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# A Community Mental Health Services Facility for the York - Chester - Lancaster Catchment Area

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**A Community Mental Health Services Facility  
For The York - Chester - Lancaster Catchment Area**



ABSTRACT

As approximately nineteen million people in the United States are in need of mental health services, the delivery of mental health services to such a large portion of the population has been aimed toward a community level. As no two communities are alike, no mental health delivery systems or facilities within these systems are exactly alike. (2)

A Community Mental Health Services Facility  
For the York - Chester - Lancaster Catchment Area

By

Robert H. Sanders

A terminal project submitted to the Faculty of the College of Architecture, Clemson University in partial fulfillment of the requirements for the degree of

Master of Architecture

August, 1976

After careful study of an established three county catchment area in South Carolina, York-Chester-Lancaster, a delivery system was formulated to serve the catchment area and to merge with the existing state delivery system.

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## ABSTRACT

An estimated nineteen million people in the United States, or about one in ten, have emotional problems that require professional attention.(1) Since 1963, delivery of mental health services to such a large portion of the population has been aimed toward a community level. As no two communities are exactly alike, no two mental health delivery systems or facilities within these systems are exactly alike.(2)

This study examines the evolution of the community mental health center and the demands placed on the center today. A specific community mental health care delivery system is proposed and an architectural solution to the system's major facility is developed.

After careful study of an established three county catchment area in South Carolina, York-Chester-Lancaster, a delivery system was formulated to serve the catchment area and to merge with the existing state delivery system.

Throughout the scope of this paper, the author has assumed the role of architect and planner, a combination of roles which is required because of the complexity and inconsistency of parameters affecting design for the mentally ill.

To my departed dog, Lobo.



## DEDICATION

The author wishes to express appreciation for the assistance given by those associated with the preparation of this study.

To William E. McNamee, F.A.I.A., Dean of the College of Architecture, who has provided this opportunity.

To George C. Means, Jr., A.I.A., Professor, College of Architecture, whose influence on my work is apparent and who contributed to my studies at Clemson.

To Hugh W. Hall, P.E., Associate Professor, College of Architecture, for his support and guidance during the preparation of this study.

To my fellow classmates and friends, especially David Dillman and Joe Young.

To my departed dog, Lobo.



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## PREFACE

The author feels it is essential to relate the approach that was taken throughout the entire scope of this study, so as to adequately explain the purpose of its various parts.

A problem was identified in concern with a particular area of today's health care delivery and extensive research was begun to aid the author in defining the problem and in developing a solution.

Through the synthesis of this gathered data, the author found direction towards developing those variables which are most influential to an appropriate solution. These variables were then carried through a programmatic process to formulate architectural factors and design criteria.

These factors or concepts were then applied to a particular situation in order to produce an architectural solution.



**Part I**



EVOLUTION OF THE COMMUNITY MENTAL HEALTH CENTER  
PRE 1963

Mental illness and mental retardation are among our most critical health problems. They occur more frequently, affect more people, require more prolonged treatment, cause more suffering by the families of the afflicted, waste more of our human resources, and constitute more financial drain upon both the Public Treasury and personal finances of the individual families than any other single condition.

President John F. Kennedy,  
Message to Congress, February 5,  
1963

"The time has come for a bold new approach." These words, spoken by President John F. Kennedy in his February 1963 message to Congress on mental health and mental retardation, stimulated a new era in the care and treatment of the mentally ill. "The Community Mental Health Center Act, passed by Congress in October, 1963, marked an unprecedented public commitment to provide comprehensive mental health services to all Americans without regard to race, creed, or ability to pay.(3)

The concept of community mental health is not entirely new. The community mental health movement was a result of events of the nineteenth century. Paradoxically, these events took mental patients away from their communities and placed them in custodial isolation. This, of course, was not the intention but was the unfortunate result.(4)



Public care for the mentally ill was practically non-existent in the United States of the early nineteenth century. Members of the community who were mentally ill were either confined in jails or simply sent out of the community entirely. Primarily a reaction to these conditions, Dorothea Dix began her crusade to have treatment facilities established by each of several states. "Certainly, when Miss Dix visited the East Cambridge jail in 1841 and saw what the New Englanders of her time did with insane persons, she had no intention bringing about the rigid, isolated, overcrowded public mental hospital system that eventually resulted from her crusade.(5) The public transferred its responsibility for the care of the insane to the states. Unfortunately, as the initial public concern faded, the concern for adequate budgets to maintain and develop the mental hospital also faded. Consequently, the hospitals became crowded, neglected, and inhumane.

In 1908, Clifford Beers published his book, A Mind That Found Itself, which told of his three years in mental hospitals. Beers, appealing to private citizens for help, initiated the community mental health movement in the United States. The Connecticut Society for Mental Hygiene, founded by Beers in 1908, became the National Committee for Mental Hygiene in 1909. Since that time, the committee evolved into the National Association for Mental Health. The impact and influence of the citizen's mental health movement has fluctuated in the past sixty-six years. However, the

comprehensive research in areas relevant to mental health.



movement has continued to serve as the "public conscience" regarding the affairs of the mentally ill.(6)

During World War I, some advances were made in the area of early diagnosis and treatment of emotional disturbance. However, at the outbreak of World War II, the level of public concern showed a marked increase.(7) Under provision of the Selective Service Act of 1940, men eligible for the Draft received psychiatric screening as part of their medical examination. During the war, military medicine advanced the knowledge and use of a variety of short-term therapies. This was prompted by the hundreds of thousands of psychological casualties produced by the holocaust.

After the close of World War II, suddenly the problem of mental illness became a matter of national significance. Two million men had been excluded from military service because of neuropsychiatric defects. Neuropsychiatric disabilities proved to be the most frequent cause for medical discharge of those men who had been inducted into the service. By the end of the war, the state hospital patient population had risen to 450,000 and continued to rise. By 1955, there were 550,000 such patients throughout the nation.(8)

In 1946, Congress passed the National Mental Health Act which provided a budget for the augmentation of facilities and services, training of professional personnel, and comprehensive research in areas relevant to mental health.



The statute also made possible the initial organization of the National Institute of Mental Health in 1947.(9) However, the public had not begun to accept the idea that a mentally ill person could be treated and his illness controlled outside the mental hospital. Also, the public mental hospital program had become entrenched and was slow to change its traditions.

With the 1950's came improved treatment techniques and the use of psychoactive drugs which demonstrated that mental illness in many cases could be controlled and alleviated. With the aid of mass media, public interest began to grow. Then in 1955, Congress adopted the Health Amendments Act which provided funds to states to support demonstration projects in mental health services. Also in 1955, the joint Commission on Mental Illness and Health was organized and began the first nationwide study and analysis of the extent of mental illness in the United States.(10)

The final report of the Commission was published in 1961 with the title "Action for Mental Health." At the time, it was found that half the hospital beds in the country are occupied by mental patients. One family in three would at some time place one of its members in a mental hospital. At some time in his life, one person in 10 would be sufficiently ill mentally or emotionally to require professional help.(11) The findings and recommendations of the Commission report became the foundation upon which the national mental health program and the community mental health center program were developed.(12)



In October, 1963, the Congress adopted the Community Mental Health Center Act."

Viewed from a historical perspective, the community mental health center program promised a dramatic reversal in public policy: instead of "protecting the community" by locking up the so-called mentally ill in distant institutions, the "ill" were to be protected and cared for in their own communities. More than this, it called for massive financial participation by the federal government in an area that had long been the domain of the states, for the purpose of making mental health services available to anyone who might need them -- not merely to special target populations.(13)

The Act's provisions were specific, however, its intent allowed great latitude within which "the federal government, the states and local communities could evolve patterns of cooperation, in providing mental health services."(14)



## THE COMMUNITY MENTAL HEALTH CENTER ACT OF 1963

The primary goal of the Community Mental Health Center Act of 1963 (Public Law 88-164) was to stimulate local communities to assume responsibility for the care of their own mentally ill citizens. The emphasis on local program development and operation was to be accomplished through a partnership of federal, state, and local governments. There were four fundamental concepts embodied in the act.

The first concept of the act was one of local involvement in the development and operation of a mental health care delivery system. Emphasis was on the accessibility of mental health care. "The patient must be able to obtain needed services easily, and he must be able to obtain them without isolating himself from the people and surroundings that are familiar to him." (15)

A second fundamental concept of the act envolved the establishment of multi-service programs. Services should be comprehensive in scope, capable of meeting different needs. "Each patient needs different types of services at different stages of his illness, and different patients require a variety of services that are consistent with their age and background as well as with the nature of their illness." (16)

The third basic concept is continuity of care. An individual patient should be able to move easily from one service to another whenever his clinical needs change. Emphasis was on treatment programs being thoroughly coordinated.



The fourth basic concept called for the need of efforts to prevent mental illness as well as to treat mental illness.

For the first time, provision of preventive services became mandatory in a publicly supported mental health program. The adoption of preventive services as a stated public policy not only added a new dimension to the mental health program; it set a new direction for all health programs in the United States.(17)

Although the most innovative concept, preventive services were the most difficult to implement or evaluate. There is still some question today, whether prevention, in mental health, can actually be accomplished.(18)

The concept of local service and community orientation was implemented through the introduction of the idea of the "catchment area." The catchment area provides a means of identifying the community to be served. A catchment area was defined as a "designated geographic area having no fewer than 75,000 people and no more than 200,000 people."(19) This is based on the fact that population of fewer than 75,000 people would be too small to support the comprehensive range of services required of a mental health center. Program ties with other agencies in an area with more than 200,000 people would be difficult to maintain. Today, these limits on catchment area population, have come under a great deal of criticism.(20)

Implementation of the second concept, comprehensiveness of services, was through the definition of the services



which each center was required to provide. The services were in two groups. The first group was considered essential services. Each center was to have its own characteristics, reflecting the special needs and resources of its respective community; however, to qualify for federal funds the center had to provide at least five essential services:

1. In-patient services
2. Out-patient services
3. Partial hospitalization, such as day care or night care
4. Emergency services provided 24 hours per day
5. Consultation and educational services available to community agencies and professional personnel (21)

The act identified the second group of services as recommended but not required. The recommended services included:

1. Specialized diagnostic services
2. Rehabilitation services
3. Pre-admission and post-discharge services for state hospital patients
4. Research and evaluation programs
5. Training and education of mental health professionals (22)

The concept of comprehensive care was also defined in terms of patient population to be served. The mental health center was required to provide services to patients regardless of their diagnosis and regardless of their age. (23)

The third basic concept of the act, continuity of care, was presented in terms of those program elements most likely to provide linkages between the various services offered by



the center. Both staff and patients had to be able to move from one service to another. Information had to be able to move from one service to another.

It was necessary that the center make provisions for the free transfer of clinical records from one service to another. It was also required that the center establish procedures whereby staff members who provided care for a patient through one clinical service (for example, in-patient) had to be able to participate also in the care provided for that patient through any other service of the center. Finally, it was required that persons who were deemed to be eligible for one type of care also had to be considered eligible for all the other types of services being provided by the community mental health center.(24)

The last basic concept, "the commitment to prevention" was to follow a public health model. There are, in effect, three types of prevention: primary, secondary, and tertiary. Gerald Caplan, a professor of psychiatry at Harvard and one of the early leaders of the community mental health movement, defines these terms as follows:

Primary prevention is the reduction of the incidence of mental disorders of all types in a community. Secondary prevention is reduction of the duration of a significant number of those disorders that do occur. Tertiary prevention is the reduction of the impairment which may result from these disorders.(25)

Primary prevention was to be implemented through the mental health consultation and education programs. Consultation was to focus on program consultation provided to a variety



of community agencies, such as schools, courts, welfare departments, police, clergy, even employers. The community mental health center was to be involved in secondary prevention because of its emphasis on providing readily accessible care for acute illness, often on an emergency basis." (26) Because of rehabilitation programs and the commitment to providing comprehensive treatment services, the mental health center was to play a role in tertiary prevention.

When the Community Mental Health Center Act was adopted in 1963, Congress included provisions for federal support in the construction of facilities. The allocation of funds to each state depended on the individual state's population and socioeconomic status. The federal share ranged from one-third to two-thirds of construction cost. Once the federal share was established for a state, centers within the single state competed for the available funds. The act did not require the mental health center to be established under one roof nor all patient care be at one location. The funds could be used for new buildings, expansion, remodeling, and alterations to existing buildings.

The act also required the governor of the state to designate one state agency as having the responsibility for preparing a state plan and conducting a review of each construction grant application. The state plan was to: set forth a program for the construction of community mental health centers; determine the relative need of proposed



## THE COMMUNITY MENTAL HEALTH CENTER CONCEPT

We need a new type of health facility, one which will return mental health care to the main stream of American medicine, and at the same time upgrade mental health services.

President John F. Kennedy  
Message to Congress 1963(29)

The call for a "new type of health facility" was answered, in part, by the Community Mental Health Center Act of 1963. However, the community mental health center is a "concept or program of action," not necessarily a single organization or facility.(30)

Four major developments made the community mental health center approach feasible.

Treatment had improved. With tranquilizers, psychic energizers, improved methods of psychotherapy including group therapy and other forms of treatment, we are able to control and treat mental illness better than ever before.

Hospitalization, when necessary, was becoming shorter in duration.

Alternative resources, including nursing and foster homes, outpatient clinics, day and night hospitals, and psychiatric units in general hospitals, had proved more effective for many patients than conventional state hospital services.

While, in the past, tax monies had been the main support of mental health programs, private sources were beginning to provide more of the cost. Most voluntary health insurance plans were including coverage of in-hospital treatment of mental illness, and some were also providing a limited



amount of out-patient treatment. Also, exclusions against the mentally ill in Federal and state public assistance programs were being relaxed.(31)

With these developments in mind, Congress moved to bring mental health care back to the community.

The community mental health center has created its identity around a number of mandated services which it must provide for the community. Among these services are: in-patient services, out-patient services, partial hospitalization, community services, diagnostic services, rehabilitative services, precare and aftercare, training programs, and research and evaluation.(32)

In-patient services offer treatment for a limited time to patients needing 24-hour care, including provisions for 24-hour emergency service. After initial treatment, other arrangements are made such as day hospital or out-patient clinic. If indicated, a transfer to a state hospital may be initiated which, it is hoped, would offer specialized care.

Out-patient services offer various kinds of individual and group treatment programs, including 24-hour emergency services. These services are provided for adults, children, and families.

Partial hospitalization provides day care and treatment for patients able to return to their homes and families evenings and weekends. Night care and treatment care be



provided patients able to work or attend school, but in need of further care or without suitable home arrangements.

In community services, members of the center staff provide consultation to professional personnel in the community, such as non-psychiatrist physicians, clergymen, and other community agencies. These agencies include school systems, public health departments, courts, police, welfare departments, and recreation agencies.

Diagnostic services provide extensive examination of emotionally disturbed and mentally ill persons and screening of patients prior to admitting them to the appropriate service within the center.

Rehabilitative services, offering vocational, educational, and social programs should be provided for those within the community in need of such care as well as returning hospital patients.

Precare and after services are especially for the patient in transition. These persons are either planning to participate in more extensive programs or having to adjust to the community after extensive treatment. These services involve providing care in foster homes, halfway homes, or patients homes.

As manpower is a critical element in most centers, an effective training program is of paramount importance. The use of para-professionals has greatly aided the community mental health center movement.



A research and evaluation program is an indispensable tool to the mental health center. Collected data enables the mental health center to plan programs and initiate them when and where they are needed. Continuing evaluation of the center's programs is necessary if the center is to stay abreast of the communities needs.(33)

The optimum patient/staff relationship in a community mental health center is a personal relationship. "There must be one readily available individual, not necessarily a physician, whom the patient knows is his to confide in and to be his advocate."(34) Also, an optimum situation would be if this individual could follow the patient no matter where he is in the program. Unfortunately, clinical operations using this method would result in chaos except in a very small unit.(35)

In community mental health centers, the most popular approach to the assignment of patient care responsibility is by interdisciplinary teams. The make-up of a team can vary a great deal from the usual coalition of psychiatrist, psychologist, and social worker. For instance, one methodology for assigning responsibility is the subdivision of the entire staff into three or perhaps five teams, with a dozen or more professionals in each. The team is responsible for a particular group of patients regardless of whether they are in the in-patient service or in out-patient. This method offers excellent continuity of care, because as the patient progresses from emergency or intake through degrees of hospitalization to aftercare and rehabilitation, he has



the same persons responsible for him, if not as individuals, at least as an administrative unit. This method works well if each team has its own distinct in-patient unit, a separate day care service, and its own clinic secessions. Teams may be assigned patients on the basis of rotation or by case load or by taking those patients who enter during their day on call. Patients may be assigned to teams by geographical considerations. Management and the lack of treatment specialization are the major criticisms of this method of subdividing a staff.(36)

Another method of delegating responsibility is to assign the staff according to special clinical functions. There could be a special intake team or one which specializes in crises interventions. Staff members are assigned to teams involved with their particular area of expertise. This approach gives the mental health center the ability to provide an array of "definitive treatment modes." (37)

Responsibility for patient care can be assigned by services, such as in-patient care, day care, emergency room care, or aftercare. With each service having its own management and staff, more efficient operation is possible. This method also permits service staffs to develop new and distinct treatment philosophies and approaches.(38)

The team approach, particularly the geographical team, is considered the better approach for more chronic facilities such as state hospitals or for long term ambulatory



care. In a large short-term intensive facility with multiple types of clinical and managerial problems, the functional service assignment is considered the best approach. (39)

One of the fundamentals of community psychiatry, the community mental health center being its tangible structure, is the fact that "emphasis has changed from the professional treating a passive-dependent patient to a mobilization of community resources to prevent the labeling of individuals as sick." (40)

The traditional admission unit accepts referrals of people who are already identified as "patients" and "sick," and in the process of history-taking the patient becomes aware that the staff expects him to take the role of a sick person. These expectations affect the patients' self-image, and they also affect his family and other people in this social system, who now view him as a significantly different person. This image may linger indefinitely, as demonstrated so dramatically and tragically by Senator Thomas Eagleton's fate as a vice-presidential candidate. (41)

Another approach to treatment in the community mental health center is through the concept of the therapeutic community. "Therapeutic communities are organizational systems for bringing about therapeutic change in interpersonal relationships." (42) Under this concept, patients are significant individuals within the system.



Mental hospitals in the past were staff-centered rather than patient-centered (to some extent they still are) operating on the basic assumption that staff know what is best for the patients: Treatment prescribed under those circumstances emphasizes that patients are passive recipients of services designed by professionals, in the way that nonpsychiatric patients in general hospitals receive care. (43)

The therapeutic community can be defined further by several characteristics: two-way communication; shared decision-making, designation of leaders on the basis of natural abilities and leadership qualities rather than formal education; multiple leadership in a multidisciplinary system; significant roles for nonprofessionals; significant roles for patients; and social interaction. (44)

A therapeutic community is a relatively new approach and deviates greatly from traditional systems in medicine and psychiatry. Not without criticism, the approach is viewed with great expectations. The therapeutic community concept, in various interpretations, has been applied in many areas of the United States. The "village system" in South Carolina is one such example.

1963 - The Centers for Disease Control (CDC) authorized Federal grants -- over 51 months -- in support of research on the cost of professional and community mental health services.

1967 - Authorization of construction and staffing grants was extended (P.L. 90-21) through the fiscal year ending June 30, 1970.



## COMMUNITY MENTAL HEALTH CENTER LEGISLATION THROUGH TODAY

The adoption of the Community Mental Health Center Act in 1963 gave life to the "bold new approach" called for by President Kennedy.(45) This act was the first in a long and continuing legislative history of the community mental health center.

Originally, the community mental health center legislation was to include provisions for two kinds of federal support. Grants were to be made both to assist in the construction of mental health center facilities and to assist in meeting the costs of staffing these facilities. It was not until 1965 that Congress adopted legislation authorizing federal support for the costs of staffing community mental health centers. Staffing support was to be available to all community mental health centers, regardless of whether or not they had previously received any construction assistance.

1963 - Adoption of the Community Mental Health Centers Act (P.L. 88-164) authorized Federal grants to support construction of community mental health centers.

1965 - The Centers Act was amended (P.L. 89-105) to authorize Federal grants -- on a declining basis over 51 months -- in support of financing initial cost of professional and technical personnel of community mental health centers.

1967 - Authorization of construction and staffing grants was extended (P.L. 90-31) through the fiscal year ending June 30, 1970.



1968 - The Centers Act was amended (P.L. 90-574) to authorize Federal grants for the construction and staffing of community facilities and services for alcoholics and narcotics addicts. These amendments also permit States to use a portion of funds allotted for centers to help cover the cost of State planning for community mental health services.

The construction program established in 1963 was administered according to the terms of the initiating legislation until 1970. In that year, Congress adopted a series of amendments.

1970 - The Centers Act was amended (P.L. 91-211) to extend authorization for construction and staffing grants to community mental health centers and to facilities for alcoholics and narcotics addicts through the fiscal year ending June 30, 1973. The 1970 amendments also:

Extend the duration of all staffing grants to 8 years;

Authorize a higher percentage of funds in support of construction and staffing for programs in poverty areas;

Provide for grants to support development of mental health service programs in poverty areas;

Permit additional staffing grants to support further development of consultation services in all community mental health programs authorized under the statute;

Establish a new program of grants to support further development of children's mental health services, including construction, staffing, training, and evaluation.

The Centers Act was amended (P.L. 91-513) to extend drug programs to include services for drug abuse.



The Centers Act was amended (P.L. 91-515) by adding a new subsection dealing with maintenance of effort for staffing grants.

1973 - The Centers Act was amended (P.L. 91-616) to add a new section to authorize grants and contracts for the prevention and treatment of alcohol abuse and alcoholism.

The major change introduced by this legislation regarded a change in the concept of the federal share. With the passage of the 1970 Amendments, it was possible for centers serving poverty areas to receive construction support amounting to as much as ninety percent of the total costs of construction. Eligibility for this increased level of funding depended only on designation of the center's catchment area as a poverty area by the federal government.

The 1970 legislation also increased the level of federal staffing support. The time span that centers were eligible for staffing support was increased from fifty-one months to ninety-six months (eight years). The percentage of federal support was also increased. Centers serving designated poverty areas became eligible for a much higher percentage of federal staff support.

1972 - The Centers Act was amended (P.L. 92-255) to provide that community mental health centers, funded after June 30, 1972, must provide services for drug abusers living in their service area, if the Secretary determines that such services are necessary and feasible. (Centers must also assist the Federal Government in treatment and rehabilitation programs, when feasible.) Additional funds were authorized to meet the staffing costs occasioned by the enforcement of these new drug program requirements. The



legislation also authorized additional funds for special project grants for narcotic addicts and drug dependent persons.

- 1973 - Authorization of community mental health center construction, staffing, and children's services of alcoholism and drug abuse programs was extended (P.L. 93-45) through the fiscal year ending June 30, 1974.

Last year, 1975, Congress adopted another series of amendments to the Community Mental Health Center Act. The full content of this legislation reached local levels late in 1975. Mental health centers are now in the process of implementing the legislation.

- 1975 - The Community Mental Health Centers Amendments set forth in P.L. 94-63 authorize Federal funds for "the purposes of initiating new and continuing existing community mental health centers and initiating new services within existing centers, and for the monitoring of the performance of all federally funded centers to insure their responsiveness to community needs and national goals relating to community mental health care."

The major change initiated by these amendments is the extension of the community mental health center's essential services from five to twelve. Some of these services had been considered earlier as recommended. A few of these services were already being offered, but in very limited programs. Today, a comprehensive community mental health center must offer:

Taken from a memorandum from Dr. Raymond E. Ackerman, Deputy Commissioner Community Mental Health Services.



1. In-patient service
2. Out-patient service
3. Partial hospitalization service
4. Emergency services
5. Consultation and education  
(to include promotion of the prevention and control of rape)
6. Precare service
7. Aftercare service
8. Children's services
9. Services for the elderly
10. Half-way house services
11. Alcohol services
12. Drug addiction services

The legislation extends the provisions for federal staffing support. Although the staffing grants are still on an eight year basis, the initial percentage of federal support is higher while in the last two years the percentage is considerably lower. Special consideration is given to centers in designated poverty areas concerning planning grants, staffing grants and special program grants. The legislation requires mental health centers to operate a fee collection and reimbursement program. The center must assume an increased role in financially supporting itself. Provisions were introduced for extending the mental health centers recommended services including family planning, rape prevention and control, migrant health care, and mental health of the elderly.

\*Taken from a memorandum from Dr. Raymond E Ackerman, Deputy Commissioner Community Mental Health Services.



By July 1975, Federal grants for construction and/or staffing of services had been made to 603 centers in all 50 states, Puerto Rico, Guam, the Virgin Islands and the District of Columbia, covering about eighty-seven million Americans. When in operation, the 603 centers will serve approximately 41 percent of the nation's population. With the latest legislation the community mental health center of today is, as it has been since inception, in the midst of change and expansion.

Planning for a community mental health center usually begins with an identification of need. This involves balancing the anticipated rate of mental illness against available mental health resources in a community. (46) Determining the relative need includes: 1. taking an inventory of existing treatment resources within the community; 2. taking an inventory of non-psychiatric agencies which come into contact with mentally ill people and may assist them; 3. determining the extent of mental illness within the community.

A community generally has certain mental health objectives it wants to emphasize. These objectives, as well as the collected data, should be incorporated in developing the goals of the community mental health center. These goals must be clearly defined at the beginning of the planning process. (47)



## PLANNING THE COMMUNITY MENTAL HEALTH CENTER

It is clearly the intent of legislation that the community mental health center provide an expanding scope of service within the community. Consequently, in planning a mental health center, it is necessary to investigate the community to be served.

The community may be defined in several ways in addition to the legislated catchment area or state and county boundaries. The community can be defined by pattern of transportation. These may include private as well as public.

Planning for a community mental health center usually begins with an identification of need. "This involves balancing the anticipated rate of mental illness against available mental health resources in a community." (46) Determining the relative need includes: 1. taking an inventory of existing treatment resources within the community; 2. taking an inventory of non-psychiatric agencies which come into contact with mentally ill people and may assist them; 3. determining the extent of mental illness within the community.

A community generally has certain mental health objectives it wants to emphasize. These objectives, as well as the collected data, should be incorporated in developing the goals of the community mental health center. These goals must be clearly defined at the beginning of the planning process. (47)



Another fundamental task involves creating an organization and designing a service delivery system. Two approaches to community mental health center programs have emerged. They may be categorized as following either a "medical practice model or a human services model." (48)

The medical practice model of a community mental health system has a structural arrangement in which the mental health center, under medical leadership, assumes responsibility for and perhaps even supervision of all the communities mental health services. The resources of other agencies function in a basically supporting role. The comprehensive community mental health program is schematically represented as a circle, at the center of which is the community mental health center. Around the periphery are the community agencies and facilities, each with its own particular functions and goals. The mental health center's role is that of coordinator of existing services, innovator of new services, educator, administrator, and consultant to the community. (49)

Within the structural pattern and network of liaisons in the evolving human services model, the mental health center is just one of a variety of community resources which participate in cooperative ways to serve the mental health needs of all citizens. This model is particularly evident in rural areas and in those urban mental health programs which have a strong social action component. The mental health facility and other agencies work jointly with the same troubled families, cooperate in the development of new programs, and try to minimize competition with each other. (50)

The community mental health center may choose to either centralize or decentralize services. This decision is based



on the center established goals and administrative considerations. "The mandate of the community mental health center is to deliver readily accessible treatment and prevention services and to ensure continuity of quality care without regard to the patient's ability to pay a fee." (51) "Accessibility" and "continuity of care" are the key words. Centralized services may create problems in accessibility; however, continuity of care is stretched by decentralized services. However, two issues advocate exploration of decentralizing possibilities: "many regions have built-in problems of geographic and psychological inaccessibility such that no one location can meet the need of all segments of the population; and some components of center's program may need less accessibility than others." (52)

Closely related to the decision to centralize or decentralize is the location process. "The placement of a mental health service is a vital determinant of its physical and psychological accessibility." (53) Accessibility is one of four "relevant variables" in the location process. The other three are cost, availability of manpower, and relative need which was discussed earlier.

Accessibility, both geographic and psychological, should be studied carefully. Geographic accessibility may be measured in terms of distance, travel time, and cost of travel from various parts of the catchment area. Psychological accessibility is much more difficult to measure. An aid is to view it in terms of barriers to available services.



Cost is a major factor in considering any locational decision. The locational cost attached to a new construction is usually high because of land values. Often the choice of less expensive land results in an inferior or inaccessible site. (54)

The availability of professional and non-professional manpower is a crucial element in center planning. If staff cannot be acquired, services must be tailored to the existing manpower supply. (55)

The American Society of Planning Officials in an article by Gail Ornstein in 1967 investigated planning for a community mental health center. A list of locational criteria was established.

First, the site itself should be large enough to contain facilities adequate for present needs as well as to allow for future expansion. This last criterium is especially important because of the difficulty of calculating the actual need for the center's services and the likelihood that over-all demand will increase once new services are provided. Second, the location of the site should reflect the goals of the mental health center.

One of the goals is to provide treatment while permitting the patient to reside in and remain a citizen of his community. In order to achieve this, patients themselves, as well as their families and friends, must be able to travel from their homes to the center and back again in the course of the day. The center, therefore, must be located close to



the residential districts of the community and must be easily accessible.

Another goal of the center is to give comprehensive community care to those who could not otherwise afford it. Therefore, the center should be easy to reach by public transportation as well as by private cars. A location should not be chosen without careful investigation of bus and rapid transit routes.

Another consideration in locating the center is that "the more easily the center can be reached, the greater will be the flow of activity through it and consequently the greater the acceptance of the center into the community." The center, therefore, should be located in the main stream of daily activity. In suburban areas, the shopping center provides an ideal location. For example, the North Center in Daly City, California, is located on the second floor of a shopping center. In a large city, location on a major commercial street offers similar benefits. For example, Albert Einstein College of Medicine, Brooklyn, New York is presently experimenting with "store front" mental health centers located along well-traveled streets in an effort to provide mental health services for a five-square-mile area of one of New York City's worst slums.

Location is also important for the staff. Psychiatrists and other mental health professionals are often hired by a center on a part-time basis and may have a private practice



and/or a university appointment as well. They, therefore, prefer a location convenient to their own offices or the university.

Although physical proximity to a general hospital which provides psychiatric services is by no means a requirement, it does offer certain advantages to a CMHC. For example, it makes following patients in both the in-patient and out-patient stages easier, and facilitates continuity of care. (56)

In order to explore the architectural implications of the community mental health center, one must consider the nature of the people involved. The mentally ill person often suffers from disturbances of thinking, perception, and emotion. One of the more serious psychiatric illnesses is schizophrenia. "An environment which is good for the most gravely ill will be no less good for others. (57)

A person suffering from schizophrenia may experience distortion in self perception, perception of others, space perception, and time perception. These perceptions vary among of their age, social status or even their mental status. "They are quite genuinely worried that they may be happening or may have become even more paranoid." (58) Some patients have great difficulty recognizing other people. All people may look alike or they may all appear different all the time. Many kinds of spatial distortion occur in schizophrenia. "This is a field in which architect, psychologist,



32

THE ARCHITECTURE OF THE COMMUNITY MENTAL HEALTH CENTER

There is probably no other building type in which design is more critical or its influence more demonstrable than in architecture for mental health. (57)

To design a community mental health center in the middle of the twentieth century is a challenge involving the principles of programming and design which make close collaboration essential between mental health specialists who think in terms of milieu for therapeutic purposes and architectural specialists who think in terms of visual, physical, and aesthetic environment. (58)

In order to explore the architectural implication of the community mental health center, one must consider the nature of the people involved. The mentally ill person often suffers from disturbances of thinking, perception, and emotion. One of the more serious psychiatric illness is schizophrenia. "An environment which is good for the most gravely ill will be no less good for others. (59)

A person suffering from schizophrenia may experience distortion in self perception, perception of others, space perception, and time perception. Some patients become very unsure of their age, social status or even their sexual status. "They are quite genuinely worried that they may be becoming or may have become some other person." (60) Some patients have great difficulty recognizing other people. All people may look alike or they may all appear different all the time. Many kinds of spatial distortion occur in schizophrenia. "This is a field in which architect, psychologist,



psychiatrist, and sociologist can work together fruitfully; for although it is in the schizophrenic that these disturbances are most frequently manifest, under stress and fatigue they readily occur in children, many adolescents, and some adults." (61) Another affected and closely related perception is that of time. Time perception is grossly and mysteriously altered in many psychiatric illnesses.

Although the community mental health center as a building type is still relatively new and indistinct, some design criteria have emerged. Combining the considerations for the user's physical and psychological needs with existing observations will provide an insight into the architecture of the community mental health center.

As perceptual difficulty is a primary handicap of the mentally ill, ambiguity must be avoided.

Avoid anything, says Dr. Osmund, which makes heavy demands on the patients' impaired perceptual apparatus. Avoid ambiguous and muddled design, too much complication, even though it may be aesthetically interesting. Avoid too much space, and too many people infringing on the sick person. Insure that shapes, color, lighting, textures are unambiguous, that corridors and spaces are clearly defined, that living space of the biologically derived kind is provided. (62)

Clarity of form and space is a necessity in the mental health center. A patient should be able to sense where he is and be able to move between the various parts of the center without difficulty. (63) The architectural design elements should be distinct and identifiable. One element or function



should be clearly distinguishable from others. All activities and parts of the facility should not appear to be other than what they are.(64) A patient should be able to differentiate readily between the indoors and the outdoors. "A sense of enclosure must be adequately established, so that it is not destroyed by glass walls or the extension of the enclosure to the outside."(65) Entrances, circulation, and stairways should be accessible and identifiable.

The patients inability to distinguish between space and time can be aggravated by visual and acoustical effects in the facility. This point was discussed by a study group at Rice University in 1965.

Long corridors that have identical units of dimension make each unit seem to reappear, thereby suggesting that time is standing still. In large landscapes, the constant repetition of identical windows, whole building elevations, equally spaced trees, identical courtyards can also convey this sense of stopped time.(66)

Scale is another design factor which plays an important part in the patient's physical and psychological well being. The general scale of the facility should, of course, be compatible with the surrounding neighborhood. A monumental scale should not be used for a community mental health center. The architect should try "to avoid confronting the individual viewer with the full complexity of the building at any point, but give him instead the chance to respond to a limited portion of it."(67)

In both natural and artificial lighting, sharply contrasting bright and dark surfaces should also be avoided.



The scale of spaces, both inside and outside, must be appropriate for the number of persons using the space and for the requirements of various activities and social interaction to occur within the space. A mental health center should provide a wide range of spaces offering a full scope of social interaction possibilities. The role of personal space in maintaining mental health is very important; consequently, "a basic requirement for all social interaction of the mentally ill is the privilege of privacy." (68)

As the director of N.I.M.H. in 1967, Dr. Stanley F. Yolles said of the community mental health center, "the only future certainty is change, so flexibility is a primary objective." (69) Provisions for convertibility and expansion must be included as a requirement for a new mental health center. "The design should be based on the assumption that the treatment patterns of tomorrow will be different and for the most part unpredictable." (70) Flexibility, which implies minor architectural changes can be made to change the space itself, is requested. However, for psychological reasons, a space capable of adaptability is preferred. (71) Adaptability meaning many functions can occur utilizing the one space.

Lighting in a mental health center should be carefully studied. It is desirable to provide numerous opportunities for outlook and to provide "cheerfully" lit interiors. Glare is to be avoided. In both natural and artificial lighting, sharply contrasting bright and dark surfaces should also be avoided.



Materials chosen for a mental health center should reflect a level of quality. "Relying upon the experience that many mental patients, like the rest of us, tend to respect obvious quality and will hesitate to despoil a carpet or piece of woodwork when they would not hesitate to attack a concrete floor or a steel cot." (72) Superficial materials or finishes, such as a wood grain finish placed on a metal door, should for psychological reasons be avoided. Soft textures are generally preferable, while many changes in texture is undesirable. The interior colors should be cheerful but restful. (73)

As Dr. Stanley F. Yolles said in 1967, "since no two communities are alike, no two centers will be alike." (74) This statement might have been better phrased: "no two centers need be alike." Although every mental health delivery system is indeed unique to its community, much can be learned and applied from an investigation of previous efforts.

#### STAFF FOR THE COLUMBIA CMHC

25 Administration  
 15 Outpatient  
 5 Inpatient  
 29 Child & Adolescent  
 2 Pre-care & Aftercare  
 5 Community Services  
 Consultation &  
 Education  
 Pastoral Service  
 3 Adjunctives  
 2 Alcohol & Drug Abuse  
 2 Partial Hospitalization

2 Physicians  
 1 Psychiatrist  
 10 Psychologist  
 8 Clinical Counselors  
 9 Clinical Social Workers  
 10 Nurses  
 22 Clerical  
 1 Mental Health Technician  
 6 Mental Health Counselors  
 3 Chaplains  
 1 Child Psychiatrist  
 1 Therapist  
 9 Administrators  
 2 Trades Workers  
 2 Addiction Specialist  
 1 Mental Health Assistant  
 1 Research Analyst

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## THE COLUMBIA AREA COMMUNITY MENTAL HEALTH CENTER

### STAFF FOR THE COLUMBIA CMHC

26 Administration  
15 Outpatient  
5 Inpatient  
29 Child & Adolescent  
2 Precare & Aftercare  
5 Community Services  
Consultation &  
Education  
Pastoral Service  
3 Adjunctives  
2 Alcohol & Drug Abuse  
2 Partial Hospitalization

2 Physicians  
1 Psychiatrist  
10 Psychologist  
8 Clinical Counselors  
9 Clinical Social Workers  
10 Nurses  
22 Clerical  
1 Mental Health Technician  
6 Mental Health Counselors  
3 Chaplains  
1 Child Psychiatrist  
1 Therapist  
9 Administrators  
2 Trades Workers  
2 Addiction Specialist  
1 Mental Health Assistant  
1 Research Analyst

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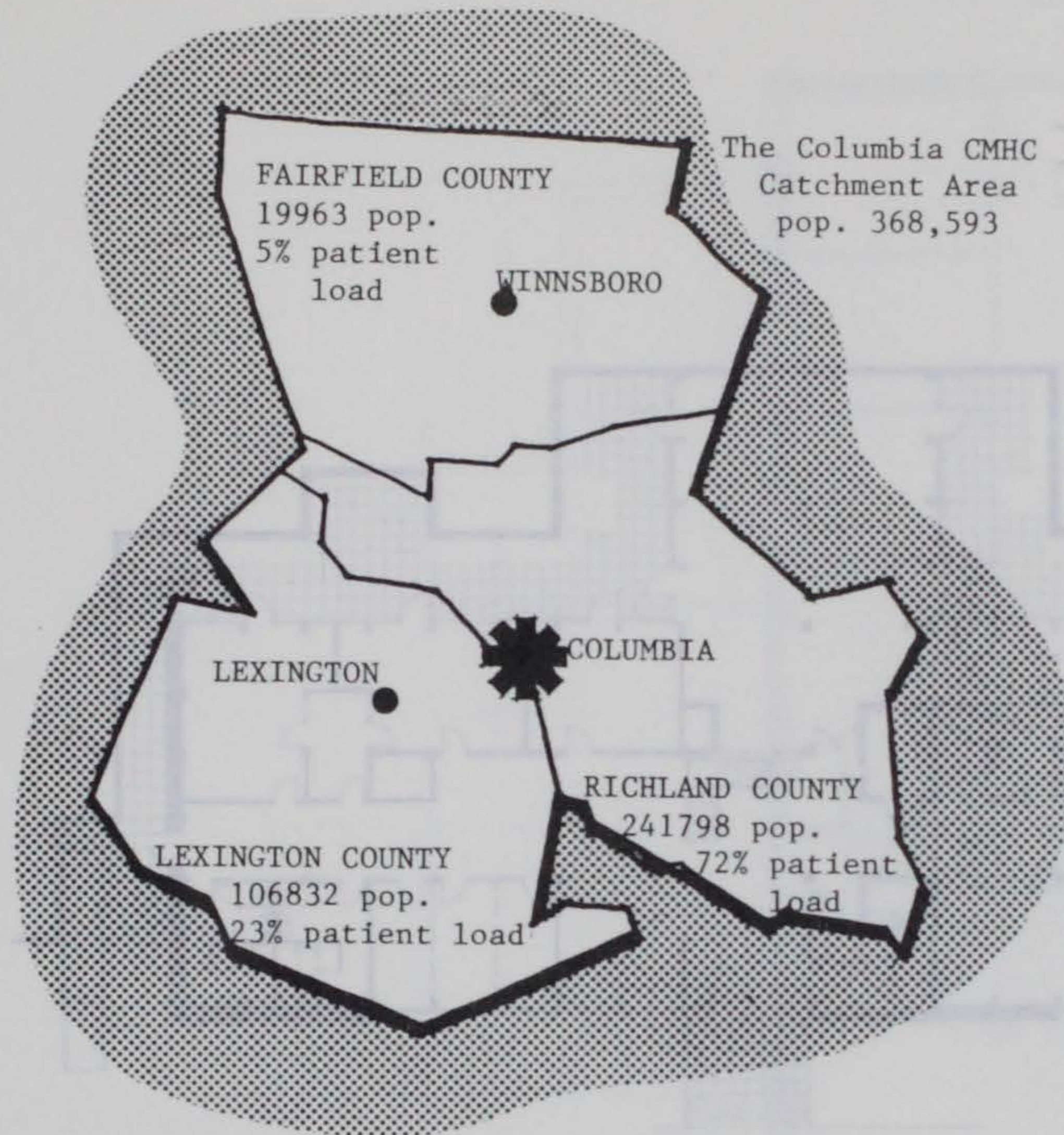
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In 1967, the Columbia Area Mental Health Center became the first operational comprehensive community mental health center in the southeastern United States. The Columbia Mental Health Center serves a three-county catchment area with approximately 368,593 inhabitants. The center is located within the largest urban center in South Carolina. Thirty percent of the catchment area's population is concentrated in the Columbia area. The Columbia Mental Health Center is located in the heart of Columbia adjacent to Richland Memorial Hospital.

The greatest majority of the services offered by the Columbia Center are offered under one roof at the Richland Hospital location. The exception to this are various after-care groups that meet in outlying towns. These groups meet in churches, community centers and a doctor's office. Most of the aftercare groups are under the direction of Columbia CMHC personnel; however, the group meeting in Winnsboro is under the direction of a local physician. It is expected that in the future a satellite clinic will evolve in this location.

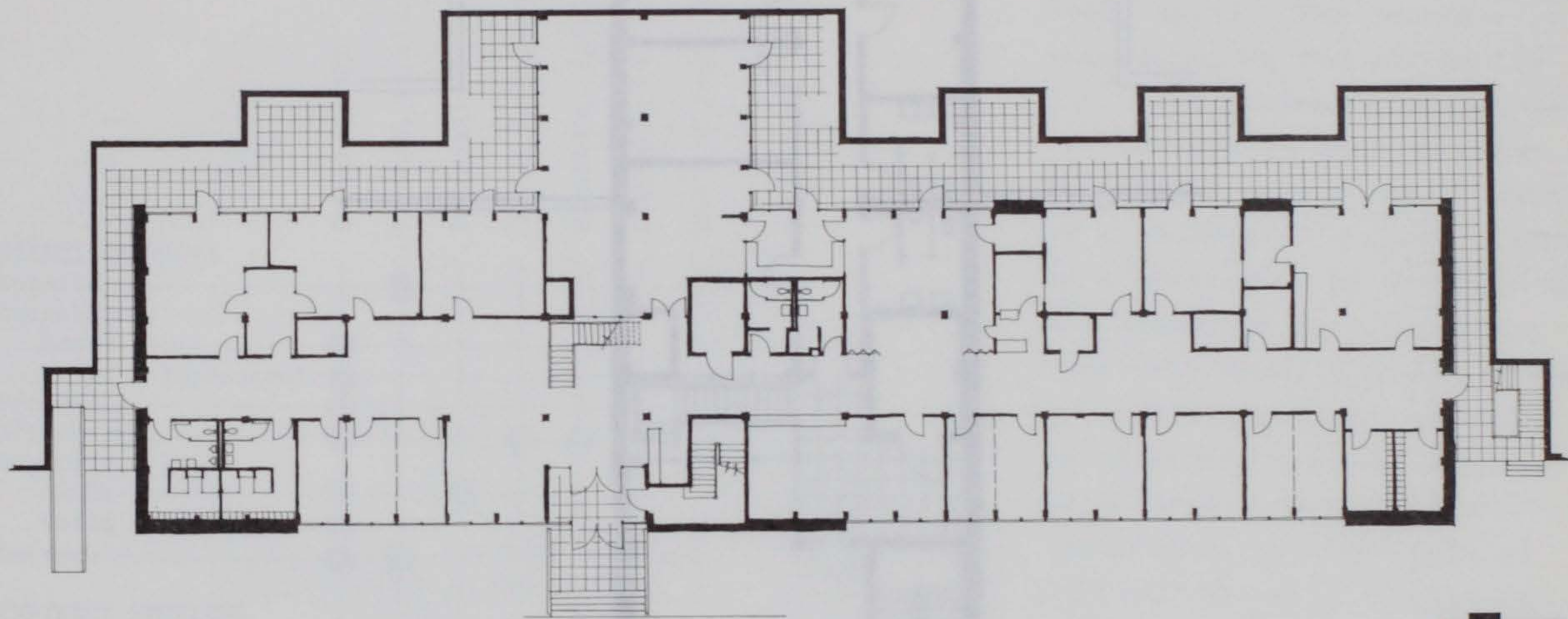
The indirect services, although administered from the Richland location, really have no attachment to any facility. Currently the Consultation and Education Section have a demonstration project under way with the Lexington County School System. Meetings and seminars take place at the





various schools within the system. The Columbia CMHC is leading other programs nationally in Industrial Consultation. Patient data is used to determine common denominators and locate businesses or factories with a high incidence of Mental Health problems. Workers from the Mental Health Center then visit and offer services. This is another indirect service which is directed from the Richland location, but takes place at various locations in industry. It should be noted that with a program directed from a central location a mobile unit could be extremely useful. Dr. Peggy Shealy, director of Consultation and Education Service in Columbia, confirmed the need for a mobile unit. Dr. Shealy indicated that larger spaces for meetings or seminars were relatively easy to





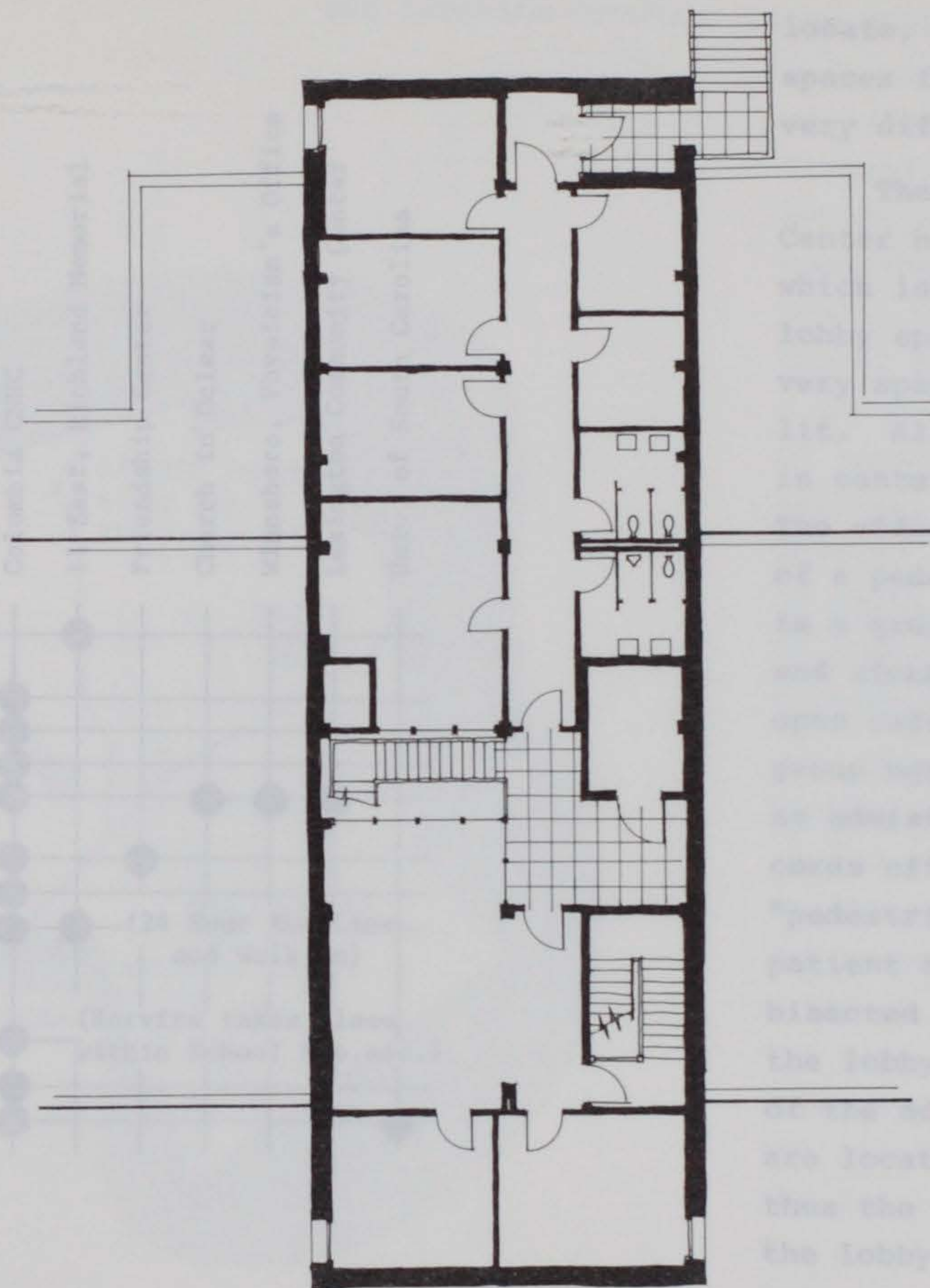


# DIRECT SERVICES

- Emergency
- Day Care
- Aftercare
- Pre-care
- Child & Adolescent
- Adult
- Outpatient
- Immediate

## INDIRECT SERVICES

- Research & Evaluation
- Pastoral Service
- Education
- Consultation and



locate, however, smaller spaces for counseling were very difficult to find. The Columbia Mental Health Center has a central corridor which is broken by a two-story lobby space. The corridor is very spacious and indirectly lit. All patient circulation is centered on this corridor. The lobby is similar to that of a pedestrian street. There is a great deal of activity on and about the corridor. The open lobby area, activity areas, group therapy rooms, as well as education, recreation and records offices open to this "pedestrian street." All patient and staff traffic is directed by public traffic at the lobby area. The majority of the administration offices are located on the second floor thus the public traffic through the lobby and up the stairs.



THE ANDERSON-ODONNELL-PIC

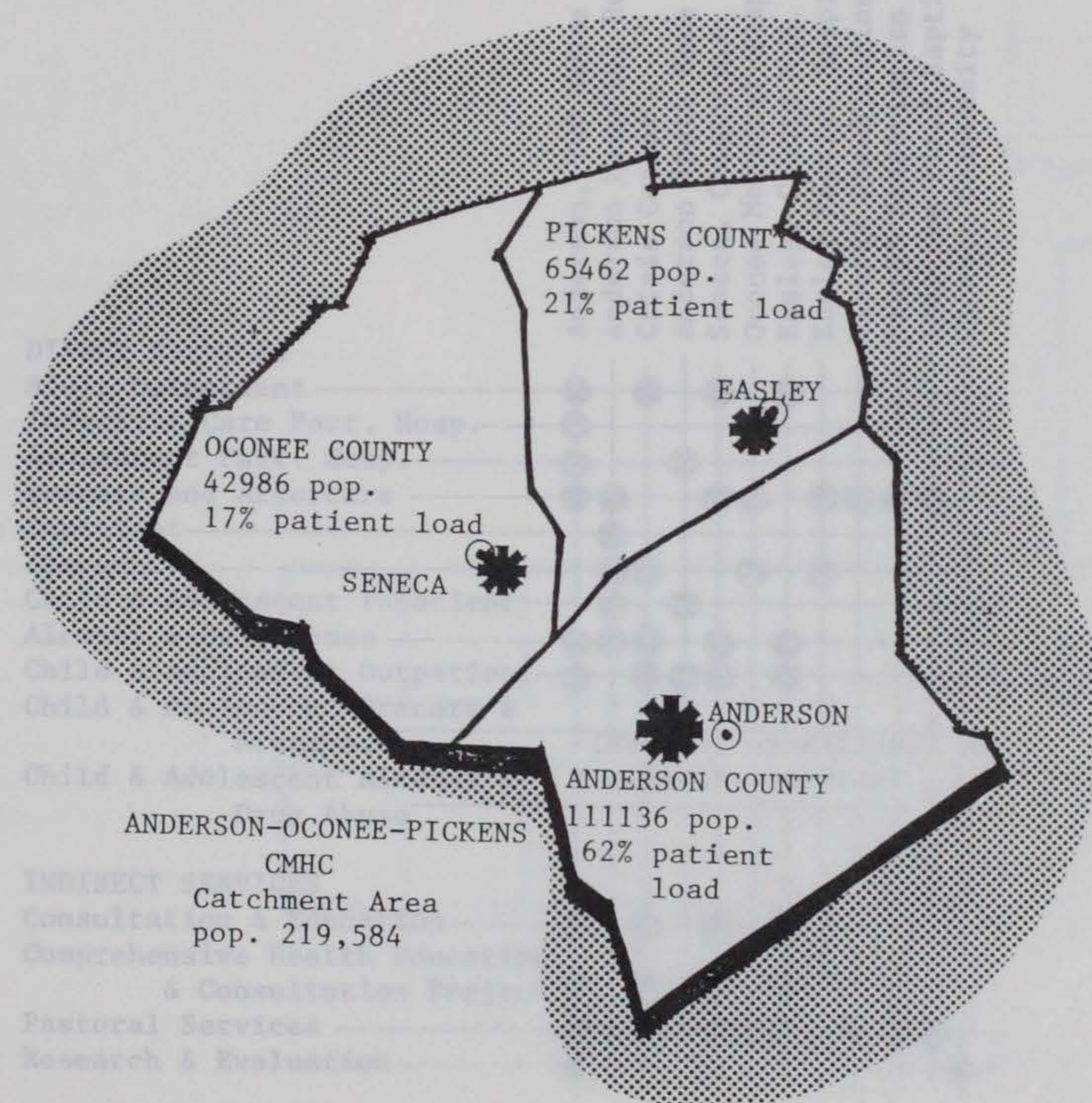
	Columbia CMHC	11 East, Richland Memorial	Friendship Center	Church in Oclet	Winnboro, Physician's Office	Lexington Community Center	Univ. of South Carolina
DIRECT SERVICES							
Inpatient		●					
Outpatient							
Adult	●						
Child & Adolescent	●						
Precare	●						
Aftercare	●			●	●	●	
Day Care							
Adult	●		●				
Child & Adolescent	●						
Emergency	●	●	(24 Hour Hot Line and Walk-in)				
INDIRECT SERVICES							
Consultation and Education	●	(Service takes place within School Sys. etc.)					
Pastorial Service	●						
Research & Evaluation	●						●

locate, however, smaller spaces for counseling were very difficult to find.

The Columbia Mental Health Center has a central corridor which is broken by a two-story lobby space. The corridor is very spacious and indirectly lit. All patient circulation is centered on this corridor. The effect is similar to that of a pedestrian street. There is a great deal of activity on and along the corridor. The open cafe area, activity areas, group meeting rooms, as well as admission officers and records office open to this "pedestrian street." The patient and staff traffic is bisected by public traffic at the lobby area. The majority of the administration offices are located on the second floor thus the public traffic through the lobby and up the stairs.



# THE ANDERSON-OCONEE-PICKENS MENTAL HEALTH CENTER



The Anderson-Oconee-Pickens Mental Health Center became a fully operational Comprehensive Community Mental Health Center in 1968. The center provides services for a three-county catchment area of approximately 212,000 inhabitants. The catchment area, located in the Piedmont Region of South Carolina, is composed of Anderson, Oconee, and Pickens counties.

The Anderson-Oconee-Pickens Mental Health Center is composed of a major facility, located in Anderson, and two satellite facilities, located in Seneca and Easley. The main facility is further supported by the Crisis Center, the Anderson Youth Home, and the Anderson Memorial Hospital. The satellite facility in Seneca maintains two holding rooms in the Oconee Memorial



	Anderson, 200 McGee Rd.	Anderson Memorial Hospital	Crisis Center	Anderson Youth Home	Seneca, County M.H. Clinic	Oconee Memorial Hospital	Easley, County M.H. Clinic	Easley Baptist Hospital	Liberty Presbyterian Church	Belton Presbyterian Church	Anderson First Baptist Church	Clemson University
<b>DIRECT SERVICES</b>												
Adult Outpatient	●		●		●		●					
Intensive Care Part. Hosp.	●											
Adolescent Part. Hosp.	●			●								
Precare and Aftercare	●	●			●	●		●	●	●	●	
Inpatient	●	●										
Emergency	●	●	●			●		●				
Child & Adolescent Inpatient	●	●		●								
Alcohol & Drug Abuse	●	●	●		●		●					
Child & Adolescent Outpatient	●	●	●	●	●		●					
Child & Adolescent Precare & Aftercare	●	●	●	●	●		●					
Child & Adolescent Alcohol & Drug Abuse												
(Not yet operational as a separate service)												
<b>INDIRECT SERVICES</b>												
Consultation & Education	●	●			●		●					
Comprehensive Health Education & Consultation Project	●	●			●		●					
Pastoral Services	●	●	●		●	●	●	●	●	●	●	
Research & Evaluation	●											●

Hospital. In Easley, the satellite facility has holding rooms in the Easley Baptist Hospital.

The mental health center provides a comprehensive range of services under the Mental Health Act of 1963. Some services, such as Precare, Aftercare, and Out-patient, are offered both in Anderson and at the satellite clinics. Services, such as In-patient and Patient Hospitalization are only offered in Anderson.

One staff mans the Anderson center, as well as the satellites. Members of the staff spend a percentage of their time in each of the facilities. However, these percentages may vary such that a majority of one's time may be spent in one of the facilities. This is especially true of the lower echelon support staff and administrative staff.



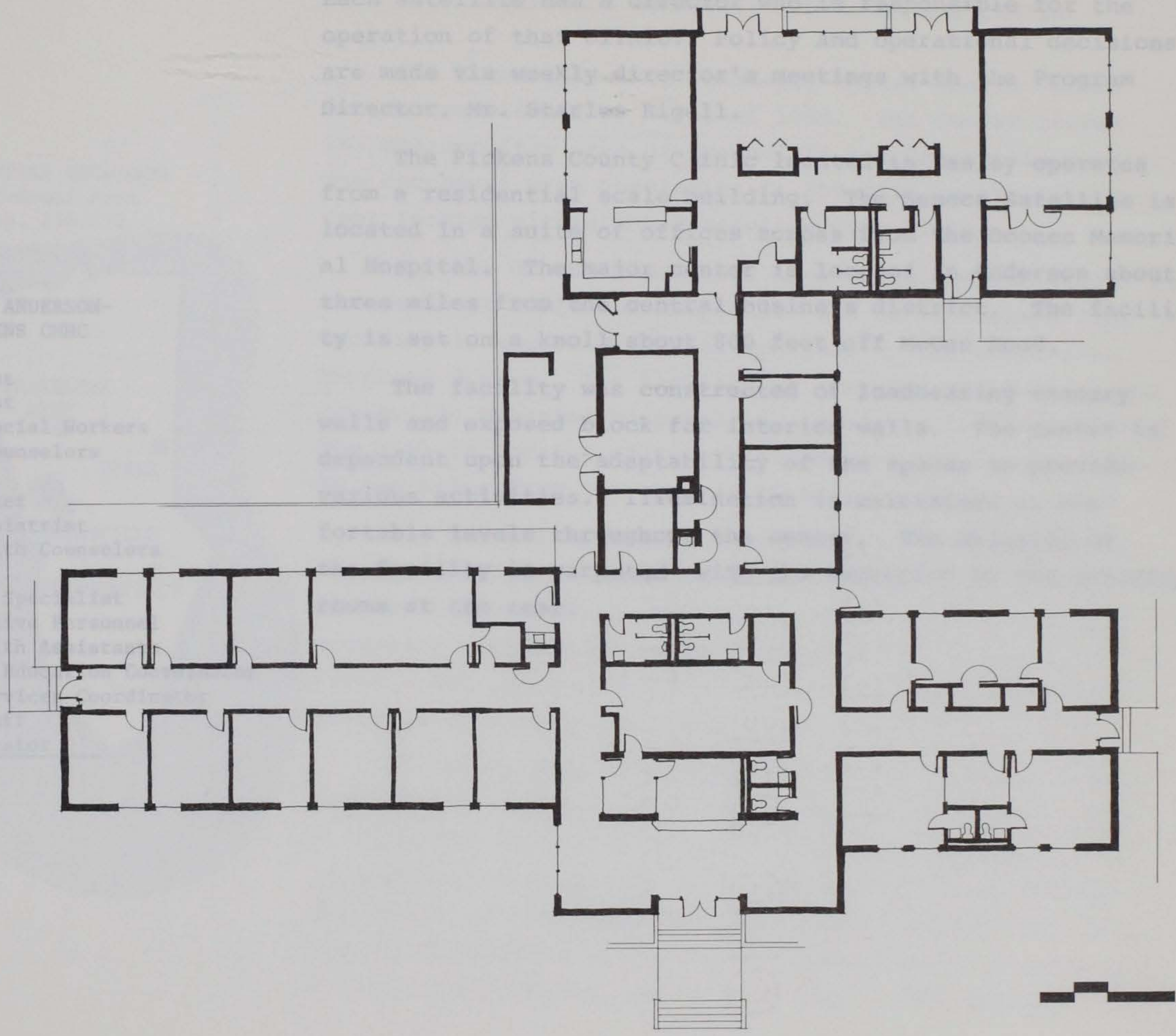
Each satellite has a director who is responsible for the operation of the facility. Policy and operational decisions are made via weekly director's meetings with the Program Director, Mr. Stanley Higley.

The Pickens County Community Center is operated as a residential facility. The facility is located in a building which was formerly a military hospital. The facility is about three miles from the center of town. The facility is set on a knoll about 10 feet off the ground.

The facility was constructed of loadbearing masonry walls and was used for storage of military equipment. The facility is dependent upon the hospital for medical services. The facility is a four-story building with a central corridor and a series of rooms on each floor. The facility is a residential facility for the mentally ill.

STAFF FOR THE ANDERSON-  
OCHNER-PICKENS CMHC

- 1 Psychiatrist
- 6 Psychologist
- 4 Clinical Social Workers
- 11 Clinical Counselors
- 2 Physicians
- 1 Social Worker
- 1 Child Psychiatrist
- 4 Mental Health Counselors
- 3 Chaplains
- 1 Addictions Specialist
- 3 Administrative Personnel
- 2 Mental Health Assistants
- 2 Continuing Care Workers
- 4 Special Services Coordinators
- 1 Nursing Staff
- 1 Health Educator





Each satellite has a director who is responsible for the operation of that clinic. Policy and operational decisions are made via weekly director's meetings with the Program Director, Mr. Starlus Rigell.

The Pickens County Clinic located in Easley operates from a residential scale building. The Seneca Satellite is located in a suite of offices across from the Oconee Memorial Hospital. The major center is located in Anderson about three miles from the central business district. The facility is set on a knoll about 800 feet off McGee Road.

The facility was constructed of loadbearing masonry walls and exposed block for interior walls. The center is dependent upon the adaptability of the spaces to provide various activities. Illumination is maintained at comfortable levels throughout the center. The majority of the facility is carpeted with the exception of the activity rooms at the rear.

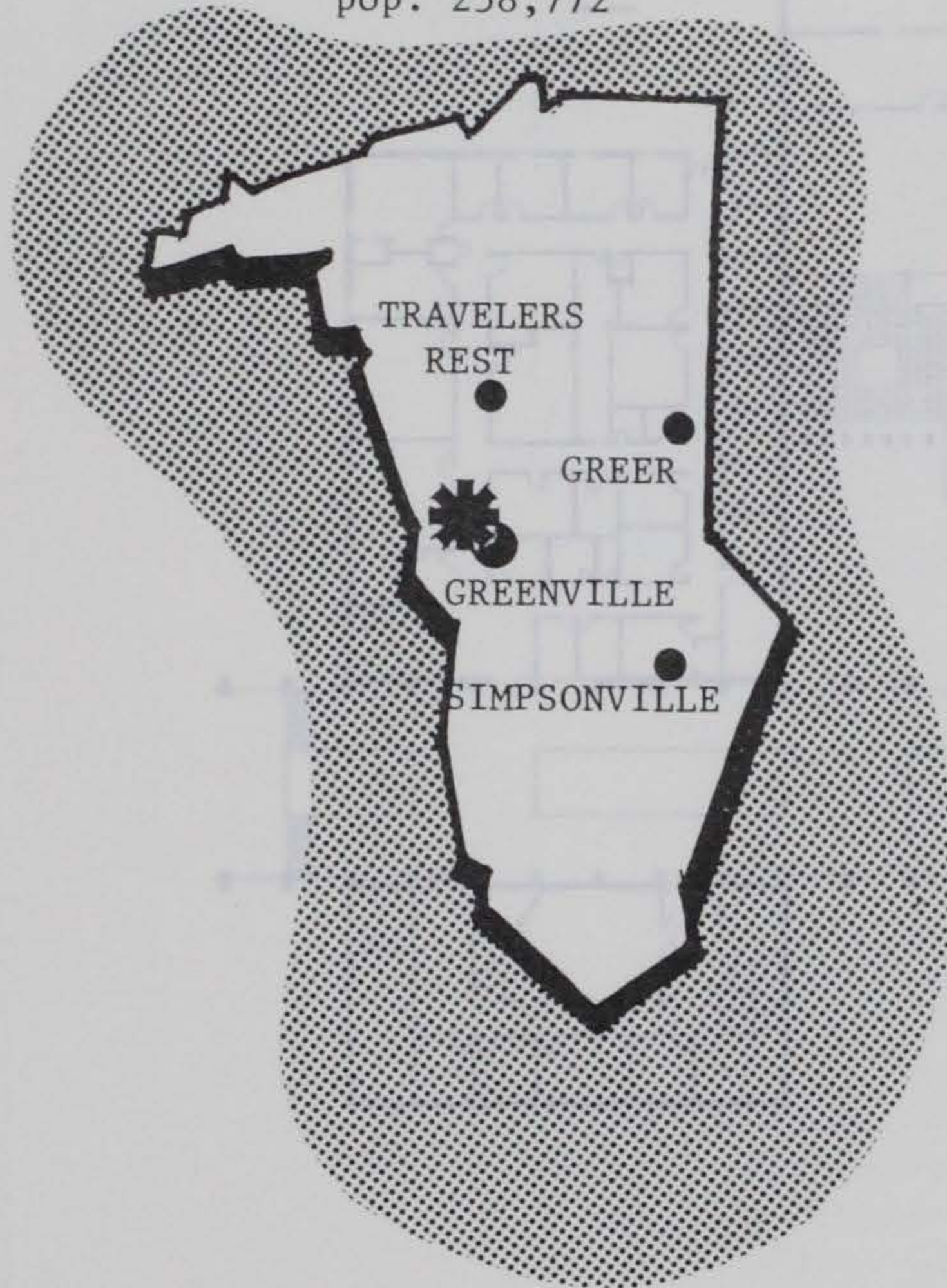
STAFF FOR THE ANDERSON-  
OCONEE-PICKENS CMHC

- 1 Psychiatrist
- 6 Psychologist
- 4 Clinical Social Workers
- 11 Clinical Counselors
- 2 Physicians
- 1 Social Worker
- 1 Child Psychiatrist
- 4 Mental Health Counselors
- 3 Chaplains
- 1 Addictions Specialist
- 3 Administrative Personnel
- 2 Mental Health Assistants
- 2 Continuing Education Coordinator
- 4 Special Services Coordinator
- 3 Nursing Staff
- 1 Health Educator



## GREENVILLE COMMUNITY MENTAL HEALTH CENTER

GREENVILLE AREA CMHC  
Catchment Area  
pop. 258,772



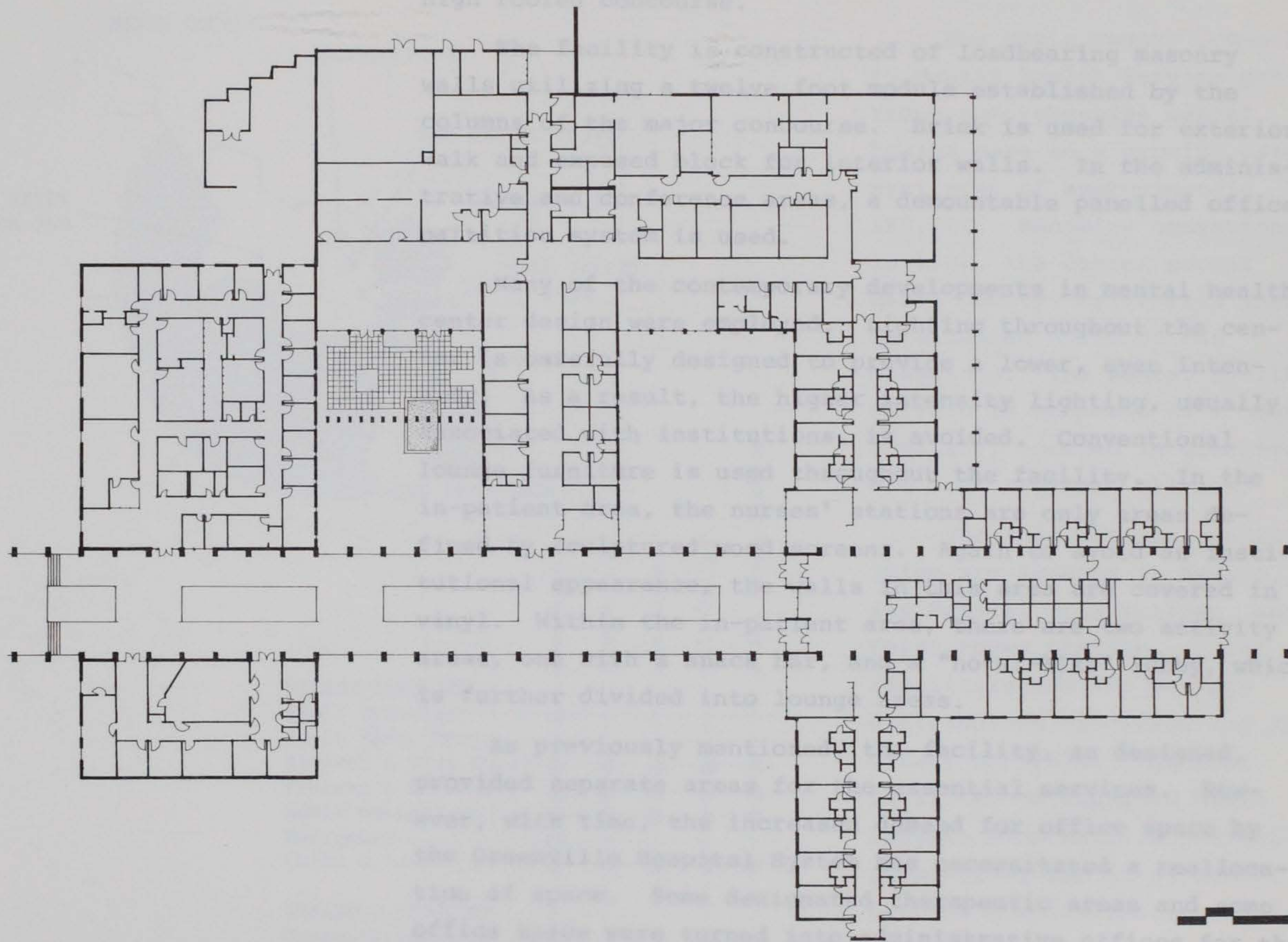
The Greenville Area Community Mental Health Center became operational in March of 1969. The Center serves the metropolitan area of Greenville and Greenville County. The catchment area population is 258,772, twenty-four percent located within the Greenville City limits.

The hub of the Greenville Area Mental Health Center is the Marshall I Pickens Hospital. The 62,000 square foot facility is a part of and is operated by the Greenville Hospital System. The facility is situated adjacent to the Greenville Memorial Hospital on a twelve acre tract of land. The site is located adjacent to the city limits approximately two miles from the central business district.

The Greenville Mental Health Center maintains three satellite clinics. Each of these clinics offer a full range of services excluding in-patient. Two of the satellites are occupying residential scale structures in Travelers Rest and Greer. The third satellite, located in Simpsonville, occupies a brick office structure.

In the Marshall I Pickens Facility, all of the direct and indirect services are located on the same site. The facility was initially designed as a compromise between a separate-pod concept and a one unified-structure concept. The result of the compromise was to give each of the five essential services its own identifiable space interrelated by corridors, courts, and covered walk. The dominant







unifying element is a 40-foot wide canal 376 foot long, high roofed concourse.

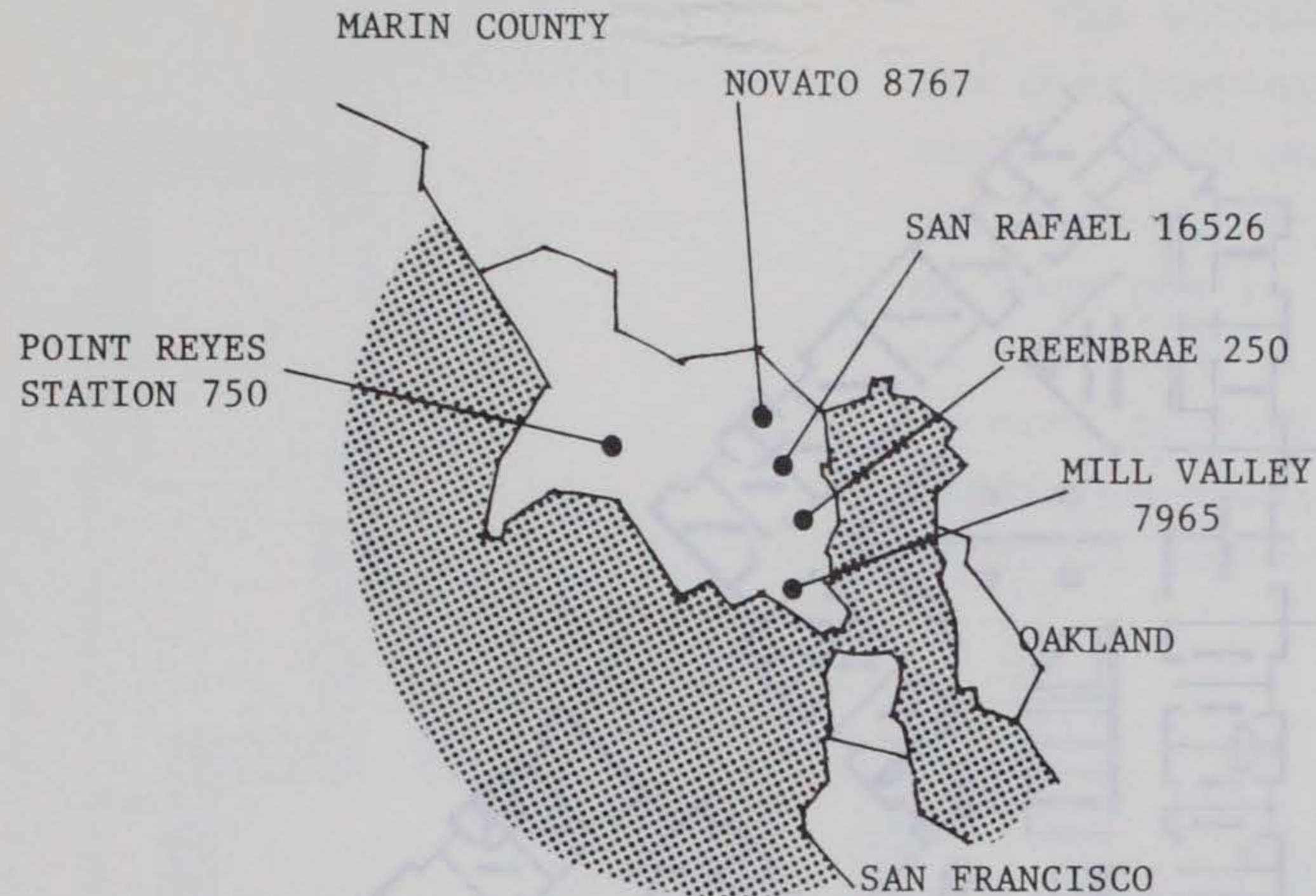
The facility is constructed of loadbearing masonry walls utilizing a twelve foot module established by the columns of the major concourse. Brick is used for exterior walk and exposed block for interior walls. In the administrative and conference areas, a demountable panelled office partition system is used.

Many of the contemporary developments in mental health center design were employed. Lighting throughout the center is carefully designed to provide a lower, even intensity. As a result, the higher intensity lighting, usually associated with institutions, is avoided. Conventional lounge furniture is used throughout the facility. In the in-patient area, the nurses' stations are only areas defined by sculptured wood screens. Again to avoid an institutional appearance, the walls in this area are covered in vinyl. Within the in-patient area, there are two activity areas, one with a snack bar, and a "hotel-like" lobby, which is further divided into lounge areas.

As previously mentioned, the facility, as designed, provided separate areas for the essential services. However, with time, the increased demand for office space by the Greenville Hospital System has necessitated a reallocation of space. Some designated therapeutic areas and some office space were turned into administrative offices for the Hospital System.



## MARIN COUNTY COMMUNITY MENTAL HEALTH CENTER



	Greenbrae	Novato	San Rafael	Mill Valley	Point Reyes Station
DIRECT SERVICES					
Adult Inpatient	●				
Adult Part. Hosp.	●				
Alcohol & Drug Abuse	●	●	●	●	●
Precare & Aftercare	●	●	●	●	●
Adult Outpatient	●	●	●	●	●
Emergency	●				
Child & Adolescent	●	●	●	●	●
INDIRECT SERVICES					
Consultation & Education	●	●	●	●	●
Evaluation	●				

The Marin County Community Mental Health Service provides comprehensive mental health care to a growing catchment area of approximately 185,000. Becoming operational in 1968, the center serves Marin County, California which is situated north of San Francisco. The Mental Health Service is composed of a base facility, located in Greenbrae, and four regional clinics.

The four regional facilities are located in Novato, San Rafael, Mill Village, and Point Reyes Station. These facilities are the primary distributors of direct and indirect services. The base facility, adjacent to Marin General Hospital, is primarily responsible for in-patient, partial-hospitalization, and emergency. However, out-patient, planning, and

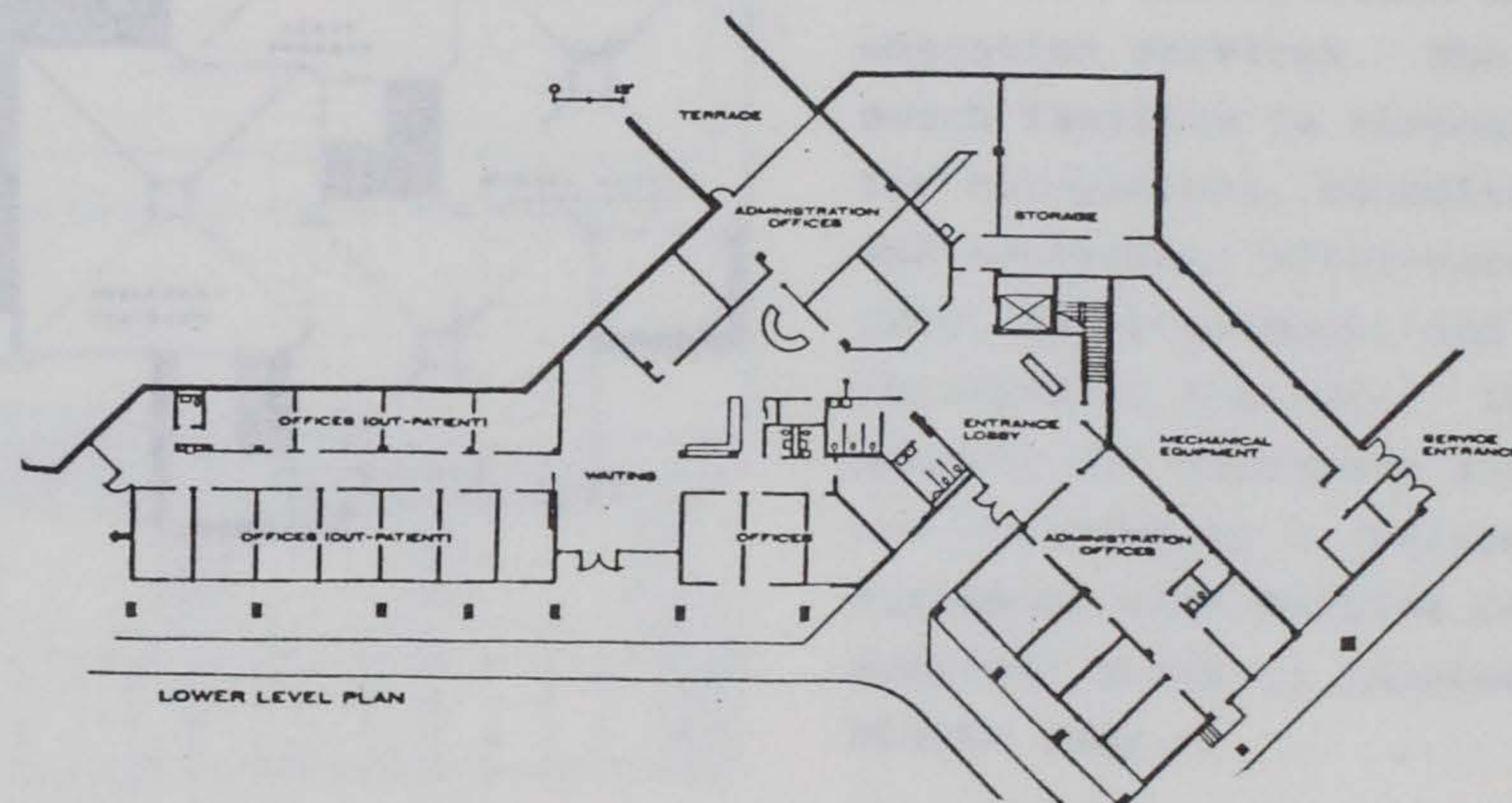






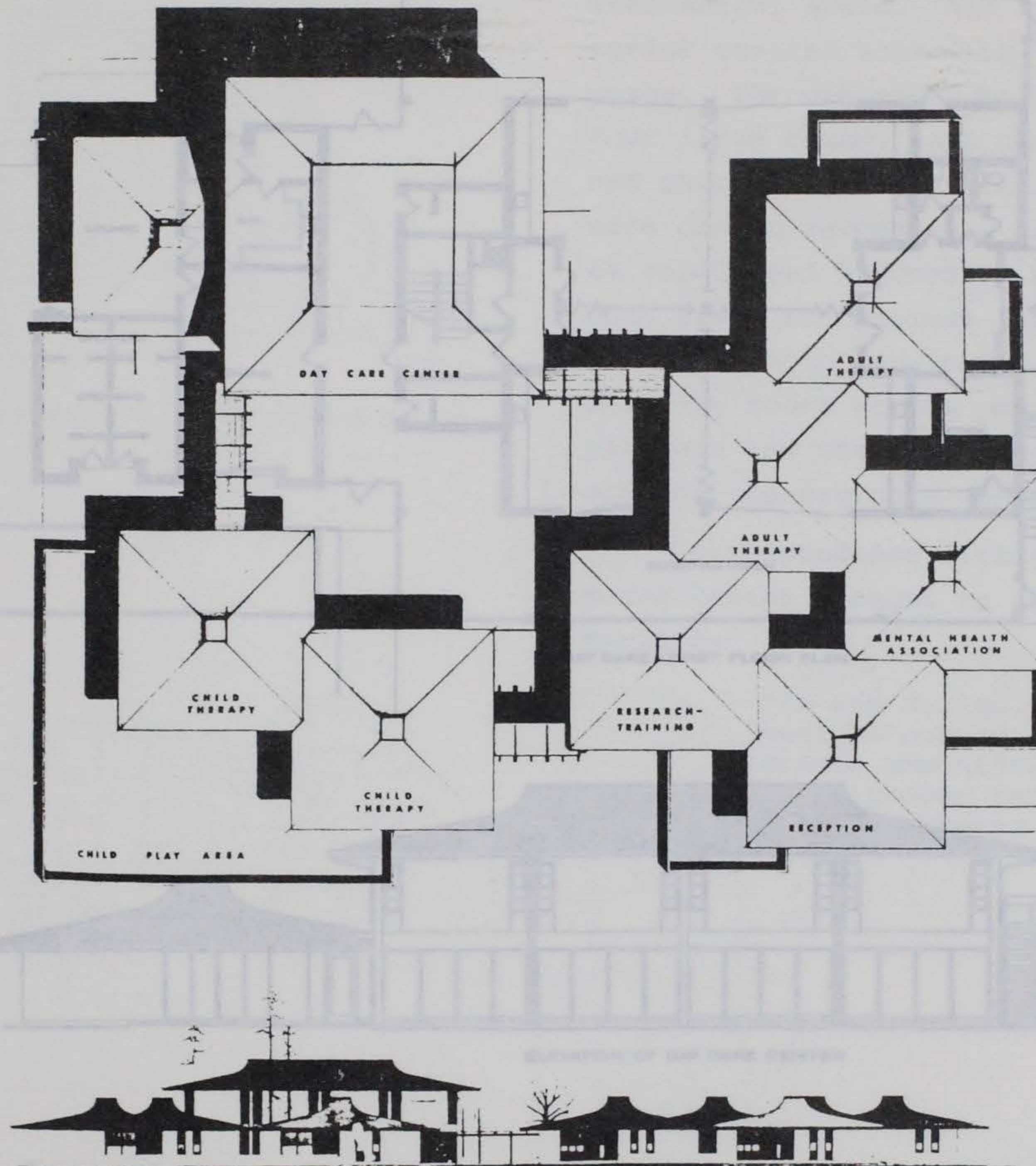
planning, and administrative services.

The second level is divided into pods. Both pods house the overlapping in-patient and partial hospitalization services. Each pod was designed to serve one treatment group and made up of patients from both services. At the center of each pod is an open living-dining area around which most of the group's activity should focus. As the two pods merge, an area providing sheared support facilities for both team staffs is created. This also enables a smaller nighttime staff to supervise patients.





# THE DAYTONA BEACH COMMUNITY MENTAL HEALTH CENTER (75)

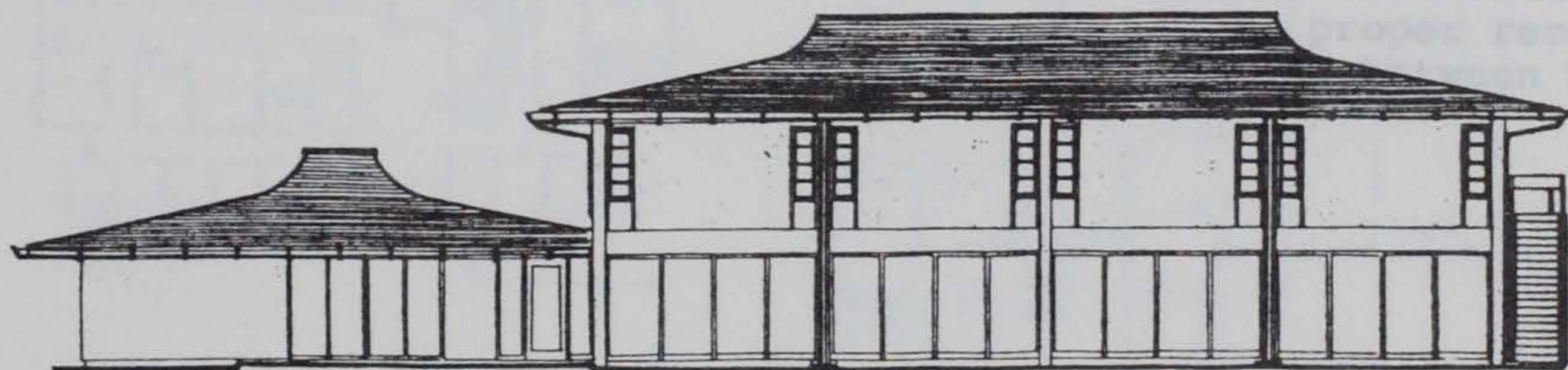
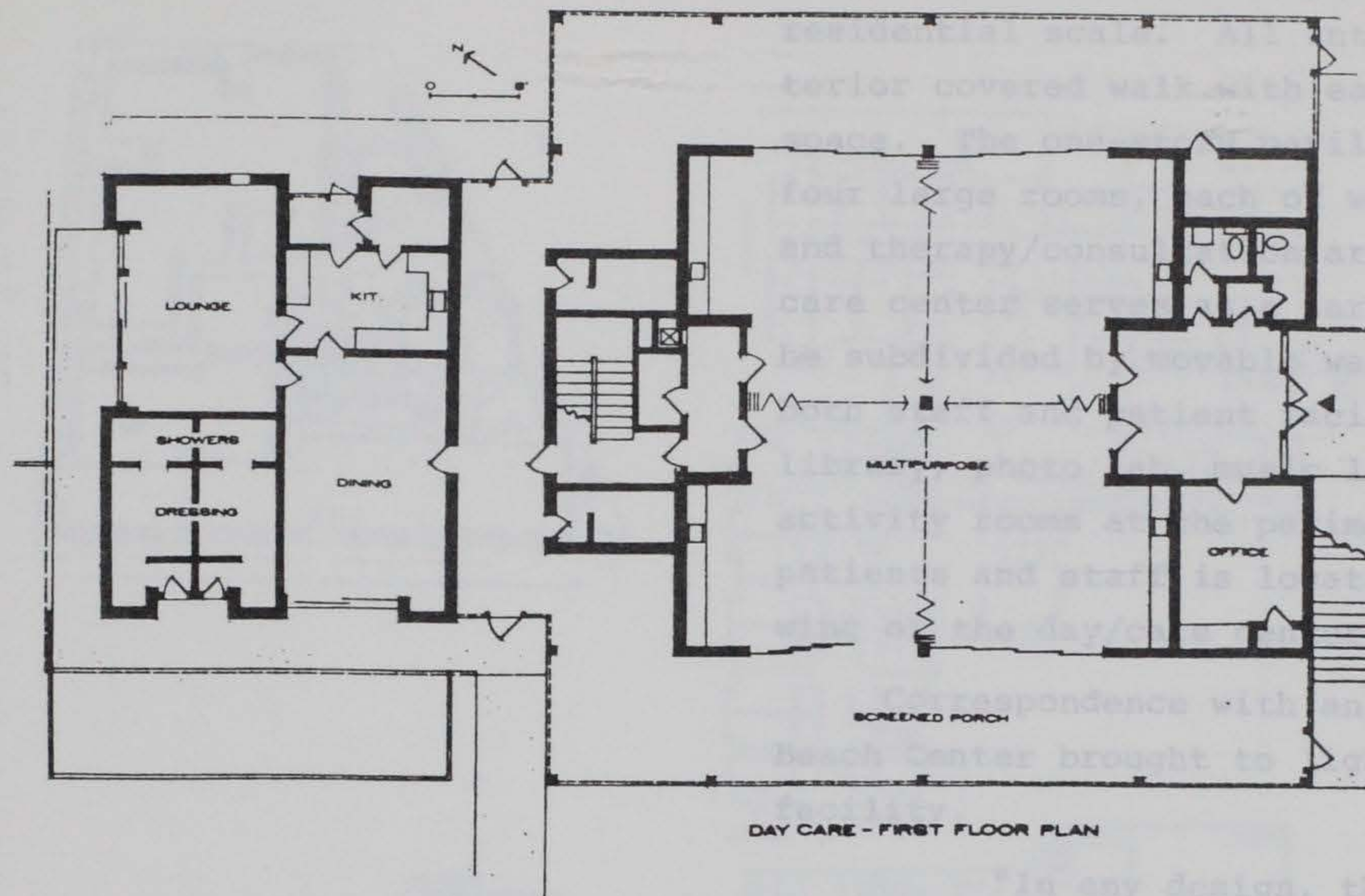


The Human Resources Center of Volusia County, Florida became operational July 1967. The center, composed of a major facility in Daytona Beach and seven satellite facilities, serves a catchment area of approximately 180,000 inhabitants.

The seven satellite clinics provide out-patient after-care, and consultation and education services. The Daytona Beach facility is responsible for out-patient, consultation and education, after-care, pre-care, day-treatment, and residential services. In-patient and emergency services are provided by a contractual agreement with Halifax General Hospital which is located four blocks away.

The major facility, designed by Tye and Mitchell Architects, is located in a residential neighborhood,





adjacent to an elementary school. Construction on the center was completed the middle of 1967. Construction costs were approximately \$310,550 or \$13 per square foot. The one-story units in the center were constructed of masonry and wood frame support. The two-story unit is constructed of cast-in-place concrete. The exterior walls are textured stucco. The interior walls are plaster and wood paneling in the one-story units and exposed masonry in the two-story unit. The floors are terrazzo on concrete slabs, and the ceilings are plaster and acoustical tile.

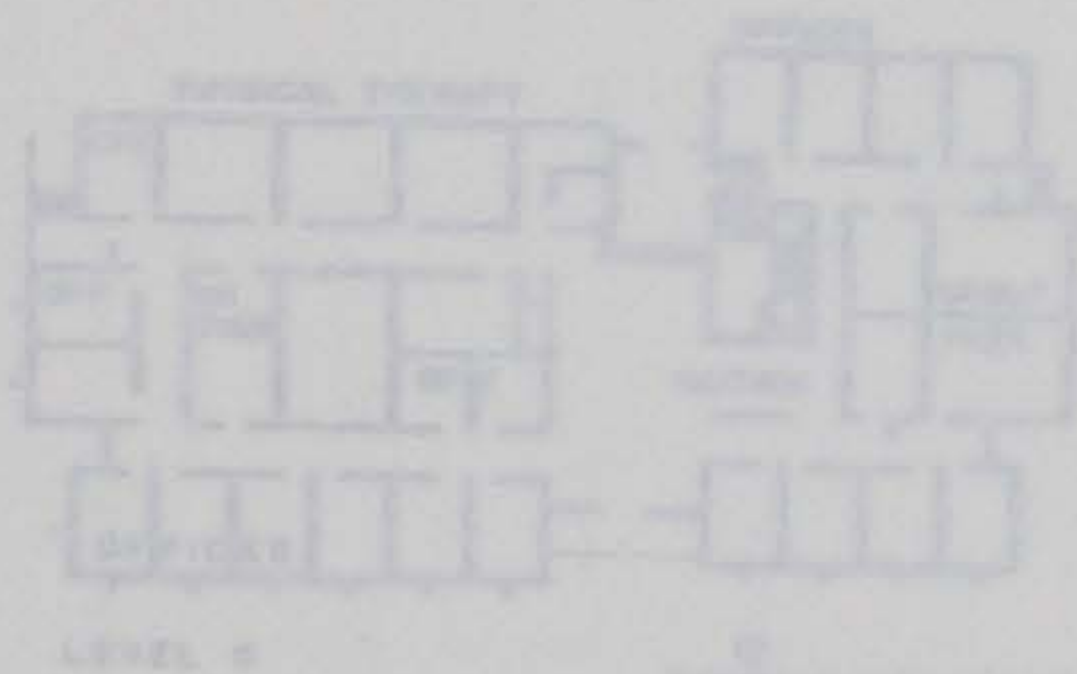
The Daytona Beach facility can best be described as a pavilion cluster. Each pavilion assumes the function of providing one of the services offered by the center. All of the pavilions are single-story, except the day-care



center which is two-story. However, the center retains a residential scale. All inter-unit circulation is by exterior covered walk with each unit enjoying its own exterior space. The one-story pavilions are essentially divided into four large rooms, each of which may be used as a staff office and therapy/consultation area. The first floor of the day care center serves as a large multipurpose space which can be subdivided by movable walls. The second level provides both staff and patient facilities including: an auditorium, library, photo lab, music listening rooms, craft and other activity rooms at the perimeter. A swimming pool for both patients and staff is located next to the kitchen/dining wing of the day/care center.

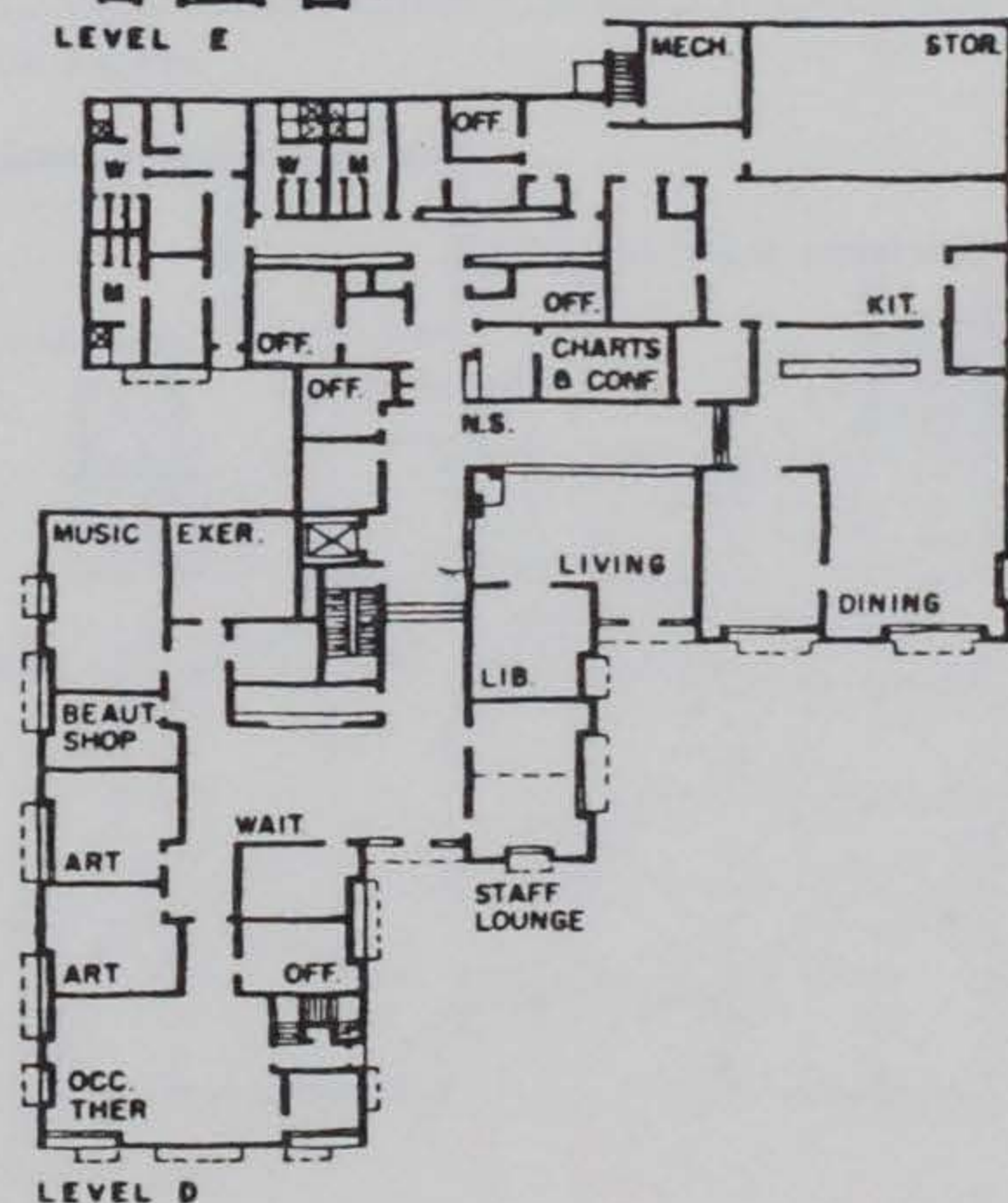
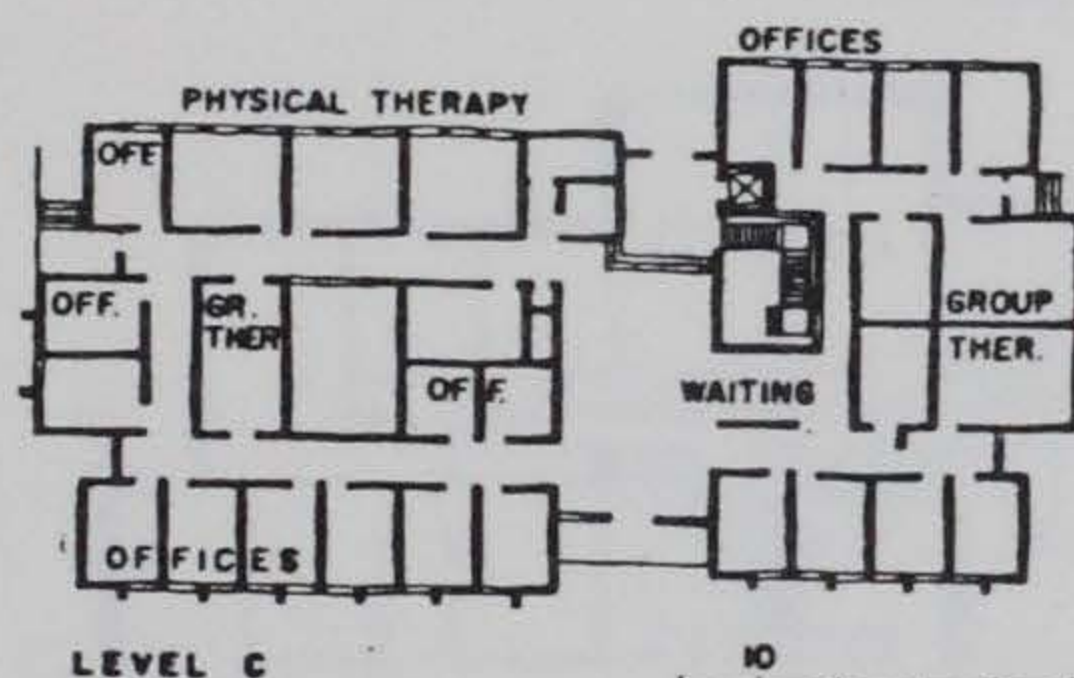
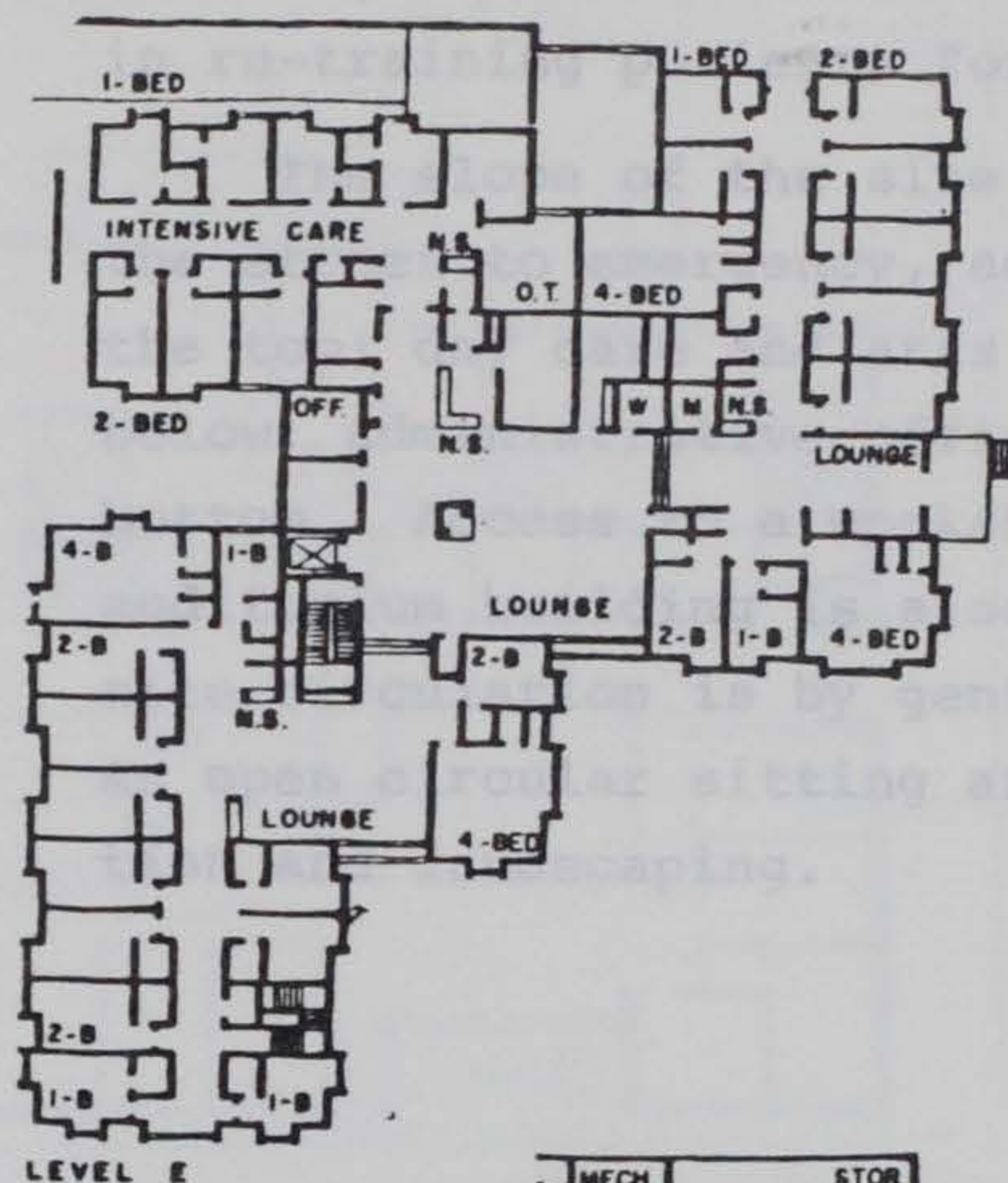
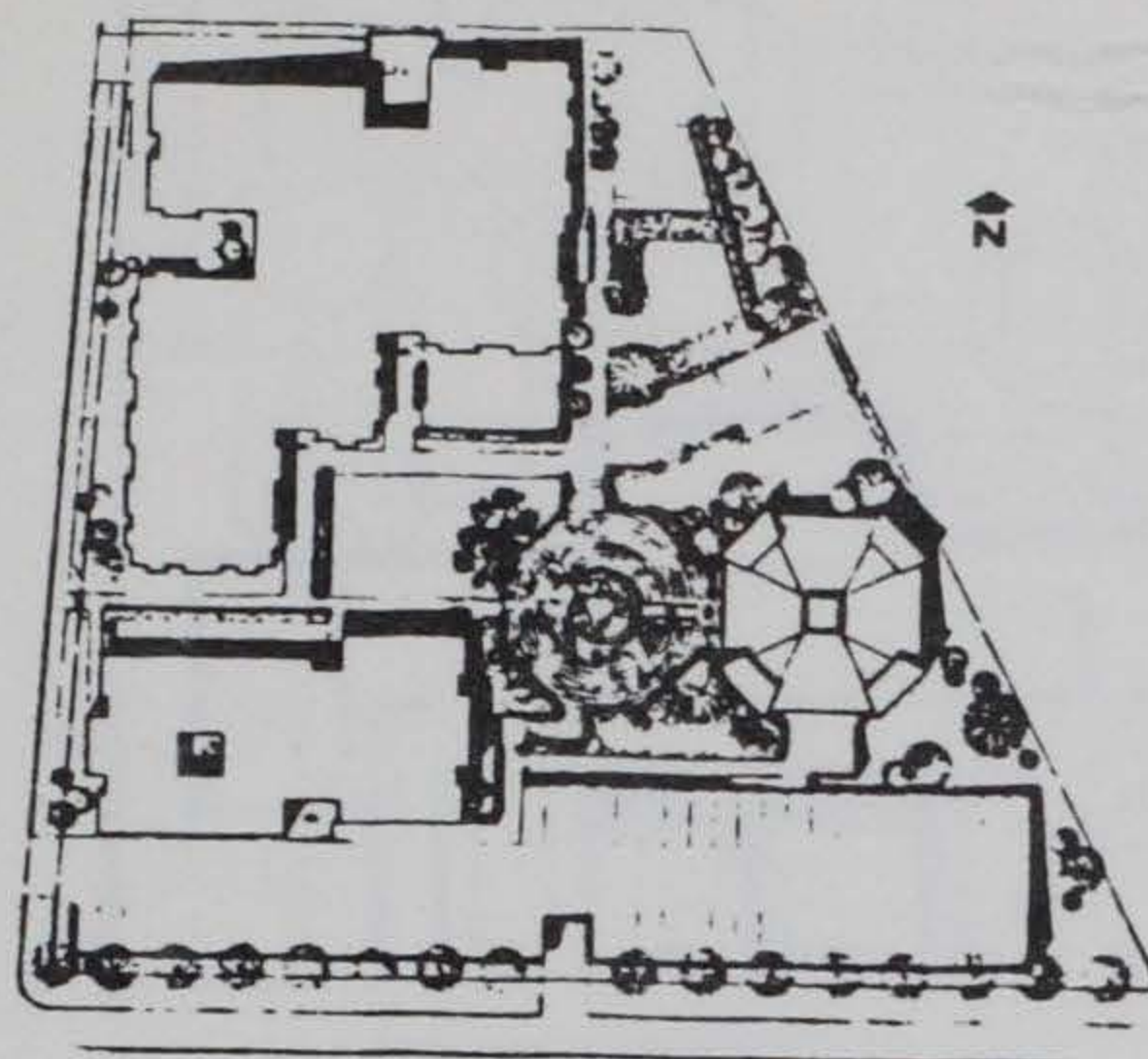
Correspondence with an administrator of the Daytona Beach Center brought to light some criticisms of this facility.

"In any design, the administrative requirements must be considered. Our physical facilities create administrative problems such as patient flow, proper reception, needless time spent walking between buildings, etc."





# THE RESTHAVEN COMMUNITY MENTAL HEALTH CENTER (76)



The Resthaven Community Health Center is a private, hospital-affiliated facility located in Los Angeles. The center was to become operational in 1968. In this urban center all services are located on one site.

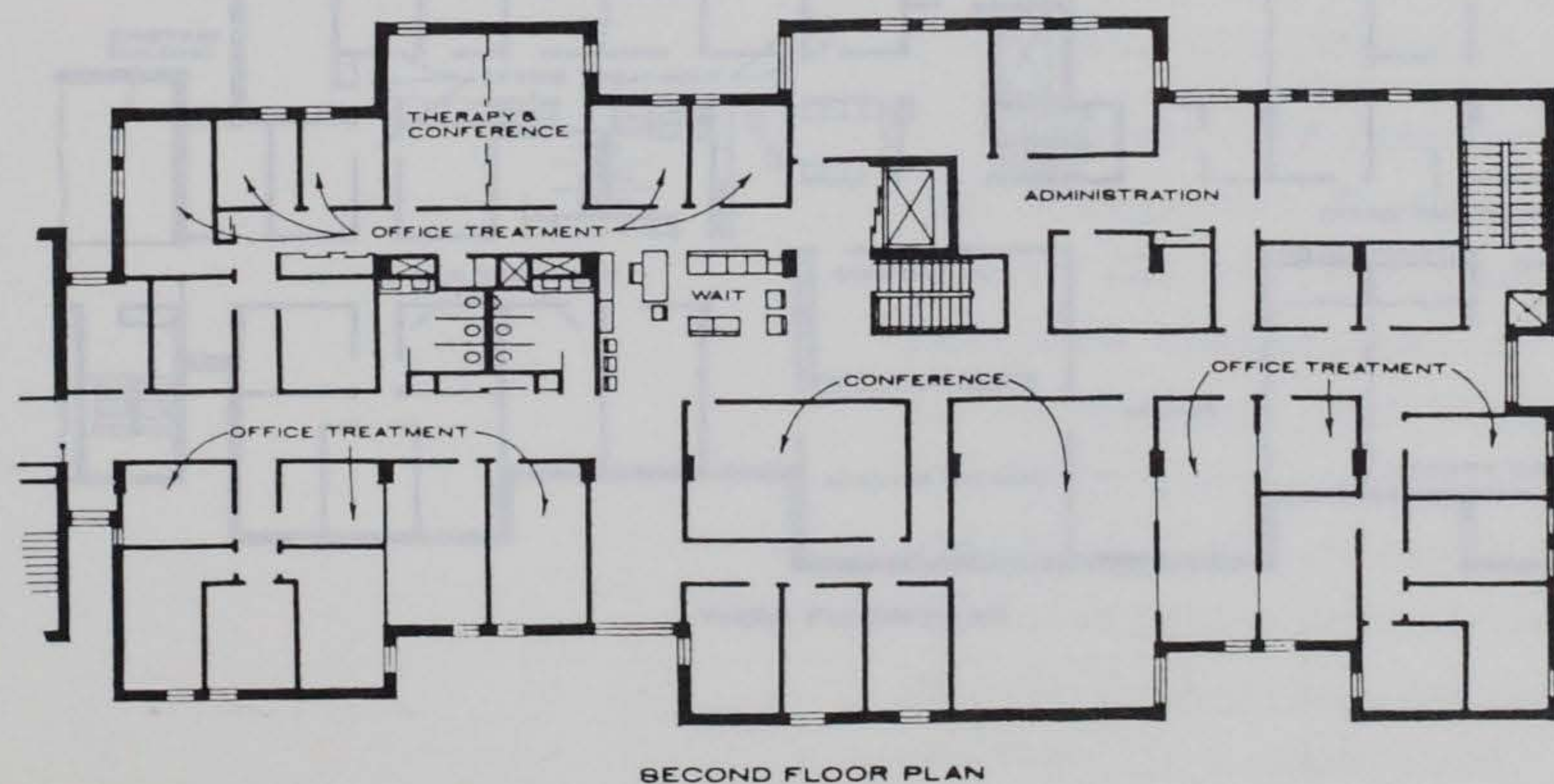
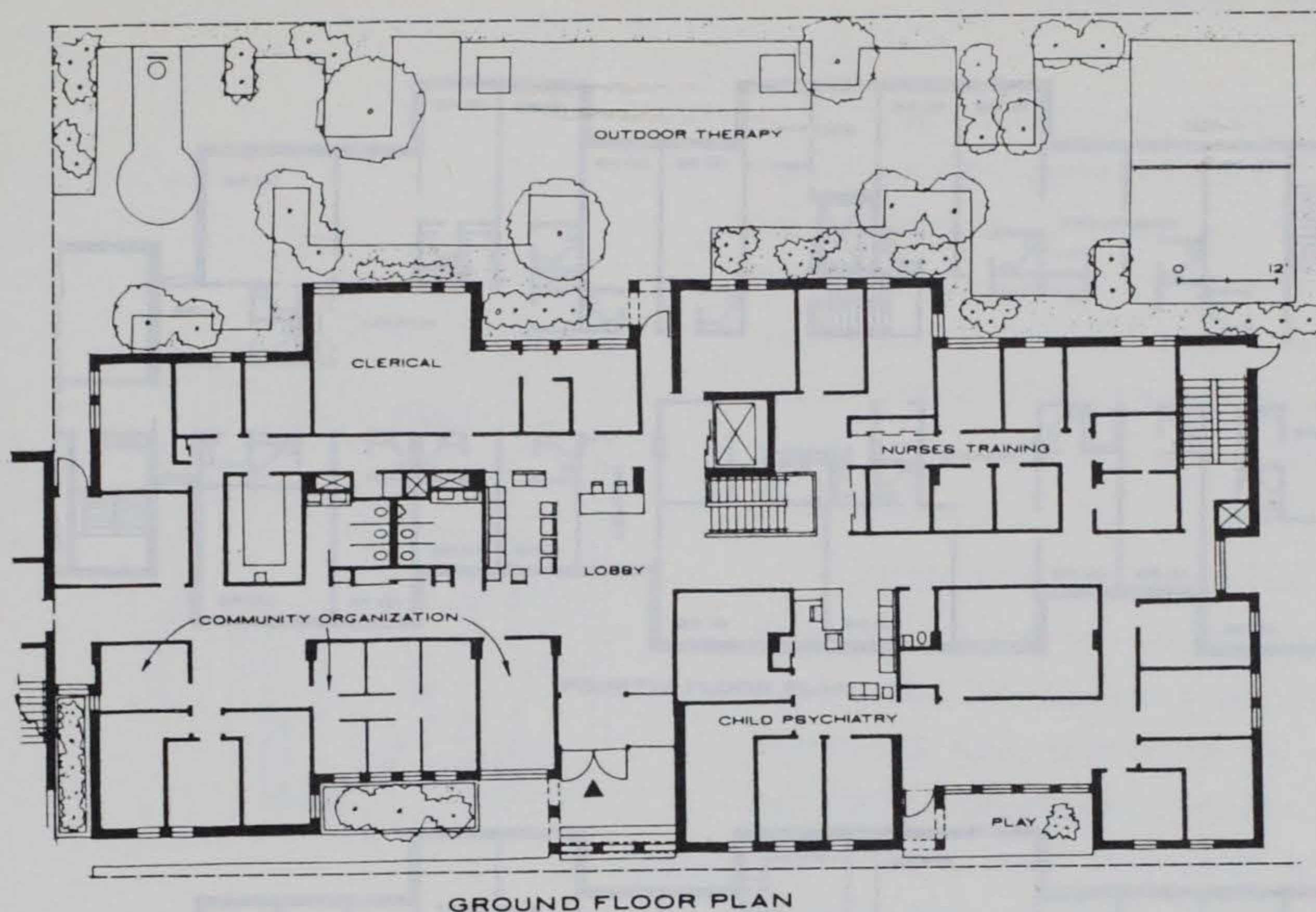
Situated on a sloping site, the center is composed of three buildings stepped down the slope. The over-all design objective of the architects, Kaplan and McLaughlin, "was to make the buildings specific and identifiable because in mental health patients the ability to perceive is limited at best and may be quite impaired." (77) To help patients find their way to scheduled activity areas, building exteriors avoid repetitive modules and are differentiated by form. "Since the center functions as a







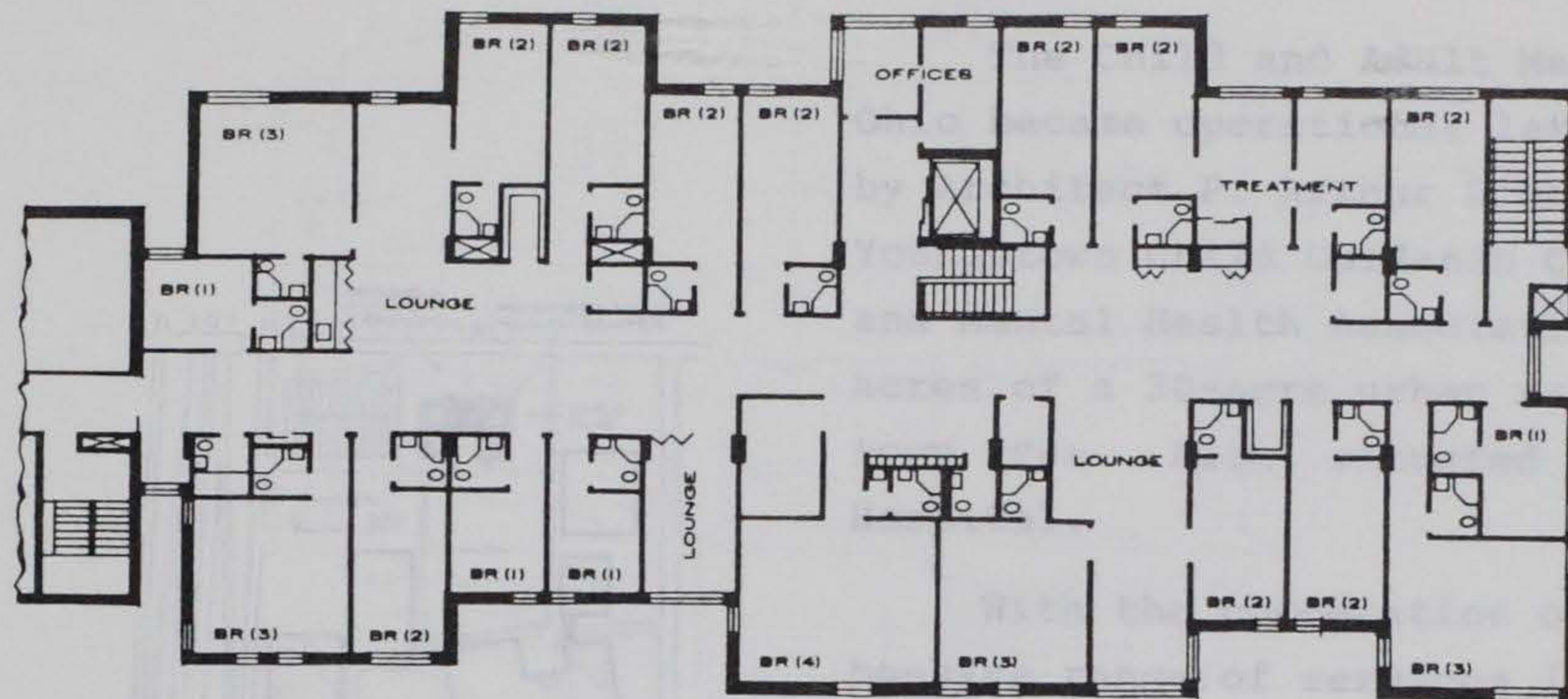
## BROOKLYN COMMUNITY MENTAL HEALTH CENTER(79)



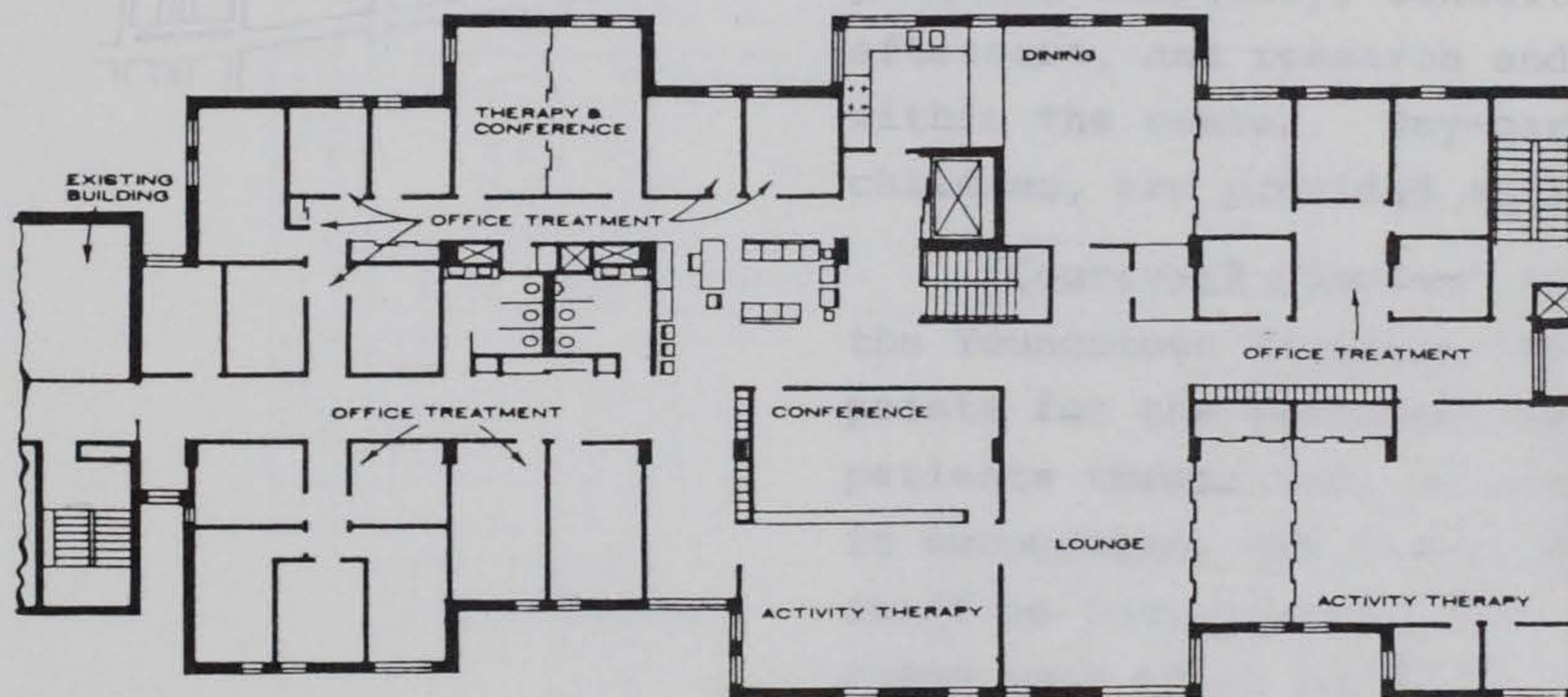
Becoming operational in 1967, the Maimonides Hospital of Brooklyn Community Mental Health Center provides the services of a comprehensive center to a catchment area of approximately 108,000. The population consisting primarily of working-class and middle-class inhabitants.

The architects, Candill, Rowlett, Scott and the staff would have preferred a horizontal plan for the center: "first, for the spatial flow necessary in promoting the socialization and interaction that is an important goal of modern milieu therapy; second, for a more intimate human scale and freer accessibility.(80) However, limitations imposed by the site and zoning regulations necessitated a vertical stacking arrangement.





FOURTH FLOOR PLAN



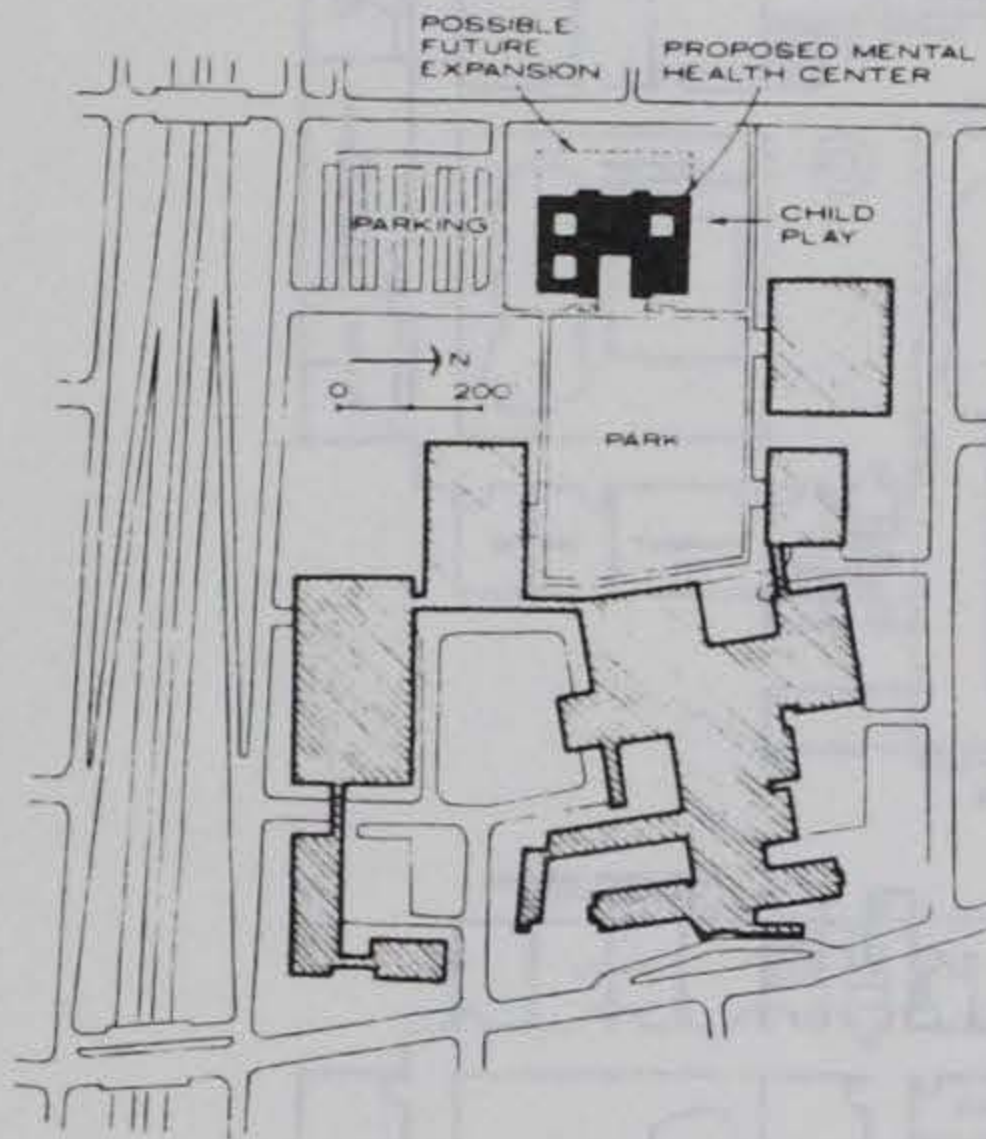
THIRD FLOOR PLAN

Corridors within the center widen at intervals into open lounge, secretarial, and waiting areas. Bedrooms and offices are grouped around the spaces.(81) Offices are arranged according to treatment group. Psychiatrists and social workers offices, for instance, are located in the treatment area of their respective involvement.



# THE YOUNGSTOWN COMMUNITY MENTAL HEALTH CENTER(82)

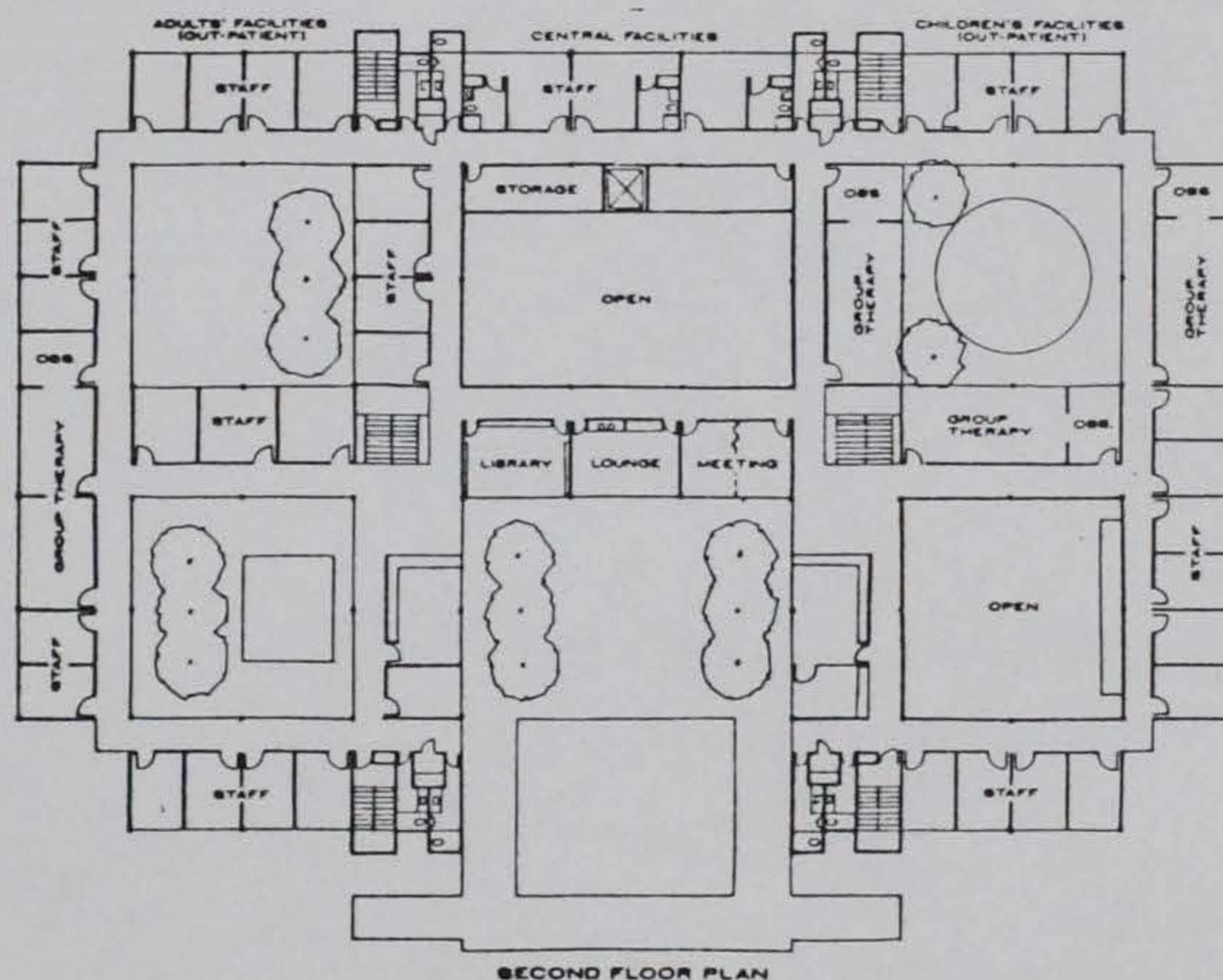
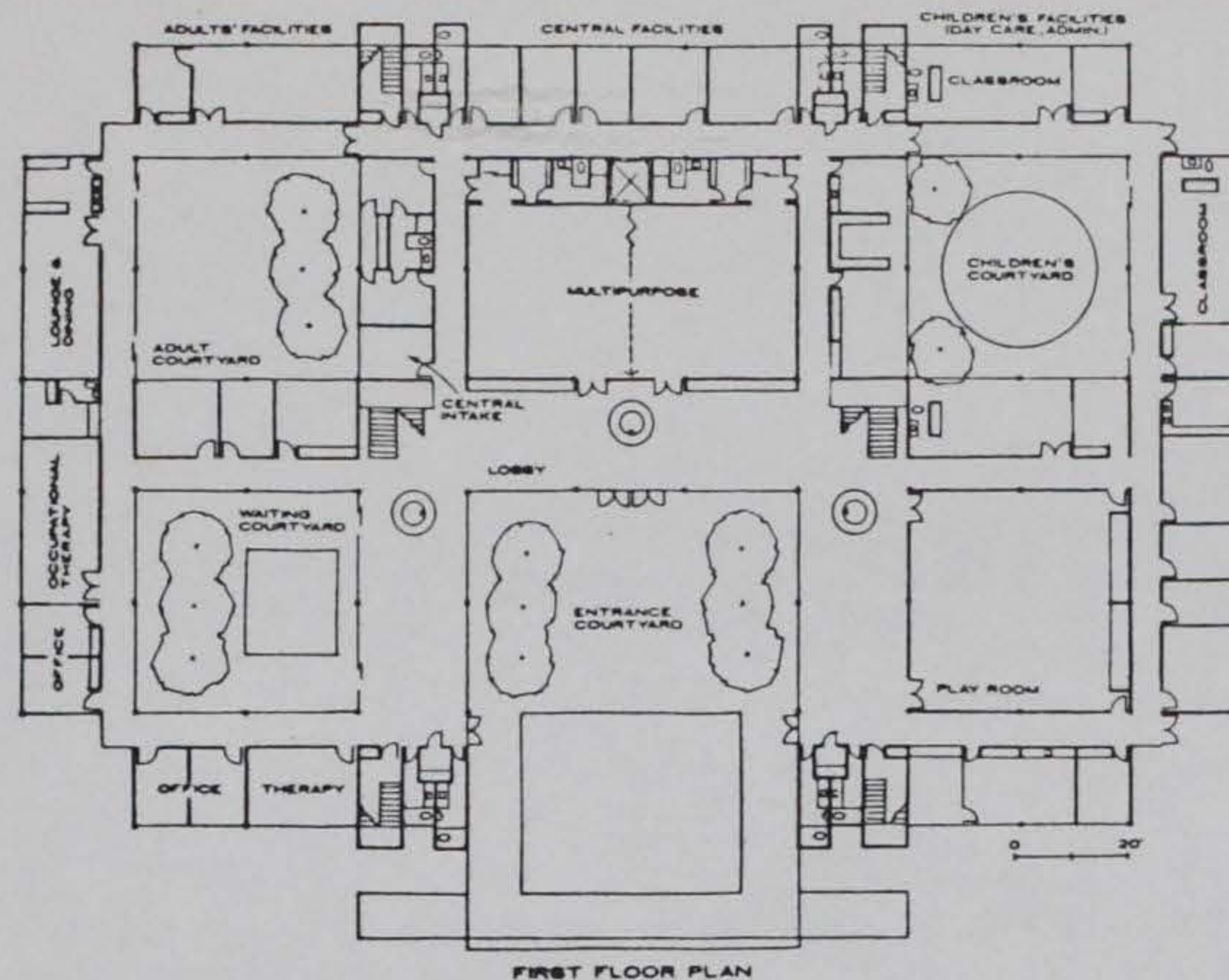
The Child and Adult Mental Health Center of Youngstown, Ohio became operational late in 1968. The center, designed by Architect P. Arthur D'Orazio, represents the union of the Youngstown Child Guidance Clinic, Adult Mental Health Clinic, and Mental Health Association. The Center is located on 5½ acres of a 30-acre urban renewal tract adjacent to the downtown area. Also, situated in this tract is St. Elizabeth's Hospital.



With the cooperation of the nearby hospital, a comprehensive range of services is offered by the Youngstown Center. The in-patient program is provided by St. Elizabeth's Hospital and coordinated with the center's programs. Out-patient, emergency, consultation and education, precare and aftercare, and research and evaluation services are provided within the center. Day-care programs, both for adults and children, are provided at the center.

"Courtyard Complex" is the best descriptive phrase for the Youngstown facility."(83) "The courtyards are focal points for the treatment units so that interaction among patients themselves, as well as between patients and staff is encouraged, and visual surveillance on the part of the staff is facilitated."(84) The two-story facility is divided into three portions. The center portion, providing administrative and shared multi-purpose space, is flanked by adult services and children's services. Each portion relates to a courtyard. One enters the facility through a





courtyard and into the central portion. The adult wing has two courtyards, one of which is an area for waiting and informal therapy, the other, for adult day-care and therapy. The children's wing has a courtyard and an interior two-story playroom.

The Youngstown Center was constructed for approximately \$782,825 or \$19.57 per square foot. A precast concrete frame supports the concrete slab floors and roofs. Interior walls are made of vinyl-covered gypsumboard panels on a movable partition system. The partition system is integrated with the concrete waffle ceiling system and provides a great deal of flexibility within the facility.



**Part II**



## MENTAL HEALTH CARE DELIVERY IN SOUTH CAROLINA

The trend today is toward comprehensive community treatment of the mentally ill. The object is to treat the patient in an environment which is not too different from the one he is accustomed. Because the system is familiar to his background, the usual period of adjustment is shortened and treatment is facilitated.

Toward this trend, in 1970 the South Carolina Department of Mental Health began to pursue a "new direction" in its delivery of mental health care. Five years ago the Mental Health Commission approved a new master plan for the Department of Mental Health which initiated "The Village System." (85)

"The Village System," an overall health care delivery system for the mentally ill in South Carolina . . . conceived jointly by the South Carolina Department of Mental Health and the Health Care Facilities Planning and Design Studio of the Clemson University College of Architecture. (86)

The purpose of the "Village System" is to offer a coordinated range of treatment programs and settings so that a person may receive treatment appropriate to his difficulty at or in a location commensurate with his abilities. Toward this purpose the "Village System" will interlace villages and community mental health treatment programs. Thus, each of the community mental health programs can have its ability to serve a catchment enhanced by association with a Regional Village and additional Special Villages. (87)



The state of South Carolina has been divided into fourteen catchment areas, each area developing and establishing community mental health center and clinics. As of 1976, ten of the mental health centers have attained full comprehensive status. Only four clinics remain to make this transition to full status. Several centers provide satellite units in the more populous communities in the area served.(88) The fourteen catchment areas are coordinated by the Division of Community Services under the Department of Mental Health.(89)

The catchment areas are divided into four geographic areas within the state, the Midlands area, the Piedmont area, the Pee Dee area, and the low-state coastal area. Each region is to be served by a village located within its respective area. Also serving the village regions will be several "special" villages located in the Columbia area, such as the newly opened Morris Village for alcohol and drug addiction. The first of the four-village system is now well under construction near Columbia. Village "A" will serve the midlands region.

The state also provides accredited psychiatric services at the South Carolina State Hospital and at Crafts-Farrow State Hospital. Supporting the psychiatric programs in the state, the William S. Hall Psychiatric Institute educates the professional staffs of the future and stimulates an active program of research and education through seminars and selected patient care.(90)



The vast majority of persons with mental disorders have problems of such a mild nature, that the only portion of the "Village System" with which they need to come in contact would be the community mental health center. Thus these centers would be located as close to the actual source of patients as possible, and should maintain an atmosphere close to that which is most familiar to the majority of patients. These patients would be treated on an out-patient basis, with the basic treatment modality being group therapy. Every effort should be made to treat each patient in an environment that most nearly duplicates that which he lives, works, and plays in every day.

For those patients whose disorder is of a more acute nature, the community mental health center would administer initial treatment, make arrangements for admitting the patient to an intensive treatment facility, oversee the patients' treatment during his stay at the in-patient facility, and administer aftercare following his discharge from the intensive treatment facility. Thus, even though this patient is not always right at the community mental health center, the center's staff is always in contact with him, and aiding in his treatment. This "continuity of care," which is one of the three major goals of the "Village System," is an extremely important factor in the success of the treatment. A possible elaboration on this could be termed "continuity of environment," for this too would further reduce the possibility of noxious factors hindering a patients' recovery.



The second of the goals of the "Village System" is "flexibility." The word is self explanatory, and refers to treatment environment, treatment programs, and activities. All facilities and programs must remain flexible, in order to be able to design the best possible treatment program for any particular individual.

The third of the major goals is termed "opportunity for therapy." Since therapy is the major treatment modality in the "Village System," every patient must be given every opportunity for therapy. This should occur constantly and in various environments simulating real life situations. Thus the design of the intensive treatment facilities is that of a miniature town, where all life situations can occur. Therefore, since the community mental health center operates as out-patient facilities, they should possibly be designed to simulate activities which occur away from one's home, such as work, recreation, going to church, eating at a restaurant, going shopping, and so on. Thus, we see a duplication of certain elements in both the intensive facilities, and the out-patient facilities, and it is just this that provides flexibility, opportunity for therapy, and continuity of care as the patient moves through the system.

The South Carolina Department of Mental Health, in order to maintain the momentum of the "new direction" initiated in 1970, has four major objectives for the next five years.



(1) A constant reduction of the patient population at the Central institutions to its lowest possible level by making the central hospitals play a more specialized role rather than their present broad, general psychiatric role.

(2) The construction of new and modern intensive treatment psychiatric facilities at the four planned villages in key geographic areas of the state - the Midlands, the Piedmont, the Pee Dee and the Low-state Coastal area.

(3) The completion of the 14-center community mental health system so that it will provide screening, precare, aftercare, out-patient, in-patient, short-term hospitalization and any other programs and services needed to prevent or postpone long-term hospitalization.

(4) A continuation of the broad, practical working relationship the Department of Mental Health has with its sister agencies and the development of a program of exchange, coordination and cooperation in programs of mutual patient interest.(91)

"Four operational villages, a fully operational system of community mental health center and satellites, smaller central institutions to handle the long-term chronic patients or those special needs that cannot be provided in the communities or the villages."(92) This is the goal of the "new direction" in mental health care delivery in South Carolina.



## THE YORK-CHESTER-LANCASTER CATCHMENT AREA

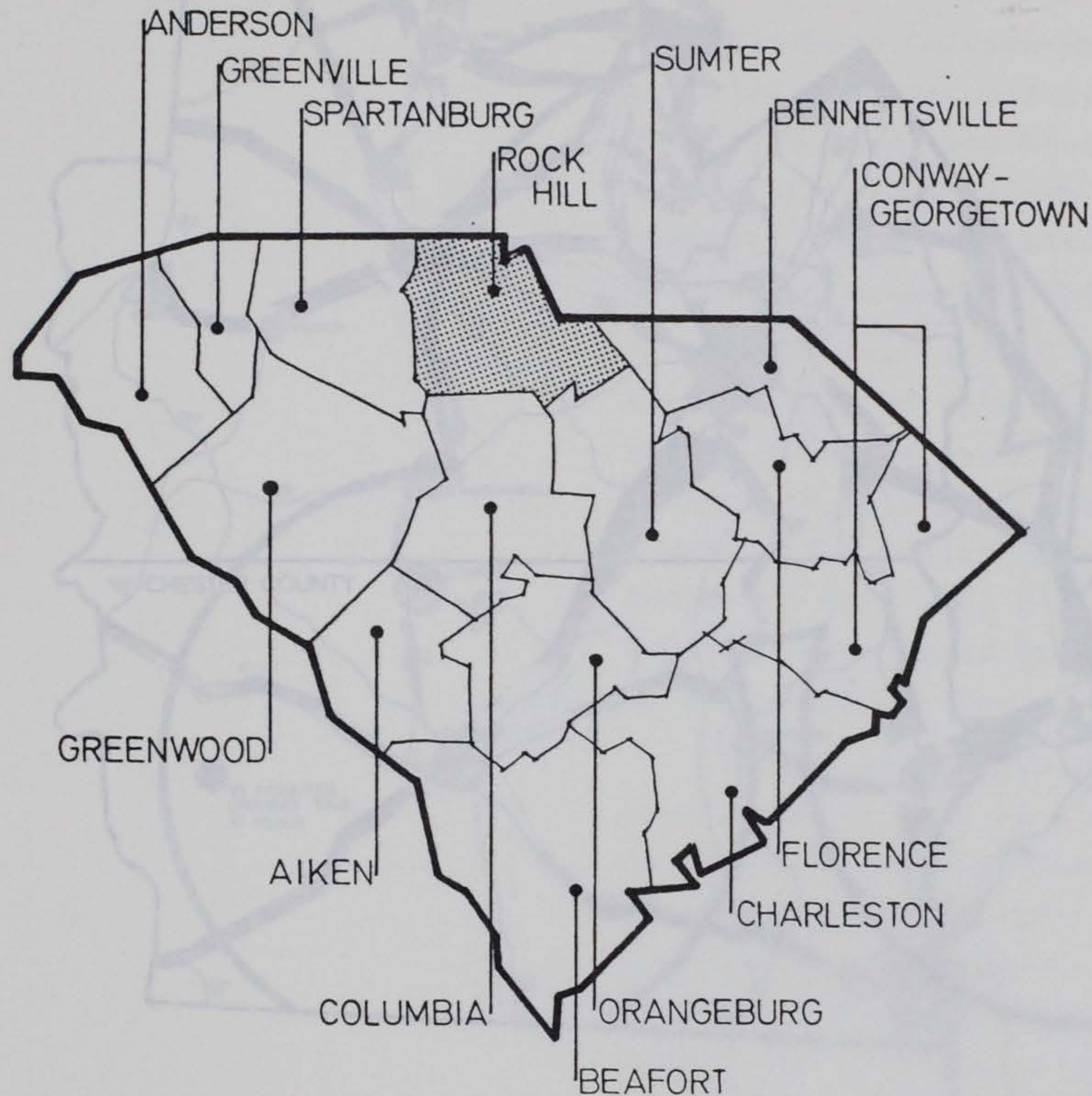
The York-Chester-Lancaster catchment area is one of fourteen in South Carolina. The catchment area is composed of three counties -- Chester, Lancaster, and York in the north central part of South Carolina. It is in the Piedmont section with textiles as the main industry. The formerly rural area is rapidly industrializing and urbanizing. Even the rural families (55%) are largely suburban and non-farm. York County has 55 percent of its population living in cities while only about a third of those in Chester and Lancaster live in urban places.

The population is predominantly native-born and Protestant. The major minority race is black which comprises one-fourth of the population in Lancaster and York Counties and 39 percent in Chester County. Urbanization has increased heterogeneity with respect to religion. The inward migration has also brought in residents from many states and several foreign countries.

The population has increased about 10 percent, 1950-70, a lower rate of increase than the state or nation. Moreover, the increase was confined to Lancaster and York Counties while Chester showed a decline in each decade of this period. There was a net gain in white population in Lancaster and York Counties and a net loss in non-white population, 1960-70. Both racial groups showed a net loss in Chester County but non-whites had a net loss twice as great as that of whites. York and Lancaster Counties are closer to Charlotte and have



## CATCHMENT AREAS IN SOUTH CAROLINA

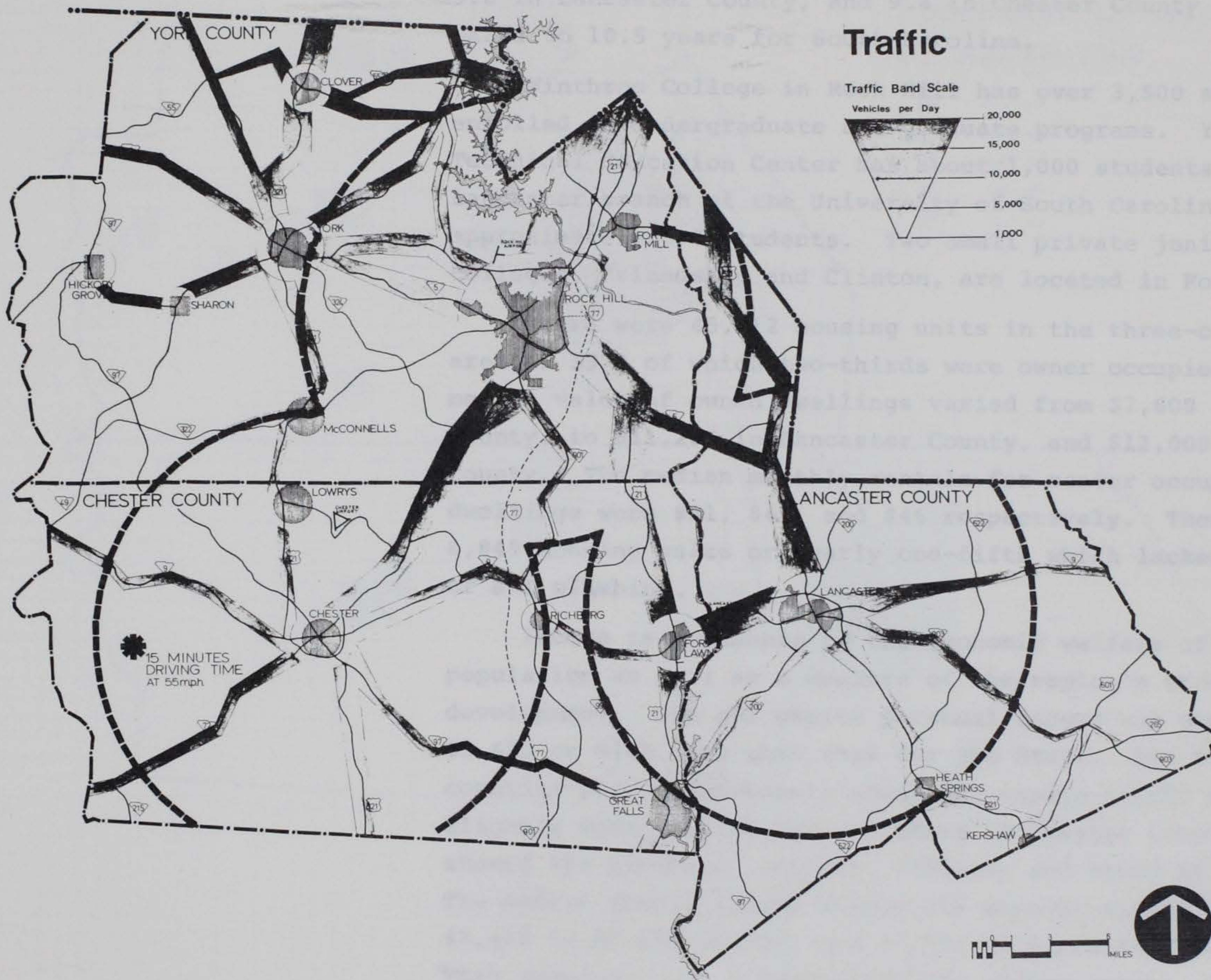


shared more of that city's industrial growth. The more rapid growth of York and Lancaster Counties may be expected to continue while Chester County may be expected to begin to gain rather than continuing to lose population as a result of the location of industrial plants in that county.

The construction of Interstate 77 which has connected Rock Hill with Charlotte and eventually will connect Rock Hill with Columbia, and the development of the Carowinds Amusement Park on the border of and partially within Mecklenburg County, North Carolina and York County, South Carolina will greatly stimulate population growth, especially in York County.

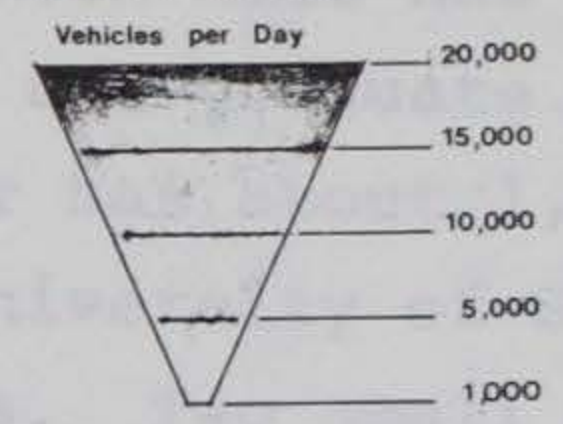
The educational attainments of people in this region have been increasing but at a slower rate than that of the State. The median years of



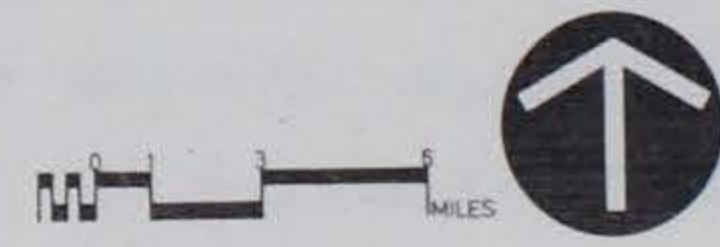


# Traffic

Traffic Band Scale



15 MINUTES  
DRIVING TIME  
AT 55mph





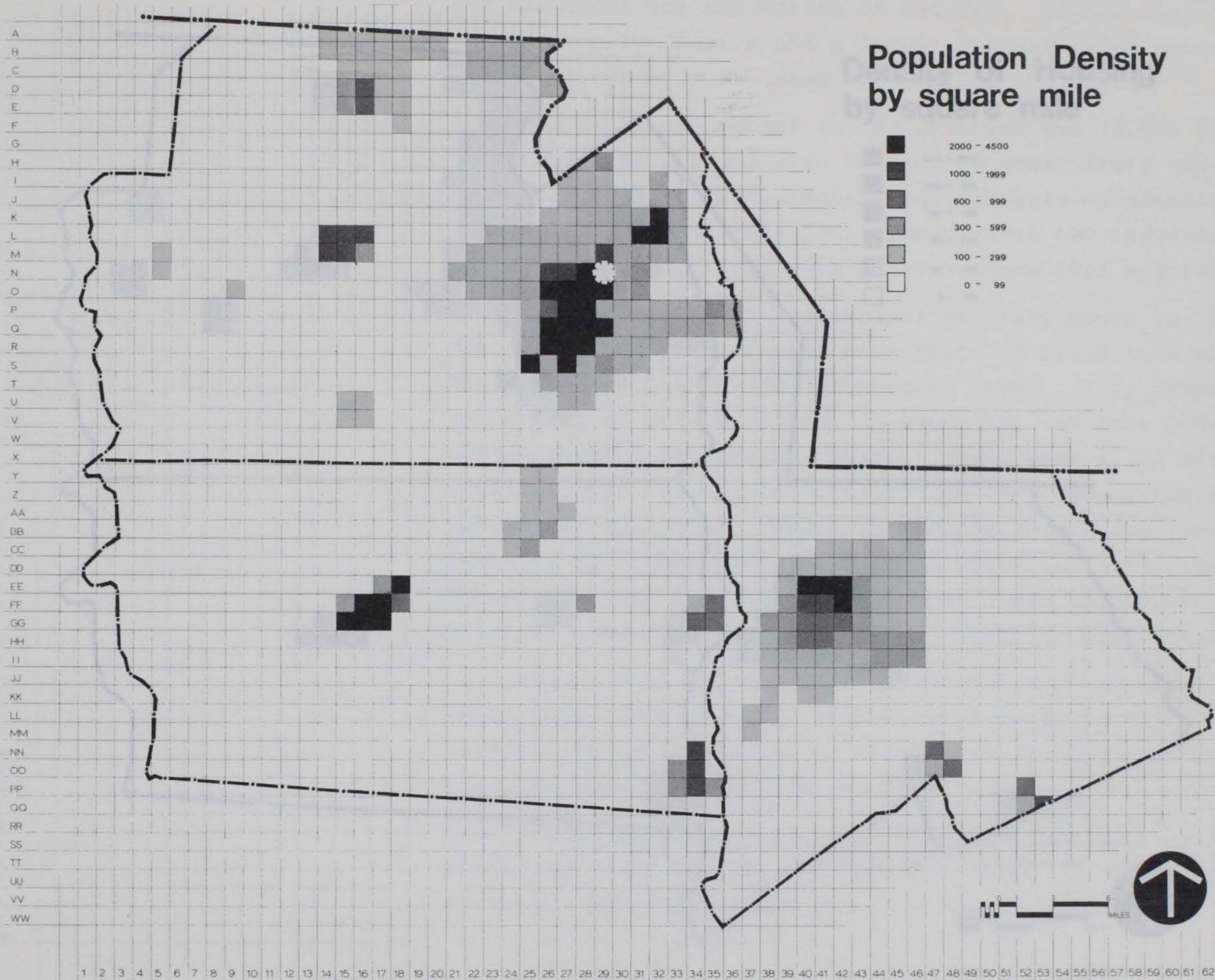
education completed in 1970 was 10.1 years in York County, 9.8 in Lancaster County, and 9.4 in Chester County as compared to 10.5 years for South Carolina.

Winthrop College in Rock Hill has over 3,500 students enrolled in undergraduate and graduate programs. York Technical Education Center has about 1,000 students. The Lancaster branch of the University of South Carolina has approximately 500 students. Two small private junior colleges, Friendship and Clinton, are located in Rock Hill.

There were 45,412 housing units in the three-county area in 1970 of which two-thirds were owner occupied. The median value of owned dwellings varied from \$7,600 in Chester County, to \$11,200 in Lancaster County, and \$12,000 in York County. The median monthly rentals for renter occupied dwellings were \$31, \$41, and \$46 respectively. There were 8,849 housing units or nearly one-fifth which lacked some or all plumbing.

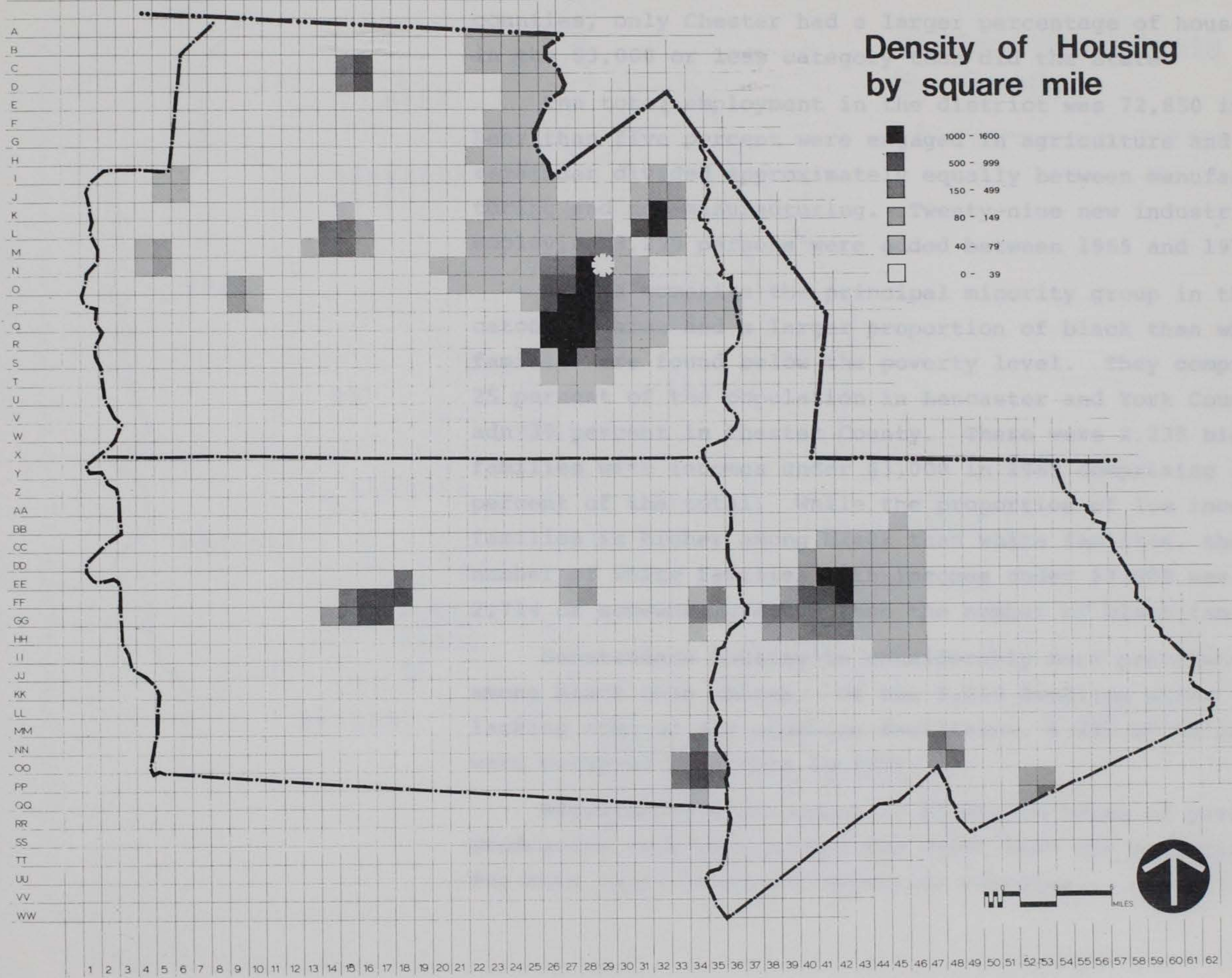
Income is a measure of the economic welfare of the population as well as a measure of the region's economic development. The per capita personal income was about \$2,625 or \$100 less than that for the State. All three counties had approximately equal per capita income of slightly more than \$2,600. Incomes in Chester County showed the greatest increase, 1965-69, and stood at the top. The median family income showed the greater variation from \$7,410 to \$8,399 in York and \$8,561 in Lancaster County. This compares with a South Carolina median income of \$8,367







# Density of Housing by square mile



and an income for the Nation of \$10,048. Of the region's  
only Chester had a larger percentage of households  
or 1990 category.  
employment in the district was 72,850 in 1970.  
were wage, agriculture and the  
between manufac-  
new industries,  
between 1965 and 1970.  
group in the  
proportion of black than white  
poverty level. They comprised  
Lancaster and York Counties  
black  
77  
income



and an income for the Nation of \$10,048. Of the region's counties, only Chester had a larger percentage of households in the \$3,000 or less category than did the State.

The total employment in the district was 72,850 in 1970. Less than five percent were engaged in agriculture and the remainder divided approximately equally between manufacturing and non-manufacturing. Twenty-nine new industries, employing 3,290 persons were added between 1965 and 1970.

Blacks comprise the principal minority group in the catchment area and a larger proportion of black than white families are found below the poverty level. They comprised 25 percent of the population in Lancaster and York Counties and 39 percent in Chester County. There were 2,235 black families with incomes under \$3,000 in 1969 comprising 27 percent of the total. While the proportion of low income families is higher among black than white families, the number of white families with incomes under \$3,000 was 2,714 or somewhat greater than the number of black families.

Substandard housing is considerably more prevalent among black than whites. Of the 8,849 dwelling units lacking some or all plumbing facilities, 5,239 or 59 percent were occupied by blacks in 1970.

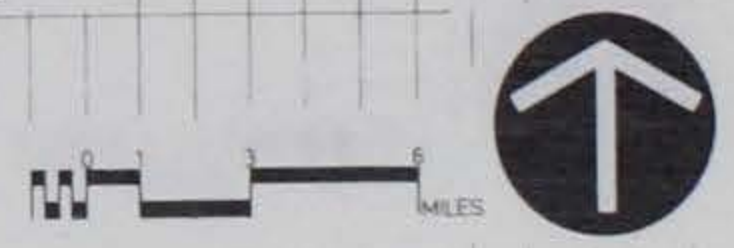
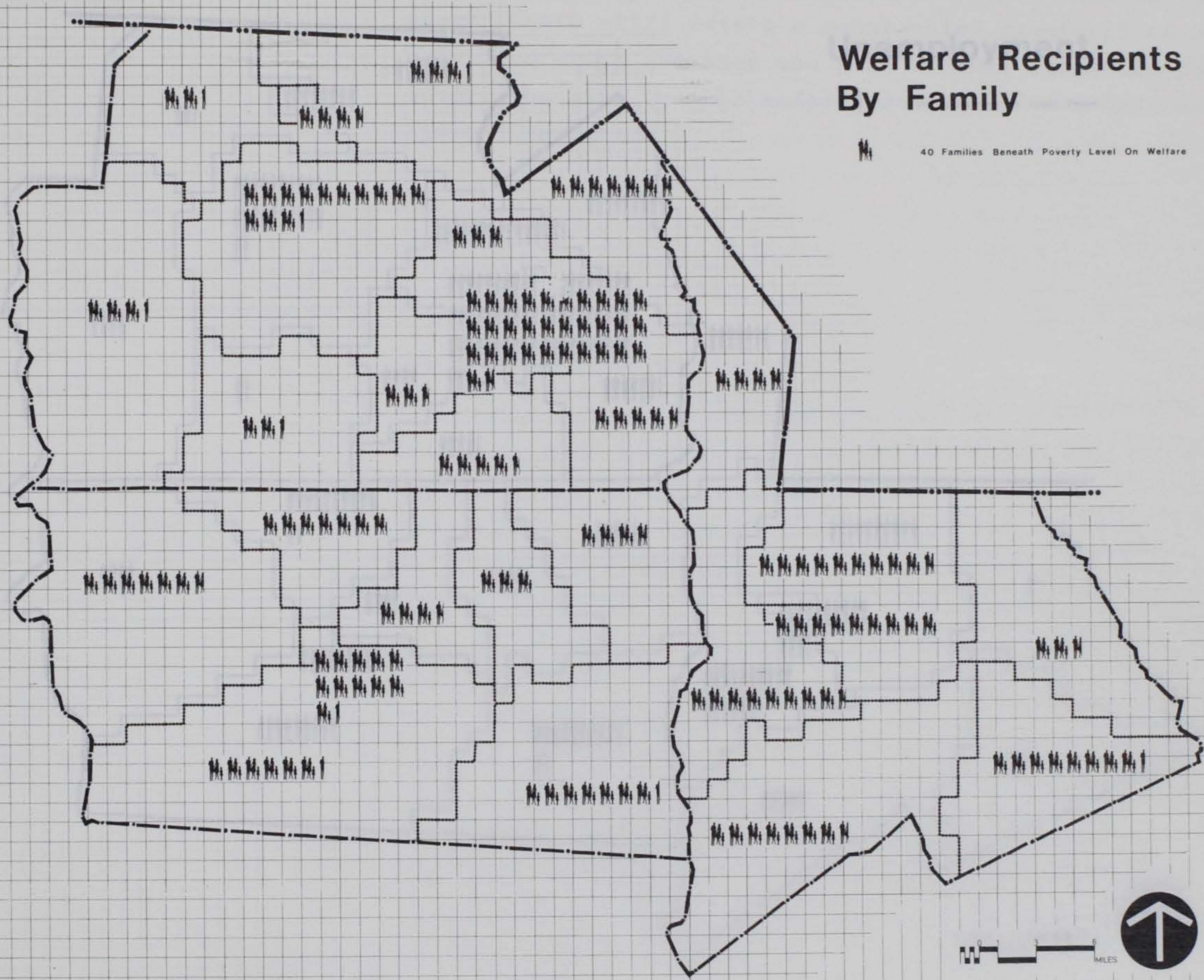
Educational achievement of blacks in terms of percent graduating from high school was about half the percentage for both races in their respective counties.



# Welfare Recipients By Family

 40 Families Beneath Poverty Level On Welfare

A  
B  
C  
D  
E  
F  
G  
H  
I  
J  
K  
L  
M  
N  
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Q  
R  
S  
T  
U  
V  
W  
X  
Y  
Z  
AA  
BB  
CC  
DD  
EE  
FF  
GG  
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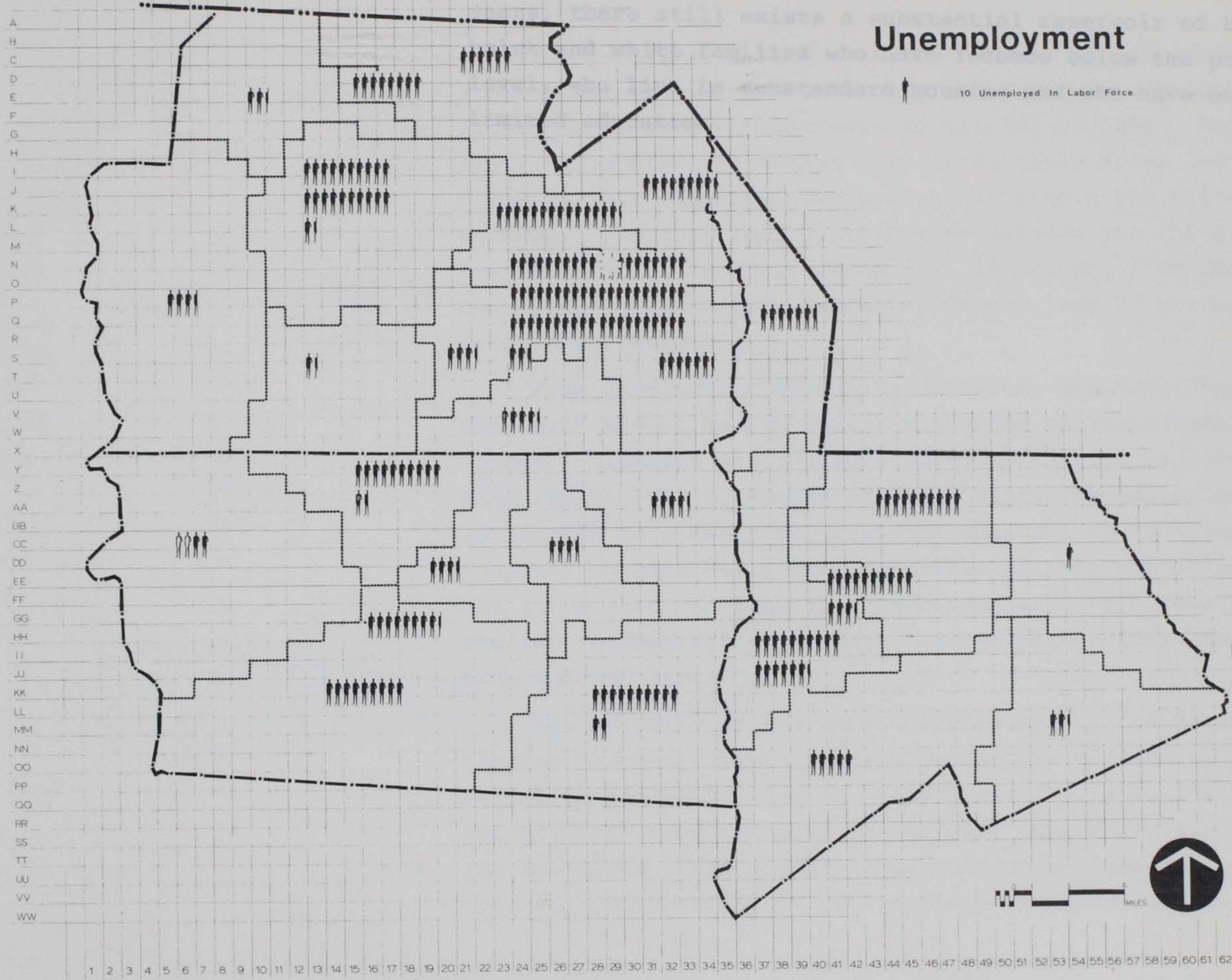
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62



# Unemployment

10 Unemployed In Labor Force

## Unemployment





Although improvements have been substantial in recent years, there still exists a substantial reservoir of both black and white families who have incomes below the poverty level, who live in substandard housing and who have only limited education.

At present, the center utilization rate is slightly above one percent. Although low, one percent is within the national average. The case load distribution between the three counties within the catchment area is: 18 percent from Chester County, 25 percent from Lancaster County, and 57 percent from York County.

From very modest beginnings in 1961, the York-Chester-Lancaster Mental Health Center has grown to comprehensive status. Although still understaffed, the staff has grown from six in 1961 to twenty-eight in 1975. The main facility is located in a two-story building adjacent to York General Hospital in Rock Hill. Two satellite clinics are maintained, one in Chester and the other in Lancaster. Both facilities utilize residential structures located within their respective communities.

The majority of the services provided by the York-Chester-Lancaster Mental Health Center are offered at the Rock Hill facility. The in-patient service is located in the adjacent five building of the York General Hospital. The satellite clinics offer only out-patient services. They are not operated as mini-centers in themselves but



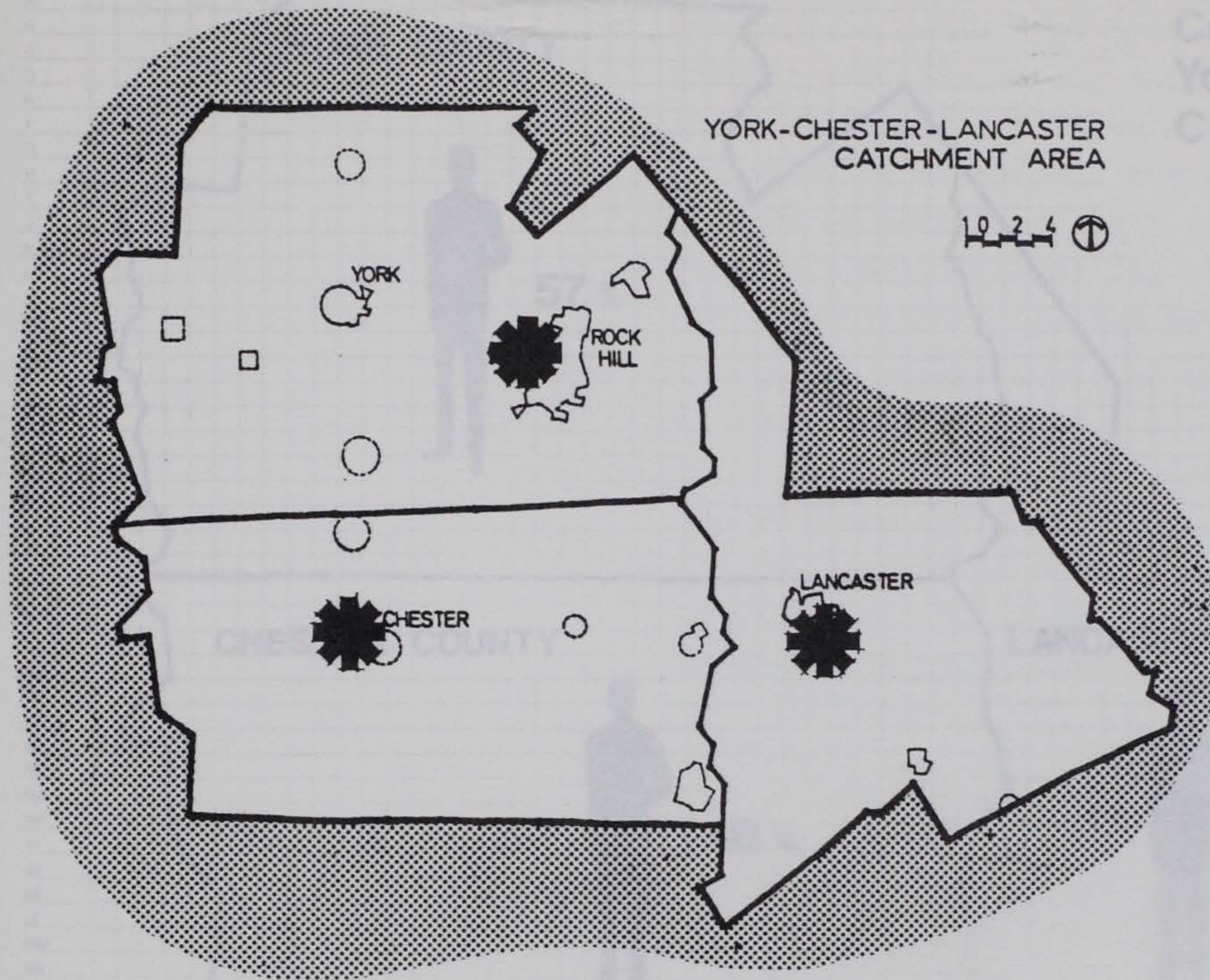
## THE EXISTING COMMUNITY MENTAL HEALTH CARE DELIVERY SYSTEM

The York-Chester-Lancaster Mental Health Center serves a catchment area of approximately 158,355 inhabitants. This figure is expected to increase to 181,000 by 1980. At present, the center utilization rate is slightly above one percent. Although low, one percent is within the national average. The case load distribution between the three counties within the catchment area is: 18 percent from Chester County, 25 percent from Lancaster County, and 57 percent from York County.

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rather are a part of the total program. Patients from Chester and Lancaster Counties may come to the Rock Hill facility for services not offered in the satellites.

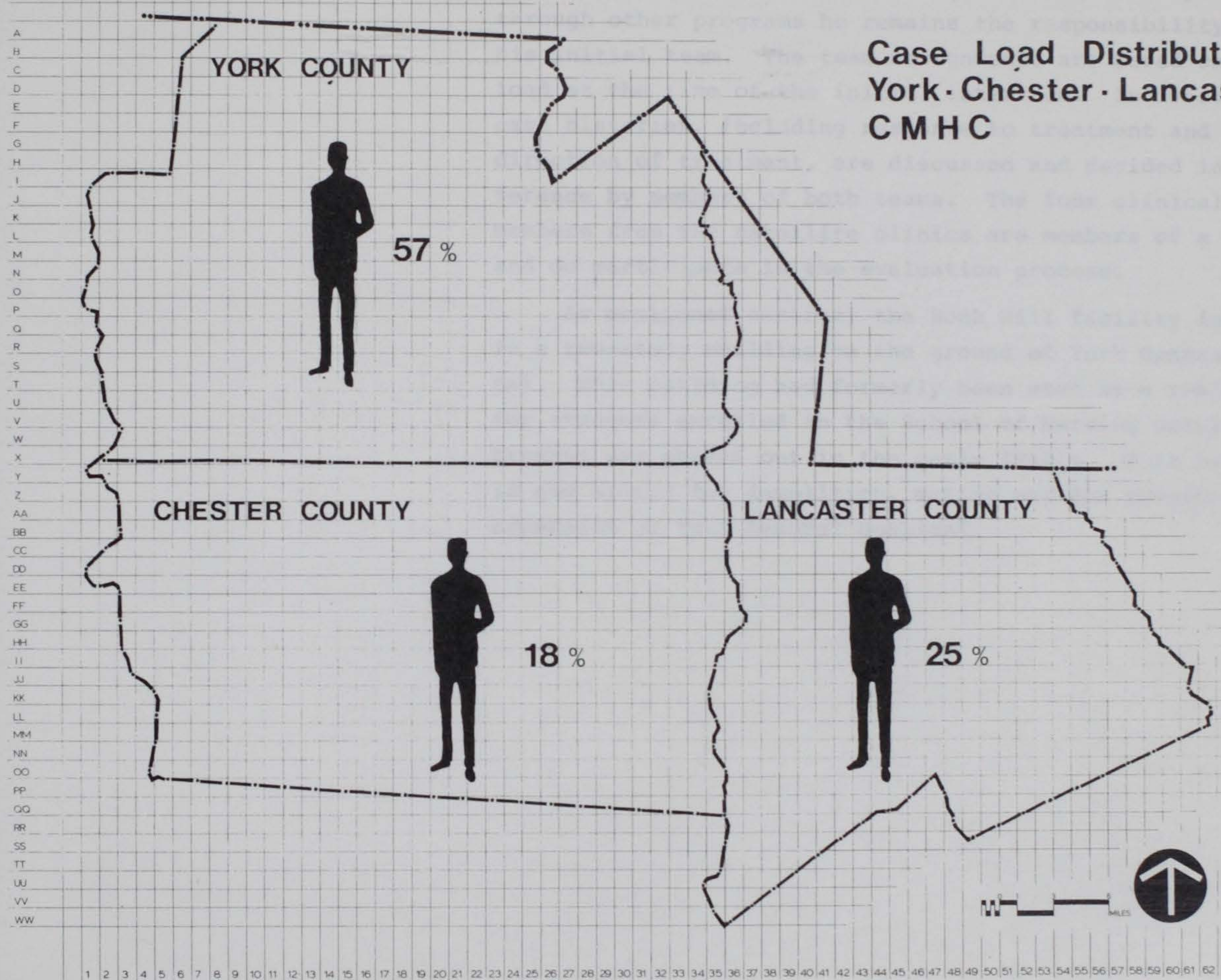
The York-Chester-Lancaster Mental Health Center was established under the 1963 legislation which requires five essential services. The center provides in-patient care, partial hospitalization, emergency service, out-patient diagnosis and treatment, and consultation and education programs. In addition, the center provides precare, screening and aftercare programs. A program for the treatment of substance abusers has also been included in the center's services.

The center's staff is composed of two interdisciplinary teams. Upon admission to any of the center's programs an individual's case is



assigned to one of the teams. As the individual progresses through the program, the responsibility of the team shifts to the individual. The team's role is to provide support and encouragement, not to direct the individual. The team's role is to provide support and encouragement, not to direct the individual. The team's role is to provide support and encouragement, not to direct the individual.

# Case Load Distribution York · Chester · Lancaster CMHC





assigned to one of the teams. As the individual progresses through other programs he remains the responsibility of his initial team. The team assignments are based on case load at the time of the initial interview. Individual case histories, including response to treatment and future direction of treatment, are discussed and decided in conference by members of both teams. The four clinical staff members from the satellite clinics are members of a team and do participate in the evaluation process.

As mentioned earlier, the Rock Hill facility is located in a two-story building on the ground of York General Hospital. This building had formerly been used as a residence for students enrolled in the School of Nursing until the program was phased out in the early 1960's. This building is now slated for demolition, making way for physical plant expansion of York General Hospital.



## **Part III**



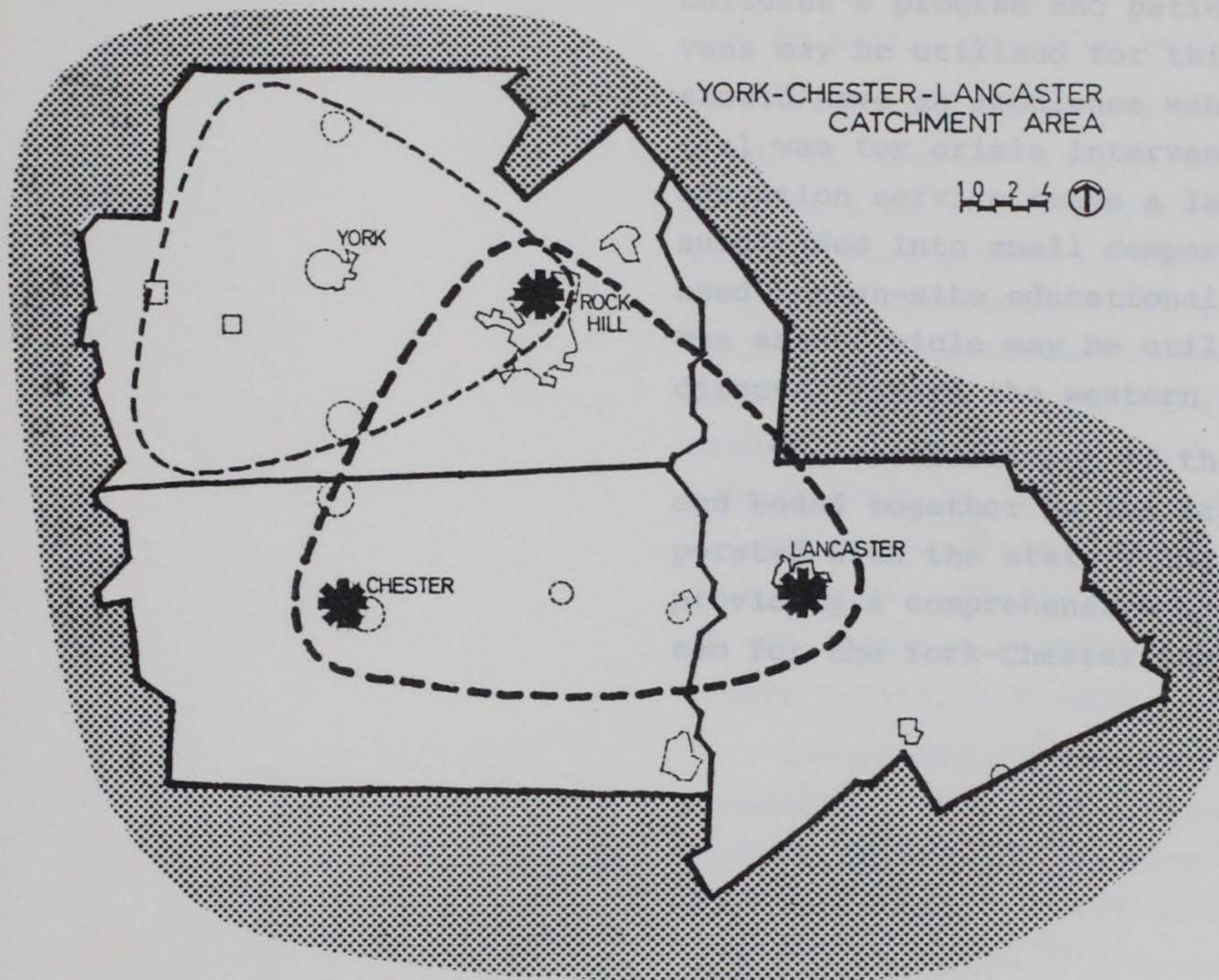
## THE PROPOSED COMMUNITY MENTAL HEALTH CARE DELIVERY SYSTEM

In proposing a community mental health care delivery system for the York-Chester-Lancaster Catchment Area and designing a facility for that system, the author was called upon to synthesize and decide on a multitude of pertinent criteria. The considerations ranged from existing and proposed delivery systems, programs, and policies to recent legislation, projected need, and future trends. The author's decisions were based on research, direct observation, and interviews. Professionals from both the Mental Health Center staff in Rock Hill and the Department of Mental Health in Columbia were interviewed.

The author proposes that the community mental health care delivery system for the York-Chester-Lancaster Catchment Area be composed of four elements. First, a facility offering comprehensive services as specified by the 1975 legislation, Public Law 94-63, should be located in Rock Hill. Second, a satellite facility offering out-patient diagnostic and treatment services should be located in Chester. Third, a larger satellite facility with additional staff offering out-patient diagnostic and treatment services should be located in Lancaster. The fourth element involves transportation. Transportation should be provided between the Rock Hill facility and the satellite facilities.

The community mental health services facility located in Rock Hill should serve as the hub of the delivery system.





The Rock Hill facility should be the most extensive and should provide comprehensive mental health services as defined by the 1975 legislation.

1. In-patient service
2. Out-patient service
3. Partial hospitalization service
4. Emergency services
5. Consultation and education
6. Precare service
7. Aftercare service
8. Children's services
9. Services for the elderly
10. Half-way house services
11. Alcohol services
12. Drug addiction services

The satellite facilities, both Chester and Lancaster, should continue operation in their present location. In addition to out-patient diagnostic and treatment services, the satellites should offer precare, aftercare, and alcohol and drug addiction services. The clinics should serve as a pick-up point for the children's service and patient referral.



The transportation element should consist of a shuttle service between the facilities and mobile units to augment the emergency service and the consultation and education service. The shuttle service is primarily for use by the children's program and patient referral. Nine passenger vans may be utilized for this service. The emergency service should have an ambulance vehicle for emergency and a commercial van for crisis intervention. The consultation and education service needs a large van or truck which may be subdivided into small compartments. This vehicle is to be used for on-site educational and industrial consultation. The same vehicle may be utilized in an outreach program directed toward the western third of York County.

The establishment of the three facilities, augmented and bound together by the transportation system and incorporated with the state Village System, is a step toward providing a comprehensive mental health care delivery system for the York-Chester-Lancaster Catchment Area.

Street repair, and subdivided housing.

Geographically, socioeconomic groups have no clear boundaries. However, the centroid of the low income group appears to be just south of the central business district. An intermittent belt of middle income residential areas circumscribes the first group. However, the middle income area does extend far to the north and west. The high income residential areas are dispersed throughout the county and to the far north.



## LOCATION OF PROPOSED COMMUNITY MENTAL HEALTH SERVICES FACILITY

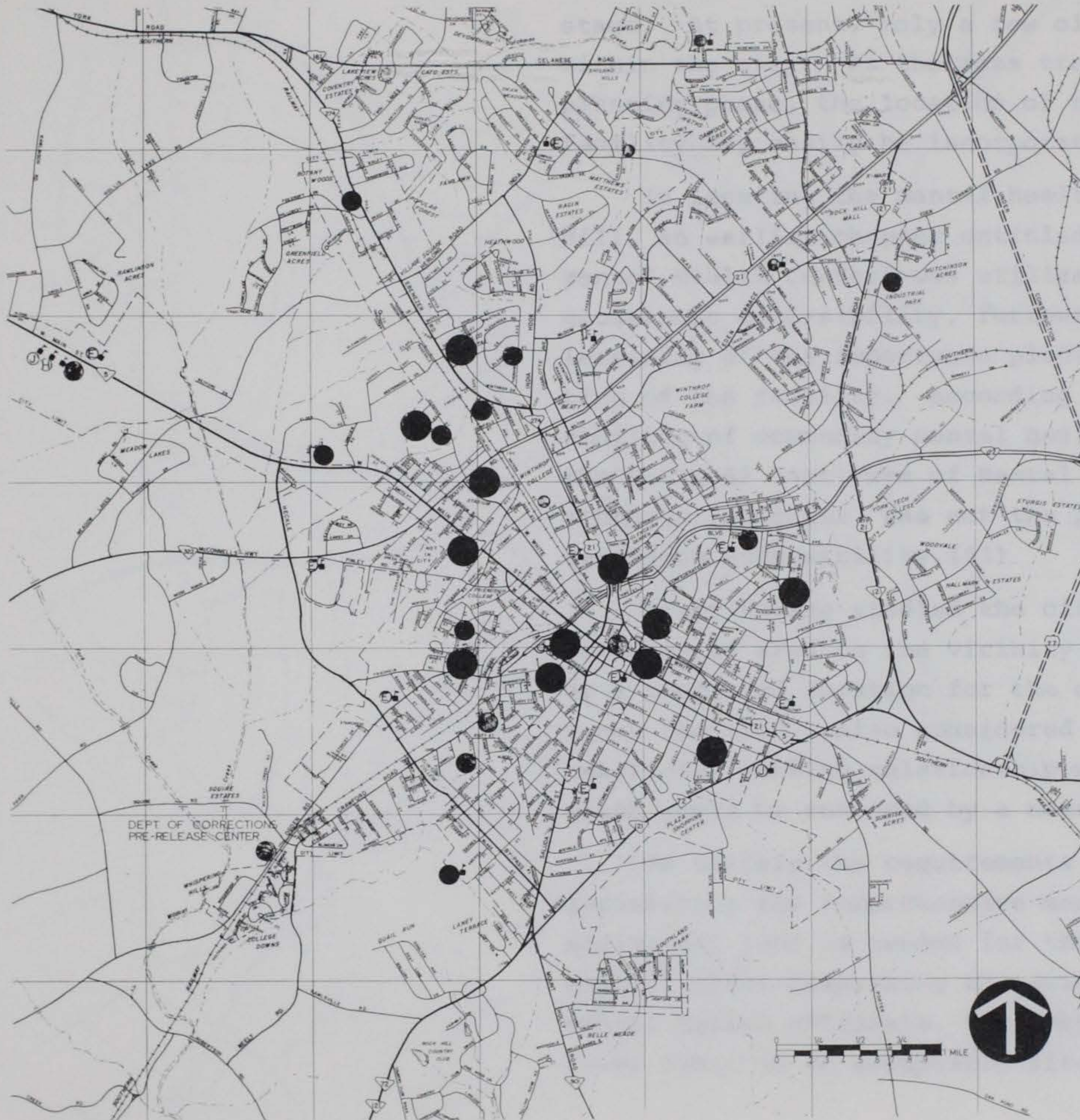
The hub of the mental health care delivery system in the York-Chester-Lancaster Catchment Area is the facility located in Rock Hill. For this reason, the author chose the Rock Hill facility to develop as a terminal project.

Rock Hill, with a population of 35,457, is the most populous area within the three county catchment area. The city of Rock Hill is undergoing a period of rapid growth and change. Industrial expansion, the development of the Carowinds Amusement Park, and the completion of the link with Charlotte are major factors influencing this growth. Rock Hill's suburbs and the city's business areas are expanding north and northwest toward the Catawba River and Lake Wylie. In 1970, Rock Hill was designated a Model City and began receiving funds for urban renewal and community development. The initial phase of the program started work on tot lots, neighborhood centers, sewer line installation, street repair, and subsidized housing.

Geographically, socioeconomic groups have no clear boundaries. However, the centroid of the lower income group appears to be just south of the central business district. An intermittent belt of middle income residential areas circumvents the first group. However, the middle income area does extend far to the north and west. The higher income residential areas are dispensed among the middle income areas and to the far north.



# Community Services



- CITY HALL AND POLICE
- EM ● S.C. STATE EMPLOYMENT SERVICE
- W ● WELFARE DEPARTMENT
- FS ● FOOD STAMP OFFICE
- SS ● SOCIAL SECURITY ADMINISTRATION OFFICE
- FEDERALLY SUBSIDIZED HOUSING
- YORK COUNTY HOSPITAL
- WORKING WOMEN
- SC ● SENIOR CITIZENS' CENTER
- COMMUNITY RECREATION CENTER
- VR ● VOCATIONAL REHABILITATION SCHOOL
- DEPARTMENT OF CORRECTIONS
- PRE-RELEASE CENTERS
- Y ● YOUTH OFFENDER PAROLE
- DAY CARE
- EO ● ELEMENTARY SCHOOLS
- JO ● JR. HIGH SCHOOLS
- HO ● SR. HIGH SCHOOLS





Rock Hill's mass transit system is in the planning stage. At present, only a few older buses serve major areas within the city. As the mass transit system is still in the planning phase, the location of the mental health services facility may easily be incorporated in the system.

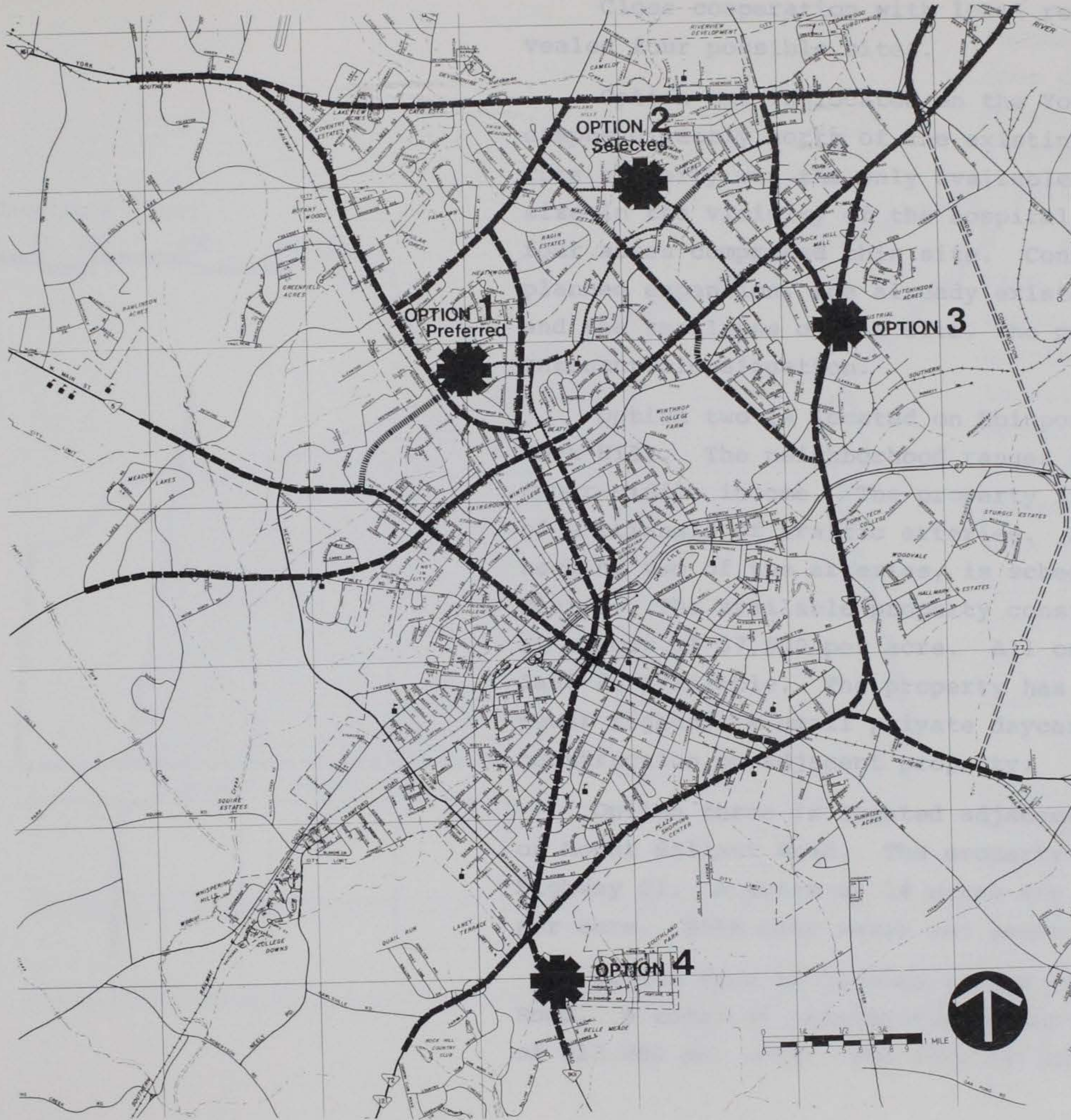
In locating the mental health services facility in Rock Hill, an earlier chapter entitled "Planning the Community Mental Health Center" was utilized. However, with regard to geographic accessibility, further research substantiated a lessening of the importance placed on the geographic location of the facility. According to a study of the accessibility of community mental health centers contracted by the National Institute of Mental Health in 1972, the location, although important, was not the primary criterion in determining accessibility.(93)

After having studied the city of Rock Hill, the author selected an area in the vicinity of York General Hospital as a preferred location for the community mental health services facility. Also considered in this decision was the beneficial working relationship with York General Hospital which would be enhanced by a nearby location.

To satisfy the requirements established by the 1975 legislation for comprehensive mental health center status, additional land is needed for the increased range of programs. After discussing the issue with local community mental health officials, ten acres was agreed upon as the lower limit to an acceptable site.



# Location and Circulation Study



- Arterial
- Collector
- Proposed



Close cooperation with local real estate agents revealed four possible sites.

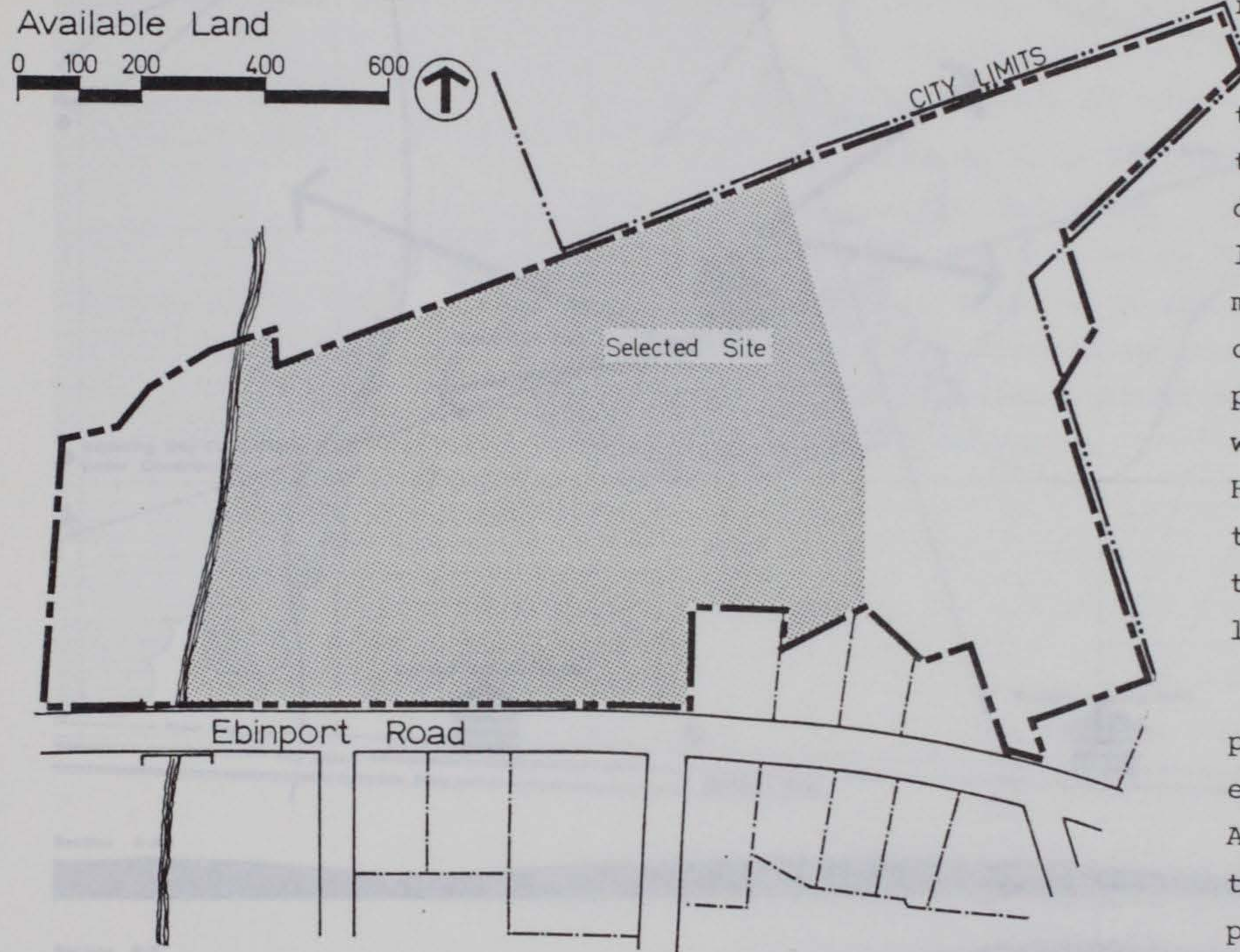
Option one is located on the York General Hospital campus directly north of the existing mental health center. This property was the only available land of any significant size in the vicinity of the hospital. Unfortunately, only four acres comprised this site. Considering the hospitals planned expansion, the already existent parking problem, and the smallness of the site, the property presents an untenable situation.

Option two is located on Ebinport Road in north central Rock Hill. The neighborhood ranges from lower middle to upper middle income. The property is located in the center of a triangle of traffic arteries. Ebinport Road, connecting two of the arteries, is scheduled for collector status. The available property consists of eighteen acres at a cost of \$7,500 per acre. All or any portion of the land is available. The property has city water rights and sewer rights. A small private daycare center is under construction on adjacent property.

Option three is located adjacent to the Industrial Park on Mount Sallant Road. The property is situated just off highway 21. A total of 14 acres are available at \$9,000 per acre. Both city water and sewer are available.

Option four is located to the far south on Mount Holly Road. A total of seventy-five acres are available at a cost of \$13,000 per acre. The site is located between lower





income and lower middle income developments. The property on highway 901, is a major artery. City water rights are available.

After careful consideration of the four location options, the author chose to develop option two for the location of the community mental health services facility. The existing and proposed transportation network and the fact that Rock Hill is growing in the direction of the site should offset the extremity of the northern location.

Option two, as mentioned previously, consists of an eighteen acre tract of land. All or any portion of this tract is available. For the purpose of locating the community mental health services facility, approximately fourteen acres east of the creek was selected. The real







estate agent indicated that the property west of the creek could be included at no additional cost. The hill west of the creek provides a buffer area and controlled view. Beyond the hill, a small private daycare center is presently under construction. The site is bounded on the north and the east by residential lots. The area to the south, across Ebinport Road, is also residential.

The building site is located on the crest of the hill which runs north and south. The majority of the crest and the west slope is covered by deciduous growth. The remainder of the site, with the exception of the open area to the east, is covered by young evergreen growth. The facility is situated just within the deciduous cover adjacent to the open space.



## ARCHITECTURAL PROPOSAL

The purpose of this study was twofold -- to formulate a community mental health care delivery system for the York-Chester-Lancaster catchment area and to develop a facility within the system to house these services. As the delivery system was discussed earlier, here the author will examine the architectural proposal for the community mental health services facility.

Parameters were established and used as the design criteria which formed the basis for the architectural solution. Using the author's problem seeking and problem solving techniques, the following concept and schematic drawings were developed.

The concept is a response to the 1975 legislation concerning community mental health centers and a reflection of the attitudes of the therapeutic community. Also of great influence were some of the proposals of Dr. Humphrey Osmond and the South Carolina Village System which is soon to become operational.(93)

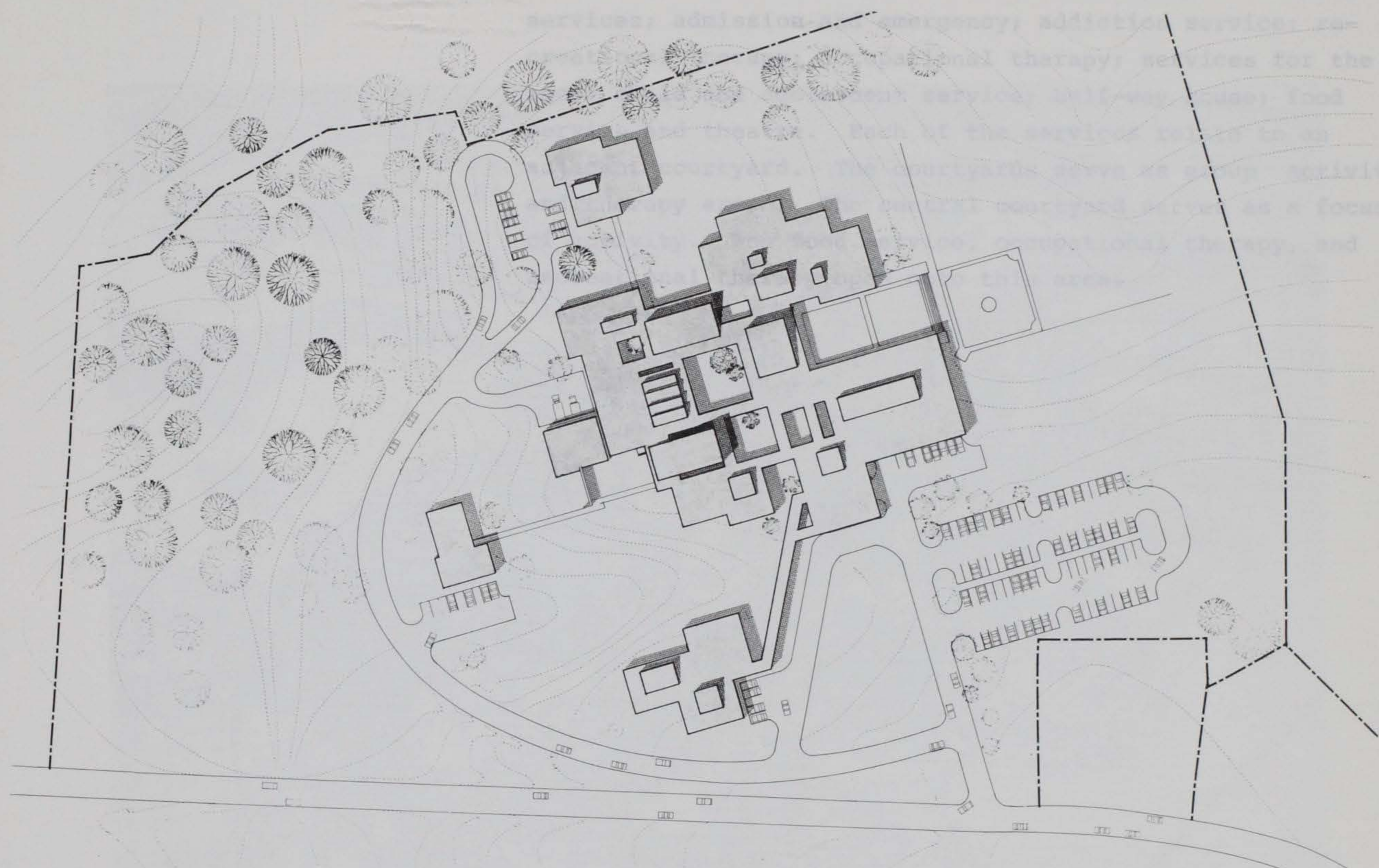
The facility, although under one roof, is broken into the various services required by law and support activities needed to maintain the programs. Although an individual's treatment may be initiated in one unit, for example outpatient, he is made aware of the whole and of the constant activity activity of the facility when he goes to any of the ancillary services, for instance occupational or recreational therapy.





Community Mental Health Center  
York · Chester · Lancaster





# Community Mental Health Services Facility

York · Chester · Lancaster

Site Plan

Scale: 1" = 40'-0"

0 20 40 70 120

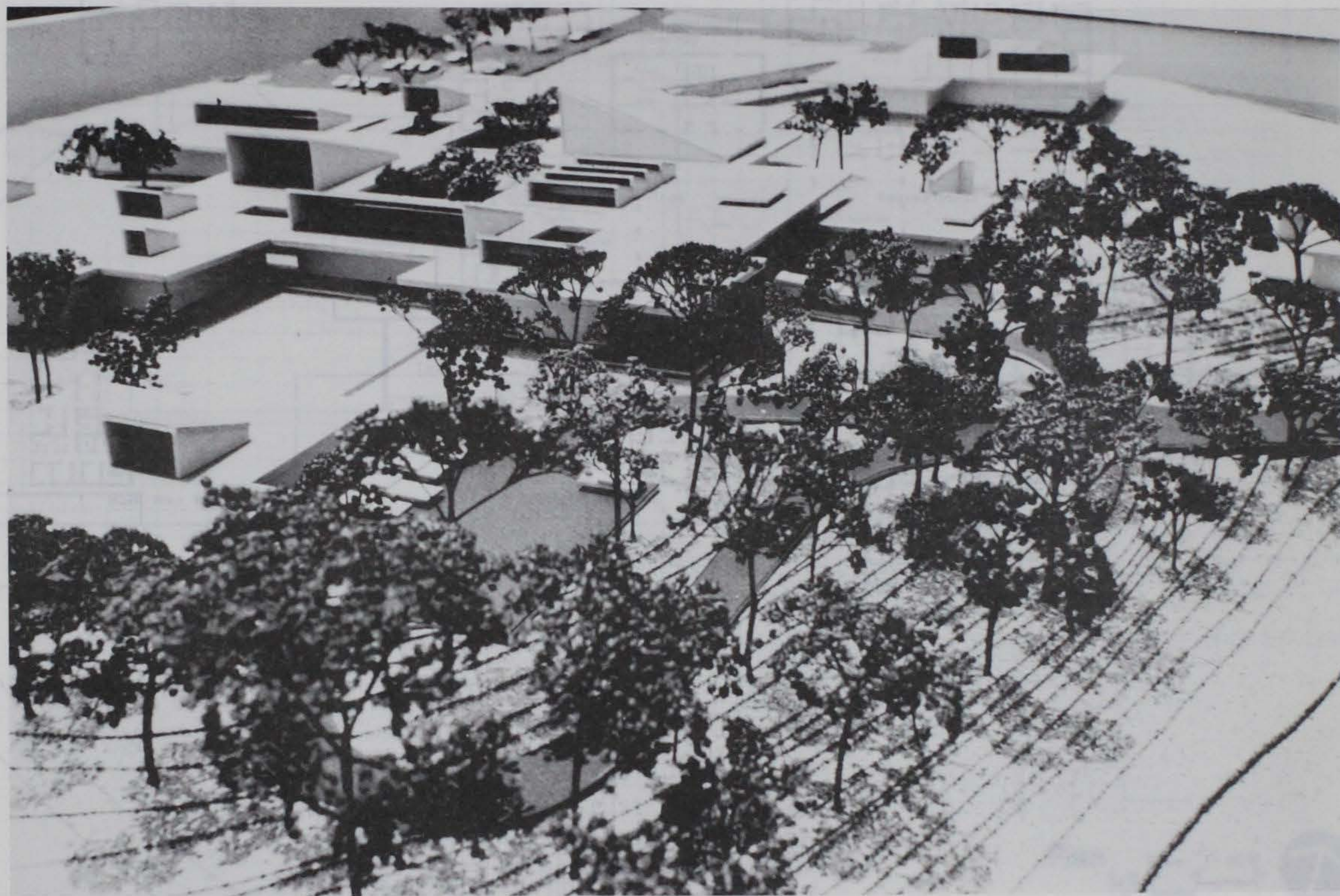


Robert H. Sanders



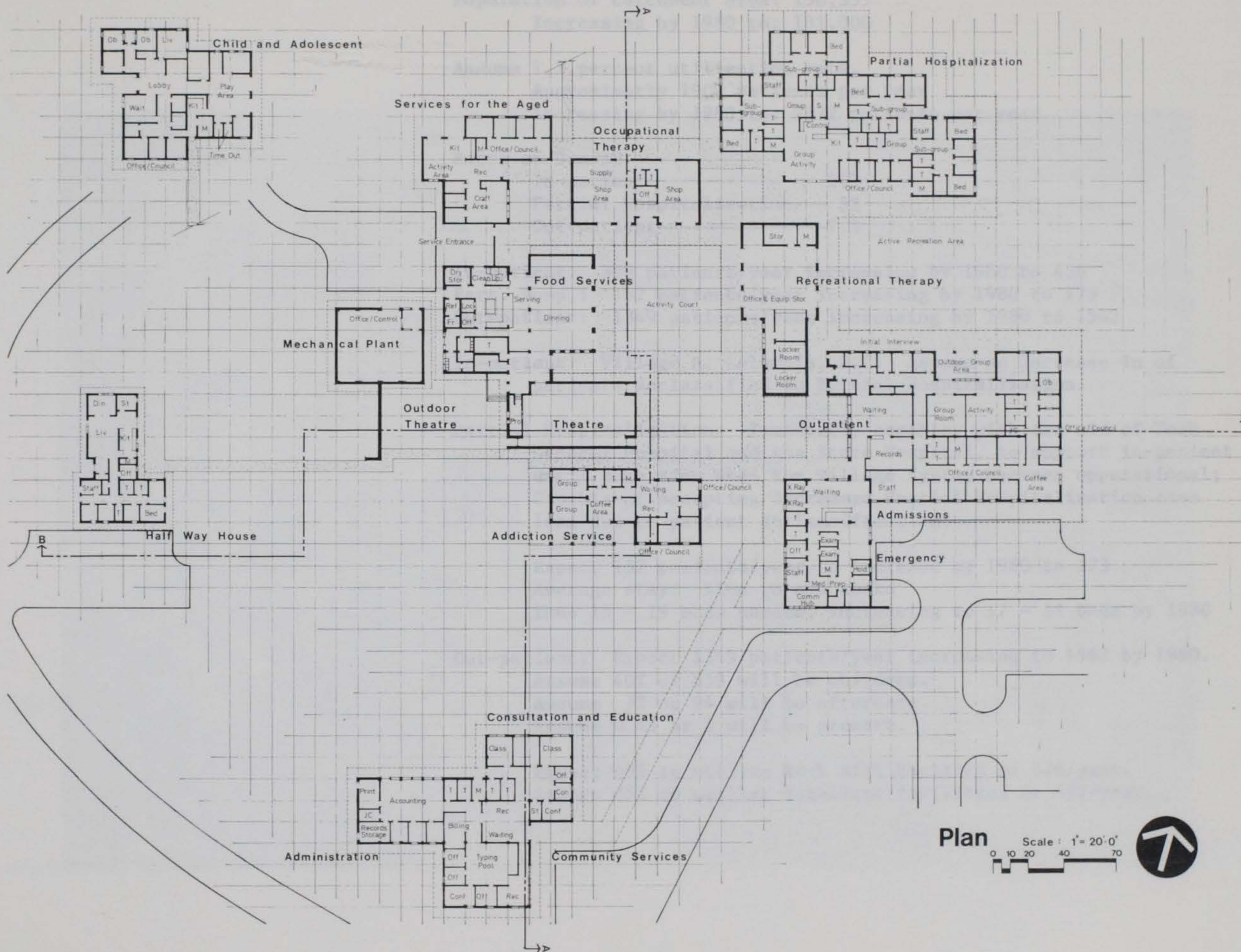
The facility consists of eleven major functional areas: administration, consultation and education, and community services; admission and emergency; addiction service; recreational therapy; occupational therapy; services for the aged; child and adolescent service; half-way house; food service and theatre. Each of the services relate to an adjacent courtyard. The courtyards serve as group activity and therapy areas. The central courtyard serves as a focus of activity. The food service, occupational therapy, and recreational therapy open onto this area.





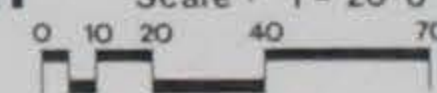


Population of catchment area: 158,352  
Total area: 1,200 acres



Plan

Scale: 1" = 20'-0"





Population of catchment area: 158,355  
Increasing by 1980 to: 181,000

Assume 1.2 percent utilization rate.  
Approximately 1900 patients per year  
Increasing by 1980 to: 2172 patients per year

Rates of Demand  
In-patient-----21%  
Partial Hospitalization--- 8%  
Out-patient-----71%

In-patient: 399 patients/year increasing by 1980 to 456  
Part. Hosp.: 152 patients/year increasing by 1980 to 173  
Out-patient: 1349 patients/year increasing by 1980 to 1542

In-patient: Village A, Columbia, S.C. Assume an increase in of  
patients declassified to Partial Hospitalization.

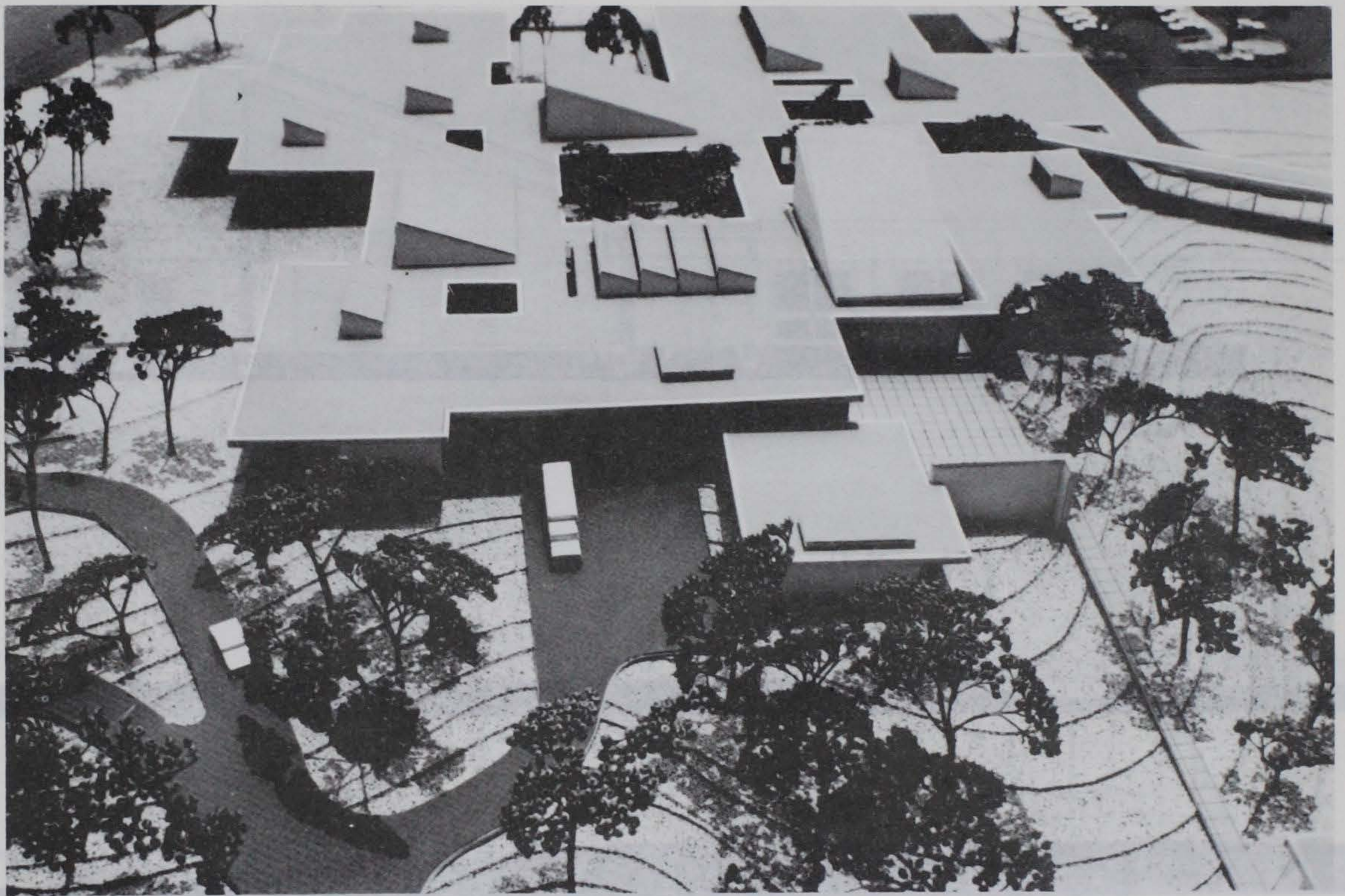
Partial Hospitalization: Immediately capable, with the aid of York  
General Hospital and the State Hospital, to support in-patient  
until such time when the Village System becomes operational;  
Capable of accepting increased Partial Hospitalization case  
load due to patient declassification.

Expect 152 patients/year to increase by 1980 to 173  
Average stay: five to six weeks  
Thus 15 - 19 beds needed, increasing to 17 - 21 beds by 1980

Out-patient: Expect 1349 patients/year increasing to 1542 by 1980.  
Assume 40% or 539 will be children.  
Assume 7% or 94 will be aftercare.  
Assume 0.4% or 5 will be precare.

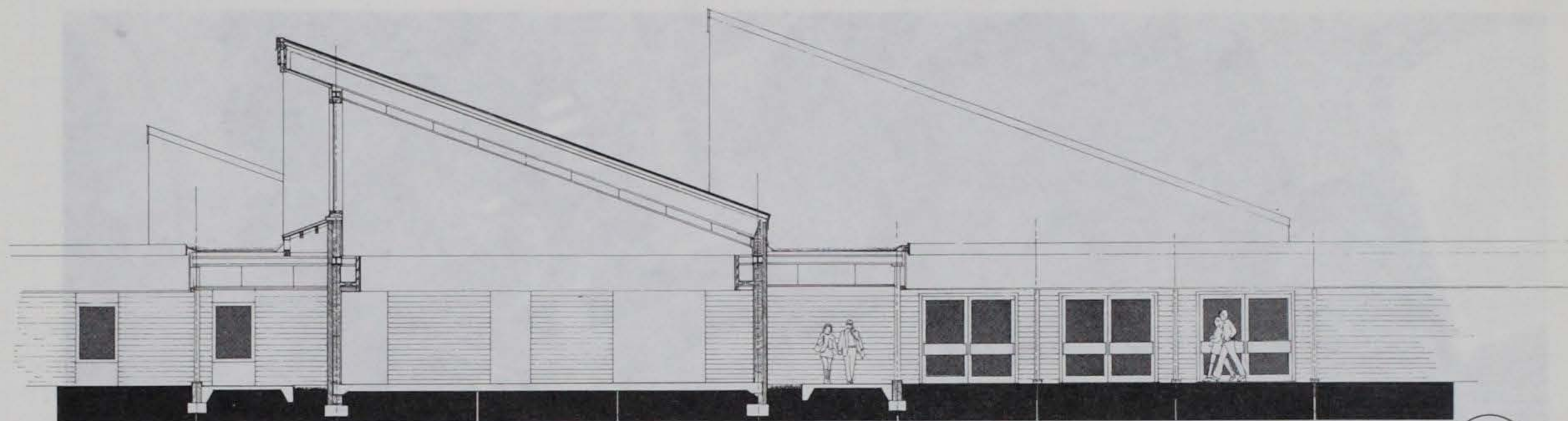
Expect 65% to utilize Rock Hill Facility or 876/year.  
Expect 35% to utilize satellite facilities or 437/year.





Elevations and Sections

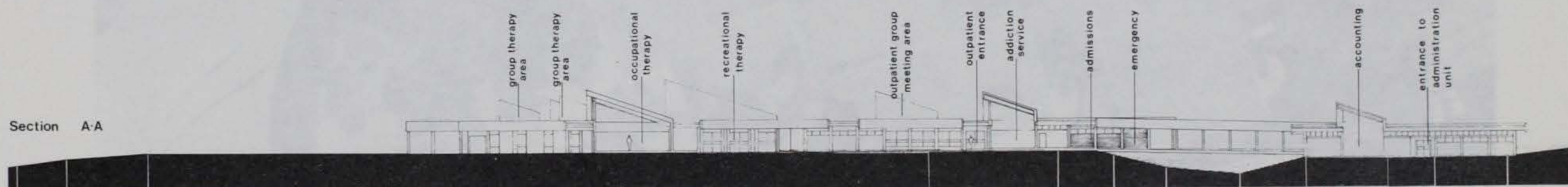




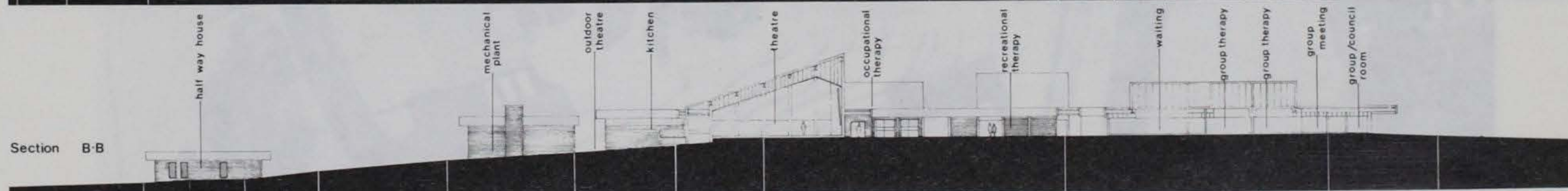
Scale : 1/4" = 1'-0"



Section A-A

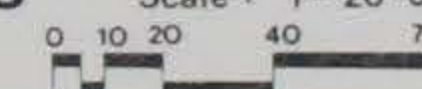


Section B-B

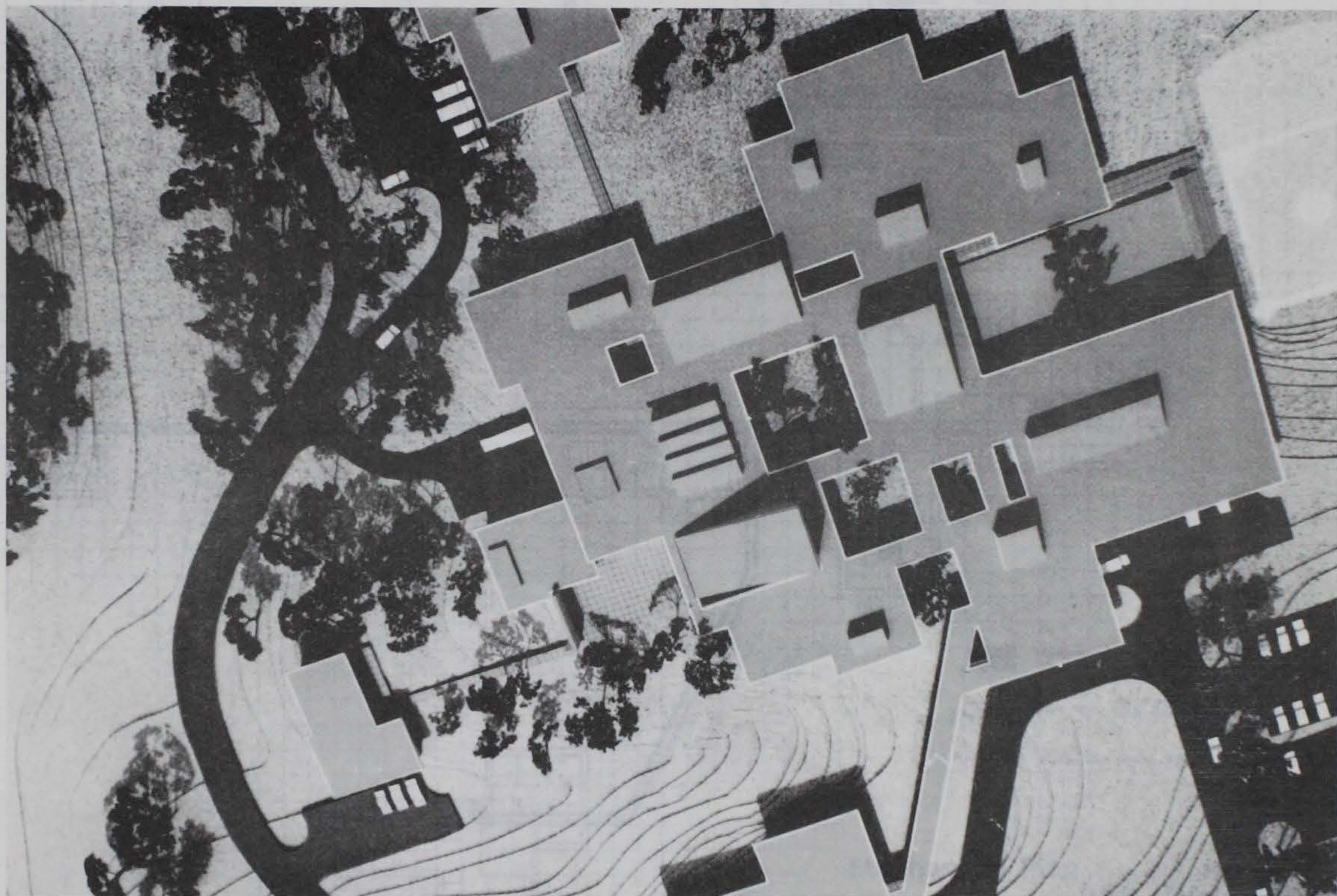


Elevations and Sections

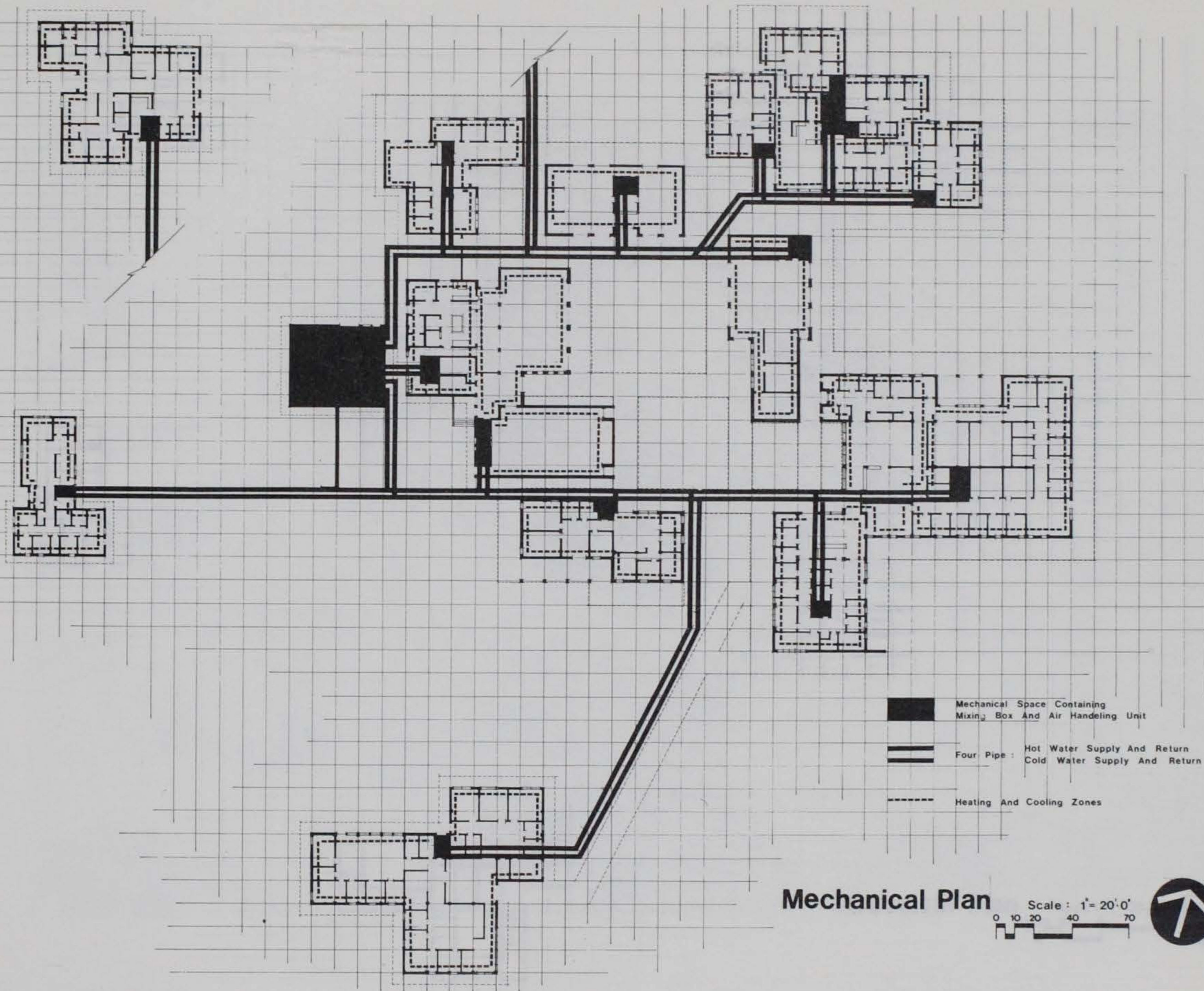
Scale : 1" = 20'-0"









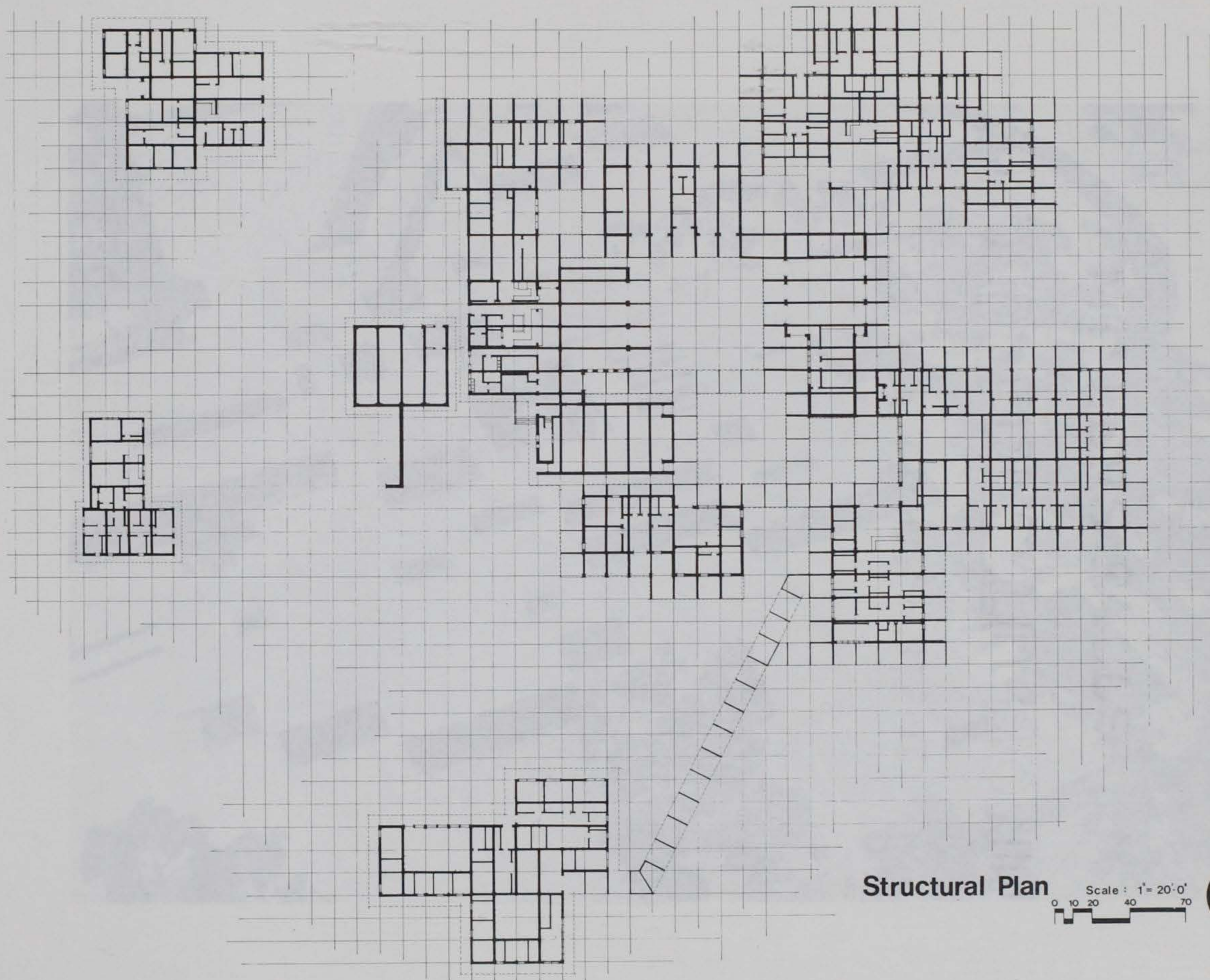


**Mechanical Plan**

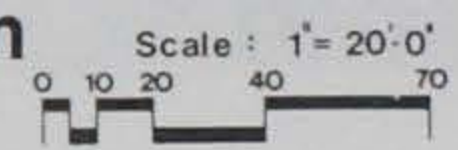
Scale : 1" = 20'-0"  
0 10 20 40 70







Structural Plan









## **Part IV**



## SUMMARY

This study has attempted to form an understanding of the community mental health center as a program and as a building type. The author's proposal, both the delivery system and the facility, is a present-day solution. This course was pursued purely for academic reasons.

Based on this author's research and observation, the future of the community mental health center as a building type is nebulous at best. The community mental health program, locally and nationally is in great turmoil. The demands placed on the local community mental health center by the 1975 legislation has already been proven, in many states, to overtax available resources. Resources, in this case, does not only refer to state and local funds but to manpower and facilities.

"There are no known, foolproof answers as to how best to care for those labeled "mentally ill" -- just as there are no widely accepted answers to the questions of what "mental illness" is.(94)

Any program aimed at reducing human suffering can only be looked upon as an experiment, a tentative step in providing better services, discovering answers. More important, any programs as broad in scope as the community mental health center program must have built-in evaluation from the very start, and enough flexibility to change, to accommodate the evolution of new methods, perhaps even to disband.(95)



The status of the community mental health program is under scrutiny at this time. Not until the direction of the program and the role of the mental health professional is clarified can the design professional once again take his place in the team.



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