

INCREASED SECURITY

Two highly publicized incidents in St. Louis and one in Kansas City in 1996, where patients, or former patients with histories of violent crimes walked away from confinement, resulted in a public outcry for review of the policies and procedures by which patients were granted passes and privileges, or conditional releases to the community. The resulting knee-jerk reaction by the Missouri Legislature was to adopt the so-called "McBride Law."

Under this bill, security issues, and the process to be used when a team determines a patient is ready for release, were tightly defined.

For instance, in the past when a treatment team determined that a patient was ready for conditional release, an application would be made to the probate court here in St. Joseph, or in the patient's home town. Now, the court of original jurisdiction, the court in the county where the patient will reside, and the St. Joseph probate court must be notified. If the patient fails to earn his release, he must wait at least one year to file again.

The call from Jefferson City locking down this institution came on a Friday afternoon in late August. Eventually, a fenced exercise area was created on the west side of the Buchanan Building. No off-grounds trips were allowed, and all activities had to be accomplished on the ward.

Staff handled the situation very well, and in spite of concerns that the patients would not tolerate the new security conditions, the over-all mood was upbeat. There were reports of patients taking an active role in diffusing potentially violent confrontations between patients.

Pass privileges were restricted, and for a while patients were not allowed to leave the ward, for any reason. Eventually, a pass system was developed with three levels of privilege which allowed patients to earn their way 'up' the system. This whole process was designed to keep the forensic, or court referred patients, confined. Voluntary commitments were basically not affected by the new regulations.

Security won't be as much of an issue in the new building because the three courtyards were designed to allow outside activities, but don't show an outward appearance of being secured areas.

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III UPDATE ADDENDA

- + Social Work Services
- + Psychological Services
- + New service paradigm
- + New facility

SOCIAL WORK SERVICES 1944-1997

INTRODUCTION

The practice of social work was late in coming to institutions for the mentally ill. The Elizabethan Poor Laws indicated some compassion for indigent persons in England many years ago, however, the transition to American was much, much later. Mary Richmond and Dorothea Dix were among the first proponents of better treatment for the mentally ill. As a result, St. Elizabeth's Hospital in Washington, D.C., was one of the first mental institutions to provide social services to persons with mental illness. Missouri much later made provision for social work services in their mental institutions. According to record, the St. Joseph State Hospital employed a social worker briefly during World War II. In 1944, the first social work was employed to provide services to approximately 2,900 patients.

After the termination of Charles Pierstaff in 1944 due to insufficient hospital funds, there was no social worker on staff until 1956. At that time, the Clinical Director, Dr. Gus Waraich, insisted that the superintendent employ a social worker to meet some of the patients' needs. There was no activity therapy, music therapy, volunteer services or other patient services, but these were gradually added. Miss Billie Stewart was employed as a social work assistant; however her duties did not include therapeutic social work toward the release of patients. Instead she was required to provide tangible services such as gathering and summarizing social histories, shopping for patients, planning birthday parties, censoring outgoing mail, issuing visitor permits, and occasionally contacting community social agencies. Miss Stewart had to ask her outside friends to come in and help with these services to patients on the admission unit because it was too much for one person. The rest of the hospital wards had none of these services at that time. A master's degree social worker, Mrs. Lena Smithson, was added to the social work staff in 1958. She resigned about a year later because of the nature of the workload. There was no time to use her professional skills with patients and/or relatives. Another professionally trained social worker and a case worker were employed about the time Mrs. Smithson left. The admission rate of new patients increased considerably; therefore, services had to be limited to the patients in the admissions building.

Early in 1960, Dr. Manson B. Pettit, a Board Certified Psychiatrist at St. Elizabeth's State Hospital in Washington, D.C., became the hospital superintendent. Many changes were occurring in the treatment of the mentally ill throughout the United States; therefore, Dr. Pettit insisted on a more therapeutic approach with patients and families. Other departments such as activity therapy, volunteer services, medical records, etc. had added staff during the previous three or four years, but the social work staff still consisted of only one social worker and two social work assistants (staff members at that time included Ms. Stewart, Elsie Poage, and Grace Leach).

Dr. Pettit stressed better patient care in the hospital and emphasized the need to release patients who did not require continued hospitalization. In April, 1960, he employed Calvin C. Carson, MSW, with the following stipulations: (1) that Mr. Carson and the other three social workers, with the aid of the medical, psychology, nursing and other support staff, screen patients for release; (2) that patients be returned to their own families, if possible, or to boarding homes or nursing homes, according to patients' needs; and, (3) that aftercare programs be developed and implemented so that transition from the hospital to community living would be more successful.

As a result, The Social Work Director suggested that Family Forums should be held on the weekends so that families could come to the hospital to learn more about mental illness and the needs of released patients. Shortly thereafter, the Superintendent, the director of Psychology and the Social Service Director met with relatives on Sunday afternoons to help them better understand the ramifications of mental illness and the need for patients to be released when ready. Gradually social workers were added to staff and many of the tangible services previously mentioned were delegated to other departments. Thus, social workers could concentrate on the release of patients throughout the hospital - not just from the admissions building. There was some opposition to releasing patients who worked in the laundry, food service, hospital farm, etc. because there was not enough paid staff. As funds became available, more support staff was added; therefore opposition lessened. The superintendent was very supportive to all departments and allocated funds as they became available to all departments such as activity and music therapy, volunteer services, vocational rehabilitation, etc. He constantly endeavored to recruit competent, qualified professional staff.

In 1961, the social Service Department was certified for the professional training of social work graduate students from the University of Missouri School of Social Work. The first social work student was Mike Devitt. He provided individual and group therapy, supervised by a professional worker. He placed several patients in jobs outside the hospital and also served as a part-time vocational counselor until his graduation. Later, social work graduate students from the University of Kansas received their practicum social training with the Social Service Department of the St. Joseph State Hospital. In the mid 1970's, undergraduate social work students from Missouri Western State College in St. Joseph were added to the program.

When Dr. Liam O'Brien became Superintendent in 1966, he requested the Social Work Director to arrange for outreach mental health clinics in Maryville, Albany, Chillicothe and Cameron. A psychologist and social worker were already conducting family therapy

sessions in Kansas City. Mr. Carson obtained free office space in the hospitals in these four respective towns. A full-time social worker was assigned to the four clinics and a State Hospital psychiatrist went one day a week in the Maryville and Chillicothe clinics. The two other clinics received consultation as needed.

Many patients were placed out during the ensuing years; however, many boarding homes did not provide sufficient social/recreational activities. Outreach and aftercare social workers complained about inactivity for patient residents. As a result, Mr. Carson and Mrs. Jane Urquart of the St. Joseph Mental health Association, wrote a grant proposal and obtained \$10,000 per year for three years from the Missouri Division of Mental Health. A full-time community social worker was employed to provide activities away from the boarding homes. There was no money to rent space so Mr. Carson contacted several churches which were willing to provide free space. Various activities were provided five days a week and the boarding home operators were required to furnish transportation to and from the activity site. After the three-year grant was depleted, the State Division of Mental Health provided funds to continue the full-time employment of a community social worker. The State Hospital also assigned a casework assistant to the program.

The program proved so successful that the Division provided funds for a full-time community activity social worker in Chillicothe, Mo., where a number of released hospital patients resided. Betty Moore, the social worker in the area at that time, working with the support of Ed Davis, the DMH social work supervisor, set up a program within the community for recreation and re-socialization, calling the program "CRR". The program utilized community resources to begin to take our clients out into the community three or four times a week - to lunch, to shop, for games and other social activities, and some to jobs.

The Veterans Administration and other hospitals now refer and pay for released patients to the Community Recreation and Resocialization Program. The St. Joseph group, under the direction of Martha Gooding, has rented its own club facilities with ample space for various activities and day trips are planned to sports events and points of interest.

Public awareness and community participation is imperative for quality care both inside and outside mental hospitals. Therefore, over the years, the Missouri Legislature appropriated additional financial funding which brought about increased staffing and treatment programs for inpatients and outpatients. The Social Service Department, with the support of the Superintendent and other hospital staff, was instrumental in obtaining grant funds to share knowledge about mental illness/health with others outside the hospital. Beginning in 1969, Social Service sponsored monthly seminars on various aspects of mental health, and the need for community support. Welfare workers, ministers, school teachers, college students and physicians were invited to the hospital to attend and participate in seminars conducted by well-known professionals who discussed types and treatment of various types of illness of adults and children. Over 300 hospital staff and persons from the community attended the seminar on suicide which was conducted by a nationally known authority from California.

After three years, grant funds were no longer available for the continuation of these seminars. No professional research was conducted to determine their effectiveness. Nevertheless, many constructive verbal and written comments were made by those attending; the County Welfare Department in northwest Missouri wrote the Director of Social Service and the Superintendent stating how helpful the information received from the seminars was to their staff.

As the patient population decreased from 1960 until the present, many changes in staffing and programs inside and outside the hospital have occurred.

The aftercare staff became a separate unit from the original Social Work Department in the 1970's, and was ably directed for a number of years by Ann Signoracci who currently is the chairwoman of the hospital's Advisory Board.

Many services have been contracted for and funded by the Missouri Department of Mental Health. For example, the St. Joseph Family Guidance Center now administers the outreach clinics to which released patients are referred.

Special thanks goes to all hospital staff, families and community persons who have make it possible for patients to live in a less restrictive environment than was previously provided by St. Joseph State Hospital. A very special thanks to social workers Billie Stewart Vories, Grace Leach (now deceased) and Nadine Cronk Furman who should be remembered for their dedicated work toward better services to patients and families in spite of the many obstacles encountered. Dr. Manson Pettit and Dr. Liam O'Brien should always be remembered as pioneers in bringing about many positive changes for better patient care.

Submitted February, 1997
Calvin C. Carson, MSW (retired)

HISTORY OF PSYCHOLOGICAL SERVICES

The hospital's founding in 1874 predates the official beginning of the science and practice of psychology. As most college freshmen learn, Wilhelm Wundt started a new academic discipline in 1879 when he identified his Leipzig University project for the study of subjective experience as a "psychology" laboratory.

The fledgling science remained essentially an academic and experimental field throughout the first half of the twentieth century. Most adherents were reluctant to consider practical

applications, fearing that there was an insufficient body of findings to do so. As exceptions, intelligence testing gained some popularity during and after W.W. I, a few child guidance clinics were developed in the 1920's and 30's, and some applications of industrial psychology were made in efforts to enhance worker productivity. However, applications in the area of mental illness were left to psychiatry, with "abnormal psychology" concentrating on experimental efforts in support of that medical specialty.

As an example of this, the first documentation referring to a psychologist at St. Joseph State Hospital occurred in the 1940's. It summarized the work of Mary F. Robinson who, in doing her dissertation research for the University of Chicago, described the cognitive functioning of patients following psychosurgery (lobotomy and lobectomy) performed in the facility.

The overwhelming demand for military mental health services during World War II created the need for many more practitioners than could be met by psychiatric medicine. That crisis was solved by using academically trained psychologists, and a new profession emerged - clinical psychology.

Willis H. McCann, with a doctorate in abnormal psychology from the University of Indiana, was the pioneer psychologist in state service in Missouri, having done some intelligence testing at the hospital in Nevada in the late 30's. In 1949, after completing his military career and working for a short time in industry, "Mac" brought the new discipline to St. Joseph State Hospital (then State Hospital #2) as the first full time psychologist. Using a Rogerian client-centered approach, he instituted individual psychotherapy as his primary mode of working with patients, and his results in promoting positive change quickly earned him acceptance and respect from his colleagues in medicine.

In the 1950's McCann introduced a novel form of group therapy that gained widespread professional acclaim. This methodology, "Round Table Group Therapy", was initially funded through a grant and used an elaborate closed-circuit recording studio system in which groups of patients were able to experience feedback of the verbal interactions between themselves and peers. The patients used this feedback to make judgments regarding their readiness for advancement and/or release; through this procedure a self-government process was introduced to the facility.

The success of this program contributed to the recognition of clinical psychology as an important hospital resource, and McCann was given responsibility for forming a distinct Department of Psychology by the superintendent, Orr Mullinax. He served as Chief Psychologist and department director until his retirement in 1968.

The department grew in size and stature during the mid- and late 50's and through the 1960's, complemented by the medication advancements in psychiatry and similar growth in the fields of psychiatric social work, nursing, hospital chaplaincy, and ancillary therapies. In the early part of this period the work of the psychologists, primarily testing and psychotherapy, was concentrated in the admissions and acute care area, a single building (Woodson) with a 180-bed capacity. They functioned as part of the psychiatric team, a

concept implemented in the hospital by the dedicated and charismatic medical director, G.S. Waraich.

An increase in admissions of children and adolescents called for specialized programming. With the active participation and consultation of a psychologist, Ellis Shutts, a committee organized the Youth Program in 1962. This project occupied its own building by 1963, and included an education component that, with an expanding teaching staff, evolved into a renowned state-accredited school, the Woodson Academy. The Youth Program grew quantitatively and qualitatively to the extent that it became a separate facility, Woodson Children's Psychiatric Hospital. Ron Dittmore, who had previously served as the leader of the Education Department in St. Joseph State Hospital and had extensive graduate training in clinical psychology, was its first director.

The increasing discharge rate, attributable particularly to advances in medication, underscored new needs during the 60's. One of these was for patient vocational assistance, and a vocational assessment and training program, beyond the scope of occupational therapy and hospital job assignments for patients, was established in 1964. This began with a single counselor and quickly expanded to a full-scale cooperative project between the hospital and the state agency for vocational rehabilitation. Hospital psychology staff members were active participants and colleagues in the program.

The expansion of outpatient services in 1966 into a full-time clinic was a response to the need for patient post-discharge treatment. Psychiatrists, social workers, nurses, and psychologists staffed the program which ended when its operations were incorporated into the services offered by community mental health centers in the 1990's.

In 1967, the medical director requested staff cooperation in the development of a specific alcoholism treatment program. This program, with the involvement of a psychologist, a social worker, a nurse, an occupational therapist, and a few psychiatric aides, started in one 25-bed ward. As was the case with the Youth Program, this project grew until it became a separate 50-bed state supported facility until being transferred to private vendors in the 1980's.

Dr. Liam O'Brien, employed as superintendent in 1966, initiated the geographic unit plan in the hospital. This, along with the specialized treatment programs, resulted in the decentralization of the psychology department and assignment of psychologists to the specific units located in various campus buildings. The number of psychology staff, under the professional direction of Ken West, increased to ten in the 1970's and was composed of the professional psychologists with specific unit assignments, and paraprofessional psychological technicians. The technicians, centrally located, administered standardized assessment instruments with interpretation and report preparation functions performed by psychologists.

The deinstitutionalization movement, a national thrust, was reflected in the community placement initiative started in the hospital under the leadership of the Director of Social Service, Calvin C. Carson, in the late 1960's. All hospital clinical disciplines, including

psychology staff, were involved in the process of determining the readiness of patients for placement in community resources, usually nursing and boarding facilities.

This movement was accelerated by the Caswell Consent Decree of 1978. This court decree resulted from a class action lawsuit and required the hospital to arrange promptly for the community placement and oversight of a large number of long-term patients. Among the effects of this process were a strengthening of the team collaboration functions of facility staff and administrative preparation for impending dramatic reduction in the size and scope of the hospital. This, in turn, has flavored all the facility planning up to the present; from a peak census of nearly 3000 patients in the 1940's, the hospital anticipates a capacity of 108 in 1997.

This downsizing was accompanied by an increasing emphasis on professional quality during the 1980's with the development of more effective treatment planning and implementation processes, establishment of productivity and quality assurance measuring mechanisms, and enhancement of staff development programs. Psychology participated actively role in these operations, as demonstrated by departmental endorsement of the new state psychology licensure law, establishment of licensure training as a recruitment incentive, and use of a program consultant with outstanding credentials, Bernard Lubin.

As the number of patients decreased, the comprehensiveness of hospital services was reduced, reflecting the state's mandate to transfer mental health operations to community agencies. The late 1980's and early 1990's saw the closure of the substance abuse treatment center, the geriatric program, the outpatient clinic, the vocational rehabilitation program, and several inpatient wards. These moves were accompanied by staff consolidation and reduction, a process which continues today.

The separate departmental status of psychological services was abolished in 1991 with the elimination of the director's position (McCann and West having been the only occupants), and several individual psychologist positions were deleted through attrition.

With Joe Simanek as superintendent, planning began in the early 1990's for a thorough reformation of the hospital's mission and structure. Psychiatric rehabilitation, a process involving preparation of patients for successful and satisfactory community living as well as treatment of psychiatric symptoms, was adopted and approved as the methodology of the future.

Under the leadership of the present superintendent, Ron Dittmore (previously the director of the adjacent children's psychiatric hospital), mission philosophy, staffing and organizational plans were developed with this structure in mind. A new architectural complex was designed, funded, and constructed with occupancy to take place early in 1997.

The new facility, Northwest Missouri Psychiatric Rehabilitation Center, will have allocations for three psychologists as members of the treatment/rehabilitation teams. The teams will be responsible for serving patients, most of whom will have been committed to the hospital through criminal courts, who demonstrate severe and long-term psychiatric pathology.

Beyond traditional medical and psychotherapeutic measures, the specific services will emphasize assessment and development of those skills that will assist the patients in adjusting to the community setting of their choice.

Since this report is being prepared as part of the archival documentation requested to precede the move to the new location, predictions are in order. In that vein, then, this writer offers the following opinion based on 35 years experience as a psychologist and administrator in St. Joseph State Hospital.

The rise and decline in the number of psychologists in the institution over the past four decades is a microcosmic representation of the larger chronicle of clinical psychology. After a relatively brief period of promise and prominence, it appears to be a fading profession that has served its purpose. It will sink into oblivion as its methods are adopted, revised, and enhanced by newer breeds of practitioners - counselors, specialized psychotherapists, assessment technicians, pharmacologists, educators, rehabilitation specialists, case managers and facilitators. In fifty years, perhaps even sooner, clinical psychology will be regarded as we view buggy-making, Rorschach testing and psychoanalysis today: quaint, historically valuable enterprises, but outmoded by the march of progress.

Kenneth D. West
November 1996

NURSING SERVICES

The first Director of Nurses was hired in 1960. Prior to that time, Registered Nurses were stationed in the Medical/Surgical Building which housed those patients which required more intensive medical and surgical intervention.

The Hospital was run by Shift Supervisors and Hospital Attendants. Registered Nurses would only go into the outlying buildings if they were called for a more in-depth assessment related to a medical problem.

Marge Barr, R.N., first Director of Nurses, placed emphasis on more training for the hospital attendants. More RN's were hired and placed in the outlying buildings with much reluctance from the hospital attendants. A training program for the hospital attendants began in 1961.

SUPPORT SERVICES

C.I.S.

This service is responsible for extensive data gathering, conversion and transmission for all clinical and administrative DMH systems processed at the Central Processing Unit for St. Joseph State Hospital, Woodson Children's Psychiatric Hospital, and Albany Regional Diagnostic Center.

The staff evaluate and procure EDP hardware and software for use of hospital networked data processing applications and study equipment specifications to ascertain most efficient, cost-effective methods of operations.

They also supervise implementation and maintenance of all EDP operating equipment, software, files, and logging of equipment malfunction and down time.

PURCHASING

This group directs and coordinates the technical purchasing functions of the hospital and tactfully works with the State Division of Purchasing to carry out these functions. The staff handles contracts on land leases and other contractual services required by the hospital.

They are responsible for working out the preparation of the hospital budget under the supervision of the Assistant Superintendent/Administration. Additionally, they are especially responsible in preparing the detailed breakdown of Expenses and Equipment items and the overall assembly of the budget, meeting the required deadlines.

ACCOUNTING

The Chief Accountant directs the operation of the Accounting Department which provides comprehensive financial services for St. Joseph State Hospital and Woodson Children's Psychiatric Hospital.

The department coordinates the process of Accounting documents in a manner that meets the requirements of the State Auditor's Office. The Accounting Department includes accounts payables, accounts receivables, cost accounting, and the reimbursement section.

It is also responsible for the preparation of acceptable Medicare and Unit Cost Reports.

SECURITY/FIRE & SAFETY

The major responsibility of this department is to maintain and implement a comprehensive hospital-wide plan to protect lives and property. In order to provide a safe and humane environment for all persons at SJSH and WCPH. The staff responds to all emergency calls such as radio calls from the switchboard, and panic and fire alarms.

Additionally, department members check all fire alarms and sprinkler systems on a regular basis and coordinate the necessary repairs and provide continuous surveillance and corrective action on fire and safety hazards. They also maintain daily inspections of

buildings and grounds and conduct quarterly fire drills and monthly inspections of sprinkler systems and fire extinguishers.

ADMINISTRATIVE SERVICES

This administrative group includes several services: the warehouse, laundry, housekeeping service, the print shop, the post office, the switchboard, the moving crew, and the beauty shop. Among the responsibilities are directing, planning, and organizing the overall operations such as receiving and dispensing merchandise to and from the warehouse, conducting laundry services and controlling the linen supply, custodial services, mail sorting and distribution, and cosmetology services for patients. In addition, this group becomes involved in special projects such as coordinating and implementing major moves and arranging for safety/environmental inspections.

DIETARY

The dietary department is responsible for the overall operation of the food service operations for both St. Joseph State Hospital and Woodson Children's Psychiatric Hospital. These operations include menu planning, food production, serving, and clinical dietetics. Professional staff also provide nutritional education and counseling for patients and staff.

MAINTENANCE

This group is responsible for monitoring and maintaining all utility services (HVAC, water supply, waste disposal) and mechanical systems in the hospital buildings and on the grounds.

In addition, the staff provides preventative maintenance programs and assists the Assistant Superintendent/Administration with planning and implementing the capital improvement portion of the hospital budget.

submitted by

Dave Farrar, Assistant Superintendent/Administration

March 1997

PARADIGM SHIFTS

The decade of the 1990's has been a time of unprecedented change in the philosophic, administrative, and procedural environment of Missouri's public mental health delivery system. The components of this change include:

- Remarkable advances in the treatment of psychiatric illnesses, especially in terms of the new neuropharmacological therapies for schizophrenia and affective disorders.

- A shift in the traditional view of responsibility for care and treatment of mental illness from the public to the private sector.
- A continuation of the "deinstitutionalization" movement, starting in the 1960's, with its emphasis on the participation of long-term psychiatric patients in the general community rather than a life spent in a custodial facility.
- A contradictory movement emphasizing a public demand for long-term custody of psychiatric patients with histories of antisocial behaviors.

St. Joseph State Hospital has responded to these forces by making fundamental alterations in the way it operates, using its new mission ("...to assist people who have long term psychiatric disabilities to acquire and use the skills necessary to be successful and satisfied, with the least amount of ongoing professional intervention, in the community of choice") as the guiding tenet.

Starting in 1990, the hospital has: 1) planned for a controlled decrease in patient beds to the 108 level; 2) worked from concept to actualization of a completely new physical facility; 3) adopted psychiatric rehabilitation as its methodology of patient care; 4) changed from an acute psychiatric treatment center to a facility specializing in the rehabilitative care of patients with histories of criminal court involvement; and, 5) embraced an administrative approach designed to facilitate effective, win-win interactions on all levels.

One way to illustrate our new approach to treatment of the mentally ill is what we call our **Paradigm**—a series of triangles enclosed in a circle. (See attached diagram).

The base of the largest triangle is represented by our **Patients**. Without them, there would be no need for the Northwest Missouri Psychiatric Rehabilitation Center to operate. Since you have Patients, you will, of course, need **Staff** to work with the patients. Because we do have patients and staff, we need to have an idea of what we want to do, and how we will accomplish that, so we created a **Mission Statement** which directs our short term daily operations, and dictates our long term vision.

In order to be effective and meet our Mission, goals, and values, we must provide the staff with the tools they need to successfully do their job. The next smaller triangle represents those tools: **Psychiatric Rehabilitation, Part-R and the Covey Leadership Center** philosophy. The **Psych Rehab** is our treatment philosophy; **Part R** provides the training needed to maintain a safe work-site atmosphere; and the **Covey Leadership Training** allows employees and patients to develop positive personal and professional relationships that will eventually transform the hospital into a more pleasant place to work. (These three items are explained elsewhere.)

The inner-most triangle symbolizes the approach to treatment at Northwest Missouri Psychiatric Rehabilitation Center. A combination of **Medication, Professional Therapy**: either individually or in groups, and **Education**—specifically teaching the skills needed to be 'successful and satisfied' in their chosen environment, provides the patients with the

The outer circle of the paradigm illustrates our commitment to **Continuous Quality Improvement, Total Quality Management**, and the process described as **Plan, Do, Check and Act**.

The inner most item of our Paradigm is our **Focus**. You'll notice that our Mission Statement is followed by our **Values**, all of which start with the work "**FOCUS**." This was no accident.

We take pride in the fact that we 'Focus on people as individuals...', or 'Focus on providing assistance...', or 'Focus on the quality of services...', or the other six Values.

These are important, and have become an everyday approach to how we work.

Decrease in patient beds.

The reduction in patient census has, of course, been an ongoing process since the 1960's, but the 108-bed goal was determined in coordination with State Department of Mental Health officials in 1990. Hospital staff efforts have been directed toward this goal since that time, and, during the administration of the present superintendent, Ron Dittmore, definitive "part-goals" with incremental census reductions (a "glide path") have been accomplished.

These bed reductions have been accompanied by similar staff decreases; with the relatively long-term planning allowed, staff reduction has primarily been through attrition.

NEW FACILITY

The new **Northwest Missouri Psychiatric Rehabilitation Center** was designed to meet the needs of a changing society, changing patient population, and changing treatment technology.

Community based programs have greatly reduced the need for the types of hospitals typically built at the turn of the 20th century. Currently, our hospital population is heavily influenced by increased forensic (court referred) commitments, which require a greater need for security. In addition, the Psychiatric Rehabilitation model we use calls for patients to take an active role in their treatment program, which also has influenced this building's design and construction.

Initially, the building and cottage complex was designed to provide a therapeutic setting that allied both patient and staff needs. Patients wanted a facility that was open, conveniently situated, and private. Staff wanted a building that provided security, was conveniently planned for treatment activities, and developed with open visibility into patient areas. This building was built around those combined standards.

Situated on about the same amount of land as the campus south of Frederick Avenue, the building was created to combine all services and treatment under one roof, and meet future Americans with Disabilities Act (ADA) standards. Patient privacy was a

major consideration. Hospital staff have tried to anticipate the future by incorporating a patient's need for privacy, and the hospitals need for security.

Each sleeping room in the main building will have its own bathroom with shower. Patient doors can be locked from the inside by the patients. Staff will still have access to the rooms if necessary. The goal of maintaining visibility down each hallway was important and achieved. Dirty linen collection and clean linen distribution will be handled from outside the wings, and was planned to keep disruption of the daily ward routine to a minimum.

Considered a minimum security facility, the openness created by the courtyards provides secure smoking and recreational areas. Sleeping rooms all have windows that look out on the courtyards or the open area north of the building. The patient residential wings are situated adjacent to their clinical services, which greatly increases treatment team communication and efficiency.

The notion of providing support services for the patients' convenience (i.e., beauty shop, canteen, recreation, patient accounts, etc.) was also considered.

Administrative and support areas are conveniently situated for staff, and can be entered without having to go through patient areas. In addition, public accessed areas are appropriately located adjacent to the main entrance.

While the facility was designed with a 108-bed capacity, the architects allowed for possible future expansion. Another 20-bed wing could be added, and ground was available for at least one more eight-bed cottage.

Support services, such as work therapy's greenhouse, long considered an integral part of the treatment process, are located adjacent to the building formerly used as the Superintendent's residence. Plans now call for that building to be used for 'engagement' programming, what we know as the A.R.I.S.E. program.

All in all, the building and its convenient organization was designed to meet patient needs, staff needs, and fits rather nicely when compared to the hospital's Mission statement.

PSYCHIATRIC REHABILITATION

In response to the DMH mandate to reform services, and as part of the community's plan for comprehensive mental health services, St. Joseph State Hospital has currently made the transition from operating as a traditional psychiatric hospital to functioning as an extended-stay psychiatric rehabilitation center. Planning for this transition process commenced in 1990, significant steps in implementation began in 1993, and completion is scheduled to coincide with the physical move of the facility to a new complex in 1997.

One of the cornerstone principles of the Psychiatric Rehabilitation model is the belief that recovery from Mental Illness is possible and achievable. Spearheading this process is Boston University's Dr. William Anthony.

Since 1979, Dr. Anthony and his staff have conducted research, training and program development activities which assist patients in gaining and using skills and supports so they may reenter an environment of his/her choice. The Boston University Center for Psychiatric Rehabilitation model was adopted by SJSH in 1993. Rick Forbess from Boston Center for Psychiatric Rehabilitation has been the leading facilitator and instructor for our staff.

Initially, Forbess conducted classes in the Rehabilitation process for a select group of supervisors and ward staff. Rick continues to direct the training, but Staff Development instructors have been certified to continue the program with in-house training. Judith Taylor, a graduate of the Boston University Center for Psychiatric Rehabilitation joined the Hospital Staff in July, 1995, as Psych Rehab Unit Manager, and serves as an invaluable resource for this program.

Service planning is coordinated by a Core team which is composed of: the physician, psychologist, social worker, nurse, UPS (Unit Program Supervisor), and the patient. Members of the team assist the patient in identifying what they need to work on and services needed to assist them. Treatment services focus on reduction of symptoms, rehabilitation services focus on restoration of functioning, basic support focuses on caring for the basic needs of the individual, and enrichment focuses on self development. Individuals providing service to the patient, as well as the Core Team make up the service team for each individual patient.

When first admitted, the patients are assigned a 'facilitator' who is the in-hospital case manager. The facilitator works with the Service team to assure that the patient is receiving needed and wanted services. The facilitator links patients to services by negotiating with clinical consultants, or service providers to provide the requested interventions.

Among the assessments made shortly after admission is one to determine the patient's ability to participate in rehabilitation activities. The **Rehabilitation Readiness Assessment**, is used to determine the patient's status relative to rehabilitation activities. The results of the Rehabilitation Readiness Assessment are summarized in a Status Goal which helps focus all rehabilitation/treatment planning. This status goal is the start of the planning of the Individual Treatment/Rehabilitation Plan, the document which reflects all Core/Service team planning efforts.

Not all patients are ready for the rehabilitation process. As a result, an alternative program was created to help the lower functioning patients gain some 'survival' and work skills. The **A.R.I.S.E. (Adult Rehabilitative Independent Skills Education)** program was started in early 1996 to provide a non-threatening, structured environment for patients to learn basic skills and become engaged with staff and other patients. This successful program has been recognized for its innovative approach to patient education, and is a classic example of how the rehabilitation process is supposed to work.

Other components of rehabilitation services include:

- **Setting an Overall Rehabilitation Goal (ORG)** which helps a patient choose where s/he will live, learn, work and/or socialize. The patients go through a series of activities to identify possible alternative environments from which to choose, identify what is personally important to them as standards for making a choice, and then choosing the alternative that best fits the personal criteria.
- **Conducting a Functional Assessment**, which assists the patient in identifying and defining the critical skills necessary to be successful and satisfied in their chosen environment. The use of the critical skills is evaluated in order to determine which skills need development, and which skills are skill strengths.
- **Conducting a Resource Assessment**, which assists the patient in identifying and describing the critical supports s/he need to be successful and satisfied in the chosen environment, and what resource will provide that support.
- **Developing Skills**, which help the patient learn a new skill through Direct Skills Teaching. In addition, patients may already know how to do a skill, but cannot use it because of barriers that are related to being ill, or lack of using it. Programming Skill Use will assist the patients in identifying barriers to skill use and developing a plan to overcome those barriers.

Last, but not least, is discharge planning. In order for patients to be successful and satisfied in their chosen environments, they need to plan their transition to the community. The rehabilitation process begins in the hospital, but providers in the community need to take the information identified by the rehabilitation process and use it in planning services in the community. Rehabilitation does not come to an end upon discharge, but is an evolutionary process. Community providers have the responsibility to assist the patient's continue the recovery they have begun here.

#####

PART-R' DRASTICALLY REDUCES NEED FOR RESTRAINT/SECLUSION

One of the most dangerous and costly issues facing hospital staff has been the violent and abusive patient. In an effort to provide staff with the tools they need to manage potentially violent patients, an alternative to the then current Physical Crisis Intervention (PCI) was needed.

Professional Assault Training-Revised (PART-R), which was developed by a former psychiatric aide in the California mental health system, was identified after an exhaustive search. PART-R's main function was to provide the patient care staff with known and

conspicuous behaviors which when observed, put into motion a pre-established one-to-one agenda to 'defuse' the situation. In January, 1995, Mabel Welch and Thelma Wyrick, attended a training program for trainers in Alameda, CA., for the specific purpose of comparing PCI to PART-R.

Their recommendation was to implement the process as soon as possible. The program, developed by Paul Smith, Ph.D., and administered by Professional Growth Associates was endorsed by St. Joseph State Hospital in September, 1995, and the first training class for facilitators was held in December, 1995, here at SJSH.

In addition to Welch and Wyrick, other facilitators trained at that first session were Dorina Hummer, Janet Wykert, Debbie Garrison, Dane Bradford and Dawn McDaniel.

The results have been dramatic.

As recently as April 1992, SJSH experienced 212 hours of restraint and seclusion. (The accompanying chart shows 'hours per bed days,' which is a recognized unit to gauge effectiveness without having to compare like-sized hospitals or patient populations. The numbers were gleaned from Restraint and Seclusion reports, and incident reports. In addition, DMH Department Operating Regulations (DOR), require that surveyors review 100 percent of all chart notes specifically written in response to an incident or assault.)

The trend identified in the chart is important to note, because it shows the dramatic decrease in use of restraints and seclusion.

With the implementation of Part-R, restraint and seclusion hours dropped dramatically, until in February, 1996, when we recorded '0' hours. The next few months saw little spikes in the graph, with monthly totals in the teens or less. These numbers could be traced to specific patients who were acting out for a variety of reasons. In June, the total was again '0' hours.

The tools provided by Part-R included listing 'triggers' in each patient's chart with specific responses for specific situations. Staff was trained to recognize any unusual patient behavior that could lead to a crises.

The benefits for staff are also remarkable.

Workmen's Comp claims directly resulting from patient assaults dropped drastically as did the number of days missed due to injury. The number of 'called-in' sick days declined, and the stress level was reduced hospital wide.

SJSH is the only Missouri facility using Part-R.

In the past year other facilities have heard about our success and sent clinical teams to observe our process. Adjacent states have also sent nursing and security staffs to observe and ask about Part-R

As a result, in May this year, SJSH will once again serve as host to a regional training program for trainers. Professional Growth Associates will provide the certification program.

Administrative philosophy.

COVEY TRAINING ADDED TO EMPLOYEE SKILLS ARSENAL

In mid-1996, Staff Development started facilitating the Covey Leadership Center's workshops on the **"Seven Habits of Highly Effective People," "First Things First,"** and **"Principle-Centered Leadership."** The goal was to have every employee trained by the end of fiscal year 1998.

Stephen R. Covey has created a holistic approach to effectiveness that is based on processes which unite personal and professional performance. The **'Seven Habits of Highly Effective People'** workshop is the core of the Covey Leadership Center's curriculum. The inside-out approach to personal leadership emphasizes effectiveness and quality of work life as foundational components for creating organizational change.

The Seven Habits are behaviors which include fundamental principles that are instrumental in creating trust (and trusting) relationships. When incorporated into an organization, staff are affected in four major areas: personal growth and individual development; interpersonal human relationships; job and managerial performance; and organizational systems reflected in core mission, vision and values, operational strategy and infrastructure.

The **'First Things First'** workshop provides the means by which staff can effectively plan their most important issues ('big rocks') each week so that they are more effective with their supervisors, employees, and their families. It also provides leadership in planning for the time away from the work site. Covey calls this the 'Sharpen the Saw' habit, or renewal—doing something for your well being.

The principles of **'Principle-Centered Leadership'** are universal, and a unique approach to quality and organizational performance based on trust and trustworthiness.

Hospital Superintendent Dr. Ron Dittmore was introduced to the Covey philosophy when Hospital Management Assistant John Thornberry gave him a copy of Dr. Covey's book "Seven Habits of Highly Effective People." Dr. Dittmore read the book, attended a training session at the Covey Leadership Center, Provo, Utah, in April, 1996, and decided that the workshops would benefit the entire hospital staff. He hoped that with staff actively working to build relationships, the work sites would become more positive, productive, and synergistic. Thus, the patients would be the ultimate benefactors of this new work-site culture.

Twenty-two hospital employees were certified to facilitate the 'Seven Habits' and 'First Things First' workshops. These employees represented all hospital departments and shifts. The list of 22 facilitators includes:

- Diane Armstrong, Dietary Director
- Julie Atkins, RN, Buchanan Unit
- Lynn Baker, Staff Development Officer
- Vernalee Carter, Administrative Assistant to the Superintendent
- Scott Clark, Management Trainer and Special Projects
- Bob Current, Patient Advocate
- Gail Current, Recreation Therapist III, Activities Director
- Ed Currier, Carpenter Shop Foreman
- Dick Gibson, Education Supervisor/Director of P.R.E.P.
- Mary Blakley-Gorman, Personnel Analyst
- Kathy Hubbard, Administrative Assistant, Staff Development
- Cathy Leake, Psychiatric Rehabilitation Facilitator
- Ronda Mahoney, Chief Accountant
- Bobbi Newhard, LPN, Buchanan Unit
- Carla Page, Recreation Therapist II
- Kim Stephens, Security Officer II
- Sheryl Webb, Activity Aide II, P.R.E.P.
- Norbert Wilmes, HVAC Shop Foreman
- Kay Woolard, Psychiatric Aide II, Buchanan Unit
- Janet Wykert, Investigator
- Thelma Wyrick, RN IV, Clinical Trainer and Quality Assurance
- Dr. Ron Dittmore, Superintendent

The first in-house workshop took place in November, 1996, with monthly classes conducted thereafter. When the Woodson Children's Psychiatric Hospital staff was available, they, too, were added to the training.

Later, Dr. Dittmore, Vernalee Carter, Scott Clark and Lynn Baker were certified to facilitate '**Principle-Centered Leadership**,' which was offered to the Administrative Executive Committee and the Interdepartmental Committee.

At the time of the new building dedication and the creation of this time capsule, St. Joseph State Hospital/Northwest Missouri Psychiatric Rehabilitation Center is the ONLY Missouri State agency currently teaching the Covey workshops. The Department of Corrections, and the Division of Child Support Enforcement of the Department of Elementary and Secondary Education have both indicated that they want to start the programs, but have been unable to work out procedures to acquire the training materials.

Covey Leadership Center workshops have been adopted by the remaining 49 United States, and 27 foreign governments. In addition, programs are offered to most of the 'Fortune 1,000' companies, and at public forums throughout the World.

EPILOGUE

We are justifiably proud of the contributions and advancements that have been made in the century and a quarter of St. Joseph State Hospital's existence. We pray that this tradition of community service will endure through the years and that the future readers of this document will be able to attest to this continuation.

Accordingly, this is dedicated to those who have gone before and those who will come after.

EDITORS' NOTE:

Many people contributed to the creation of this document and this time capsule. Their names appear throughout the publication. Without their help this narrative could not have been completed in a timely fashion

We have tried to describe how much psychiatric care has improved since the hospital opened in 1874. The state-of-the-art in treating mental illness at this hospital has progressed from what we today consider to be barbaric and in some cases in-humane, to a more patient centered approach. That is a value judgment we make in 1997, based on our perspective. In the 1950's when lobotomies, insulin and electric shock therapy were used, it was their valued opinion that they were doing the right thing.

The Glore Psychiatric Museum has chronicled those forms of treatment, and will hopefully, still be operating as a valuable source of information about how mental illness affected the patients, their families, and their communities.

We have learned that patients suffering from mental illness can recover, and become productive members of society.

That was our mission. That was our vision.

We plan to dedicate this capsule in late May, 1997, with the hope that it will be opened during the lifetime of our immediate descendants so that they may benefit from the items we leave to history.

Part of the struggle this committee had to deal with is the date upon which the capsule should be opened. True, the hospital has been in existence since 1874, but we cannot guarantee that this building will still be an operating psychiatric facility 50 or 100 years from now.

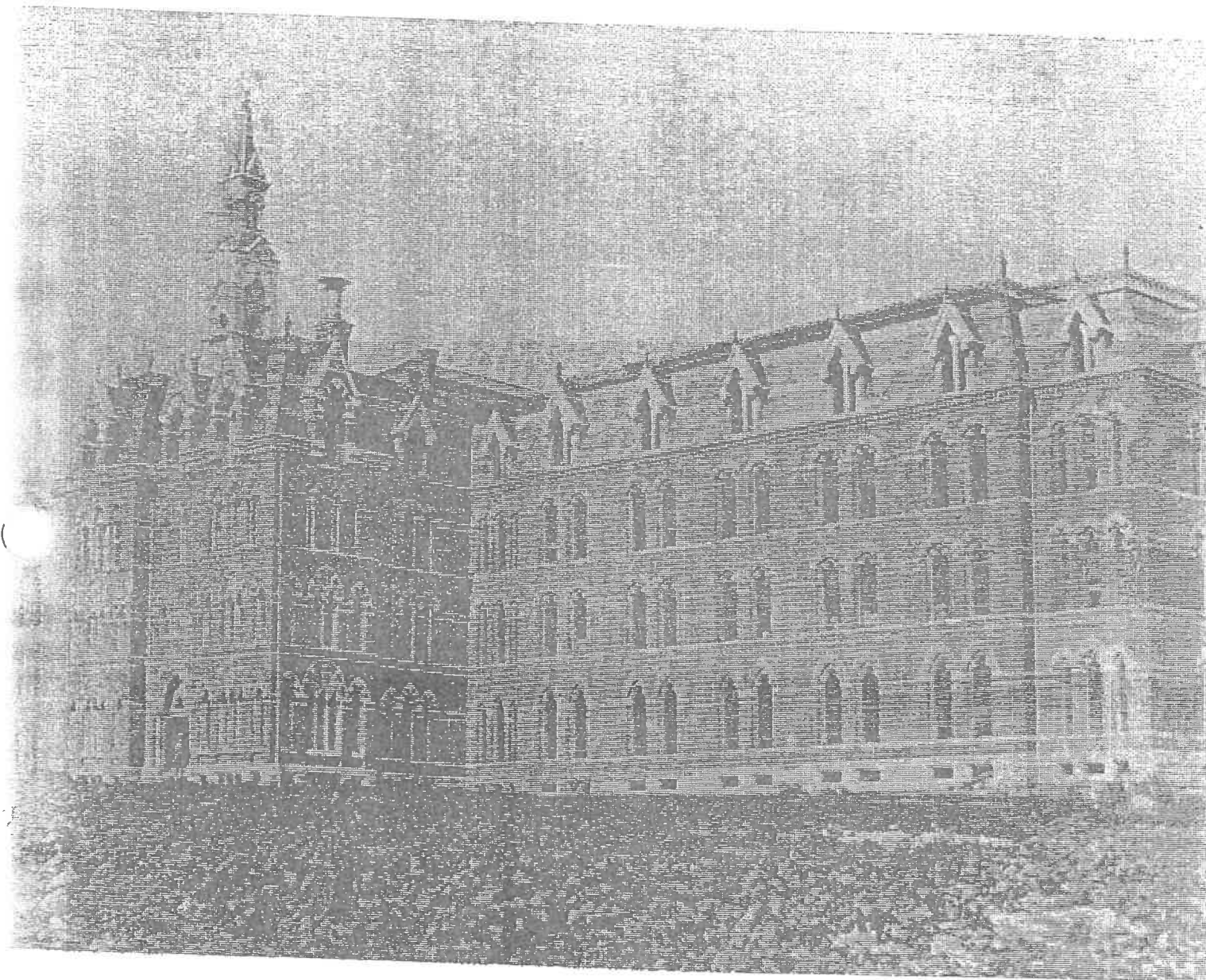
If the progress and inroads accomplished in the last 50 years is any indication, treatment of the mentally ill will not need a building like this too much into the future. We hope that goal is reached.

In the meantime, we leave for posterity a few items that we think might be of interest, hoping you will gain a clearer idea of what it was like living and working in 1997.

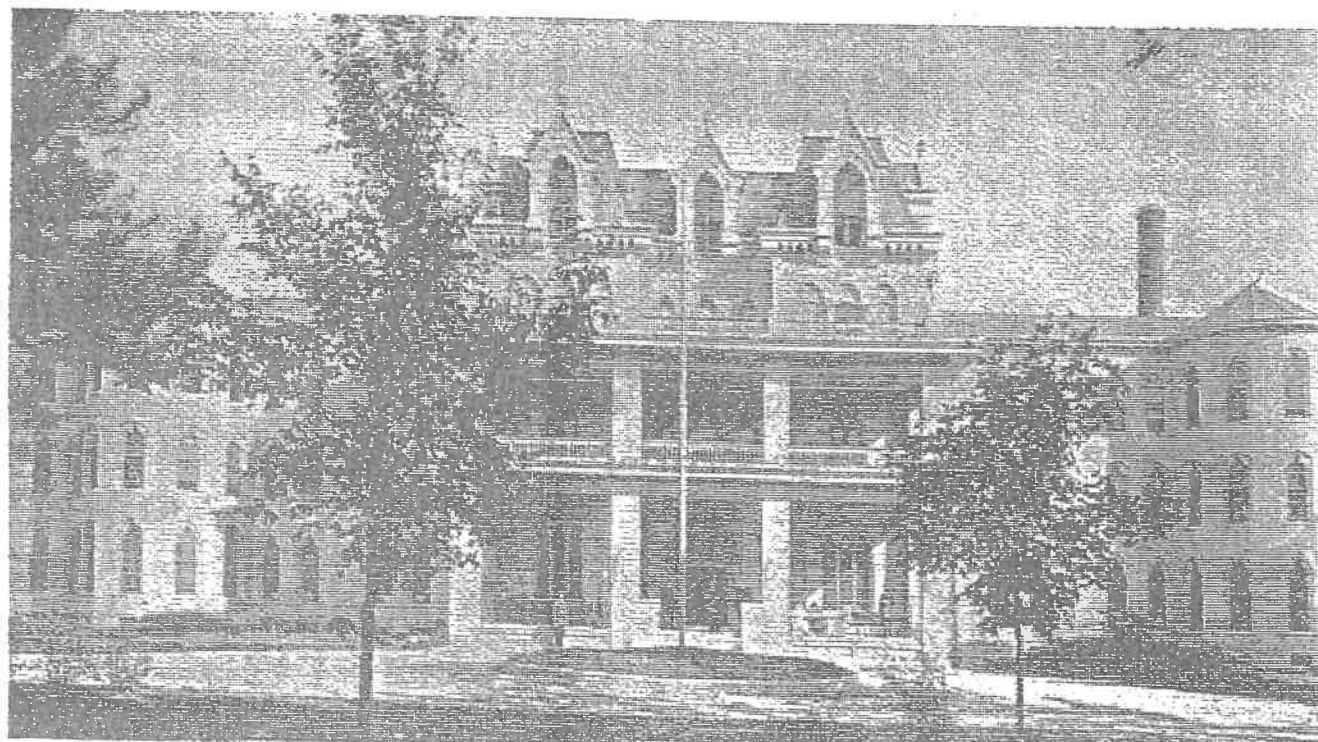
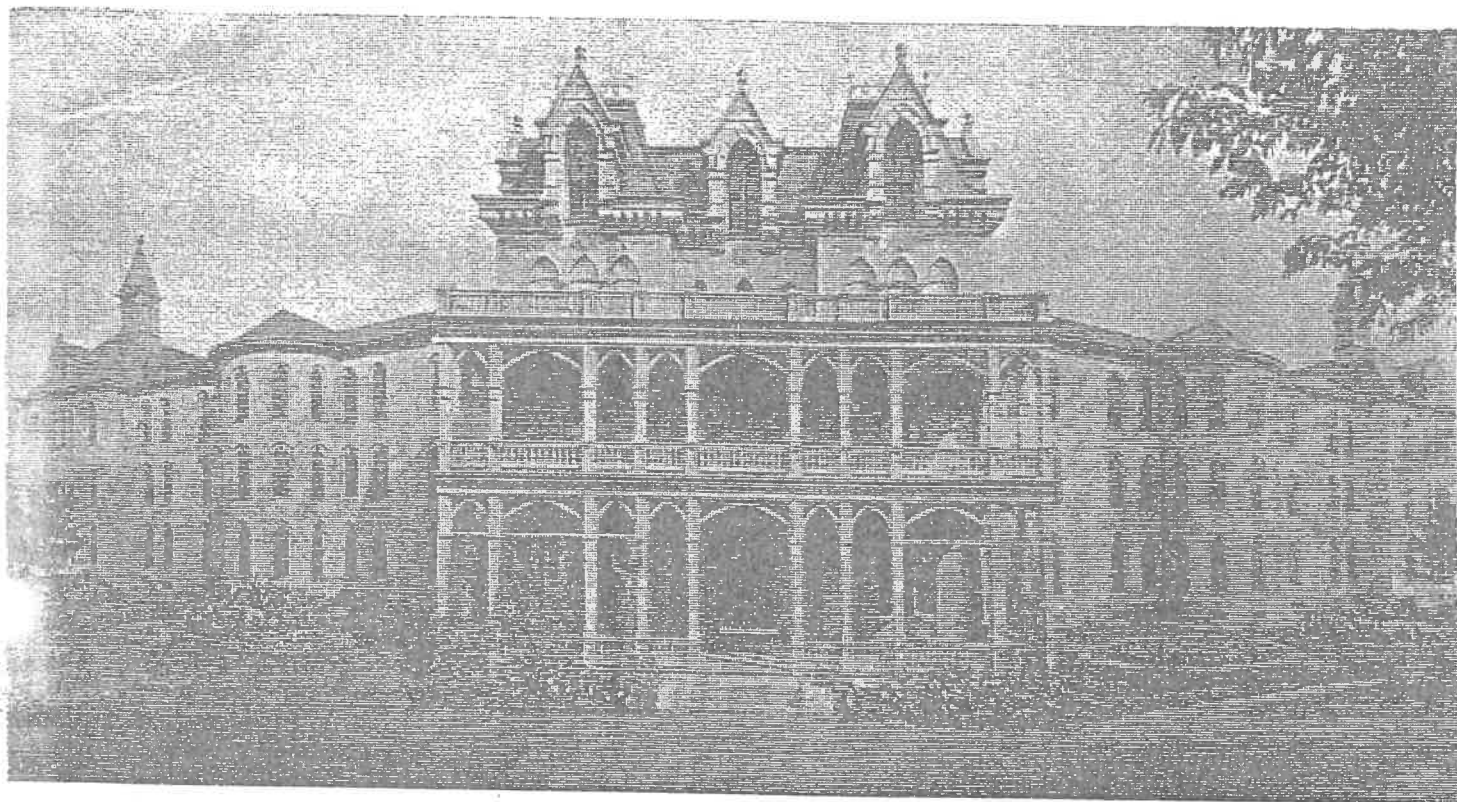
Scott Clark
Management Trainer and Special Projects
May 30, 1997

Myrna Hopkins
Glore Psychiatric Museum

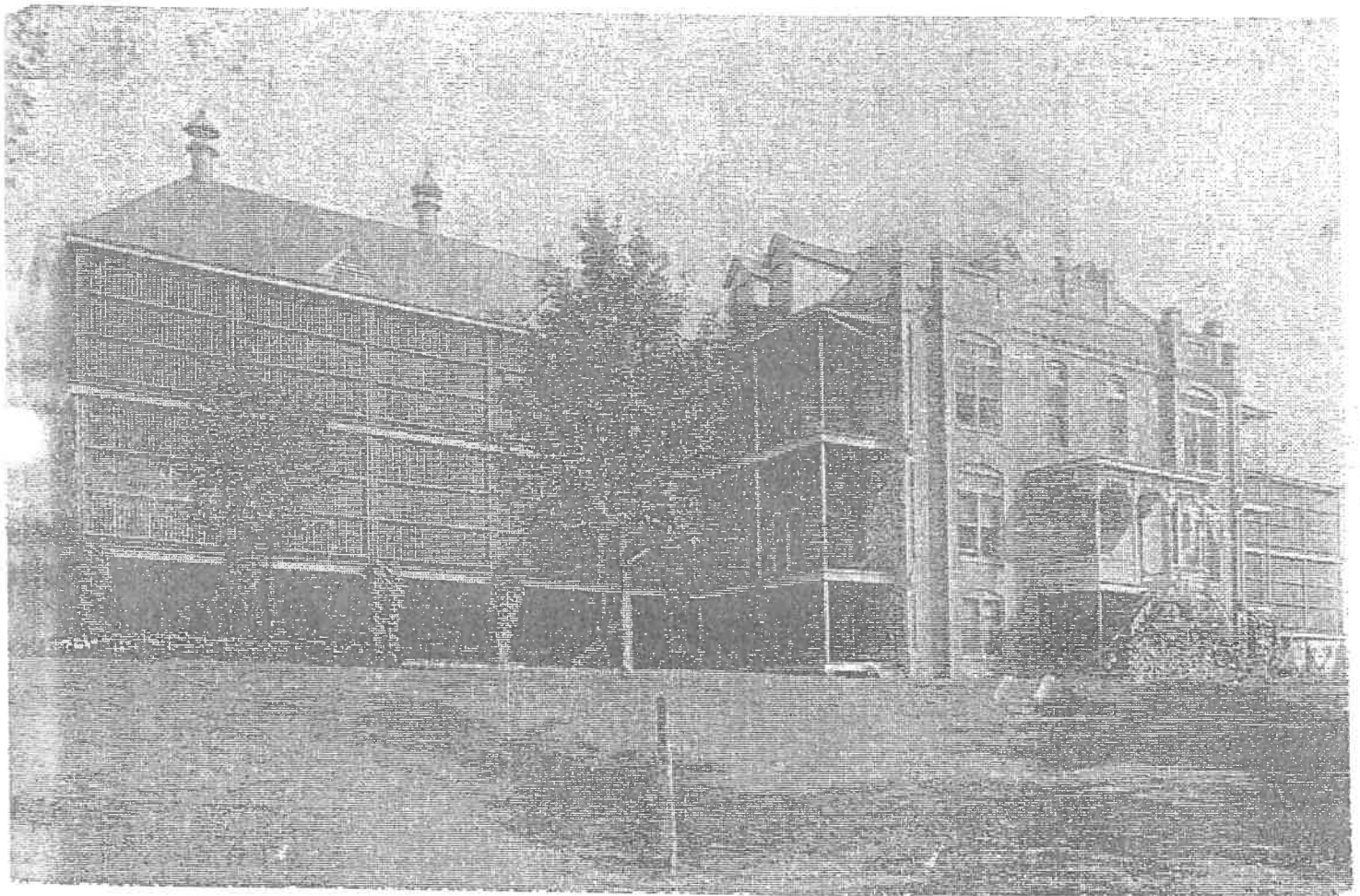
State Lunatic Asylum #2, opened November 9, 1874



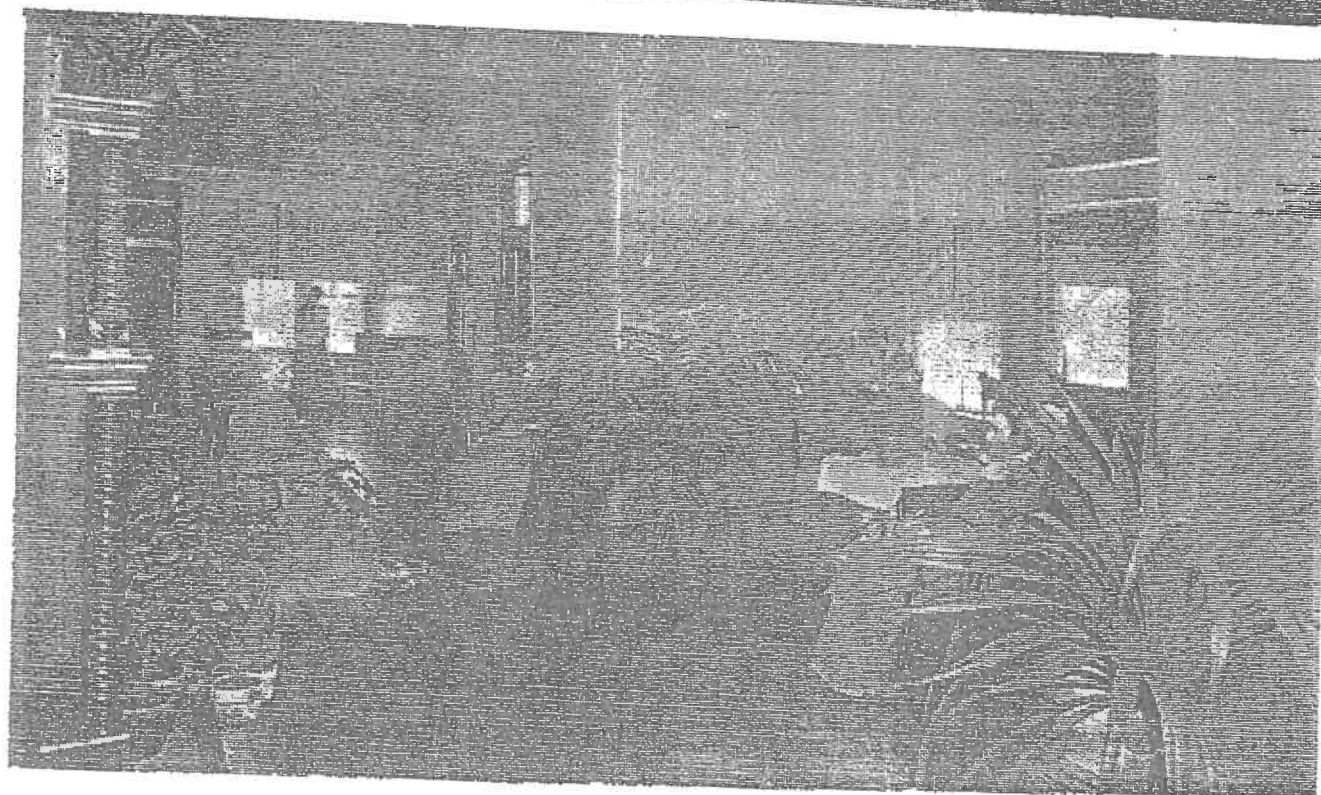
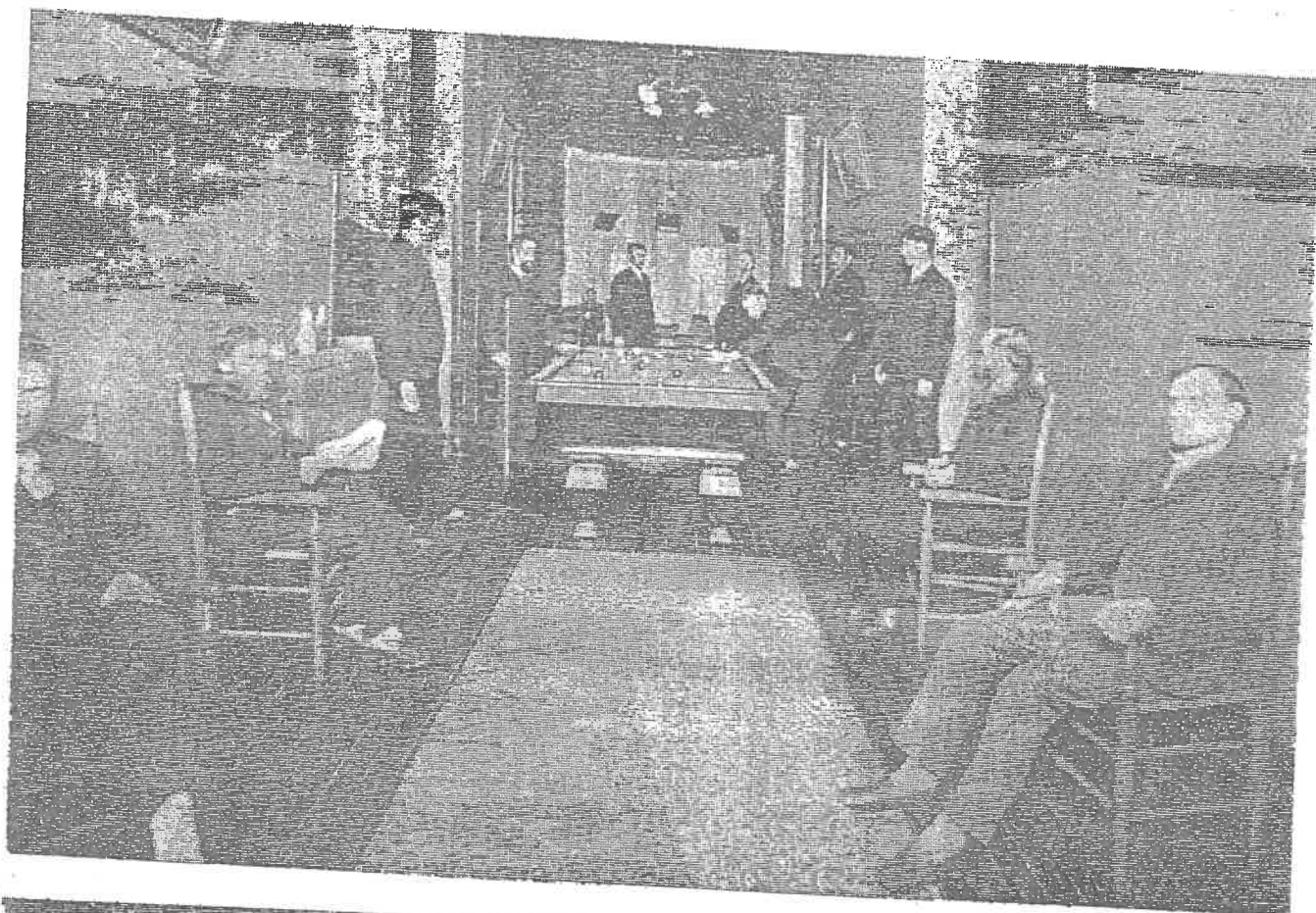
Destroyed by fire in 1879, the new Hospital opened April 1, 1880. Top photo shows hospital administration building in 1907. In 1903, the name was changed to State Hospital #2. Lower photo shows the same view in 1913.



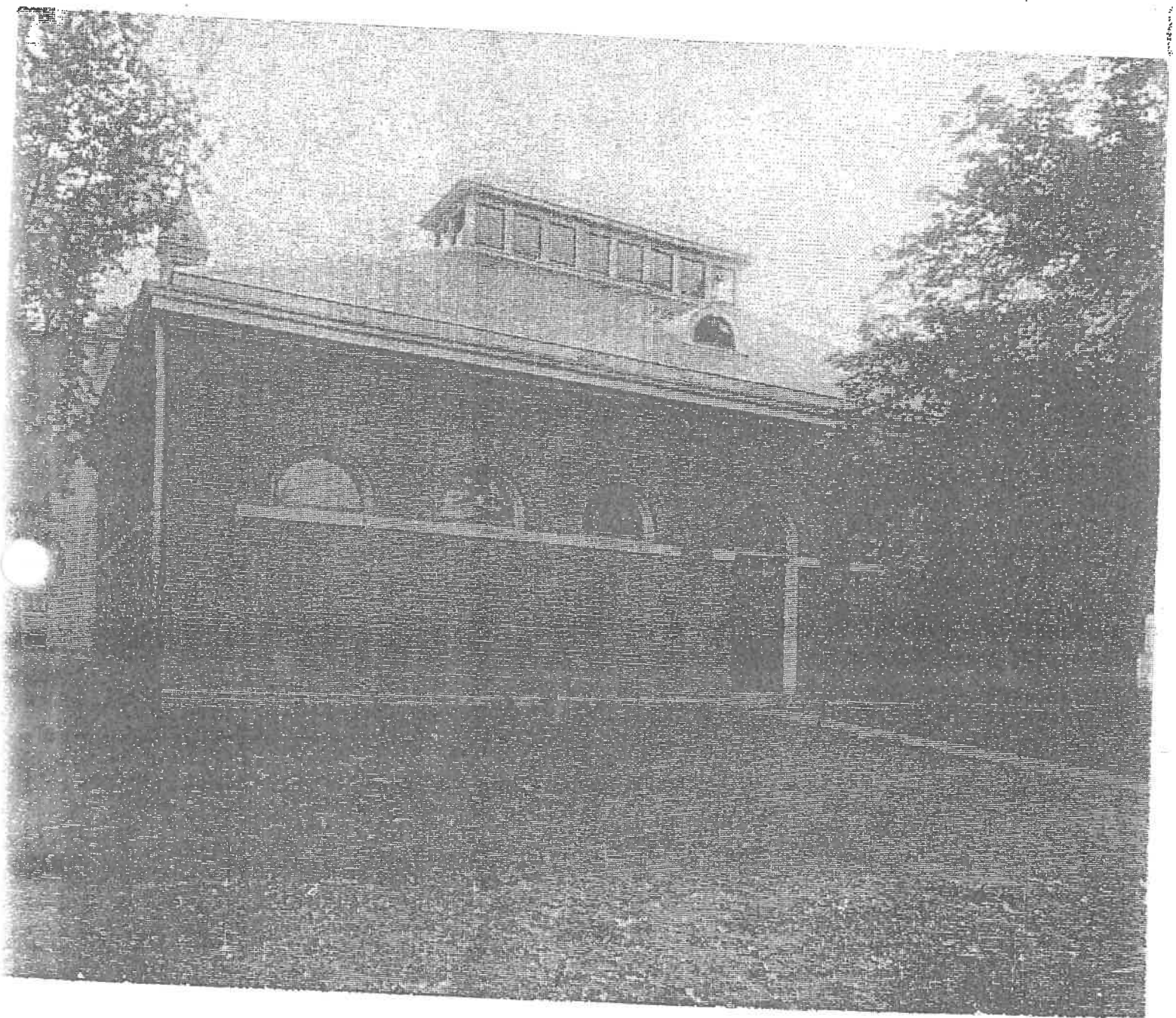
'Hospital Unit' shown in 1893. Later it was called the 'Detached Unit for Men,' then 'Progress Hall.' It's last service for the State Hospital was as the canteen and recreation center. In 1996, it was given to the Department of Corrections as a laundry building and training center.



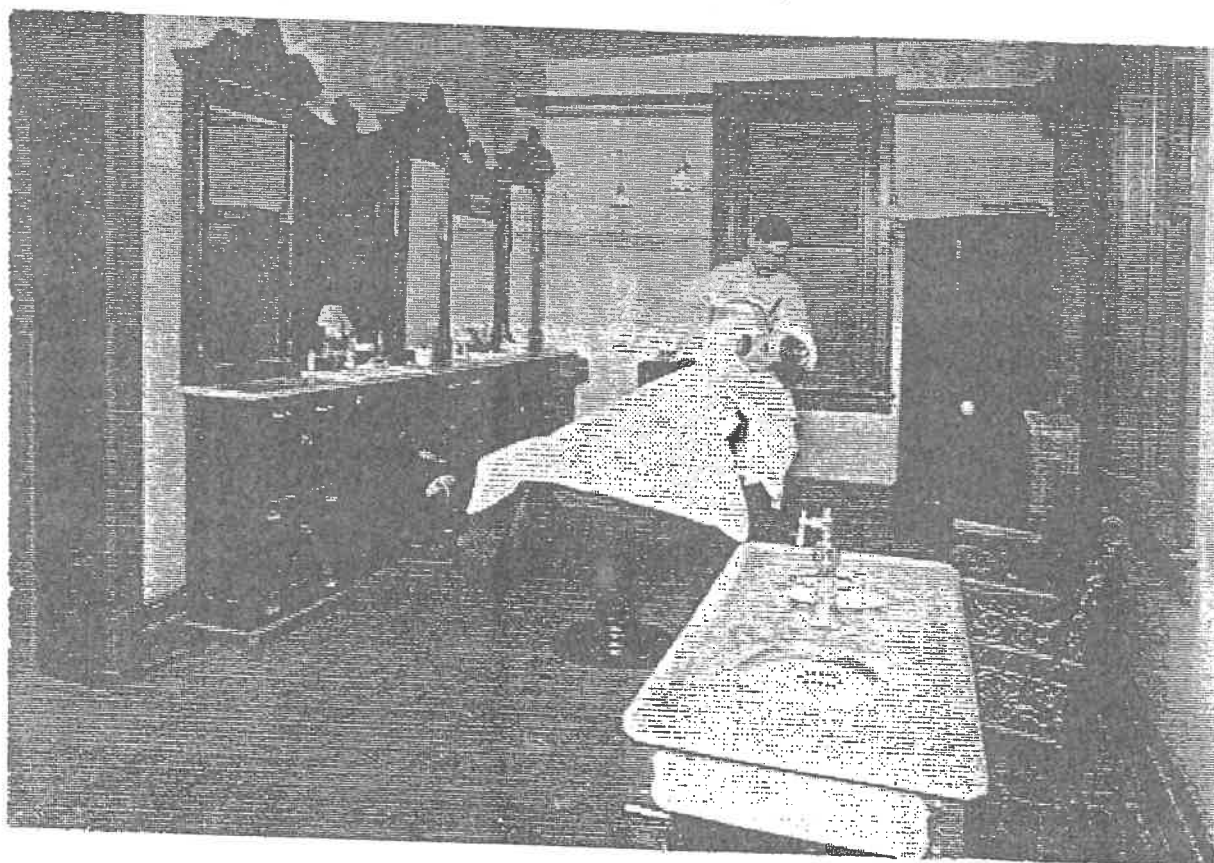
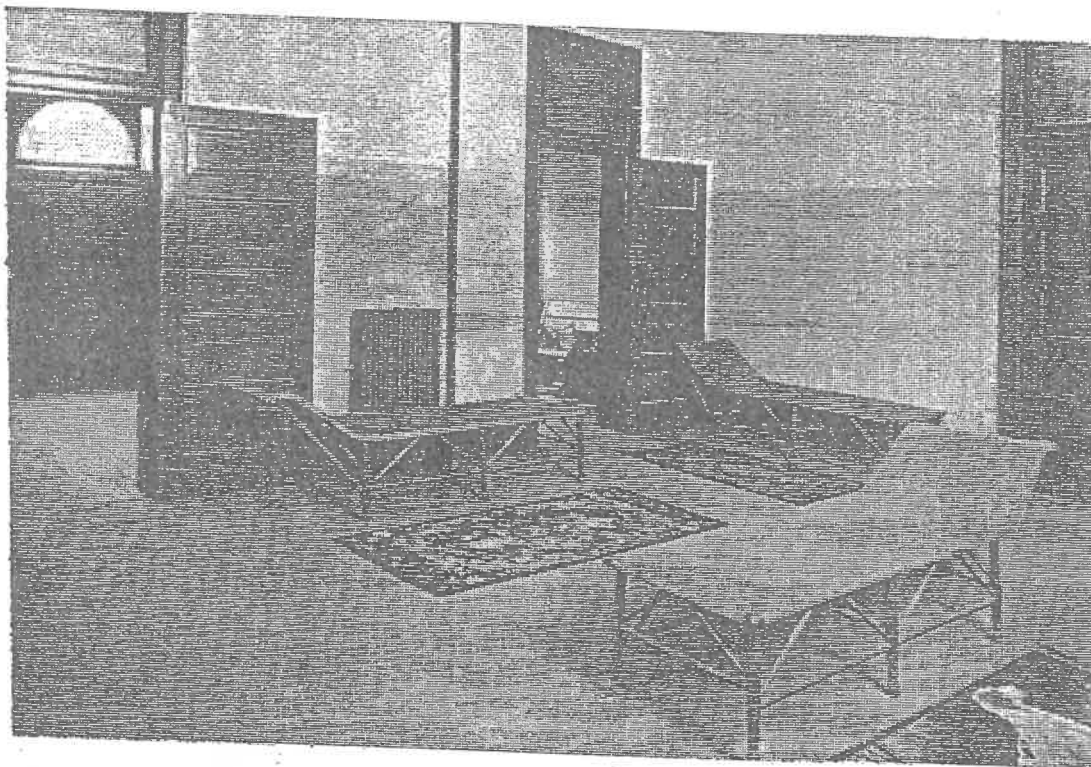
*Top: Male 'Ward No. 9' taken about 1905.
Bottom: Female 'Ward No. 37' taken about 1905.*



Bath house, 1897 to 1900.



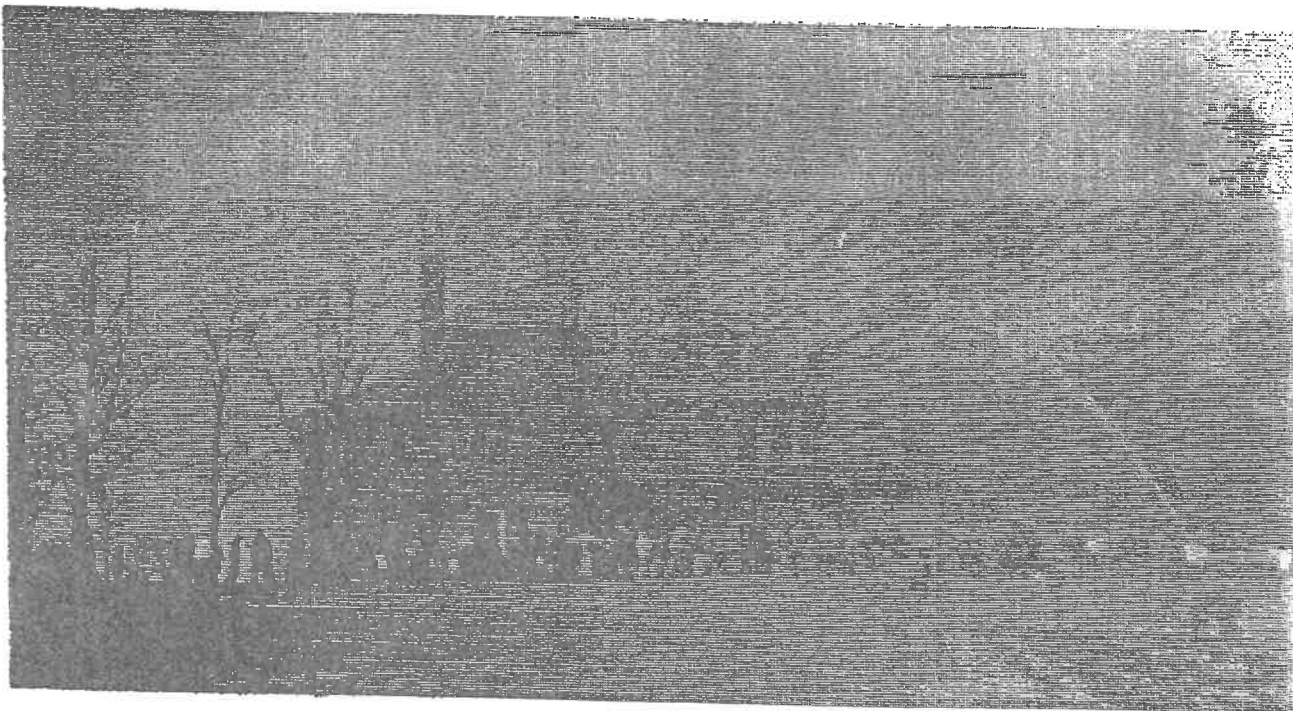
*Top: Bath house cooling room, 1897.
Bottom: Patient Barber shop, 1897.*



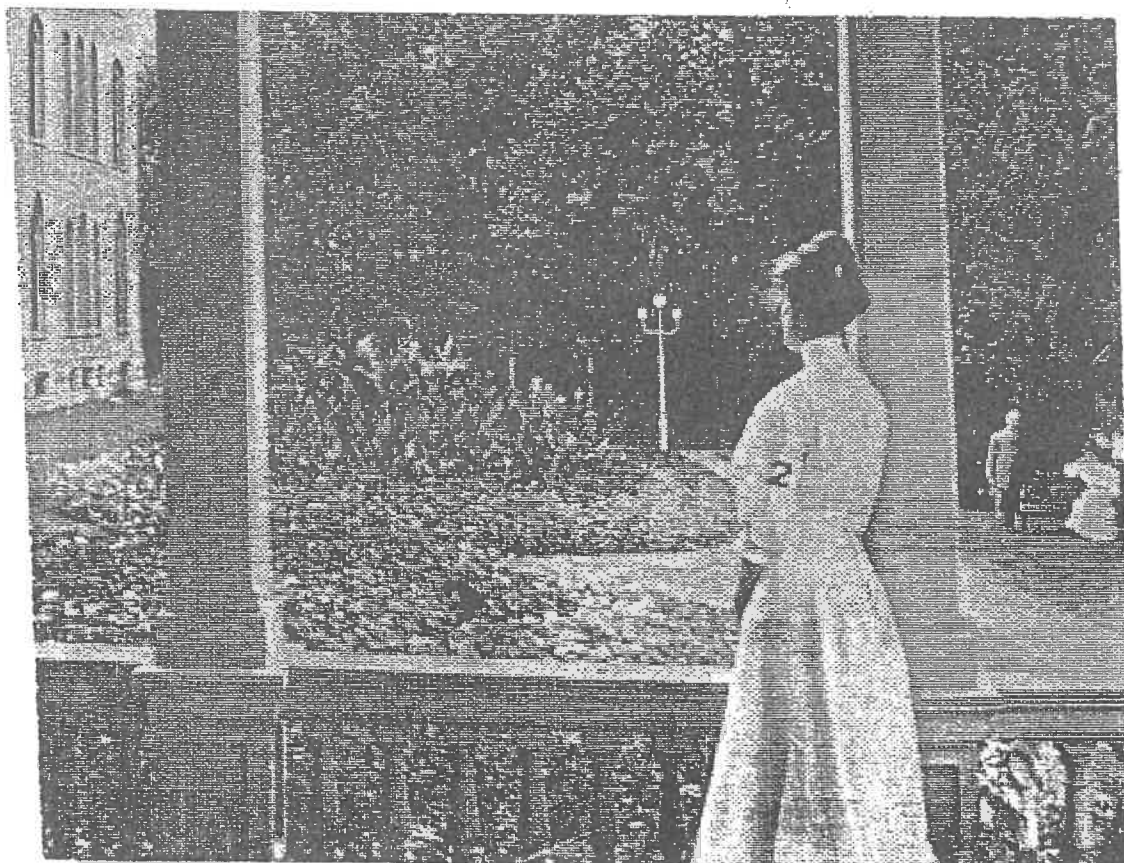
Patients were dressed and taken for a walk every afternoon. (photo taken 1890)



'Bigger Building,' later called the 'Hadley Building,' and later yet 'Central Station for Men,' and 'Workingman's Building,' was converted into a Sheltered Workshop for patients in the 1980's. The top photo shows the recreation room. The bottom photo shows the building nearly destroyed by fire, Jan 29, 1922.



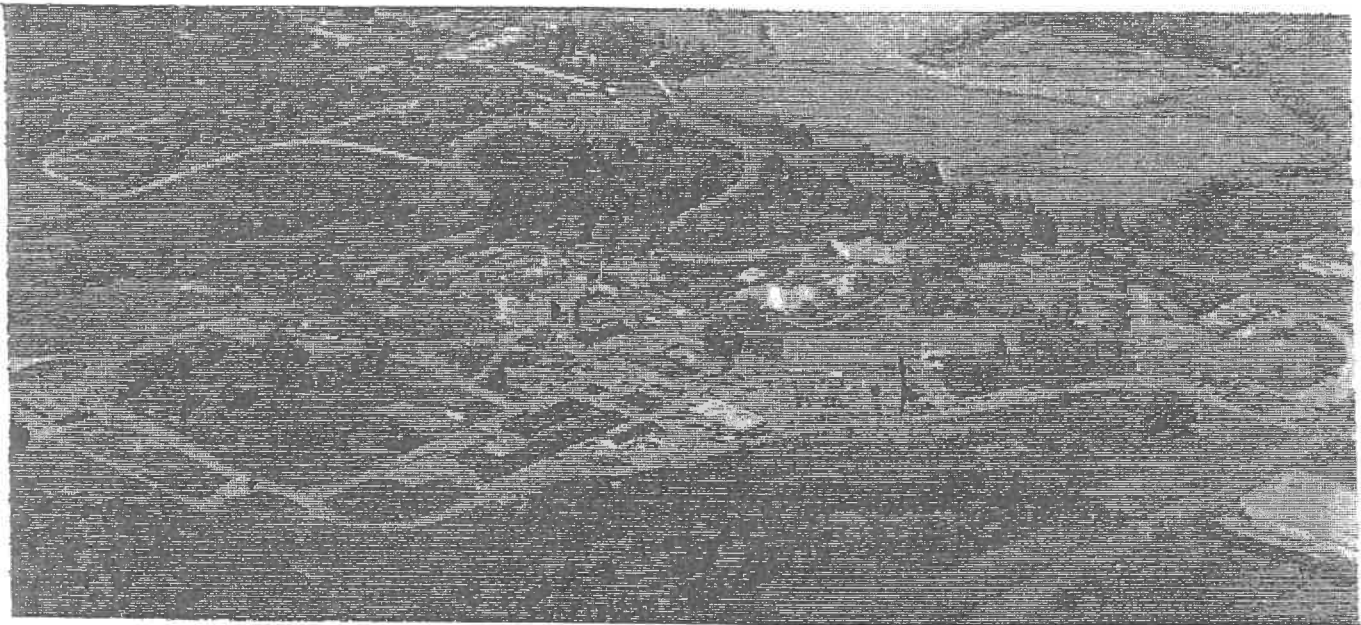
Top: Dr. C.R. Woodson, Hospital Superintendent (1890-1907), conducting a nursing class. (photo taken 1905). Bottom: A view of the so-called sunken gardens to the south of the Administration Building front porch. (photo taken in the early 1900s)



Patient workers in the Greenhouse, taken in early 1920s.

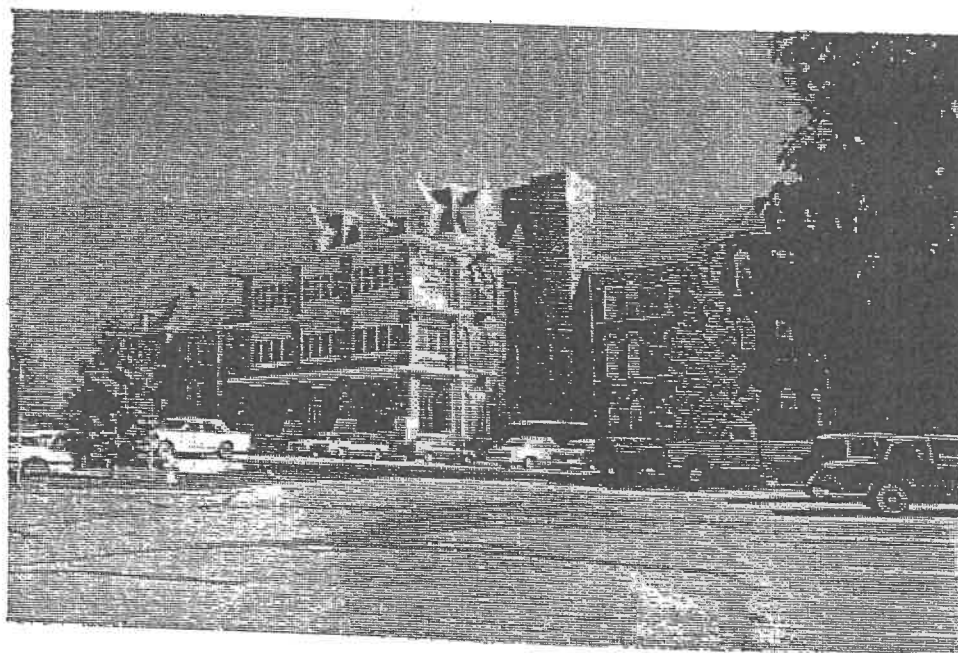
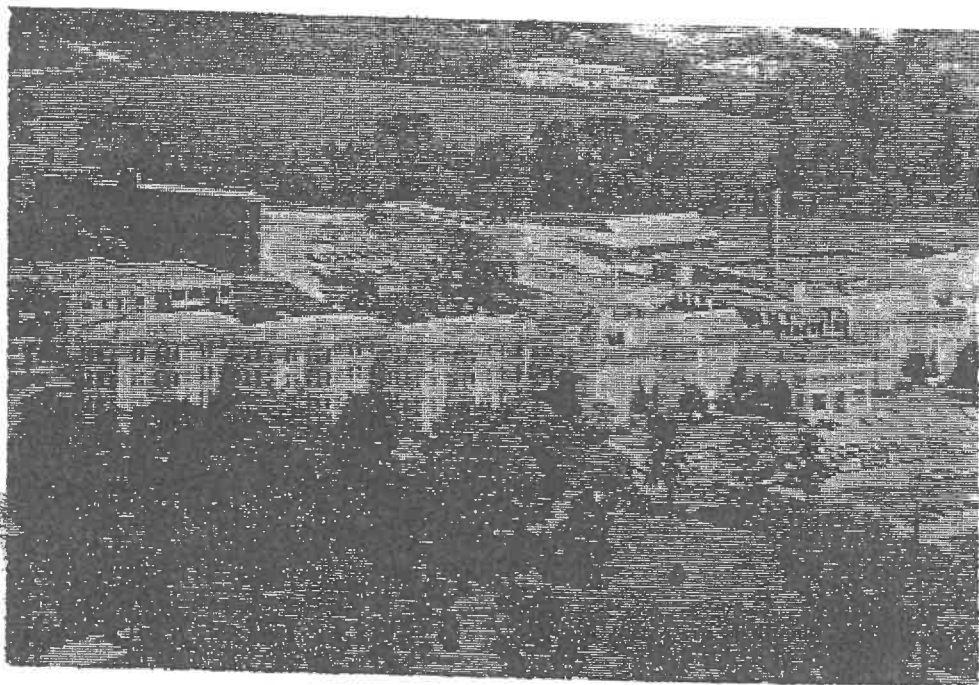


Top: Aerial view of campus looking northwest. (photo taken 1991)
Bottom: Aerial view of campus looking south. (photo taken 1991)

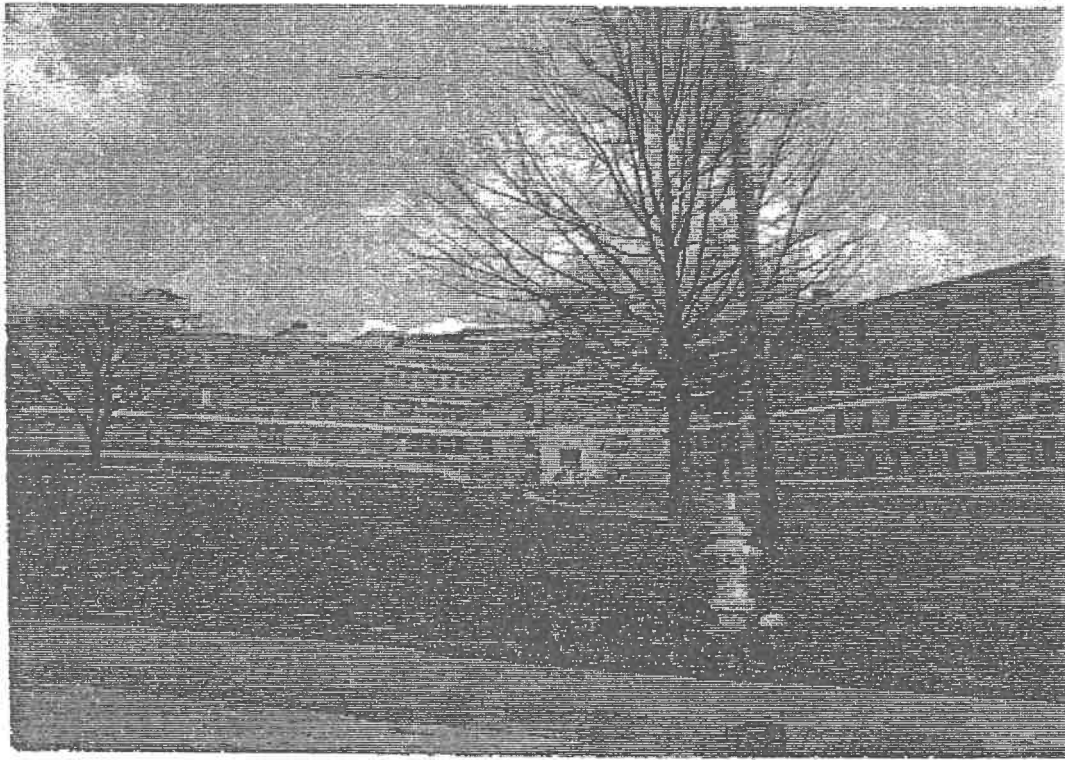


Top: Aerial view of 'Center Building', taken before extended wings were removed in the late 1970s.

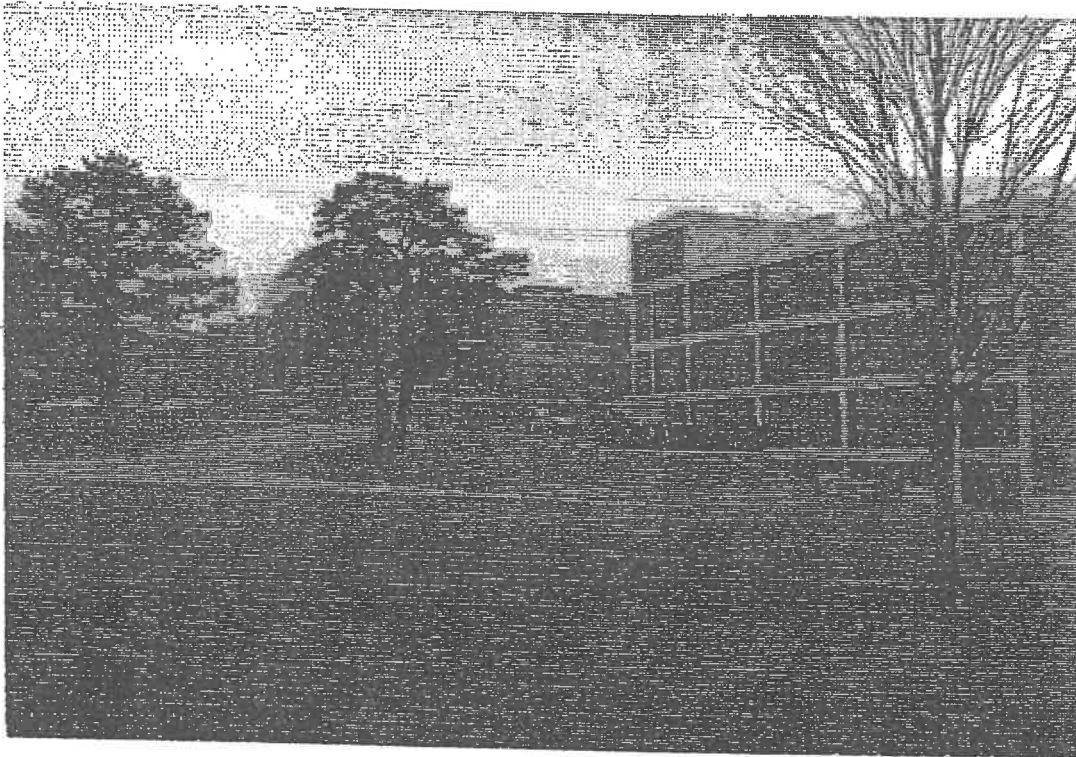
Bottom: Center Building as it appeared in 1991.



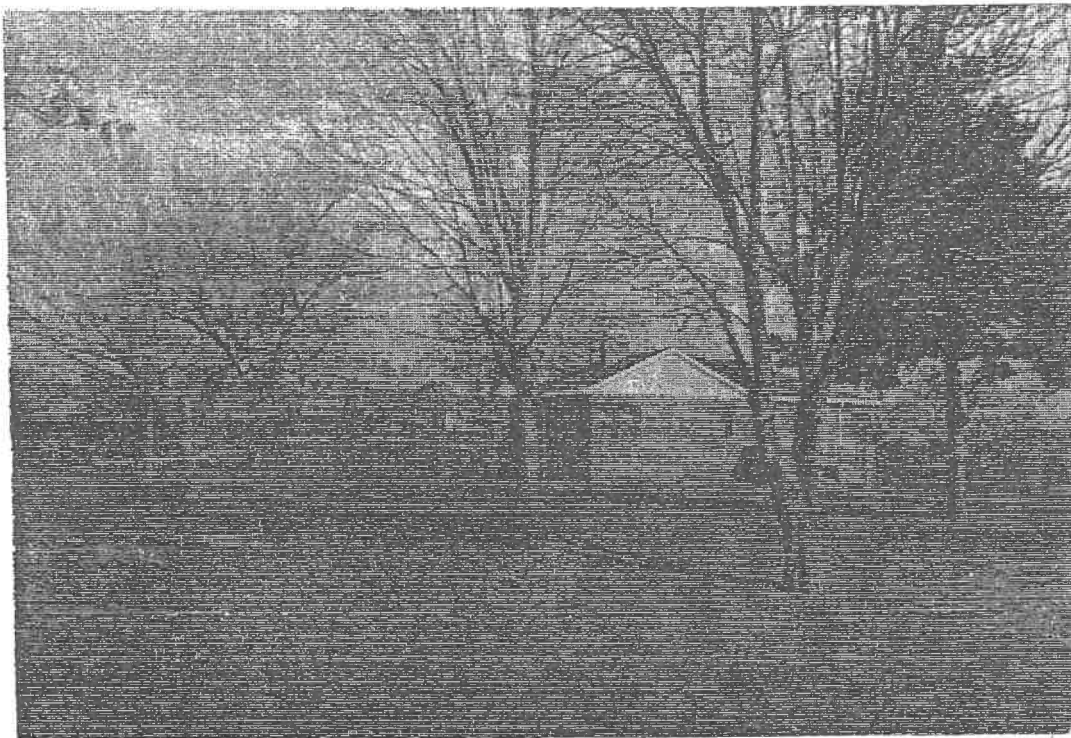
'Park Building', dedicated in 1937, was named for Governor Guy Park, a St. Joseph native. It became one of the Department of Corrections substance abuse facilities in 1995, and was the first of several buildings taken over the DOC before the State Hospital moved across the street.

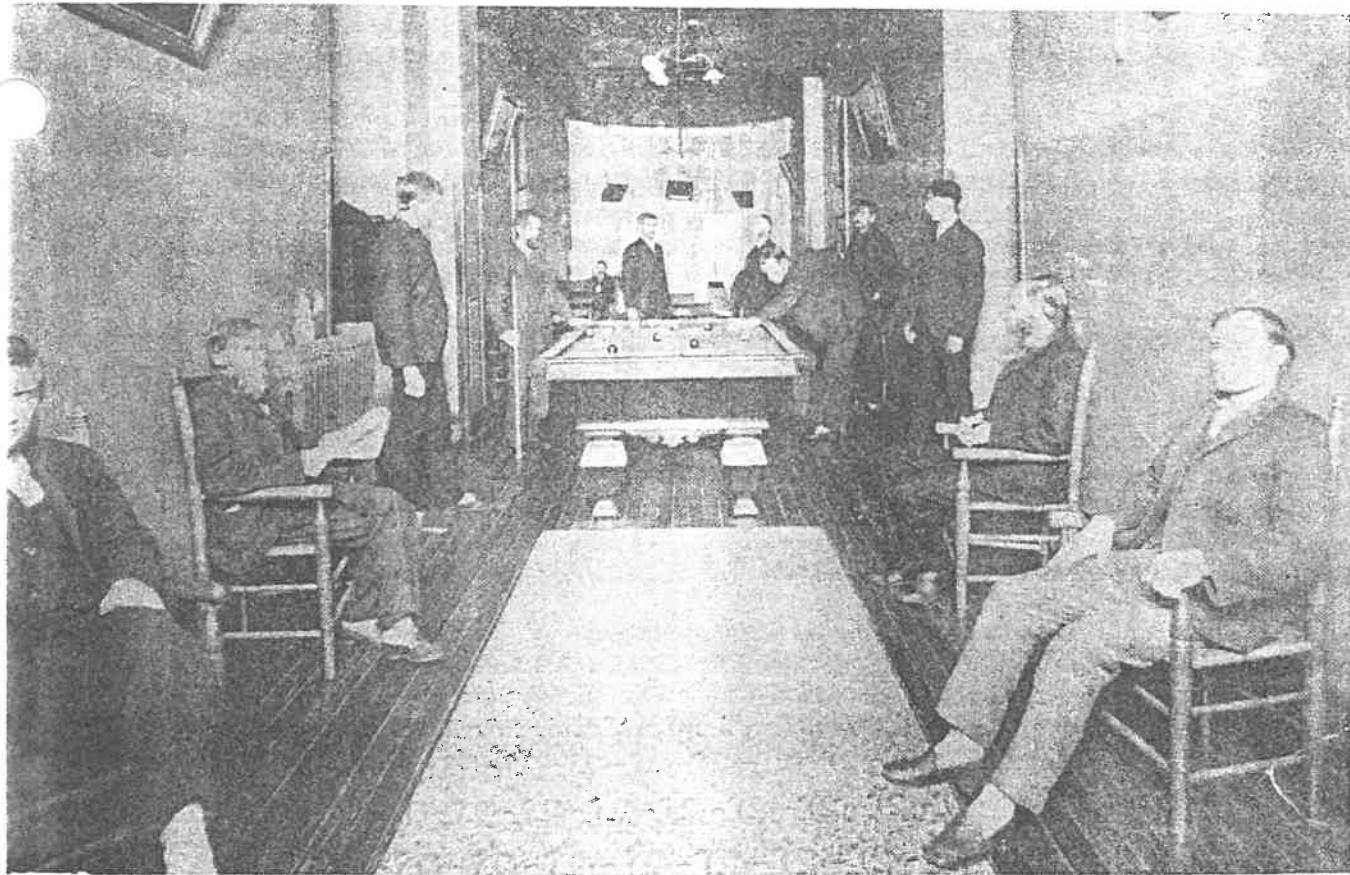


Top: 'Glore Building,' formerly known as 'M and S (Medical and Surgical) Building.' Wards were located in the background. The four-story annex in the foreground was built in 1968. Among other features of the annex were two surgical suites, recovery area, and a morgue and autopsy room located in the basement which served not just the hospital, but St. Joseph and Northwest Missouri. When the new facility was opened across Frederick Avenue, the Annex became the new home of the Glore Psychiatric Museum.



A view of the Cottages located on the western edge of the campus where professional staff lived until the early 1980s. In some cases, patient and families stayed in the Cottages during visits. When the Department of Corrections took over the Park Building, the prison superintendent lived in one of the cottages.

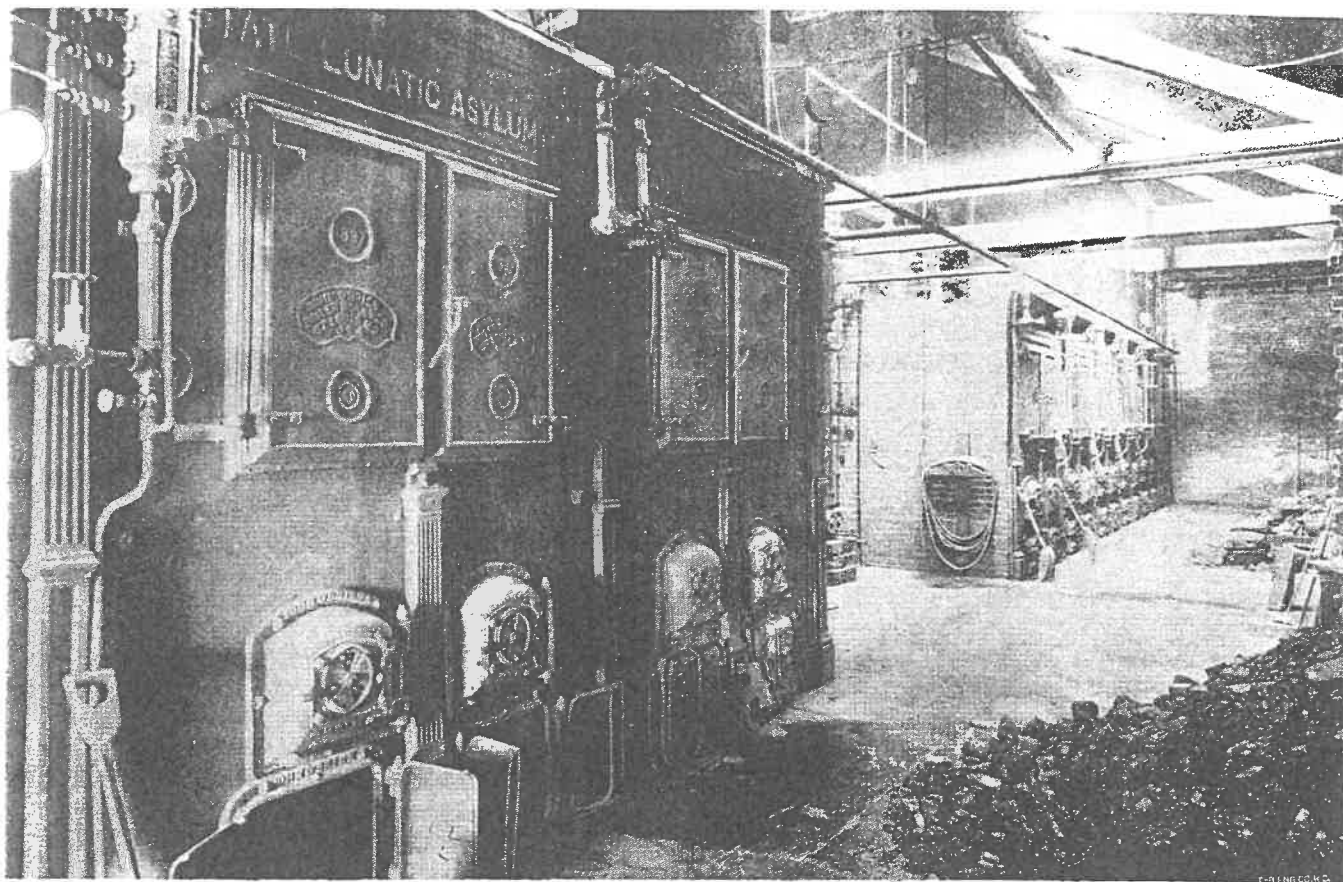




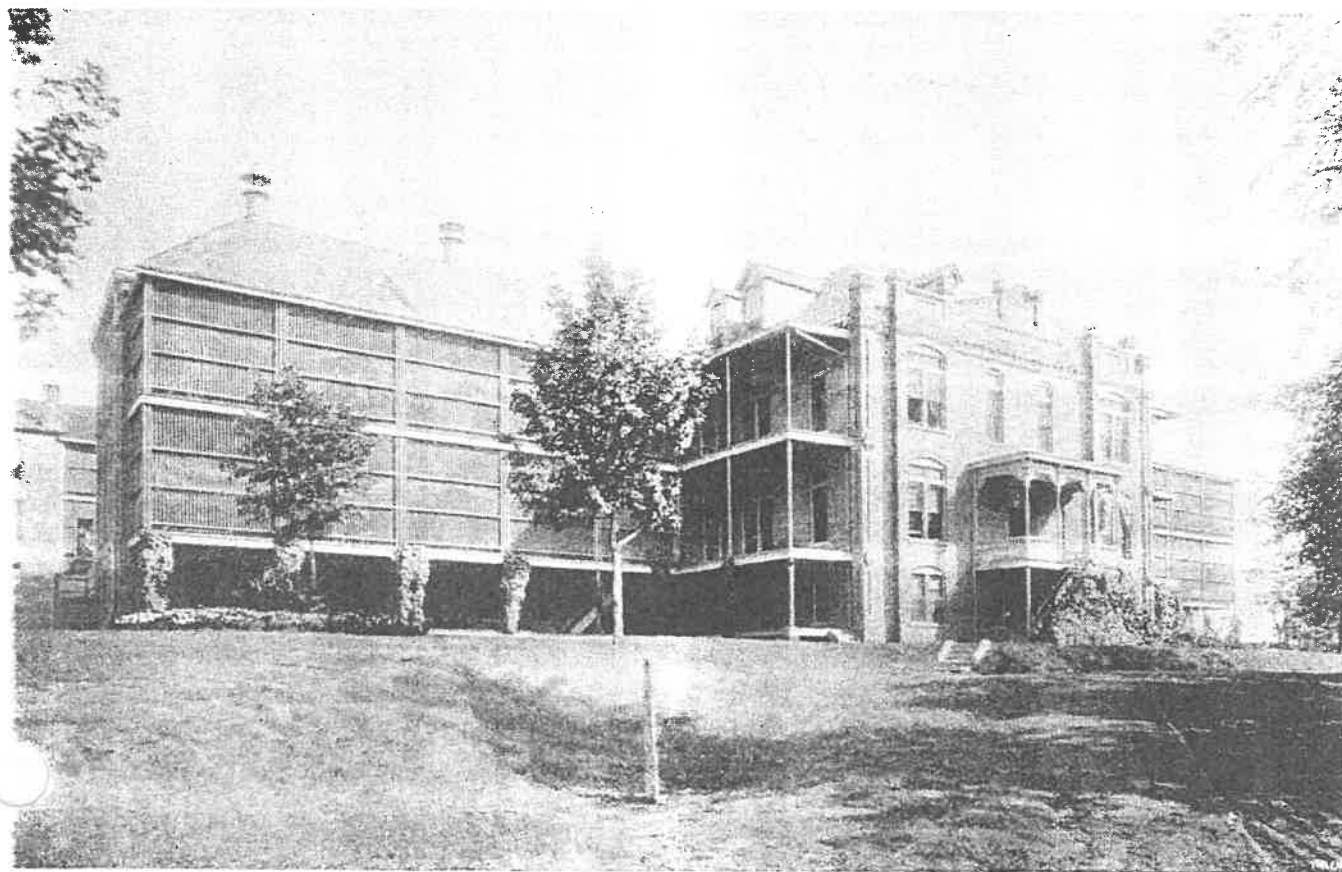
MALE WARD



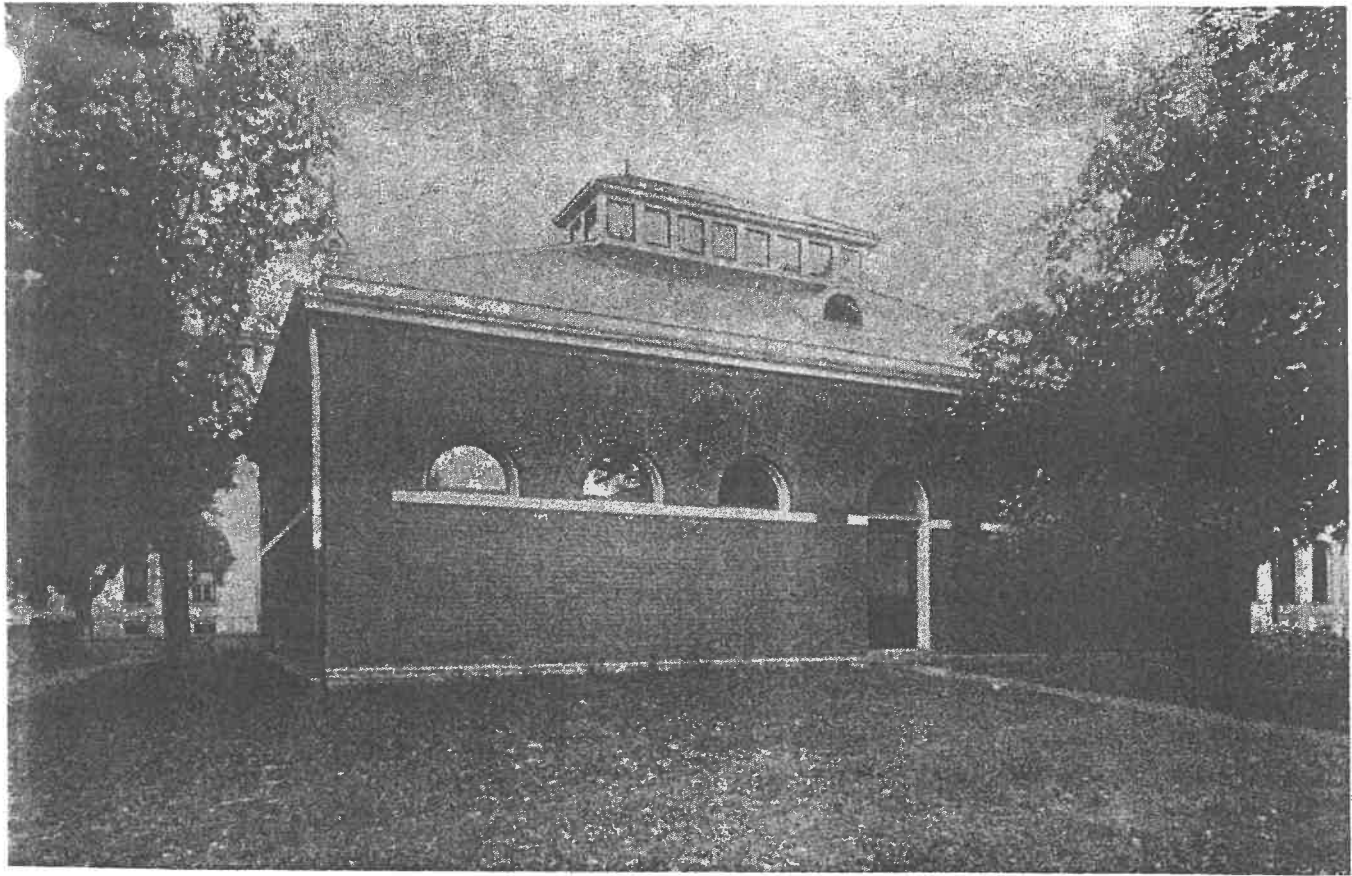
FEMALE WARD



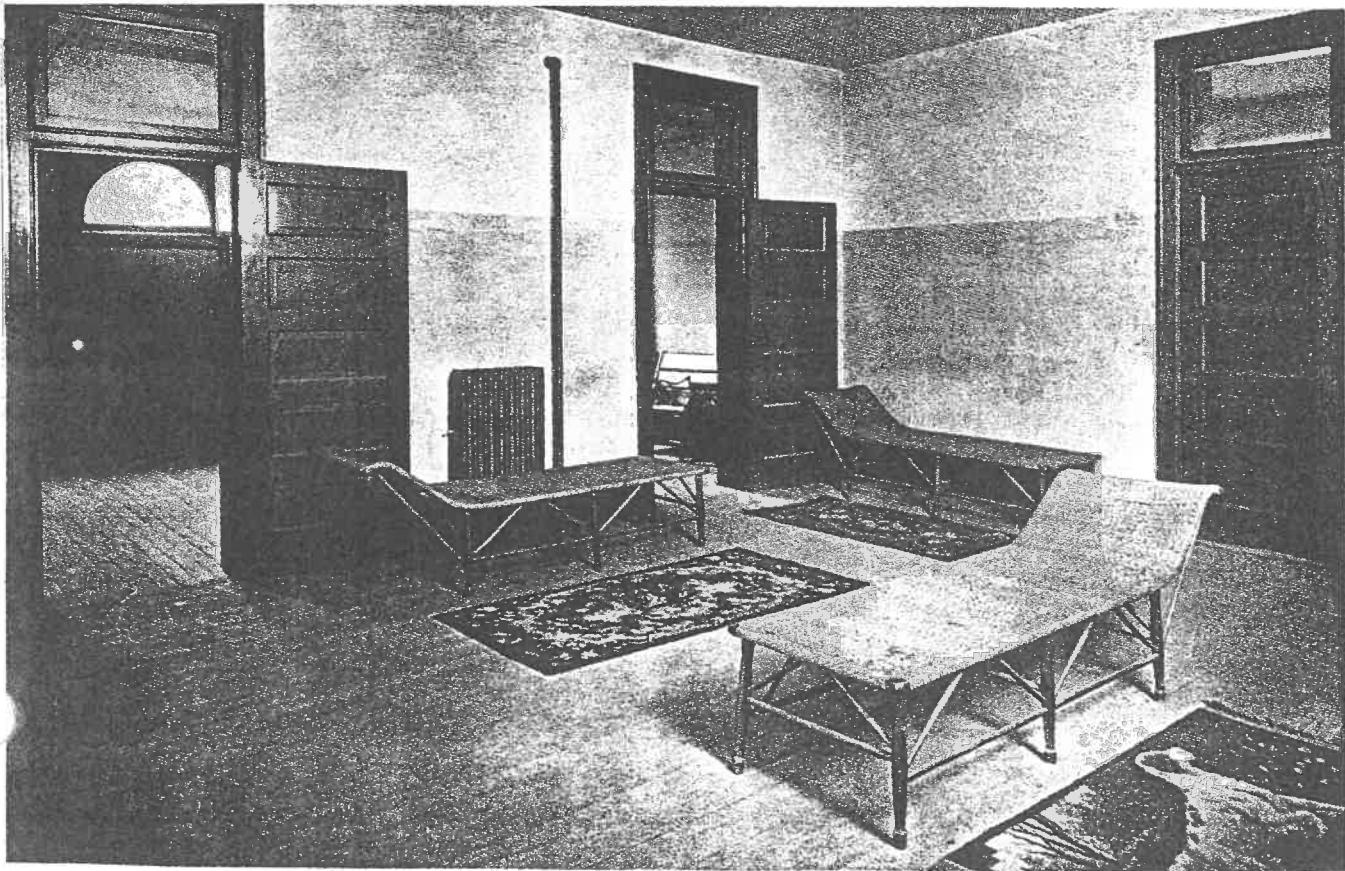
FURNACES AND BOILER ROOM



HOSPITAL UNIT - 1893 LATER DETACHED UNIT FOR MEN NOW PROGRESS HALL



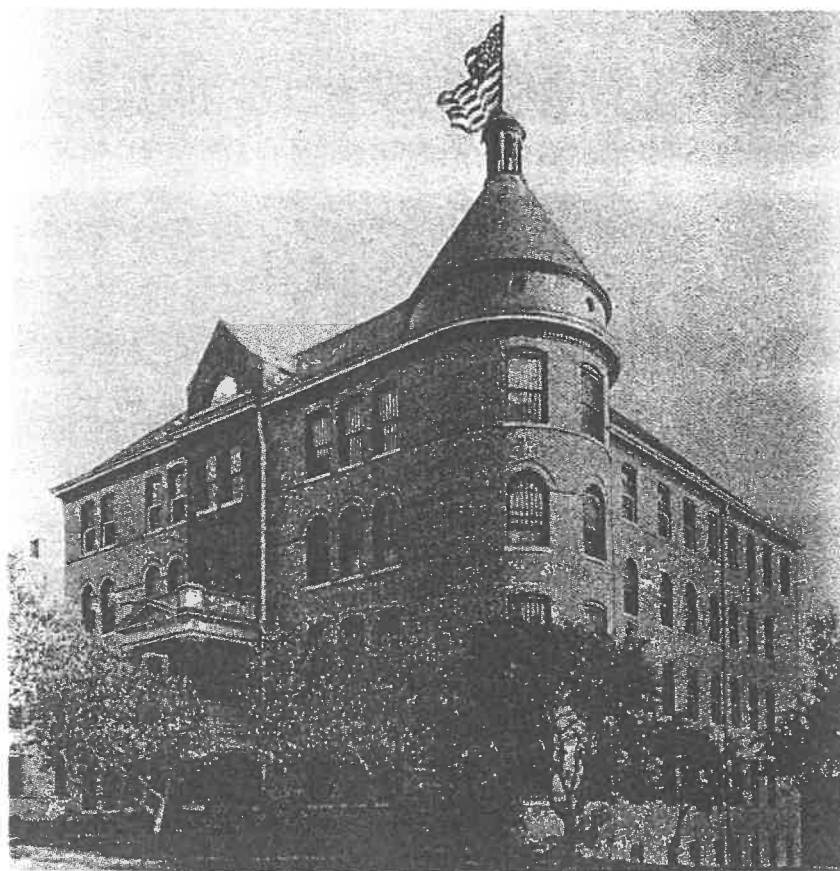
BATH HOUSE



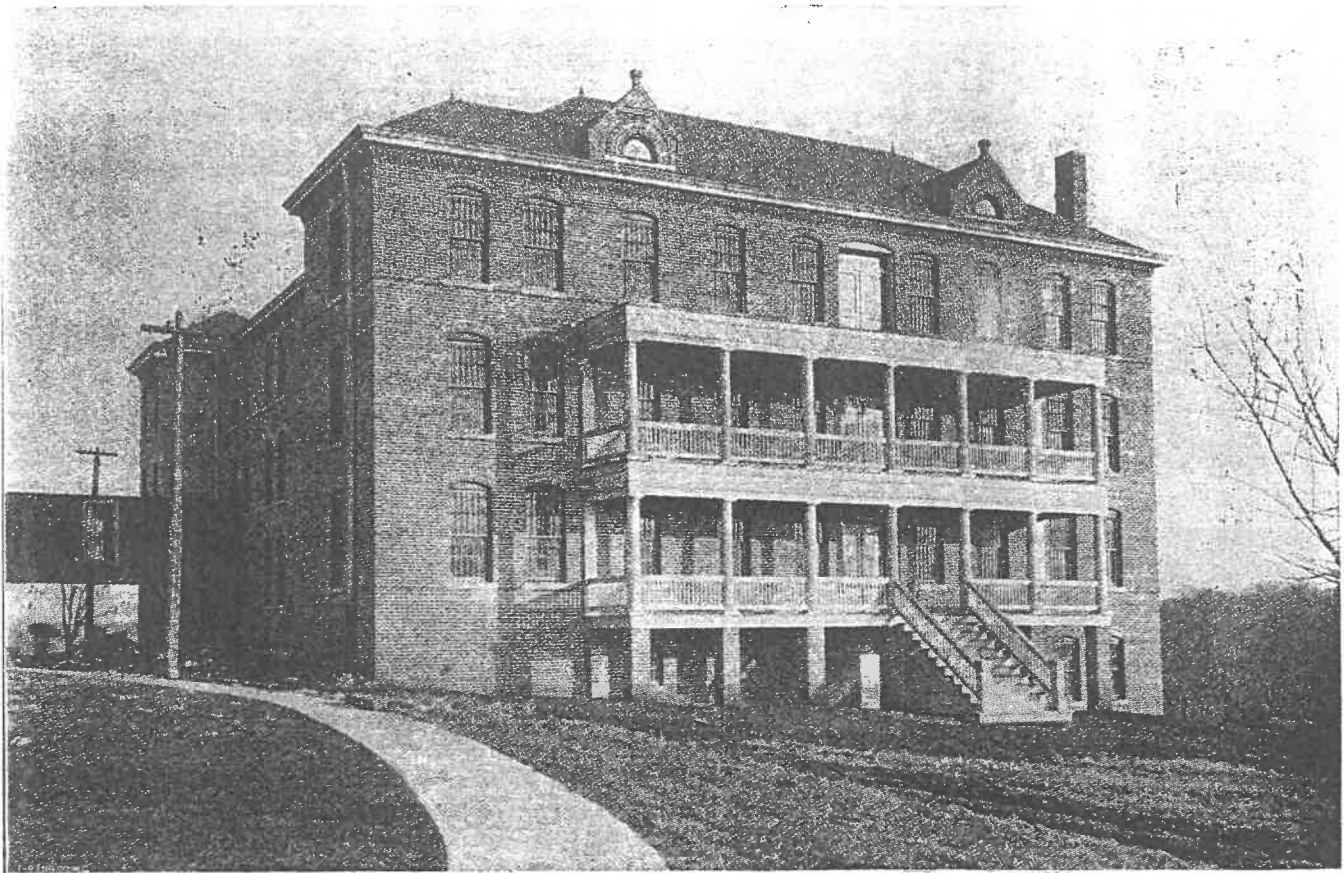
COOLING ROOM IN BATH HOUSE



BARBER SHOP



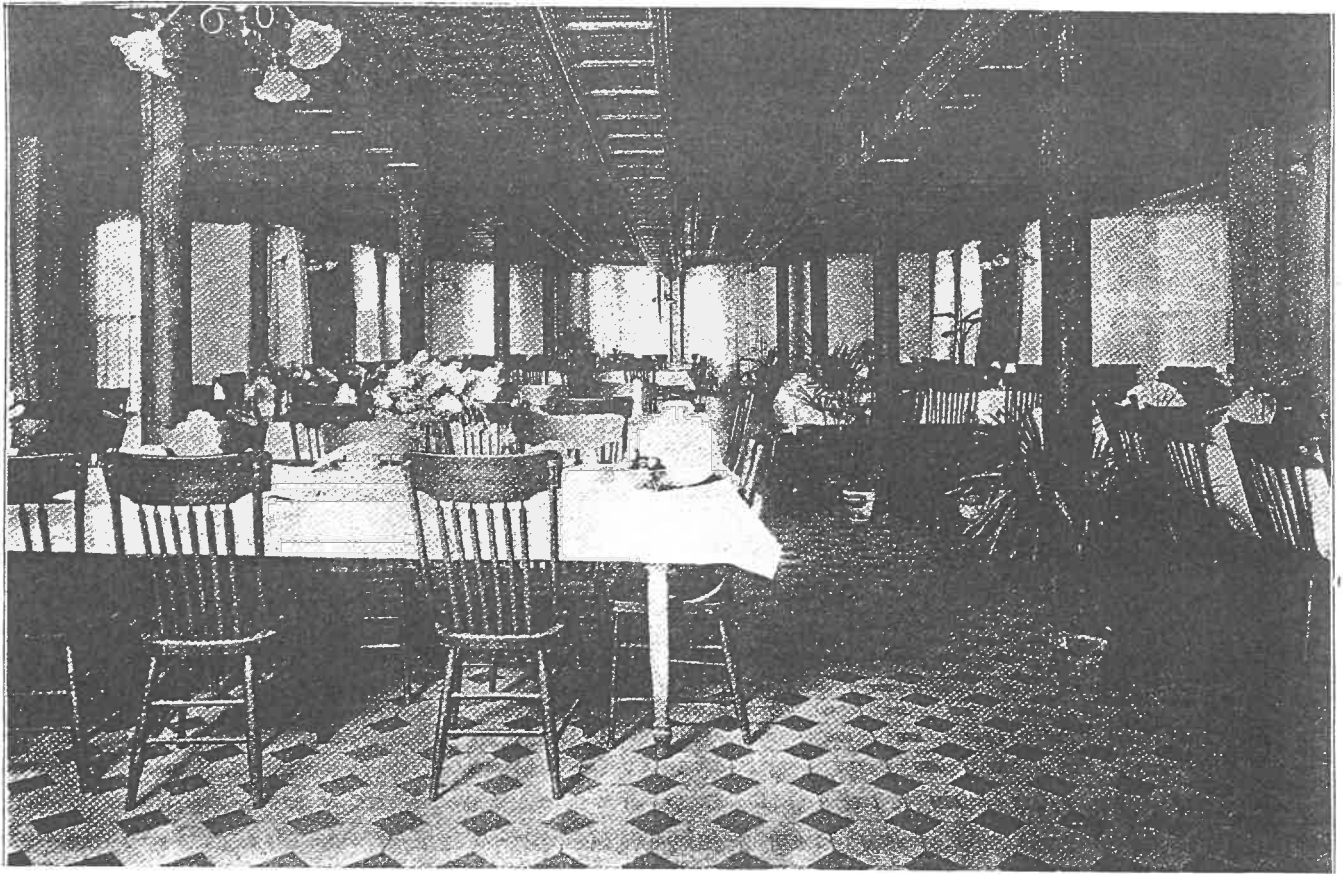
FEMALE INFIRMARY



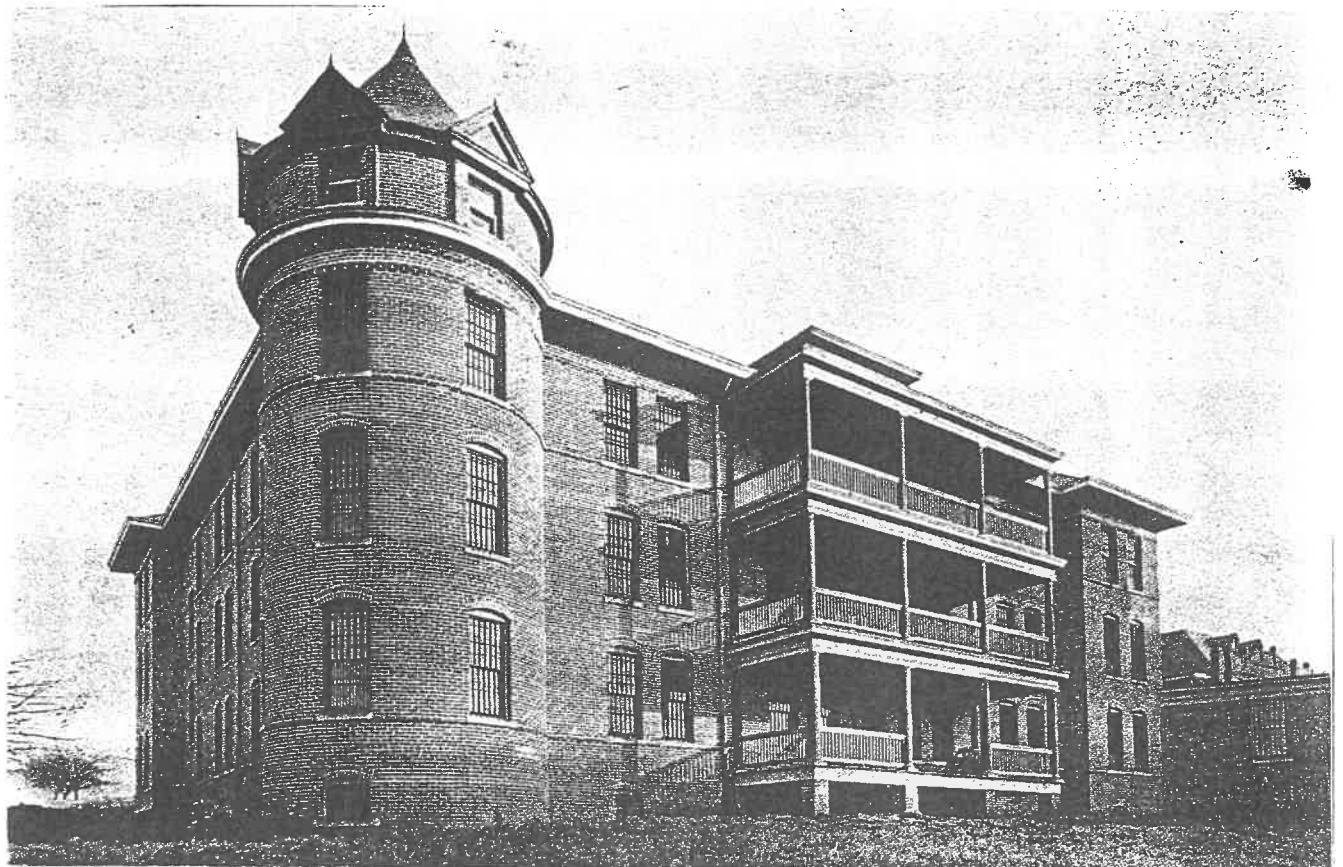
THE NEW BUILDING WAS LOCATED SOUTH OF FEMALE INFIRMARY



PATIENTS ON NEW ROAD - DIX DRIVE



DINING ROOM IN NORTH BASEMENT OF CENTER BUILDING



IT'S NOW THE STAFF DEVELOPMENT CENTER

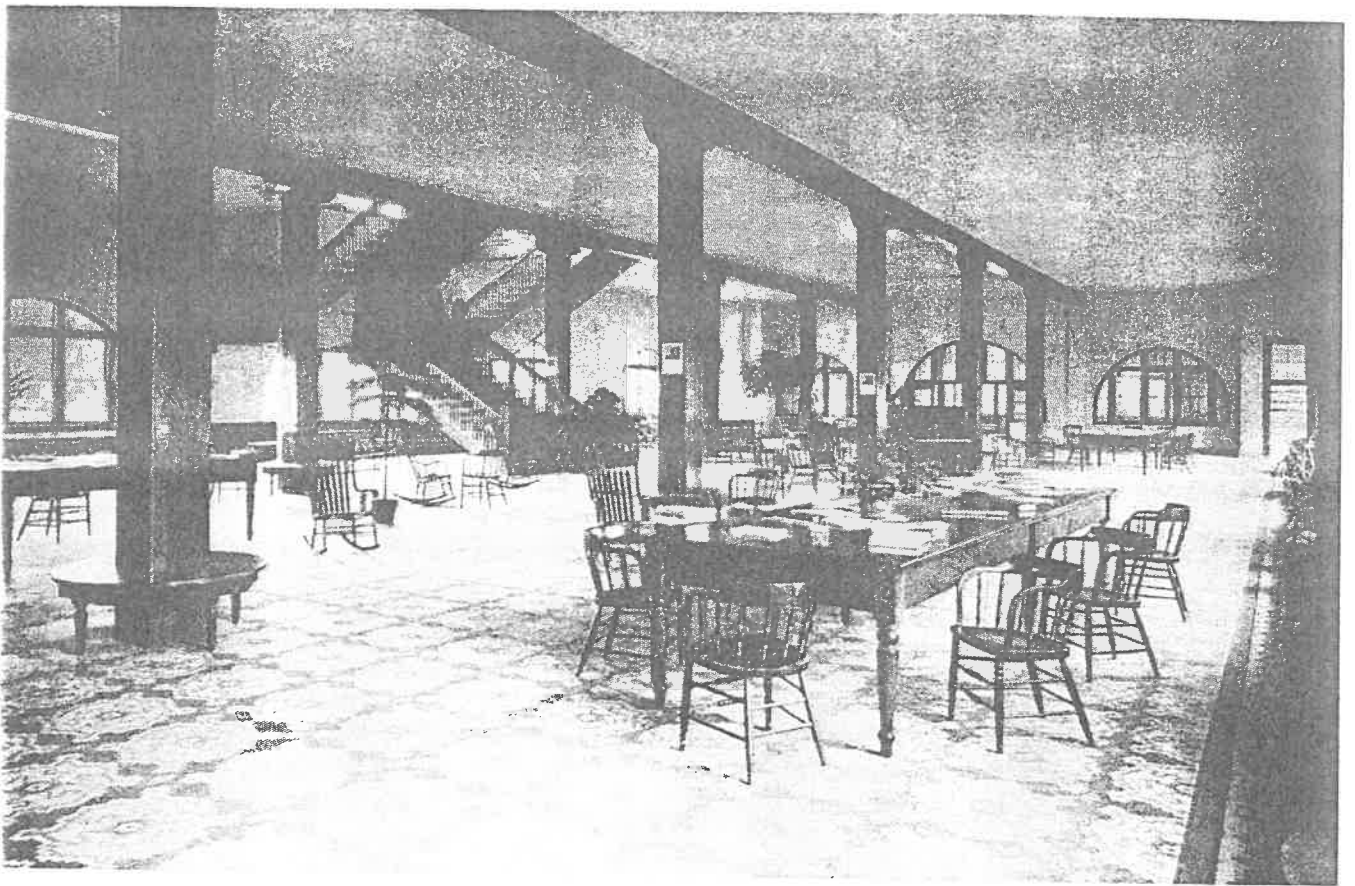


DR. WOODSON INSTRUCTING CLASS OF NURSES

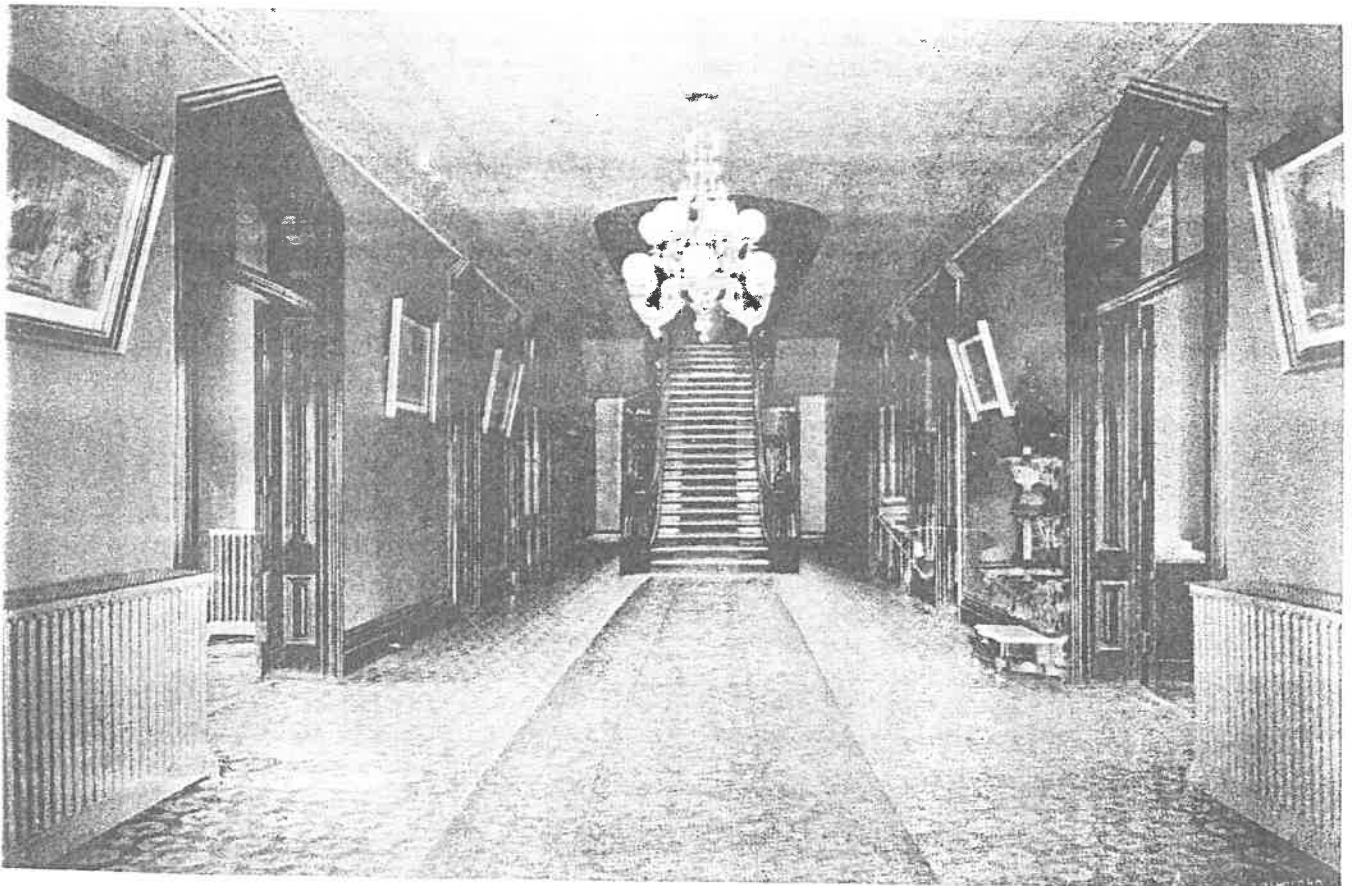


BIGGER BUILDING OR CENTRAL STATION FOR MEN

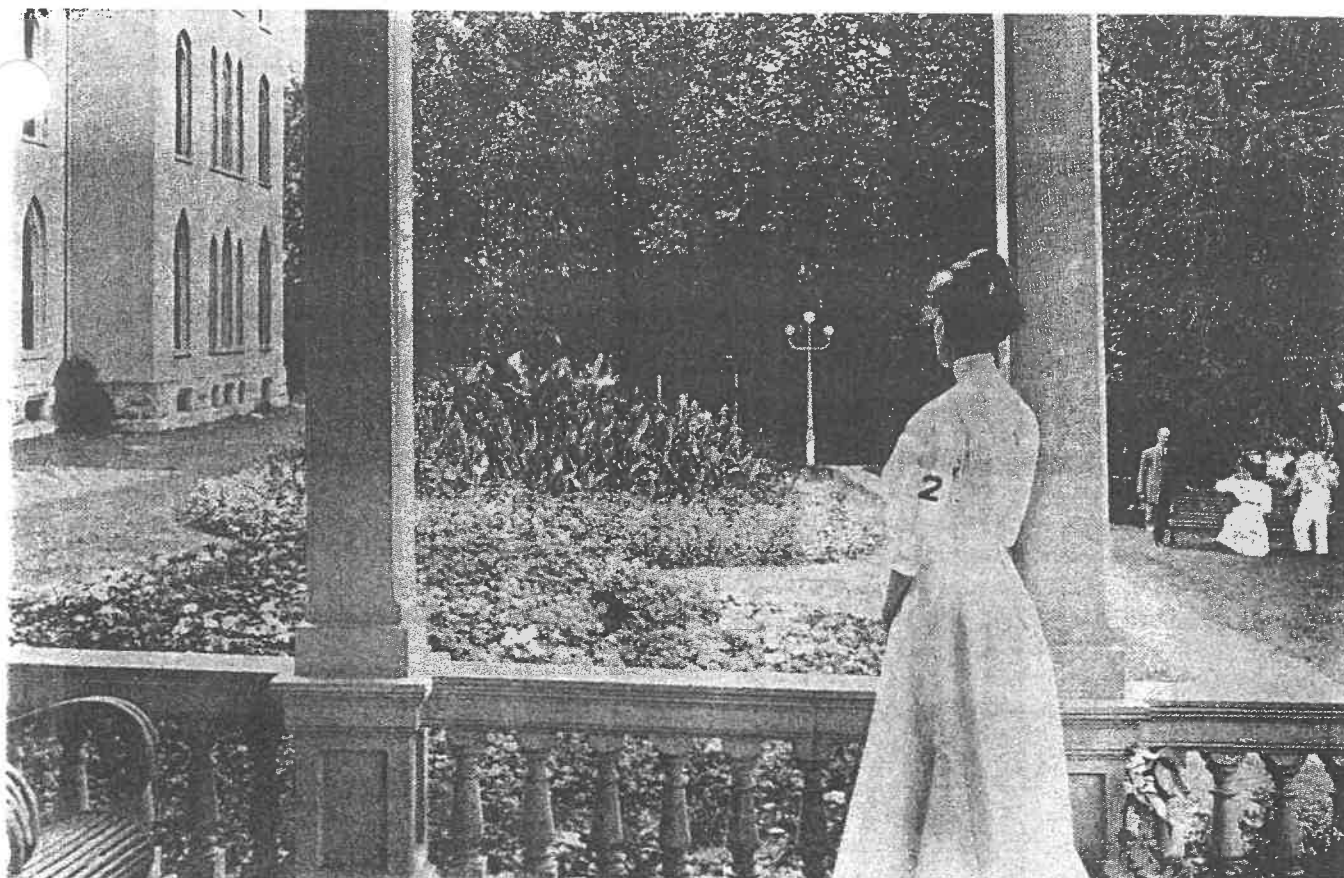
TODAY IT'S THE SHELTERED WORKSHOP



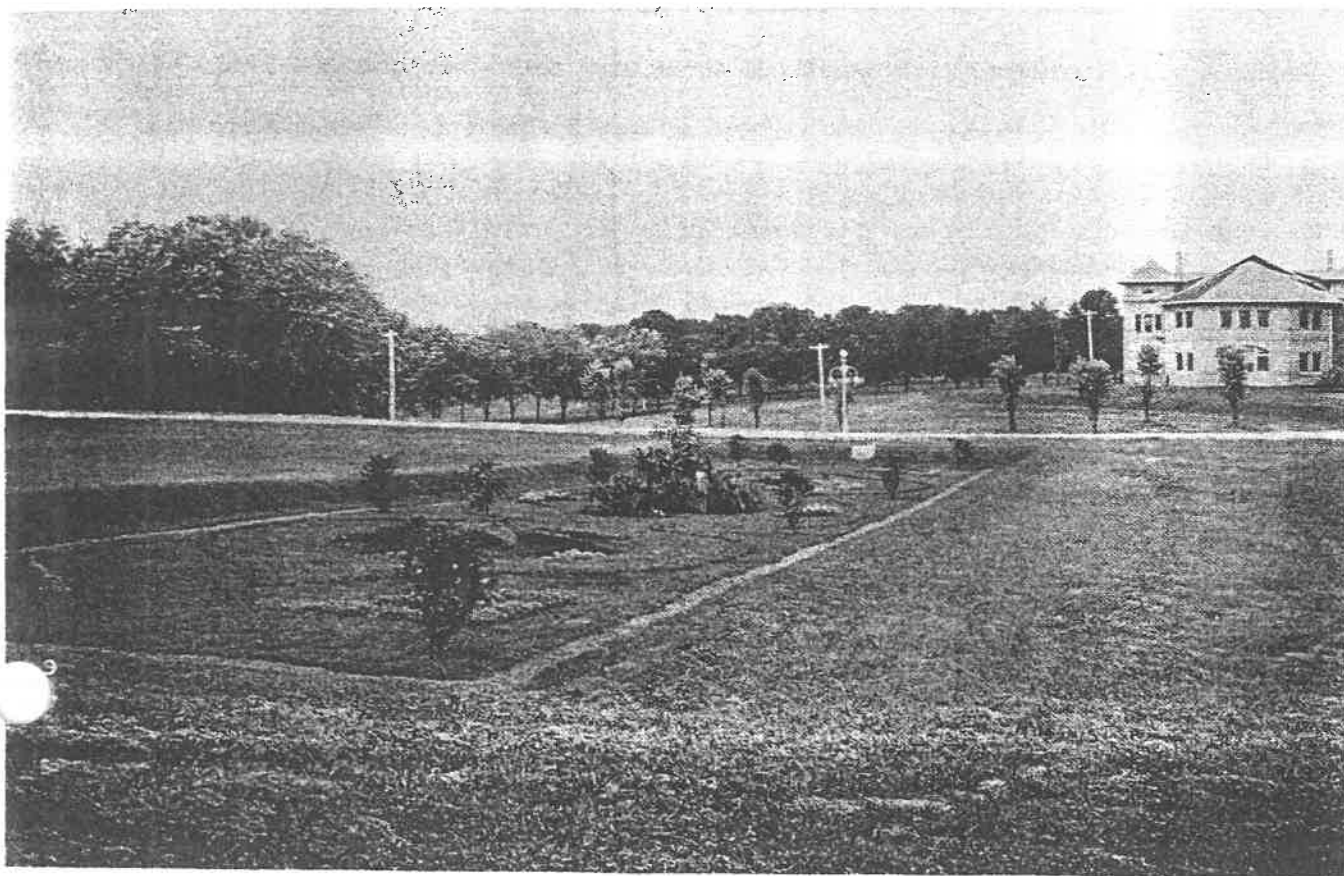
CAREY BUILDING OR CENTRAL STATION FOR WOMEN



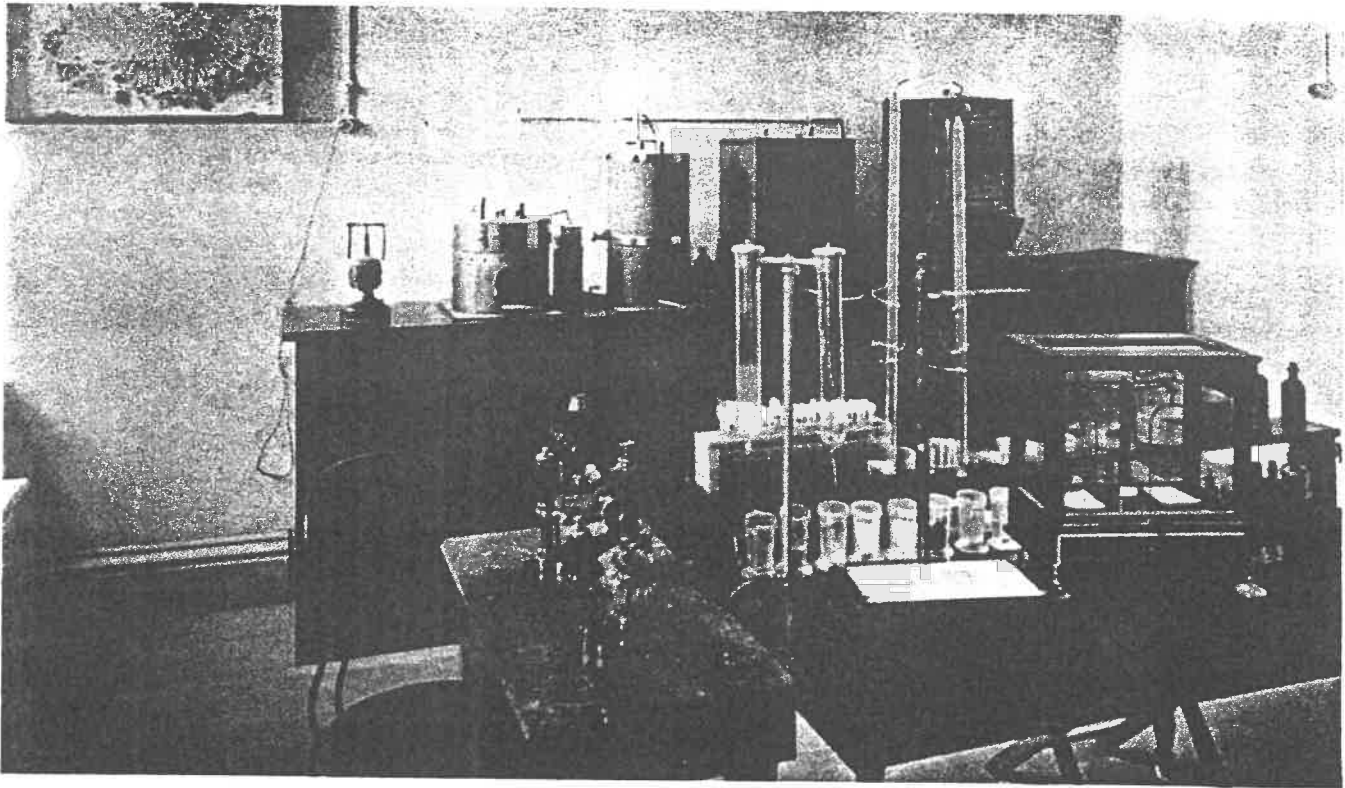
LOBBY OF ADMINISTRATION BUILDING



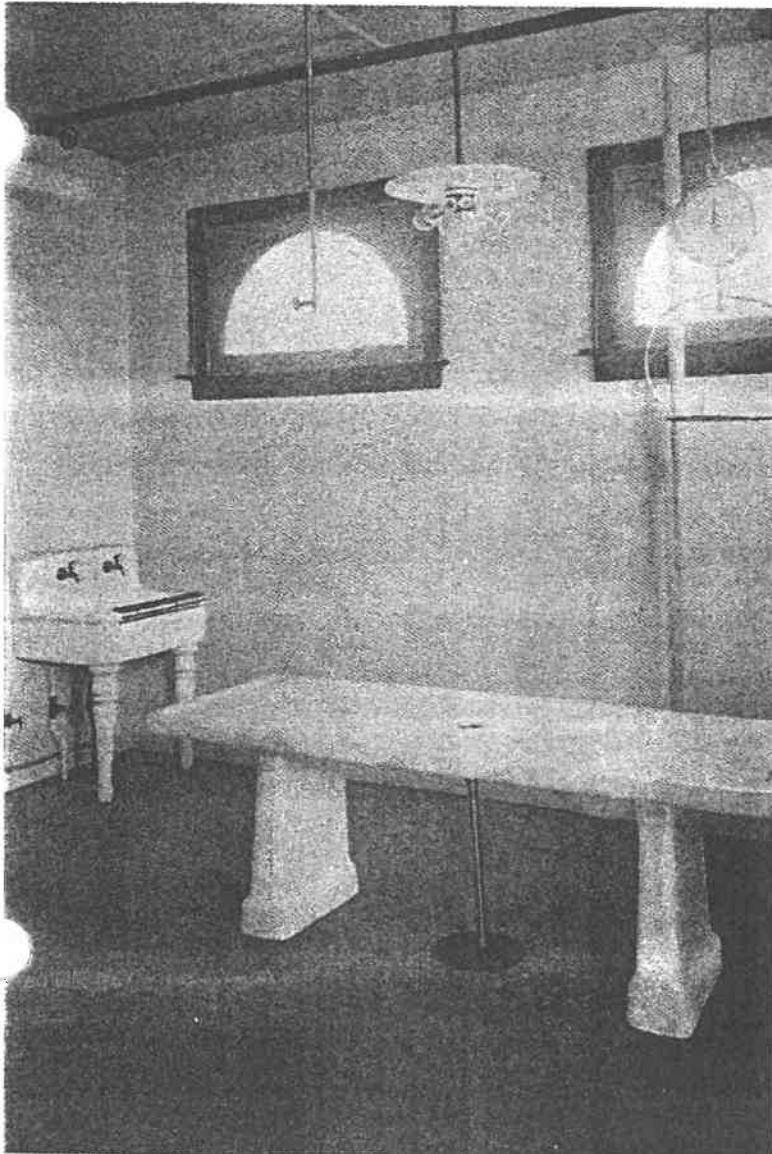
VIEW TO SOUTH OF FRONT PORCH - THE GARDENS



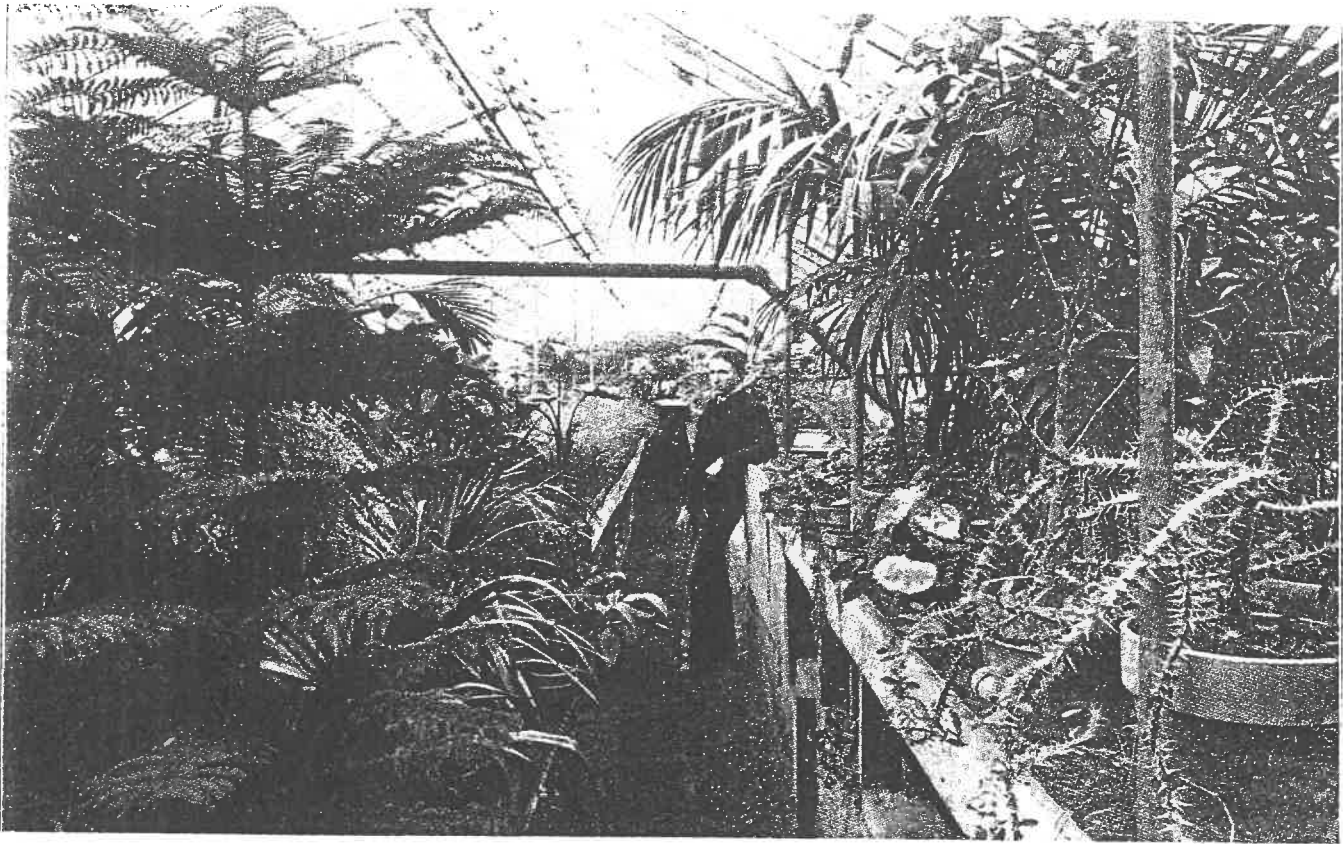
SUNKEN GARDEN ON FRONT LAWN OF HOSPITAL



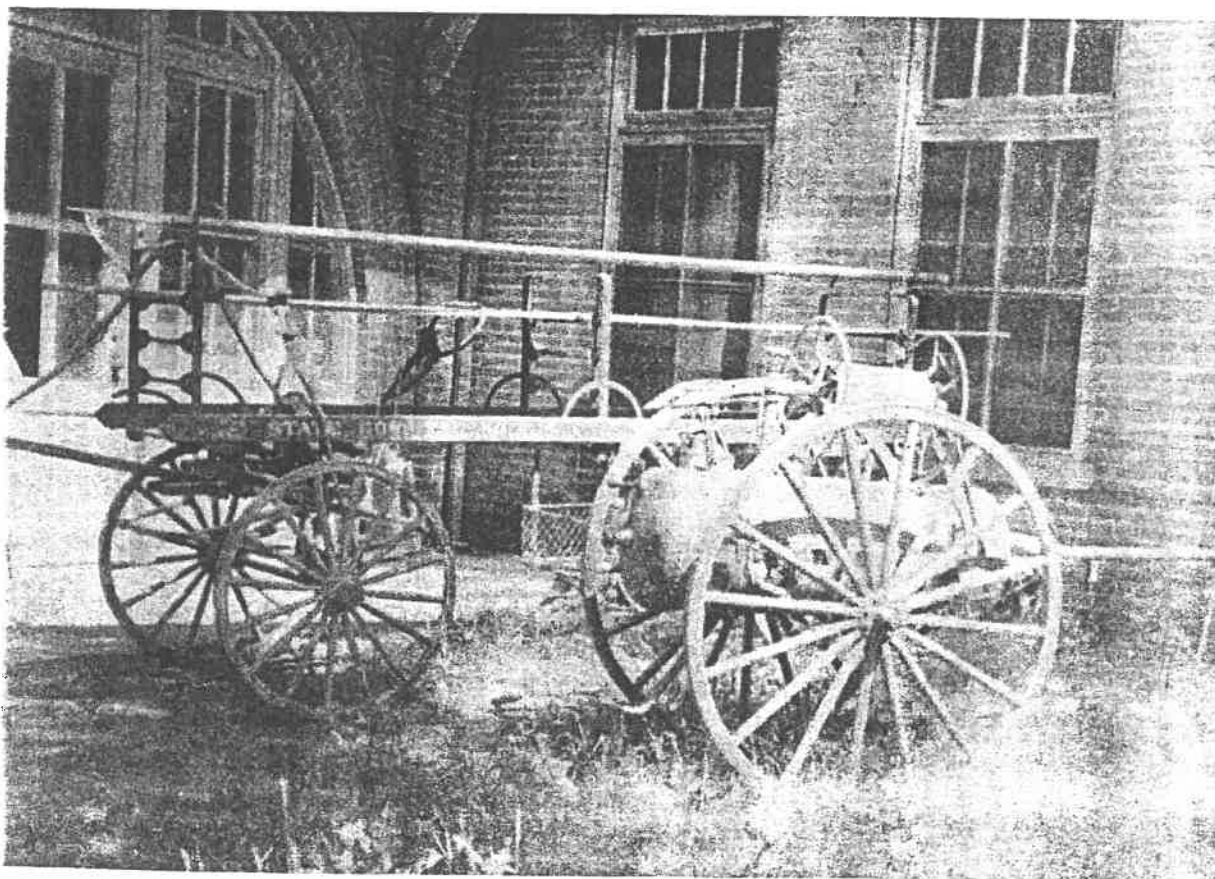
LABORATORY



MORGUE



GREENHOUSE



FIRE PUMP WAGON



THE BIGGER BUILDING
IS DESTROYED BY FIRE!

FORMERLY CENTRAL STATION
FOR MEN



REBUILT AS FEMALE
INFIRMARY



RENAMED HADLEY BUILDING