

A CASE STUDY OF ADMINISTRATIVE COMMUNICATION ON  
BIDDLE SECTION, TOPEKA STATE HOSPITAL

by 3735

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A MASTER'S REPORT

submitted in partial fulfillment of the

requirements for the degree

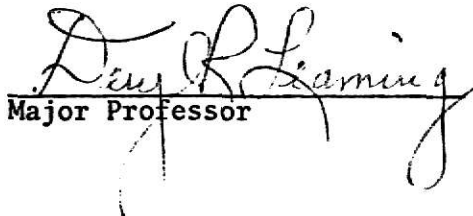
MASTER OF SCIENCE

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## ACKNOWLEDGEMENTS

This report grew out of the ability of others to listen with understanding. The aides and adolescent girls on BH-1 at Topeka State hospital listen "with the third ear" to what others think and feel. It is this capacity to listen creatively which leads to real communication. The existence of this report is a tribute to the following people who, each in his own way, have listened creatively to the meaning beyond the words, and to each I am very grateful.

Everette Dennis was the first to hear the heartbeat of the study. He recognized its scope and potential and guided its creation. He helped me put it in perspective and into words. Dr. James Horne, whose door was always open, enlarged my understanding of the processes I attempted to describe. He gave me invaluable criticism and advice as he acquainted me with all facets of communications on Biddle section at Topeka State hospital. At separate times and in separate ways, Dr. Deryl Leaming and Carolyn Foland thoughtfully structured the framework for the experiences which led eventually to the study. Carefully and critically, Dr. Ramona Rush read the report and identified its weaknesses. And my children helped me find that scarce commodity--time--by giving of their own.



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## CHAPTER I

### INTRODUCTION

This study was the outgrowth of a three month internship in the public information office at Topeka State hospital during the summer of 1969. The intern's major project for the summer was to work with Biddle section of Topeka State hospital on a brochure. The intern's interest in the structure of communications on Biddle grew during three months of almost daily contact with patients and staff on this unit.

In order to understand more completely how communications interface an organization and affect the behavior of its individuals, the analysis of the communication system on Biddle section as it was observed in the summer of 1969 was attempted. In this context "communications" refers to the flow and feedback of information among and between individuals, between groups of people on the unit, and between individuals or groups of individuals and functional entities (i.e. central administration, the team).

The problems examined in the study were: How did the communication process work on Biddle and how did it influence behavior? How were verbalized concepts communicated and reinforced? How did the staff reach a consensus with which it could work? Who made decisions and how?

#### The Focus of the Study

The focus was on staff communications within Biddle section. This was examined mostly within the formal communication structure of the section.

Such a communication study, however, could not be done in isolation. Where it seemed pertinent, other levels of communication and other communication systems were examined in relation to this one.

Staff communications were examined in relation to one project, the brochure. The assumption was that this would be representative of the communication process as a whole. Outside evidence which further substantiated the author's findings was included.

The communication process was examined in terms of seven statements which were incorporated in the brochure. These seven concepts, which Biddle section had of itself privately and wished to project publicly, represent some of the primary concerns of the professional staff on Biddle in the summer of 1969. They are:

- (1) Biddle uses the team approach exclusively in treating patients.
- (2) The psychiatric aide is the basic member of the treatment team in that the aide is most directly involved in the patient's treatment and spends the greatest amount of time with the patient. The aide is actively involved in the patient's treatment.
- (3) The professional staff is available for consultation and, at times, direct help to:
  - (a) the non-professional staff on Biddle
  - (b) professionals and mental health caregivers in the communities which Biddle serves.
- (4) The patient is a member of the treatment team.
- (5) Biddle gives high quality psychiatric treatment to its patients.
- (6) Biddle wishes to work closely with other community caregivers and with community mental health facilities for optimum individual and community results in the area of mental health.

(7) Biddle considers itself a member of the larger community mental health team and is willing to change in response to changing community needs.

### The Scope of the Study

The study dealt with the observations of the intern, an outsider to the section, who as an individual with a specific purpose attempted to interact with the communications system of an organization (Biddle).

The study attempted to find answers to the following questions.

-Did the communication system contribute to the cooperation of patients, staff, and the larger community (here meaning both the larger hospital community of Topeka State and the fifteen county area Biddle serves) in compiling the brochure?

-Was verbal communication reinforced by other kinds of communications--such as nonverbal? On what levels was it reinforced--staff-staff, staff-patient?

-How did the goals and attitudes of members of the staff and some patients change in relation to certain aspects of the brochure? How did the communication process lend itself to this?

-Was action within Biddle section based on the seven concepts noted above? What changes in behavior, both in patients and staff, resulted? What direction did these changes take?

-What relation was there of a "feeling of community" among staff and patients to the communication system?

-What breakdown of communications occurred? When, where, and under what circumstances? What were the possible reasons for each communication breakdown?

-What impact did outside communication systems--the state; central administration; other treatment sections at Topeka State; Shawnee county and the Topeka community; the communities which Biddle serves--have on Biddle and vice versa?

-What was the believability to aides of the unit message in various types of communication? This included communications between aides and professional staff on Biddle, aides and the intern, aides and central administration, and aides and patients.

-What were the apparent safeguards in this communication system? What were its weaknesses?

### The Background

#### Biddle Section

Biddle section is one of three adult inpatient units at Topeka State hospital. It serves fifteen counties in east-central Kansas. In the summer of 1969 Biddle had seven wards with a total capacity for 242 patients. The brochure in Appendix C discusses Biddle section in detail.

#### The Internship

The internship program was a cooperative venture between the Public Information Office at Topeka State hospital and the Mental Health Mass Communications Program in the Department of Technical Journalism at Kansas State University. Its purpose was to provide the intern with insight into problems in the mental health field and experience in the field of journalism. The fact that this was a learning experience as well as a work experience is important, for it contributed substantially to the amount of contact the intern had with Biddle and to the final form of the brochure.

So that the intern could understand better the dynamics of group therapy, arrangements were made for her to attend daily group meetings on an adolescent girls' ward on Biddle. The article, "BH-1", in Appendix D describes the treatment program on this ward and the communication process between the patients and the staff. During the ten weeks the intern was in daily contact with patients and personnel on Biddle, she had an equal amount of contact with other parts of Topeka State hospital, such as other treatment sections, central administration, and the public information office.

#### The Brochure

Compiling the brochure about Biddle section extended over the three month summer internship period. Reviewing and revising it extended into the winter of 1969. The brochure represents the thinking of the section's professional and non-professional staff, of the patients on the section, of the director of public information and the intern, and of members of the fifteen-county community which Biddle serves. The brochure grew out of the need expressed by caregivers and professionals in this community for more information about the section. These caregivers and professionals became the public for whom the brochure was written. The public included nursing home administrators and personnel, public health nurses, ministers, county welfare workers, probate judges, county attorneys, local medical doctors, mental health centers and clinics, mental health associations, law enforcement officers, sheriffs' staffs, school counselors, mental health boards, legislators and county commissioners.

The original purpose of the brochure was to meet this public's need for facts. Soon after the project began it became evident that the staff



also wanted to give the public a feeling for how a patient experiences life in a mental hospital. Thus a second purpose, that of creating an emotional tone to the brochure, evolved.

#### Personal Impressions Which Bear on the Study

During the summer of 1969, members of the Biddle professional staff claimed the section had the highest staff morale of the three adult inpatient units at Topeka State. The director of public information, who routinely attends meetings on all three sections, supports this statement.<sup>1</sup> This ties in with the intern's impression, which grew as she worked with the section, that it "had something" which similar organizations often lack. The key seemed to lie in what was being communicated on the section and how. The responsibility for those communications lay mainly with the professional staff under the guidance of the section chief. It seemed that what was verbalized was reinforced by action. This appeared to lead to a good working relationship among all levels of staff in a majority of situations. This impression is what first interested the intern in studying the communication process on Biddle.

#### The Importance of the Study

The objective analysis of this communication system is pertinent to understanding many trends in the mental health field, in the changing social structure of this country and in the field of communications today. It brings to light some of the underlying problems and how they develop.

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<sup>1</sup>Carolyn Foland, personal interview, Topeka State Hospital, March 1970.

### Definition of Terms Used

Throughout the study, the following terms have been interpreted as defined below. Whenever the meaning has been changed, this has been noted, and the new context of the word has been explained.

- "TSH"- Topeka State hospital; this is one of three state mental hospitals in Kansas; it is located in Topeka.
- "Biddle section" - May be referred to simply as "Biddle" or "the section"; this is one of three adult inpatient treatment units at TSH; it serves fifteen counties in east-central Kansas.
- "section chief" - The psychiatrist who heads Biddle section.
- "psychiatric aide" - May be referred to just as "aide"; either male or female employee at TSH who has successfully completed a thirteen week psychiatric aide's training course given by the hospital.
- "the team" - Highly variable from ward to ward and situation to situation. Basic members of each team are the aides, a nurse, a social worker, an adjunctive therapist, and a psychiatrist. The team is used often to include a number of other staff. Patients may also be included.
- "clinical services meeting" - A weekly meeting of the clinical services committee. Members of this committee include all ward psychiatrists on the section; the section's head aide, nurse, social worker, psychologist, teacher, chaplain, dietitian, adjunctive therapist; a vocational guidance counselor, TSH medical physician and the public information director.
- "section meeting" - A weekly meeting for all staff. In actual practice, each ward maintains minimal staff coverage for this hour and representatives from the day shift staff attend the meeting.
- "the community" - Will refer to the fifteen-county area which Biddle serves unless otherwise defined. See Biddle brochure in Appendix C for the location of this geographic area.
- "central administration" - Most often will refer to the superintendent of TSH and certain individuals and departments that are directly responsible to him, such as the director of clinical services, the director of education, etc.
- "DIM" - The Division of Institutional Management; this division is responsible for all eleven state institutions in Kansas. The superintendent of TSH reports directly to DIM, which reports directly to the state board of social welfare.

- "Kansas Health Workers" - A union composed of aides from TSH and the Kansas Neurological Institute. To call attention to grievances, the union staged a one-day "work-in" at TSH in June, 1968. This action led to a series of unpleasant events which culminated in a strike by the union against TSH.
- "the intern" - The author of the report.
- "therapeutic community" - When defined according to the following concepts this term can be applied to Biddle.<sup>2</sup>
  - a) The total social structure of the treatment unit is involved in helping the patient become mentally healthy.
  - b) The primary goal of this complex organization of people is to provide therapeutic experiences for the patients.
  - c) All relationships within the treatment community are regarded as being potentially therapeutic.
  - d) The goal of treatment is to help the patient become aware of the effect of his behavior on others and to understand some of the motivation underlying his actions.
  - e) Responsibility for treatment is shared between staff and patients; they share in decision-making and also in participation in the treatment process.
  - f) There is group diagnosis. The patient is seen from different professional perspectives. This gives a more complete picture of the patient upon which to base team treatment.
  - g) Staff roles often blur and change in relation to the patient. However, this does not imply that distinctions between various professions and between professional and non-professional staff disappear. The sense of one's own unique professional role need not get lost.<sup>3</sup>

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<sup>2</sup>James B. Horne, M.D., Biddle section, Topeka State hospital, March 1970.

<sup>3</sup>Adapted in part from Alan M. Kraft, "The Therapeutic Community," American Handbook of Psychiatry, ed. by Silvano Arieti, III, (New York: Basic Books, Inc., 1966) 542-51.

## CHAPTER II

### LITERATURE REVIEW

#### Relevant Mental Health Literature

During the second world war experiments with the treatment of service personnel using the principles of social psychology gained acceptance and laid the groundwork for continuing experiments since then. Maxwell Jones describes some of these early attempts in The Therapeutic Community. Dr. James Horne, section chief of Biddle, states that the community methods of treatment described in this book are his model for treatment on Biddle. Although normally Biddle is not referred to as a "therapeutic community" this term is permissible as defined in the introduction. A recent summary of the American interpretation of a therapeutic community has been made by Alan Kraft.<sup>1</sup> The mode of treatment on Biddle is described by the staff as milieu therapy.

Biddle uses the team approach exclusively in treating patients. The psychiatric aide is the most directly involved in the patient's treatment, spends the greatest amount of time with the patient, and works therapeutically with patients and families. Thus the psychiatric aide is called the basic member of the team.

The present role of the psychiatric aide on Biddle differs sharply from the aide's role in the past. The psychiatric aide is now seen as an active participant in the patient's treatment.

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<sup>1</sup>Ibid.

How recent a departure this is from the traditional role of a psychiatric aide at TSH is noted in the detailed account of the Ward H project by its directors.<sup>2</sup> This project, which started at TSH in 1960 and lasted four years, was based on Austin DesLauriers' theory regarding schizophrenia. "In brief, this theory held that schizophrenia was indicative of a step missed in the maturation of an infant--the step in which the infant learns the boundaries of his body and then of his ego."<sup>3</sup>

Colarelli and Siegel felt that implicit in this theory, which is one of incomplete personality development, is the fact that the patient cannot reach out and establish contact with others because he has never learned how. For this patient, therefore:

It is the contact with another person which is important; and it must be a whole person involved with the whole patient, rather than simply a "therapist."

Essentially the problem is being present and constructing a relationship with the patient. To do this, one must be intrusive, a model for the individual, a helper but also someone who requires the patient to grow and eventually assume increasing responsibility.<sup>4</sup>

In the Ward H project, psychiatric aides were selected to play this role. In addition, they were made responsible for the treatment of "hard core" chronic schizophrenics selected for the project. During the first few months the aides exhibited intense anxiety.

...what were the sources of this reaction to their new role? Certainly one source was found in the departure from the traditional role of the aide at the hospital. Seldom before had aides been given this kind of direct treatment authority and responsibility

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<sup>2</sup>Nick J. Colarelli and Saul M. Siegel, Ward H, An Insight Book, (Princeton, New Jersey: D. Van Nostrand, Inc., 1966).

<sup>3</sup>Ibid., p. 12.

<sup>4</sup>Colarelli, p. 13.

because the aide was supposed to lack the training to deal with the patient's problems. Her capacity to be of help to patients was seen as extremely limited in any therapeutic sense. Her former role was primarily that of a custodial person; her responsibilities were not previously defined in terms of persons or patients, but rather in terms of function, that is, the protection of the patient from himself and provision for his physical care....  
 .....  
 The capacity of the aide to be consistently and responsibly therapeutic had long been untested because it was assumed that they couldn't be.<sup>5</sup>

How the role of the psychiatric aide at TSH changed between 1960 and 1964 is also described by Colarelli and Siegel.

It is difficult to assess the effect of the project on the hospital....In any given situation, the project could have been the stimulus that caused changes elsewhere in the hospital. It might have been a catalyst that accelerated ongoing trends or was part of a larger trend, that is, part of a Zeitgeist. The project's concurrence with many of these trends was evident....

For example, the hospital began to reappraise the roles of all its personnel and began to look especially at the use it was making of its aides. Although the institution had a history of commitment to the importance of the aide in patient treatment, for many reasons this philosophy had been honored more by the spoken idea than in actual fact. The project demonstrated the validity of the therapeutic capability of the aides. By the time of its completion it was no longer atypical in the institution for an aide to have the responsibility for a group of patients or for her to have an intensive therapeutic relationship on a one-to-one basis.<sup>6</sup>

The first training course for psychiatric aides began at TSH in 1950. A trend toward training programs gathered momentum following a series of newspaper exposés<sup>7</sup> of conditions at the hospital in 1948;

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<sup>5</sup>Colarelli, pp. 36-37.

<sup>6</sup>Colarelli., pp. 189-90.

<sup>7</sup>Charles W. Graham, Kansas City Star, three part series, September 1-3, 1948. John McCormally, "The State Hospitals--A Kansas Crisis", Emporia Gazette, ten part series, October 27-November 7, 1948.

conditions which Dr. Karl Menninger described as "'abominable, medieval, criminal!'"<sup>8</sup> Following the exposés, TSH joined in the Menninger Foundation-Veterans Administration hospital training program for psychiatric residents. At TSH, other training programs for mental health personnel followed. With more professional staff and better trained staff available, active treatment for TSH patients became possible.

Then in 1960 under the Kansas Plan, TSH divided into four semi-autonomous sections or "little hospitals" under a central administration. Each "little hospital" served the people of a specific geographic area. Patients from Shawnee county were an exception. They were placed on all four sections. In 1968, a further refinement of this plan led to strict geographic assignment with all Shawnee county patients being placed on one section. By 1969, there were three adult inpatient sections at TSH and each one serviced a specific geographic area of Kansas.

Under this plan general hospital policies are decided at the central administration level. The specific treatment program on any section, however, is determined by the professional staff and the chief of that section under these broad policies. Some of the channels of communication under this plan are indicated in a Master's thesis at Kansas State university.<sup>9</sup> In general, personnel policies come under central administration; patient treatment is determined by the section staff. Thus all staff at

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<sup>8</sup>Quoted by John McCormally in "The State Hospitals--A Kansas Crisis", No. 9 of the series.

<sup>9</sup>Carolyn G. Foland, "The Development of the Office of Public Information of the Topeka State Hospital" (unpublished thesis, Kansas State University, 1969).



TSH receive messages from two distinct sources--and a little less directly from a third source, the state, personified by DIM.

Concepts have been changing about the community's role in the treatment of mental illness and about professional and non-professional roles in the mental health field. New concepts have burst into full bloom during the past ten years.

The Joint Commission of Mental Illness and Health in 1961 pointed the direction treatment of mental illness should take.<sup>10</sup> In the middle years of the 1960's community mental health centers, offering a variety of modes of treatment, grew up around the country. Prairie View mental health center in Newton, Kansas, which is in Biddle's cachement area, won the American Psychiatric Association's coveted gold achievement award in 1968.<sup>11</sup> Prairie View and Biddle cooperated closely for several years on an aftercare program which started in 1964 under a demonstration project grant from the National Institute of Mental Health.<sup>12</sup> Prairie View received a construction grant in 1966 under the Community Mental Health Centers Act of 1963 and a staffing grant in 1967.<sup>13</sup> Biddle, as has been demonstrated through close cooperation with Prairie View, is dedicated to cooperating with the community and to redefining its role as necessary in relation to the wider concept of community psychiatry and mental health.

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<sup>10</sup>Action for Mental Health, Science Editions (New York: John Wiley and Sons, Inc., 1961).

<sup>11</sup>"The 1968 Achievement Award Winners," Hospital and Community Psychiatry, October, 1968, p. 311. "Gold Award: Partnerships for Community Services--Prairie View Mental Health Center, Newton, Kansas," Hospital and Community Psychiatry, October, 1968, pp. 312-14.

<sup>12</sup>"Gold Award," p. 312.

<sup>13</sup>"Gold Award," p. 314.



Although members of the professional staff had recognized the capabilities of the aides at least by the early 1960's, aides were still working under job descriptions approximately fifteen years old in the summer of 1968. While professionals were reluctantly recognizing that non-professionals often were naturally equipped to engage patients in active treatment, the non-professionals were becoming increasingly active in trying to gain recognition for their skills on an official level. The potential was present for aides' resentment, for they were often given increased responsibility without the opportunity for recognition, increased status or pay, or upward job mobility to go with it. The Kansas Health Workers strike in Topeka in the summer of 1968, which involved aides from TSH and from the Kansas Neurological Institute, was one result of this discrepancy.

On Biddle in the summer of 1969 the aides were still getting conflicting communications. The professional staff was saying to them: you are capable of being trained to do more, we will help you, you can do as good a job in many respects as we can. And DIM and the central administration at TSH were saying: we are trying to help you get more training and education but be patient. Many aides were distrustful of communications from central administration and DIM. The message from these two sources only the year before (during and following the strike) had been: we cannot meet your demands. Nevertheless, central administration was working on several programs to meet the aides' needs for more education. One of these programs, it was hoped, would eventually lead to an associate-of-arts-degree which offers

middle level training for mental health workers.<sup>14</sup> And DIM had launched a "new careers" experimental study program.<sup>15</sup>

During these years, the general public's concepts of mental illness appeared to be changing toward a wider understanding and acceptance of mental illness. Changes in attitude appeared in the young and well educated and in the lower class and poorly educated.<sup>16</sup> During the summer of 1969 Biddle staff's changing attitudes concerning the use of patients in pictures for the brochure reflected its sincerity in wanting to keep faith with this changing public attitude.

#### Relevant Literature Concerning Communication

The problems of communication within a mental hospital are spelled out dramatically by Ken Kesey in One Flew Over the Cuckoo's Nest. Big Nurse ran the ward. She controlled the patients and the aides as well as the physician who was supposedly in charge. McMurphy, a rousting redheaded patient, tried to change the system after he was admitted. What he communicated to others on the ward was directly opposed to Big Nurse's control of all in this "therapeutic community". The book reveals the subtle unconscious, nonverbal and latent forms of communication which can exist side by side

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<sup>14</sup>The possibilities of this program and its recent growth are examined by Alfred M. Wellner and Ralph Simon in "A Survey of Associate-Degree Programs for Mental Health Technicians," Hospital and Community Psychiatry, June, 1969, pp. 166-69.

<sup>15</sup>The position of "psychiatric technical specialist" was created as of July 1, 1969 for this purpose.

<sup>16</sup>Harold P. Halpert, "Surveys of Public Opinions and Attitudes About Mental Illness: Their Implications for Programming Communications Activities," Paper for First International Congress of Social Psychiatry, August, 1964. Paul V. Lemkau and Guido M. Crocetti, "An Urban Population's Opinion and Knowledge About Mental Illness," American Journal of Psychiatry, February, 1962, pp. 692-700.

with a formal communication structure and which can even supplant it. The truth about kinds and levels of communications revealed in the book should not be disregarded because the book is a novel. As Chief Broom, the deaf and dumb narrator of the story says, "...it's the truth even if it didn't happen."<sup>17</sup>

Other covert communication problems in mental hospitals are pointed out in a study by William Caudill and Edward Stainbrook.<sup>18</sup> Concerning this study they said:

We felt that some further understanding of the multiple sources of many problems might be gained by acquiring a better knowledge of the hospital as a social system. Our goal in this paper is simply to present and to analyze brief examples of several types of problems in communication within a wider context of events than is usually accorded them in the daily work of the psychiatric hospital.<sup>19</sup>

One of the points that Kraft emphasizes is that communication within a therapeutic community is most important. "This includes communication of all kinds, manifest and latent, verbal and nonverbal, conscious and unconscious, and at all levels--patient-patient, patient-staff, and staff-staff."<sup>20</sup>

But just how closely communication is felt to be linked with any organization is indicated by the following quotations.

There can be little doubt that communication is central to the life of organizations. Some even say it is a base of organization

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<sup>17</sup>Ken Kesey, One Flew Over the Cuckoo's Nest, Compass Books (New York: The Viking Press, 1964), p.8.

<sup>18</sup>"Some Covert Effects of Communication Difficulties in a Psychiatric Hospital," Psychiatry, XVII (1954), 27-40.

<sup>19</sup>Ibid., p. 27.

<sup>20</sup>"Therapeutic Community," p. 544.

structure....

.....  
 ...it would seem that the consequence of developments in communication theory has been to place greater emphasis on communications as an organizational factor and as a means of creating structure.<sup>21</sup>

If the viewpoint is taken that information constitutes the life-blood of the functioning organization, the channels and apparatus for the transmission of such information become the organization structure....the message becomes in a sense the basic component of organization analysis,....<sup>22</sup>

One other area appears to be particularly relevant to this study.

It concerns the credibility of the communicator. How an audience perceives a communicator depends not only on his powers but also on the past experiences and preconceived attitudes of the audience.

...a recipient may believe that a communicator is capable of transmitting valid statements, but still be inclined to reject the communication if he suspects the communicator is motivated to make nonvalid assertions. It seems necessary, therefore, to make a distinction between 1) the extent to which a communicator is perceived to be a source of valid assertions (his "expertness") and 2) the degree of confidence in the communicator's intent to communicate the assertions he considers most valid (his "trustworthiness"). In any given case, the weight given a communicator's assertions by his audience will depend upon both of these factors, and this resultant value can be referred to as the "credibility" of the communicator.<sup>23</sup>

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<sup>21</sup>John M. Pfiffner and Frank P. Sherwood, "Formal Organization as a Communication Structure," The Government of Associations: Selections from the Behavioral Sciences, ed. by William A. Glaser (Totowa, New Jersey: The Bedminster Press, 1966), p. 148.

<sup>22</sup>Ibid., p. 143.

<sup>23</sup>Carl I. Hovland, Irving L. Janis and Harold H. Kelley, Communication and Persuasion: Psychological Studies of Opinion Change. (New Haven: Yale University Press, 1953), p. 21.

## CHAPTER III

### STRUCTURE OF THE COMMUNICATION PROCESS ON BIDDLE

#### Patterns of Formal Communication

Two general patterns emerge. One concerns the individual patient and his ward. The other concerns administrative policies, decisions, and problems relating to the section as a whole or to more than one ward.

#### Concerning the Patient and the Ward

A psychiatrist serves as section chief on Biddle. Also each ward team is headed by a staff psychiatrist. The staff psychiatrists have the final authority in the running of each ward and the section chief in the running of the whole section. However, most of this authority is delegated. The psychiatrist is responsible for the patient's evaluation and treatment. But primarily he works with each patient through the other members of the treatment team.

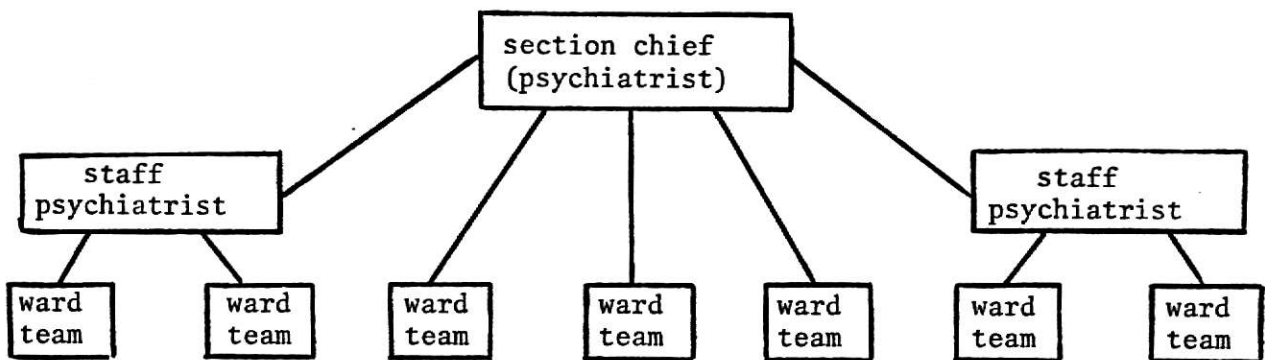


Fig. 1.--A psychiatrist is head of each treatment team.

#### The team

Each of the seven wards has a treatment team. In some respects each team has a slightly different composition from any other team and within

its own structure from time to time. For example, when a patient is thought to be nearly ready for vocational rehabilitation, the vocational rehabilitation counselor may work actively with the team in this area; at another time he might have no contact with this team.

Certain members of the team are responsible for active treatment while other members may serve either as active participants in the patient's treatment or in an advisory or ancillary capacity. Psychiatric aides, a psychiatric nurse, social worker, adjunctive therapist, and psychiatrist are found on every team, whether all provide active treatment or whether some offer consultation only. Additional members of any team at any given time may include a teacher, vocational guidance counselor, psychologist, alcoholism counselor, or chaplain.

Each team meets at least once a week. The structure of the meetings varies widely between teams. One purpose of these meetings is to inform all team members of what has transpired during the week. Another purpose is to look at individual patients in light of their present treatment program and their progress and to change treatment plans as needed. Decision making varies with the team. The physician is head of the team and has the final responsibility for decisions. However, if the team is sophisticated and skillful, aides and other team members may do most of the decision making with the implicit consent of the physician. Patients do not attend these weekly team meetings.

The patient as a member of the team.--Within six weeks after admission a D and A (diagnosis and assessment) conference is held. The patient often is present at this team meeting where a tentative diagnosis is established and a plan of treatment formulated. Whether the patient attends the meeting

or not he is made aware of the team thinking and decisions concerning his treatment.

Until a patient wishes to make changes in his life he will not enter into active treatment. Until the team can engage the patient in active treatment, it can only work passively with him by structuring his environment. When he enters into active treatment he is then considered a member of the team.

Shift reports.--There are three shifts which give around the clock coverage to each ward. Between each shift a report of previous activities, problems, and decisions is shared with the oncoming shift. In the main, the report concerns the patients and the running of the ward.

#### Concerning the Section--Administrative Policies, Decisions and Problems

##### The clinical services meeting

This is a weekly meeting of the clinical services committee. The section chief chairs the meeting. This is the policy making group for the section. Decision making within the group is variable depending on the problem. In general, a consensus is sought concerning decisions. This group decides on the approach to be used to a problem and on what should be taken to the whole section for decision, for discussion, or for informational purposes.

##### The section meeting

Once a week all available day shift staff attend this meeting. The section chief chairs the meeting and brings to this group problems, concerns, and information from both within and without the section. This meeting is not

usually used to discuss individual patient or ward problems, but, instead, more general problems or policy decisions which might affect all the staff and/or patients. This group may decide, at times, to take problems back to the ward teams and sometimes through the teams back to the patients.

### Individual Lines of Communication

#### Other staff members

Each staff member is involved in several lines of communication; one concerns other team members and the authority invested in each member of the team; another concerns the discipline to which the staff member belongs. The culture of a discipline is transmitted from the head of the discipline at the central administration level through the head of the discipline on the section to other members of the discipline.

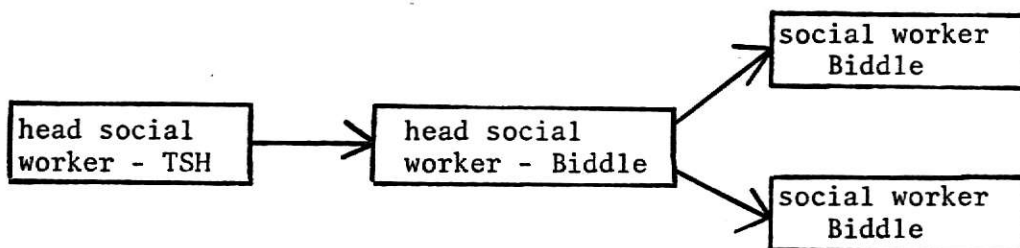


Fig. 2.--Lines of authority within a discipline.

Through these different lines of communication conflicting messages may reach a staff member. Needs of the section may dictate a different approach to a problem than is usually practiced by members of a discipline. When these problems arise--as they often do--the differences are worked out between the section chief and the head of the discipline at the central administration level.



### The section chief

Patterns of communication between the section chief and the rest of the section are diagrammed below.

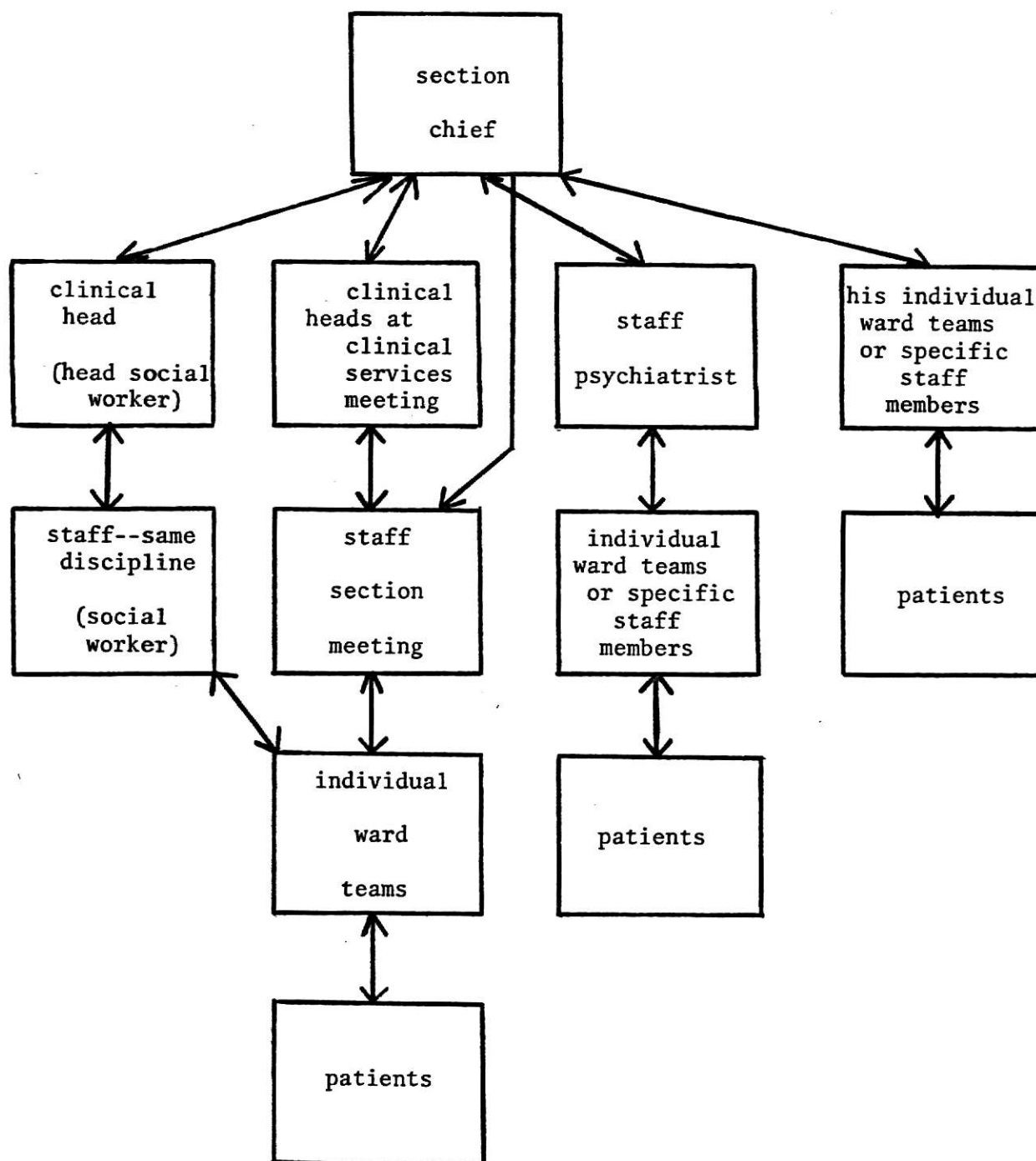


Fig. 3.--Communications between section chief and section.

Since the section chief, other psychiatrists, and the psychologists may take patients in individual psychotherapy or may have therapy groups which cut across ward lines, the pattern is more complicated than illustrated above. However, for the purpose of this report it is adequate.

### Patterns of Informal Communication

#### Role Assumed by Section Nurse

It became apparent when the head nurse of the section was off an extended period of time because of illness that she played a vital role in communications on the section. She had developed a pattern of making ward rounds about three times a week. This kept her constantly informed about all the wards on the section. She, in turn, supplied small links in the communication chain to keep all the ward staffs well informed and communications current and circulating.<sup>1</sup>

#### The Grapevine

This pattern of informal communication is found within every organization. On this section it seems to have its greatest impact in relation to communication systems which impinge on the section and especially in relation to messages from central administration and DIM.

### Summary

A closer examination of the specific roles of various staff members and of patient-staff relationships is afforded by the brochure.<sup>2</sup>

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<sup>1</sup>Dr. James Horne, personal interview, Topeka State hospital, March 1970.

<sup>2</sup>Refer to "The Hospital Team" in the brochure--Appendix C.

It needs to be noted that a very similar formal communication structure is common to the other two adult inpatient treatment sections at TSH.

## CHAPTER IV

### IMPINGING COMMUNICATION SYSTEMS

#### The Diagram

This illustrates in a general way what outside communication systems influence Biddle and vice versa.

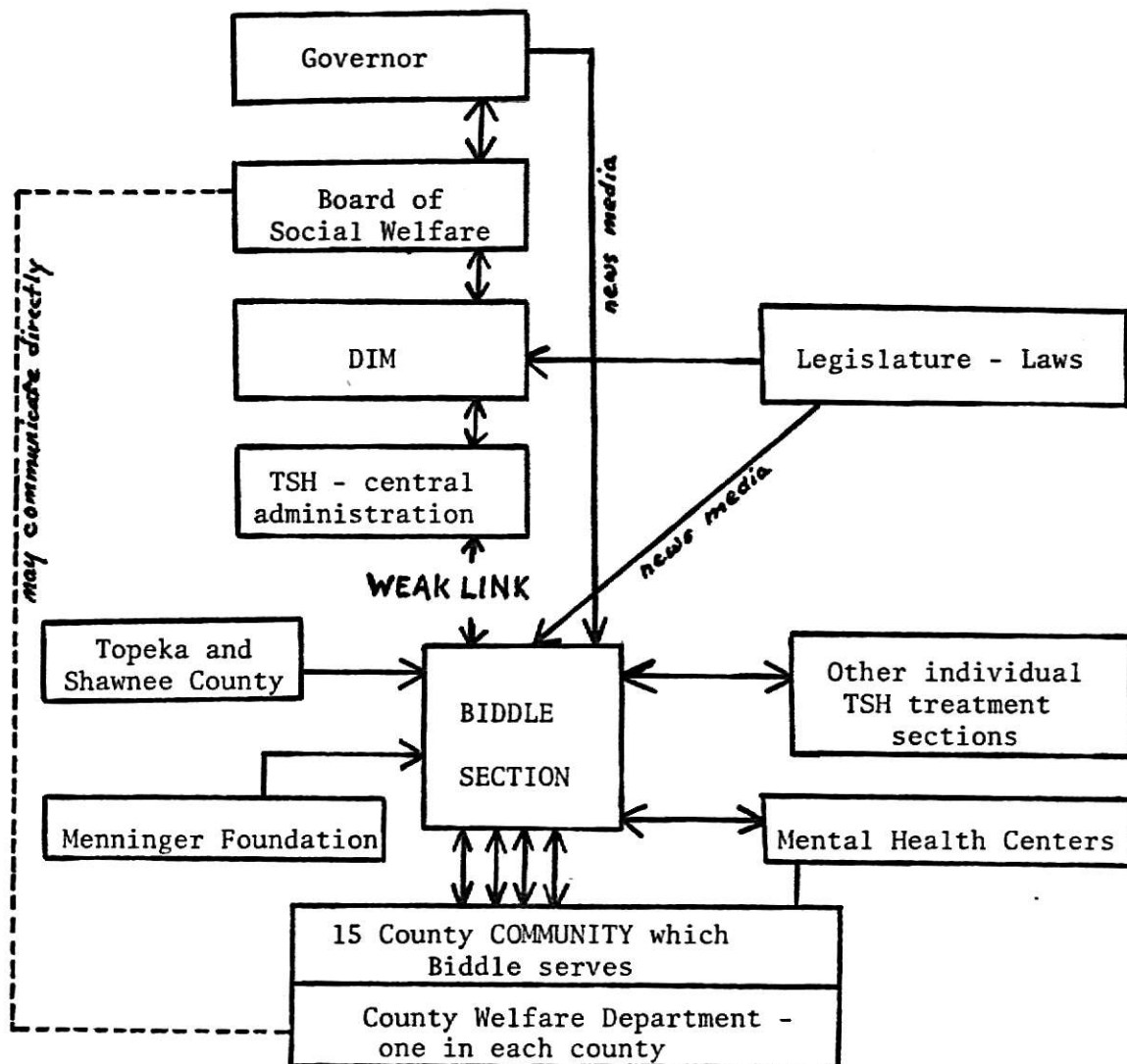


Fig. 4.-- Biddle and impinging communication systems.

### Common Ways in Which These Systems Interact with Biddle

#### The Community Biddle Serves

In order to develop closer ties with this fifteen-county area, Biddle sponsored "community day" in the fall of 1968 and repeated it in the fall of 1969. Biddle asked the caregivers who attended "community day" how the section could better meet their needs. The brochure developed as a result of Biddle's interest in responding to these needs.

The types and ages of patients sent by the community to the hospital influence the treatment program on the section and determine the kinds of problems, in part, which the section faces. In turn, the section influences the community by placing patients in nursing homes and offering consultation to community caregivers and professionals.

#### County Welfare Departments

Each county has a department and these departments may communicate directly with the board of social welfare. The section has found that in many counties the county welfare director is the section's most valuable link to the community.

#### The Mental Health Centers

Development of mental health centers like Prairie View has influenced the role which Biddle plays in the community as well as influencing the number and kinds of patients admitted to the hospital.

#### Topeka and Shawnee County

The city of Topeka and Shawnee county influence Biddle because the hospital is located in this area. Patients' lives are directly affected by

the willingness of Topeka employers to hire the mentally ill and by the willingness of educational and training facilities in the area to accept patients. The use of facilities like the public swimming pools depends on the acceptance of patients by the general public.

#### The Menninger Foundation

Biddle is influenced from this source through news media channels and through the hospital's use of consultants from the Menninger Foundation.

#### Other TSH Treatment Sections

Decisions made by other treatment sections influence Biddle and vice versa. One example in relation to the brochure makes this clear.

The other summer student in the public information office worked with Eastman (one of the other adult inpatient treatment sections at TSH) on a brochure. Following Biddle's first discussion about using a patient for pictures in its brochure, the student suggested the same idea at an Eastman clinical services meeting. The idea was not accepted, and the student was not aware of further discussion about it on that section. Four to six weeks later Biddle decided to use the idea. At an Eastman staff meeting when the student mentioned Biddle's decision, the Eastman staff immediately decided to follow suit.<sup>1</sup>

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<sup>1</sup>As reported by Jean Hershey, summer 1969.

The Central Administration at TSH, DIM  
and the State (the Governor  
and the Legislature)

Fiscal matters and broad policies legislated by these groups greatly influence Biddle. For patients, the amount budgeted to run the section (and the whole hospital) is reflected by the number and quality of treatment programs which are available. Biddle's primary need is for personnel. The section feels it is grossly understaffed for what it is being asked to do. Many of the best aides--because they care and give of themselves extensively --become emotionally exhausted by the third or fourth straight day at work. But because of a shortage of personnel they must work six days before having a day off. Under these circumstances, the quality of care and help which patients need cannot be consistently maintained. And working conditions and wages for staff are directly affected by decisions at these levels.

In Figure 4 the breakdown in communications between the central administration at TSH and Biddle is indicated by the label "weak link". There is very little effective communication to the section at this point. To compound the problem, communications from the section concerning its needs and problems are largely ignored by the legislature.<sup>2</sup>

One source of staff frustration is the delayed response to budget requests. Each January, preparation of the budget which will go into effect in July of the following year (eighteen months later) is begun. The budget request for needed personnel and equipment is revised by central administration and DIM before being submitted by the governor to the state legislature. In addition to this built-in governmental time lag, the state has

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<sup>2</sup>Dr. James Horne, personal interview, March, 1970.

been economizing in recent years. The result has been continued failure by the legislature to adequately respond to the section's repeated requests for increased personnel, wages, and equipment. To complete the helpless stance of the staff, collective bargaining is not legalized or legitimized for state employees. As a group the staff cannot stand up and bargain in a self-respecting way for what it knows or believes is needed. And disconcertingly, the section finds there is continual direct bombardment through the news media from the legislature and the governor's office.<sup>3</sup>

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<sup>3</sup>Ibid.



## CHAPTER V

### THE BROCHURE, THE INTERN AND BIDDLE

The intern worked under the public information director who was responsible to the superintendent of TSH. She was assigned by the director to work with Biddle on a brochure about the section.

Two of the three adult inpatient sections at TSH, Biddle and Eastman, are located outside the geographic area which they serve. It is felt that this makes for added problems in communication and understanding between these sections and their communities. In an attempt to bridge this gap, Biddle sponsored a "community day" for various community caregivers and professionals in the fall of 1968. The visitors were asked to fill out a questionnaire by which Biddle attempted to assess (1) the visitors' needs in relation to Biddle and the community, (2) how meaningful the community day program was to the visitors, and (3) how communication and understanding between Biddle and the community could be improved.

Carolyn Foland, the public information director, regularly attended weekly clinical services meetings on each section. She became aware of concern by Biddle staff for a better working relationship with the community. The staff recognized that there were unmet community needs and communication problems between the community and the section.<sup>1</sup> Thus, for the

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<sup>1</sup>See Section Meeting minutes dated August 14, 1968, August 21, 1968, October 9, 1968 and October 16, 1968 in Appendix B.

summer of 1969, she offered the services of the two summer students in her office to Biddle and Eastman to help these sections develop brochures.

### Implementation

The public information director made the initial contact with the Biddle section chief, Dr. James Horne, concerning the brochure. She instructed the intern that her initial step should be to arrange a meeting with Dr. Horne.

#### Setting the Scene--The First Meetings

##### With the section chief

The intern's first contact with Biddle section was a half hour meeting with Dr. Horne, at which the following steps were suggested:

- (1) Intern to attend next clinical services meeting. At that time she would meet the staff's clinical services committee and ideas for the brochure would be discussed. The intern should attend these meetings weekly.
- (2) Intern should attend weekly section meetings. The section chief gave the intern a preliminary introduction to the structure of the section concerning section meetings, the ward set up, and the use of teams and team meetings.
- (3) Dr. Horne made one hour of his time available to the intern on a weekly basis. The time for that weekly meeting was scheduled.
- (4) The intern should get feedback from everybody possible concerning the brochure. Dr. Horne indicated that "yes" he had many ideas about what he wanted in the brochure and "no" he would not share them with the intern at that time.

The clinical services meeting

Dr. Horne introduced the intern to all the staff present at the first meeting and explained the purpose of her presence. Discussion about the brochure and the public for whom it should be written followed. Before the meeting closed, Dr. Horne set up the structure by which the intern could begin gathering information. He suggested that the intern meet individually within the next week or two with each member of the clinical services committee. He suggested that she also schedule appointments with several committee members who were not present at this first meeting.<sup>2</sup>

The first misconception.--The minutes from this first clinical services meeting stated in part:

Discussed meetings of Biddle Staff members with...., graduate student in Mental Health Mass Communications program, who is assigned to this section for the summer. Decided to work with her in writing a booklet for the people we work with,....all of whom refer patients.

The intern was amused at the way this was worded so, at the next meeting with Dr. Horne, said, "Gee thanks for agreeing to work with me!" as she showed him the minutes. He immediately retorted, "The joke's on you. The memo means what it says."

Then he went on to explain that whether the brochure was developed or not did indeed depend on a consensus of the clinical services committee and that the idea could have been rejected at that meeting. Until this moment the intern had been under the impression that the decision to have a brochure had been firm before her first contact with the section.

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<sup>2</sup>Clinical Services Meeting minutes dated June 13, 1969 in Appendix A.

The incident was brought up by Dr. Horne at the next clinical services meeting where the joke on the intern was appreciated by all.

#### The section meetings

The intern attended the first section meeting as an observer only. At the second section meeting she was introduced to the staff and her presence explained. The staff was told the brochure needed to represent the thinking of the whole section. For this to be accomplished the intern would need to visit the wards and attend team meetings.<sup>3</sup> A representative of each ward was called on to give the intern the day and time of that ward's weekly team meeting. Ideas concerning the content of the brochure were brought up. For example, at this meeting the staff expressed concern because communities do not tell patients the truth. Sometimes patients are not told they are being brought to Topeka State hospital or are promised that they will be in the hospital only a limited period of time, whereas on admission no one knows how long the patient will stay.<sup>4</sup>

### The Decision Making and Communication Structure as It Evolved

#### Functioning of various groups

Clinical services meetings.--It immediately developed that this was the primary decision making group for the brochure. This group structured the intern's role, roles to be played by the rest of the section and by the community, and their own role.

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<sup>3</sup>Section Meeting minutes dated June 25, 1969 in Appendix B.

<sup>4</sup>See "Admission" in brochure--Appendix C.

Section meetings.--In regard to the brochure, these meetings were used, in general, as a clearing house for all levels of staff concerns. At these meetings problems were clarified and discussed, information disseminated to all the staff, and decisions delegated to the section were made. As the same members of the staff do not attend section meetings each week this "group" is never constant. However, the authority of the group, whatever its composition, appeared to be accepted by the whole staff.

Teams and team meetings.--Decisions relating to the running of the ward and to the treatment of the patients were made by the teams. Teams operate differently on different wards. But regardless of the structure or the operation of the various teams there appeared to be one constant--the concept of the "team approach" in treating patients.

Roles accepted, assigned and developed

Role of the section chief.--Dr. Horne opened up channels of communication to the intern and helped to keep these channels open throughout the summer.

At the clinical services meetings and the section meetings, both of which he chaired, time to discuss problems or answer questions in relation to the brochure was routinely provided. He also provided the initial structure through which the intern could begin to collect information. The intern was included in a visit by a small group of Biddle staff to Prairie View mental health center. During this visit the intern was given time to discuss with Prairie View personnel the kind of information which they felt should be included in the brochure.

Dr. Horne made available to the intern one hour weekly of his time. Because of this, problems could be dealt with as they arose and information gathered over the summer without serious interruption. In effect, these weekly meetings meant that a resource and referral person was continuously available to the intern.

Role of the community.--Various methods of feedback were employed by Biddle staff so that the brochure would meet the needs of the community for information about the section. The staff, both individually and collectively, gave the intern many suggestions about how to get an accurate picture of what the community wanted and needed to know about Biddle. After the first clinical services meeting, the intern was given the breakdown of the questionnaires from the 1968 county day. Later she was given the questionnaires, themselves, to review. As mentioned above, she was included in one of the bimonthly trips which staff on the section make to Prairie View mental health center. Dr. Horne called the judge of Osage county and paved the way for the intern to visit there, although time limitations prevented the intern from carrying through on this suggestion.

Later developments, in the fall of 1969 after the intern had left, indicate how important Biddle staff felt it was to get adequate feedback from the community. Selections from the brochure were on display at county day in October 1969. The staff decided that an evaluation sheet should be included with the brochure when it is sent out, and that the needs expressed by county caregivers at the 1969 county day should be incorporated in the brochure before it went to press. In addition, copies of the rough draft

of the brochure were sent to eight people in the community for review and criticism.<sup>5</sup>

Role of the intern.--At the second clinical services meeting the intern asked the group to define her role. During this and several subsequent meetings it became clear that the intern was to: (1) collect information from professional and non-professional staff on all wards and shifts in order to make the brochure as broad based as possible, (2) assess, using various sources, the information needs of the community regarding the patients, admission procedures, the hospital and Biddle section, (3) learn about the entire section and get a feeling for its treatment program, its problems and the differences within the section (to do this, it was suggested that the intern get acquainted with all shifts and all the wards), (4) understand admission policies and the treatment program from the patient's point of view (for instance, it was arranged for the intern to be present during an admission), (5) write the copy for the brochure and submit it to the staff for review, and (6) gather ideas for the format of the brochure and present these to the staff.

Role of the clinical services committee. Members of this group, both individually and collectively, outlined the areas which factual material in the brochure should cover.<sup>6</sup> They structured the intern's relationship to the community and to the rest of the staff. They picked the

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<sup>5</sup>See Clinical Services Meeting minutes dated September 12, 1969, October 17, 1969 and October 24, 1969 in Appendix A.

<sup>6</sup>For an example see Clinical Services Meeting minutes dated June 27, 1969 in Appendix A.

public for the brochure, reserved the right to review and edit the final copy, and decided on the color of the cover of the brochure.

They outlined the sources from which information would be collected and considered. This included, before the brochure was completed, the community, the professional and the non-professional staff on Biddle and allied services, patients on Biddle, experts outside the section (particularly in relation to legal admission policies), the intern, and the director of the public information office.

They determined the emphasis of the brochure. For example, the importance of the team in the patient's treatment needed to be understood in the community and became a point which was emphasized in the brochure.<sup>7</sup> The importance of giving the community not just the facts but a feeling for what it means to be in a mental hospital is reflected in the final form of the brochure. This concern came across to the intern and led to a meeting of the minds along specific lines:

- (1) "Tell it like it is."
- (2) Help the community understand what the patient is like and the problems the staff must deal with.
- (3) Emphasize the team concept and its use--show the team in action.
- (4) Explain the "whys" behind certain rules.
- (5) Show the patient's role in treatment.
- (6) Help the community understand its role in helping the patient and the staff.
- (7) Acknowledge the "extended community" concept and Biddle's role

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<sup>7</sup>Refer to Clinical Services Meeting minutes dated July 25, 1969 in Appendix A and to the brochure in Appendix C.



in relation to the whole community.

- (8) Give an emotional tone--a feeling for "how it is"--so the community can understand what the hospital is like for the patient.

This committee delegated many decisions to the whole section so that involvement in the brochure was broad-based. The brochure was designed to meet specific needs of a wide segment of the community and to represent the thinking of the whole section.

Role of the teams.--The role of the teams overlapped the role of the clinical services committee in regard to deciding on the factual material and the areas of emphasis to include in the brochure. This was because the intern was instructed to gather information from the whole section. In addition, many members of the committee were also involved with one or more teams. Individual teams and team members facilitated the gathering of information and other material for the brochure by their close and continued cooperation with the intern.

However, decisions about the brochure which involved the patients were taken back to individual ward teams for discussion. The use of quotations from patients and the use of patients' pictures in the brochure ultimately depended on individual team decisions. A consensus from the whole staff was obtained at section meetings before final decision-making was delegated to individual teams.

### Dimensions of the Brochure

#### Objectives

The first stated objective of the brochure was to present facts about the section and the hospital to professionals and caregivers in the

community. This was to be information for which the brochure's public had indicated a need. Yet, from the beginning of the project the staff was aware of wanting to include in the brochure not only facts but a feeling for the patients, for the section, for what treatment is and for what it means to be mentally ill. They wanted the public to experience the hospital and treatment as the patient knows it. In attempting to do this, various stages evolved in the development of the brochure.

### The Stages of Development

#### Relating to the factual information

Communication channels were used to involve 1) the intern in the section and 2) the section in contributing information for the brochure. Lines of communication proceeded from the section chief to the clinical services meeting; then from the clinical services meeting directly to the ward teams or through the section meeting to the ward teams. The intern collected information at clinical services meetings, section meetings, team meetings; and from individuals on the section, in the community, and in the larger hospital (TSH). This was a continuous process over the whole summer. For instance, it was at a section meeting late in August<sup>8</sup> that an aide mentioned that the hospital's alcoholism program should be included; with this the rest of the staff concurred.

In turn, the intern read samples of the copy both at clinical services meetings and section meetings at various times during the summer. Then the

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<sup>8</sup>August 20, 1969 Section Meeting.

clinical services committee spent several months reviewing and editing the intern's final copy.<sup>9</sup>

The second dimension of the brochure developed slowly over the summer. Eventually two techniques were used which, it was hoped, would convey an emotional tone through the brochure and enable the public to get a feeling for the patients and the section.

#### Relating to use of quotations

The intern felt that quotations from patients would help the community to see the hospital and the treatment program through the patient's eyes. Thus it was suggested that facts in the brochure be presented in conjunction with statements by patients about the hospital, the treatment program, and mental illness. This would contribute to the goal of "tell it like it is" as well as to an understanding of both the patient and the section.

The clinical services committee was receptive to the idea. The intern suggested that patients on one ward might be willing to contribute in this way to the brochure. It was acceptable that the intern discuss this with the ward team. The intern was invited by the ward aides to explain the idea to the patients. The patients chose to participate, so the aides structured a group meeting and skillfully drew out individual feelings about being in a mental hospital, about the treatment program, and about the section. The quotations in italics in the brochure are from the patients on this ward. The quotations reflect the same opinions these patients express in private. These statements of the patients' feelings are woven into the factual mater-

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<sup>9</sup>See Clinical Services Meeting minutes dated October 17, 1969, October 24, 1969, November 7, 1969 and November 14, 1969 in Appendix A.

ial throughout the brochure and are kept relevant to the facts being presented.

Relating to use of pictures.

The use of pictures in the brochure to create an emotional tone developed in a much more complicated manner. It seemed that the staff expected to use pictures in the brochure right from the beginning. As ideas about using pictures began to be explored in clinical services meetings it appeared to the intern that pictures could be used both to unify the brochure and to tell a story. As an example of how this could be done, the intern showed the clinical services committee a very effective and appealing brochure put out by a general hospital. Then the intern presented the idea of using a patient--one who could be recognized, who would appear in many of the pictures, and with whom others could identify--in the pictures rather than someone posing as a patient. The patient would be shown in various situations which most patients encounter during their hospital stay. The patient could be shown being admitted to the hospital, interacting with an aide, scrubbing walls, being in seclusion, or visiting with a friend in the coffee shop.

TSH had never before permitted patients to appear in pictures for publication where they could be identified. Some of the staff expressed grave doubts about the idea; however, it was not rejected completely.<sup>10</sup> The staff objections to the use of patient pictures as proposed were valid within certain contexts and led the intern to several times state that patients pictures should not be used unless everyone on the staff was com-

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<sup>10</sup>See Clinical Services Meeting minutes dated July 11, 1969 in Appendix A.

fortable with the idea. The staff objected for the following reasons:

- (1) TSH policy did not allow such use of patients' pictures.
- (2) Therapeutically it might not be good for the patient--the staff should question why a patient would volunteer and why the staff would permit the patient to be used.
- (3) The patient might volunteer and then regret the decision in the future.
- (4) The brochure would be evidence which the community could use against the patient since it would conceivably be in circulation for years.

The intern's position on the use of the pictures as presented to the staff was:

- (1) In her opinion there was a changing community feeling toward mental illness--a healthy growing attitude that mental illness is not something to be ashamed of and hide. Furthermore, this attitude needed support; in effect, Biddle would be supporting it by using a patient in the pictures.
- (2) Only patients, themselves, can authentically convey the message of what it means to be ill or troubled, to be in treatment, or in a mental hospital. In pictures, staff can never adequately substitute for patients.
- (3) The authenticity of the brochure would be increased. The section would more truly "tell it as it is" by presenting the unit and its treatment program as it existed at the moment.
- (4) Where patients are active members of the treatment team their choice should be considered. Thus the staff would be keeping

faith with how it says the section functions.

- (5) The use of one patient predominantly in the brochure would give it unity and a personal message. It would help to say-- this is about people, not just statistics or facts.

This use of patients in pictures was discussed in clinical services meetings for several weeks. It was then decided that "this matter is to be discussed by the teams and the patients and then finally in Section Meeting to come to some decision."<sup>11</sup> The idea was presented in section meeting and then taken back to the individual teams for further staff discussion. Later the teams presented the idea to the patients and allowed interested patients to volunteer to be in the pictures.<sup>12</sup> It was decided by the section that "each ward is to submit the names of those patients who volunteer to have their picture taken. They should be screened for appropriateness by the ward staff."<sup>13</sup>

Resistance to the idea was dissipated slowly through discussion. It took four to six weeks for the section to work through its feelings and to select a patient from those who had volunteered. Before making the final decision about using a patient the clinical services committee considered how the idea might affect the patient both during treatment and afterwards when back in the community. The committee decided that two of the seven volunteers might be appropriate candidates but that the final selection from among the volunteers (who were all on the same ward) was to be left

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<sup>11</sup>Clinical Services Meeting minutes, July 25, 1969. See Appendix A.

<sup>12</sup>See Section Meeting minutes dated July 30, 1969 and August 6, 1969 in Appendix B.

<sup>13</sup>Section Meeting minutes, August 6, 1969. See Appendix B.

to the ward team. Legal aspects were discussed but the decision was made to go ahead with the idea.<sup>14</sup> Actually, the clinical services committee had delegated the decision to the section. Even after the clinical services committee decision to go ahead with the idea, the staff was asked again at a section meeting by both the section chief and the intern to voice any objections if any were held. It was explained again that pictures should not be used as proposed unless the whole section was in agreement, for the decision had too far reaching consequences for any objection to be overruled.

### Communications

#### Concerning the Copy and the Quotations

There appeared to be a consistent structure on Biddle which involved ways communication can flow, agreement on basic underlying concepts by the professional staff, and the professional staff's support by action of verbalized communications to the intern, to each other, and to the rest of the staff. That communication was open and certain basic tenets agreed upon does not imply there were no differences of opinion. The intern did not encounter communication problems while collecting factual material or quotations for the brochure.

#### Concerning the Pictures

The idea of using a patient who could be identified throughout the brochure was taken back to all the ward teams. The problems this would present and the thinking of the clinical services committee, both for and against the idea, was explained. Ward teams were asked to discuss the

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<sup>14</sup>See Clinical Services Meeting minutes dated August 8, 1969 in Appendix A.

idea and then present it to the patients. The idea was discussed at several section meetings by the entire staff. During this same interval Dr. Alfred Paul Bay, superintendent of TSH, was contacted and his permission requested for such a step.

After the teams presented the list of volunteers, and after permission was given by Dr. Bay and the idea had been approved at both section and clinical services meetings, the intern was instructed to take the pictures. She was told to contact the ward team which had submitted the names of the seven volunteers. She was to convey the message that final selection of the patient was to be by that team, and she was to make all further arrangements through the team.

#### Communications with BH-4 staff

BH-4, a woman's ward, submitted the names of seven volunteers at section meeting. Several of these patients were considered by the clinical services committee to be appropriate candidates to be used in the pictures. As an example, Dr. Horne mentioned one specifically that he thought might be a good candidate, and the staff discussed the reasons why in detail. After this meeting the intern was told to contact the team on this ward.

Choosing the patient.--The intern contacted the ward by phone and arranged to be on the ward at a time designated by the staff. Once on the ward, she attempted to make contact with the ward nurse to explain the situation but was referred to members of the team who were busy in the office. Finally one nurse trainee and one aide (who divided her time between charting and listening to the intern) discussed the matter with her. A second aide, the day shift charge aide, was in and out of the office during this time. The nurse on the ward was elsewhere. The intern, while explain-



ing what decision the clinical services committee had come to, mentioned that Dr. Horne had felt a certain patient might be appropriate and why. The intern emphasized, however, that it was up to the ward team to make the selection; using this one patient was a suggestion only.

After a brief discussion, those of the team who were present felt that the patient mentioned by Dr. Horne would be appropriate. A time was set up for the following week when the intern would again talk to the team and then to the patient regarding specific plans for picture taking. The intern, being uneasy about whether this was a "team decision", tried to be sure the nurse and the day shift charge aide were informed about the decision and in agreement with it. When the intern left it appeared that all the staff present were in general agreement on the one patient. The intern was uncomfortable with the selection, having seen the patient previously at a party on another ward.

The next week when the intern arrived on the ward at the appointed time she was met by agitated members of the team. This time the day shift charge aide was spokesman for the group. Behavior of the selected patient during the interval had caused the team to reconsider its decision. At this point they felt they had been wrong in selecting this patient--that the decision was not in the best interest of either the patient or the ward. It should be noted that every member of the team who was present was actively interested and involved at this point.

When the intern immediately sanctioned the group's decision to reverse itself about the patient, saying that the decision was to be a team decision with which all members should agree, the charge aide responded with disbelief. The silence which followed was broken when the aide mumbled, "It usually

doesn't work this way." The aide continued to exhibit disbelief that the new team decision would be accepted immediately and completely. Finally, in hopes of convincing the aide, the intern added helplessly that she had been uneasy with their previous decision and would welcome another patient being picked instead. This convinced the team that the decision was indeed theirs. Their relief was felt. All concerned began to plan actively with the intern about another patient who, they all had agreed, would be a more appropriate choice. By the time the discussion was over, the team had planned with the intern what the next steps would be. The team would discuss the decision with the patient. If she was still agreeable to posing for the pictures the intern would talk with her--explain about the shots which were wanted and discuss the patient's feelings about the brochure, etc.

Preparatory steps taken.--Communications at this point became quite involved. The intern found it necessary to communicate closely with the ward team, the patient, the ward psychiatrist, and the hospital photographer who would be taking the pictures. With the advice and counsel of both the section chief and the public information director she was able to do this successfully.

The ward psychiatrist was on vacation when the team decided to change to another patient for the pictures. The intern was advised by the section chief to get in touch with the psychiatrist at home. The psychiatrist endorsed the team decision and explained why therapeutically it was a good step for this patient to have taken.

After the team had told the patient of its decision and had determined that the patient was still willing to volunteer for pictures, a meeting was arranged between the intern and the patient. The nurse trainee was present at the meeting as the representative of the team. The intern wanted to be sure that the patient had considered the various implications of this move. She also acquainted the patient with the types of pictures which were wanted. The patient was told that if she had objections to any of the proposed pictures they could be omitted.

What the section had decided also had to be presented to the hospital photographer in detail. He was a former patient and had many feelings about protecting the patients and their rights to privacy. What shots the intern hoped to use, why the section had decided to use a patient, that the superintendent supported the project--all were explained in detail.

When time came to plan out the details, the patient, the nurse trainee (who was designated again by the day shift to handle this), and the intern met again. The nurse and patient were asked to make suggestions concerning certain pictures. When problems developed which revolved around finding the patient a "substitute mother" for one picture the intern contacted the ward psychiatrist again.

The psychiatrist had returned from vacation. During the meeting the intern discussed all that had transpired in detail. In turn, the psychiatrist pointed out to the intern how the patient was manipulating the nurse; where there was breakdown in team functioning and the consequences of this; and how the patient's present behavior indicated healthy changes in attitude and the significance of these changes.

Noting that the aides on the afternoon shift had not been involved, the psychiatrist arranged for the intern to meet with them and explain about the brochure and the pictures of the patient which were wanted. The intern then left a list of the proposed shots for all three shifts to examine and accept or reject. Thus, through the direction of the psychiatrist, all three shifts were eventually involved in deciding on the pictures.

Taking the pictures.--When the intern initially contacted the ward, certain members of the team had not been available to the intern or had been "too busy" to discuss the project. Following the acceptance of the team decision to use another patient, this changed. From that point on, the intern found the staff available as needed to make the project a success. What could have proved to be an impossible task of rounding up people and getting appropriate changes made for what was needed, instead became a highly rewarding and most pleasurable series of experiences.

Staff members discussed the project with all the patients at ward government meetings and with the patient who had volunteered. They helped her work through her feelings. They helped her plan what she would wear and get ready.

The day that the pictures were taken on the ward all the staff on duty cooperated to make this a success. Different team members were available to help move furniture, get needed props, set up rooms and be in the pictures. They freely offered suggestions which changed and enhanced the pictures and contributed to their validity and believability.

One shot was to be of the patient in seclusion. When the only appropriate seclusion room was occupied, the staff decided to take the seclusion

patient out on the ward so the room could be used for the picture. Then to take the shot, the photographer needed the hall lights out; they were on the same switch as the day room lights, but the staff turned them off even though other patients were inconvenienced for a while.

This kind of staff participation and cooperation continued over the period of two to three weeks the pictures were planned for and taken. For instance, on another day the patient was needed to pose for pictures with a male patient from another ward. Although it was inconvenient, the staff saw that arrangements were made and followed through so that the patient was available and ready on very short notice.

#### Communications with F Cottage staff

There had been several discussions on the section about the need for male patients to also appear in some of the pictures. The staff felt that only the one patient should be identifiable in the pictures but that other patients could be used in pictures where they could not be identified. Up the time of the section meeting on August 20, no male patients had volunteered for the pictures. That day at section meeting the problem came up again. This prompted a male aide to ask many questions about the brochure. Before the meeting closed, personnel on two men's wards, BH-3 and F Cottage, said they might have patients who would volunteer. They were to let the intern know.<sup>15</sup> On BH-3, the patient who initially agreed to be in some of the pictures backed out.

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<sup>15</sup>See Section Meeting minutes dated August 20, 1969 in Appendix B.

Communications between the intern and the male aide on F Cottage were accompanied by long periods of silence. When several days after the section meeting the intern had not heard from the aide, she contacted him. He needed a little more time but would get in touch with the intern early the following week. The following week he put the intern off again saying there was a little trouble, but he would get it straightened out and let the intern know soon who would be available.

Quite by accident, the intern mentioned this conversation to the ward psychiatrist. The psychiatrist looked knowing and said--he didn't tell you what kind of trouble did he? Then it was explained that the aide had taken matters into his own hands without going through the team, so other team members were seeing to it that any decisions made were team, not individual, decisions. When problems finally were ironed out, the staff and patients helped make this last part of the project a success also.

## CHAPTER VI

### THE AIDES AND THE MESSAGE

What is the believability of the unit message in various types of communications to the aides on Biddle? How do the aides communicate and interact with various other groups? What kind of communication problems arise? Why do they arise?

#### Philosophy of the Section and the Section Chief

The philosophy of the section chief can be found in two unpublished papers. In a paper entitled "Clusters" he says:

For the purposes of this paper let us define "cluster" as a group of people of approximately equal authority-responsibility for direct or indirect functions contributing to patient treatment...

Decisions should be reached by consensus since they require the wholehearted cooperation of all cluster members to be effective. The head of the cluster may make some decisions but unless they are acceptable to all members of his cluster they will not be carried out effectively. Veto power does not rest on any individual's "right" but on the need of a cluster for consensus if it is to function effectively. All members of a cluster share a common duty to consider the many factors involved in a decision and to work out an agreeable course of action.<sup>1</sup>

The TSH Reorganization Committee, of which Dr. Horne was chairman, stated in its September 1969 report under the section entitled "Responsibilities of the Section Chief":

He will be responsible for establishing effective means of communication among members of his section. He must encourage staff participation in the resolution of differences about treatment goals for specific patients so that such decisions are not made unilaterally. He must maintain the integrity of the team concept by insuring participation by all disciplines in treatment planning so that

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<sup>1</sup>"Clusters", (August, 1968.) From the personal file of Dr. Horne.

high quality multi-discipline treatment can be implemented. He is also responsible for personnel without clinical departments. The aides are, at present, in an ambiguous position. They are included in "nursing services" with registered nurses. Aides are officially represented at a section level, but not at the hospital level. (Except for selected representatives from the sections, invited by the Clinical Director to his weekly meetings).<sup>2</sup>

However, Dr. Horne said about Biddle, "I was just lucky to plug into a pretty good communication system. I didn't set this all up."<sup>3</sup>

#### Position of Aides at TSH

As stated above, the aides are in an "ambiguous position" within the hospital structure. They are included in the nursing service department and are not officially represented at the hospital level. They are represented on the clinical services committee on the section level. In the past they have not been involved in hospital decision making. As reviewed in chapter two, the role they were assigned in the past differed greatly from their present role on Biddle. But the aides needs, potentials, and resources have not been fully recognized and used until recently. In many ways, the aides still feel they are not getting the recognition, acceptance, and help they deserve and need; and they resent this.

In addition, they are trapped between poor paying jobs and the huge educational gap which still exists at TSH between the professional and non-professional staff. For these aides, however capable they might be, it is exceedingly difficult to move up the career ladder.

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<sup>2</sup>"Reorganization Committee Report [Topeka State Hospital]," p.3. (Sept. 26, 1969)

<sup>3</sup>Personal interview, March, 1970.



Another factor is the social status of this group. Many can find no satisfactory alternatives for employment outside the hospital.

The perceived availability of outside alternatives is a function of the social status of the participant. Members of low status groups will perceive movement to be more difficult than will members of high status groups. Thus, we would predict lower voluntary turnover among Negroes than among whites, lower among Jews than among Gentiles, lower among foreign-born than among native-born citizens.<sup>4</sup>

The communications structure as previously described is common to all the adult inpatient sections at TSH. That it is not the communication structure itself but how it is used which has importance for the aides, can be illustrated by this example from a ward on another section of TSH.

The intern's first week at TSH was spent on one ward on another section. There she got acquainted with the patients as well as the personnel and routines on all three shifts. By the third day, the intern was aware of a strong undercurrent of tension among the staff. The reasons for this were not known. It should be noted that this ward differed in one respect from any ward on Biddle; it was a training ward for resident psychiatrists. At a team meeting which the intern attended, the resident psychiatrist in charge of a disturbing young patient insisted that the staff suggest how this patient should be handled. No one offered a suggestion. The resident demanded an answer a second and then a third time. Finally, when he became quite insistent on an answer, one aide made a suggestion. Then other aides joined in; quickly the aides reached a consensus as to how the situation should be handled. The resident voiced his opposition to their

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<sup>4</sup>James G. March and Herbert A. Simon, Organizations (New York: John Wiley and Sons, Inc., 1958), p. 102.

idea. Then other residents at the meeting demanded the resident make a decision about how the staff was to handle this patient. The resident's decision (which was forced on the staff) was the exact opposite of the one they had suggested.

Another example of how decisions are made on other sections at TSH shows up in the earlier example of the way Eastman section decided to use patients' pictures in its brochure.

The Believability of the Unit Message  
to Aides on Biddle

From the Professional Staff

The professional staff gave consistent evidence of supporting verbal communications by other types of communication. In regard to the brochure, the professional staff continuously reaffirmed its verbal communications to the rest of the staff through action. The professional staff (the clinical services committee is composed of all professional staff with the exception of the section aide) said that the brochure should involve the thinking of the whole section--thus it was discussed at section meetings and team meetings. Responsibility for decisions regarding the patient's welfare was delegated to the patient's individual team and to the section as a whole. The professional staff supported these section and team decisions.

The professional members of the team on BH-1 give the aides the choice of whether or not the patients should contribute to the brochure. In turn, the aides gave the patients the final choice.

The team on BH-4 was told to decide on the patient who would be used in the pictures. The team's choice and its decision to change that choice were supported.

When the decision about using the patient's picture was given to the section by the clinical services committee, that committee then upheld the section's decision.

Thus aides were given responsibilities and supported in decisions where they were given the authority to decide. Conversely, they were told by the professional staff on occasion what the professional staff thought should be done. There again, other kinds of communication supported the verbal one. For instance, the professional staff said that decisions regarding patients should be team decisions.

On F Cottage when the aide misread the message and tried to decide about the patient without including the team, the patient was not allowed to participate in the pictures until the problem was straightened out. Rather than allowing the aide to make this decision on his own, the professional staff enforced the use of the "team decision" concept.

On BH-4 when the psychiatrist learned that other shifts were not being involved in decisions about the patient's pictures, she saw to it that the intern discussed the pictures with the afternoon shift.

#### From the Intern

The intern attempted to give the aides a consistent message. Conversely, at no time during these three months did she feel that her presence was resented or unwelcome. She experienced cooperation at all levels beyond what had been anticipated or would have been expected.

#### Involving the Patients

A number of aides were very skilled in working with the patients therapeutically. Aides took an active part in drawing out the vital, relevant

feelings of the patients for the quotations in the brochure. They determined the best choice of patients for the brochure--both in terms of the patient, herself, and in terms of the other patients on the ward. Thus, the wrong patient was not used for the wrong reasons.

From the Central Administration and DIM

A strong current of dissatisfaction, disbelief and anxiety was present among the aides during the summer of 1969. Many of the problems which precipitated the Kansas Health Workers strike during the summer of 1968 were still present. The June 23, 1969 issue of an underground publication, periodically distributed among TSH employees, presented some of the reasons for the continuing unrest.<sup>5</sup>

Much of the unrest stemmed from policies and decisions made by DIM and central administration. Dr. Bay's (superintendent, TSH) position regarding how aides would be chosen for the experimental educational and training positions which were just opening up was an example.<sup>6</sup>

Lack of good communications (see Fig. 4) as well as poor quality messages to the section from DIM and central administration served to increase anger and unrest among the non-professional staff (often among the professional staff as well). Thus, during the summer of 1969, there was little believability by aides in the unit message from these two sources.

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<sup>5</sup>See "The Beginning or the End" in Appendix D.

<sup>6</sup>See the Section Meeting minutes dated July 23, 1969 and the three following ones dated July 30, 1969, August 6, 1969 and August 13, 1969 in Appendix B.

That some of the aide's anger toward central administration and DIM would spill over into Biddle administration might be anticipated. That conversely, Biddle administration might be linked with central administration and DIM and suffer in believability might also be expected. Dr. Horne says that both situations do occur; and they must be watched for and guarded against constantly.<sup>7</sup> For instance, the section chief agrees with the staff that more personnel are needed in certain areas and says he will request more personnel for the section. After eighteen months of waiting the staff finds the personnel still are not forthcoming. How can the section chief be believed?

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<sup>7</sup>Personal interview, March 1970.

## CHAPTER VII

### SUMMARY AND CONCLUSIONS

#### Mental Health for Patients

Biddle is a therapeutic community which derives much of its effectiveness from the kind of communications which structure it as an organization. The patients are everybody's prime concern.

The quotations in the brochure are an indication of how the patients feel about the care they receive on Biddle. And Biddle staff tells the Kansas legislature:

Only active treatment can permit 280 admissions per year with 40% currently being discharged in less than 60 days. Only active treatment can meet the needs of more and more patients admitted at younger and younger ages. (in 1968 Biddle admitted 13 patients 15 years of age or younger and 89 patients 16 to 24 years of age. One third of the patients presently being treated are 25 or younger.)<sup>1</sup>

Another indication of the quality of treatment is found in the readmission rate. TSH has the lowest readmission rate of the three mental hospitals in Kansas.

#### Staff Mental Health

The purpose of a mental hospital today is to bring better mental health to its patients. But what about the mental health of its staff? Caudill and Stainbrook say:

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<sup>1</sup>From a report entitled "Biddle" which contained the section's budget requests for 1971. From personal file of Dr. James Horne. (Typewritten.)

It also needs to be stressed that work and research must be done on the mental health of the entire staff and not only the patients... we must learn more about how to incorporate the individual within the primary group, and these groups within a structured organization, so that the goals of the individual, the group, and the organization can receive reasonable satisfaction.<sup>2</sup>

Aides have been trained to look for and interpret the various ways patients communicate. These communications may parallel, oppose, or even supplant verbal communications. It should be supposed that staff members are as sensitive to communications from other sources as they are to those from the patients. Thus it is all the more important for the administration to be aware of the kinds of communications it gives the staff. Verbal communications must be supported by other forms of communication to be believed.

#### Feeling of Community

Staff on Biddle appeared to have a "feeling of community." The observations of high morale on the section by "outsiders" helps to substantiate this fact. Probably one of the best indications of such a feeling was the high degree of cooperation which the intern received from the staff. And everyone on the section (with the possible exception of certain patients in seclusion) was potentially accessible to the intern. There were many problems which the staff faced in the summer of 1969. There was a shortage of personnel. There was a continued loss of personnel (often without adequate replacement) due to low wages and, compared to the rising cost of living, an inadequate pay scale. There were poor communications from outside the section in areas which were of vital concern to the staff. If

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<sup>2</sup>Caudill and Stainbrook, p. 40.

the brochure helped strengthen the "feeling of community", it probably was because of the broad base of involvement. A number of staff contributed information and ideas which were incorporated. All the section contributed to the decision about using a patient in the pictures.

### Strengths and Weaknesses of the Communication System

It takes a while for a consensus to develop on controversial matters. Decisions, if they are going to be valid and upheld by the staff, must not be forced. When time is of essence, the process can be frustratingly slow. Another problem, for the intern at least, was where to find the time to involve everyone who should be involved.

One of the system's major strengths is that when staff is involved in making decisions which then are respected and upheld, cooperation and action along the lines of decision seem to be almost guaranteed. A major safeguard in such a system is that when many people think about a problem from many angles the chance that a serious mistake will be made is lessened.

### Communications Reviewed

The use of a consensus as well as involvement of all personnel in this therapeutic community was evident. Decision making was shared with the patients. Furthermore, authority, when delegated, was upheld and respected.

The communication system on Biddle appeared viable. It did not appear that it was routinely bypassed or that another system was substituted instead.

The concepts enumerated in the introduction as being important concerns of the professional staff were reinforced consistently by other kinds of communication. Thus there was some acceptance of the fact that what was



verbalized was meant. Outside communications, often because they were transmitted through the Biddle administration, caused problems in regard to the believability of verbal messages. Therefore, there was testing and a not always ready acceptance of the fact that what was said was meant.

For instance, one complaint by staff about central administration was that staff opinions were asked for about a decision after the decision had been made, not before.

#### Relation of the Intern to Biddle

The intern's primary allegiance was not to Biddle. Furthermore, her association with the section was to be for a time limited period. Thus she did not develop the same amount or kind of involvement that a permanent staff member might have. This semi-detachment enabled the intern to be an observer as well as a participant.

The findings of the intern can, in large part, be substantiated by the experience which a journalist with the Topeka Capital-Journal has had on the section since the summer of 1969. The journalist<sup>3</sup> was interested in writing a long feature article about the section. Staff feelings toward the journalist, toward the project, and about whether the decision concerning the article was really the staff's to make can be found in the minutes of section meetings from December 31, 1969 to February 18, 1970.<sup>4</sup> These minutes give a telling account of how hard it was to break down resistance and bring anger out into the open. The minutes not only indicate how long and involved

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<sup>3</sup>Mrs. Stannie Anderson

<sup>4</sup>Found in Appendix B. Refer especially to the minutes of the January 14, 1970 and the January 28, 1970 meetings.

the process was, but also how much anger the staff finally expressed and worked through.

It appears that both the professional and non-professional staffs in mental hospitals need to be understood as individuals. There is a need for correctly assessing the roles various forms of communication play in facilitating or hindering human understanding among personnel. To put it another way, the promotion of good mental health through communication is needed by staff as well as patients. The examination of the communication process on Biddle can be regarded as one attempt in this direction.

#### Suggestions for Further Studies

Within the mental health field today there is a great lack of needed manpower and an almost equally great confusion of roles. To add to the confusion, communications between people can occur on many levels and in many ways; often those involved in the communications are unaware of the ways in which they are communicating and are unaware of what they are communicating.

A comparative study of several communication systems with an analysis of results obtained under different systems of organization might be illuminating. A study, in depth, of communication using non-professional staff as the focus might shed more light on the reasons for unrest among this segment of mental hospital personnel. A study of the professional staff where traditional roles are being threatened might show how this influences communications with other staff members and how this, in turn, influences the behavior of both groups.

This kind of communication study could be applied to organizations other than mental hospitals.

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## Appendix A

# **ILLEGIBLE DOCUMENT**

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

**THIS IS THE BEST  
COPY AVAILABLE**

*Biddle*

## CLINICAL SERVICES MEETING

6-13-69

A letter is to be sent to the Board of Social Welfare recommending clarification of the policy on hiring Conscientious Objectors. Dr. Bay is trying to help. Dr. Procter will follow up on a letter to be signed by the Biddle Staff, asking for clarification to be sent to the Board of Social Welfare, via Dr. Bay.

Discussed meetings of Biddle Staff members with Mrs. Glazzard, graduate student in Mental Health Mass Communications Program, who is assigned to this section for the summer. Decided to work with her in writing a booklet for the people we work with, e. g. Mental Health Centers, County Welfare Departments, Probate Judges, County Attorneys and physicians, all of whom refer patients. She will be meeting with the Clinical Services Committee in the next week or two and will discuss this further.



*Biddle*

CLINICAL SERVICES MEETING

6-27-69 69

Dr. Rainbow conducted the meeting in Dr. Horne's absence.

A discussion about Chaplain Parker's questionnaire as to whether personnel should wear uniforms or not was started. The idea was to find out how relatives of patients, personnel and patients felt about this. Not all inclusive, just a small group to be polled. Not a vote, just a survey, this came from an idea used in Colorado. In the long run, Dr. Bay will make the decision, however. Then the question of, if no uniform, what form of identification, button, badge, etc? The Statesman can publish the results of the survey and also the Public Information Office may be notified of things coming up in committee meetings which are newsworthy.

Dr. Procter mentioned that if we take psychology internes from accredited schools and we are accredited, the government furnishes money for certain programs. We will have none after August, because we have no internes.

Dr. Lindsley becomes available but we will have no money. Dr. Lindsley is coming for final time this next Wednesday. Woodsvlew will not be able to use him because of chaotic conditions at this time of year. Could we use him on Wednesday at 10 A.M. or maybe use Dr. Schlesinger's time slot? It was agreed we would check with the teams first to see if they want to use him.

Mr. Wilson, head of the teaching unit, finishing second week of summer school today. Student schedule mostly completed. Records have been mixed up. A few students have taken the same course over and have lost credits. We should have transcripts of students 25 and under. We should have a form letter set up to send to schools for transcripts. Mr. Wilson uses a mimeographed letter and telephone service.

It was suggested to put mention of school and transcripts in booklet Mrs. Glazzard is preparing for Biddle Section. This would be helpful. It would also be well to have not only grades of students, but behavioral information.

Are travel cards for students necessary or successful? Not handled too well, either by wards or teachers, but it was felt should be continued (and improved upon in handling) as it may be an incentive to get there and back on time. Patients feel there is some interest in them.

Mrs. Glazzard brought up the question of the legal aspects of various types of admission, such as the difference between informal and voluntary. It was explained that informal admission, which was new to some and hazy to most, is when a person asks to be admitted on his own sayso. He may stay as long as he desires, but when he leaves the hospital grounds, he is to be discharged. There may be a feeling of necessity, such as overnight or over a weekend, to keep from getting drunk or using drugs, etc. By this time the discussion was becoming too involved and time consuming, so the meeting had to be concluded.

The first order of business is a correction on last week's notes. Chaplain Parker was credited with issuing the questionnaire, when as a matter of fact it was a joint venture, the Employees' Council.

Dr. Procter announced that Michelle Kemp, who has a B. A. from Washburn has been hired and will report Monday possibly. Her husband is a Math Instructor at Washburn and they will likely be here in Topeka only 9 months to a year. Mr. Suderman was fired after working 2 weeks without pay and 4 days with pay because he was a C. O. The Council of Churches and the Monnonite Church are going to work on this also. The Board which had 2 members and came up with a tie, now has 3 members so a decision may be reached.

In the matter of uniforms or not, it was also mentioned that there has been a strong suggestion for name plates for all employees.

A member of the faculty of the University of Maine who lectured here last week was impressed with Topeka State Hospital, the high level of aide training and with the contact between the sexes, as they are entirely segregated in all areas and he feels Topeka State Hospital is about 100 years in advance of their facilities.

Julie Neufeld, who is working in Paraguay mentioned that it was noted in one of their bulletins that the soup should be served cooler so the patients would not burn their hands, and also they called the institution an Insane Asylum.

Mrs. Glazzard will try to have readable copy of factual information for the next meeting. It was suggested when she asked "How is a patient oriented into the ward?" that this might be a good subject for a Section Meeting. She suggested several approaches and showed some brochures from other institutions in various areas. Should there be a unified theme? A quote from a patient for a heading, perhaps. To set up some particular point. Then she suggested using actual patient's pictures, to educate the community that mental illness is on a par with physical illness. Most disagreed on this, as they felt that many communities are not ready for this yet, even though they must be educated to it. It is along slow process and it was felt that it would be at the expense of the patient, although it would be entirely voluntary. It would be effective but too drastic and though the patient might be willing now, in later years when the publication was still in use, he might regret his decision. It is against hospital policy, but this area is changing also, but all of these things are very touchy and take a long, long time.

Biddle

## CLINICAL SERVICES MEETING

7-25-69

Dr. Horne and Miss Galle reported on their Thursday trip to Lawrence. There seems to be a great deal of dissention between agencies there, Probate Court, Welfare Agency, Mental Health Center. No one has clearly defined duties, no one particularly follows up on cases. Some of the trouble is because the Mental Health Center does not have a psychiatrist. They are trying to obtain one for at least 60% time.

Mr. Nisbeth and Mr. Dirik seem to overlap in their areas. Mr. Dirik is officially the head, but to all intents and purposes, Mr. Nisbeth is. Also he is easier to deal with, Mr. Dirik tends to be very rigid. It appears everyone knows something about all of the cases, but no one is responsible for continuing follow-up or in charge. No assurance that anyone will carry through. Neither Mr. Nisbeth nor Mr. Dirik like Topeka State Hospital, most particularly the latter.

At the County Welfare Office, Dr. Horne may be able to meet with the new Director at the Bert Nash Clinic, which may help, at least the problem is understood a little better.

Anne Douglas wants to come to Biddle next Thursday until September 6, she would be quite helpful in group testing and helping Michelle Kemp. This suggestion seemed mutually agreeable.

The fact that the team does a lot of work together, helping each other, as well as with the patient is rarely mentioned, this team work is the basic factor of the whole operation and should be included in the booklet in this manner. Mrs. Glazzard talks to the BHL girls today for ideas. The patients seem eager to see her and talk with her. She had some suggestions as to format, such as using direct quotes of the patients and then leading into a discussion or rather explanation of that particular phase, which would be more interesting, just as factual but more pleasant reading. Then the subject of using pictures was brought up, should they be real patients or someone substituting for them. It was not decided, although the picture theme seemed to appeal to most (with one or two dissents). This matter is to be discussed by the teams and the patients and then finally in Section meeting to come to some decision.

## CLINICAL SERVICES MEETING 8-8-69

Dr. Rainbow is now on vacation. She will return after next week and Dr. Horne will leave for 2 weeks. Dr. Procter is getting married tomorrow and will be gone for a month. Mrs. Sylvester will be gone 2 weeks beginning Monday. Tom Coleman or Alice Hurst will fill in for her in her absence. Mr. Coleman has mononucleosis, but it is not known how severely. Mrs. Gehr should be back Monday.

Dr. Simpson, Dr. Horne and Mr. Dallum (Budget) will be on the wards 4 to 5 today. Dr. Procter mentioned getting wooden wardrobes to put beside the beds, but this was ruled out on account of fire hazard. Metal lockers have been requested in the budget. There will likely be no major changes, as some day they will either rebuild or dispense with this area and so nothing much will be done, even though this may not occur for 20 years.

Dietary has 5 kitchens and 14 dining rooms, with only a skeleton crew, no provision made for sickness or vacation, so they have a very real problem.

Liz Clark has resigned. So far no replacement. She desires no commotion about her resignation. Miss Galle will get a list of what she has tried to do and what her goals were, so we can talk to the legislators, etc. this fall about our failure to achieve these goals. Chaplain Richardson goes on vacation next week and Chaplain Parker has some possibilities for a replacement student.

In re Mr. Suderman, the new member of the Board of Social Welfare feels so far he is too inexperienced to make a decision in the matter, so it was deferred.

There have been 7 volunteer patients to permit use of their picture in the booklet. Two, it was felt would be quite good. It was tentatively decided that the patient who has volunteered, even though she is past the age of consent, part of her treatment, could be to obtain the cooperation and consent in writing from her parents. Also the legal aspects could be explored. We have Dr. Bay's permission, with valid consent of the patient, etc. We will go ahead with pictures as soon as consents are cleared. Mrs. Glazzard mentioned that she had many, many good "quotable quotes" from the patients.

She also mentioned that the climate at Winfield was very good with the community. These people are accepted in jobs and all community areas. Dr. Procter mentioned that this is true more often with retarded people than with psychiatric patients. The problems are different.



COMMUNITY SERVICES PLANNING

8-15-67

Public Information Office has set up a meeting with Mental Health representatives in our area to meet Wednesday, August 16, here at the Hospital (1 day workshop). There will be slides, lectures, etc. and at 2:45 P.M. Hospital staff will meet with them for discussion of cooperation between Mental Health Centers and the Hospital in the area of after care work in the community. This meeting will be held in Eastman Administration Bldg., Multi-purpose Room, basement. Dr. Lankford and Miss Galle will attend, among others. Also an aide, a nurse and an Adjunctive Therapist.

Pictures for the booklet were taken of Dr. Horne, Mrs. Fouts, Mrs. Plinn, Miss Galle, Mrs. French, an aide and the patient, Linda Baker, in Dr. Horne's office. This is not an ideal group for a D & A but a usual one.

Discussion of County Day and a date to be set, last year it was October 10. It was suggested that we might get the patients more involved in County Day.

Julia Kenfeld, a nurse at Prairie View REC, who has just served 3 months in Paraguay, will be here on 8 Tuesday, August 19, for the regular monthly meeting, they come here one month and the next month a group from the hospital (staff) visits them. Miss Kenfeld will talk about her experiences in Paraguay. Some of them are pretty grim.

Natalia Hill who has her Ph D in Social Work may be here as a Social Work Teacher and Supervisor, (but on the SWII level).

Discussion will continue to be held as to how 2 social workers can be stretched to cover the area needed and how aides, etc. may be utilized in some areas. However, if we do too good a job, the Legislature will say "Why bother, you aren't hurting. Just keep up the good work."

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Pictures for the booklet were taken of Dr. Horne, Mrs. Fouts, Mrs. Flinn, Miss Galle, Mrs. French, an aide and the patient, Manda Baker, in Dr. Horne's office. This is not an ideal group for a B & A but a usual one.

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## CLINICAL SERVICES MEETING

8-29-69

Sister Mary Stephen arrived unofficially Thursday, but is to be here officially Tuesday, September 2. There was discussion about where she was to be assigned, it is BH3. She will meet with all 3 shifts. Also it was discussed as to what she would wear, habit or ordinary clother. It was unanimously decided that whatever she was most comfortable in and also how she was to be addressed, which was decided the same way, whatever she is most comfortable being called. So it will probably be habit without veil and Sister Mary Stephen. Dr. Douglas will leave on vacation Wednesday, September 3, about a week before Dr. Procter returns. Miss Galle is leaving on vacation for 2 weeks, starting Tuesday, September 2. Liz Clark may fill in some. Mr. Packard will be here until September 12.

Mrs. Glazzard had the pictures from which selections are to be made for the brochure, they were excellent, really caught the spirit of the varying stages. From the pictures, it was felt that the patient seemed to relive her experiences, such as her earlier stages and later improvement.

Dr. Kowalski called Dr. Rainbow to acquaint her with a new program, which had been expended to include 2 aides from Biddlefor further education. This is a course to be presented at Washburn, under Dr. Weinbaum of Special Services, which when completed will give credit for a 2 year Associate Degree. The fees will be paid from a fund, under the Child Development Program, with the aides combining their ward work with a particular patient and their instruction at Washburn. Dr. Kowalski and Dr. Weinbaum will come to a meeting at shift change time and talk with some of the interested parties.

It was tentatively decided that the booklet would be bound in olive green paper.

B. L. L.

CLINICAL SERVICES MEETING

9-12-69

County Day form letters and card enclosure were approved as set up. Some who were at County Day last year mentioned wanting to see the wards and particularly how the patients were fed. The final idea was to show them some of the menus, of maybe a serving place, not at meal time.

Mrs. Gehr is to be notified of the count of invitations so she will know how many packets are to be prepared.

Mr. Phil Towle, Social Group Worker, is returning soon. It was suggested he be invited to a Section Meeting - he would like to observe how our teams work together. He would like to visit some of the wards also.

Peggy Glazzard is to be invited to County Day. It is hoped (but not expected) that the booklet (brochure) will be ready for County Day.

Also it was suggested and agreed that an evaluation sheet be included with the brochure to be handled by Dr. Procter when returned to us.



B. d. d. c.

CLINICAL SERVICES MEETING

10-17-69

Most of the discussion was a resume of County Day, what to and what not to do next year. Most everyone seemed pleased with the way it came off.

Dr. Hiltner can come 10 to 11, Thursday, October 30 and once a month thereafter.

Dr. Linsley will be here this Thursday.

Dr. Steve Shelton, wants orientation program on 2 wards each month, starting next Friday, October 24.

It was mentioned that Chaplain Parker did a very good job as moderator. It was noted that the people who came this year were more concerned and more open in their discussions. The idea emerged that community services were often in a power struggle and compete for funds.

A suggestion was made that perhaps we could have County Day, by separate counties and include people who would not ordinarily be included. There were few repeats this year from last, mostly new people for orientation. Opening lines of communication is the most important part of County Day.

What we learned from County Day should be incorporated in reviewing brochure material. Check 3 x 5 cards information against brochure material.

## CLINICAL SERVICES MEETING 10-24-69

First thing on the agenda was an announcement regarding contributions to the Flower and Gift Fund, which had not been handled since March, as the Secretary was unaware of this facet of the program. This is 50¢ per month and will be taken care of on a monthly basis from now on.

The rest of the time was taken up with discussion and suggested changes in the wording of the rough draft of the brochure. Everyone agreed that Mrs. Glazzard did a superb job and only scattered changes would be made.

The suggestions were to be sent to Carolyn Foland, who would edit them and if she felt it expedient, discuss them with Mrs. Glazzard.

It was suggested that copies of the rough draft be sent to the following people for suggestions, with a 10 day deadline:

Judge Nold  
Judge Cotton  
Judge Wilson  
Julia Dryden

Ron Wiebe  
Ellen Welch  
June Garrett  
Anna Reed

This was done.

CLINICAL SERVICE UNIT 11-7-69

Corrections and suggestions will be incorporated in brochure to be completed and sent to Virginia Boland very soon.

A pilot program with Hill will run several weeks, was suggested, then see what more special supervision is needed. Mr. Warner, Dr. Douglas and Miss Galle could be special consultants. As on some wards there is no social worker, nor has there been for some time, the aides need to know how to cooperate with case work and family relationships, in view of a return to the community by the patients.

Mr. Barnes is one who needs a supervisor to help with clinical work in his work with alcoholism.

Adjunctive therapy would prefer to be associated with the team, as it is now set up. All meetings seemed to point up strongly the need for a tight, close working ward team. No new syndrome, just more of what is now being done.

The alcoholism group is having a meeting Saturday, A.M. 8:30 to 12, which hopes to coordinate some programs. It was also brought out that it would help for the counselor (Mr. Barnes) to sit in on preadmissions when they are concerned with alcoholics and also to have a copy of any preadmission which is concerned with this phase. Secretary was asked to see that this was done in the future. Mrs. Jahn will represent the section for part of the Saturday meeting.

New psychology intern, Kathleen Corrigan, has dual citizenship, completed her masters in Mexico, but came here as a United States citizen. She has very little clinical experience and will probably be here only 6 months.

Elaine Melvin transferred to Asana in October, to average up positions, as Middle has 1 empty position. Social worker shortage discussed, but no real decision. More positions but pay is so low they can not be filled.

## CLINICAL SERVICES MEETING

11-14-69

Dr. Milner will be here next week, Thursday, November 18, 10 to 11 AM, then again in December. Chaplain Black may present a case for Dr. Milner to discuss.

Chaplain Barker told about a meeting in Denver. Some of them were sent out in the field with various groups, his assignment was with a black panther group, for the visitors to see the other side of the coin.

A workshop dealing with children's problems from 10 to 3, Friday, November 21, at 1615 West 9th, Topeka-Shawnee County Health Department. Dr. Greenwood, Coordinator, with several other speakers.

The brochure for Middle Section is almost ready for the printers. County Day Committee is still meeting, the question is, is County Day a time for listening, a time for education or for making plans for the coming year?

The groups planning County Day this year worked independently and it came off fine, but would be easier and stronger to plan more together. Dr. Horne reported on "66 Hands for Youth" discussion in Imperia meeting--the gap where the kid is not in trouble with the law, but is leading up to this, such as truancy, school failure, etc. The need is to work with the family as well as the child, however, sometimes the family does not want to work with us.

Legislatively speaking, military and highways get what they want, because they know how to ask and have strong organizations. Health, education and welfare get what is left over, so we will have to learn the lesson they have learned so well.

One of our Adjunctive-Therapist 1's resigned to go to work for Goodyear.

## Appendix B

*Biddle*  
SECTION MEETING MINUTES

~~11/11/81~~  
June 25, 1969

Mary Robinson, the high school student who has been observing on Wards E and F, gave her impressions of the hospital. This led to a brief discussion of what time patients get up.

Group testing is still suspended - letters regarding Mr. Suderman's situation have been sent to the proper authorities by the psychology department and by Dr. Horne.

Dr. Procter, in response to a question about testing, said that the Personal Data Questionnaires would be available to wards who want to use them. He also volunteered to meet with any wards to discuss use of the forms.

Dr. Horne mentioned a testing research program at the Menninger Foundation and expressed some possibilities that this testing might be available to us.

Mrs. Glazzard, graduate student, who is working through our Public Information Department this summer was introduced. One of her projects this summer is compiling an information booklet for officials in the counties we serve regarding admission procedures. She will be visiting wards at scheduled times to talk with personnel about what should be included in the booklet, and at other times just to observe ward procedures.

There were some questions raised about the gates (barriers) at the hospital entrances and why there was no more discussion about them before they were put up. Also there was some discussion about new careers and upward mobility. This program is not fully outlined yet so anyone with suggestions and/or comments regarding this program should communicate them to Dr. Horne while planning is still going on.

Grand Rounds is cancelled in July and August.

Meeting adjourned.

Dr. Horne/K. Ellis, R.N.  
Recorder

SECTION MEETING MINUTES July 2, 1969

Mrs. Sylvester announced that there would be swimming this week. There was a quick count of each ward and how many patients from each ward would go.

There will be a Starlight trip next week. It will be CanCan.

There will be a trip to Prairie View July 10. Anyone interested in going please let Section Office or Nursing Office know. The following are going: Dr. Horne, Mrs. Ledbetter and Mrs. Ellis, R.N..

The gates at the hospital entrances were discussed, particularly how the chains disappeared the first night they were up.

The janitor and the watchman have asked that the doors, front and back, in the Section Office be locked.

Mrs. Glazzard was asked if she had any comments at the present. She said no.

Summer church attendance has been fairly good.

Most of the meeting was spent in the discussion of admission policies and the legal procedures of admission. Many had a fairly good idea of the legal procedures but not definitely clear cut in all admissions.

Dr. Horne

SECTION MEETING MINUTES

July 9, 1969

The staff should keep impressing on the relatives the shortage of staff. One relative wrote to the Governor, telling him about the shortage.

Dr. Rainbow is on the Staff Development Committee. A grant has been given to the hospital. It is \$25,000.00 for three years. It is to pay for a coordinator who will coordinate staff development.

Dr. Bay will give three lectures at different times for personnel who were oriented.

The yearly census on June 30, Biddle had the best all patients were accounted for.

There are some feeble rumors about residents on Biddle but the consensus was no. There definitely would have to be more staff to train residents.

The Student Day questionnaire results were discussed. There were some very good ideas and some poor ones also.

Mr. Terrill announced Mr. Minor would start next Monday, 15th as voc. rehab. counsellor for the section.

Dr. Calleja will be gone after August 1st to Woodsvlew.

Mrs. Flinn announced she would be gone until August 11, 1969.

Mrs. Glazzard asked the section to discuss the clothing for new admissions - how much, what kind and other ideas so they could be included in the handbook. There was some discussion about this.

Dr. Horne



*File*  
SECTION MEETING MINUTES

*Public Department  
(Committee)*  
84  
July 16, 1969

Introductions of new personnel were made. Mrs. Kemp, psychometrist, will take a half-time job. We will be able to have group testing again, but will have to escort to and possibly from testing.

Mr. Ted Minor is a full-time Vocational Rehab. Counselor. He has two years experience at Fitzsimmons.

Dr. Gabriel Yunez is here for the residency program, but has medical complications. The question of what he can do for an indefinite period of time was raised. He worked for a year at Osawatomie. It was suggested that he cover during Dr. Calleja's absence and during Dr. Rainbow's and Dr. Horne's vacations in August. Also he can help during the time when Dr. Calleja is going to Woodsvew and until Dr. Johnson gets here.

The Psychiatric Technical Specialist program was discussed. It is somewhat vague and indefinite and can be in any field that the person is interested in. Dr. Procter stated a PA II would take a cut in pay of \$100 if they trained to be a psychometrist.

Mr. Pawl, Dr. Horne and Mr. Meinholdt are making rounds on the section to survey the repair and maintenance needs. They will go to BH next week.

Bed capacities have been cut. We have been handling the same amounts of admission even with fewer beds. We have fewer readmissions than the other hospitals. We have 37% and OSH 47% and ISH 51%.

There was some discussion about Prairie View doing some of our preadmission work. They could recommend type of admission and tell families how to go about getting P.C. and M.E. with the 90-day extension. It was felt that the actual signing of voluntary papers should be done here between physician and patient.

Prairie View is establishing a community service team.

Meadowlark has become a 26 bed Rehab Center with a mattress factory on the grounds.

Dr. Ann Douglas will probably come to Biddle until her resignation date in September. It was felt if she likes us we may be able to get her to stay.

Dr. Horne

3.11  
SECTION MEETING MINUTES

July 23, 1969

Dr. Yunez and Mrs. Kemp and Mr. Miner were again introduced to the Section.

Dr. Horne and Miss Galle will go to Lawrence to visit clinic and welfare department. Staff was asked to tell any problems with these two agencies to Dr. Horne and Miss Galle. Several problems were cited.

The Lawrence Volunteers were discussed. They helped with the picnic on BH-4. They appear to be interested in the hospital.

Dr. Yunez will return to the Residency Program as soon as possible.

Dr. Procter said Mrs. Kemp will gradually orient to group testing this week and next Tuesday group testing will begin again.

There will be a psychology post doctoral intern on the Section. The question was asked how would the Section like to orient them. The feeling of the Section was to assign the intern to an aide on one ward.

Dr. Johnson	D Cottage and BH-3
Dr. Gracia	Ward E and Ward F
Dr. Rainbow	F Cottage and BH-4
Dr. Horne	BH-1 and Sect.

The above are the new assignments.

The post doctoral intern will be assigned to two wards and oriented on one of the same wards.

Dr. Rainbow reported from Staff Development. The aides at this time don't know what sort of form to fill out for application form. The committee does not know much about this. Dr. Bay did come to the meeting by demand. He said this aide application was his "baby".

This project gets vaguer each time it is discussed, the new classification of Psychiatric Technical Specialist.

*File*  
SECTION MEETING MINUTES

*Public*  
86  
July 30, 1969

Farewell Coffee for Dr. Mebed 2 - 4 p.m., July 31, 1969 Thursday at Stouthart Building.

Dr. Calleja will go to Woodsvlew August 1, 1969.

Dr. Johnson will be here Monday, August 4, 1969.

Dr. Yunez has gone to Mayo Clinic for a medical opinion of his condition.

Dr. Rainbow will be on vacation for two weeks starting August 4, 1969.

Mr. Packard will be on vacation for three weeks starting Monday, August 4, 1969.

Dr. Douglas will come to the section July 31, 1969.

Dr. Procter will be gone from August 8, 1969 until September 8, 1969.

Dr. Douglas will fill in for Dr. Procter while he is on vacation. She will be leaving the hospital September 5, 1969. Dr. Douglas will be on the BH-3 Team.

The pamphlet the section is making up was discussed. There was discussion on who it would be given to and whether there should be pictures, specifically a patient's picture, to make the book more illustrative.

The pamphlet will be distributed to the following in BH Counties:

- a. Courts, judges, clerks, etc.
- b. Welfare
- c. Mental Health Clinics
- d. Ministers
- e. Physicians
- f. ~~Physicians~~ Public (discretely)

There could be a patient's picture to illustrate the book and some of the patients' names that are willing to be used will be submitted August 6, 1969 at Section Meeting.

Mrs. Sylvester made an announcement for Tom Coleman that there would be a Ping Pong Tournament at Slagle Bldg. August 4, Monday 3-4:30 p.m. and Friday August 8, 1969, 4-5 p.m.

There is a position classification questionnaire to be filled out by every employee.

Again there was considerable discussion on the Psychiatric Technical Specialist positions. There will be a program, but what, when and where is still very vague.

There are six applicants who have asked for a meeting with Dr. Bay for clarification of this program.

Dr. Bay said at Employee's Council there would be six positions available for TSH aides.

Dr. Horne

## SECTION MEETING MINUTES

August 6, 1969

Dr. Johnson is here!! He came last Friday.

Mrs. Benson is the new nurse on BH-4 in the Graduate Nurse Program.

Dr. Horne reported that he is working on his cabin and we can shoot for a mid-September party.

The budget was cut from 96 new positions in the entire hospital to 34. No aide positions for PA IIIs. No increase in social workers in the adult in hospital service. Granted two social workers for Special Services, one for Day Treatment Alcoholic program and two for the Childrens OPD. Four alcoholism counselors were granted. Dr. Bay has asked that they reconsider and give us more of what we asked for.

The questionnaires about job duties must be completed. Any person who does not fill out one for his position will have his position automatically deleted. Be sure to put in the scout work plus the D&As, conferences with doctors, social workers, teachers, psychologists, families and all the other routine and also very special things you do. Be sure to put your immediate supervisor as your charge aide.

Mrs. Ledbetter reported that the group that had requested to meet with Dr. Bay had been informed that he would not meet with them, that a committee to select the applicants will be formed, and that they could ask questions of them.

The Section brochure was discussed. Each ward is to submit the names of those patients who volunteer to have their picture taken. They should be screened for appropriateness by the ward staff.

We can take 14 patients and 2 staff to "Damn Yankee" Friday at Starlite. Each ward is to select 2 patients to go.

The question was raised if we are going to have a consultant this fall. Dr. Horne is pursuing this with Dr. Kowalski.

Be sure all school referrals are in. Check about recent admissions.

Rounds with Mr. Meinholdt and Mr. Pawl are completed. They have worked on some of the air conditioners and turned BH-3's fan around to do a better job.

Dr. Horne

SECTION MEETING MINUTES

August 13, 1969

Dr. Horne opened the meeting by reading a letter from Peter Packard stating he is resigning to go to Topeka V. A. Hospital on September 15, 1969 for a higher salary.

This will make four additional vacancies in the Social Service Dept. by the 1st of October. This includes Elizabeth Clark, the Chief of Social Services.

It was discussed as to whether or not it is time to start writing to the legislators explaining about situations such as this. It was agreed that now is the time. Starting in September meeting with the State Dept. of Social Welfare will resume.

The section brochure is ready to be assembled soon. A patient from BH-4 is to be pictured. Pictures will be taken sometime next week.

Clinical-Education Service meeting was attended by Mrs. Turner who asked some very pertinent questions regarding the Psychiatric Technical Specialist program. The Staff Development Committee is to pick the 6 - 8 rest of the trainees. The message got through that the way it was presented gave reason for lots of angry, suspicious feelings.

The program still is an opportunity for people to develop additional skills.

The trainees will work 80% of the time and go to school 20% of the time and be paid full salary.

Everyone who is interested should still apply.

County Day is in October and we will start planning for it in September.

Dr. Horne goes on two weeks vacation starting next week.

Dr. Horne

*Section*

SECTION MEETING MINUTES August 20, 1969

Dr. Rainbow chaired the meeting.

The meeting was a detailed discussion concerning the pamphlet Mrs. Glazzard is making for BH Section.

Many details were brought up - some clarified, others still in the discussion stage.

F Cottage and BH-3 personnel are to decide on patients to pose for some pictures that are to be in the pamphlet. The personnel is to let Mrs. Glazzard know who the patients are that are selected.

Dr. Rainbow:

## SECTION MEETING MINUTES

December 31, 1969

Miss Valdivia's last day is today. She will go to Eastman January 5, 1970.

Mr. Towle's schedule has not been clarified as of yet but should be in the near future.

Dr. Johnson and Sister Mary will host two nuns at 1:00 p.m. today on BH-3 and possibly D Cottage. They are professionals and interested in group processes.

There was considerable discussion concerning Stannie Anderson, a newspaper reporter who will be coming out in the next couple of weeks to talk about writing a long article on BH Section. It is to be about the section as a whole. She will discuss her ideas in the Section Meeting in about two weeks. If the Section agrees to having her she will be around at intervals for about 2 - 3 months gathering her data.

The consensus of the Section Meeting people today was that it sounded like a good idea and seemed to want to have her come.

Dr. Horne asked that everyone take this back to the wards and discuss it and be prepared to discuss this more at the next meeting January 7, 1970.

Sister Mary announced today was her last day and she would be going to Woodsvlew. She still will have her group of patients on Biddle.

Dr. Horne



Dr. Jordan from Osawatimie will be coming to the section as a new physician Feb. 1 or 2, 1970. He will be going to some of the Menninger resident lectures.

January 22, 1970 Dr. Hiltner will be on the section. Chaplain Black will take care of the presentation. This will be discussed more next week.

There will be 15 nurses from foreign countries touring Feb. 3, 1970 from 9:00 a.m. to 11:00 a.m. on BH-4 and F Cottage.

Grand Rounds today will be presented by Dr. Panthel.

Miss Ann Carroll, teacher at Topeka State, will be doing the WRAT on the section. She will notify the wards prior to coming to do this test. The patients doing the test will be students in classes. She will need a room, table and two chairs. It will take about 20 minutes per patient. She will be doing this from 3 - 5 p.m. Mon. thru Fri. She will begin Friday on BH-1.

There was considerable discussion about Stannie Anderson coming on the section to do a feature article on Biddle. This will be in the Midway Section of the Capital-Journal.

Following are comments from the section concerning her coming:

- a. There was an unfavorable comment that sometimes what is told to the reporter is not what is written in the article.
- b. The more people of Kansas read about the mental hospitals in Kansas, whether it be negative or positive is important.
- c. Maybe we should reserve the right to see that the facts are presented accurately before it is published.
- d. The staff questioned if Miss Anderson would be out on P.M. and night shifts.
- e. When will this article be published? Will it be before the adjournment of legislature this spring? It was agreed no matter when it would be good publicity.

There was some discussion about moving Wards E and F. At the moment the structural plans are in Dr. Bay's office for him to look over. There was some question when BH staff talked with Mr. Pawl and Mr. Meinholdt that the bathroom facilities and amount of floor space for the number of patients was not adequate.

Remodeling would be expensive and where the money would be obtained is still in question.

The section asked for some mobile classrooms from Washburn several months ago. So far no word on these. Educational facilities have priority on these mobile units.

Dr. Horne



The trip to Prairie View is cancelled this month. There will be a trip there in February, the date will be announced later.

Dr. Horne will not be gone next week as planned.

Mrs. Stannie Anderson, Capital-Journal reporter was present at the meeting and the meeting was turned over for discussion concerning the article she wants to write about Biddle Section. Following are detailed comments from Mrs. Anderson and the staff of Biddle:

Why does she want to do a story about TSH and Biddle in particular?

Families wonder what happens to the patients when they come in and her purpose is to try and tell the public about the programs, treatment, etc. through the eyes of a patient. To tell the human side of the hospital.

This will require good back up work with the staff and she must be on the ward with the patients plus good interviews with the staff.

This story will not be just from the viewpoint of the patients or staff but both.

Think of the reporter as 100,000 readers and them seeing the Section through her eyes.

She will be around quite a bit on the wards and talking to the staff. She will be on in the P.M.'s and nights. The staff can help her decide how much time she needs to spend on P.M.'s and nights.

She will not be taking notes on the ward. She will not be on the wards for over two hours at a time.

Wants all the staff to make suggestions on what they feel she should see.

Dr. Horne will take Mrs. Anderson around with him when he makes late rounds and introduce her to the staff.

She will not be looking for specific things. Just want a general picture. Some things will be good, some things may be bad but she will try to see it like it is.

Mrs. Anderson realizes what the patients tell her is not 100% correct and they can distort the picture.

The staff felt this was a good thing to have a reporter tell about the Section, suggesting the interest herself in team meetings, morning reports with patients and staff, see how the volunteers work with the patients, see how aides work with families and patients.

It was pointed out to Mrs. Anderson the aides and AT work closer with the patients here than at Henningers and you have to see it to believe it.

This article will be a long article with pictures, the patient's pictures and case histories will be disguised and will appear in Midway.

She will not approach any patient, they will have to come to her.

The ward staff should talk with the patients on their respective wards about a reporter being on their ward and get their reactions. The purpose of her being here should be told the patients.

It was brought up to Mrs. Anderson there is a certain amount of hostility toward her concerning an article she wrote during the strike and it was felt she supported the strikers. It was felt this must be brought out in the open and discussed. She said she was aware no doubt there were some feelings about this and the strikers had the same feeling that she supported the non-strikers and she felt she only wrote how she saw it. She said she had no feelings one way or the other about the strike.

She said what she was trying to do now had nothing to do with the strike and was only interested in the patients.

She asked the personnel, "Can you deal with me and the patients and can you trust me? If you can't then this article can't be done."

There was some concern about if she could deal with the feelings or could she understand the feelings she gets from the patients. This she said is where she uses the staff people as resources.

Her parting comment at this meeting was she wanted to do this article and really truly make a good effort.

Mrs. Anderson will be at the next section meeting January 21, 1970 for more discussion.

Dr. Horne

Miss Julie Kenfeld will not be here tomorrow 1-22-70. He will go to Prairie View in February. The particular date will be announced later.

Dr. Hiltner will be here 1-22-70 10:00 a.m. to 11:00 a.m. in the D Cottage of Camp. This is a change in location. Mrs. Ellis, R.N. will let Chaplain Black know of the change.

Mrs. Ellis, R.N. asked the section if a group of nurses from hospitals in town could tour and spend time on some of the wards Feb. 26, 1970 in the p.m.. The section agreed and Wards BH-4, D Cottage and Ward F volunteered to tour the visitors.

Dr. Horne read a paper from Dr. Bay "Status of our Budget Request for the Year beginning July 1, 1970 (Fiscal Year 1971). Following is the paper in total:

January 16, 1970

At this point, the Governor's budget proposal provides for the following. It should be borne in mind that this budget proposal will now be considered by the Legislature and is still subject to change by them.

In Salary and Wages, the budget proposes:

1) Administration - The addition of one Account Clerk II in the Business Office to maintain the ledgers of a cost accounting system.

2) Neuropsychiatric Services

a) Fourteen (14) positions, formerly identified as Out-Patient Service, are transferred to the Woodview Section.

b) One (1) position, formerly shown under Adjunctive Therapies, is transferred to Biddle Section.

c) In the recently established Alcoholism Program, our present allocation of seven (7) positions is reduced to two (2) positions for Alcoholism Counselors.

3) Engineering and Protection - Two (2) additional positions of Patrolman are provided.

Under the heading of Other Operating Expenses (which includes all expenditures except for salaries and for the purchase of equipment), there are in general very adequate and realistic allocations of money for all of the hospital's normal expenses. There is an increase of money available to cover the increased costs of the new telephone system. There appears to be an adequate provision for the purchase of food, taking into consideration rising prices of food and the probable hospital populations. There appears to be adequate provision to cover the increased costs of our educational program. There is provision to close the institution's Bakery which is no longer profitable to operate at our present population level, and to purchase bakery goods.

The following sums are provided for major repairs and capital expenses:

\$62,000 for various fire and safety needs  
\$ 5,000 to demolish the former T.B. Cottage  
\$35,000 to replace one air-conditioning unit on Eastman Section  
\$73,000 to repair various roofs in the Eastman Section

The demolition of the T.B. Building and the replacement of the air-conditioning unit on Quonteen are recommended for the current year in order that work may begin on these two projects before summer.

All of the hospital's requests for new programs, or for additional personnel to carry on existing programs, have been deleted from the budget as it stands at the present time.

The Governor's budget message calls attention to the fact that our current budget of \$7,089,000 is an increase of more than \$1,000,000 over the previous year (\$6,089,000), or an increase of 19% from Fiscal Year 1969 to Fiscal Year 1970. Almost all of this represents increased employee salaries and benefits. The present recommended budget for 1971 represents an increase of about \$100,000, or 1.4% over the present year. This increase does not include any increases which might be necessary to place into operation the recommendations of the Public Administration Service Survey.

Alfred Paul Bay, M.D.  
Superintendent

It was brought up that the patients loiter on 2nd floor Biddle by the concession machines. There was some discussion on this and it was decided the patients who abuse the privilege of ground pass and the area around the machines will be dealt with individually.

There was also discussion on where should patients go on cold days while on ground pass and the Quonteen is closed. No solution to this problem came about at this time. One of the very loud and clear comments was the Quonteen is supposed to be for patients, then why is it not open all day on the two days the patients have the least to do.

Also the question of why does the items in the Quonteen cost so much more than the same items off grounds. There is to be some research done on this, but at the present no committee was appointed to look into it.

The meeting from this point was turned over for further discussion with Mrs. Stannie Anderson about the article she wants to write for the newspaper.

It appeared the section was slightly leaning toward the position yes the article should be written as we have a need to be understood and the public needs to understand.

Mrs. Anderson won't be able to please everyone with the article.

There was much silence in the discussion.

The strike feelings were brought up but one of the staff felt the section should be mature enough to forget these feelings and look ahead and be concerned about all their feelings.

It was stated you could assume the above but the childish objections must be heard prior to the start of the interviewing.

A newspaper article is never fair to all of John Q. Public.

Some staff said show her what we are trying to do and let her write it. This is a good way for the public to know about us and what better way is there and what better coverage could you get.

Dr. Horne

The topic of Grand Rounds was announced. The personnel are encouraged to go.

The trip to Prairie View will be Feb. 19, 1970. Anyone interested are asked to call the Adm. Office. Tentative people wanting to go are:

Mrs. Benson, R.H.

Dr. Horne

Mrs. Alexander

Mrs. Gehr, R.H.

Mrs. Doss, A.T.

Mrs. Nelson, A.T.

Dr. Procter

If interested please arrange coverage with your supervisor.

The discussion on how do we make decisions on the section, Dr. Horne said sometimes he feels he may make decisions without too much discussion.

How do the section personnel feel decisions are made here on Biddle.

For instance, whose lap is the decision of whether Stannie Anderson should come or not, in at the present time?

No answer about the above at the present.

The personnel brought up the paper Drs. Chapman and Bey wrote about the hospital for their third year paper. They said they didn't get any feed back but was promised they would. They had to go out in search of it and found it in the library.

Whose decision is it who sees what and when if ever?

There are outside controls that effect some decisions.

You have the right to expect feed back. Sometimes you have to holler loud for it.

How does the section feel about decisions that are controlled in the section, like County Day, new policies and Stannie Anderson, etc.?

Dr. Horne asked do you feel like the decisions are made prior to the discussion and all the discussion amounts to is a lot of hot air?

Ward wise the personnel feel they have a voice, like County Day. They feel they can say no and it is their decision.

Dr. Horne pointed out by the wide grins in the group he wondered if maybe they really did feel that most decisions were made prior to discussion of it in a Section Meeting.

Again the aides said they felt like they had a voice in whether they had to do something or not.

Some decisions the personnel have no choice because even when it is brought up at the start the decision has already been made.

Stannie Anderson coming to the section, Dr. Horne brought it to the section meeting as he thought it was a good idea and he wanted to know what the other personnel thought.

It was asked what can we do about what she writes and we don't like it. The hospital, including the section, have no editing privileges of a journalist's work.

Again it was asked what do you think about Mrs. Anderson coming.

It was brought up we should not say yes but mean no, because this will not work. It has to be full cooperation.

It was also stated if you don't take a stand then you wouldn't have to accept the responsibility of a decision.

It was brought up that maybe it would be better to have a journalist that actually was very proficient in the psychiatric field, "they would understand better".

But it was suggested maybe a lay person, as Mrs. Anderson is, could write better because she could write it in a way that the public could understand, what and how of the treatment of patients.

She will be writing this article through the eyes of a patient.

This should be helpful to the patients we serve and maybe they can understand better.

Some of the aides thought Mrs. Anderson was already here and asking where was she.

They thought she had started Jan. 15, 1970.

She is not here and the section still has calling off privileges.

Many times personnel say it's a shame people don't know what we do at the hospital. This is a chance for people to know.

What pressure does a ward feel if they decide they don't want Mrs. Anderson on their ward?

At this point of the discussion about Mrs. Anderson there has been no decision, period. This discussion must be taken back to all the wards and a decision must be made.

Just about 1/3 of us is a substantial minority, and will the decision be and how will it be made?

James is tired of being nice to visitors. Be yourself and don't put on a happy face all the time.

What do the other two shifts think about this. There has not been a lot of feedback and they should let people know how they feel.

Talk about this and have a decision by next meeting 2-4-70.

Dr. Ray was on the section 1-27-70 and he was not too impressed with all the litter about the buildings. This should be each ward's responsibility to see the litter is picked up.

Dr. Ray and Mr. Paul were on D and F Cottages to see how the two wards could be reversed so W and F wards could be moved into them.

The discussion about the prices in the Quonteen were brought up and there is a committee who will check the prices outside and the Quonteen. The members volunteered and are Mrs. Ellis, R.N. and Mrs. Benson, R.N.. Anyone may feel free to feed them information pertaining to this price survey.

Dr. Horne



SECTION MEETING MINUTES

February 4, 1970

The following personnel will be going to Prairie View Feb. 19, 1970: Dr. Horne, Miss Hoover, R.N., Mrs. Doss, A.T., Mrs. Alexander and Mrs. Gehr, R.N..

Dr. Hiltner will be on F Cottage Feb. 12 in the F Cottage Conference Room. They will present a patient to him. He will be there 10:00 a.m. to 11:00 a.m..

Dr. Jardon, new staff physician on Wards E and F was introduced.

There was some discussion about changing the names of D and F Cottages. There was no enthusiasm whatever on this subject.

Mr. Towle will not be coming to the section as a consultant. The programs set up to use him will not be discontinued but another consultant will have to be gotten.

The possibility of using consultants within the section or the hospital was discussed.

Dr. Horne mentioned there has been some communication with Dr. Weinbaum concerning outside consultants for the section.

The subject of Mrs. S. Anderson was brought up for discussion. The decision was made today to have her come to the section. There are some reservations but there is a willingness to accept her on the section.

Personnel wanting to talk to her are to contact Mrs. Gehr or Mrs. Shaw for an appointment.

Dr. Horne will invite her to come to the next section meeting Feb. 11, 1970 and have her discuss how she would like to pursue her job.

PAS (Public Administration Service) have field representatives at the hospital. They have no answers at the present but are prepared to present an estimate of the new Pay Plan.

The Quonteen Price Committee have not done any work on this project.

Dr. Horne

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BIDDIE SANITATION MEETING MINUTES

February 18, 1970

Mr. John Oliver who is to be the C.T. on BH-3 was introduced.

It was announced that Mrs. Hurst is in Stornant-Vail Hospital with the flu. Mr. Ken Barbour is in Kansas City with a malignancy and Mrs. Tockey has a dental problem and has been advised to go to Mayo Clinic.

There is to be a free seminar at Hawley Auditorium at F.A. on Saturday, February 21, 1970 from 8:30 to 5:00 p.m. It is for first line supervisors in hospitals, nursing homes and other health related institutions. Registration is through Walker House at St. Francis Hospital.

Mr. Olson the new Vocational Rehab. counselor was introduced. He is replacing Mr. Minor who will be on BH the rest of the week. Mr. Olson went to work on BH-3 as an aide.

There was a discussion about the bill that gave 28 positions to K.H.I. and how these can be allocated when the necessary had been given that there would be no changes until the Classification Survey recommendations were in.

The Superintendent at K.H.I. lobbied well and got a separate bill introduced.

There was a question about how these positions will fare when the Classification Survey report is made.

There will be a meeting at the Auditorium during the noon hour today to discuss legislation that will affect state employees. The meeting is sponsored by K.A.P.E.

There will be a trip to Prairie View tomorrow. They will meet at 7:30 behind the Section Office. Dr. Horne, Mrs. Gehr, Mrs. Alexander, Mrs. Brown, and Mrs. Doss are to go.

There was a short discussion about the proposed withdrawal of services the 20th of February and March 1 and 2. It is a matter of individual freedom what everyone does. There was some feeling that people who worked extra time, may not this time. Some of the 8 - 5 people may be on call 12 hours. It was felt that District may be hit hard since the kitchen had a problem from the Health Workers officers.

Ford can be brought in, but it is expensive.

Mrs. Starnie Anderson will start next week on the section.

Tuesday Feb. 24	F Cottage
Wednesday Feb. 25	BH-3
Thursday Feb. 26	BH-4
Monday March 2	D Cottage
Thursday March 5	Ward F
Friday March 6	BH-1
Ward B	Anytime

There was a general discussion about the Clinical Services Meeting. Biddie is the only person that sent a representative. They feel isolated and that they can't speak for all sides. There was a general discussion



## Appendix C

## IMPRESSIONS OF A STATE HOSPITAL

*"Before I came in, I knew everything was all wrong---I made things worse. I was trying to make things so bad they'd send me somewhere."*

### BIDDLE

And the community recognized the patient's cry for help.

Community mental health is growing. The mental hospital is no longer the focal point of treatment for mental illness, though it remains an integral part of the communities it serves. Its treatment team works as part of a larger team effort for mental health.

BIDDLE SECTION of Topeka State Hospital is a treatment community.

*"This is a place to get well for illness of the mind. . .Everything that happens to you here helps you get well."*

It is one of three adult inpatient sections at Topeka State Hospital (TSH), Topeka, Kansas. Patients admitted to Biddle come from one of 15 counties in east-central Kansas. They are housed in a collection of old buildings. Because of the structure of the buildings, men and women must live on separate wards.

The same treatment team admits, treats and discharges the patient. There are no "back wards" where patients are separated by age or diagnosis. The patient remains on the ward where he is admitted until discharged from the hospital. Wards range in size from 23 to 50 beds.

A day area, seclusion rooms and very limited storage space is found on each ward. There are few single rooms and sleeping in a dormitory, with from 3 to 19 others, allows the patient very little privacy.

An intensive treatment program makes possible more than 280 admissions each year to this 242 bed section.

#### THE CHANGING TIMES

*"One of my big gripes is no one prepared me at all for hospitalization. I thought there were padded cells and people chained to the walls--- I was scared stiff."*

The idea of chains and padded cells at TSH persists in the community today. And not so long ago care was very different from what it is now. Until after World War II, TSH offered little hope. It was a place for custodial care for 1800 patients. Patients entered expecting to spend their lives in the hospital. Many did.

A series of newspaper exposés in 1948 started Kansas on an active treatment approach. The clinical staff was increased. TSH, in association with the Menninger Foundation, began training psychiatric residents; other training programs for mental health personnel followed.

The mid 1950's saw the advent of tranquilizers and energizers. These drugs helped relieve and control many of the severe symptoms of mental illness; patients taking these drugs often become more amenable to treatment. The complexion of the mental hospital changed and patients began to enter expecting to return to the community.

During the 1950's, as the staff increased, the patient population decreased until, by 1959, TSH had 900 personnel and 1300 patients. However, during this period, the admission rate rose steadily. Only 200 patients were admitted in 1950; 900 were admitted in 1959.

In the 1960's, the concept of community psychiatry led to mental health clinics. Day hospitals, halfway houses and special treatment programs combined to keep the patient closer to the community. During these years, the hospital population itself changed; it got younger. In 1954, TSH had 625 patients over 65 years of age, but today it has fewer than 40.

The median age of patients on Biddle section today is 34 years. Teenagers make up almost 1/3 of the patient population. Since Kansas presently has inadequate child and adolescent facilities, patients as young as 12 are admitted to adult wards. Teenage patients on adult wards make heavy demands on staff and, if the needs of all patients on Biddle are to be met, more clinical staff--specially trained staff--and new kinds of programs will be necessary.

These young people bring complex problems to the staff. Treatment goes beyond the individual patient to his family and community; they must cooperate and become involved if treatment is to be successful.

#### ADMISSION

*"When I was first admitted, I came in smiling and grinning all over; it was so inappropriate."*

It is frightening to enter a mental hospital.

Each patient reacts differently, but each needs support and preparation for this step. Before the patient is admitted, it must be determined if the person can use help and the kind of help he needs. When it appears that a person needs hospitalization:

Contact the mental health center which serves his county. Personnel at the center will determine whether he should be seen there first or referred directly to Biddle.

If there is no mental health center, contact Biddle. The Biddle section secretary will arrange an appointment for a pre-admission interview or schedule an admission time. If consultation is desired, ask to have the physician return the call.

PRE-ADMISSION INTERVIEW. Whenever possible, an interview is arranged at the hospital so that the patient, his family, hospital personnel and community can decide together on the best plan for treatment. Inpatient care may not be the treatment of choice. Some persons profit more from remaining in the community for treatment. There are some problems the hospital cannot treat, although this may not be determined until treatment is tried.

ADMISSION. It is upsetting to the patient to enter the hospital; it is hard for other patients to adjust to a new patient, too. For these reasons, admissions should be scheduled ahead of time. Then ward activities can be arranged so the staff will be available to the new patient when he arrives. The admission procedure takes time. While the psychiatrist talks with the patient, other staff see the family. Then the patient is admitted to the ward where the staff checks his personal belongings and orient him to the ward. If the scheduled appointment cannot be kept, notify the section secretary of the change and the time the patient will arrive.

The patient does not need many personal belongings at first. He should bring only the items listed below. Nothing of great value is allowed; old family Bibles, engagement rings, expensive watches, house titles, large sums of money cannot be replaced if they disappear. As the patient's needs change, he will let his family know.

Special needs of the patient on admission:

- Proper admission papers. Without these, it is illegal for the hospital to admit a patient.
- An accompanying relative. Even when a law officer brings the patient, a relative or friend should come, too. A psychiatrist or social worker is usually available to talk to the relative, who often gives the hospital vitally needed information about the patient which may not be available from any other source. In turn, the relative is acquainted with hospital regulations and the treatment approach as it will apply to the patient.
- To be told the truth. The patient needs the truth. He should be told, "You are sick and we are taking you to the state hospital."
- No promises about length of hospitalization. No one knows how long the patient will stay. Patients admitted on a Protective Custody order will have a mental illness hearing within two weeks, but the patient will not be discharged necessarily at that time.
- The family physician's report. A pertinent medical history, medical diagnosis and current list of medications is important. The medications themselves should not be brought to the hospital. The hospital must know if the patient has a physical disease---diabetes, a heart condition---at admission time.
- A report from the referring psychiatrist or mental health center.
- A summary of social casework findings if the patient was previously seen by a community agency.

Personal needs of the patient on admission:

A shortage of storage space for luggage makes it necessary to bring the following items in a cardboard box rather than a suitcase.

- five changes of everyday clothes (maximum). Bring only what the patient owns and is washable (the hospital does not have dry cleaning facilities)
- two pairs of shoes
- sweater and coat (depending on the season)
- pajamas and robe (washable)
- purse with lipstick and cosmetics in plastic containers
- toothbrush and toothpaste
- electric razor if the patient has one
- postage stamps
- carton of cigarettes (the smoker must be at least 16.) Encourage the family to send the patient additional cartons frequently.
- spending money. Spending money is needed for incidentals. The patient is allowed \$3 a week. He may keep it on the ward in cash or buy a "quonteen" book and use coupons for his purchases. Each patient has an account in the chief clerk's office where larger amounts of money can be deposited for the patient to use as needed. Money can be deposited at time of admission or sent, in the patient's name to:

Chief Clerk's Office, Box #6, Topeka State Hospital  
Topeka, 66606

What the hospital provides:

Each ward provides a TV set, scissors, razors, clippers, nail files, lighters (built into the walls), ironing boards and irons, radios and record players, paper and pencils.

Cost of hospitalization:

For the first 60 days, the charge is \$22 a day; it is \$9 a day, thereafter. For families who cannot afford the total cost of hospitalization, there is a sliding scale based on income. Arrangements can be made with the reimbursement officer.

The Kansas statute of limitations cancels any remaining hospital debt after three years.

Twenty per cent of the hospital's total operating budget each year must come from payments on patients' accounts.

Veterans who are eligible for care in a Veteran's Administration hospital should be sent there directly.

*"At first I tried to make the family believe everyone here was cruel and mean. I wrote letters about it. I swallowed pins to prove how bad being in the hospital was for me, and to make my family do something. Now I think I should be in the hospital."*

Many patients try to manipulate their family or hospital personnel in order to avoid treatment or get out of the hospital. This is a common pattern of behavior. Hospital rules and procedures are designed to control the patient until he can understand and control his own behavior.

Visiting

Adjusting to the hospital takes time. Customarily, no visitors are allowed the first two weeks. A ward physician will write an order giving



permission for visitors and specifying who may visit when the patient is ready. Usually the hospital does not contact the family to report on the patient's progress.

Visitors under 16 are not allowed on the wards.

Cameras and picture taking are not allowed on hospital grounds.

Jewelry, money, candy and matches should be left with ward personnel, not given to the patient.

Visiting hours are: 2 - 4 p.m. daily and 7 - 9 p.m. on Wednesday and Saturday. Special permission is needed for evening visitors.

#### Mail

Letters to the patient are never opened or censored by the hospital. Relatives usually are encouraged to write. If the team feels the patient should not read a letter, it will be returned, unopened, to the sender.

Letters from the patient are read by personnel before mailing. If the content is inappropriate, this is discussed with the patient and the letter is given back to be rewritten.

#### LEGAL ASPECTS OF ADMISSION

*"Even though I was committed, I eloped (ran away) five times. It has helped to be committed. My parents couldn't take me out. If I'd been on voluntary, I would have left first chance I got."*

*"No, Good Lord, I'm not sorry that I stayed here."*

Hospital admissions may be either voluntary or involuntary. An increase of voluntary admissions---from 20 to 50 percent in recent years---indicates

a growing public acceptance of treatment for mental illness. The person who wants and needs help and who has support from family and community usually utilizes hospitalization best.

At the time of admission, most patients are experiencing psychic pain. As they become more comfortable, they may not feel the need for treatment so acutely. Therefore, helping each patient make the right admission choice may insure him the treatment he needs.

Two methods of admission which are preferred on Biddle because they actively involve the patient in decisions about treatment from the start, are:

1. Voluntary.

2. Protective Custody, Mental Evaluation and 90 Day Continuance.

Voluntary Admission. This may be the admission of choice when patient, family and community acknowledge the patient's need for hospitalization. However, the patient can discharge himself by signing a five-day notice. If it is felt that the patient might discharge himself before completing treatment, then involuntary admission may be preferable.

1. An application for admission can be made by a person 16 years or older; by either parent only if applicant is under 16; by a guardian of the applicant. If the proposed patient is incompetent, guardian signs application thru welfare.
2. The application must be signed by a physician---though not necessarily a psychiatrist.
3. The person must be a Kansas resident for one year prior to application.
4. The hospital admits the person at its discretion.

5. The patient can be discharged any time hospital and patient agree to terminate treatment.
6. The patient can be discharged against medical advice by signing a five day notice. This notice of intent to leave must be in writing and must be signed. It goes into effect as soon as the patient hands it to any hospital employee. By 5 p.m. on the fifth calendar day after the notice is received, the hospital must have a court order to hold the patient or must discharge him.

If the patient changes his mind about leaving the hospital, his withdrawal of the five day notice must be in writing, also.

Involuntary Admission. There are a number of kinds of involuntary admissions. Those discussed below involve probate court action.

Protective Custody (P.C.) Order. Unless the order specifies protective custody at TSH, the hospital does not have to admit a patient on a P.C. order alone. This order should be issued in conjunction with an order for a mental evaluation.

P.C. and Mental Evaluation (M.E.) Order.

1. A hearing to determine whether the patient is mentally ill must be scheduled 7-14 days after the order.
2. The hospital must submit a written mental evaluation to the court three days before the hearing.
3. Because court records of mental illness are privileged, hearings are not public.

Before, or at the time of the hearing, one of the following choices must be made. The patient can:

1. Sign voluntary admission papers if the hospital concurs.
2. Sign a 90 day continuance of the mental illness hearing.
3. Have a mental illness hearing before a judge and accept the judge's finding of mentally ill or not mentally ill. Or the patient can request a jury trial to determine mental illness.
4. Receive a hospital discharge if the hospital feels the patient does not need treatment.

P.C., M.E., and 90 Day Continuance. Whenever possible, the patient should be encouraged to sign a 90 day continuance at time of admission.

1. Before the hearing, the patient applies (through a court appointed attorney or his own) for a 90 day continuance. This postpones the mental illness hearing 90 days and during this time, it is often possible to involve the patient in treatment.
2. At the end of 90 days, the patient can request another 90 day continuance thru his attorney. These requests may be repeated as necessary.
3. The court can assign one continuance of 7 days.
4. The patient cannot discharge himself.
5. The hospital can discharge the patient at any time the medical decision is made that the patient is no longer mentally ill.
6. This type of admission helps insure that the patient will receive treatment without being declared mentally ill.

#### Emergency Admission

1. On holidays, weekends, or nights when the court is not in session,

a regular police officer may escort the person to the hospital and sign the admission form. The behavior of the patient which indicated hospitalization was needed must be described by the police officer.

2. The hospital admits the person at its discretion.
3. A reputable citizen (most often a family member or friend) may sign the admission form. In this case, a qualified physician (often a hospital physician) must also sign the admission papers.
4. The police or family must go to court as soon as it opens on the first court day after the patient's admission because the hospital must dismiss the patient by 5 p.m. that day if there is no court order.

For information regarding other kinds of admission procedures, contact the hospital.

Change of Venue. The probate court, at its discretion, may change the venue of the patient from his home county to Shawnee county where the hospital is located. Court hearings are held regularly at the hospital by the Shawnee county probate judge. This service is provided for the convenience of patients and hospital personnel.

#### THE HOSPITAL TEAM

Biddle uses the team approach exclusively in treating patients.

*"If you could see what the aides do for us. They're not required to care about us---but they do. They take us shopping on their days off. They feel we need it and they enjoy it, too."*

The psychiatric aide is the basic member of the treatment team. He is with the patient 24 hours a day and is involved directly in the patient's treatment. With his years of experience and through consultation from the nurse, social worker and psychiatrist, the aide is able to work therapeutically with patients and families.

The psychiatric nurse helps guide the patient's treatment either by working directly on the ward with the aides or through consultation. Biddle has so few nurses that on most wards they can offer the aides consultation, only.

*"At first I felt I wasn't going to get any treatment because I wasn't seeing a doctor."*

The psychiatrist is the head of the treatment team. He sees each patient on admission. He is responsible for the patient's evaluation and treatment. Occasionally he leads group therapy or has a patient in individual psychotherapy. But primarily he works with each patient through the other members of the treatment team.

All psychological testing is done by the psychologist. About 70 per cent of Biddle patients have been tested. A personal interview and a battery of tests, usually given soon after admission, help the team to understand the patient and plan his treatment program. The psychologist treats patients in individual and group psychotherapy.

*"I used mother---I demanded from her because I knew she was weak and couldn't say 'no.' She's changed now since the team's worked with her."*

Acting as liaison between the patient, his family and community, the social worker helps the team understand the environment from which the patient came and helps the family and community understand the patient's

problems and how he can be helped. The social worker may meet regularly with family members for casework treatment. This is to help the family understand and use better the interaction between the patient and the family. Compiling a patient's social history, supervising visits between the patient and his family, consulting with community social workers and nursing home personnel are other ways that the hospital social worker works with the treatment team, the family and the community.

*"I'm thinking about studying again. Before, it always seemed so far away, like I might do it sometime. Now I'm talking to the aides about it."*

Educational and vocational planning continues with the patient while he is in the hospital. On admission, or shortly thereafter, the hospital needs a school transcript for the patient whose education has been interrupted. Behavior reports from the school about rebellious, antisocial or docile behavior can also be very valuable to the team.

Special Education teachers at the hospital help patients, either individually or in small classes, continue with their education. The teacher works closely with other members of the team so that learning becomes not only educational but therapeutic.

The vocational rehabilitation counselor works with the team to assess the patient's job aptitudes and interests and to determine if he needs job placement or job training first. The counselor makes the community contacts which lead to on-the-job training; technical, vocational or business schooling; college education; or a satisfactory job placement. The overall goal is the patient's successful personal and vocational adjustment back into the community.

*"What do we do at the hospital that helps us? The sewing project helped us to learn to work with other people. . .Industrial assignments. . . Dancing helps---cards, too. Everything helps."*

Recreation, music and occupational therapy--adjunctive therapy---is an integral part of treatment on every ward. The adjunctive therapist helps plan activities as part of the patient's total treatment program. Through adjunctive therapy, a patient can work out problems, test new ideas, regain skills, learn how to work with others and try out new ways of behaving or adjusting. The interpersonal relationships which develop are more important to treatment than the activity itself.

Roman Catholic and Protestant worship services are held every Sunday at the hospital. A chaplain trainee is available to the patient for pastoral visitation and counseling. He is available to the patient's minister for consultation. Community clergymen are encouraged to contact the chaplain through the chaplain's office or section secretary. Seminars for ministers in the community are offered on request.

Two alcoholism counselors are assigned to Biddle as part of the hospital's alcoholism program. They work in the community as well as with patients in the hospital who are alcoholics.

The medical doctor sees each patient within 24 hours after admission. At this time, the patient gets a complete physical and neurological examination, which is repeated yearly. Whenever a medical problem develops, the psychiatrist refers the patient to the medical doctor. The patient is transferred to the medical-surgical ward if necessary. Major surgery is done in a Topeka city hospital; minor surgery at TSH. Specialists in Topeka are consulted whenever necessary.



Laboratory tests and dental work are done at the hospital, too.

All departments work closely with the treatment team. The dietary department cooperates with the adjunctive therapy and nursing departments for picnics and parties. Bus service for patients to community activities---to swim, bowl or attend a play---is provided by the transportation department. And the grounds crew and maintenance department keep the hospital in repair.

#### TREATMENT

*"Before I was admitted I was told I would not see a doctor much and would get treatment without knowing it. I can see that's what's happening to me."*

Milieu therapy, in which the patient's total environment contributes to his treatment, is used on Biddle. Recreational activities permitted the patient, privileges granted, restrictions on what he can do, kinds of ward jobs assigned, responsibilities given---all are used in his treatment. Along with this, the team uses skilled "criticism" of the patient's attitudes and behavior to guide him. Little individual psychotherapy is done; most patients respond better to group therapy. Individual psychotherapy may be continued after discharge. Continuous interaction between members of the treatment team helps the patient get the treatment he needs.

*"I can see now the team had to do what they did to make me get better."*

The team evaluates each patient's problems, needs and assets; then each treats the patient in a manner consistent with the evaluation. Treatment is different for each patient; while one needs firm limits and controls, another needs encouragement to express himself more freely. Reevaluation by

the team continues throughout hospitalization, so that, as the patient's problems and needs change, his treatment changes, also.

*"I resisted treatment for a year."*

Anyone who needs to be admitted to the hospital needs treatment. But, just as mental illness takes a long time to develop, adequate treatment takes time. It is hard work to give up old patterns of thinking, feeling and behavior. It is painful to change. To avoid psychic pain (which can be more intense than physical pain), the patient may refuse to become involved, emotionally withdraw from the situation or physically run away---elope.

Thus, for many patients, treatment moves slowly. Sometimes the best the staff can do is wait until the patient is ready to work on his problems. Because the staff is not actively engaged with a patient at a given time does not mean he is not receiving treatment. Treatment begins when the patient walks in the door and often does not end on discharge.

*"When I was first admitted, I didn't think I had any problems. Now I'm beginning to see I do; but it's a hard job to change."*

Treatment helps the patient change. In order to change, he must take a clear look at his life situation and face up to contradictory wishes and irrational hates and fears, as well as evaluate the choices he has. Choices are the backbone of treatment. The team supports the patient in making reasonable choices, but does not make the choices for him.

### Seclusion

*"I thought I had to kick and scream to get into seclusion. Seclusion enforced discipline until I could discipline myself."*

Seclusion is never a permanent method of treatment; it is used for therapeutic or protective purposes, not punishment. It is used to prevent a patient from harming himself or others, to help him control "acting out" behavior or to encourage him to think about his problems.

In strict seclusion, the patient, in pajamas, is locked in a room which is bare except for a psychiatric (meaning less destructible) mattress on the floor and a blanket. Less strict kinds of seclusion are used according to the patient's problems or needs. Patients in seclusion are under continuous observation by the staff.

#### Locked wards

Wards are usually locked on Biddle; this decision is often made jointly by patients and personnel. Wards are locked to protect patients. The confused cannot wander off so easily. Those with the desire to elope or on suicide precautions are protected from their impulses.

#### Daily Living

Patients are expected to participate in the routines of daily living. They keep the wards clean and care for their personal belongings. Washing clothes, ironing and mending are part of the daily routine as well as mopping floors, dusting, cleaning bathrooms and making beds.

Each ward has regular times for meals, for getting up and for going to bed. Within this framework, each patient has a different daily routine which changes as his needs in treatment change. One patient leaves early in the morning for a fulltime job in the community; another is confined to the day area on the ward so the staff can keep him under careful surveillance; a third goes to class each day at the hospital school.

Sometimes specific tasks which have great therapeutic significance are assigned to patients.

*"I'm washing walls because I can't express my emotions." "Washing walls helps take out frustration, too. It's constructive instead of destructive. It helps you wash your anger away."*

Patients learn to help themselves and each other. Most wards have a group project. The patients on one ward make large stuffed dolls to sell, and with the money from this project, have bought a typewriter, record player and sewing machine for the ward.

#### D and A - Diagnosis and Assessment

One month to six weeks after the patient is admitted, the team meets with him to discuss his diagnosis and treatment. Based on the initial observations of each member of the team, this conference is important in understanding the patient's problems and deciding on the direction of future treatment. Since the patient's treatment often started before hospitalization and usually will not end with discharge, it is desirable to have professionals from the community who have worked with the patient attend this conference, also.

#### Medication

The use of medication---tranquilizers and energizers---is carefully regulated by the psychiatrist and governed by the patient's needs. It is used to alleviate severe symptoms of mental illness and may make the patient amenable to treatment. It is not used to mask the patient's symptoms nor to make him docile so he'll be less trouble. The absence of medication can also be useful in treatment, and after admission, patients are sometimes taken off drugs. Some patients, however, need the control of regulated medication and many have been able to return to the community while continuing on a regulated dose. But medication does not cure mental illness.

### ECT - Electroconvulsive Therapy

Today, ECT is used very selectively and on very few patients. But when used, the change in the patient is usually pronounced. Without active treatment, however, ECT only gives temporary relief of symptoms.

### LEAVING THE HOSPITAL

*"It's frightening to get well when you've never been healthy in your mind."*

As the patient begins to get well the team helps him prepare to return to the community. A visit home, a weekend pass, going back to school, getting a job---all are steps along the way.

It is possible for the patient to return to the community without being discharged immediately. On Limited Leave, the patient may leave the hospital for a specified length of time. On Convalescent Leave, he returns to the community for an indefinite period and goes back to his local physician for care.

For one patient, returning to the community means going home again. For another, it means starting a new life on his own. For each, it offers a mixture of hope and fear.

### THE COMMUNITY

*"The sickest people are people who won't admit they're sick. Half our society's sick."*

According to conservative estimates one out of every ten persons is mentally ill and one out of every 13 will be in a mental hospital sometime in his life.

Mental illness presents a challenge to which many of the communities Biddle serves are vigorously responding. In the 15 county area there are four mental health centers: Central Kansas Mental Health Center in Salina; Bert Nash Clinic in Lawrence; Lyon County Mental Health Center in Emporia; Prairie View Mental Health Center in Newton. Some of these centers serve several counties. They offer a wide variety of care.

Community attitudes toward mental illness are changing and professionals in the community are often instrumental in bringing about the change. In many communities, small business employers are now willing to hire patients and former patients.

Among other projects, Mental Health Associations are helping provide aftercare for patients returning to the community.

Volunteers from the community not only help individual patients on Biddle, but whole wards as well. They give parties, provide material for patients' sewing projects and buy furnishings which make the wards more homelike. Above all, they give their time and interest.

Biddle, recognizing its responsibilities to the counties it serves, is striving to meet the following goals:

1. Notify the community of major happenings to the patient such as discharge, elopement, marriage.
2. Contact the referral agency before the patient is discharged back to the community.
3. Provide consultants for professionals and other workers in the community.
4. Work with the community to develop new mental health resources.

Biddle hopes to be able to accommodate itself to changing needs in the community.

Today, many chronically ill patients who are regulated on medication and who have reached their optimum level of readjustment are placed in nursing homes. The Biddle staff is available for consultation to nursing home personnel and local physicians who run into problems in caring for former patients. The hospital will readmit any patient whose problems cannot be successfully handled by the nursing home. Social workers and psychiatric aides are also available to work with nursing home personnel so that the placement will be successful.

## Appendix D



## THE STATESMAN

## BH-1

"What's wrong with being angry?" the aide asked.

"If the group expected me to do something I didn't see the value in, even if it was for my own good, I'd be angry, too."

It was almost 1 p.m.

Seventeen girls and an aide on BH-1, Biddle Section, Topeka State Hospital, were nearing the end of a group meeting. For half an hour the group had been discussing a patient's behavior with her. Now she was angry and upset. The aide supported the patient's feelings even as the group helped her look at her pattern of behavior.

BH-1, an adolescent girls ward, has 21 patients whose ages range from 13 to 32.

The physical setup of BH-1 reveals the central place group therapy has in the life of the ward. In one large corner of the dayroom a rectangular arrangement of chairs and couches has a permanent place. It is here three times a day that group meetings, each at least a half hour in length, are held. Normally all patients on the ward participate unless they are restricted from the group.

Each day at 8:15 a.m., 12:30 and 6:30 p.m. the patients meet to discuss their problems. Under the perceptive leadership of psychiatric aides the girls support each other in treatment even as each one works on her own problems. Working together, the girls help each other gain the kind of insight which leads to change and growth.

Normally only one psychiatric aide and an attendant work the day shift. Even this amount of coverage is not always available on the afternoon and night shifts. Dr. James Horne, chief of Biddle Section and BH-1 ward physician, says he gives the ward 1 - 2 hours of consultation a week. The nurse and the adjunctive therapist for the section are available for consultation only. The social worker for the ward covers two other wards besides. At weekly team meetings the ward psychiatrist, social worker and nursing consultant meet with the day aide for an hour. At times the adjunctive therapist, a teacher or the vocational rehabilitation counselor may be present, also.

In spite of the small number of personnel BH-1 has an active treatment program. One patient who came to BH-1 from another mental hospital says, "Despite the various therapies there, they didn't grasp the individual and work with problems like they do here."

What makes the difference?

The aides, who communicate closely with other members of the team, make the group an active part of the total treatment team.

(Con't. on page 13)

BH-1 con't.

"Tell us how you want the group to help you," an aide says to a patient.

Each girl is expected to discuss her problems with the group as well as individually with the aides. The group works hard to involve each girl in meaningful therapy. Various methods are used. Giving an "observation" is one of the most effective ways. Either patients or aides may give an "observation" for either unacceptable behavior or attitude. This is discussed by the group with the girl who is given the observation. Then after considering the seriousness of the problem, the underlying reasons for it, the patient's understanding of and attitude toward it, the group presents a "solution."

Sometimes a "solution" is ward restriction, chair restriction or seclusion. But whatever "solution" is imposed it is given to help the girl think about her problems, work on them and get involved in meaningful treatment.

Speaking from experience, the girls say:

"Being put in chair restrictions will help you if you let it."

"I thought I had to kick and scream to get in seclusion. That wasn't true. Seclusion enforced discipline until I could learn to discipline myself."

The group participates actively with the rest of the ward team in making decisions. Visits with relatives, off the ward passes, even whom new patients may talk to is regulated by group rules and decisions. And the group reinforces decisions made by the rest of the team. Finally the patient stops resisting treatment and begins to work actively on her problems.

"I can see now that the team had to do what they did to make me get better."

The aides, working with the rest of the team, see that the girls get new opportunities as they are ready for them, whether its learning to make their own clothes, going back to school, finding a job or returning to the community. These are goals each girl can take for her own as she sees them slowly become reality for others in the group.

The combined mental health of the group, the honesty with which the girls face their problems, the insight and concern of the aides who are their group leaders and the close support and guidance given by the rest of the team enable BH-1 girls to change; to get well; to leave.

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*A book review by Dr. Heinz M. Grawmann, Chief Psychologist at Topeka State Hospital, has been published in Contemporary Psychology, 1969, Vol. 14. The book, "What Are You Doing, Diagnostician?" is by Pieter B. Bierkens.*

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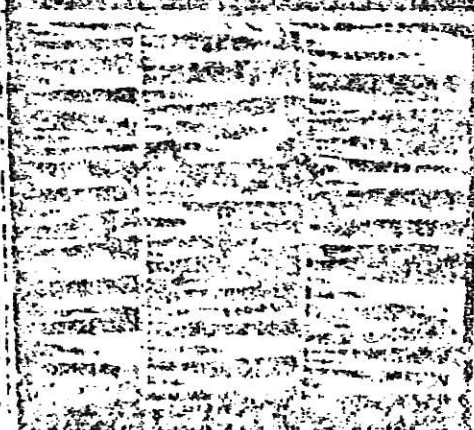
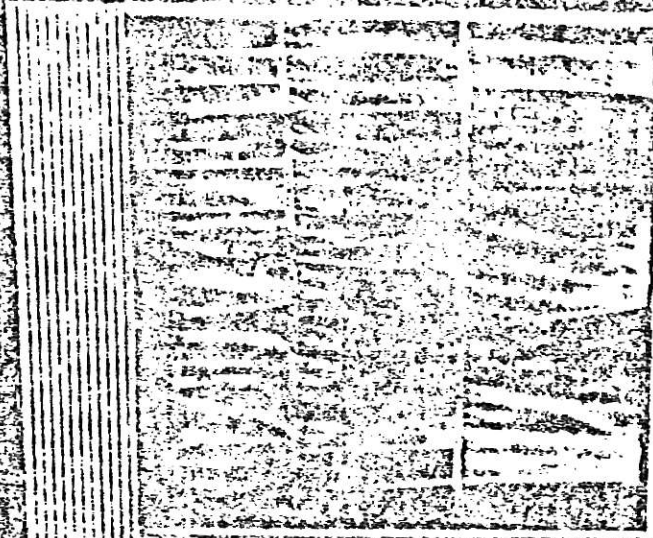
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✓ WE MUST SPEAK TO THE PEOPLE

To the dietary workers at T.S.H. and K.N.I., we are aware you are suffering hardships in your jobs. We know you are working double hard to maintain your jobs, due to the shortage of help. We know dietary workers are quitting faster than they can be replaced. There are some wards having to go to different areas to eat their meals due to help shortage. ( Especially on the children's unit of T.S.H.). We know some dinning areas are serving patients on paper plates due to help shortage. YOU KNOW ITS NOT YOUR FAULT, THE SHORTAGE OF HELP EXIST. Your difficulty probably has never been reported out of the institutions where you work. WE EXTEND TO YOU AN INVITATION TO COME TO OUR OFFICE AT 1412 EAST 6th Street to discuss your difficulties and help us work out a strategy to combat it. We know you are fearful of losing your jobs, if you speak out. THE HEALTH WORKERS, GUARANTEE THEY WILL NEVER PUT ANYONE'S JOB IN JEOPARDY BY TALKING WITH US. Dietary Workers, you must realize, we are powerless to help unless, you tell what the problems are. Let's evaluate your job. First you were looking for a job when you found that one. How much is a job worth???? When it exposes you to over work and under pay. Your supervisors are not interested in your welfare, their interest is that they maintain their position and management stays off their back. To the Aides in Nursing Service that are helping dietary workers, WE SUGGEST YOU QUIT, because you are not helping DIETARY WORKERS, YOU ARE HELPING MANAGEMENT NOT TO DO ANYTHING ABOUT DIETARY'S PROBLEM. Aides, Your job description doesn't cover you handling food in any form. Hospitals administrators could change the plight of dietary workers if they so desired. I know of Doctors who

WE MUST SPEAK TO THE PEOPLE cont'

has been given as much as \$5,000. raise if they stay on the job. Management doesn't hold your service as being important because they know you will not stick together and work for a common goal. If you could only see, you are the heart of any hospital, because everyone MUST HAVE FOOD TO SURVIVE. COME BY OUR OFFICE AND DISCUSS YOUR PROBLEM FOR WE KNOW SOMETHING CAN BE DONE, BY THOSE WHO CARE.

Emerson Stamps, Chairman  
KANSAS HEALTH WORKERS

#### CURIOSITY CORNER

If the nurse shortage is as bad as we are lead to believe, why is one of the best paying position left vacant by LEAVE OF ABSENCE?????

If the nurse shortage is so bad, how can one nurse be assigned to a psychiatric ward with less than 12 patients?????

- ✓ Is it true that a plan is being considered to use psychiatric aides to do dietary work???
- ✓ Has any body ever asked personnel department at T.S.H., and K.N.I., why they can't recruit dietary workers?????
- ✓ Is it true, that an award winning treatment program is going down the drain at T.S.H., because of the dietary department?/
- ✓ How come the personnel department doesn't publish the names of those employees leaving and new employees in the STATESMAN?????

WHERE'S THE FIRE cont'

It's here, all over America I'm talking about a fire that burns in POOR AND BLACK MENS SOULS, a fire that cannot be put out by your racist attitudes, by your military, your arrogance or by your assassinations of leaders in this country. I'm talking about a fire in Black Youth that has removed it self from Black Religion that old time religion, because they cannot identify with IT WAS GOOD ENOUGH FOR MY DEAR OLD FATHER, IT WAS GOOD ENOUGH FOR MY DEAR OLD MOTHER, IT WAS GOOD ENOUGH FOR ALL THOSE BIBICAL CHARACTERS IN THE BIBLE, and I can only say here, THANK GOD for the awareness of Black Youth that it was only a yoke around their neck and had choked generation after generation to death and since this new Awareness, they can deal with this and we can move on to the promise land. This is where the fire is, COMPLETE AWARENESS OF ONE'S SELF IDENTITY AND THE PROBLEMS THAT EXIST IN THIS COUNTRY. That the complete structure of this society is out of order, it has been out of order since the begining, and since we have become awareness of our position in this society. We can deal with this, we will deal with this by ANY MEANS NECESSARY.

Clanton Cunningham, Vice-  
Chairman KANSAS HEALTH  
WORKERS

#### LITTLE ADMINISTRATORS

From our oast effort, Let's move on to our Job Specification. Which has not and will not change soon, for they were set aside again, by the finance council, for another study by a Firm from out of state. It simply means, that after 20 years



## LITTLE ADMINISTRATORS cont'

they still have to spend more money to find out what we are doing. But we know, this is a damn lie, it is just another way to keep the non-professional down, and gain some time in which they will have another Bullshit story to tell us. In this issue we will print our job descriptions, maybe some of you really don't know what you are suppose to be doing.

PSYCHIATRIC AIDE I

KIND OF WORK: Responsible work under the supervision of a ward charge in a ward of mental patients in a state mental institution.

DISTINGUISHING FEATURES OF WORK: Employees in this class are responsible for carrying out the work schedule of the ward, and for the individual care of patients in the wards. An employee regularly supervises the work of aide trainees and hospital attendants, and has charge of the ward in the absence of the regular ward charge. Work is performed under the general supervision of the ward charge aide or nurse and the doctors.

EXAMPLES OF WORK: (Illustrative Only)

Observes and reports mental and physical condition of patients. Receives and prepares new patients. Keeps ward clean and orderly through washing, dusting, mopping, sweeping, and emptying trash. Keeps bed linen clean and changed. Gets patients in and out of bed at proper times. Dresses or helps dress patients. Supervises and directs the work of aides on duty in the absence of the

regular charge aide. Makes rounds with nurse and doctor to<sup>130</sup> receive instructions on care of patients in the absence of the regular charge aide. Performs related work as assigned.

**REQUIREMENTS OF WORK:** Considerable knowledge of the techniques of caring for mental patients. Ability to direct subordinates in the care of mental patients. Ability to follow oral and written instructions. Good mental and physical health.

**MINIMUM QUALIFICATIONS:** Successful completion of a basic training program for psychiatric aides of at least 3 months duration; or completion of other nursing training acceptable to the State Personnel Division.

#### PSYCHIATRIC AIDE II

**KIND OF WORK:** Responsible work in charge of a ward of mental patients at a state mental institution.

**DISTINGUISHING FEATURES OF WORK:** Work includes supervision of the work of lower level aides and hospital attendants who are engaged in the nursing care of mental patients. Employees are responsible for the work schedule, manner of care and general operation of the ward. Work is under the general supervision of the section supervisor, the nurse and the doctors but smaller details are left to the aide to work out.

**EXAMPLES OF WORK:** ( Illustrative Only)

Keep ward clean and orderly through washing,

dusting, mopping, sweeping, and emptying trash. Keep bed linen clean and changed. Get patients in and out of bed at proper times. Dress or help dress patients. Observe and report mental and physical condition of patients. Administer medical care as directed. Receive and prepare new patients. Supervise and direct work of aides on duty. Make rounds with nurse and doctor to receive instructions on care of patients. Performs related work as assigned.

REQUIREMENTS OF WORK: Considerable knowledge of the techniques of caring for mental patients. Ability to direct subordinates in the care of mental patients. Ability to work with professional people in the field of psychiatry. Ability to follow oral and written instructions. Good mental and physical health.

MINIMUM QUALIFICATIONS: Successful completion of a basic training program for psychiatric aides, preferably of at least three months duration, and a advanced training program for psychiatric aides of at least 6 months duration; or completion of other nursing training acceptable to the State Personnel Division.

What would happen to our program if we would regress back to the job specification they have set up for us. This would bring the Doctor's ( who have somehow managed to stay in the back ground) right down front. They should be told that our moral standard and dedication means as much to us as their

does and we will not be used and abused anymore, we ask them to help our patients by standing with us for job mobility, but they have made no attempt otherwise then to give us some lip service about what should be done. I have yet to hear them tell the people in D I.M., I will not ask the non-professional to do things that are not in his job specification, if you want them to take the role of a group therapist or social worker give them the credit and wages to go with the work. But I have seen them pat you on the back and tell you, what a good job you are doing and how much more they want you to do. Instead OF helping they keep asking more of us. Most of us do it, then get off in a corner in small groups and complain about doing everyone else job without credit. But if we stop doing all that we are not getting credit for they would change our status or spend a bundle of money trying to find some professional to do the job, so check this job specification closely. TO THE LITTLE ADMINISTRATORS, I SAY, STAND BY YOUR PEOPLE, DON'T LET THEM BE ABUSED ANYMORE.

A HEALTH WORKER

Robert Cunningham

## How to turn Black in Ten Easy

### Lessons

#### LESSON III

Your progress to date has been admirable. Lets continue with social pointers. You must now begin to reject any and all Rent a Darky invitations. Unfortunatley, there are still those Whites who feel it is slightly risque and sorta naughty to have an exotic brother or two on display at their parties.

A CASE STUDY OF ADMINISTRATIVE COMMUNICATION ON  
BIDDLE SECTION, TOPEKA STATE HOSPITAL

by

MARGARET JEAN FENTON GLAZZARD

B.S. in Nursing, University of Michigan, 1952  
B.A., Washburn University, 1967

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AN ABSTRACT OF A MASTER'S REPORT

submitted in partial fulfillment of the

requirements for the degree

MASTER OF SCIENCE

Department of Technical Journalism

KANSAS STATE UNIVERSITY  
Manhattan, Kansas

1970

## ABSTRACT

The attitudes and behavior of individuals within an organization are influenced by the nature of its communications. These communications can take different forms and follow various channels. There can be conflicting messages from different sources or even from the same source.

In regard to patients, mental hospital staffs have become highly trained in the art of receiving communications, interpreting them, and responding to them in a therapeutic manner. The vital role communication plays in the goal of better mental health for patients has received a great deal of attention and close scrutiny. Much less attention has been given to the role communication plays in relation to staff mental health or to the needs and problems of staff.

During the summer of 1969, the intern in the public information office at Topeka State hospital worked with Biddle section on a brochure. Biddle section is an adult inpatient unit at Topeka State hospital serving fifteen counties in east-central Kansas. The brochure was to meet the needs of the caregivers and professionals in this community for information about the section. While gathering information for the brochure and planning its format, the intern became familiar with the structure of communications on Biddle and was able to observe it on a day-to-day basis. The intern became a participant in as well as an observer of the communication process.

Responsibility for communications on Biddle lay mainly with the professional staff under the guidance of the section chief. The professional staff gave a consistent message to the non-professional staff as well as to

the community and to the patients. Verbal communication was reinforced by action. This led to a good working relationship among all levels of staff in a majority of situations. Communications on the section served to develop a unity of purpose and a consensus among the staff.

Outside communication systems impinged on Biddle. The non-professional staff during the summer of 1969 were often angry about and mistrustful of communications especially from administrative sources outside Biddle. These outside communications influenced the believability of communications on the section.

Lines of communication were examined in relation to the brochure on the assumption that this would be representative of the communication process as a whole. The communication process was examined in terms of seven concepts which had been incorporated in the brochure. These were concepts which Biddle had of itself privately and wished to project publicly. They represented some of the primary concerns of the professional staff in the summer of 1969. One of these concepts was that Biddle uses the team approach exclusively in treating patients. Another was that the psychiatric aide is the basic member of the treatment team in that the aide is most directly involved in the patient's treatment and spends the greatest amount of time with the patient.

The professional staff reinforced these and other concepts by non-verbal communication. Thus the entire staff was involved in decision making and treatment on the unit. The lines of formal communication were used, not by-passed, and when authority was delegated decisions were supported.

Other units at the hospital have the same channels of communication, the same impinging communication systems, and the same verbalized concepts. The good morale and high degree of cooperation found among the staff on Biddle was related to the consistent reinforcement of verbalized messages and concepts. The relative absence of "double messages" from the professional to the non-professional staff promoted mental health on the section.