREVENTION:

This concept is to lower the residual defect level of cases of mental disorder per unit of population of risk over a designated period of time.

Community psychiatry can be practiced with two alternative orientations according to its primary goal. It can be the treatment and rehabilitation of the mentally disordered people, or it can be the reduction in the frequency of mental disorders. The second approach is that of preventive psychiatry is consisted of the three types of prevention which are stated above. A preventive Community Orientation is not opposed to treatment of individual patients. In other words, the community approach does not sacrifice the rights of mentally disordered individuals to the healthy group, but seeks to further the welfare of disturbed individuals as much as possible by a rational plan to distribute resources among them in the most profitable way.⁹ There are some similarities between treatment-oriented community psychiatry and prevention-oriented community psychiatry. They both include primary prevention activities, i.e. to lower the rate of mental disorders, both provide services for the maximum number of current and past patients and both involve a systematic attempt to mobilize community resources most efficiently

and effectively for this purpose. They both lead to coordinated community programs utilizing many service units, like out-patient clinics, short-stay residential units, day and night hospitals, long-stay mental hospitals, institutions for chronic patients and for retarded, disturbed and psychotic children. Both emphasize active collaboration with other community agencies and institutions. These programs are categorized as examples of comprehensive community psychiatry.

7. SOME PRINCIPLES OF COMPREHENSIVE COMMUNITY PSYCHIATRY¹⁰:

- * The patient is the focus of the program.
- * The program is comprehensive. It includes primary, secondary, tertiary prevention, casefinding, investigation, diagnosis, treatment and rehabilitation services.
- * The patient is seen as being constantly affected by his interpersonal and social environment.
- * Mental disorder is considered as an episode in a patient's life.
- * The purpose of psychiatric intervention is to return the patient as soon as possible to his ordinary life situation.
- * Psychiatric intervention is an artifact in a patient's life.
- * Psychiatric programs should therefore focus on continuous movement of the patient as rapidly as possible through a variety of successive treatment stages to eventual return to the community.

- * Continuity of therapeutic relationship should be provided from beginning to end of intervention, and if possible, in successive interventions.
- * Treatment should be segmental and not global.
- * Active communication must be maintained among all levels of the program.
- * Psychiatric responsibility should extend beyond unit boundaries such as home, psychiatric out-patient clinic, sheltered workshops, and so on.

8. PREVENTIVE INTERVENTION:

A preventive intervention is focused upon individuals through methods based upon face-to-face contact. It includes:

- * DIRECT INTERVENTION:

This focuses on the individual and his emotionally meaningful environment during crisis.

- * INDIRECT INTERVENTION:

This takes place by the provision of mental health consultation to the community caretaking agents whose role brings them into contact with the individual during his period of crisis.

9. BACKGROUND:

The progress made in the postwar period on psychiatric work with children has been comparatively slow. The concept of child guidance as an interdisciplinary cooperation has developed to a significant extent in comparatively few countries and has not made the general impact in the last fifty years that

at one time looked likely. One of the reasons for this is that child guidance requires a complex and sophisticated level of organization of the social welfare services in the community for successful operation. Another reason for the slow progress is that child psychiatry, of all branches of psychiatry, is the most involved in patterns of family life and the functioning of the culture generally. It is therefore a unique concept for different cultures.

In most countries, the majority of the professionals have entered the field of child psychiatry from a basis of training in the principles of adult psychiatry, so that the specific psychiatric problems of children have nowhere received the attention that they need; free from preconceptions from other fields of study. Again, in most countries psychologists have approached the problems of child guidance from their previous experiences of education and social workers from general social welfare work. There is now a growing volume of literature dealing with various aspects of child guidance problems; e.g. from the practical aspect and from the preventive aspect.¹¹

FOOTNOTES

1. Ivan Nellist, Planning Buildings For Handicapped Children, (London: Crosby Lockwood & Son Ltd., 1970), p. 2.
2. Gerald Caplan, An Approach to Community Mental Health, (New York: Grune & Stratton, 1961), p. 1.

3. Kenneth Bayes, The Therapeutic Effect of Environment on Emotionally Disturbed and Mentally Subnormal Children, (London: By the Author, 37 Duke Street, 1967), p. 2.
4. Ibid., p. 4.
5. Nellist, p. 6.
6. Leigh M. Roberts, Community Psychiatry, Anchor Books, (New York: Doubleday & Company, 1969), p. 5.
7. Ibid., p. 4.
8. Gerald Caplan, Principles of Preventive Psychiatry, (New York: Basic Books, 1964), p. 1.
9. Ibid., p. 111.
10. Caplan, An Approach to Community Mental Health, (New York: Grune & Stratton, 1961), p. 233.
11. Kenneth Soddy, ed., Mental Health in the Service of the Community, (London: Tavistock Publications, 1967), p. 124.

III. NEW TRENDS AND VARIOUS MODELS IN CHILD PSYCHIATRY

The advances in civilization occur as a product of evolving cultural patterns. Following World War II in Western Europe and in the United States new philosophies and new trends arose in the care of mentally ill adults and children. These were focused on the community care and treatment in the patient's home locale rather than in a distant and isolated institutional setting. The attention has shifted from institutional psychiatry to psychiatric practice within the community. The community has become a focal point of prevention, therapy and rehabilitation.

The new concept that the community is ultimately responsible for the mental health of its members was accepted. This concept has implied that an individual's mental health depended partially on his interaction with his socio-physical environment and that it is, in effect, described by one's own community.

The psychiatric child care, and family and child counseling programs have also changed in this direction. Hospitalization of children has begun to be studied from the psychological point of view. Simultaneously, the concept of preventive psychiatry gained importance **with** the community psychiatry. The psycho-analytic therapy was gradually replaced by the relationship therapy which is a close means and end type of relationship between the therapist and the child.¹

Socio-economic factors, new understanding of mental

illness, more optimism about treatment, and increasing interest from lay groups who saw delinquency and other aberrant behavior as psychiatric problems combined to create an increased demand for psychiatric and mental health services.

Although the progress in mental health work among children has been slow in most countries, yet in every country welfare work with children is attempted. In most of the countries of Europe and North America there are more or less comprehensive systems of psychological and social services for children, in parallel to modern mental health principles, offering counseling and guidance in relation to child welfare clinics, and comparable facilities in respect of children with educational and behavioral difficulties, and children who are delinquent or suffering severe mental retardation or disorder.²

In the United States there has been an increase in psychological counseling services integrated with the school system and also closely related to parents through parent-teacher cooperation. School counselors who are members of school staffs are used. They are also specialized in understanding the psychological difficulties of children. Through the National Mental Health Act of 1946, grants became available to the states in developing mental health programs outside the state hospitals. The National Institute of Mental Health was constituted in 1949. It has supported and conducted research into the causes of mental health, supported the training of mental health personnel, and

aided the states in developing improved programs and facilities to save the mentally ill and to promote mental health in the community. On October 31, 1963, the "Mental Retardation Facilities and Community Mental Health Centers Construction Act" was constituted. This brought about the construction of a new type of mental health facility that is the Community Mental Health Centers, which have included facilities for the mentally handicapped children.

In the 1920's, the Commonwealth Fund promoted the establishment and growth of the child guidance movement. Again in Great Britain the implementation of the Education Act of 1944, which included provisions for children with psychological problems no less than for those with physical handicaps, has resulted in a great movement towards the integration of special education facilities for maladjusted children. These included arrangements for special home teaching, day special schools and classes, residential schools where psychological treatment is available, and the aftercare of maladjusted children.

Partly because of the lack of comparable records among different countries, and because of the wide variations in the interpretation of these concepts from country to country, it is not possible to evaluate the extent of child guidance centers and similar social provisions in the various countries. Thus in some countries child guidance clinics are provided as part of the educational system and the problems are approached from the educational point of view, while child neuro-psychiatric clinics

are established under general hospital auspices, and still others are conducted by mental hospitals.

Many clinics and centers are intended for the parents rather than for the children concerned and there is a movement for the establishment of family guidance centers, which are variously interpreted in different parts of the world. But it is a widespread experience that the greater the attempt to provide help with mental health problems of children, the more the facilities are used and the greater the realization of the need for them.

Some specific disorders of children have recently attracted more attention in two main directions. One is the problem of mental retardation and provision of facilities, with mostly state or public institutions, and the other group which consists of behavior disorders, ranging from delinquency and psychopathic behavior on the one hand to child psychosis on the other. The best kind of accommodation and the most appropriate form of treatment for disturbed and psychotic children still needs further research and experiment.

The figures that are available about existing accommodations show the inadequacy even in developed societies. In the United Kingdom, there are ten units, ranging from twenty to sixty beds each, for severely disturbed and psychotic children, and two units with thirty-four and fifty-four beds for adolescents; this to serve a child population of approximately 13 million.

It is a fact that in all countries where residential treatment facilities are available for disturbed children most of the facilities offer a "mental hospital" type of care. Facilities to enable the rehabilitation of disturbed children and their return into the normal education are usually very poor.

There has been a recent development, to date restricted largely to the United States and West and North European countries, in the care of young children in hospitals. It emphasizes the need of continual maternal care for children who are separated from their mothers and family environment. This movement started in the United Kingdom, has spread to a number of countries in the British Commonwealth and in Europe and, to a lesser extent, to the United States. Children's hospitals in the United Kingdom encourage parents to arrange for their young children to be visited by someone close to the child for periods of at least one hour daily, and to make additional visits as required by the needs of the individual child. In the case of very young children, the mother may be admitted too, and share in the hospital care of her baby. Although these changes are still strongly resisted in many parts of the world, it has been an interesting experience in the countries where they have been adopted. There is no public reaction in favor of a return to the old ways. Advances in the area of mental deficiency, in the education of retarded children, in social care, have been seen during the postwar period. The practical problems concerning diagnosis, treatment, education, and the vocational and social

rehabilitation of mentally defective children have been reviewed in America, Great Britain, and other countries.

In Great Britain, special schools for mentally defective (subnormal) children were integrated in the state education system at a lower level of educational potential and special training centers were provided by local health authorities. They were designed for imbecile (severely subnormal) children who are incapable of profiting from more formal schooling. It is now the duty of local government in Great Britain to provide suitable educational and training facilities for all retarded children capable of response.

In social care, the most useful development in many countries has been the formation of associations by the parents of mentally handicapped children. In the United Kingdom, the Mental Health Act of 1959 played a major role in the social care of mentally defective children, removing the certification procedure from mental deficiency provisions or mental subnormality. Thus the admission of mentally defective individuals to hospitals in the United Kingdom is no longer under certificate but informal, like any other hospital admission and in the case of children, requires only parental consent. The traditional big institution approach is being replaced by the new forms of part-institution/part-home care approach, e.g. part-time stay in institutions, daily attendance at industrial-type workshops, cottage-style homes, daily work under contract with individual employers or in sheltered employment outside the institution

while sleeping in a hostel, and so on. It is obvious that there will be a continuous need for the custodial type of institution for those who are taken care of in the best way in a protected hospital-type atmosphere where their needs can be met effectively and economically. For those individuals with physical and mental difficulties and lack of possibility of care in their family greater possibilities of sheltered employment within the institution are now being explored.

Institutions in many countries are undertaking training programs including instruction in ordinary daily living, like simple items of social behavior, such as shopping, how to order a meal in a restaurant, make a telephone call, and so on. The main objective of these training programs is to help those being trained to re-enter normal community life and be at least partly self-supporting. In order to function properly, a training institution needs to have very close links with the community it serves. It also necessitates a free interchange of personnel and patients between the institution and community. In Denmark, there are 22,000 mental retardates. 13,00 live in the home; 9,000 live in some sort of state facility; 3,000 are in workshops; and 5,000 are in schools and day care centers.³ In England and Wales some 80,000 mental defectives are living in the community under the supervision of local health authorities.

In Scandinavian countries, the care for mentally ill is based on the "principle of normalization." It means "...to let the mentally retarded obtain an existence as close to normal as

possible."⁴ It was developed especially in Sweden and Denmark and includes these basic points:

*Mentally retarded individuals in Scandinavia have the right to a normal rhythm of day. This implies a normal daily schedule. They have the right to get up, get dressed, and to eat their meals at the normal time in a familylike atmosphere when others normally do it.

*Mentally retarded individuals in Scandinavia have the right to a normal routine of life. They live in one place, go to school or work in another. They participate in leisure time activities in still other places. All of these places are kept segregated and separate. In other words, living - learning - recreational activities are segregated from one another.

*The principle of normalization implies that every mentally ill person is entitled to a normal rhythm of year. Everyone has the right to find times to change their life situations, to observe holidays and special days in a normal family-like way.

*Every mentally retarded or disturbed child is entitled to normal developmental experiences of the life cycle, and has the chance to experience a full childhood in a family-like setting. Education is compulsory for every mentally retarded person regardless of his level of functioning. They are also expected to experience everything a normal youth would experience. During the adult years, they are expected to do productive work as adults as close to normal as they can get. The therapeutic effect of environment is given particular importance. Facilities are

designed to remove the institutional character, and replace the personal and human family character needed for children.

*The choices, wishes and desires of the mentally retarded are honored. Efforts are made in helping every human being to feel themselves what is right or wrong, what they should or should not do.

*The principle of normalization implies that everyone has the right to live and experience in a bisexual world inasmuch as they are able.

*Every individual who is mentally retarded, is entitled to apply normal economic standards to their own lives. He is entitled to make his own living inasmuch as he can, and to have his own pocket money.

In summary, Scandinavian countries, especially Sweden and Denmark, have improved their philosophy, psychiatric programs and facilities to a significantly high level. Some quantitative comparisons between Sweden and the United States show this high development: There are approximately 200,000 mentally ill in state institutions. Five percent of the 200,000 are in institutions with fewer than 500 patients. Sweden has 12,000 mental patients. Five percent of them are in institutions above 500 patients. Again in Sweden, 40 percent of the mental patients are in institutions with patient population under 100. Twenty-five percent are in institutions with over 300 patients. It has spent twice as much money for mentally retarded, in comparison to the United States. The State subsidizes about 30 percent of

running cost of the facilities.

Between 1946 and 1956 in the United Kingdom and in the United States, the numbers of psychiatric hospital beds and trained personnel required have been carefully estimated. It has been suggested that the standards used have a reasonable degree of relevance to the needs of other countries in Western Europe. The WHO (World Health Organization) Expert Committee on Mental Health in 1953 recommended a tentative minimum number of "essential" psychiatric beds, "which any country, regardless of its level of economical development, should aim to provide" for the segregation and treatment of those requiring hospitalization or "emergency psychiatric inpatient care." In most countries the statistics available relate only to patients who have attended hospitals or out-patient clinics; therefore, the planning of hospital-bed provision must remain, to a certain extent, as an empirical and experimental process.

According to a forecast which was made in 1960 by the British Ministry of Health, by 1975 the number of beds in mental hospitals in Great Britain would be reduced by half and general hospitals would increasingly take over the treatment of the mentally ill. Whatever may be the principal trends in the hospitalization of psychotic patients in the future, it is obvious that in most countries the main type of hospital treatment of mental disorder will continue for many years as the separately designated psychiatric hospital treatment.

TABLE I⁵

NUMBER OF BEDS IN COMPLETE PSYCHIATRIC HOSPITALS PER
HUNDRED THOUSAND OF THE POPULATION IN 27 COUNTRIES (1959)

No. of beds per 100,000 population (1959)	Country
2- 49	Colombia, Guatemala, Honduras, Iran, Pakistan, Peru, Taiwan, Thailand, Yugo- slavia
50- 99	Brazil, Costa Rica, Japan, Portugal, USSR
100-149	---
150-199	Austria, France, Germany(Federal Republic), Israel
200-249	---
250-299	---
300-349	Australia, Canada, Finland, Switzerland, USA
350-399	UK
400-449	Sweden
over 450	Ireland, New Zealand

A parallel study showed that the countries that had fewer than a hundred beds per hundred thousand population in 1951 had increased this ratio by over 100 percent in the next ten years. In many countries, there has been an increase in out-patient activity since 1948. Statistics published in the United States show that between 1954 and 1959 the number of out-patient clinics increased by 16 percent , and the professional man-hours of clinic services rose by 37 percent.

TABLE II⁶
 NUMBER OF PSYCHIATRIC OUTPATIENT CLINICS
 PER ONE MILLION POPULATION (1959)

No. of psychiatric outpatient clinics per one million population	Country
0.01-0.4	Brazil, Colombia, Pakistan, Province of Egypt(UAR), Taiwan, Thailand
0.5 -0.9	El Salvador, Peru, South Africa
1.0 -1.9	Austria, Costa Rica, Guatemala, Honduras
2.0 -4.9	Canada, Finland, Israel, Leba- non, Portugal, Switzerland
5.0 -9.9	England & Wales, Scotland, USA, USSR
10 and over	France, Ireland, Japan

Because of the different interpretations, in different countries, of what is a psychiatric out-patient clinic, these figures are not strictly comparable. In some countries, a psychiatric out-patient clinic includes consultation services and out-patient treatment, and some do not.

In general, the United States has facilities like Community Mental Health Centers, Child Guidance Centers--in hospital complex or separated, Psychiatric Out-patient Clinics, Psychiatric

In-patient Facilities--in general hospital complex or in mental hospital, Day and Night Hospitals, 24 Hour Service Mental Hospitals, Transitional Facilities, such as Half-way Houses, Foster-homes and Sheltered Workshops.

In Great Britain, diagnostic centers, Junior Training schools, Special Care Units for severely disturbed children, residential hostels, sheltered workshops, educationally sub-normal schools and combined facilities, consisting of a Special Care Unit, Junior Training School and Adult Center, Hostel and Workshops, or a combination of some of these, are existing facilities for the mentally handicapped children.

In Scandinavian countries, particularly in Sweden and Denmark, there are Workshops, Day Care and Youth Centers, Psychiatric Social Clubs, Residential Hostels, Schools with special education, normal Boarding Schools with the integration of mentally disordered children, Residential Apartment Blocks for mentally ill, Homes for autistic children and Vocational Training Schools. Mental Health personnel are trained in the three-years personnel training school.

In Turkey, where the author comes from the first organized, modern mental health facilities were constituted after the foundation of the new Turkish Republic in 1923. In parallel to other social reforms which were done by Ataturk between 1923-35, new general hospitals with psychiatric units and mental hospitals were founded. In the 1960's, the in-patient services were

reviewed, and a new National Mental Health Plan was constituted. During the post-war period, according to this plan, new regional mental health centers were programmed, designed, and constructed by architectural competitions. These new facilities possess the similar characteristics with mental hospitals, in-patient and out-patient, emergency services and so on. As out-patient facilities, Mental Health Dispensaries and Mother-Child Health Centers were developed. Mental Health Dispensaries are functioning as Child Guidance Centers and there are about ten of them. There are only three Child Guidance Centers in three main metropolitan areas. According to the National Mental Health Plan, the Child Guidance Centers, Mental Health Dispensaries, Mother-Child Health Centers and their functions are planned to be combined in one type of facility, named Public Health Centers. Such a center will include functions, e.g. out-patient child guidance, diagnosis, treatment (occupation, play, individual, group, speech, recreational and physio-therapy), case-finding, rehabilitation and continuous developmental control of the mother's and child's health. There are five Faculties of Medicine with psychiatric units in five cities, of which two are metropolitan areas. Besides these, there are also segregated mental hospitals in Turkey. Ninety-five percent of the Mental Health Institutions belong to and are administered by the State.⁷

At the 1960 Congress of the World Health Organisation, Mr. Cambo, from his experience in Nigeria, warned the mental health professionals from all over the world⁸:

In planning and organising mental health services, psychiatry in underdeveloped countries could profit considerably from avoiding the mistakes already committed in very advanced countries of the world. When we, however, try to abstract a lesson from European and American experience we must make sure that it will apply in the contemporary African situation. This is no easy matter, and we are getting more and more convinced that an independent diagnosis of our position may prove more profitable in the end than a borrowed remedy.

The Study Group of the World Health Organization also agreed that there is no evidence to justify looking upon the practices of those countries with the most developed mental health services and research facilities as if they constitute a kind of universal blueprint, widely applicable to other countries. Cultural differences are very important and in communities where the mental health services are undeveloped, the mentally ill might live as well by being allowed to remain in the conditions in which they are happiest or best adjusted socially, at least until there is more specific and more locally valid knowledge of mental hospital treatment. The professionals in mental health and related fields of countries where there is great need and where there are very limited facilities for the treatment of the mentally ill should be warned against the adoption of any single and exclusive approach to the problems caused by mental handicap and the facility to solve those problems. For instance, mental health services based exclusively on one particular form of treatment, like pharmacotherapy or some other physical method, or on a psychological approach, may prove to be undesirable in the long-run. They may also be

dangerous in blocking more balanced development in the field of mental health. On the other hand, some well-developed type of therapeutic practice supported by the full authority of a modern treatment center, under controlled conditions can be imported, as long as cultural applicability is taken into account.

Generally, there is no ready-made and universally applicable criteria for programming a psychiatric facility for a particular culture. Every program and its application should fit into the physical, cultural, social and economical structure of its environment. Designing psychiatric facilities, especially for children, involves a team-work, including designer and the professionals from the fields related to mental health. There are still questions to which answers are unknown at the joint points of related disciplines. This subject needs further research.

In this study, a special effort was made in considering the opinions of individuals from child psychiatry and related fields, before giving design decisions. Program and design were considered as modifiers of the existing mental health structure, rather than as a radical approach which may deny the existing values. The opinions of professionals from the United States and Turkey were given equal consideration to overcome the difficulty in giving cross-cultural decisions with regard to the programming and design process.

FOOTNOTES

1. Clark E. Moustakas, Psychotherapy with Children, Ballantine Books, (New York: Harper & Row, 1970), p. 4.
2. Kenneth Soddy, ed., Mental Health in the Service of the Community, (London: Tavistock Publications, 1967), p. 125.
3. Robert Perske, "The Scandinavian Principle of Normalization", (unpublished paper, Topeka, 1970), p. 44.
4. Ibid., p. 46.
5. Soddy, ed., Mental Health in the Service of the Community, p. 65.
6. Ibid., p. 103.
7. Opinions expressed by Prof. Dr. Ridvan Cebiroglu from University of Istanbul, in his letters during 1971.
8. Soddy, p. 150.

IV. BACKGROUND INFORMATION ON TURKEY

a. ETHNIC-HISTORICAL BACKGROUND

The term "Turk", applied in its wider meaning, refers to the Turkic speaking people of Turkey, the Soviet Union, Chinese Turkistan and East Iran. Islam, the religion of nearly all Turks is the significant unifying link among Turks. In the Soviet Union, all the nationalities classified as Tatars are Turkic-speaking. It is probable that many people who were unrelated to the original Turks adopted either wholly or in part their speech and their social organization. The Avars were probably Turks. They and the Magyars had adopted the Turkic tribal organization when they appeared in Europe. Many Hungarian words are of Turkic origin. The original Turks lived in the regions north and west of China, in South Siberia and in Turkistan. In Turkistan, the oldest Turkic inscriptions (Orkhon inscriptions) have been found. Turks were nomadic and pastoral people. They made excursions into territories to the south and west, and established several powerful empires, like the Uigur Empire of Central Asia in the eighth and ninth centuries, Khazars, Cumans, Petchenegs in South Russia and South East Europe. In the past Anatolia, which is the Asian part of the present Turkey, was invaded by various empires. Thus, today's Turkey contains monuments of ancient and classical civilizations.¹

In the history of Europa and West Asia, two Turkish

groups played dominant parts: the Seljuks and the Osmanli (Ottoman) Turks. Osmanli Turks were a minor tribe and had been placed to the border area of the Byzantine Empire by Seljuks. At the beginning of the eleventh century the Turks began to conquer Anatolia. From the seventh century onwards the Central Asian Turks came into closer contact with the Islamic people of the Near East, from whom they adopted the Islamic faith and the Arabic script. By the end of the tenth century masses of Turkish immigrants from further east entered the country and the Turkish Muslim civilization replaced Greek Christianity. The Seljuk empire fell apart in the 12th century. The highly disciplined organization of the Osmanli Turks enabled them in the 14th century to make themselves masters of the ruins of the Seljuk empire in Anatolia. The Ottoman Empire was at the height of its power in the 16th century. The people of modern Turkey, which was founded after the collapse of the Ottoman Empire in 1918 at the end of the First World War, are called Osmanli Turks.

Mustafa Kemal, later surnamed Ataturk, meaning father of the Turks, reorganized a new army to fight against seven nations who dominated Anatolia after the First World War. In 1922, the final phase of the war of independence directed by Ataturk began. Foreign armed forces withdrew, the Sultan's Cabinet resigned and the Sultan of the Ottoman Empire himself went into exile. The Constitution of 1926 provided for an elected Parliament and the executive power. Turkey has become a democratic republic from 1923 up to now.

b. GEOGRAPHICAL - ECONOMICAL BACKGROUND

Turkey is a republic situated partly in Europe and partly in Asia. It lies between the Black Sea and the Mediterranean Sea. It is somewhat larger than Texas and has more than 35 million people. Turkey borders with Bulgaria and Greece on the west, with the Soviet Union on the northeast, with Iran on the east, and with Iraq and Syria on the south. The Turkish language is spoken by 99 percent of the people. The capital is in the midland, named Ankara.

Turkey is, to a lesser extent, an agricultural country. In the early 1960's about two-thirds of the active population were engaged in farming. The largest part of the agricultural land is taken up by cereals, mainly wheat. After the Second World War grain production increased, owing to technical improvements. However, production is still subject to violent alternations. The main export crops are tobacco and dried fruit. Production of textile fibers, mainly cotton of good quality, has also been fostered. Turkey exports honey of excellent quality. and dairy products. It is one of the world's leading producers of chromite. Copper mining has been expanded and has become the basic item in an increasing export trade. The fisheries of the sea of Marmara, Mediterranean, Black Sea and Bosphorus constitute an important industry. There are also fishing grounds in the numerous rivers and lakes. Industrial development has started lately in Turkey, owing to the unfavorable political and economic climate under the Ottoman Empire. Turkey can

provide most of the local demand for cement, glass, leather, and textile material. After the 1960 revolution, there has been an increasing improvement in industry. The share of industry, as a whole, in the country's national income rose from ten percent in 1927 to 38 percent in 1967. Ten percent of the working population are at present employed in industry. The 1961 constitution grants to Turkish Labor all the rights as enjoyed in the West, like the right to form unions, to bargain collectively and to strike, to rest, to have great social security and medical care.²

c. CULTURAL BACKGROUND

The cultural heritage of the country was derived from Ottoman society. It contains some of the most significant monuments of ancient and classical civilization. Because of the religious restriction, for centuries an artist of international stature has not emerged in painting and sculpture. The art of miniature developed only. In the 20th century, new approaches in painting, sculpture, theater, and music were developed, leading to a Modern Turkish Art which had its own origin in the nation's history.

Ataturk's social reforms played the most important role in the Turkish people's way of life. Besides the use of the Latin alphabet, Western calendar, measurements of weights, a new Turkish literature and architecture were created. Later the architecture was influenced by some European - Bauhaus members

who came to Turkey during the Second World War. Education is free in all government schools. Primary education is, by law, compulsory for both sexes between the ages of seven and twelve. There are eight state universities and several other institutes or colleges of higher education.³

d. SOCIO-ECONOMICAL DEVELOPMENT IN TURKEY

United Nations statistical data shows that Turkey is a developing country. The national per capita income increased from Turkish Lira (TL) 1,326 to TL 3,125 in the period from 1962 to 1969, according to the statistics released by the Union of Turkish Chambers of Commerce, Industry, and Commercial Markets. The first five years development plan was started in 1965. Turkey's development rate during the first five-year plan was 6.7 percent. 1971 Program of the Second Five Year Development Plan was published. During the first year of the second five-year plan, an increase of 0.3 percent raised the development rate to seven percent.

The major problems which effect the development rate in Turkey are the rate of population increase, the average birth rate, the population distribution according to age, and the growth of urbanization. The rate of population increase in cities is 21 per thousand, and in villages 27 per thousand. (Twenty-five per thousand is the average rate.) The average birth rate is 40-66 per thousand in villages and 31 per thousand in cities.⁴ Figures show one of the highest rates in the world.

The majority of the Turkish population is very young and they form the unproductive group. 43 percent of the total population are under 15 years old.

The urban population of Turkey will double by 1985. 59percent of the total population will live in cities, and 92 percent of those in cities with populations of over 100,000. A "national plan" has been prepared by the National Planning Office which foresees a balanced growth or urbanization. The plan divides Turkey into eight planning regions and nineteen smaller sub-regions or program areas. Twenty-four cities have been chosen as "development centers", throughout the country. The four metropolitan centers will be Istanbul, Izmir, Ankara and Elazig.⁵ (See map, p. 40)

FOOTNOTES

1. "Turkic Peoples", Encyclopedia Britannica, 1970, XXII, Pp. 400-406.
2. "Economy in Turkey", Encyclopedia Americana, 1970, XXVII, p. 266.
3. Walter F. Weiker, "Cultural Life in Turkey", Collier's Encyclopedia, 1971, XXII, 53 G.A.
4. Turkish Student Association Newsletter, Editorial, March 27, 1971.
5. Ibid.

**THIS BOOK
CONTAINS
NUMEROUS PAGES
THAT WERE
BOUND WITHOUT
PAGE NUMBERS.**

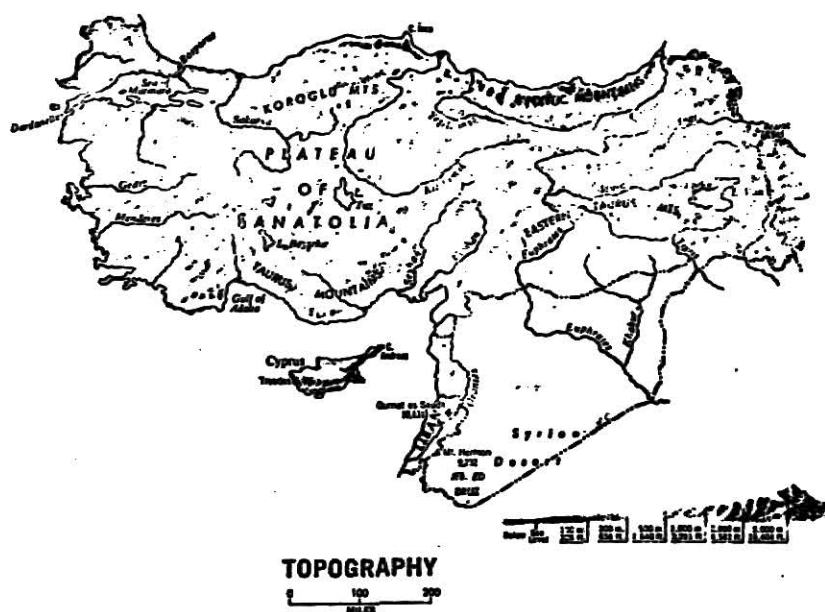
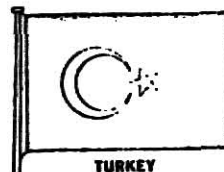
**THIS IS AS
RECEIVED FROM
CUSTOMER.**

EXPLANATION OF PLATE I

Topography, Agriculture, Industry and Resources of Turkey

PLATE I

TURKEY
 AREA 296,185 sq. mi.
 POPULATION 31,118,000
 CAPITAL Ankara
 LARGEST CITY Istanbul (greater) 1,466,525
 HIGHEST POINT Ararat 16,945 ft.
 MONETARY UNIT Turkish pound (lira)
 MAJOR LANGUAGES Turkish
 MAJOR RELIGIONS Mohammedan



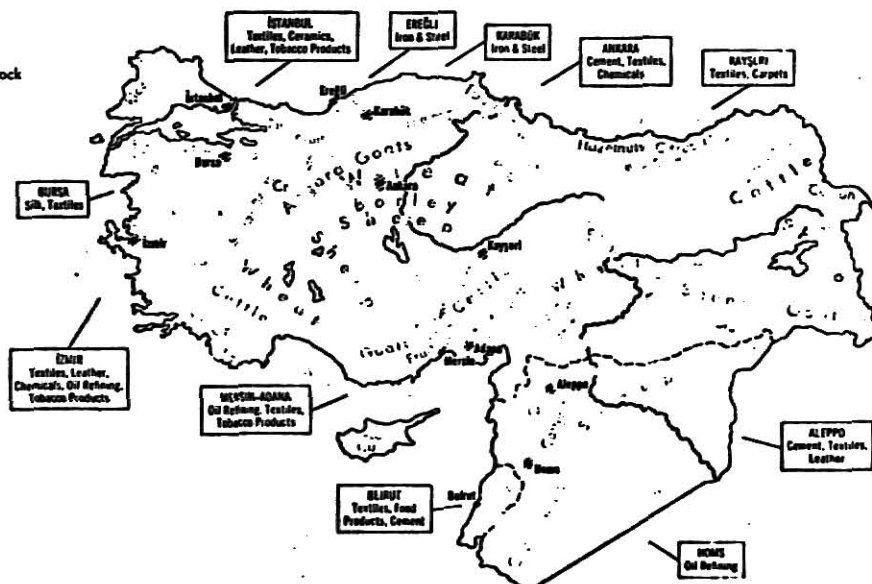
AGRICULTURE, INDUSTRY and RESOURCES

- DOMINANT LAND USE**
- ☐ Cereals (chiefly wheat, barley), Livestock
 - ☐ Cash Crops, Horticulture, Livestock
 - ☐ Pasture Livestock
 - ☐ Nomadic Livestock Herding
 - ☐ Forests
 - ☐ Nonagricultural Land

MAJOR MINERAL OCCURRENCES

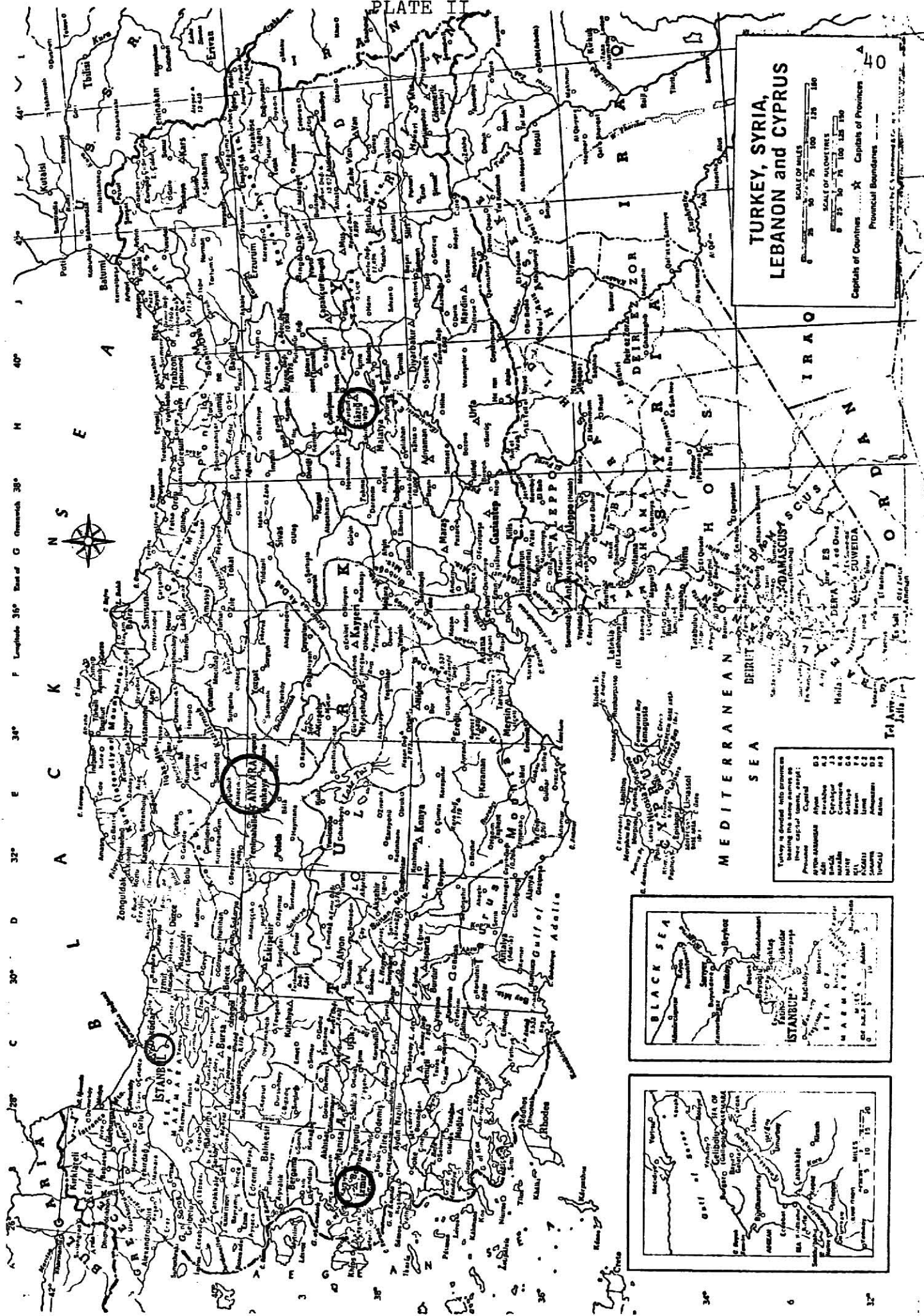
- Asbestos
- C Coal
- Cr Chromium
- Cu Copper
- Fe Iron Ore
- Na Salt
- P Petroleum
- Pb Lead
- Zn Zinc

- Water Power
- Major Industrial Areas



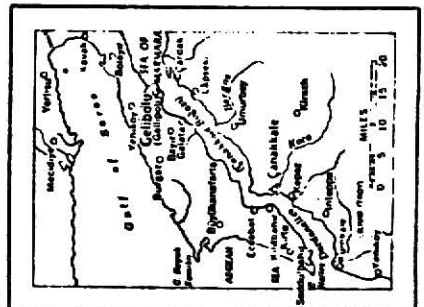
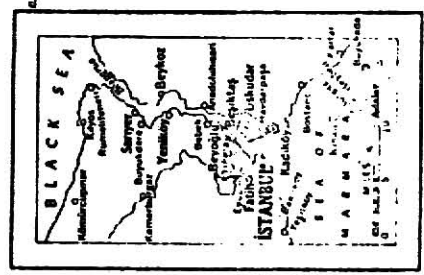
EXPLANATION OF PLATE II

Provinces and Metropolitan Areas of Turkey



**TURKEY, SYRIA,
LEBANON and CYPRUS**

Capitals of Countries . . . ☆ Capitals of Provinces
Provincial Boundaries

[illegible]

V. A PSYCHIATRIC PROGRAM FOR CHILDREN MENTAL HEALTH CENTER IN GÖZTEPE, ISTANBUL

The psychiatric needs and functions determine the architectural program. In Turkey, it is required for metropolitan areas (Istanbul, Ankara, Izmir, Elazig) to have at least one children's psychiatric center for each area. Again for future development, it is desirable to have two to five Child Guidance Centers which provide out-patient services only, for every city. State Schools for mentally retarded children should also be programmed and designed in future developmental areas. In determining the program, previous literature, existing programs and institutions in the United States and Turkey, interviews with individuals from mental health institutions in the United States and in Turkey were taken into consideration.¹

a. ESSENTIAL ELEMENTS:

The essential elements of the program are stated below^{2,3,4}:

1. REFERRALS:

These come from public schools (kindergarten, elementary and secondary), from police, private medical doctors and psychiatrists, families and hospitals.

2. CATCHMENT AREA;

This is proposed as the city of Istanbul. Admissions for both in-patient and out-patient services will be accepted from the families who live in Istanbul.

3. CAPACITY:

The center will consist of both in-patient and out-patient services. The out-patient services are provided for 20 children. In the United States, with the same number of staff, out-patient services could be provided only for five to ten children. In determining the number of children (20), existing conditions and structure of Turkey were considered. The in-patient services include six residential cottages, each has 16 beds. The maximum total number of children who will live here at one time is 96. Apart from the Child Guidance Center and Residential Cottages, Day school and Training Center will provide educational facilities for 96 children who will live in the institution and, for 30 children from the community. Children's ages are limited to ages of three to sixteen. After sixteen, the problems and training programs change. It is desirable to have an upper borderline or age limit between children and teenagers.

4. SEX:

Children are from both sexes. There is no restriction on either sex. Considering the cultural structure of Turkey, it is proposed to provide separate bathroom and sleeping facilities for boys and girls after nine years old.

5. TYPES OF HANDICAP:

Children with various mental handicaps, except severely retarded ones, will be admitted to the center. The ultimate aim is to help them in developing their skills and

return them to the community and to their families.

6. STAFF:

The personnel of the institution will consist of professionals from psychiatry and related fields, administrative clerks, aides, volunteers, student trainees from the medical and psychology schools, nurses, student nurses, and various service personnel, e.g. chauffeur, janitor, cooks, other kitchen personnel, gardener and so on. Besides the director of the institution, the Child Guidance Center will include a team formed by a child psychiatrist/psychotherapist, a psychologist, two social workers, one speech therapist and one physiotherapist, plus aides, nurses, student trainees, and a secretary of the head of the team who is usually a child psychiatrist with medical educational background.

The administration will include the director of the center, and his secretary, administrative clerks as receptionist, switchboard clerk, business and personnel office clerks and a record librarian. The kitchen and cafeteria will include personnel who work in the kitchen preparing food, storing the food, cleaning dishes, cooking, and a dietitian. The day school and training center will consist of the supervisor, teachers with special training, including a teacher for physical education classes and one for practical training classes, several aides and students. Each residential cottage will consist of house parents

during the night, aides and student trainees, volunteers, and kitchen personnel during the day. Technical services will include janitors, a chauffeur and gardener.

b. SERVICES - FUNCTIONS:

Services which will be offered in the institution can be classified under six main sub-groups:

1. ADMINISTRATIVE SERVICES
2. PSYCHIATRIC AND EDUCATIONAL SERVICES
3. RESIDENTIAL SERVICES
4. SOCIAL AND RECREATIONAL SERVICES
5. INDUSTRIAL SERVICES
6. TECHNICAL SERVICES

1. ADMINISTRATIVE SERVICES:

The administration of a psychiatric center complex is of great importance to its functioning. The administration of functions related to professionals, and, generally to staff, the organization of the necessary relationships between the institution, other community agencies and state institutions, parents, medical schools, the financial administration of the institution, distribution of the salaries of the staff, organization of balanced linkages among the different functional units of the center, e.g. Child Guidance Center, Day School, and Residential Units, even Sheltered Workshops in the future, and of informative meetings among the staff with various backgrounds are all included in this group. The proposed administrative structure of the institution should fit into the existing power structure of its social environment in Turkey. The Administrative

Services are provided in the Administration Building.

2. PSYCHIATRIC AND EDUCATIONAL SERVICES:

Both in-patient and out-patient services are provided for the mentally ill children, their parents and for the community. The out-patient psychiatric services for children, counseling and consultation services for parents and community focus in the Child Guidance Center. Psychiatric functions of the Child Guidance Center include history-taking, diagnosis, treatment-therapy and case-finding for children; counseling, psychotherapy and training for parents, education for community, parents, technical personnel, and students from related fields.

* PSYCHIATRIC SERVICES:

These are provided by the Child Guidance Center. The Child Guidance Center is basically an agency to improve the adjustment of children to their environment, especially to their emotional and social relationships, so that they may be free to develop to the limit of their individual capacities. The center has extensive relations with other social and medical services; mental hospitals, psychiatric out-patient units of the general hospitals, and mental health dispensaries; its clients come mainly from schools, hospitals, police, out-patient clinics and social services. Close cooperation with case-finding organizations is necessary, not only in regard to the selection and receiving of children, but also with regard to the treatment. The Child Guidance Center should be equipped to play an expert role in psychological and social viewpoints of the children's

development. It involves a multidisciplinary approach. The child guidance team is used for diagnosis and therapy and consists of a psychiatrist, a psychologist and one or two social workers, a physiotherapist and a speech therapist to solve the problems caused by the complexity of psychological disorders in children.

The training and special experience of the medical psychiatrist are needed for an understanding of the causal factors, physical disorders and psychiatric symptoms. A psychologist is vital to examine the psychological causes and symptoms in detail and to evaluate accurately the child's abilities and the way in which they are expressed. The social worker deals with the environmental influences, the definition of these influences, and the way each child is affected by them. At least one of the members of the child guidance team should have a special training in psychotherapy. In team work, there must be constant formulatory discussion and comparison of the different view-points. In other words, an organic, functional and emotional relationship is necessary among the members of the team.

The modern conception of child guidance is that not only the child but the whole family needs treatment. A diagnosis of the family has to be made, after each of its members has been examined both as an individual and in his relationship to others. The family as a whole needs individual and collective therapy, considering the complex interaction between its individuals and

their environment. In the Child Guidance Center, there are diagnostic, therapeutic, and preventive (consultation) tasks, with regard to the children and their parents. The basic functions of the child guidance process are⁵:

•History-taking: The situation is quite different from traditional clinical work in behavior disorder cases. The clinical work of the physician follows this pattern:

Questioning - Symptoms - Signs - Diagnosis.

History-taking by means of interviews is, in many ways, as vital for the diagnosis as is the psychological and psychiatric examination of the child. It calls for the participation of all the members of the child guidance team, especially of the psychiatrist and the social worker. History-taking may have a decisive therapeutic effect on the parents and may change their attitudes toward the child. The case-history method is also necessary during the after-care period, or during the regular and necessary check-ups. The social worker plays an important role in social investigation. He establishes a relationship with the parents. The purpose of the social investigation, carried out either at the center or at the family's home, is to gather as much information as possible on the history of the child and the parents, and on the social and economic aspects of the family problem. In the tradition cultural structure of Turkey, most of the social workers are women.

•Diagnosis: A real distinction cannot be made between the stage of diagnosis and therapy. Diagnosis for children is

based on four principles:

- ..The study of the child's behavior disorders, their history and evolution.
- ..The study of the child's personality in its present state. It includes the child's conflicts, defense mechanisms, reactions, psychomotor development, which may be involved in his relations with his family and his environment.
- ..The study of the child's family. It includes the information on the social, economic and cultural basis of the family life.
- ..The study of the social and economical, cultural and emotional aspects of the environment of the child's family.

Diagnosis involves observation of the child's behavior in relation to his:

- ..physiological and social life, i.e., sleep, appetite, cleanliness, enthusiasm in his daily routine.
- ..teachers, i.e., resistance, confidence, communication.
- ..group life, i.e., his relationships with other children and the reactions he arouses in them, his place and role in the group.

There are four main approaches to diagnosis in Child Guidance Centers:

- ..Psychiatric examination - psychiatrist
- ..Somatic examination - speech therapist, physiotherapist, psychiatrist
- ..Psychological examination - psychologist
- ..Social, cultural, economical examination - social worker

Two main types of behavior disorder can be distinguished:

- Reactional disorders, linked to the environmental conditions
- Structural disorders, independent from the environmental conditions.

Maladjustment can be related to family, to school, and to society as a whole.

•Treatment: Child Guidance Centers use several methods of therapy, ranging from the simple interview to long, systematic and deep psychotherapy. The proposed center also undertakes educational therapy, such as the treatment of specific difficulties in learning to read and to count; the correction of speech disorders, including stammering, and the correction of motor disabilities by means of physical exercises. The Center also provides occupational therapy by organizing the child's leisure, or giving him some task to do. There are two possible types of child psychotherapy:

- Expressive methods in which play is an essential element.
- Relationship methods which emphasize the relationship between the psychoanalyst and the child.

These psychotherapeutic methods in the child guidance center are applied in two ways:

- Individual Psychotherapy - Preference is given to play therapy based on symbolic expression and its creative value.
- Group Therapy - The therapeutic value of spontaneity is emphasized.

The proposed Child Guidance Center also involves the psychotherapy with parents. Four psychotherapeutic methods can be

used in treating the families of children under the center's care:

- Counselling
- Contact therapy
- Systematic psychotherapy
- Group Psychotherapy

•Case-finding: The children in need of care and treatment are divided into two main groups: Mentally subnormal and emotionally disturbed or behaviorally disordered. One of the functions of the Child Guidance Clinic is case-finding. Mildly subnormal children are often capable of living and working in the community. The proposed center will work with an educational institution to treat children with educational problems. The center also sends its educational psychologist into the schools, where the teachers will draw his attention to the subjects with which a child is having difficulty.

•Preventive work and consultation: The Child Guidance Center offers a therapeutic service for children presenting mental disorders, and in addition, carries out work which is essentially preventive. The Center can examine all children and the families systematically in its area. The size of the area is determined by the center's resources and is limited so that the systematic case-finding does not supply more cases than could be given therapy.

•The educational role of the child guidance center with regard to community, parents and technical personnel: In recent years preventive psychiatry is being applied in the form of mental health consultation to community, families and technical personnel

in the related fields.

••Community education: Community can be educated directly through the Child Guidance Center, using public lectures, the press, books, pamphlets, study kits, leaflets, brochures, reference lists, exhibits, set displays, radio, and films. Radio and films are particularly suitable for the communication of mental health ideas to children. By means of mental health education, a better understanding and acceptance of children's difficulties by their parents, are provided. Some other advantages of mental health education are that it can lead to a better understanding of the kind of educational action that can be therapeutic, and a closer understanding of the help that the Child Guidance Center can provide.

••Parents' education: Regular and frequent meetings with parent groups are valuable in enabling parents better to understand the part they must play and to fit the theoretical knowledge they are given to their personal problems in their own families. In practice, it is almost impossible to draw a line between group education and group psychotherapy to parents.

••Educating technical personnel: As a community organization, the Child Guidance Center is completely dependent on collaboration with various other institutions. There is a common base of knowledge and understanding about mental health principles needed, among the medical practitioners, nurses, social workers, clinical psychologists, teachers and educators of all kinds, judges and police within these institutions. The discussion groups may be formed with multidisciplinary representation.

Discussion sessions are based on case material from the Child Guidance Center and also on case material derived primarily from clinics, courts, hospitals, police headquarters, and the various other institutions. The Child Guidance Center takes the lead in this work and offers consultation services for professional groups and other social agencies. Consultation can be offered in four different directions:

- ...Client-centered case consultation
- ...Program-centered administrative consultation
- ...Consultee-centered case consultation
- ...Consultee-centered administrative consultation

The Center can also play an important role in the community organization, e.g. public relations, organization of volunteers and stimulation of citizen action.

Research: The Child Guidance Center may collaborate in research on handicapped children. The records of the activities of the center, evaluation and statistical studies of the results play the most important role in research activities of the center.

Training: The Center also offers daily training services for nurses and students from medical and psychology schools.

* EDUCATIONAL SERVICES:

The educational services are mainly provided by the proposed Day School and Training Center. The ultimate aim of the education here is to produce a balanced person able to exercise his mind and capable of further development in the most hopeful

direction. To achieve this the child should have an awareness, interest and the ability to communicate. He should be backed up by confidence in others and confidence in himself. He must be acceptable to society. Communication can lead to social and activity training, to education, to the fullest possible development. In the next step, that is the architectural response, the problem facing the designer is to determine what facilities are needed, what environment and what kind of interior and outdoor spaces can best help in this design.

Children in the school can suffer from a variety of mental handicaps in varying degrees, or from physical handicaps (example: lacking motor development) or both. In the school, the specialist teacher to children ratio is proposed to be one to ten. The Day School and Training Center will consist of pre-school and elementary classes. The education in the school as a whole is less formal than that in the public schools. The emotionally disturbed or disordered, mildly retarded and trainable children between the ages of three and sixteen will be admitted from public schools, police headquarters, psychiatric units of the hospitals, and families. Children may be switched to a different type of treatment, like hospitals. Classes are usually divided according to ability, rather than according to age. Classes are mixed and consist of between 15 and 20 children. Five elementary school classes, considering the public school system in Turkey, and two nursery classes, one for new beginners and the other for more improved children, are provided. The

School serves 90 in-patient and 30 out-patient children.

The children attend on a day-time basis, keeping the same times, having the same breaks and holidays as a normal school. They arrive by the institution's coach or minibus, which collects them from various established picking-up points and they normally have their mid-day meal at the residential facilities, except in bad weather conditions when they can have it at the school. The day time routine is similar for both resident and non-resident children at the school. Classes are less formal than in normal schools. At the nursery stage, activity is basically all play. In upper level classes, a more organised educational discipline can be applied. Manual art and craft activities are often used, together with music and movement, physical games and training, dancing, household and domestic training. Most of the children develop a good sense of rhythm.

3. RESIDENTIAL SERVICES:

The residential services are provided for 96 children and some staff. The ultimate objective is to provide the children with a home-like family atmosphere. Each Residential Cottage provides sleeping, dining and recreational facilities for the children. There are six cottages, each has sleeping, dining and recreational facilities for 16 children. Residential Cottages are mixed until the age nine, after nine, they may be limited to either all male or all female accommodation or mixed. Each cottage has house-parents who take care of the children during

the night. Residents use the kitchen and dining facilities for breakfast, mid-day meal and dinner. Some resident children can use the cottages on a five-day week basis, returning home at the weekends. Some are permanent full-time residents. There will not be any force or pressure on children to send them to the Day School and Training Center. Some children can stay in their cottages during the day, if they wish to. They can also attend the therapy in the Child Guidance Center, if necessary.

The Cottage is the environment for disturbed children to relax, to satisfy their social and recreational needs, like games, hobbies (painting, drawing, reading), listening to radio and records, music and other quiet activities, also to educate and train themselves in everyday life tasks, like cooking, setting the table, washing dishes, laundry and gardening.

The maximum flexibility is provided in sleeping facilities, one-bed rooms, two-bed rooms, three-bed room, and four-bed room, considering the social relationships between the children from different age groups.

Residential facilities for staff are also provided. Sixteen female and eight male aides can stay in the institution overnight and have their meals in the staff cafeteria together with other staff.

4. SOCIAL AND RECREATIONAL SERVICES:

Social and recreational facilities are provided for children

parents, community and staff. A staff cafeteria with a capacity of 200 serves to staff, parents and visitors. It offers both indoor and outdoor dining facilities. The staff lounge gives the opportunity of informal staff discussions, relaxing, drinking beverages, Turkish coffee and tea. Separated lounges for nurses, student trainees and volunteers are also places to relax. Lounges, hall, waiting, display and various play areas serve the same purpose. A multi-purpose hall and swimming pool in the Day School and Training Center are opened to the activities with regard to community. Outdoor play areas, playgrounds and fields for organized ball games possess therapeutic value. Existing and proposed trees, vegetable and flower gardens, people's places, are the areas where the training and recreational therapy can be applied most effectively. The proposed Youth Club will play the most important role in meeting the social and recreational needs of the mentally disordered teenagers.

5. INDUSTRIAL SERVICES:

The proposed workshop facilities are considered in this group. They will serve the mentally ill adolescents and adults in the future as places where they can get social and industrial training. A few of the older children who are the residents of the center can enter Sheltered Workshops at ages under 16. This happens when they seem unlikely to develop further at a school, but show interest and aptitude in practical work.

Work consists of fabrication in timber, wire and light metal work, assembly, packing, the making of simple wiring assemblies, light electronic circuits, in short, any type of work which is within the occupant's capabilities and for which there is demand. Work is undertaken for local employers on a sub-contract basis with the approval of the unions, and agreed rates are paid. Rates are low since output and consistency are both uncertain.

6. TECHNICAL SERVICES:

The maintenance and all technical facilities needed for the institution are considered in this group. It includes the parking facilities, the central heating system, electricity, plumbing and sanitation systems, switchboard and storage facilities.

FOOTNOTES

1. Opinions expressed by Prof. Dr. Ridvan Cebiroglu of the University of Istanbul, in his letters during 1971.
2. Opinions expressed by Dr. L. H. Rappoport during informal discussions at Kansas State University, 1971.
3. Opinions expressed by Dr. E. R. Sinnett during an interview at Kansas State University, 1971.
4. Opinions expressed by Mr. W. D. Morton during an interview at Fort Logan Mental Health Center, Denver, Colorado, 1971.

5. D. Buckle and S. Lebovici, Child Guidance Centres, (Geneva: World Health Organization, 1960), p. 48.

VI. AN ARCHITECTURAL PROGRAM FOR CHILDREN MENTAL HEALTH CENTER IN GÖZTEPE, ISTANBUL

The Architectural Programming Process includes Site Analysis, Site Selection, Site Planning, Space Requirements in terms of children, personnel and public capacity, areas, heights, positioning of spaces, Functional Space Relationships and Departmental Linkages related to the amount of traffic flow among various sections of the program.

a. SITE ANALYSIS AND SITE SELECTION:

Selection of a suitable site is very important, from the physical and social view-points. There has always been a good deal of prejudice against the mentally handicapped and people do not want to know about mental disturbance. Many children suffering under mental handicap have a great desire to be accepted, therefore the siting of buildings for them within the living community is important and valuable. Site A and Site B, both in Istanbul, were analyzed separately and compared in the light of physical and social site objectives stated below:

1. PHYSICAL ANALYSIS:

* OPTIMUM AREA:

An important objective is the size of the site.

- Space for buildings
- Space for outdoor children activity
- Space for landscaping

•Space for future growth and expansion

•Space for parking

* SUBSURFACE AND SURFACE CHARACTERISTICS:

They refer in particular to the foundation material, the level of the watertable, earthquakes, topographic surface, vegetation, kinds of trees and view orientation. They determine the structural system, the gradient of paths, the flow of utilities, the use of indoor areas and the visual aspect. Slopes of up to one in ten can be utilized by means of terracing and ramping. Another advantage of a slightly sloping site is that safety and security precautions such as fences can be hidden very effectively.¹

* ATMOSPHERIC FACTORS (CLIMATE):

The atmospheric factors include solar angles, days of sunlight, ranges of temperature and humidity, precipitation, days of snow, wind direction and force. All these may influence the orientation of structures, their shielding or exposure to sun, the equipment for cooling or heating, the fenestration, lighting, the building materials, the cover and planting in general.

* SONIC FACTORS (ACOUSTICS):

Environmental noise, the existence of the noise sources, like physical plants, schools, and traffic noise, influence the site selection and the location of the buildings.

2. ANALYSIS OF MAN-MADE CHARACTERISTICS:

* OPTIMUM COMMUNICATION:

The location of the site has a particular importance with regard to the catchment area of the institution, accessibility by pedestrians, closeness to the main lines of communication and ease for public transport.

* TECHNICAL SERVICES:

The presence or absence of the water, plumbing, electricity and sewage.

* EXISTING LAND USE PATTERNS:

They influence the relations between the mental health institution and the community. The residential areas are more convenient for the integration of the institution in the community. The site should be well placed to share the life of the community. There is always the need to stimulate interest and awareness.

* ZONING RESTRICTIONS:

They are important in site planning, and their control over the vertical or horizontal growth and shape of the buildings.

* RELATIONSHIP WITH OTHER MENTAL HEALTH INSTITUTIONS AND SCHOOLS:

A children's psychiatric center should have external

relations with other institutions, particularly psychiatric units of hospitals and schools.

* COST:

The realization of the project depends on the cost of the site.

3. THE COMPARISON BETWEEN SITE A AND SITE B:

Site Objectives	SITE A	SITE B
*OPTIMUM AREA	Convenient for the first two stages of construction which cover approximately 6,000 m ² total, but not for the future youth club and workshop facilities (see plate V)	Convenient for all stages of the construction and for all facilities (see plate XIV)
*SUBSURFACE AND SURFACE CHARACTERISTICS	Second degree earthquake district, hardly any trees and vegetation, "fill" soil. (Four per-cent grading in N.S. direction (see plate VI)	Second degree earthquake district, existing forest, trees, public park and vegetable garden, two and one-half per-cent grading in NE-SW direction (see plate VII)
*ATMOSPHERIC FACTORS	See Plate III, Table III	Same with SITE A See plate III
*SONIC FACTORS	Noise of the amusement fair across the road, during summer months, traffic noise, close to business district and workshops, bus depots.	Traffic noise in Bagdad Avenue, especially in summer, residential district, no physical plant, sound of the train can be heard, possibility of screening environmental and traffic noise by means of trees

PHYSICAL-NATURAL FACTORS

	Site Objectives	SITE A	SITE B
PHYSICAL-NATURAL FACTORS (CONT'D)	*OPTIMUM COMMUNICATION	Located in Old Istanbul, close to hospitals, in European side, public transportation (bus) available.	In Asian side, close to hospitals in Asian side only, public transportation (bus, train and boat) available.
	*TECHNICAL SERVICES	Water, electricity and sanitation are available.	Water, electricity and sanitation are available.
MAN-MADE CHARACTERISTICS	*EXISTING LAND USE	Business and residential district, density is high.	Residential district, density is low.
	*ZONING	Zoning regulations for business districts. Front and side gardens are three meters, back yard is six meters minimum wide. ²	Zoning regulations for residential districts. Front and side gardens are five meters, back yard is six meters minimum wide. For sites larger than 30 meters, ten meters front garden is required.
	*RELATIONSHIP WITH HOSPITALS AND SCHOOLS	Close to two hospitals (one with psychiatric unit) and two elementary schools (see plate IV).	Close to one hospital and two elementary schools (see plate IV).

According to the Site Evaluation, Site B was chosen.

TABLE III
CLIMATOLOGICAL DATA OF GÖZTEPE,
ISTANBUL, TURKEY (1967)³

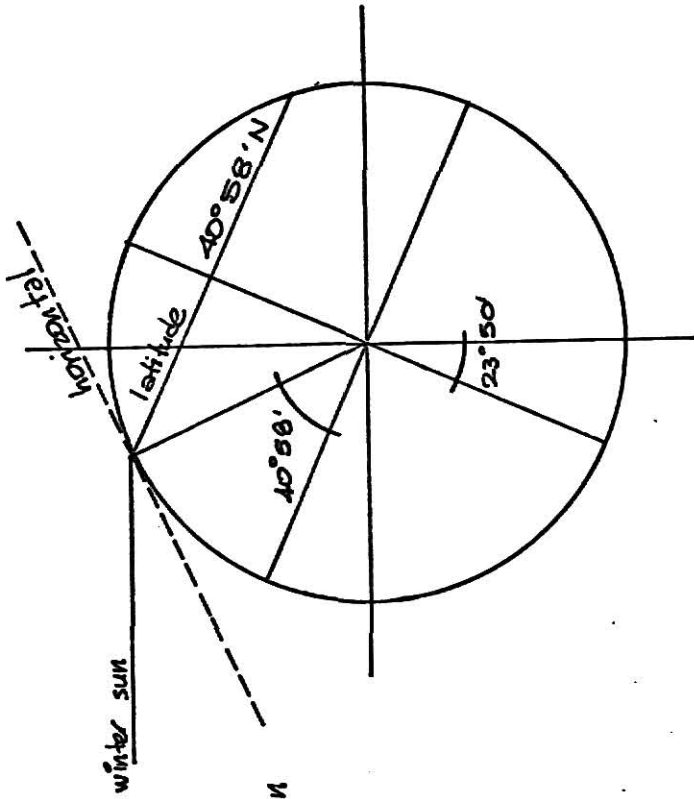
Location: Göztepe, Istanbul, Turkey
Latitude: \varnothing : $40^{\circ} 58'$ N.

MONTH	AIR TEMPERATURE °C (MEAN)			RELATIVE HUMIDITY %	PREVAILING WIND DIRECTION (OD 36) AND AVERAGE VELOCITY(m/sec)		PRECIPITATION (IN PER MONTH mm)
	MAX.	MIN.	AVER.				
JANUARY	7.9	1.8	4.6	79	NE, N, SE	3.0	118.3
FEBRUARY	6.4	0.0	3.0	87	NE, ENE	1.9	50.0
MARCH	10.8	3.2	6.7	83	NE, ENE	2.5	47.9
APRIL	16.7	7.6	11.8	80	NE, SSE	2.0	48.1
MAY	21.4	12.4	16.6	85	NE, SSW	2.0	24.3
JUNE	25.8	15.0	20.3	83	NE	1.6	30.8
JULY	29.0	19.0	23.9	84	NE	2.7	2.8
AUGUST	30.0	19.1	24.3	80	NE, ENE	1.3	0.0
SEPTEMBER	25.8	15.9	20.3	82	NE, WSW	1.7	41.6
OCTOBER	20.9	12.7	16.1	87	NE, NW, ENE	2.0	44.3
NOVEMBER	15.8	7.7	11.3	84	SE, SSE, NE	1.7	43.0
DECEMBER	11.6	5.4	8.6	83	SSW, SW, NE	3.4	98.7

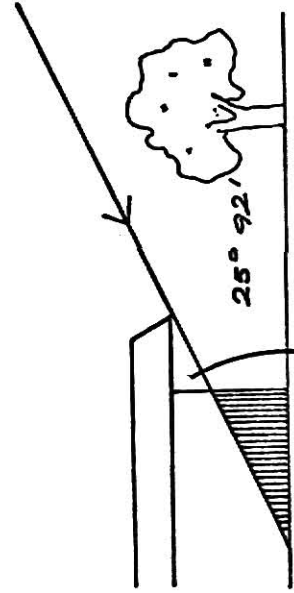
EXPLANATION OF PLATE III

Critical Solar Angles in Göztepe, Istanbul, Turkey

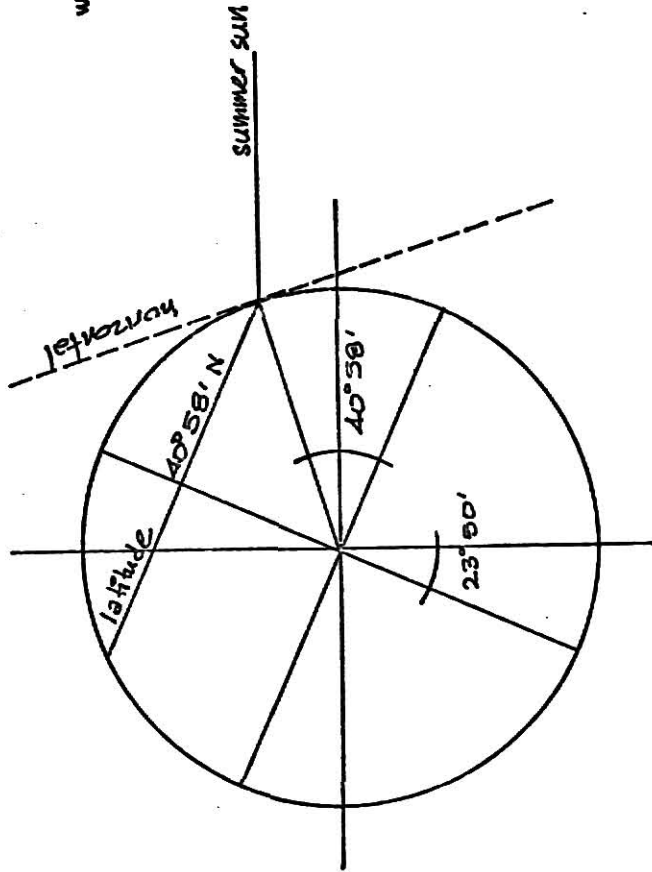
winter



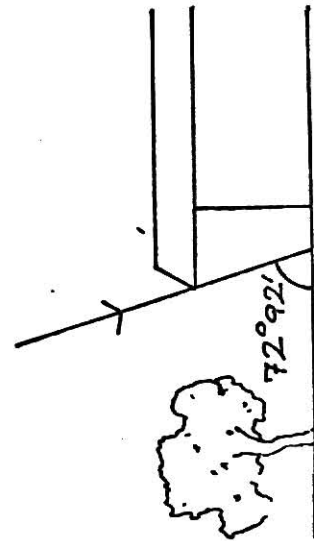
critical solar angle : $90^\circ - 40^\circ 58' - 23^\circ 50' = 25^\circ 92'$



summer



critical solar angle : $90^\circ - 40^\circ 58' + 23^\circ 50' = 72^\circ 92'$



critical solar angles in Göztepe - Istanbul, Turkey
latitude : $40^\circ 58'$ North
height from sea level : 39 m.

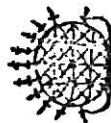
EXPLANATION OF PLATE IV

Major Health Institutions of Istanbul

ISTANBUL

PLATE IV

DEPARTMENT OF PUBLIC RELATIONS
MINISTRY OF TOURISM AND INFORMATION
ANKARA - TURKEY



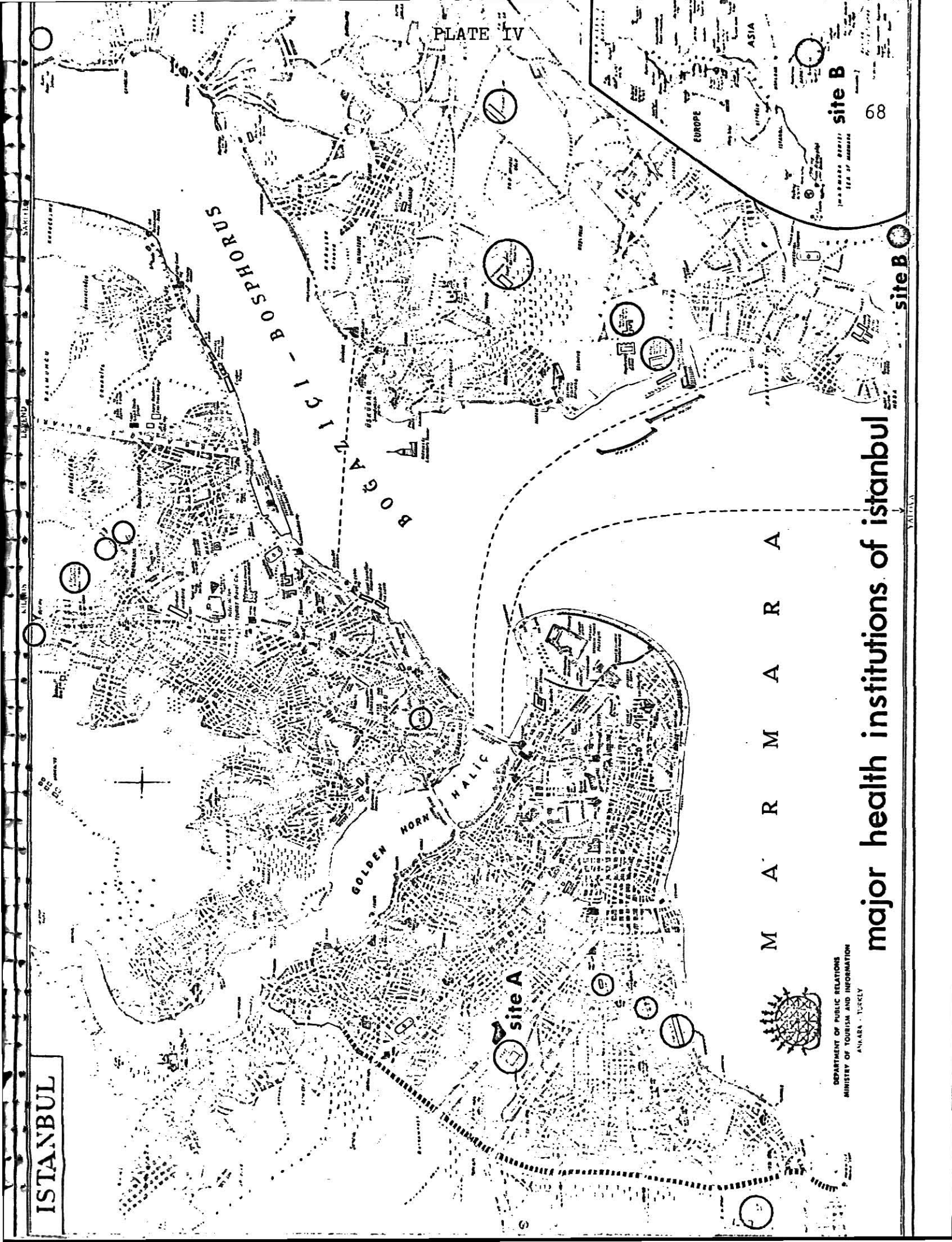
M A R M A R A

major health institutions of istanbul

site B

68

site B



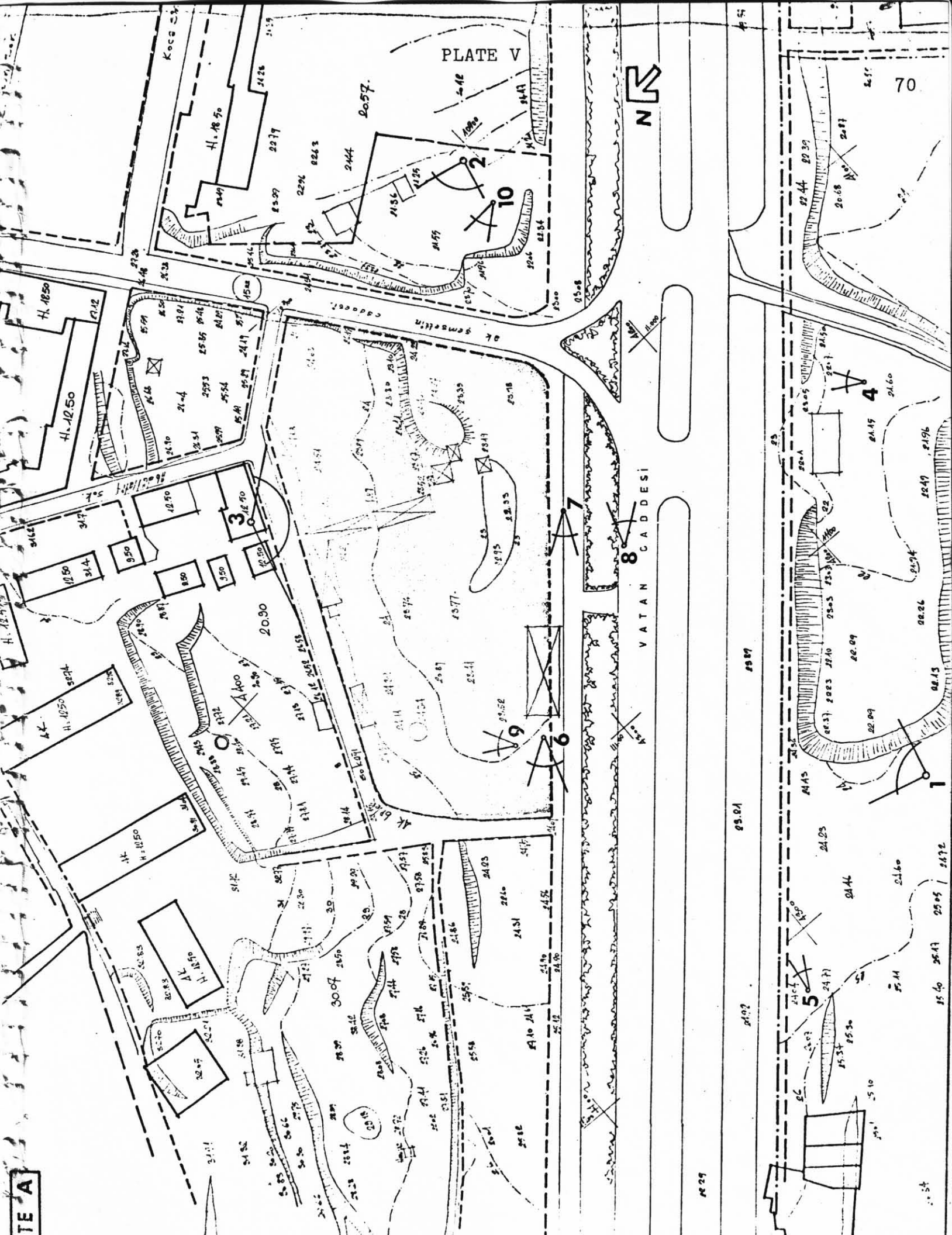
EXPLANATION OF PLATE V

The Location and the Plan of the Site A

ILLEGIBLE

**THE FOLLOWING
DOCUMENT (S) IS
ILLEGIBLE DUE
TO THE
PRINTING ON
THE ORIGINAL
BEING CUT OFF**

ILLEGIBLE

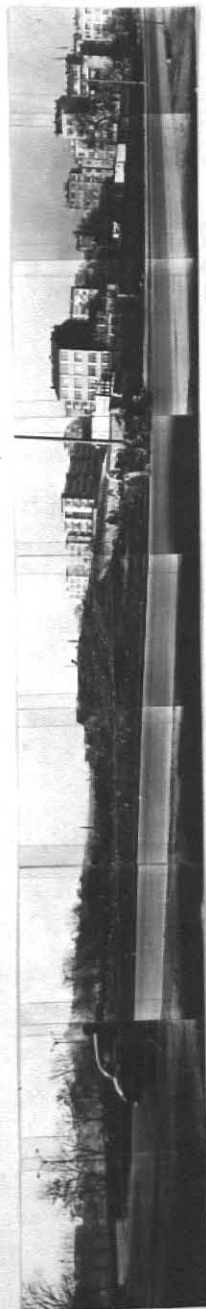


EXPLANATION OF PLATE VI

Different Views of Site A

**THIS BOOK
CONTAINS
NUMEROUS
PICTURES THAT
ARE ATTACHED
TO DOCUMENTS
CROOKED.**

**THIS IS AS
RECEIVED FROM
CUSTOMER.**



panoramic view 2



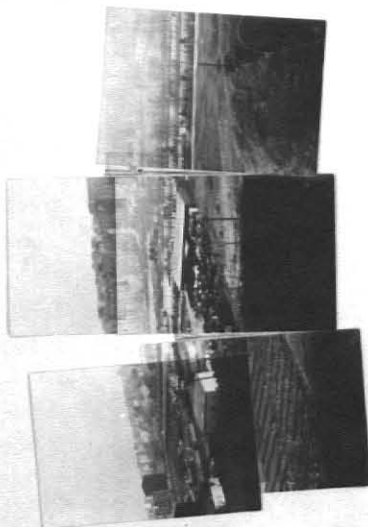
view 4



view 6



view 8



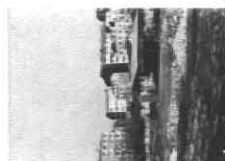
panoramic view 3



view 5



view 7



view 9

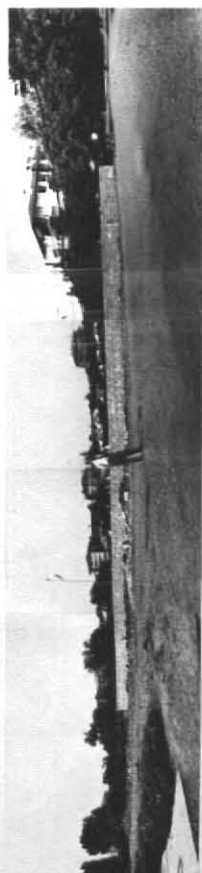


panoramic view 1

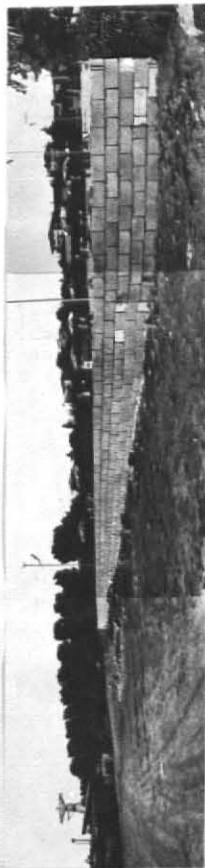
different views of SITE A

EXPLANATION OF PLATE VII

Different Views of Site B



view from southwest



view from south



view from west



view from east



view from east



public park and gardens

different views of site B

b. PROJECT CONTENT:

Elements of the physical facilities, the kind and the quantity of spaces they require, and their relationships, are all determined by the human and non-human activities, human scale and the sizes of furniture and equipment.

1. TOTAL AREAS:

*AREAS FOR BUILDINGS.....

- Administration, Staff Cafeteria.....
- Staff living areas and child guidance center.....
- Day school and training center.....
- Residential Cottages.....
- Sheltered Workshops (future development).....
- Youth Social Club (future development).....

*AREAS FOR OUTDOOR CHILDREN ACTIVITY.....

*AREAS FOR PEDESTRIANS (FOOTPATHS).....

*GRASS AREAS.....

*AREAS FOR PARKING AND ROADS.....

2. ELEMENTS OF THE PHYSICAL FACILITIES-AN ARCHITECTURAL RESPONSE

*MAIN PARKING AREA

*ADMINISTRATION

- Entrance hall and lobby*
- Receptionist's room
- Business Office-Accounting
- Records room
- Personnel office
- Center director's room
- Secretary to the director
- Conference and meeting room
- Public toilets
- Staff Cafeteria
- Kitchen**
- Staff toilets
- Staff lounge and library
- Residential Unit for aides (male)
- Residential Unit for aides (female)
- Volunteers' Room
- Student Trainees' Room
- Nurses' Room
- Staff toilets and showers
- Circulation areas

*CHILD GUIDANCE CENTER

- Entrance Lobby, waiting and secretary
- Psychiatrist's Room
- Psychologist's Room
- Occupational therapy room
- Group therapy room
- Individual therapy rooms (2)
- Physiotherapist's room
- Social Worker's rooms (2)
- Children's toilets
- Speech therapist's room
- Speech and hearing testing unit
- Circulation areas
- Central Heating Unit
- Storage areas

- * including waiting and display areas
- ** including storage

*DAY SCHOOL AND TRAINING CENTER

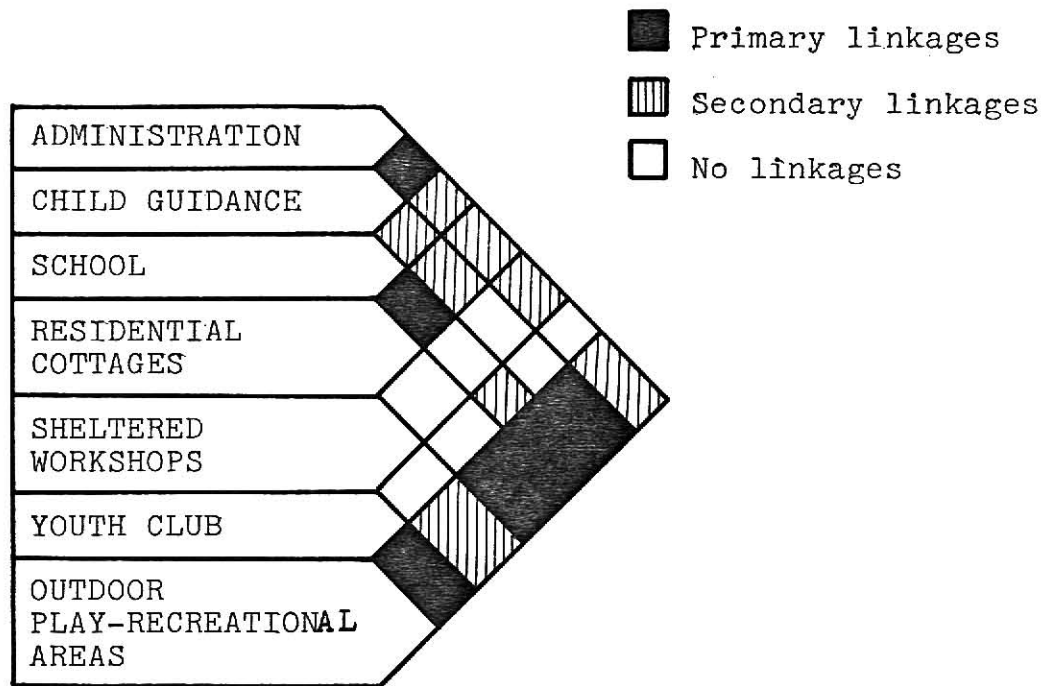
- Parking area
- Entrance hall and lobby*
- Supervisor's Room
- Staff toilets
- Staff lounge
- Library
- Practical Room
- Toilets for children
- Showers and cloak rooms for children
- Kitchen
- Multi-purpose hall
- Paddling and swimming pool
- Classrooms
- Toilets for nursery classes
- Storages
- Circulation areas

*RESIDENTIAL COTTAGES

- Lounge and playroom
- Dining area
- Kitchen
- Houseparents' apartment
- Linen and ironing room
- Laundry room
- Toilets and bathrooms for children
- Single bedrooms
- Double bedrooms
- 3-bedroom
- 4-bedroom
- Circulation areas

* including waiting areas

3. DEPARTMENTAL LINKAGES:



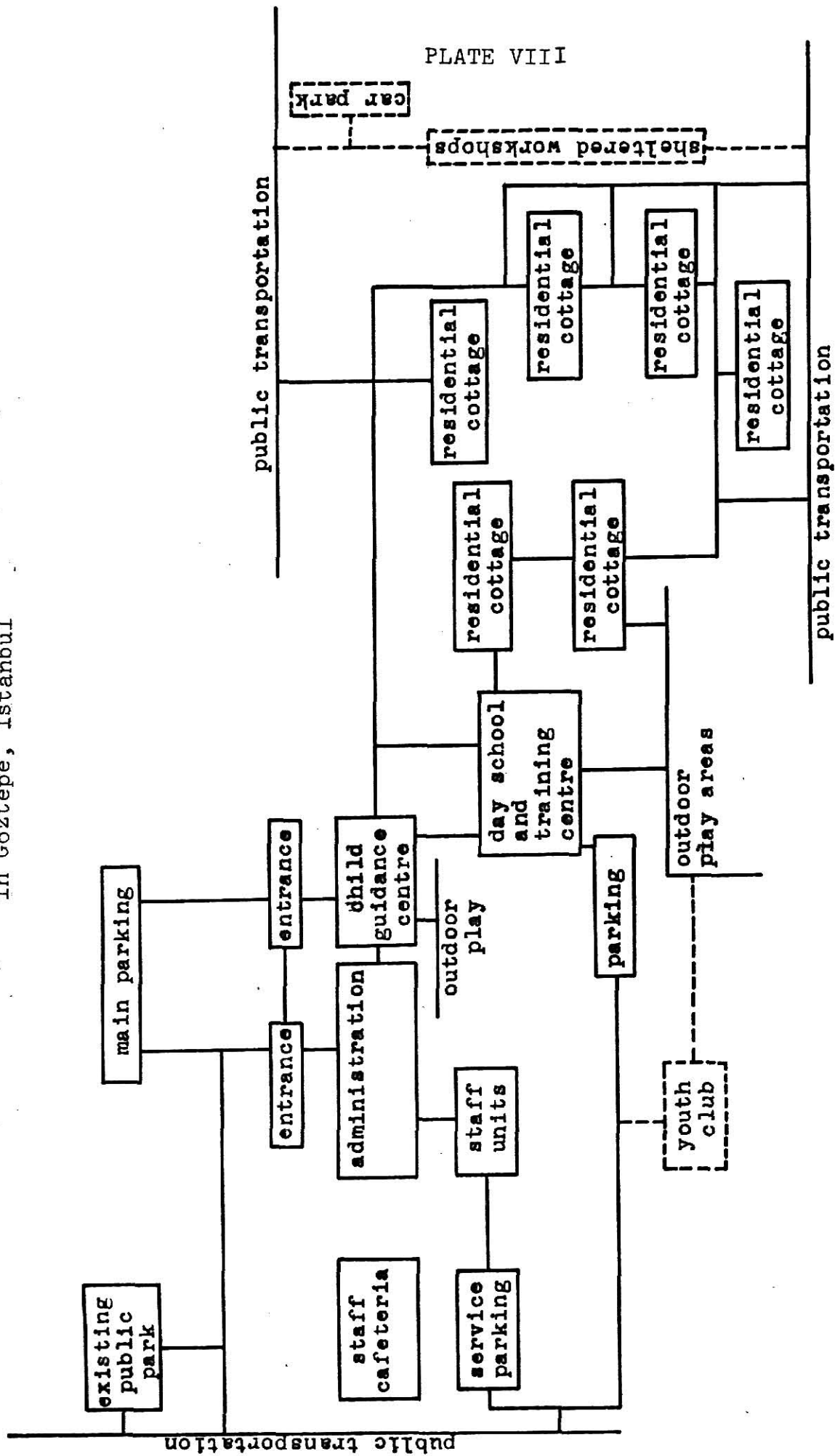
4. FUNCTIONAL SPACE RELATIONSHIPS:

Functional relationships between required spaces are considered, with regard to indoor and outdoor traffic flow of children, staff and public:

EXPLANATION OF PLATE VIII

Functional Space Relationships of a
Psychiatric Center for Children in
Göztepe, Istanbul

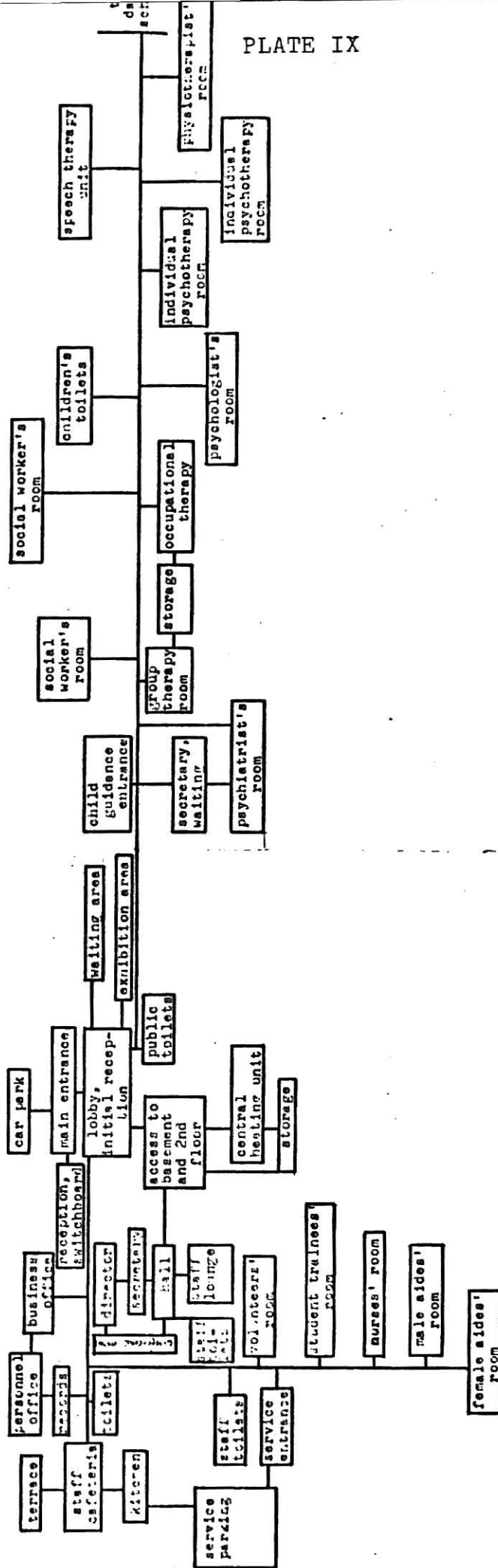
Functional Space Relationships of a Psychiatric Center for Children in Göztepe, Istanbul



EXPLANATION OF PLATE IX

Functional Space Relationships of
Administration - Cafeteria - Staff Units
Child Guidance Center

administration - cafeteria - staff units and child guidance centre.



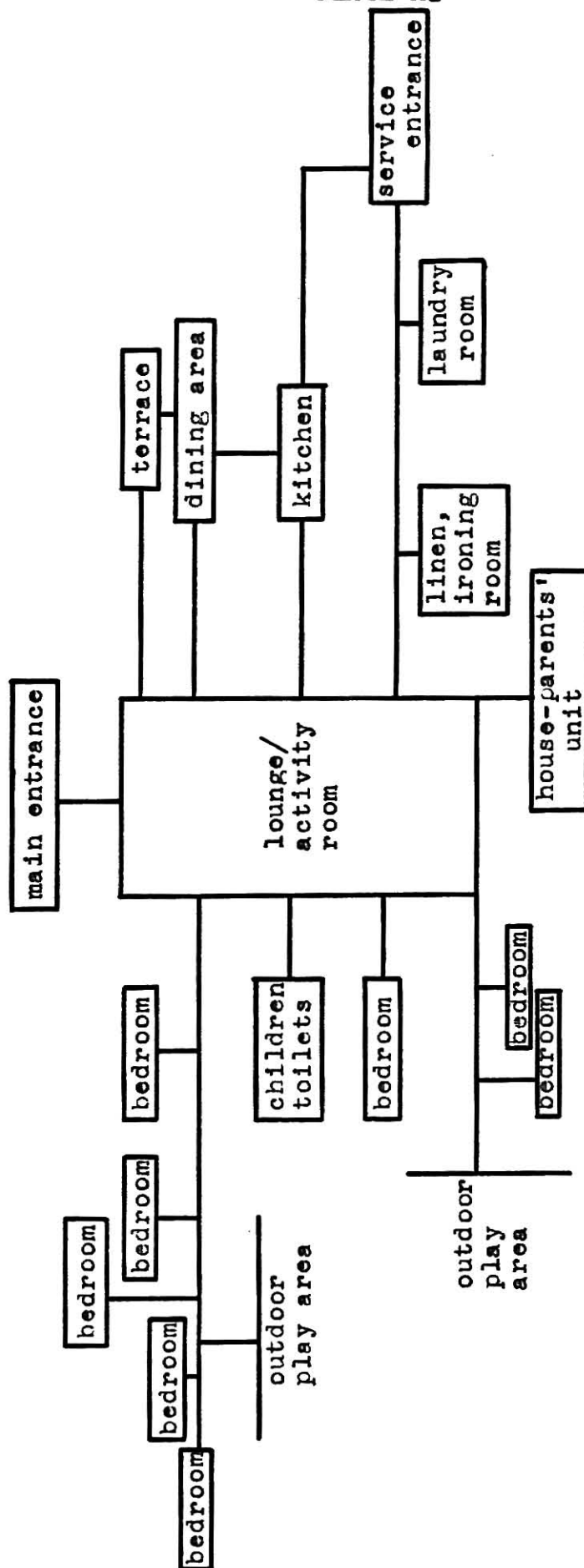
EXPLANATION OF PLATE X

Functional Space Relationships of
Day School and Training Center

[illegible]

residential cottages

PLATE XI

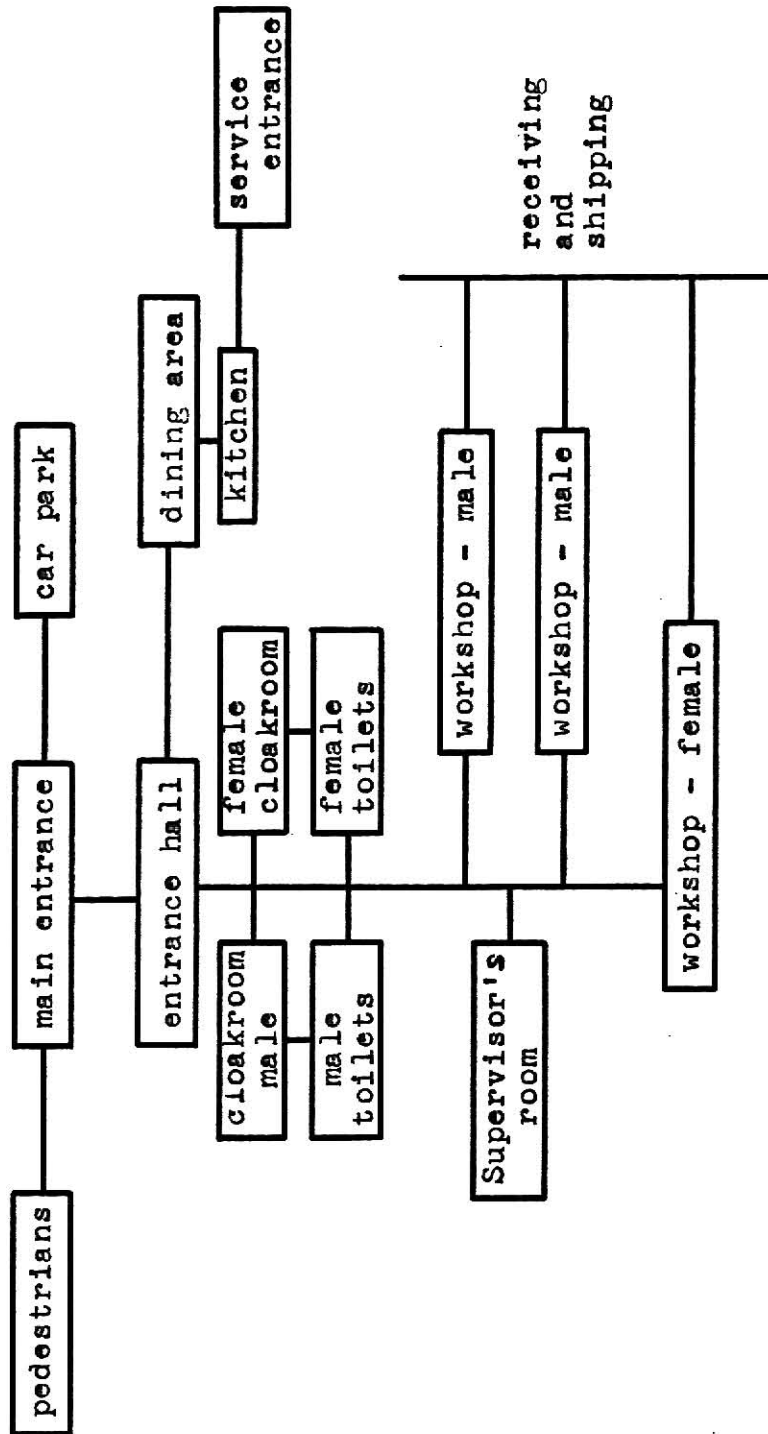


EXPLANATION OF PLATE XII

Proposed Functional Space Relationships of
Sheltered Workshops

sheltered workshops

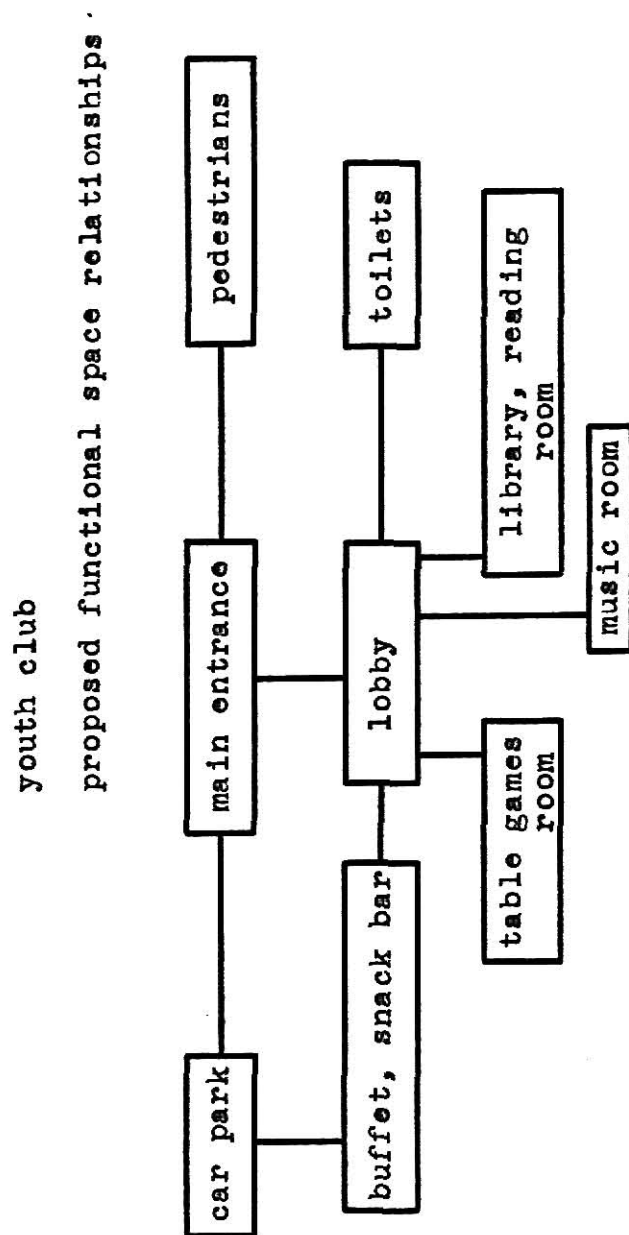
proposed functional space relationships:



EXPLANATION OF PLATE XIII

Proposed Functional Space Relationships of
Youth Club

PLATE XIII



5. ELEMENTS OF THE PHYSICAL FACILITIES IN DETAIL:

* MAIN PARKING:

The average ratio of cars to population in Turkey is one car for 20 persons or five families. Considering this data, a parking area for 60 cars is provided. The parking lot is located in front of the administration building, close to the main entrance, screened by existing trees. In locating the car park, particular consideration was given to the existing trees and public park.

* ADMINISTRATION:

The administrative services are provided here.

• Entrance hall, lobby includes waiting and exhibit areas where the graphic work of the children can be displayed. Maximum flexibility is provided in the exhibit area by means of portable dividers. The waiting area has access to the terrace which is protected from sun by canopies. The initial reception and information desk are close to the main entrance.

• Administrative offices are provided with maximum flexibility by portable separators, for different needs in the future.

• Center Director's room is located in the second floor, providing a more quiet environment for him. The same design approach is applied for the conference room, staff lounge and library.

•Staff cafeteria should have a convenient location for the majority of its users. Outdoor dining facilities and view to the public park are also provided.

•Kitchen has its own service access for the food loading. Staff toilets and washing facilities are designed close to the cafeteria.

•Residential units for aides consist of lockers, toilets and showers. Facilities for changing clothes and cleaning are provided for the volunteers', student trainees' and nurses' rooms. They can also be occupied during the break hours.

* CHILD GUIDANCE CENTER:

•A separate entrance is provided for the Child Guidance Center. It is close to the parking lot and to the waiting room. The creation of a corridor atmosphere is avoided. Indoor and outdoor play areas for children are provided. Each professional and member of the child guidance team has his own room.

•Social workers' rooms are located close to the entrance to provide easy access by the public.

•Psychiatrist's and psychologist's room have the necessary furniture for interviews and play tools and shelves for toys. Also, observation possibility in the group and occupation therapy rooms are provided.

•Both group and individual therapy rooms have access to outdoor play areas, wash basins, sinks and furniture. Group and occupational therapy rooms are provided with portable individual cells for children, storages and flexible arrangements. Play

therapy rooms are protected from the N.E. wind.

- Children's toilets are designed with sufficient dimensions considering the physically handicapped children.

- Speech therapy unit is located at the SW end of the block, far from noise.

- General storage and central heating unit are located in the basement, mostly because of the economical reasons.

* SCHOOL AND TRAINING CENTER:

- A direct road and parking area are provided to serve children who will come by coach or minibus, and for public who attend the community related activities.

- Entrance hall and lobby is the joint point of NE and SW entrances. The NE entrance is for out-patient children and the SW entrance is for in-patient children. Waiting and display areas are provided in the hall.

- The Supervisor can observe both entrances and outside from his room. An interview room is also provided for him.

- Staff toilets serve the special teachers, student trainees, and aides.

- The staff lounge is located in a quiet part of the building. It is also a place for informal staff discussions and for drinking beverages.

- Library is planned to serve both the students and the community, particularly parents. It will be possible to check out books related to children's mental health.

•In nursery classes there are no desks. Direct access to outside play areas is required. For the advanced nursery class, movable partitions and chalkboards can be provided, in addition to toys and play equipment.

•Elementary school classes are provided with desks, wash basins and storage facilities.

•Practical rooms are provided for the children who do not have desire and intellectual ability in other class. They have the chance to develop their motor skills and to do practical work. Practical room has direct access to the outdoor areas. Sinks, small house kitchen set-up, cookers, work benches, tool storage and timber store are provided.

•Toilets include mirrors and wash basins. In nursery classes wash basins and mirrors are in the classroom, with space divisions. Approximately 12 children should have their own bathrooms and toilet facilities.

•Cloakrooms are close to the entrances and to classrooms. For the elementary school children, pegs and benches are provided. Nursery classes hang their coats within the entrance to their classrooms.

•Buffet type of facilities are provided in the kitchen. In bad weather conditions, children can have their mid-day meal in the school. It also offers a buffet food service for the special meetings.

•Multipurpose hall is used for physical education, rhythm and movement classes, music, dancing, ballgames, team games,

teacher/parent meetings, group film and displays, and school assemblies. It requires 3.60 meters minimum ceiling height. A storage adjacent to the hall and portable platform/stage are also proposed. The hall is located conveniently for the public access. The storage may serves as a resource and Institutional Aid Center, consisting of portable teaching materials, equipment, films, books, science equipment, display boards and panels, records, tapes, puppet theater, and so on.

•Swimming pool is utilized for the purposes of waterplay, paddling and swimming by children.

* RESIDENTIAL COTTAGES:

In designing the cottage, the principle of "planning as home-like as possible" plays the most important role.

•Lounge and playroom is designed flexible to allow various activities at the same time. Different spaces for hobbies, painting, drawing, for play games, and for quiet activities, like listening to music, radio, looking at pictures, are designed. The lounge has easy accesses to the outside, and has a fire place. Pet-keeping, gardening, because of their therapeutic values, are allowed.

•Dining area is adjacent to the kitchen and is provided with outdoor dining facilities.

•Kitchen is designed as a home kitchen and is a place for the training of older girls and boys in housework.

•Houseparents can work at other places during the day, but

after the end of the day school, they take care of the children, especially during the night. Cooking, bathroom, bedroom and living room facilities are provided for houseparents.

- The clean and soiled linen are stored in the linen room. It can also be utilized for training some children in the use of the ironing board.

- Laundry room can also be used for training some children in the use of laundry equipment besides for washing small items.

- Toilets and bathroom are provided for children. Until the age of nine, boys and girls are allowed to use the same bathroom facilities. The bathroom tubs are elevated for the convenience of the attendants.

- In the bedrooms each child has his own corner, locker and own identity. Each room has wash basins. Single bedrooms are generally used for noisy children.

- Outdoor play areas are important in the development of the children's tactile awareness, motor planning, body balance, body awareness, depth perception, spatial relationships, laterality and kinesthetic awareness. They are protected from the strong wind and include pools for paddling, water play and swimming, areas for sand play, sand trays, climbing frames, swings, merry-go-round, jungle gym, tree trunks, large diameter pipes, blocks and similar creative play equipment.

FOOTNOTES

1. Kevin Lynch, Site Planning, (Cambridge, Mass.: The M.I.T. Press, 1962), p. 72.
2. Istanbul Belediyesi İmar Talimatnamesi, 1970, (Istanbul: Belediye Basimevi, 1970), p. 12, in Turkish.
3. T.C. Tarım Bakanlığı, Devlet Meteoroloji İşleri Umum Müdürlüğü, Yıllık Meteoroloji Bülteni, 1967, (Ankara: Basbakanlık Basimevi, 1969), in Turkish.

VII. ARCHITECTURAL DESIGN CONSIDERATIONS

a. LANDSCAPE DESIGN:

The creation of a family-like atmosphere is considered both in designing the indoor and outdoor spaces and in suggesting finishes for the interiors.

The existing public park, which is at the East corner of the site, and the vegetable gardens are not removed. They are to be integrated into the program with their therapeutic value and visual image. Public park and playground can be used by the community, children, staff and visitors of the center, and provide a desirable view to the cafeteria. Each cottage has its own small flower garden. Children can plant their own flowers in these small gardens and in the existing vegetable and flower garden. A green house is also suggested for the future. The existing small forest at the NW of the site can be used for picnics and has therapeutic value with its visual image. The existing and proposed trees are designed to serve three main purposes¹: (1) As physical boundaries: They are used as borderlines between grass and paved surfaces, playgrounds and footpaths, parking lots and sidewalks. (2) As visual screens: These are higher trees at eye level and used for screening undesirable views, such as asphalt surfaces, parking areas, gasoline stations, and transportation lines with heavy traffic. They can also be used as barriers against traffic noise and prevailing wind. (3) To provide shady areas:

They are used for shadowing building facades and exterior spaces like footpaths, people's places, benches and playgrounds. They are usually higher trees than those in the previous two groups. By nature of their very expanse, panoramic views, they lose their appeal more quickly than confined views which have the promise of more beyond the edge of their framing features. This difficulty is overcome by grouping planting to frame a series of confined views.²

In relating the designed buildings to their setting, our main approach is non-interference with topography. In other words, the buildings are designed so that they are located on the land in a way which does not disturb natural configuration. The undesirable possibility of air pollution by industrial smoke is eliminated by selecting a site in a residential area. The administration building is located relatively far from the main transportation road, (Bagdad Avenue) to avoid the traffic noise and smells. The school building is located relatively far from the SE boundary of the site to avoid disturbance of the neighborhood by the noise of school children. A satisfactory interrelationship of architecture and landscape is achieved in various ways: (1) By relating buildings to the views, like facing the cafeteria to the park, and residential cottages to the panoramic sea views. (2) Extending and repeating an outdoor treatment inside the buildings, like the water fountain and plants in the main lobby of the administration, planting in the entrance hall of the day school. (3) By designing

buildings in such forms so that the landscape seems to flow into the building, like the design of the classroom wings of the day school. The classrooms and hallways are surrounded by landscape and outdoor environment to provide a continuous relationship between landscape and architecture, between interior and outdoor spaces in the minds of the users of the buildings.

Footpaths are designed in a way following routes through the grounds which are independent of other traffic. People take the shortest visible route ahead unless their attention is distracted by some feature of special interest. Special consideration is given to plan footpaths logically so that pedestrians willingly follow them. Long, covered walkways between buildings are not designed to avoid an institutional feeling and to provide a situation as normal as possible.

The regular watering of plants is suggested in an economical way, by means of irrigation systems built in during construction. For trees in hard surfaced areas, underground irrigation systems, and for beds and plant boxes, overhead, fixed spray watering systems are suggested. Specialist advice should also be sought.

b. INTERIOR SPACES:

In the child guidance center a corridor effect is avoided by providing low cupboards and transparent separators. The hallways in the school building are designed to allow natural

light which can also eliminate the corridor effect. Activity rooms, like play and occupational therapy rooms in the Child Guidance Center, and pre-school classrooms in the school, are with movable partitions and individual booths for children to allow both privacy and communality, individual and group activity, and the changing needs of the teaching and training programs.

All educational, training and play activity, dining areas are provided with direct access to the outside on sunny days. The removal of the windows is also suggested for providing shady play areas under good weather. Classrooms have chalkboards and screens for showing films. Sharp corners are avoided in designing hallways in the day school. In the child guidance building and day school breaks in corridor walls are designed to give light. They can also be used for personal and group spaces, plants and so on. The corridors and hallways with opening doors in equal distances are avoided.

Special consideration is given in relating buildings to Turkish tradition. The staff cafeteria is designed in traditional Turkish T-shape plan of the old houses. The roofs of the administration building, classrooms and residential cottages are designed in relation to the pitched roofed residences of the neighborhood. A unity in the architectural characteristics of the administration, school and residential cottages is provided.

c. STRUCTURAL SYSTEM:

Although the functional character of the program requires single story buildings, a reinforced concrete frame system is applied, considering the earthquake characteristics of Istanbul. Reinforced concrete is preferred to steel construction due to the steel industry in Turkey. The availability of labor in reinforced concrete construction is also considered. Special effort is made to design a simple and clean structural system, and to show it in the elevations. Folded concrete spans are used in the multipurpose hall and swimming pool areas allowing high ceiling and large openings in NE-SW direction.

The components of the structural system, e.g. flat floor slabs, columns, beams and ribs are integrated into the modular system. In a modular coordination system distances between axes are related to the building elements: supports, walls, floors, ceilings, trusses, rafters, roof covering, windows and doors. The fixing of a module for the axes-distance provides the basis for the standardization of the building elements and their perfect fitting and assembly. Serial production and availability of the standardized building elements and furniture result in savings in labor, materials and time. It also simplifies supervision.

d. ENVIRONMENTAL CONTROL SYSTEMS:

1. HEATING:

Buildings require constant space heating and are therefore centrally heated. The central heating plant is located in the basement floor of the administration block. A caretaker is responsible for the heating installation and is employed part-time only. A fuel-fired boiler is the commonest type of installation in Turkey. Wall and floor surfaces should be reasonably warm since many children are likely to lean against walls and particularly to sit on floors. Heat distribution in Turkey is most commonly provided by means of a low-pressure hot water system with radiators of convector type blowing warm air into the room at selected points. Normal hot water radiators, which are traditionally used, are not particularly to be suggested since there is the risk of children burning themselves.

2. HOT AND COLD WATER SERVICES - PLUMBING AND FITTINGS:

Toilets are provided with plumbing walls which allow repairing. A thermostatically controlled mixing valve in showers can avoid accidents. Each residential cottage has a washing machine with dryer, and ironing facilities. Linen stores are used for spare clothing, both top clothes and underclothes, as well as sheets, blankets, cases, towels and bed linen.

3. VENTILATION:

Natural ventilation is provided with regard to the economy and "normality" to simulate small-scale home conditions. In giving this design decision, the building technology in Turkey is also considered. Artificial ventilation may be needed in toilet areas, kitchens and laundry rooms as an auxiliary to natural ventilation.

4. LIGHTING:

* NATURAL LIGHT:

It is mostly used in design. Special consideration is given in designing windows which are domestic in scale and feeling, and give an effect of normality. Flexibility in ventilation is considered in the subdivision of windows. In the elevations facing Southwest sun control elements and wider canopies are provided. Skylights are designed for giving natural light to the central corridor in the Child Guidance Center, to the toilets, showers, locker rooms and classrooms in the school. It is suggested to utilize these skylights for natural ventilation. The functional differences between the roof levels of the various parts of the buildings are also used for natural lighting.

An attractive, home-like effect is achieved by the use of curtains, especially in residential cottages. Blackout screening arrangements are provided for film display in the multipurpose

hall and meeting/conference room.

* ARTIFICIAL LIGHTING;

It is suggested that the artificial lighting should be as "natural as possible". Tungsten lighting is provided for the residential spaces such as bedrooms, lounges, dining rooms and even for classrooms and other dayrooms. A lower and softer level of illumination is needed for bedrooms and low illumination night lights are used in corridors and circulation areas. All fittings should be of a pattern which is easily maintained and renewed. Plastic lighting fittings are preferable to glass, especially for the rooms where ball games are likely to take place.

5. NOISE:

Acoustically treated ceilings are suggested in speech, play and occupational therapy, psychiatrist's, social worker's and psychologist's rooms, office areas. Suspended ceilings can also be used for hiding plumbing and pipes. The director's room, staff lounge, volunteers', nurses' and student trainees' rooms, speech therapy center are located in relatively quiet corners of the buildings.

6. FINISHES:

Their appearance and impression, cost, maintenance, variability, texture, thermal properties, fire and sound resistance are important.

FOOTNOTES

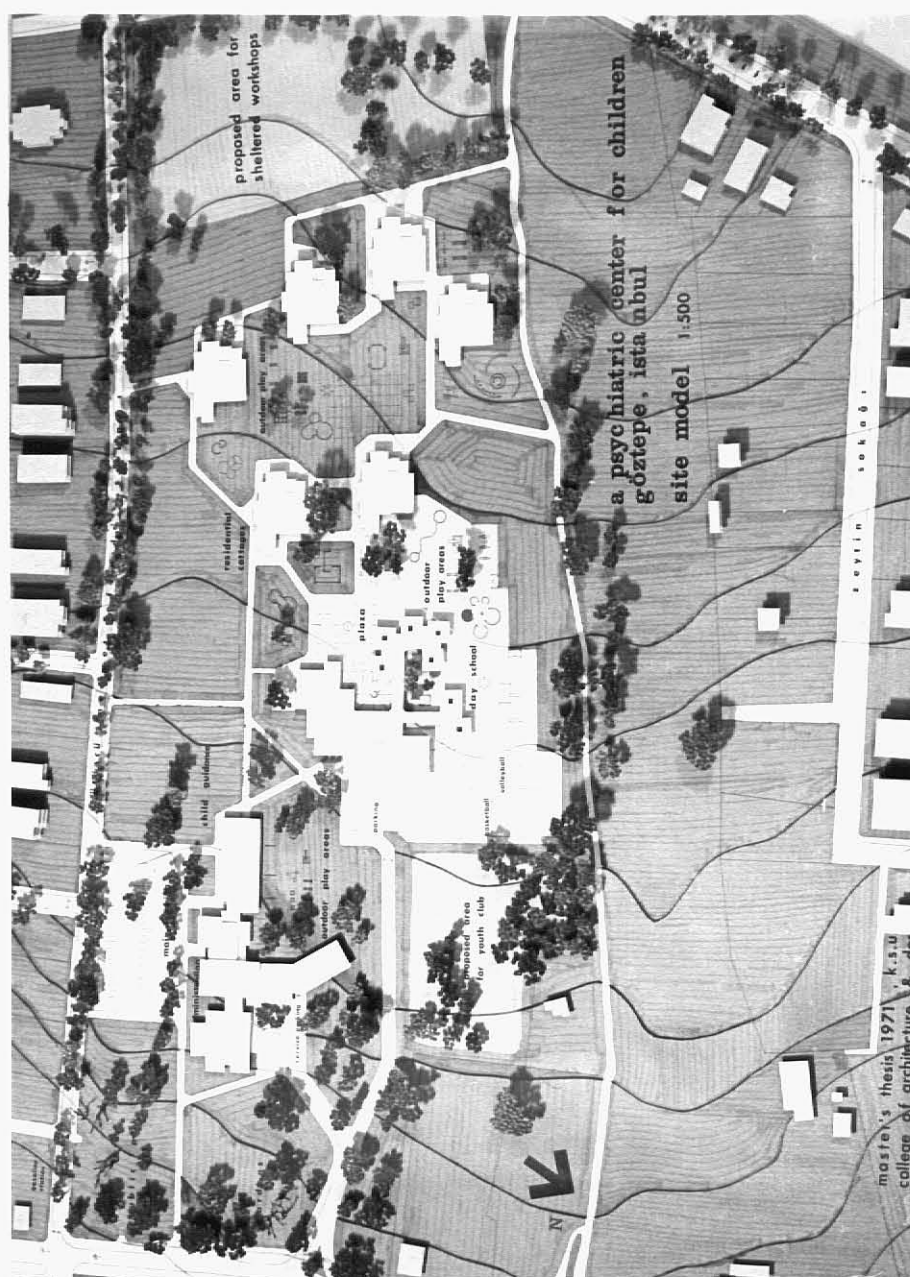
1. Opinion expressed by Professor Weisenburger during an informal discussion at Kansas State University, 1971.
2. Bodfan Gruffydd, Landscape Architecture for New Hospitals, (King Edward's Hospital Fund for London, 1967), p. 11.

VIII. GRAPHIC PRESENTATION

EXPLANATION OF PLATE XIV

Site Plan of a Psychiatric Center
for Children in Göztepe, Istanbul

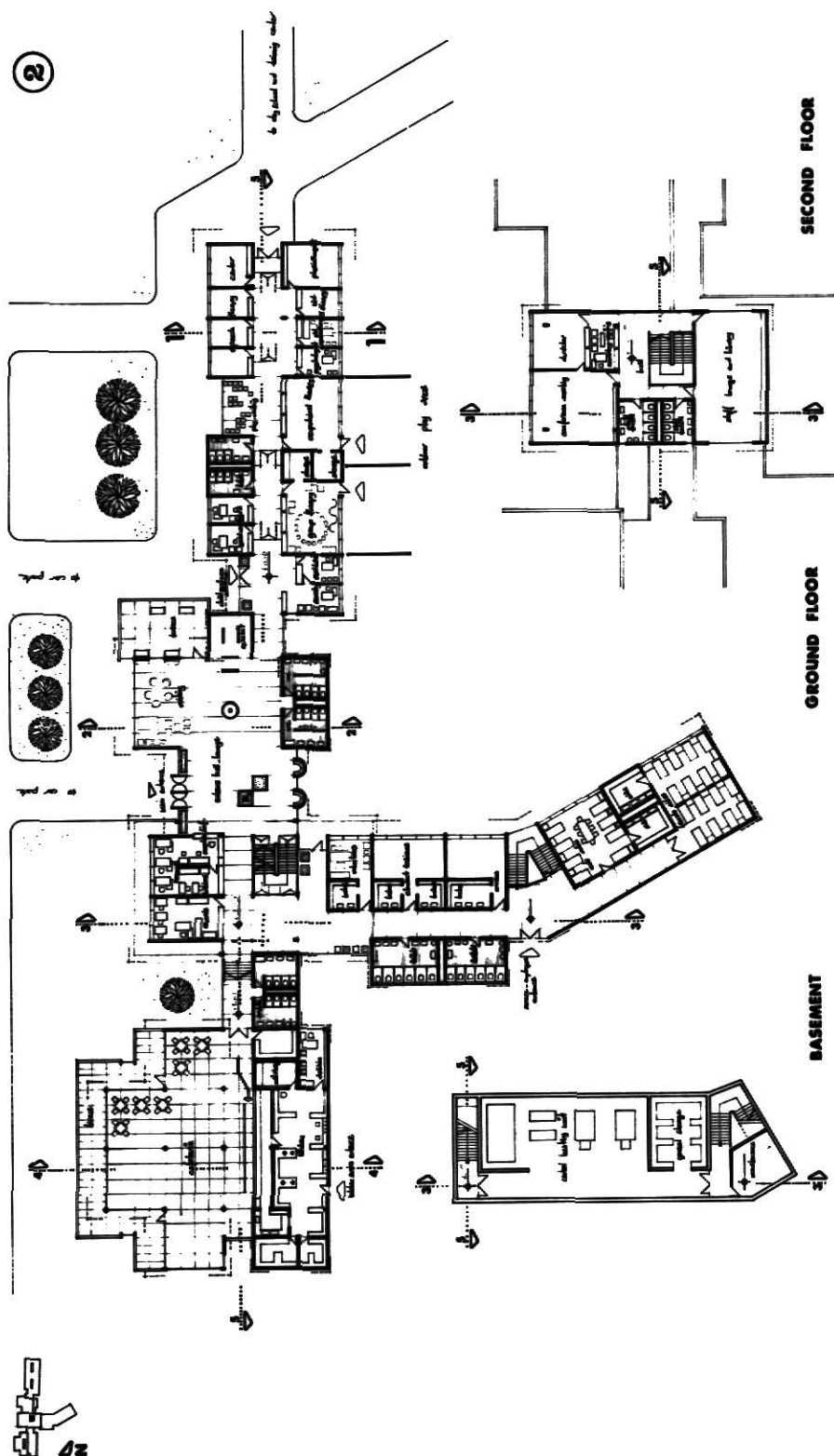
PLATE XIV



EXPLANATION OF PLATE XV

Plans of Administration

PLATE XV



ADMINISTRATION PLANS

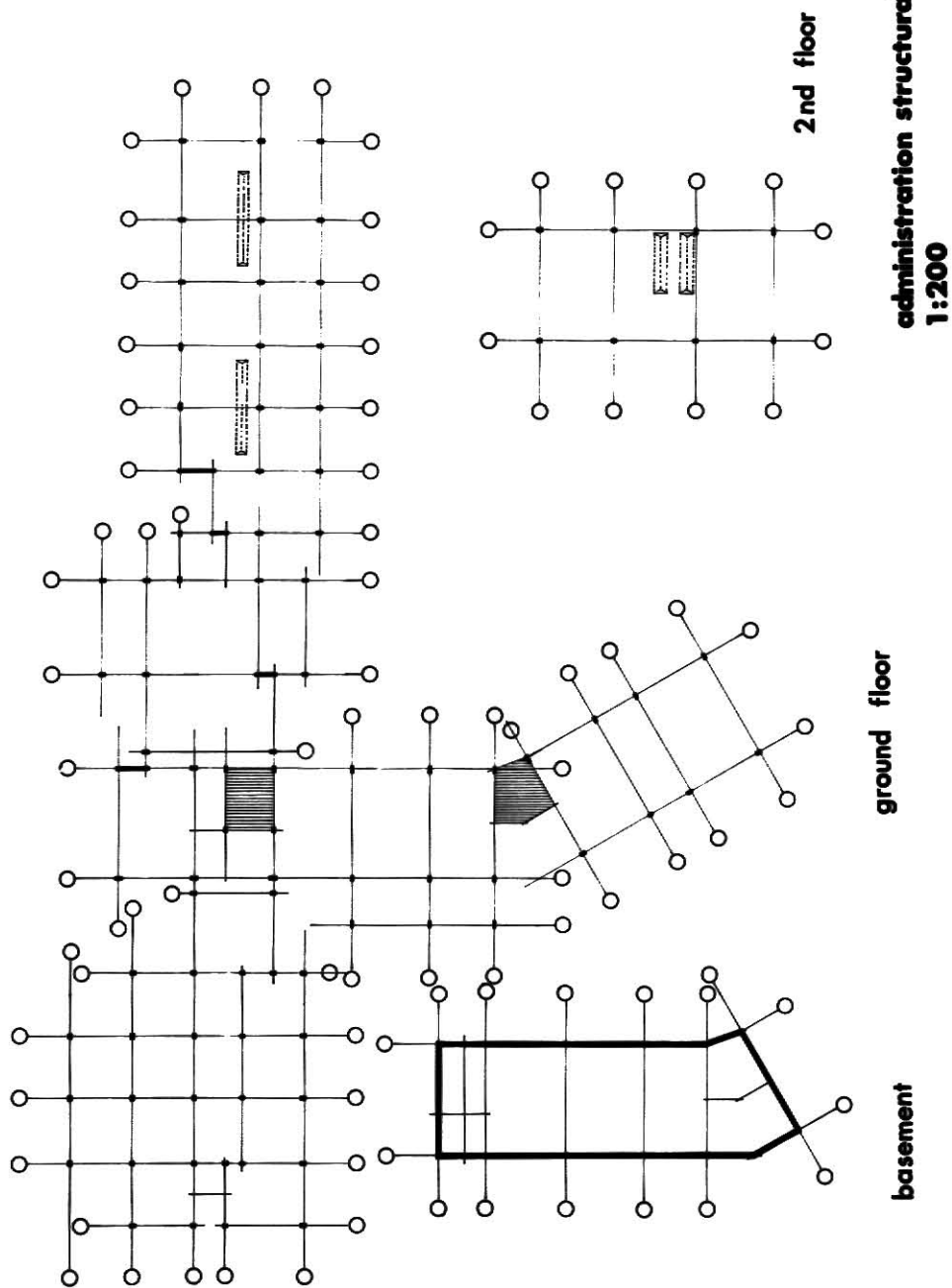
1:200

EXPLANATION OF PLATE XVI

Structural Plans of Administration

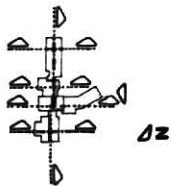
PLATE XVI

3

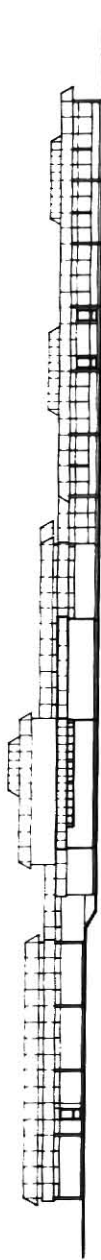


EXPLANATION OF PLATE XVII

Sections and N.W. Elevation of
Administration



4



NW ELEVATION

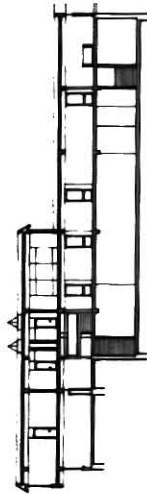
PLATE XVII



SECTION 1-1



2-2



3-3



4-4



SECTION 5-5

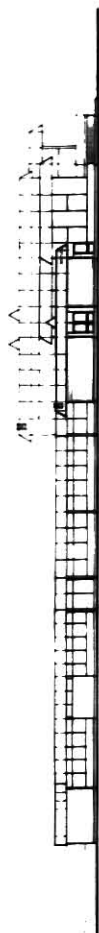
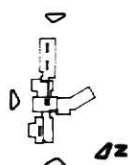
ADMINISTRATION
1:200

EXPLANATION OF PLATE XVIII

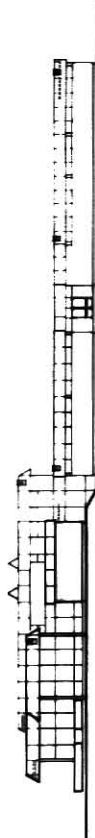
Elevations of Administration

PLATE XVIII

3



sw elevation



ne elevation



se elevation

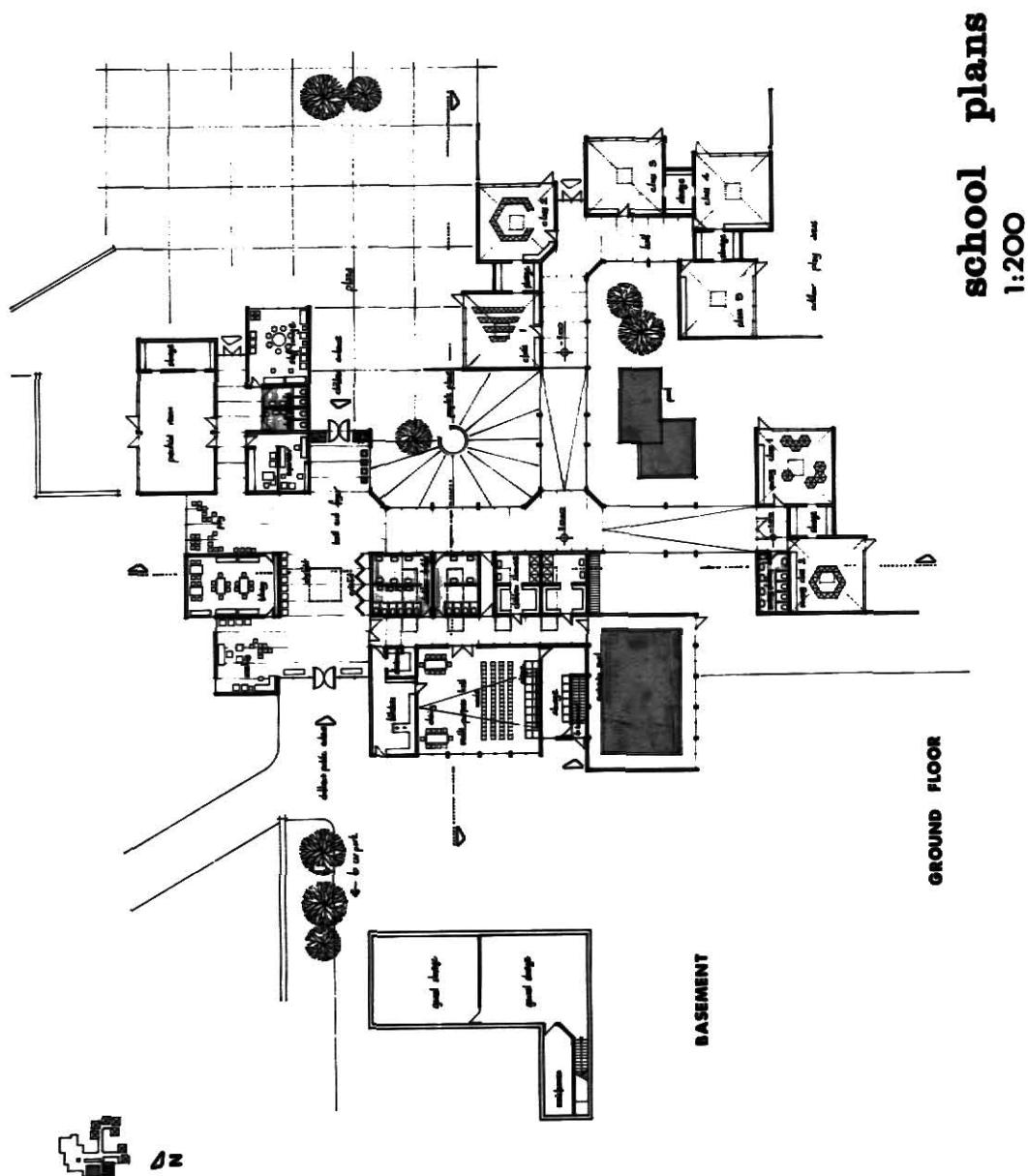
administration

EXPLANATION OF PLATE XIX

Plans of Day School and Training Center

PLATE XIX

②



EXPLANATION OF PLATE XX

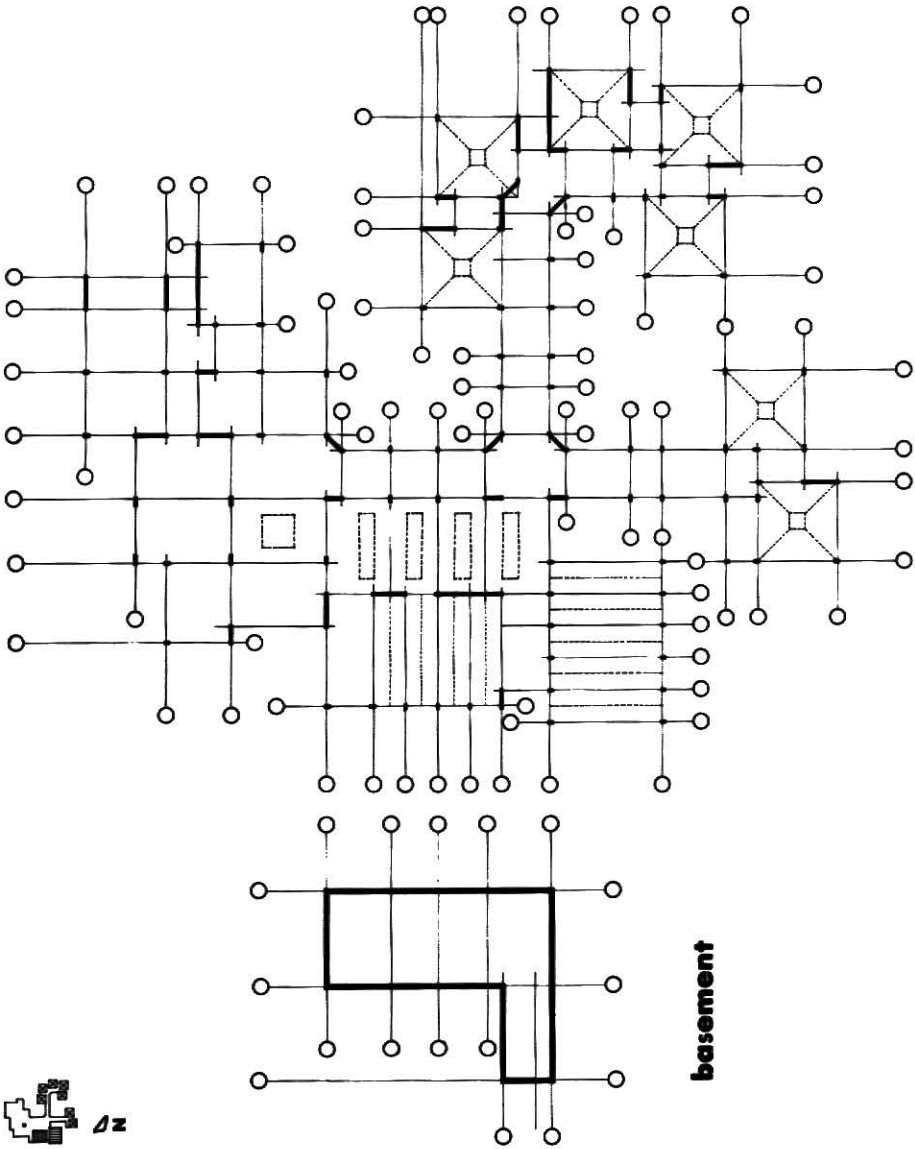
Structural Plans of Day School and
Training Center

PLATE XX

7

ground floor

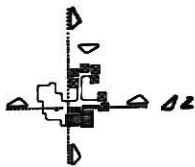
school structural plans
1:200



EXPLANATION OF PLATE XXI

Sections and S.W. Elevation of
Day School and Training Center

PLATE XXI



8



SW ELEVATION



SECTION 1-1



SECTION 2-2

school
1:200

EXPLANATION OF PLATE XXII

Elevations of Day School and
Training Center

PLATE XXII

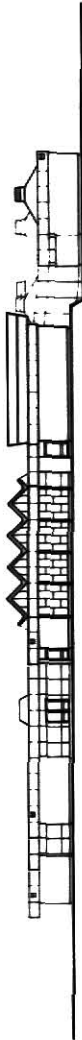
9



nw



se



ne

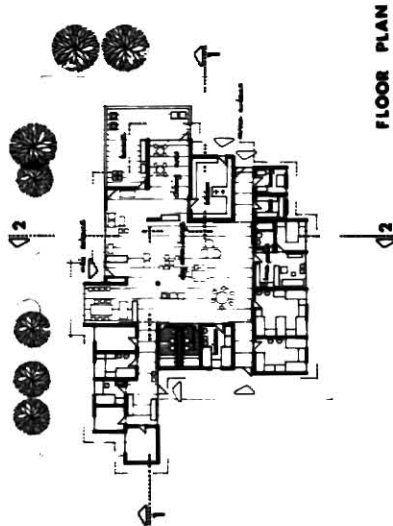
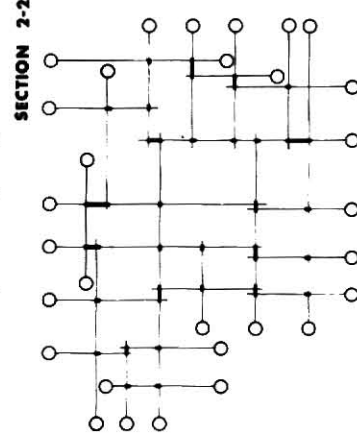
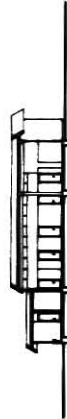
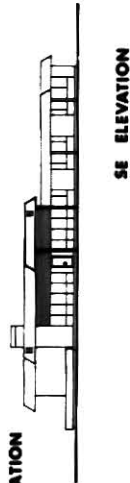
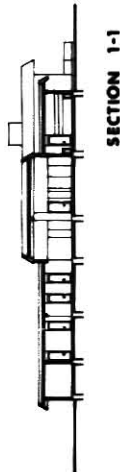
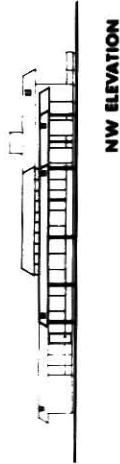
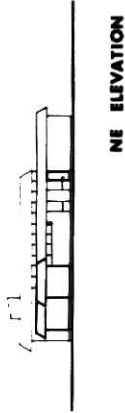
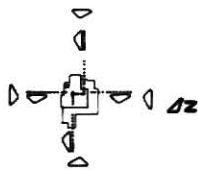
school elevations 1:200

EXPLANATION OF PLATE XXIII

Plans, Sections and Elevations of
a Residential Cottage

PLATE XXIII

10

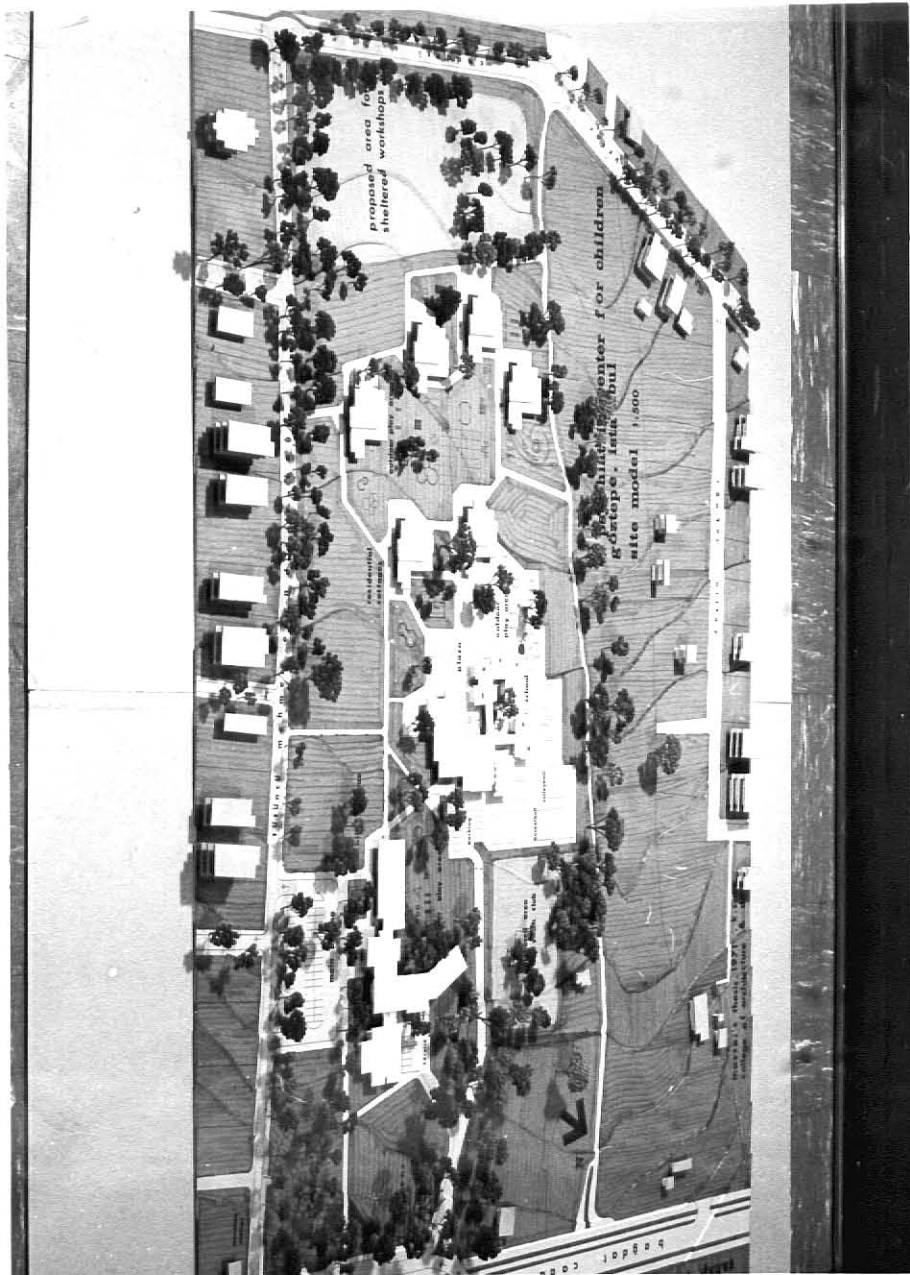


residential cottage
1:200

EXPLANATION OF PLATE XXIV

North-west view of the Center

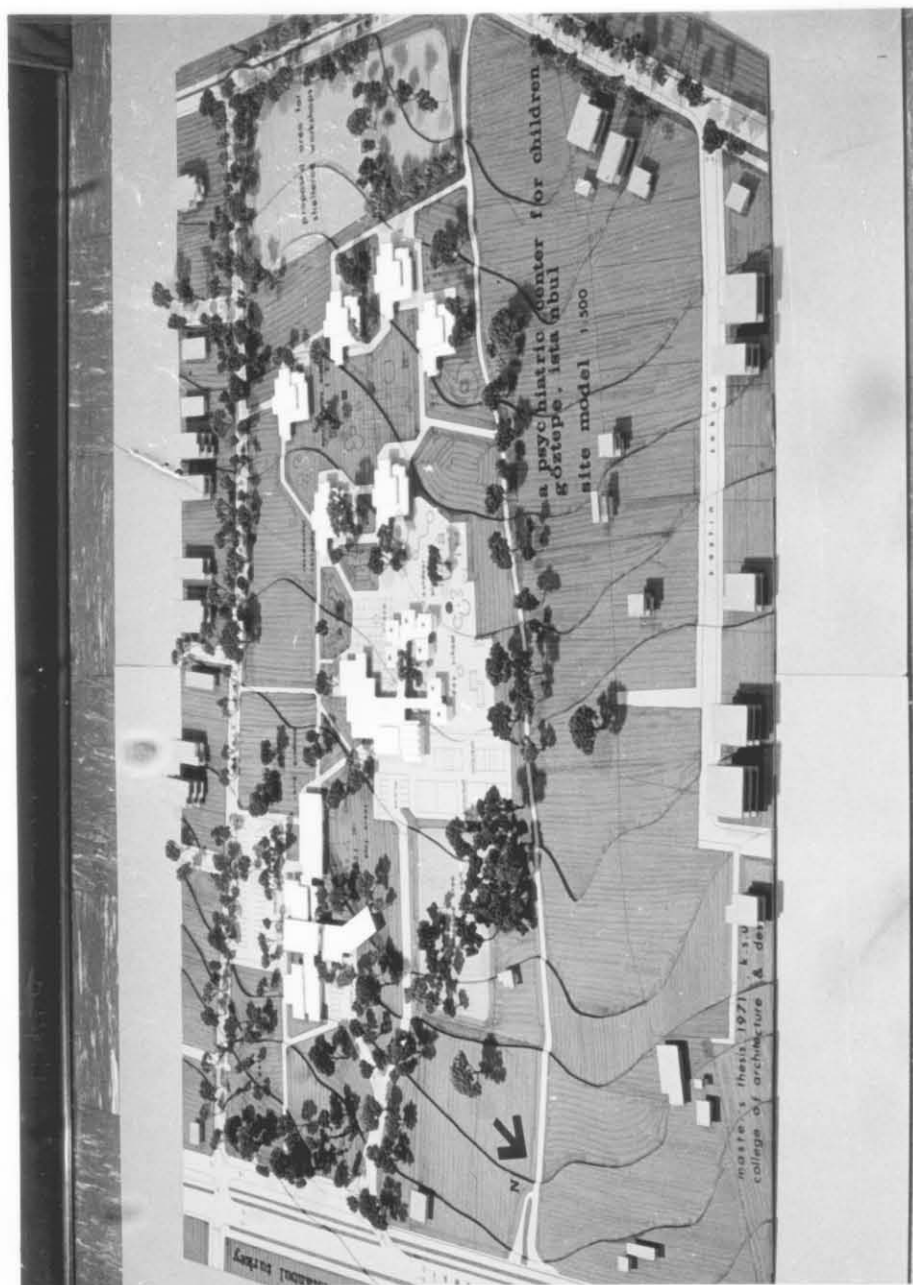
PLATE XXIV



EXPLANATION OF PLATE XXV

Birds-eye View of the Center

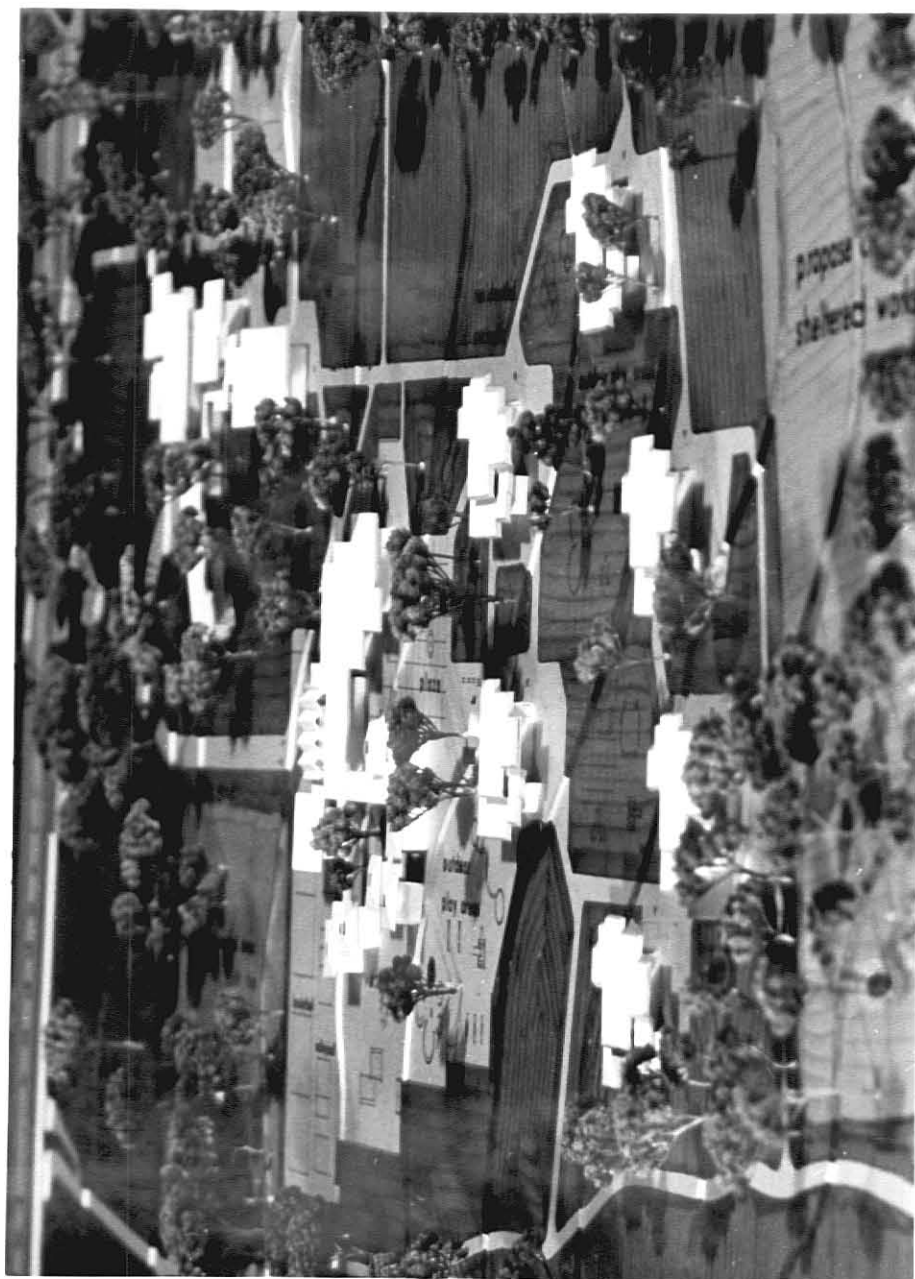
PLATE XXV



EXPLANATION OF PLATE XXVI

A Close View of the School, Cottages,
and Outdoor Play Areas

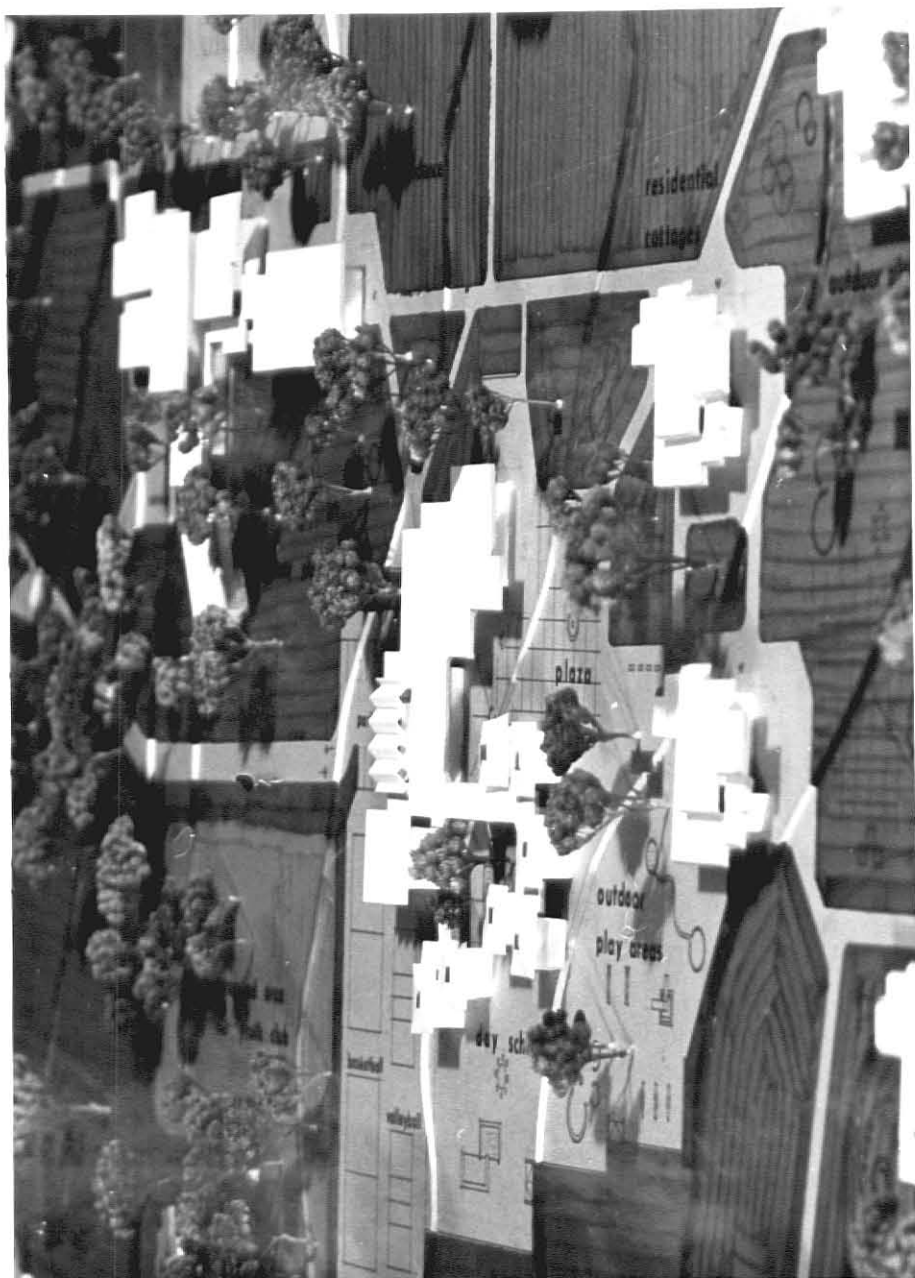
PLATE XXVI



EXPLANATION OF PLATE XXVII

A Close View of the School, Plaza,
and Outdoor Play Areas

PLATE XXVII



IX. CONCLUSIVE STATEMENTS ON THE PRESENT AND FUTURE

Through the studies of the historical background of childrens' mental health activities which can occur in such a complex, we come to the conclusion that the problem is not limited to only functional adequacy. 'Form follows function' probably is still valid, as well as the function being permanent, but designing such a complex involves further emotional and behavioral concepts. Every effort should be made to meet the physical and emotional needs of the users of this facility in the best way. Research on the user requirements are not yet completed. Is a rectangular room formation best? Do colors always have the same effects at all times? Would an informal, irregular room arrangement be better?

The question of care of buildings for mentally handicapped children is changing. Although money is being spent on buildings and its staff, it must be used to the fullest possible advantage. Architecturally, there is undoubtedly great room for improvement. The architectural pattern languages of the future, perhaps, can fill this gap.

The author strongly believes in the necessity of the systematic re-appraisal of planning and design or a feed-back to real-life situations. This can be gained not only by an examination of existing buildings, but by a careful study of the activities carried on within them, plus a careful analysis of these activities. The flexibility in the functions and activities

and its reflection in the architectural design are also to be considered.

It seems that the only way in which designers and childrens' mental health professionals alike can gain more knowledge and more accurate information of needs is by means of methodical experiment. Bad examples of the past are also to be considered. The day when the environmental designer's dilemma is solved will be the first day of a new revolution in architecture.

BIBLIOGRAPHY

Books

Bayes, Kenneth. The Therapeutic Effect of Environment on Emotionally Disturbed and Mentally Subnormal Children.

London: By the author, 37 Duke Street, 1967.

Buckle, D., and Lebovici, S. Child Guidance Centres. Geneva: World Health Organization, 1960.

Caplan, Gerald. An Approach to Community Mental Health. New York: Grune & Stratton, Inc., 1961.

_____. Principles of Preventive Psychiatry. New York: Basic Books, Inc., 1964.

Gruffydd, Bodfan. Landscape Architecture for New Hospitals. London: King Edward's Hospital Fund, 1967.

Lynch, Kevin. Site Planning. Cambridge, Massachusetts: The M.I.T. Press, 1962.

Moustakas, Clark E. Psychotherapy with Children. Ballantine Books. New York: Harper & Row, 1970.

Nellist, Ivan. Planning Buildings for Handicapped Children. London: Crosby Lockwood & Son Ltd., 1970.

Roberts, Leigh M., and others, ed. Community Psychiatry. Anchor Books. Garden City, New York: Doubleday & Company, 1969.

Soddy, Kenneth, ed. Mental Health in the Service of the Community. London: Tavistock Publications, 1967.

Articles

- "Economy in Turkey", Encyclopedia Americana. 1970. Volume 27.
- "Turkic Peoples". Encyclopedia Britannica. 1970. Volume 22.
- Weiker, Walter F. "Cultural Life in Turkey". Collier's Encyclopedia. 1971. Volume 22.

Bulletins, Newsletters

- Istanbul Belediyesi. Imar Talimatnamesi, 1970. Istanbul: Belediye Basimevi, 1970. (in Turkish) (Municipal Administration of Istanbul-Zoning Regulations, 1970. Istanbul: Municipal Printing Office, 1970.)
- T. C. Tarim Bakanligi Devlet Meteoroloji Isleri Genel Müdürlüğü. Yıllık Meteoroloji Bülteni, 1967. Ankara: Basbakanlik Basimevi, 1969. (in Turkish) (Ministry of Agriculture, Annual Bulletin of Meteorology, 1967. Ankara: Government Printing Office, 1969.)
- Turkish Student Association Newsletter. Editorial, March 27, 1971.

Unpublished Works

- Cebiroglu, Ridvan. Notes taken of opinions expressed by Professor Dr. Ridvan Cebiroglu of the University of Istanbul in his letters during 1971.

- Morton, William D. Notes taken of opinions expressed by William D. Morton during an interview at Fort Logan Mental Health Center, Denver, Colorado, 1971.
- Perske, Robert. "The Scandinavian Principle of Normalization". Unpublished paper, Topeka, 1970.
- Rappoport, Leon H. Notes taken of opinions expressed by Dr. Leon H. Rappoport during informal discussions at Kansas State University, 1971.
- Sinnett, E. R. Notes taken of opinions expressed by Dr. E. R. Sinnett during an interview at Kansas State University, 1971.
- Weisenburger, Ray. Notes taken of opinions expressed by Professor Ray Weisenburger during informal discussions at Kansas State University, 1971.

APPENDIX

T.C.
İSTANBUL ÜNİVERSİTESİ
TIP FAKÜLTESİ
NÖRO - PSİKİYATRİ KLİNİĞİ
Çapa

Sayı :

19. Nisan - 1974
Pazartesi

Sergili Şehap :

yazımı çok zor okuyabildiğim için bu kez
doktor ile yazayım demistim, acele An-
karaya geldik. nasip olmadı. Türkiye
de Anz-Çocuk sağlığı merkezleri artık
yazıldı. Buralarda Pediyatri ve Gynecologie
çalışıyor. Ayrıca büyük Akıl sağlığı
merkezleri var. onun için Community
mental health ayrı tip artık olamaz
Bunun yerine akıl sağlığı dispenseleri var.
Çocukta ; adult da bekliyor. Bunaya
ana çocuk sağlığı artık konulamaz. o halde
serin. Child Psychiatric clinic veya child
guidance center kurulması gerek. Mektubumun
2 inci sayfasında söylediğim 5 fonksiyonlu
merkez i burada resmi yerlere kabul ettiremeyiz.
onun için : child Psy-guidance and day school
olabilir -

1. şehir içinde meclisler köyünde olmalıdır.
2. Şehir yolunda Sarıyer 19. ci sig. Hast. civarında
olabilir
2. Bütün şehir yarar.
3. Mentally handicapped Cp. için day school - Workshop
eklenebilir.
- ④. Co. Psikiyatrisi outpatient, inpatient - Speech therapy center
day school - Workshops - Garden - aile Counselling.
- ⑤. Child Psychiatrist - Psychologist - ④-6 - ③-5 - ⑤-8
Speech Therapist - aile Counsellor = 8. hafta - Doktorlar
2-3 2-3.
- ⑥. 2 - 16 yaş - Sex oyunları 9 dan sonra yasak.
Biz 1 - 3 yaş makte yapalım. 3 - 16 kız, 3-16 oğlan
1-7

Sahap Cakin
1605 Anderson, Apt. 23,
Manhattan, Kansas 66502

March 18, 1971

Mr. William Morton
Research Department
Fort Logan Mental Health Center
Denver, Colorado 80215

Dear Mr. Morton :

I am a graduate student of Architecture in Kansas State University, Manhattan, Kansas. And I am interested in the design of Mental Health Institutions. Since my thesis is related to this subject, I decided to see various Mental Health Institutions and facilities in this country. My advisor, Mr. Leon Rappoport gave me your name and address. I would like to come to Denver during the Easter recess and visit Fort Logan Mental Health Center. April 6 or April 7 1971, (preferably morning) are the most suitable dates for me. I will appreciate it very much if you will let me know about the possibility of my visit on one of these dates. I thank you very much for your kind attention.

Sincerely Yours,

Sahap Cakin

William Duke Morton
Program Evaluator
Fort Logan Mental Health Center
3520 West Oxford
Denver, Colorado

Mr. Sahap Cakin
1605 Anderson, Apt. 2 3
Manhattan, Kansas 66502

Dear Mr. Cakin:

I would be happy to make any arrangements necessary for your visit. I am not sure about the exact nature of your visit; but, if you are going to study the physical layout of Fort Logan, I suggest that it will take more than a single morning.

If you will write me regarding the questions you have, the things you would like to see etc., I will make appointments for you with the people most qualified to supply you with answers.

Please convey my greetings to Leon. I am soory I missed him when he was in Denver. However, for the last 8 months I have not been fit company for anyone. Fortunately, things have begun to staighthen themselves out and I am beginning where I left off.

Please write me as soon as possible as to your choice of day(s) (either the 6th or 7th of April if fine with me), and the questions you have so that I can make whatever appointments will be necessary.

Sincerely Yours,



Program Evaluator

Sahap Cakin
1605 Anderson, Apt. 23,
Manhattan, Kansas 66502

March 28, 1971

Mr. William Duke Morton
Program Evaluator
Fort Logan Mental Health Center
3520 West Oxford
Denver, Colorado

Dear Mr . Morton :


I thank you very much for your kind letter. The design of a community mental health center will be my thesis. This is the basic objective of my visit to Fort Logan. Since I read the survey study named "The Community Mental Health Center, An Analysis of Existing Models," I have a rough idea about Fort Logan Mental Health Center now. It tells a little about the area served, physical setting, administration, staffing, patient services (referral, intake, outpatient, part-time and day program, alcoholics , and transitional services), financing, consultation to schools and training programs in Fort Logan in June 1964.

I have no idea about the changes and additions since 1964. I will be glad if I can have a general site trip which gives me the idea about the physical layout, buildings, the extension possibilities of buildings and transportation system.

1. What are the significant changes and/or additions in the institution since 1964 ? (buildings, services, staff) do you have a children service now?
2. How does a single patient spend his time in the institution?
(from his admittance till his discharge)
3. My particular interest is the children services. I would like to see and get information about children services. (for example; educational, rehabilitation, theurapic services etc.)
4. What are the relationships between the institution and the community?
(in professional level, in parents level etc.)

I will be in Denver on the 6th and 7th of April whole days. Since I did not have any other appointment, I am available on Tuesday whole day or Wednesday whole day. I will appreciate it verymuch if you let me know the exact date and hour which is fine with you.

Sincerely Yours,


Sahap Cakin

Sahap Cakin
1605 Anderson, Apt. 23,
Manhattan, Kansas 66502

March 28, 1971

Mr. William Duke Morton
Program Evaluator
Fort Logan Mental Health Center
3520 West Oxford
Denver, Colorado

Dear Mr . Morton :


I thank you very much for your kind letter. The design of a community mental health center will be my thesis. This is the basic objective of my visit to Fort Logan. Since I read the survey study named "The Community Mental Health Center, An Analysis of Existing Models," I have a rough idea about Fort Logan Mental Health Center now. It tells a little about the area served, physical setting, administration, staffing, patient services (referral, intake, outpatient, part-time and day program, alcoholics , and transitional services), financing, consultation to schools and training programs in Fort Logan in June 1964.

I have no idea about the changes and additions since 1964. I will be glad if I can have a general site trip which gives me the idea about the physical layout, buildings, the extension possibilities of buildings and transportation system.

1. What are the significant changes and/or additions in the institution since 1964 ? (buildings, services, staff) do you have a children service now?
2. How does a single patient spend his time in the institution?
(from his admittance till his discharge)
3. My particular interest is the children services. I would like to see and get information about children services. (for example; educational, rehabilitation, therapeutic services etc.)
4. What are the relationships between the institution and the community?
(in professional level, in parents level etc.)

I will be in Denver on the 6th and 7th of April whole days. Since I did not have any other appointment, I am available on Tuesday whole day or Wednesday whole day. I will appreciate it very much if you let me know the exact date and hour which is fine with you.

Sincerely Yours,


Sahap Cakin

STATE OF COLORADO

145

Ethel M. Bonn, M.D.
Director



Hilbert Schauer
Executive Director
Department of Institutions

FORT LOGAN MENTAL HEALTH CENTER
3520 West Oxford Avenue, Denver, Colorado 80236

April 2, 1971

Mr. Sahap Cakin
1605 Anderson, Apt. 23
Manhattan, Kansas 66502

Dear Mr. Cakin:

I have made arrangements for you to meet with people who will be able to answer your specific questions.

Please be in my office at 8 a.m., April 6, and I will try to get everything taken care of. I am in Room A-204 and your best chances for finding it would be to ask at the Information Desk in the lobby.

Sincerely,

A handwritten signature in black ink that reads "William Duke Morton". The signature is written in a cursive style with a large, stylized "W" and "M".

W. Duke Morton
Program Evaluator

WDM/ft

ILLEGIBLE DOCUMENT

THE FOLLOWING
DOCUMENT(S) IS OF
POOR LEGIBILITY IN
THE ORIGINAL

THIS IS THE BEST
COPY AVAILABLE

NEW HAVEN STATE SCHOOL
 Patients on the books
 Dec. 31 1970

146

Patient current age	Resident in hospital		Total by sex		Total by age group	Percent by age group
	M	F	M	F		
0-4	00	00	00	00	00	000.0%
5-9	13	02			15	003.5%
10-14	73	30			103	024.0%
15-17	55	42			97	022.6%
18-24	73	61			135	031.5%
25-34	27	37			64	014.9%
35-44	05	05			10	002.3%
45-54	00	05			05	001.2%
over 54	00	00			00	000.0%

total by sex 243 192

total 435

(These statistics were taken while some
 of the patients were home for Christ-
 mas and therefore not included.)
 were

Patients in cottages

Cottage A	Girls	10-17	
Cottage B	Boys	10-30	
Cottage C	Boys	7-15	
Cottage D	Boys and Girls	15-49	
Cottage E	Boys and Girls	16-40	
Cottage F	Boys and Girls	4-12	

RENE' A. SPITZ CHILDREN'S DIVISION
of the
FORT LOGAN MENTAL HEALTH CENTER

THE NEW

PROGRAM The Division's aim is to provide 24 hour diagnostic and treatment programs for emotionally disturbed children who have not responded to other community programs, or who are incapable of using other community resources. Stated generally, the treatment goal of the Division is to help each child

modify his behavior and deal with his feelings, so that he may develop his social and intellectual potential as fully as possible.

The Division will work with each child and his family until his growth process has resumed. This, rather than some arbitrarily chosen social or intellectual accomplishment, will be the criterion for discharge from treatment.

Discharge does not mean that the child will be dropped. At the time each child is discharged, staff members will review with his parents the growth that child achieved during his treatment. Staff will explain the goals the child is currently working toward and help the parents understand their role in furthering the child's growth. If schools or other social agencies will be involved, Division staff will help make any necessary arrangements.

ORGANIZATION OF THE

CHILDREN'S DIVISION Four decentralized but coordinated treatment teams carry out the treatment program. They are assisted by a division-wide staff comprised of 2 child psychiatrists, 2 child psychologists, a psychoeducational coordinator, a nursing educator-consultant, and 2 social workers. One social worker has specialized in foster home development and maintenance, and small group homes; the other has expertise in intensive home treatment.

A pediatrician and a speech pathologist consult with the four teams on a part-time, contractual basis.

THE SHORT-STAY

TREATMENT TEAM Trailblazers, the Division's short-stay team, limits the length of stay in 24 hour care to four months. The average length of stay has been about 2 months. Children in 24 hour care reside in the cottage 7 nights a week. The Trailblazers cottage has a bed capacity of 13, and the team will treat a maximum of 5 children in day care at any given time. Unlike the other teams, Trailblazers admits children directly to day care.

While this team admits children aged 6 to 14, most of its patients are 13 to 15 years old. In working with this age group, the team staff seeks to use strengths in the child's personality as a basis for the constructive resolution

of his conflicts and accomplishment of the concurrently existing developmental tasks of the early and middle adolescent years.

~~Staff on Trailblazers includes 3 social workers, one of whom is team leader, 2 teachers, 7 nurses, and 10 psychiatric technicians. The treatment modalities used are therapeutic community, behavioral therapy, individual and family unit therapy, parent counseling, and psychoeducational program, and occasionally chemotherapy.~~

THREE LONGER-STAY TREATMENT TEAMS

Together, the three longer-stay teams -- Pioneers, Explorers, and Pathfinders -- have a total capacity of 47 beds. Each team is divided into two subunits of 7 or 8 children. Pioneers Cottage houses a unit of girls aged 10-14, and a unit of boys aged 10-12. Explorers Cottage houses a unit of boys and girls aged 6-9, and a unit of boys aged 12-14. Pathfinders Cottage houses a unit of boys aged 10-12, and a unit of boys aged 12-14.

On admission, children on these three teams enter the 24 hour program. They cannot be admitted directly to day care. Day care may, however, later be used as a transition from residential treatment to outpatient or discharge status. The anticipated average length of stay on 24 hour care is six months, with anticipated maximum of two years.

~~To keep the child in treatment from becoming an "outsider" to his family, children in 24 hour care will spend weekends at home if such an arrangement is possible.~~ Staff will assist parents in planning for weekends and will provide consultation during weekends as needed. The weekends at home will provide parents with an opportunity to practice child management skills learned in individual and/or group counseling. Children who cannot return to their own or foster homes on weekends will be placed in small group foster homes supervised by Division personnel.

~~Each longer-stay team has as its staff a non-medical team leader, a head nurse, 2 social workers, 2 teachers, and 12 child-care workers. Child-care workers are psychiatric nurses, psychiatric technicians, or mental health workers.~~

The therapy program on the longer-stay teams embraces the concepts and operations of object constancy, group process, behavior therapy, and an augmented psychoeducational program.

ADDITIONAL

PROGRAMS Within the limits of its resources, the Children's Division offers ~~professional training, consultation,~~ research, and the contribution of personnel to child-centered community mental health programs.

PROGRAM

EVALUATION In the summer of 1972, the Division will review in depth the efficacy of its program both in terms of the children and their families who have been served, and in terms of the overall mental health needs of children in the Denver metropolitan area.

THE CAPPER FOUNDATION FOR CRIPPLED CHILDREN
Topeka, Kansas

GENERAL INFORMATION
REFERRAL, CLINIC, AND ADMISSION
PROCEDURES

Once a family indicates an interest in seeking admission for their child to The Capper Foundation (for therapy and school,) the following steps will be followed until admission is granted or denied.

~~The Social Worker will schedule an appointment with the parents.~~
The parents must bring their child with them at this time. ~~At this time~~

~~the child will be examined by a representative from the Department of Health and Welfare.~~
~~the child will be examined by a representative from the Department of Health and Welfare.~~

Before initial visit and the scheduling of an appointment for the child to be examined in the orthopedic clinic, the family must see that the following are completed and returned to The Capper Foundation

~~Physician's Examination~~

~~Physician's Examination (Orthopedic)~~

~~Psychological Examination~~

~~Neurological Examination~~

~~Physician's Report~~

(If any of these examinations have been performed in the past six (6) months, they need not be repeated.)

When all of this material is received the staff will determine whether or not to pursue the potential admission of the applicant. If the decision is negative the admission process stops and the family will be advised; if the decision is that the admission process should continue the family will be advised of a clinic appointment by the Social Worker.

~~the date of the clinic the child will be examined and~~
~~the date of the clinic the child will be examined and~~
~~the date of the clinic the child will be examined and~~

As soon as possible, following the orthopedic clinic, a staffing will be held to determine whether or not to place the child on the ~~waiting list~~

~~the admission date will depend upon several factors including available~~
~~space in residential units and classrooms.~~

9-10-70

THE CAPPER FOUNDATION
FOR CRIPPLED CHILDREN
Topeka, Kansas

September 10, 1970

~~Admission Criteria~~

- The Capper Foundation will consider for admission any child regardless of his race, color, creed, or national origin.
- No geographic limitations will be imposed. However, it is the general policy at The Capper Foundation that any child who needs residential care should secure this service as close to his natural home as possible.
- The Capper Foundation serves young people between the ages of 6 and 21 years who are orthopedically handicapped. In order to qualify ~~for admission they must require therapeutic treatment for such therapy, physical therapy, or occupational therapy~~ and special education as an orthopedically handicapped person.
- All children admitted into the program will be accepted on a ~~three-month trial basis~~. At the end of three months a staffing will be held and a determination made to either continue the child's program or to dismiss the child. This decision will be made by the people who have worked with the child at The Capper Foundation.
- The Capper Foundation will accept for admission only those children who are, at least, educable. Generally, the policy is to not admit those children classified as trainable mentally retarded. However, realizing the complexity of classifying children as trainable, educable, etc., we will always consider each individually, using classifications as guidelines only.
- The Capper Foundation will not accept for admission any child who is blind.
- The Capper Foundation will not accept for admission any child who is deaf.
- ~~The Capper Foundation will not accept for admission any child who is emotionally disturbed.~~
- Children who require the daily service of a registered nurse for some disability not associated with their orthopedic handicap, such as diabetes, asthma, or epilepsy, will be given an additional appraisal re: their added health problem.
- If a child is accepted for admission and is to attain maximum benefit from the program it is imperative that the family cooperate and participate to the fullest extent.
- Admission to the Work-Activity Program will be considered under a different set of criteria.

PURPOSE & FUNCTION. The purpose of The Capper Foundation for Crippled Children is to treat, train and educate children who are handicapped by some orthopedic disability and who have sufficient mental capacity to understand, use and retain what they are taught.

PHYSICAL THERAPY. This department is staffed by three Registered Physical Therapists who, with the help of aides, administer therapy as ordered by our orthopedic consultants. They are responsible for all therapeutic equipment -- including walkers, standing tables, tilt tables, relaxation chairs, parallel bars, crutches, canes and braces, as needed by the children. Therapeutic treatments include stretching, exercises, relaxation, muscle education, re-education and coordination and hydro-therapy. This therapy is directed toward determining each child's potential to achieve as nearly as possible a normal walking pattern.

OCCUPATIONAL THERAPY. This department is staffed by two Registered Occupational Therapists and a trained aide. Occupational therapy is particularly concerned with the child and his ability to meet the demands of his environment. Exercise, creative and manual arts, crafts, functional toys and recreational activities are adapted by the therapists to meet the needs of the particular child. General treatment aims are always to evaluate and increase a patient's physical function in relation to activities of daily living. Orthopedic consultants prescribe the treatment which is supervised by the therapists.

SPEECH AND HEARING THERAPY. A certified Speech Therapist checks and treats the child's speech problem through the strengthening and co-ordinating of tongue muscles, of lips, jaw and cheek, and the reduction of drooling. She helps him to make meaningful sounds and to put them together to form words. She trains his thought processes essential to language development. Her tools are speech training pictures, stories, puzzles and games. She also checks hearing and gives treatment in accordance with hearing problems. In addition, a teacher of the deaf and hard of hearing works in the area of language development.

EDUCATIONAL PROGRAM. Seven classrooms are presided over by teachers in special education. Academic work is given in preschool, kindergarten, primary, intermediate and secondary. Classroom work is geared to the individual's ability to assimilate it, and much needed individual instruction is provided. The teachers are assisted in the classrooms by the therapists in seating and posture problems. There is an eleven month school year beginning in September, at the same time public schools open, and continuing through July. The Capper Foundation academic program is sponsored by The Topeka Public School System and is accredited by the State Department of Public Instruction. The teachers meet standards of training specified by the Division of Special Education of the State Department.

VOLUNTEERS:

The Capper Foundation program encourages active volunteer workers, individuals and groups. These people come from church groups, clubs, Junior League, Volunteer Bureau, Red Cross, and agencies providing treatment within the metropolitan area. Volunteers work in the classrooms and therapy sections with individual children, supervised by the teachers and therapists. They also assist during play periods with active and quiet games and during lunch periods with the children's eating problems.

RECREATION:

There is an active recreational program for the children, supervised by the professional staff of teachers and therapists who are assisted by volunteers to do individual play activities with the children. Group recreational activities include basketball, soft ball, scoop ball, croquet, table tennis, volley ball, bowling, movies and swimming. Quieter games include table games of all types. There is outdoor stationary playground equipment such as a jungle gym, climbing bars, swings and horizontal ladder. Picnics, birthday parties and entertainment provided by interested community groups are enjoyed by all the children. The children themselves have frequent opportunity to provide music, rhythm band, readings, plays and puppet shows for the entertainment of visitors.

RESIDENTIAL CARE:

Children who come from out of the city and out of the state are classified as in-patients and reside in a boarding home adjacent to the Rehabilitation Unit. Visiting is arranged for on the basis of convenience and desirability. Parents either visit their children in the boarding home or take them home for a visit. In this "home away from home" the children receive excellent care for their physical needs and loving attention during rest and play hours. Meal planning is supervised by a qualified dietitian both at the boarding home and at The Capper Foundation.

MEDICAL SERVICES:

Our medical staff is utilized on a consultant basis and includes doctors of orthopedic surgery, neurology, general medicine, radiology, E.E.N.T. and dentistry. Psychological testing and psychiatric evaluation are also available on a consultant basis. A monthly clinic is conducted by five orthopedic surgeons. At this time the children are examined and recommendations are made by them for admission to rehabilitation services if they feel the Foundation's program can be of benefit. Children may be admitted for a total program (school and therapy) or they may be admitted on an out-patient basis for therapy alone. A third classification is the clinic patient who is checked periodically only in the clinic.

DISABILITY AREAS SERVED. The disability areas to which The Capper Foundation gives service include poliomyelitis, encephalitis, meningitis, cerebral palsy, Werdnig Hoffman's Disease, amyotonia congenita, osteogenesis imperfecta, muscular dystrophy, achondroplasia, fractures, rheumatoid arthritis, galactosemia, nephritis, cystic fibrosis, aphasia, spina bifida, hydrocephalus, accidental brain damage, etc.

REFERRALS. Referrals for service are received from medical specialists, the State's Crippled Children's Commission, public school systems, county and state National Foundation Chapters, County Welfare Directors and individual contributors. Cooperative arrangements are made with any agency which feels that The Capper Foundation can be of service to the child.

COST OF CARE. Charges for school tuition, board and room, and therapy are made according to the parent's ability to pay. It is felt that parents should take as much responsibility for payment for service to their children as possible. The maximum fee is less than the actual cost of care. No handicapped child is ever denied admission for financial reasons.

ANY RACE, COLOR, CREED OR NATIONAL ORIGIN

ACKNOWLEDGEMENT

Many thanks to my advisor, Professor J. Cranston Heintzelman, of the Department of Architecture, Professor Dr. Robert P. Ealy of the Department of Landscape Architecture and Professor Emil C. Fischer of the Department of Architecture.

My deep appreciation to Professor Dr. Leon H. Rappoport of the Department of Psychology and to Professor Ray B. Weisenburger of the Department of Regional and Community Planning. Their guidance and encouragement made this work possible.

I would also like to thank Professor Walter J. Butke and Professor O. John Selfridge of the Department of Architecture, Mr. William D. Morton of Denver, Colorado, Dr. Sinnett from the Student Health Center of Kansas State University, for their help.

Finally, I appreciate the helpful efforts of my fellow citizens, Professor Dr. Ridvan Cebiroglu of the University of Istanbul, Dr. Nihat Toydemir and Mr. Imer Sunguroglu of the Technical University of Istanbul, and of my parents, Dr. Kemal and Dr. Nurefsan Cakin.

A PSYCHIATRIC CENTER FOR CHILDREN IN ISTANBUL

by

SAHAP CAKIN

Diploma, The Technical University of Istanbul, Turkey, 1969

AN ABSTRACT OF A MASTER'S THESIS

submitted in partial fulfillment of the

requirements for the degree

MASTER OF ARCHITECTURE

College of Architecture and Design

KANSAS STATE UNIVERSITY
Manhattan, Kansas

1971

This thesis is an attempt to show a comprehensive design concept and its development. It is considered as an approach to translating a children's mental health center concept into an architectural design problem and not as an end in itself. It involves a wide, horizontal background in architecture, related environmental design fields, and collective work, showing cross-cultural characteristics, and involves design decisions related to these.

The proposed methodology is based on a Functional Psychiatric Program, and the Architectural Response to it. The content, characteristics and the capacity of the program are determined by the community needs, characteristics and resources, with reference to the social and cultural dimensions of Turkey in national and in metropolitan scales. Some different approaches and their philosophies in the mental health field, the children's psychiatric programs in the United States, England, Scandinavian countries and previous literature were considered. The existing mental health facilities, administrative structure, and national economic development in Turkey were taken into consideration in determining the elements of the program. Various mental health institutions in Midwestern United States were visited and individuals from mental health fields interviewed. The opinions of the professionals in the United States and Turkey were solicited on the same subject, in order to obtain accurate cross-cultural design decisions.

In the architectural design process some man-made characteristics of Turkey, such as the industrial potential and labor market are considered in determining decisions with regard to building construction methods, structural systems, and materials. The project content and capability are determined by the previous literature, existing facilities, indoor and outdoor activities, equipment needs, furniture sizes, traffic movement and density. Functional space relationships between and within the separate divisions of the program are considered. Departmental Linkages include the primary and secondary relations between different functional divisions, such as administration, cafeteria, child guidance center, school and training center, and residential cottages.

The analysis of the physical environment includes atmospheric and sonic factors, e.g. maximum, minimum and average air temperatures, critical solar angles, the direction of the prevailing wind, air velocity, monthly precipitations, relative humidity, cloudiness, air pollution, traffic and environmental noise. In the Site Selection process, the surface and sub-surface factors are also considered. These include the existing plants and proposed landscape design, its therapeutic and physical value, earthquakes and the topography of the Site. Physical, visual and sonic screening by means of landscaping are considered. The buildings are tailored to the site, and the existing topographical character is protected.

In addition to the physical analysis, the man-made characteristics are also taken into account. The size, accessibility, community characteristics, existing land use patterns, zoning restrictions, future growth and expansion possibilities of the site, play the most important role in the Site Selection Process.

Different construction stages, indoor flexibility, construction factors, structural system, materials, physical and social community integration, and Environmental Control Systems are taken into consideration. Modular and dimensional coordination are applied in relation to flexibility and structural systems. Environmental Control Systems, including the lighting and heating systems, window sizes, and noise insulation are determined. Feed-back approach is applied to provide the relationships between the components of the whole study process.