HISTORY OF THE SOUTH DAKOTA HUMAN SERVICES CENTER
1879 – 2019: TRIALS, TRENDS, AND TRAGEDIES TO TRANSFORMATION

Kate L. Katterhagen
University of South Dakota

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HISTORY OF THE SOUTH DAKOTA HUMAN SERVICES CENTER
1879 – 2019:
TRIALS, TRENDS, AND TRAGEDIES TO TRANSFORMATION

by
Kate Lynn Katterhagen

A Thesis Submitted in Partial Fulfillment
Of the Requirements for the
University Honors Program

Department of English
The University of South Dakota
May 2020
The members of the Honors Thesis Committee appointed to examine the thesis of Kate Lynn Katterhagen find it satisfactory and recommend that it be accepted.

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ABSTRACT

History of the South Dakota Human Services Center 1879 – 2019: Trials, Trends, and Tragedies to Transformation

Kate Lynn Katterhagen

Director: Benjamin Hagen, Ph.D.

The history of the South Dakota Human Services Center (HSC), located in Yankton, SD, spans 140 years, from the Dakota Territory days beginning in 1879 to the present. The trials, trends, and tragedies promoting transformation of the state psychiatric hospital are the focus of this thesis, with an emphasis on significant events that shaped the facility. This research examines the challenges and changes in public administration, treatment methods, and psychiatric medical practices. My research was accomplished through identification, retrieval, and review of archived materials, reports, published newspaper articles, and personal accounts. Societal, political, legal, medical, and historical perspectives frame my analysis. The thesis utilizes an overview of chronological events in vignettes and mini essays to recount the history. The format accomplishes the objective of taking a history, spanning nearly fifteen decades, and focuses on specific highlights in a short chapter format. Upon completion, my research may be shared with the Mead Cultural Education Center, located on the HSC campus. This research will serve to increase understanding of the challenges faced when operating a public institution. This thesis strives to enlighten readers about psychiatric hospital services in order to reduce the stigma South Dakotans with mental illness often face.

KEYWORDS: South Dakota Human Services Center, Mental Health, Psychiatric Treatment, South Dakota History, State Hospital, Yankton State Hospital
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DEDICATION

This thesis is dedicated to the memory of Mary Lou Kostel (1949 – 2011), for her commitment to serving HSC for forty years. Mary worked as a librarian at HSC, with an interest in researching, documenting, and preserving the history of the facility during her years of service. As a family friend, my chance encounters with Mary often included her sharing stories of the history of HSC. Her enthusiasm and knowledge developed my interest in the facility from a very young age. Mary’s memory represents the many compassionate employees who dedicate their careers to HSC. Her legacy lives on through her detailed recordkeeping of HSC history.
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INTRODUCTION

This thesis reviews significant events that occurred over the decades that shaped the South Dakota Human Services Center (HSC), located in Yankton, South Dakota. In relation to national and worldwide events, I also researched the connections to HSC and noted their impact on the institution. The structure of this thesis, which focuses on specific important events that span nearly 150 years in a short chapter format, facilitates understanding such a lengthy history. This style supports telling the story of HSC’s transformation over the decades in a comprehensive manner.

Examining the historical context of HSC leads to a better understanding of the facility’s involvement with the community of Yankton and the greater role of the hospital in South Dakota’s medical services. In conjunction with this research, a historical understanding of HSC contributes to comprehension of the significance and impact of advancements in facilities, medical practices, and patient treatment, from the beginning of the campus until present day. Documentation of the trials, trends, and tragedies the staff and patients experienced allows for analysis of the notable moments throughout HSC’s history to current time. Through both the advancements and unfortunate events at HSC, the facility developed into a prominent South Dakota mental health institution.

HSC experienced its 140th year of operation in Yankton, South Dakota, in 2019. During nearly a century-and-a-half of operation, HSC experienced substantial changes that shaped the hospital, the community of Yankton, the employees, and most importantly, the patients who HSC served. Through the objective of examining the historical context of HSC, this thesis provides a more complete understanding of the facility’s involvement with the community of Yankton and the role of the hospital in
South Dakota’s medical services. A historical understanding and examination of treatments utilized, and review of the advancements in medical practices, assist with comprehension of the different practices applied to support the care of patients. Through the historical advancements and redirection following setbacks at HSC, the facility earned recognition as the state of South Dakota’s largest facility for mental health treatment. This substantial history exemplifies the importance of researching the past events at HSC for comprehension of the transformation of the facility.
CHAPTER ONE

Overview of the Human Services Center

Section One: Opening the Facility

The trials, trends, and tragedies of the South Dakota Human Services Center (HSC) began before the facility’s establishment. Moments of tribulation throughout history supported and required South Dakota’s development of the state’s first psychiatric hospital. Through legislative support, increase in territorial population, overcrowding of substantial facilities in other states, and research of a potential location, historical Midwest figures, especially Dakota Territory Governors John Burbank and William A. Howard, spearheaded the development of support and institutions for residents suffering from mental illness.

Governor Burbank’s advocacy for a psychiatric hospital to assist residents of the Dakotas in need of mental health treatment led to legislative support for such a facility. The process of authorizing a psychiatric hospital was a long-term project, that required the support of many historical figures to begin the venture. In 1879, South Dakota was still part of Dakota Territory, comprised of land that would later be divided into North Dakota and South Dakota.¹ Over ten years prior to the construction of HSC, Dakota Territory leadership recognized the need for a facility to care for residents suffering from mental illness. Governor Burbank emphasized the need for a mental hospital before the legislature in 1870, indicating that “the insane should be cared for as it was a duty of humanity to do so…provision should be made for the care of these unfortunates at

hospitals in other states, until a hospital could be erected at Yankton.”

Governor Burbank emphasized that patients needed care in facilities, but also encouraged separation from the rest of society through asylum isolation. While Governor Burbank’s words aided development of a psychiatric hospital, construction of South Dakota’s mental institution did not begin for another nine years, following substantial need for establishing the facility.

With the influx of midwestern settlers experiencing a hard and lonely lifestyle, the early leadership readily identified the need for mental health support for their surrounding townsfolk. The increase of transportation throughout the Gold Rush in South Dakota correlated with an enormous immigration to the area. Between 1870 and 1880, the statistics recording South Dakota’s population reflect that the number of residents increased from nearly 12,000 people to close to 100,000 people. With the substantial increase in population, the need for more psychiatric patient treatment rose considerably, as life during the era often took a negative toll on residents. Without the facilities to accommodate mental illness, Dakota Territory relied on neighboring states for psychiatric treatment. The absence of a mental institution in Dakota Territory forced patients to seek psychiatric treatment in hospitals in Minnesota, Iowa, and other surrounding states.

Overcrowding of facilities in neighboring states resulted in a return of current patients and refusal of additional cases, increasing the need for Dakota Territory to develop its own facility. As of July 1, 1878, Minnesota and Iowa facilities would no

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2 John Burbank quoted in Anna Goetz, “The History of Yankton County to 1886,” (Master’s thesis, University of South Dakota, 1927) 43-44.
3 See Ole Rolvaag’s historical novel Giants in the Earth for an account of the hardships of life on the plains of Dakota Territory.
longer accept additional Dakotan patients, and as of February 1, 1879, the thirty-five patients in these facilities were returned to Dakota Territory for care.\textsuperscript{5} These states, which faced their own problems with overcrowding and limited staffing, could not carry the burden of caring for Dakota Territory’s patients in addition to patients within their own state. This unfavorable news, in conjunction with the increase of population, demonstrated the need for development of a psychiatric facility in Dakota Territory. Following the news from surrounding states, Governor Howard explored the established towns in Dakota Territory to find a new location willing to assist the state’s patients suffering from mental illness.\textsuperscript{6} Eventually after much investigation and with the drastic number of people needing treatment, Governor Howard selected a location in 1878, for the Dakota Hospital for the Insane, now identified as one of South Dakota’s early public institutions.

Governor Howard and the legislature concluded that Yankton, in Dakota Territory, was the ideal location for the new psychiatric hospital, initiating plans for renovation of current buildings. While touring Yankton, Governor Howard noticed, “two large wooden buildings—one belonging to the city and one to the [Dakota] Territory that were built to house German-Russian immigrants that had surged in a few years before, so he declared a state of emergency.”\textsuperscript{7} Howard purchased the two buildings for $2,286.85, equal to approximately $58,439.99 in 2019.\textsuperscript{8}

When acquiring the two buildings, Howard visualized the expansions necessary to operate the hospital at that location. These plans required specific frame dimensions for

\textsuperscript{5} Dorothy Jeneks, “The Dakota Hospital for the Insane 100 Years Ago,” \textit{Humanist} 2, no. 4 (1979): 1.
\textsuperscript{7} Jeneks, “The Dakota Hospital for the Insane 100 Years Ago,” 2.
\textsuperscript{8} Ibid.
construction of the facility. Howard wanted the building to be 150 feet long by 23 feet wide with a wing, 50 feet by 23 feet, and a building possibly in the shape of a capital “T” to allow for a central hub in the middle of the facility.⁹ On January 14, 1879, the thirteenth session of the Dakota Territory Legislature voted and agreed to purchase these two buildings as the location of the Dakota Hospital for the Insane, the original name of HSC.¹⁰ During the opening of this hospital, Dakota Territory remained united with both Dakotas, with the hospital serving patients from the current states of both North and South Dakota.

Section Two: Changes throughout Operation

As needs changed in the early 1900s, the facility faced new obstacles as well. These trials led to transformation of the psychiatric hospital to accommodate the changing atmosphere. The diversification of patients, challenges during the Great Depression, and the currently utilized treatment units influenced the progression of HSC.

The diversification of patients at HSC pushed the facility to alter its name to emphasize additional services. Because of the variety of patients and treatments throughout the early 1900s, the facility leaders renamed the location the Yankton State Hospital, removing the negative connotation of “insanity” from the hospital’s title.¹¹ Removing the term “Insane” encouraged a more sensitive and supportive view of all patients receiving treatment at the facility. “Insane” features a negative connotation often

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⁹ Ibid.
¹⁰ Department of Social Services, HSC History.
¹¹ Ibid.
associated with stigma and suffering for patients in the facility.\textsuperscript{12} With the name change, the hospital emphasized an inclusiveness of treatments to care for patients with less commonly supported diagnosis of mental illness, such as alcoholism or substance abuse.

As trends and times changed, the hard years of the Great Depression increased the strain on citizens, patients, and staff at facility. With the increase of family struggles and unemployment, the number of people facing mental illness increased.\textsuperscript{13} During the 1930s, “the situation at Yankton was almost impossible to handle; an increasing rate of admissions combined with a decreasing budget…Overcrowding was a serious problem in the mid and late 1930s.”\textsuperscript{14} The facility struggled with decreased staff numbers. However, advancements in treatment helped alleviate the overcrowding in the facility, with the assistance of introductions of new medications and medical practices.\textsuperscript{15} While more trials and tribulations changed the facility, the hospital improved and expanded their services.

The next name change of the facility supported the hospital’s addition of services. To accommodate these changes in treatment, “On July 1, 1974, the name of the facility was changed from Yankton State Hospital to the South Dakota Human Services Center. The change was enacted by session of the Legislature to more clearly reflect the services offered.”\textsuperscript{16} The new name reflected the shift toward mental wellness, instead of ostracizing people with mental illness from society. These historical changes drastically

\textsuperscript{12} See Nick Fox’s research article “Stigma: Why the Words We Use to Describe People Matter” in \textit{Laborers’ Health and Safety Fund of North America}, 2017, 14(4) for further explanation of the stigma related to labeling patients as insane.


\textsuperscript{14} Ibid.

\textsuperscript{15} The impact of decreased staff and medical practices will be discussed in depth in individual sections of this thesis.

\textsuperscript{16} Department of Social Services, HSC History.
impacted the observations and opinions at HSC, but the facility still works to improve the lives of people with mental illness.

While knowledge of mental illness has changed greatly over the past 140 years, the goal of improved treatment continues as HSC’s focus throughout the hospital’s multiple units. Today, HSC’s facility has six treatment programs differentiated by age groups and mental illness diagnoses. These six units include: Adult Acute Psychiatric Program, Adult Psychiatric Rehabilitation and Recovery Program, Intensive Treatment Unit, Geriatric Program, Adolescent Program, and Adult Chemical Dependency Program.17 Today, HSC’s operating capacity is 277 beds.18 The design of HSC allows the facility to accommodate sixteen treatment units. The units include: Aspen I (Adult Acute Psychiatric Program), Aspen II (Adult Acute Psychiatric Program), Birch I (Adult Acute Psychiatric Program), Birch II (Adolescent Acute Psychiatric Program), Cedar I (Adult Acute Psychiatric Program), Cedar II (Intensive Treatment Unit for adults and youth), Maple I (Psychiatric Rehabilitation), Maple II (Psychiatric Rehabilitation), Oak I (Adolescent Intermediate Treatment Program), Oak II (Adolescent Long Term Program), Pine I (Adult Chemical Dependency), Pine II (Currently offline – was the former Adolescent Chemical Dependency Unit), Spruce I (Geriatric Treatment Unit), Spruce II (Geriatric Treatment Unit), Willow I (Geriatric Treatment Unit) and Willow II (Psychiatric Rehabilitation).19 While these treatment units operate currently as the service areas of HSC today, the original location of the facility lacked these sections. HSC’s mission is to “provide individuals who are mentally ill or chemically dependent with

18 Department of Social Services, HSC History.
19 Ibid.
effective, individualized professional treatment enabling them to achieve their highest level of personal independence in the most therapeutic environment.”

HSC updated the treatment facilities throughout history, which impacted the operation of the hospital today. Changes in approaches to mental illness and dangers of the original buildings motivated legislators to fund construction of new treatment facilities.

The diversification of patients, challenges during the Great Depression, and the currently utilized treatment units and methods positively affected the transformation of HSC. The economic and social atmospheres required alterations in name changes and services. Sadly, devastating events often were the precursor to update and improve the HSC psychiatric facility.

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21 This information will be proven and discussed throughout the entire thesis, as each section highlights how the historical events at HSC transformed the facility to current operations.
CHAPTER TWO

Fires at the Facility

For the many patients living at HSC during the early years of operation, fire was a devastating, yet common experience. Although HSC experienced multiple fires throughout operation of the facility, the tragedies of 1882 and 1899 increased awareness to the legislators and leaders of the many potential dangers within the hospital, reminding those in charge of the architectural and safety changes needed.

The wooden frames of the early hospital buildings were a conductor for potential traveling fires at HSC, causing tragedy of patient death. One deadly fire sparked in the wooden frame of the original hospital, starting at approximately 3:30 in the morning of April 2, 1882.\(^1\) Because the overcrowded facility included wood fixtures for all aspects of the building, the fire spread quickly from the west wing of the building. In roughly thirty minutes “the institution’s original frame building was completely destroyed by a fire which killed five inmates [as the patients were then called].”\(^2\) Because the facility treated individuals with severe mental health challenges, some patients struggled to comprehend the severity of fire and the need for evacuation; this resulted in five inmates’ deaths due to what authorities described as their “reckless and insane daring” behaviors: three patients ran back into the building, one man locked himself inside, and another died of smoke inhalation.\(^3\) Employees were unaware that patients were trapped inside, because

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\(^1\) *The Dakota Herald*, “Burning of the Insane Asylum,” *The Dakota Herald*, April 8, 1882, sec. A.


\(^3\) Leonard Mead, Dr. Adams, and Dr. Haas, “Early History of SD Human Services Center” (unpublished manuscript, 1957), typescript.
the staff focused their attention on the evacuated patients. Following the rescue of many patients from the burning building, the struggle for the facility staff did not end there.

The staff strove to rescue and safely secure everyone they evacuated but later had to combat the patients’ delusions and memories of the traumatic events. The Dakota Herald described the chaotic scene of rescuing the patients: “The lunatics rushed hither and thither screaming and whooping and some appeared determined to get into the burning building while others struck out over the prairies in great terror, going in all directions,” even with some patients escaping to never be found. The patients faced trauma in many ways, with their mental conditions affecting perception of the events. The tragic sight even affected the lives of the visiting townspeople. The Dakota Herald noted, “It was a sickening sight to the hundreds who came out from town to behold the skeletons of the three unfortunates smoking in the ruins and the body of another black and charred lying upon the ground near by.” Testimonies from observers revealed that the disturbing image remained in their minds for many years. The tragedy of the fire supported transformation through a new facility to replace the previous unit.

Although the extensive emotional and physical damage served to propel efforts to rebuild, the legislators already recognized a need for a new facility prior to the tragic fire. In 1881, the legislature already began construction of a new facility at HSC. Fortunately, the construction of the new building provided an area for patients to live after the devastation of the old facility. While the new facility was not yet completed, building had progressed enough to allow a residence for the surviving patients. Sadly, the devastation

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4 The Dakota Herald, “Burning of the Insane Asylum,” sec. A.
5 Ibid.
6 Ibid.
7 Ibid.
did not end for HSC, as new sparks started throughout other areas of the facility less than two decades later.

The destruction in the HSC Woman’s Building demonstrated the lack of fire safety procedures and the complications of overcrowding during the early years of the facility. On February 12, 1899, on a frigid snowy night, a fire began in the laundry room, located in the basement of the overcrowded facility. Sources conflict on when the fire started (at one or two in the morning), but they agreed that the fire occurred while most of the patients and staff slept. During this time period, HSC experienced the burden of overcrowded treatment units. The need to provide accommodations received greater priority than patient safety. “Unfortunately,” observed historian Bob Karolevitz, “because the asylum was filled beyond capacity, 40 female patients and a dozen attendants were housed in the two-story building with attic which was never meant to be used as a dormitory.”

As fire safety was not an early concern of the hospital, the building lacked fire escapes. The facility trapped patients with limited points of escape, until rescue came from the lead nurse at HSC.

This tragedy underscored the lack of fire safety procedures for the facility, endangering the staff and patients. In a recap of events, The Dakota Herald noted, “Hastily she [Mary Poncin, HSC lead nurse] sprung from her bed and realizing the terrible responsibility which rested upon her, she ran from room to room arousing the patients and urging them to flee for their lives,” and alerted staff to direct patients to exit via the locked front door.

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8 Mead, Adams, and Haas, “Early History of SD Human Services Center,” 2.
patients locked in for their safety, prevented the patients from escaping the deadly flames. In their attempt to get out, the patients directed to the locked door turned around in search of another exit.\(^\text{11}\) Nurse Poncin, “Having awakened them all (she thought)…flew down the stairs, unlocked and opened the front door and ran across the lawn to the engine house, 800 feet distant, and gave the alarm.”\(^\text{12}\) Unfortunately, not all the patients found an unlocked exit. Sources note that “in the confusion, eight of the women [patients] were forgotten behind a locked door…Within 20 minutes the main floor fell in.”\(^\text{13}\) Staff did not notice the absence of the trapped women until after the collapse of the facility’s main floor. With insufficient emergency procedures, inadequate buildings, and improper fire education, this fire resulted in the death of seventeen victims.

The HSC community continues to remember the victims of the fire through a memorial dedicated to those lost lives, reminding the facility of the need for safety and improvements. These seventeen patients died from the direct effects of the fire or from winter exposure to frigid temperatures during fire evacuation.\(^\text{14}\)

To this day, the HSC cemetery features a memorial in the shape of the cross in remembrance of the patients who died that day. The numbers on the tombstones represents the deceased patients’ hospital identification numbers. While that tragic event destroyed the lives of many women, this moment pushed the facility for improvements.

\(^\text{11}\) Mead, Adams, and Haas, “Early History of SD Human Services Center,” 2.
\(^\text{13}\) Karolevitz, “Fire on the Prairie: Frontier Blazes Brought Hell and Worry to Yankton’s Pioneers,” 169.
That devastating fire led the State Hospital and South Dakota’s Legislators to increase safety measures and funding for patients and staff at the facility. The overcrowded facility prevented the employees from locating all patients, revealing the need for increased staffing, safety procedures, and emergency exits in the buildings. When the fire ignited at HSC, “By coincidence, a legislative committee was inspecting the asylum at the time, so the members saw the results first-hand.”\textsuperscript{15} The legislature quickly realized that the state hospital was in desperate need of new and safer facilities. This devastating fire influenced the future of HSC, as patient and staff safety became a main concern of this overcrowded institution. This event led to improved safety features and practices for the entire facility. The designers of the replacement structures documented the downfalls of the previous hospital buildings to design an area equipped to prevent a similar tragedy. Through construction of the new Mead Building, the state legislators utilized these monumental tragedies to spark a transformation for improved treatment and housing for patients and staff.

\textsuperscript{15} Bob Karolevitz, “Fire on the Prairie: Frontier Blazes Brought Hell and Worry to Yankton’s Pioneers,” 169.
CHAPTER THREE

Mead Building

Section One: The Building

The South Dakota legislators addressed the issues of overcrowding and lack of fire safety through construction of the Mead Building in the early 1900s. The name of the building stems from Leonard Mead, a doctor and administrator of the facility. The Mead Building reflected the new trends and transformations throughout the hospital. The Mead Building brought improved facilities, as well as renewed hope. The unfortunate attention the devastating fires caused encouraged allocation of funding for construction and support for improved facilities. In the uses of the building, the increased objective of patient and staff safety, and the layout of the building, Dr. Leonard Mead utilized innovate designs to create a hospital that would stand the test of time.

The Mead Building and its function reveal how societal trends and needs of the facility changed over time. In 1909, the Mead Building opened with the original purpose of serving female patients and housing offices for the admissions area to the facility.\(^1\) The top floor of the building housed twenty nurses who worked at the HSC facility, providing easy access for patient care.\(^2\) During the Mead construction project, HSC still maintained the name of The Dakota Hospital for the Insane. The facility title reflected the lack of understanding of mental illness in that era and the general public’s desire to segregate people with mental illness. As times and

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\(^1\) Dorothy Jeneks, “The Dakota Hospital for the Insane 100 Years Ago,” *Humanist* 2, no. 4 (1979): 7.

\(^2\) Ibid.
opinions changed, the purpose of the building shifted. The Mead Building was vacated, except for the custodial storage and housekeeping department located in the basement.\(^3\)

Dr. Mead, the lead administrator at HSC, led the development of the new facility and improved treatments in the early 1900s. Before the devastating fires, Dr. Mead and other supervisors at HSC understood the necessity of new and safer buildings on the campus. Prior to the fire, these supervisors already began lobbying the legislature for funding to improve the safety of HSC for patients and staff.\(^4\) These fires were the wakeup call that the state legislature needed, and the state provided money for construction of a new fire-resistant building at HSC, later referred to as the Mead Building.

Dr. Leonard Mead, Superintendent of HSC from 1891 to 1899, combined healthcare and architecture through his supervision of the construction of the new building at HSC.\(^5\) The legislature allowed Dr. Mead to be the architect in charge of designing the new hospital building, which included flame retardant features in the architectural plans.\(^6\) Occurrences of deadly fires through the campus of HSC led to the necessity of buildings equipped with cement frames and other precautions to prevent fast-spreading flames. In addition, the new structures were designed to drastically increase the area of the facility to reduce the overcrowding of current hospitals.\(^7\) The need for safer facilities influenced the design, area, and aesthetics of the building, encouraging improved patient care.

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\(^3\) Ibid. Also, this building became vacant due to the construction of additional updated facilities, such as the Haas and Edmunds Buildings constructed in the 1950s.


\(^5\) Alfred Wenz, “South Dakota’s Wonderful State Hospital: An Appreciation of Dr. Mead,” The Dakota Farmer, April 15, 1917, 591.

\(^6\) Ibid.

\(^7\) Brian Gevik, “Yankton’s Mead Building”, South Dakota Public Broadcasting (blog).
Construction of the building began with Dr. Mead’s goal for a pleasing milieu to improve treatment and to eliminate the problem of overcrowding. Dr. Mead designed the building so that it contained 56 rooms and 5 dormitories totaling a capacity of 110 beds with the third floor as housing for 20 nurses. Dr. Mead utilized his architectural abilities to construct sufficient space with a focus on interior beauty for mental stimulation. He designed the new facility in an Italian Romanesque style. The building featured an Italian marble staircase and high decorated ceilings. Although Dr. Mead was the visionary behind the architecture and aesthetics of the facility, “The man in charge of creating the staircase was stonemason August Fanslow, who worked his craft for 36 years at the hospital.” To compliment the staircase, Dr. Mead designed large patios and many windows to encourage patients to access sunlight, for functionality as well as hoping this would improve their mental conditions. Dr. Mead utilized his extensive knowledge of architecture and his research in psychiatric treatment to design a facility supportive of positive patient care.

Throughout the facility’s uses, the efforts for patient and staff safety, and the design of the building, Dr. Mead utilized his abilities to create a hospital that was safe for all who occupied it. He applied his knowledge of architecture and medicine to build a facility designed to truly help the patients at HSC. That the building out-lived Mead is an indication of the lasting effect of his efforts.

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9 Ibid.
10 Ibid.
Section Two: Dr. Mead’s Treatment Regimens

Dr. Mead’s architectural abilities, combined with his medical knowledge, allowed him to develop innovative treatment methods for patients with mental illness. These treatment strategies promoted the transformation of patients’ lives and the facility with increased support. Through the use of beauty, experimental treatments, and application of care, Dr. Mead worked to create a facility focused on helping patients within the confines of available psychiatric treatment.

Implementing a plan to increase beauty throughout the hospital, Dr. Mead attempted to improve the lives of his patients. He stated, “In the treatment of the insane we find that their surroundings are very important. Normal people are influenced much more that they realize by the pictures and buildings about them, by beauty or by ugliness. They are improved or degraded by what they look upon. The same is true of the insane.”

Throughout his career, many individuals criticized Dr. Mead for wasting such beauty and money on society’s forgotten people. When asked the reason for the expenses and utilization of beauty, Dr. Mead provided a story of a woman admitted for acute melancholia, very similar to depression, that supported his opinion on the importance of beauty: “For weeks,” he observed, “she’d been completely unresponsive and seemed in despair. Then, one day, when her husband came to see her, she brightened and said, ‘Did you see the marble staircase, Pa? Isn’t it the most beautiful thing you ever saw?’” Dr. Mead strongly supported the idea that environment affects patients, attributing his success to the beautiful aesthetics of the facility.

12 Ibid.
The facility’s staff implemented many of Dr. Mead’s other artistic recommendations to help patients prior to the assistance of medication. During his time as administrator, Dr. Mead added artwork across the facility to increase pleasure and encourage positive mental stimulation. For instance, the catalog of artwork titled *Original Water Colors, Oils and Etchings in Collection at the Yankton State Hospital* demonstrates that Dr. Mead arranged the display of nearly 300 works of art in the facility.\(^\text{14}\) This action provided mental stimulation from beauty, encouraging engagement with the art and the world.

Additionally, Dr. Mead believed work and routine would assist with patients’ mental health. He required that each patient be assigned a daily job. Some patients worked with the laundry, while others tilled and planted crops.\(^\text{15}\) Patients worked in jobs according to their skills to feel satisfaction and pride in the successful completion of tasks. This practice encouraged purpose and responsibility, while providing structure in the patients’ lives.\(^\text{16}\) Also, employment at the facility allowed patients to develop skills to apply to work following their release from the facility, encouraging a higher quality of life after treatment.

Dr. Mead recognized that caring for patients as people, instead of as criminals, and educating others to that basic fact, was crucial to treatment success. Dr. Mead sculpted his practices around this idea: “In our treatment of them, we must keep two things in mind: primarily we hope to cure them [patients with mental illness] and, if this

\(^{14}\) *Catalogue of Original Water Colors, Oils and Etchings in Collection at the Yankton State Hospital*, (Yankton, SD: State Hospital Printery, 1937), 4.

\(^{15}\) Alfred Wenz, “South Dakota’s Wonderful State Hospital: An Appreciation of Dr. Mead,” 591.

\(^{16}\) As Dr. Mead’s treatment occurred prior to the era of mandatory, thorough charting of medical records, the outcome of employment as treatment was not accurately understood. However, Dr. Mead assumed that as approximately twenty percent of patients (data included on page 28) were admitted for illness similar to modern-day depression, that creating a purpose for those in the facility would help improve their condition.
cannot be done, we must care for them, usually until they die.”\textsuperscript{17} Dr. Mead’s practice focused on education of others for improving the lives of his patients. He even forbade the term “asylum,” and instead referred to HSC as a hospital. He believed “an important part of his work is to educate the public so that there may be better understanding and a more normal sentiment.”\textsuperscript{18} Dr. Mead sought to reduce the stigma surrounding mental health treatment by implementing a routine in the facility that created a sense of normal life. Through community events and conversation, he worked to educate the public and change perceptions of the erroneously held beliefs that all patients were dangerous. Dr. Mead’s methods provided inspiration for many hospitals around the nation to adopt similar designs and practices.\textsuperscript{19} Several psychologists studied Dr. Mead’s practices to learn more about his successful methods for improving treatment. Dr. Mead’s revolutionary plans encouraged improvement in the public’s opinions of mental health, influencing other institutions and sparking additional new approaches over time.

Section Three: Current Use of the Building

Teaching continues to be a central theme stemming from Dr. Mead’s beliefs, since the Mead Building is currently utilized as an education center for the region. The Mead Building is now referred to as the Mead Cultural Education Center (MCEC). Through construction of the museum, exhibits recapping history, and the potential impact of the project, the MCEC will continue to transform perceptions of history and mental health.

\textsuperscript{17} Alfred Wenz, “South Dakota’s Wonderful State Hospital: An Appreciation of Dr. Mead,” 591.
\textsuperscript{18} Ibid.
The Yankton County Historical Society contributed to the transformation of the Mead Building to accommodate exhibits from Yankton’s previous museum. The Yankton-based Dakota Territorial Museum relocation project began in 2008 after “the Yankton County Historical Society voted unanimously as a board of directors to pursue the Mead building, renovate it, and one day turn it into a new museum and cultural center.” The previous location of Yankton’s Dakota Territorial Museum was near the city’s Westside Park, where the original Dakota Territorial Museum opened to the public in 1971. Those involved selected Yankton as the original location because Yankton was the first capital of Dakota Territory.

After renovation to the Mead Building and the lease of the facility to the Yankton County Historical Society, all exhibits once on display at the Dakota Territorial Museum will find a new home at the MCEC in the upcoming years. The education center provides more space for the vast exhibits and important information about the history of the area. The Mead website notes: “In December 2018 the Mead Cultural Education Center was opened to the public. New exhibits will be added to the museum yearly. The Childrens Transportation museum is the first of its kind in the region.” Although the renovation of the building is not complete, the museum staff has slowly transported exhibits from the old Dakota Territorial Museum to the new education center.

Currently, the relocation project is scheduled in three phases and then a final stage to relocate the historical documents and wall decorations. The museum features a wide

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22 Ibid.
23 Ibid.
variety of exhibits, all focusing on the Dakota Territory, the Missouri River, Yankton County, and, eventually, an exhibit focusing on HSC. The two current exhibits at the education center include the Children’s Transportation Museum and the Journeying Forward: Connecting Cultures display. The transportation section includes child-sized reproductions of historic boats, wagons, vehicles, and more, that allow small children to physically explore and learn about travel in the past. The other exhibit currently in the museum is a life-sized display explaining Lewis and Clark’s journey in America. This exhibit originally was a traveling exhibit, but the Corps of Discovery selected Yankton to be the permanent location.24

The third attraction that will be relocated to the new museum in 2020 includes historical buildings known as Heritage Park, which resemble life from the past, including: a school house, outhouse, council building, barn, train caboose, and more. Most notably, the facility will add an exhibit featuring the history of HSC with actual memorabilia collected over the years. Inclusion of these exhibits will continue to educate the public in their future home at the MCEC, transforming the population with immeasurable knowledge of the history of South Dakota.

With the educational impact of the museum and building, Dr. Mead’s memory will live on for years to come. Although from the outside the Mead facility appears to be just another building, the revelation of the historical events that occurred inside touches the lives of many individuals. Promoting awareness for Dr. Mead’s contributions will influence the knowledge of others now and in the future.

24 Ibid.
CHAPTER FOUR

Patient Activities

Throughout the early years at the facility and the introduction of many of Dr. Mead’s practices, leadership came to recognize a need for patient engagement and activities. Although entertainment methods varied throughout the decades, providing patients access to activities remained consistent at HSC.

During the early stages of HSC, psychiatric medication remained nonexistent, requiring a variety of activities to engage the patients in hopes of distracting from their mental conditions. HSC utilized creative methods for patient engagement. Through implementation of leisure activities and job skill development, early caregivers attempted to return the spark that many patients’ lives lacked. The various activities and design of the campus reflects the changes in understanding of mental illness throughout the varying eras. Through utilization of various activities around the hospital, the facility worked to improve the lives of patients seeking treatment and minimize the extensive workload to the limited number of employees.

One of the early job opportunities at HSC was the greenhouse, utilized to grow garden food for the patients hospitalized at HSC. This section of the facility opened in 1907 and remained in operation until the 1970s.\(^1\) The greenhouse allowed access to sprouting vegetation and fresh-grown produce for patient enjoyment. While Dr. Mead was superintendent, the greenhouse provided daily jobs for many female patients. The greenhouse supported Mead’s vision of infusing purpose into the patients’ lives, while

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\(^1\) Dorothy Jeneks, “The Dakota Hospital for the Insane 100 Years Ago,” *Humanist* 2, no. 4 (1979): 6.
reducing the cost of food and labor to sustain the facility. As women were not allowed the opportunity to work in the fields with the male patients, the greenhouse provided female patients with access to a common way of life.²

The greenhouse encouraged female farmers to utilize their skills to assist the facility, but HSC staff provided many more opportunities for male patient engagement through farming and dairy barn opportunities. In 1910, workers completed construction on the first HSC dairy barn, which was over 14,750 square feet.³ As the initial dairy barn proved a success, the facility built “Dairy Barn A,” also known as the “Show Barn,” completed in 1917.⁴ The Dairy Barn served as the office for the farm superintendent allowing for the care of nearly 270 cattle, with 21,500 square feet.⁵ The dairy barn provided fresh milk and dairy products for patients living at HSC, while allowing patients to collaborate through caring for a herd. These barns helped patients, often farmers who struggled to succeed on their own before their mental illness, to work together to produce some of the best crops and cattle in the area. The cattle from HSC became known as “the best herd in the Midwest,” because of the knowledge from many different patients.⁶ On the 640 acres of farmland, patients and staff worked together to grow successful crops for nourishment of patients at the facility. The interaction with nature for former farmers suffering from mental illness improved their treatment, providing pride of accomplishment at the flourishing crops and cattle.

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² Ibid.
³ Ibid 7.
⁴ Ibid.
⁵ Ibid.
HSC administrators decided to build more traditional activities for patient engagement, even including a golf course. Through the construction of a golf course, HSC strived to stimulate patient enjoyment. Despite a limited budget, construction for this section of the facility began during the early stages of the Great Depression. The facility built a nine-hole golf course to improve patients’ attitudes and direct attention toward fun activities, completed in 1936.\(^7\) Originally the golf course included two greens – a short course option or the full nine-holes – located near the Kanner and Edmunds Buildings. However, the facility discontinued these extensively used holes, then selling the land to the city of Yankton.\(^8\) Eventually, HSC staff removed all traces of the golf course, but new patient engagement activities arose to replace the once lively greens.

As times changed at HSC, the facility focused more on patient enjoyment inside the facility through the implementation of an activities center. The Adams Building basement was the original location for this center, which began on November 26, 1956.\(^9\) The American Legion and Veterans of Foreign Wars organizations volunteered greatly to provide recreational activities to the patients at HSC.\(^10\) The basement provided enjoyment and activities for patients from nearly all treatment units. Due to the limited space, staff only allowed access to patients who were not on industrial therapy during the evening hours.\(^11\)

Demand soon exceeded the capacity of the basement center, so administrators contracted for construction of a new Activities Center. Construction was completed for

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\(^7\) Jeneks, “The Dakota Hospital for the Insane 100 Years Ago,” 7.  
\(^9\) Board of Charities and Corrections, “Thirty-fifth Biennial Report,” (South Dakota: Board of Charities and Corrections) 35.  
\(^10\) Ibid.  
\(^11\) Industrial therapy was analogous to contemporary Occupational Therapy or Vocational Rehabilitation.
the new building, which opened for operation on December 2, 1973. The facility cost approximately $803,560. Interestingly, the Activities Center stood as the newest building added to the old campus and now stands as the oldest building attached to the new hospital, which opened in 1996. The Activities Center currently provides space for the physical therapy program and therapeutic recreation for patients. Upon construction, the building included a “gymnasium, stage, swimming pool, 4-lane bowling alley, lounge, TV area, and game room.” This facility remains in operation to serve patients at HSC to provide enjoyment and the benefits of physical activities during their treatment. The bowling alley is no longer in operation due to cost and potential danger, but the other original features remain in use. Therapeutic Recreation promotes focus on physical, intellectual, emotional, social, and spiritual aspects of life. The HSC Activities Center significantly supports the Therapeutic Recreation aspect of treatment.

Patient activities varied greatly as professionals adapted to changes in the treatment of mental illness. The early farming activities supported patient enjoyment when psychotropic mediation was nonexistent. As medication designed specifically to treat mental illness became available and treatments became better equipped to improve mental illness, the varieties of activities shifted, along with the technological eras. The use of activities to stimulate patients’ attention filled time and encouraged fulfillment throughout the patients’ days. Patient activities provided enjoyment in an effort to alleviate the depression and despondency many patients experienced. HSC improved

12 Jeneks, “The Dakota Hospital for the Insane 100 Years Ago,” 14.
13 Ibid.
14 Ibid.
patients’ lives through increased activity, striving to remove the isolation and stigma associated with individuals facing mental illness.
CHAPTER FIVE

Reasons for Hospitalization

The need for services dictated the need for transformation of the facility. The reasons for admitting patients to HSC in the 1800s initially appears in stark contrast to the reasons for admission today. However, further investigation reveals common conditions, including anti-social behaviors, inability to deal with life pressures, illness, addiction, and more. Although there are commonalities in admissions rational, throughout the many years of HSC’s operation, treatments changed to accommodate the various approaches to mental illness. Across the decades, the approach to treatment transformed to accommodate common mental illness, while replacing the conditions no longer in need of in-patient care. Over time, the categories once classified as mental illness that required hospitalization transformed, and in doing so, reduced the number of ailments perceived as requiring hospitalization. This allow treatment to focus on patients with of more serious mental illnesses.

Historically, the reasons for admission into HSC reflected harsh individual environment or financial conditions. From December 1880 to December 1882, HSC had seventy-four patients admitted to the facility.¹ Many of those patients and medical professionals attributed their illness to problems of financial status, pregnancy and menstruation, or other issues no longer recognized as mental illness classifications. As research

¹ Dorothy Jeneks, “The Dakota Hospital for the Insane 100 Years Ago,” Humanist 2, no. 4 (1979): 14.
on mental illness remained limited during the initial years of HSC’s operation, the approach to treatment was limited as well. Many of the illnesses reflected the cause of patients’ symptoms, not the actual illness in need of treatment. This incomplete understanding of mental illness, coupled with a lack of psychotropic medication, limited the approaches doctors could take to improve mental conditions. However, the illnesses attributed to these conditions can be found in patients currently. While the environmental factors affecting mental illness remains similar presently, the medical science necessary to understand and diagnose disorders improved over time.

Currently, common conditions resulting in admission to HSC involves dementia, depression, bipolar disorder, and drug or alcohol abuse. Through increased medical research, doctors determined that “Dementia is not a specific disease. It's an overall term that describes a group of symptoms associated with a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities.” Due to the similarities in patients’ behavior and treatments required, medical professionals categorized these symptoms as dementia. In HSC’s current units Spruce I, Spruce II, and Willow I, treatment for dementia is designed to assist patients with memory loss connected to mental illness.

The common mental illness of “Depression causes feelings of sadness and/or a loss of interest in activities once enjoyed.” Several of the early patients receiving

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2 Department of Social Services, Human Services Center, accessed December 19, 2019, https://dss.sd.gov/
4 ST Cheng, Neuropsychiatric symptom clusters of Alzheimer’s disease in Hong Kong Chinese: prevalence and confirmatory factor analysis of the Neuropsychiatric Inventory, *International psychogeriatrics*, 2012, 24(9), 1465. While this article was based in China, this source reflects the world-wide trend of categorizing dementia.
treatment for conditions such as financial trouble, possibly had forms of depression. With current treatments, mild forms of depression can be managed through the proper balance of psychotropic medication, reducing the number of patients at HSC for such condition.

The next common condition is bipolar disorder, “also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks.” Bipolar disorder previously included belief that the patient suffered from menstrual derangement or other mood swing disorders. With increased medical research, bipolar disorder currently has treatment options available to reduce the effects of this illness.

In HSC’s adult chemical dependency unit, treatments occur for substance abuse, especially drug and alcohol addiction. This treatment utilizes a holistic twelve step approach of Alcoholics/Narcotics Anonymous. HSC’s holistic approach focuses on treatment of the whole person, including body, mind, and spirit. Referred to as Gateway Adult Chemical Dependency, the program is highly individualized with length of stay tailored to each patients’ needs.

Through increased medical research over time, the individualized treatments for mental health improved to accommodate the illnesses seen in patients. Modern medicine assisted in improved mental wellness and near elimination of some symptoms previously found in patients. Modern medicine affected the conditions requiring hospitalization, eliminating the need for treatment for several previously common diseases. The facility represents the opposite of the common saying, “If you build it, they will come.” Instead,

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7 South Dakota Human Services Center, Overview of Programs, (Yankton, SD: HSC, n.d.) 2.
8 South Dakota Human Services Center, Overview of Programs, 2.
HSC exemplifies that “If they need it, they will come,” as the need for mental illness treatment affected the units and medical approaches utilized at the hospital. As increased treatment nearly eradicated previously common diseases, mental illness treatment adjusted to accommodate other disorders. Through research in modern medicine, scientists discovered cures for delusions previously due to sexually transmitted diseases, such as syphilis and gonorrhea. As the advancements in psychotropic medication increased, due to Thorazine, Clozaril, and many more prescription drugs, the focus of mental health treatment shifted to treating diseases with more complicated solutions.

Over time the typical patient demographics at HSC shifted with the increase of psychotropic treatment. With increases in prescription psychotropic treatment, the length of stay at HSC reduced as the need for long-term service decreased. Organizations in healthcare found that the length-of-stay for patients declined exponentially following the implementation of psychotropic treatments. However, one of the largest impacts was the increased variety of community-based care facilities following medical advancements.

Following medication advancements, a variety of mental health facilities developed across the state to assist with patient treatment. As budgetary constraints altered, the need for cost containment for treatment methods grew. The Centers for Medicare and Medicaid Services (CMS), Joint Commissions on Accreditation of Healthcare Organizations, or the South Dakota Department of Health fund many

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healthcare facilities, restricting the maximum spending for organizations.\textsuperscript{11} Utilization of these departments for facilities ensured accreditation with proper licenses and reimbursement for funds. The different departments sparked growth of stand-alone facilities to reduce the number of people receiving in-patient treatment at HSC.

Several local facilities launched community-based and more economically feasible options for patients with mental illness in order to distribute the funding for treatment. An option for patients in need of supervision is the Cedar Village Assisted Living Facility (CVALF) in Yankton, South Dakota. CVALF opened in 2003, as a twenty-bed facility “designed to provide permanent supported housing for individuals who are homeless because of severe and persistent mental illness.”\textsuperscript{12} Several other long-term care facilities modeled on CVALF grew throughout South Dakota, but CVALF remains influential to HSC because of the close proximity.

Other facilities developed to support out-patient treatment, reducing the cost of constant care for patients not requiring extensive supervision. The Community Mental Health Center system developed affordable out-patient treatment services. Lewis and Clark Behavioral Health Services (LCBHS), located in Yankton, South Dakota, provides out-patient treatment. This facility strives “To pioneer and sustain comprehensive, integrated mental health and substance use treatment services that promote the health and quality of life of our community members.”\textsuperscript{13} Through increased care facilities, instead of hospitals, the organizations allow out-patient office, as well as home-based, treatment or

\textsuperscript{11} Centers for Medicare & Medicaid Services, We’re putting patients first, accessed December 31, 2019, https://www.cms.gov/
a home-like community-based out-patient atmosphere, removing the standard in-patient environment. These facilities promote treatment, through cost effective services. Addressing the budgetary options of treatment, the reasons for admission to HSC changed over time.

Through the years, the approach to mental health treatment transformed to accommodate common mental illness, while offering community-based treatment for the conditions no longer considered in need of in-patient treatment. The transformation of the facility tied directly to the evolving need for services. The historical approaches reflect similarities between the conditions for hospitalization over time. The transformation of HSC reflects the traditional needs for services throughout history, with significant developments in research affecting the admissions into the facility.
CHAPTER SIX

Rest View Cemetery

The Rest View Cemetery is the final resting place of many past residents of the hospital, with over 1,000 burials. The history of HSC’s cemetery spans from the hospital’s earliest years of operation. The cemetery provides a reminder of the devastating moments throughout the history of the hospital.

The early years of the cemetery’s existence represented the lack of attention devoted to people with mental illness. When the cemetery first opened in 1885, “only a mound of earth marked the graves of those patients buried at the Hospital.” During the original era of the hospital, the cemetery lacked the bright beautiful flowers or the stone planter that are now features on the grounds. Instead, staff in 1885 noted that the place “gave one a feeling of sadness and regret to think that these unfortunates could not have a better resting place.” The lackadaisical approach to patient burials may reflect a lack of concern with regard to those who suffered from mental illness during the time period. The patients were buried without even a sign to point their family to the proper grave.

Eventually the stigma around mental illness decreased slightly, and families often wanted to bury their loved one with his or her relatives. Members of the HSC staff noted that by “the mid 1950s, because of increased understanding about mental illness, relatives of patients were more willing to reaccept them back into their homes and communities.

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3 Elmer Aiken, Rest View, (Yankton, SD: State Hospital Printery) 2.
rather than hide them at Yankton.”

The changes in mental health treatment, medication, and deinstitutionalization during the 1960s guided families toward accepting their loved ones back into the home. With a decrease of long-term patients because of improved treatments, burials at the cemetery became infrequent. The hospital eventually discontinued burials in the cemetery in the 1950s, after 1,500 burials, but HSC staff, responding to a special request allowed for one last burial in 1999. After the last burial, the gravestones still stand in memory of the deceased patients.

The cemetery’s design promoted patient confidentiality, utilizing a conservation project to track the location of burial plots. The markers at each gravesite include a number instead of the deceased’s name in order to maintain the patients’ confidentiality. However, some families chose to provide their own marker with the deceased loved one’s name.

HSC receives occasional requests from the families of deceased patients, seeking to track the location and number of their loved one’s grave. In 1941, a Work Progress Administration project completed a file documentary correlating the numbers of the graves with the patients’ names. While this list remains confidential, HSC can assist families in tracking down the grave of a relative. The creation of a registration list of patients was not the only restorative project to occur in the HSC cemetery.

Renovation occurred to improve the grave markings of deceased patients to allow families to visit the location of their buried relative. Jim Anderson, head groundskeeper at

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4 HSC staff, Rest View Cemetery. (Yankton, SD: State Hospital Printery).
HSC during 1992, spearheaded a project to search for markers sunken and buried underground throughout the years. The project required the grounds keepers to search the cemetery for all gravestones. The groundskeepers utilized a 1933 map and a probe to uncover the graves: “It [the probe] clinks. We know when we reach one…Some take less than a minute to find, some take 15-20 minutes,” stated Anderson. The groundskeepers worked to uncover the graves to provide families knowledge of where their loved ones’ remains lie: “The important thing is that we can take them [families] and say this is where the relative or friend of the family is located.” The focus of the project was to restore the cemetery to the peaceful state that the Rest View name originally inspired.

The graves impacted HSC by allowing the facility a location to bury the deceased patients. Originally, the forgotten cemetery represented the eras when psychiatric treatment was shielded from the public. The peaceful surroundings include beds of flowers designed to lull the dead to permanent sleep. The name of the cemetery originated so that as “you seat yourself and look out over the well-kept fields of the Hospital farm toward Yankton, and you know in your heart why this has been called ‘Rest View.’ And here, in the beautiful solitude surrounding you, the sleeping await the call to wake.” The resting place of the facility holds extensive memory of the patients that HSC served throughout the years. The Rest View Cemetery remains the permanent resting place for many early patients at HSC.

7 Ibid.
8 Ibid.
9 Ibid.
10 Aiken, Rest View, 2.
CHAPTER SEVEN

Kanner Building

Improvements continued at HSC with the construction of a new section, later referred to as the Kanner Building, began in 1954. Although the “Kanner Building” was not the original title of this medical center, the facility and Dr. Leo Kanner were crucial pieces in the advancement of HSC. Kanner transformed the facility and patients’ lives through the building’s uses, his research, and his dedication to treating patients with care.

While the Kanner Building is no longer utilized for mental health treatment, the building was historically significant in its original uses. The “Hospital Building,” the original name of this location, was originally a tuberculosis unit.¹ When tuberculosis was a prominent illness, an isolated unit was necessary to prevent infectious exposure to other patients. HSC administrators converted the facility to house several other agencies and organizations during the late 1990s, after a decades long decline in tuberculosis patients.² Now referred to as the Kanner State Office Building, the location provides space for Yankton’s Department of Motor Vehicles, Rehabilitation Services, Job Service, and other agencies. Although the building itself is noteworthy in history, the greatest significance rests with the man for which the building bears his name.

Dr. Kanner improved treatment for child patients through his revolutionary research in understanding autism. Dr. Kanner was an Austrian psychiatrist, who

¹ Dorothy Jeneks, “The Dakota Hospital for the Insane 100 Years Ago,” Humanist 2, no. 4 (1979): 14.
graduated from the University of Berlin. He became an assistant physician at Yankton’s hospital in 1924 to 1928. Through application of his research to real-world cases, Dr. Kanner gained substantial knowledge on child psychiatric treatment. He was referred to as the “father of American child psychiatry” for his specialization, specifically in understanding and coining the term of early infantile autism. Psychologists and specialists still utilize Dr. Kanner’s descriptions of autism in many hospitals for diagnosing patients. Pioneer Psychiatrist Dr. Emil Kraepelin influenced Dr. Kanner’s treatment through “a biological basis for mental illness and stressed humane care and careful observation of the insane.” Through application of these early principles, Dr. Kanner researched the treatment of children unable to relate to others.

Dr. Kanner’s most famous work was his 1938 research titled “Autistic Disturbances of Affective Contact” that analyzed eleven children – three girls and eight boys – assessing the children’s “inability (from birth) to relate to people and objects in an ordinary fashion.” Those children featured similar traits throughout childhood, as well as similar socioeconomic and cultural backgrounds. Dr. Kanner conducted his research on these children at the Johns Hopkins Hospital, where he went after leaving HSC in 1928. Kanner’s findings noted that many of the children suffered with delayed speech development, difficulty relating normally to others, often had a remarkable memory,

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3 Ibid.
4 Ibid.
6 Ibid.
9 Ibid.
could learn easily, and sometimes faced difficulty when eating. Kanner was one of the first psychiatrists to conclude that children faced genetic issues and defects from birth, instead of displaying early forms of mental illness, such as schizophrenia. Based on this research and continued success throughout his career, “Kanner authored ten books and nearly 300 academic articles on autism, psychiatry, psychology, education, history and folklore. He was appointed Associate Professor of Psychiatry at Johns Hopkins in 1933, Professor of Child Psychiatry in 1957 and Professor Emeritus in 1959.”

Dr. Kanner’s research at Johns Hopkins Hospital was instrumental in increased understanding of adolescence mental illness, and his impact on HSC led to the “Hospital Building” being named in his honor.

While Dr. Kanner’s employment at HSC was before publication of his famous article about autism in children, his work with the patients supported his research and his teaching. A medical student noted the compassion he identified when hearing Professor Kanner present a case study of a child who refused to speak for several weeks. After Dr. Kanner succeeded in encouraging the child to talk again, a student questioned the doctor on how he could succeed and accomplish such a difficult feat. Dr. Kanner stated, “Well son, just a little trick that I learned over the years, which is, if you treat every person—child or adult—gently and kindly and as a real person, they frequently will speak to you when they won’t speak to anybody else.”

Dr. Kanner applied this belief during his short time at HSC.

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10 Ibid.
Throughout his career, he received many honors and awards from national associations, including the First Annual Award of the National Organization for Mentally Ill Children.\textsuperscript{13} Kanner’s biography noted, “While practicing at the Yankton State Hospital, Kanner began publishing, including a series of articles on mental health in various psychiatry journals.”\textsuperscript{14} Dr. Kanner’s legacy continued in the form of staff learning from his lessons, advancements in child psychiatry, understanding of the condition of autism, and the building on the HSC campus named in his honor. The decision to rename the facility to the Kanner Building resulted from his extensive research in mental illness and improvements to cognitive functions, specifically focused on child psychology.

The dedication of the building honored Dr. Kanner for his advancements in psychiatry. On July 24th, 1980, Dr. Kanner attended the ceremony.\textsuperscript{15} The building was formally named the Doctor Leo Kanner Memorial Admission Unit.\textsuperscript{16} In a State of South Dakota Executive Proclamation, Governor William Janklow noted that the name change was due to “Doctor Kanner’s outstanding contributions to the profession of medicine and to the children of the world.”\textsuperscript{17} In addition, November 10, 1980 was proclaimed as Doctor Leo Kanner Day again for his contributions to medicine.\textsuperscript{18} The Kanner Building holds a small display acknowledging the significance of the man for whom the building is named. Dr. Kanner’s substantial contributions to psychiatric treatment touched the lives of many.

\textsuperscript{13} Henry Travers, “Embracing a Deep Peace in My Soul: The Father of Autism and Treatment of the Insane in South Dakota,” 506.
\textsuperscript{14} Ibid.
\textsuperscript{15} Humanist, “Kanner Unit Dedicated,” 1.
\textsuperscript{16} Ibid.
of many individuals, positively impacting the experiences of patients and medical care staff.

The act of naming this building in his honor was a historical event that teaches many of his transformational treatment and continues his legacy today. In his short time at HSC, Kanner’s life-improving research shaped the future for treatment and understanding of autism. His legacy continues today because of his influence and research in the medical field. Dr. Kanner transformed the lives of patients through the building’s uses, his research, and his dedication to treating patients with care.
CHAPTER EIGHT

Historical Treatments

Treatments at HSC changed as common hospital practices improved with advancements in science and medicine. As early medical practitioners lacked the most recent knowledge of psychiatric treatment, many physicians took drastic measures to try to rid patients of their disorders. These included shock therapy and lobotomies, which often had life-altering consequences for patients. As medical advancements continued to improve, the treatment practices transformed to adapt to the new research.

Section One: Shock Therapy

In the early years of operation, prior to and after the availability of medication, the asylum staff utilized shock therapy as a treatment option for patients. Shock therapy is defined as “the treatment of mental illness by the artificial induction of coma or convulsions through use of drugs or electric current.”¹ The purpose of the therapy is to induce the body into shock, through trauma, to cause a reaction in the brain that would hopefully relieve the symptoms of some types of mental illness. Shock therapy was commonly utilized in two main forms, electroshock therapy and hydrotherapy, with the goal of restoring improved mental health for patients.

HSC staff adopted the process of Electroconvulsive Shock Therapy (ECT). They defined ECT as “a treatment for severe episodes of major depression, mania, and some types of schizophrenia. It involves the use of a brief, controlled electrical current to

produce a seizure within the brain.” The result of this treatment can lead to diminished symptoms or disappearance of the effects of mental disorders. The process of ECT typically requires six to twelve seizures, with generally three treatment sessions per week, as HSC doctors prescribed. HSC implemented ECTs as a potential treatment to cure mental illness.

Staff utilized ECTs on patients with severe depression, schizophrenia, and other debilitating forms of mental illness, believing this procedure could cure most conditions. After the invention of the ECT in Italy in the 1930s as a possible “miracle cure” for mental illness, the medical practice spread around the world in the early 1940s to relieve the symptoms of neurobiological disorders on patients. Following the invention of the new procedure and construction of the treatment capabilities at the Mead Building, the Yankton psychiatric hospital included an electric device built directly into the main walls to conduct enough electricity to cause mini seizures in the patient’s brain. This procedure was introduced at HSC as early as 1937. The hospital built the ECT equipment into the treatment ward to provide staff convenience while working with patients. Early ECTs across the country occurred with occasional detrimental results:

“Patients were also receiving the therapy while fully conscious and without ways to ensure relaxed muscles, often leading to a traumatic patient experience or possible

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3 Ibid.
4 Ibid.
damage to the bones, muscles, and spinal cord.” Although HSC did not document the early success and failures of ECTs, readers can assume that the early practices were less successful than intended, as a worldwide movement spread to eliminate the use of ECTs.8

Following the widespread use of ECTs to cure many varieties of neurobiological disorders, medical practitioners began to realize the harm the procedure caused, stopping that trend for the medical treatment. Throughout the 1980s, several states restricted the practice of ECTs in hope of protecting patients’ rights, allowing a choice before utilization of an ECT.9 Also, hospitals administered the ECTs without anesthesia, which unfortunately resulted in patient memory loss, broken bones, confusion, and other physical and medical effects.10 The treatment practice often created more health problems for patient and medical practitioners, instead of resolving mental illness, transitioning to a decrease in use of the practice. While South Dakota did not ban ECTs, the staff temporarily ceased utilization of that treatment method at the facility because of the potentially harmful effects on patients.

As early treatments did not often find successful results, research continued to transform with more successful options for patients with mental illness. Improvements in anesthesia allowed medical practitioners to administer ECTs with diminished physical harm and broken bones.11 Eventually, ECT therapy returned to HSC, with five patients receiving that treatment during 1996.12 As medical advancements improved, the practice

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8 The earliest procedures of ECT occurred prior to mandatory patient charting, resulting in limited research on the success and impact of these early medical practices.
11 Ibid.
12 South Dakota Human Services Center, 1996 Fiscal Report, Yankton, SD: Human Services Center.
of ECT continues to this day because of medical improvements. Currently, “evidence indicates that for individuals with uncomplicated, but severe major depression, ECT will produce substantial improvement in approximately 80 percent of patients.”¹³ Commonly ECTs are utilized for patients with severe depression, mania, catatonia, and dementia.¹⁴ While ECT includes some risks, medical practitioners transformed the process to improve mental illness treatment for patients.

Another method of shock therapy utilized was hydrotherapy, involving the use of water to create intense psychological reactions in patients. Many early medical practitioners believed, “Water was thought to be an effective treatment because it could be heated or cooled to different temperatures, which, when applied to the skin, could produce various reactions throughout the rest of the body.”¹⁵ Hydrotherapy at HSC utilized cold temperatures, by wrapping a patient in a blanket and placing him or her in a bath of freezing ice water.¹⁶ This tactic of hydrotherapy induced the conditions of hypothermia, which early medical practitioners believed would stimulate a patient’s mind into a shock-like state, hoping to reduce the conditions of mental illness. The staff performed these procedures in a “6-foot long claw-foot bathtub.”¹⁷ As cold water decreased the velocity of blood flow to the brain, reducing patients’ mental and physical activities, early practitioners believed this practice would improve the mental status of unruly, violent patients with the diagnosis of psychosis.¹⁸

¹⁴ Mayo Clinic, Electroconvulsive therapy (ECT).
¹⁷ Ibid.
¹⁸ St. Joseph’s Regional Mental Health Care London, Hydrotherapy.
cost and the limited alternatives during the early years of treatment, hydrotherapy was widely utilized in many mental asylums.\textsuperscript{19}

While the success rates of shock therapy at HSC were not accessible, medical practitioners in Yankton and around the nation, generally discontinued the practice of hydrotherapy following the discovery of more effective and humane psychiatric interventions and psychotropic medications. The transformation of medical treatments, nationwide trends, and increased technology allowed, and ultimately temporarily discontinued, the use of shock treatment throughout psychiatric facilities. As research increased knowledge about the dangers of shock therapy, the facilities around the world altered treatment to provide improved care for patients.

Section Two: Lobotomies

In addition to the dangers of shock therapy, lobotomy treatments included many potential threats to patients. Psychiatric hospitals across the nation, including HSC, implemented the permanent, and now seemingly barbaric, method referred to as a frontal lobotomy. According to the Merriam Webster Medical Dictionary, a frontal lobotomy is defined as a “surgical severance of nerve fibers connecting the frontal lobes to the thalamus that has been performed especially formerly chiefly to treat mental illness.”\textsuperscript{20} Following the practice of Dr. Walter Freeman, doctors employed this procedure to cure patients.

Dr. Walter Jackson Freeman II, known as the father of the lobotomy, was the leading medical practitioner of the lobotomy across the nation. Following the completion

\textsuperscript{19} Ibid.

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of his Ph.D. from the University of Pennsylvania in 1920, Dr. Freeman experimented on patients for different treatments of mental illness. He co-developed the lobotomy as a treatment for mental health conditions. On September 14, 1936, Dr. Freeman and his research colleague Dr. Watts performed the first prefrontal lobotomy in the United States. Dr. Freeman individually adapted the procedure into the transorbital lobotomy which required the practicing doctor to insert a tube through the bone behind the eye socket, severing the connection to the brain, and then injecting alcohol. This procedure was intended to cleanse the disorders of the brain. The impact of these procedures featured varying results, with lobotomies occurring in many locations around the nation.

Dr. Freeman traveled across the nation performing lobotomies on patients, even stopping at HSC. He completed or supervised 3,500 lobotomies by the end of the 1960s. Patients that Dr. Freeman treated at HSC received similar results compared to the description of the effect of lobotomies. Dr. Freeman’s scientific experimentation allowed for increased knowledge about the function of the brain. Dr. Freeman utilized his knowledge of mental abilities, gained from treating those with mental illness across the nation, to hopefully improve the lives of patients, prior to the availability of medication. Unfortunately, following the lobotomy procedure, the results of patients varied greatly; “Some patients seemed to improve, some became ‘vegetables,’ some appeared unchanged and others died.” Due to Dr. Freeman’s fourteen percent fatality rate and

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22 Ibid.
23 Ibid.
controversial utilization of an ice pick to perform lobotomies, these procedures are rarely performed today.\textsuperscript{26}

While these medical practices may seem barbaric and torturous to some today, the procedures reflect the limited accessibility of treatment options during the 1960s. Prior to the discovery of psychotropic medication, doctors had limited options to treat psychosis. While some medical staff, such as Dr. Mead, supported mental stimulation through peace, beauty, and work, other practitioners, such as Dr. Freeman, utilized the limited science available to create another possible solution. Through advancements, the treatment practices at HSC and other mental institutions shifted toward more chemical treatment and improved ECT, instead of life-altering lobotomies or hydrotherapy. The impact of scientific research on medical treatment continues to impact psychiatric hospitals across the nation, including HSC, through the use of additional treatment options.

\textsuperscript{26} Elizabeth Day, “He was bad, so they put an ice pick in his brain…,” \textit{The Guardian}, January 13, 2008, https://www.theguardian.com/
CHAPTER NINE
Advancement in Medication

Early mental health specialists relied on natural remedies and therapies. Little did they know that a stroke of luck would open a whole new regimen for the treatment of mental illness. The accidental creation of Thorazine, the first psychotropic medication, shaped the future of mental health treatment. The invention of Thorazine, scientifically known as Chlorpromazine, was critical for improving conditions of patient treatment worldwide, even though psychiatric treatment was not the original intention for the new medication. Through the creation of Thorazine as psychotropic medication, transfer to the United States from France, and the impact of the drug, the treatment practices at HSC changed significantly, improving the lives of patients.

The discoverers of Thorazine unintentionally created the first psychotropic medication through experimentation with other drugs.¹ The creators of Thorazine were investigating pain medications, which were part of a very lucrative industry. The French pharmaceutical company Rhône-Poulenc, with the assistance of chemist Paul Charpentier, set out to create a narcotic pain medication, that would stimulate the mind to reduce or prevent the feeling of pain in 1933.² Rhône-Poulenc released this drug as a possible substitute for, or potentiator of, anesthesia.³ Through experimentation of Thorazine as a surgical anesthetic, doctors uncovered the potential of the drug to produce

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¹ Psychotropic medication is defined as “any medication capable of affecting the mind, emotions, and behavior.” William Shiel, Medical Definition of Psychotropic Medication, accessed December 27, 2019, https://www.medicinenet.com/.
² Lauren Slater, Blue Dreams, (New York: Hachette Book Group, 2018), 19.
“disinterest without loss of consciousness and with only a slight tendency to sleep.”

Dr. Henri Laborit, a French surgeon and neurobiologist, was the first doctor to uncover the potential for Thorazine as a psychiatric drug. He originally utilized the drug in a cocktail mixture of 50 to 100 mg of the medication as an anesthetic supplement before operating on patients. Dr. Laborit noticed several mental effects in patients that led him to question additional uses for the drug in addition to increasing the effects of anesthesia. Doctors continued research on the physical effects of the drug and the improved attention of patients who took it for its potential to cure mental disorders.

Increased testing of the drug led doctors and researchers to uncover the potential for Thorazine to improve symptoms of mental illness in patients. The discovery of alertness, yet calmness in the patients, sparked the curiosity of researchers to consider the drug as potentially a treatment for serious psychiatric conditions. Dr. Laborit believed that the “possible use of the product in psychiatry, its potentiating action permitting, among other things, a sleep treatment with barbiturates that has an improved margin of safety.”

Through research in rats, doctors uncovered a reduction in response to adverse stimuli that would usually create a reaction in these animals. These scientists believed that this drug had the possibility to refocus the brain, removing the effects of mental illness from the body. After continued research, Thorazine treatment spread across the world eventually reaching the United States roughly thirty years after the creation of the medication.

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4 Ibid.
5 Ibid.
7 Ibid 21.
8 Ibid.
As the first psychotropic medication improved, Thorazine use expanded across the oceans to provide treatment for psychosis in the United States. The introduction of the drug into the United States was smooth, even though the salesmen initially introduced the medication as an anti-nausea pill.\(^9\) However, several French physicians and doctors published extensive research on the use of Thorazine as a mental health medication, leading the medical professionals in the United States to follow in their footsteps. Pilgrims State Hospital, in New York, was one of the first institutions in the United States to utilize the drug in hopes of treating patients with severe psychiatric conditions.\(^10\) Staff quickly saw improvements in patients’ mental functioning following Thorazine treatment.

Reports from staff at the facilities throughout the world revealed the obvious changes in patients after administering Thorazine for only a few doses. Prior to the administration of Thorazine at Pilgrims Hospital in New York, the facility’s clinical director, Henry Bill, described the “wards as dark and desperate places where each psychiatrist had 165 patients under his or her care, making it virtually impossible to practice any form of psychodynamic therapy.”\(^11\) The staff described the patients as unmanageable, before the usage of any pharmacological treatment. When asked about the impact of Thorazine in hospitals, asylum psychiatrist Martin Fleishman stated, “Patients became quieter, wards became quieter, and psychiatric aides became quieter…In short, patients became people and even more important, they became identified as people by the people who took care of them.”\(^12\) Thorazine provided patients with schizophrenia and

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\(^9\) Ibid.
\(^11\) Ibid.
\(^12\) Ibid 41.
other mental illness a chance at life again outside of an isolated institution. The results on the improvements in quality of life for patients was not an isolated incident, as people around the world found relief from the cloud of mental illness in their life. The Yankton State Hospital staff observed a similar clarity in patients when utilizing Thorazine.

Thorazine had a significant impact on HSC and improved, at least in some respects, the lives of individuals with mental illness. The implementation of Thorazine into treatment at HSC drastically reduced the overcrowded facility by no longer requiring patients to remain hospitalized for nearly their entire life. The treatment improved patients’ mental functions by providing clarity, allowing the patient to no longer need constant supervision.

Through the improvement of treatment options for neurobiological disorders in patients, HSC staff drastically reduced the number of patients requiring care in the facility. During the late 1960s, Thorazine spread throughout the United States, even reaching HSC.\(^{13}\) Prior to the release of Thorazine in the 1950s, HSC served 1,707 patients, with a decrease to 1,648 in the 1960s and even further decrease in the 1970s to 1,211.\(^{14}\) This decrease allowed over 400 people to return to the real world, instead of facing their entire life in an institution. The sharp reduction of patients at HSC improved treatment for the remaining patients, reducing the use of electroshock therapy or other potentially harmful neurological treatments.\(^{15}\) However, the greatest impact was for those

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\(^{13}\) Peter Haddad et al., Chlorpromazine, the first antipsychotic medication: history, controversy and legacy, accessed December 27, 2019, https://www.bap.org.uk/.

\(^{14}\) Dorothy Jeneks, “The Dakota Hospital for the Insane 100 Years Ago,” Humanist 2, no. 4 (1979): 15.

\(^{15}\) This reduction of patients coincides with deinstitutionalization (discussed on page 86). Understanding if Thorazine or deinstitutionalization had a larger contribution to the reduction of patient numbers is nearly impossible to conclude. However, Thorazine and later developed forms of psychotropic treatment allowed for the initiative of deinstitutionalization, as medication allowed patients to be able to no longer be isolated to asylums.
no longer receiving treatment in the facility. Life became a reality as previous patients now had the ability to be present in society. The medication improved these patients’ lives to allow experiences outside the white walls of a mental institution.¹⁶

Through the creation of Thorazine as a psychiatric treatment, approval for use in the United States, and the positive impact of the drug, the first psychotropic medication improved the lives of many patients at HSC and throughout the world. The trial of Thorazine as a psychiatric drug transformed life through patients’ release from asylums, decreased the number of residents in overcrowded facilities, and reduced workloads for overworked mental health treatment staff. As earlier statistics demonstrated, hundreds, even thousands, of South Dakotans benefited from the French scientists’ discovery. The need for ongoing research, for finding improved treatment for mental illness continued after the release of Thorazine, and even today, in an effort to encourage mental wellness and reduce delusions or violence in patients.

¹⁶ Although Thorazine was the gateway into psychiatric treatment, the medicine resulted in many negative side effects. Thorazine side effects included less-severe symptoms of “[d]rowsiness, dizziness, lightheadedness, dry mouth, blurred vision, tiredness, nausea, constipation, weight gain, or trouble sleeping,” as stated on WebMD, Thorazine Side Effects, accessed February 15, 2020, https://www.webmd.com/. In severe reactions, Thorazine caused muscle and nervous system problems, resulting in tremors and muscle spasms. The potential benefit of Thorazine generally outweighed the risks for medical professionals, by stabilizing the patients’ moods or allowing patients to no longer require constant treatment.
CHAPTER TEN

Violence and Hospitalization for Mental Illness

Mental health researcher and Director of Mental Health Policy Organization D.J. Jaffe believes, “If people with untreated serious mental illness are not more prone to violence, then mental-health experts should explain why they lock psychiatric units and put them under a system of heavy security.”¹ While many mental health organizations combat the stereotype connecting violence with mental illness, the experiences of some patients countered this belief, as seen by the death of Dr. Otto Baum. The murder of Dr. Baum reminded mental health facilities of the potential dangers of patients prior to utilization of psychotropic medication. Through Dr. Baum’s death, HSC community experienced a devastating loss reflecting the connection between violence and mental illness.

Dr. Baum lost his life while working as the clinical director in the Yankton psychiatric facility. His death resulted in the trial and conviction of the patient who killed him, but more significantly, it was a reminder to the hospital staff that some patients under their care can act upon violent tendencies. The death of Dr. Baum negatively impacted the facility, but also expressed the necessity, yet potential complications, for dealing with those facing mental illness.

The attack on Dr. Baum unexpectedly ended his life on a fall day at the Yankton State Hospital campus. At 8:00 a.m. on October 30, 1957, the sixty-three-year-old clinical director ran across the HSC campus, approached a member of the medical staff,

Dr. Elsa Riesberg, and stated, “I’ve been struck.” Following this admission, Dr. Baum collapsed, and the ambulance quickly transported him to the nearest hospital, where he died nearly an hour later. Initially having no known eye witnesses, the sheriff’s department and state agents conducted an investigation into the mysterious death. During the autopsy, the coroner noticed a puncture wound, stating “Dr. Baum may have been struck with a sharp instrument, judging from a bruise or mark on his chest.” Following the initial investigation, an unidentified patient at HSC came forward as a witness to Dr. Baum’s murder.

The patient stated he observed the attack from the window of the Ordway Building, and this patient identified fellow patient Frank Vyzralek as the attacker. Staff stated that Vyzralek had a criminal record and had been in and out of HSC since 1936. From Vyzralek’s history with violent crimes and the eyewitness’ statement, he became the primary suspect of the investigation. With a lead in the case, the investigators returned to HSC, finding an ice pick approximately 100 yards away from the location of the attack. Following a trial of the case, the jury ruled that “Dr. Baum died as the result of being struck with a sharp instrument similar to an ice pick which punctured his heart, and also that ‘it appears’ that Frank Vyzralek, a hospital patient struck the blow that caused the doctor’s death.” After this evidence, the accused patient wrote a confession to the attack.

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3 Ibid.
4 Ibid.
6 Ibid.
7 Dale Bruget, “Name Male Patient as Suspected Slayer of Dr. Otto Baum,” Yankton Daily Press & Dakotan, November 1, 1957, sec. A.
Vyzralek’s confession, written with his original misspellings, revealed his motive for murdering Dr. Baum and his need for continued mental health treatment. On November 2, 1957, Frank Vyzralek voluntarily recorded his admittance to the murder; “Dear Dr. Dalish [another doctor at HSC] – I wish you file in USA court kidnapink charge against Dr. Baker the superintendent of this institution. On Oct. 30 I the undersign is selfdence murdered Dr. Baum because hi was helping to Dr. Baker the superintendent of this institution in his kidnapink deals. I have been phisicaly and mentaly for over 2 years 100% - Frank Vyzralek.” Patient Vyzralek also informed staff that he believed Dr. Baum was the “Jewish God,” which motivated his desire to kill the doctor. Vyzralek’s confession was accepted, and he remained at the facility for continued treatment.

The ease of conviction in this case reveals the drastic changes in the court system over time, especially charges involving mental illness. Current court proceedings might possibly rule Vyzralek as incompetent to stand trial, but his letter, in conjunction with the male patient eyewitness, was sufficient evidence to convict Vyzralek for Dr. Baum’s murder. Although the state’s attorney considered a psychiatric evaluation, none occurred prior to conviction. Also, compared to modern times, the testimony from the patient in the institution at that time would have the potential to be expunged. The patient could be deemed as an unreliable witness, because of his mental illness diagnosis, indicating his lack of understanding reality. The court quickly adjudicated one patient with mental illness as violent and insane, but they relied on the testimony of another individual in the

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9 Dale Bruget, “Name Male Patient as Suspected Slayer of Dr. Otto Baum,” sec. A.
same facility for proof of Vyzralek’s conviction. This information reveals the disparity in understanding of insanity in court cases over time.

Following the murder, HSC staff and patients deeply felt the loss of Dr. Baum and needed to attend to suffering patients at the facility. As the HSC superintendent Dr. C.G. Baker stated, “Replacing him [Dr. Baum]…will be at [a] very difficult problem, since Dr. Baum knew the hospital, the patients, and the clinical routines better than anyone else.”

Finding doctors dedicated to assisting patients was not an easy task. The fact that Vyzralek was not alone in his plan to murder Dr. Baum further complicated recruiting. The facility staff moved another patient into an observational area, following the two’s conspiracy to murder the doctor. However, as the other patient did not deliver the fatal blow, the facility could not pursue legal charges. Instead, the facility placed the unnamed patient under observation at HSC, requiring more staff supervision for increased safety.

As the state identified, “The problem of dealing with patients of various types of mental derangement [often those with violent tendencies] calls for constant awareness on the part of doctors, attendants and other workers in the mental institution.” This loss of life was a sad reminder to staff to increase supervision, especially for threatening and potentially harmful behavior, to prevent additional tragedies from occurring to the staff or patients at HSC.

The murder of Dr. Baum was a reminder for staff and the facility that patients could have the potential for violent tendencies, whether or not related to their mental illness. The death of Dr. Baum transformed the life of his family, also reminding

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10 Yankton Daily Press & Dakotan, “Coroner’s Inquest Today into Dr. Baum Murder,” sec. A.
11 Ibid.
employees of the potential threat they faced while working with untreated patients.

Through Dr. Baum’s death, the criminal proceedings, the prosecution of patients who committed crimes, and the changes in standards for cases of insanity, the murder reminded individuals of the dangers of untreated mental illness in connection with violence. The death of Dr. Baum was felt across the hospital, but sadly this event was not the only moment of a devastating loss of life of a staff member at HSC.
Loss of staff life continued through the death of HSC staff member Lawrence (Larry) Pillard. The compassionate care HSC employee Pillard provided is evidenced through his commitment to supporting patients and maintaining safety. Through the life-saving act of rescuing a patient, Pillard sacrificed his own life. Even after his death, his memory continued, reminding staff even long after his death of the obligation employees have to protect and serve those in their care.

On July 25, 1974, Pillard, a Redfield, South Dakota native and a special education teacher at HSC, probably woke up assuming the day would be like any other workday. He did not expect to end the day by drowning. The Adolescent Treatment Program at HSC planned a trip to Lake Marindahl for the hot summer day. Pillard, as well as other employees, escorted and supervised a group of pre-teen and teenage patients to the lake. The day began as a normal day until, “He and other employees and patients were at the lake camping when he…[saw] the boy [an HSC patient along on the trip] floundering in deep water.”\(^1\) The employees were aware of the boy’s and other patients’ inability to swim, so the staff tried to supervise everyone. At the sight of the boy splashing in deep water, several staff rushed to rescue him. Fortunately, two other faculty members were able to

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save the drowning twelve-year-old boy, who was twenty-five feet from shore.\textsuperscript{2}

Unfortunately, the boy accidentally submerged Pillard underwater multiple times, and the other employees “attempted to rescue Pillard, but his body was found shortly after.”\textsuperscript{3} Pillard was considered a bright spot in many of the adolescent patients’ lives. HSC employees and patients truly missed the cheery educator, especially Pillard’s friend, the boy he rescued and died for on that July day.

The impact of Pillard’s generous act lives on nearly forty-five years later at HSC. In honor of Pillard’s bravery, the Carnegie Medal for Heroism was presented in his memory on July 15, 1975, almost a year following his death.\textsuperscript{4} HSC staff also provided an on-site school for adolescents, which the facility temporarily named in his honor. In 1990, “HSC education staff pursued having the school name in Larry’s memory.”\textsuperscript{5} After granting the request, Pillard’s mother, Miriam Pillard, attended the memorial ceremony. With the school bearing Pillard’s name, former students no longer faced life-long stigmatization of their hospitalization with transcripts showing credits earned at HSC, a hospital for mental illness. Later changes resulted in credits being issued by the school the child had been attending prior to hospitalization. Therefore, the facility is no longer officially recognized in Pillard’s honor. However, the facility still remembers Pillard for his compassion and courage to save the young patient, while sacrificing his own life. HSC staff proudly displays the Carnegie Medal of Honor and information about Larry Pillard to commemorate his commitment to helping the patients at the hospital.

\textsuperscript{2} Ibid.
\textsuperscript{3} Ibid.
\textsuperscript{4} Ibid.
The display in the facility’s school reflects the legacy of such a generous man, who willingly risked and lost his life to save a student. Through Pillard’s actions, he transformed the lives of patients, staff, and his special friend that he saved from drowning. Pillard tried to protect a patient, but limited measures were in place to protect the protectors.
CHAPTER TWELVE

Connections between Mental Health and Prisons

Before the fifth century, those with mental illness were often misidentified as criminals.1 Stigma prevailed during the 1800s, as people often feared individuals with mental illness exhibiting misunderstood behaviors resulting from delusions and hallucinations, believing they belonged in prison. Dr. Leonard Mead served HSC in the late 1800s; he changed HSC treatment programs, contributing to reduced stigma by caring for patients with mental health diagnoses, instead of treating such people as common criminals.

During the facility’s operation, however, there was a strong connection between HSC and prisons. As previously noted, initially patients at HSC were referred to as “inmates.” The term “inmate” is defined as “any of a group occupying a single place of residence especially: a person confined (as in a prison or hospital).”2 While the definition includes hospitalized individuals, the connotation of criminality surrounds the word. The origin of calling patients inmates possibly reflects the historical – and still apparent belief – that mental illness is a punishment for immortality or criminality.3

The numerous statistics of incarcerated individuals with mental illness reflect the connection between mental health and prisons. Even today the number of individuals with mental illness incarcerated in jail is astonishing, as nearly “2 million people with

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mental illness are booked into jails each year. People suffering from mental illness have a higher probability of being arrested, convicted, and incarcerated instead of receiving treatment for mental illness. Research noted in 2009, and updated through recent years, that “Nearly 15% of men and 30% of women booked into jails have a serious mental condition.” Society’s opinions vary greatly today on police officers’ ability to assist individuals with mental illness. The connection between mental health and criminality still are often treated similarly. On the HSC campus, the connection between the two is physically very close.

The HSC campus was home to multiple areas of the Department of Corrections throughout history. In 1970, the South Dakota legislature appropriated “funds to build a unit for women prisoners at the State Hospital at Yankton.” By “building,” the legislature renovated the vacated Sheldon building, initially built in 1911 and located on the HSC campus. The women’s unit was the first physical connection between HSC and prisons, as well as the first section of the Department of Corrections located on HSC grounds. The unit utilized the imprisoned women to assist with laundry in the immediately adjacent building and other jobs to support HSC services. The female prison unit was relocated to Springfield, South Dakota, in 1984, removing the extra support for completing laundry and other daily tasks required at HSC. The development of the women’s prison on HSC campus paved the way for other units to be established to assist with work at HSC.

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5 Ibid.  
7 Dorothy Jeneks, “The Dakota Hospital for the Insane 100 Years Ago,” Humanist 2, no. 4 (1979): 7.  
8 Ibid.
Not long after, in the mid-1970s, Yankton’s male minimum security prison, now known as the Yankton Community Work Center, opened on HSC’s campus. That prison opened “to provide support services for the Human Services Center and it has grown over the years to a working unit with a population of 150 to 240 adult inmates.” Some inmates at the work center hold jobs on the HSC campus, commonly as custodial support, food service, laundry, or grounds crews for outside projects. The male unit remains on the same campus as HSC to this day. However, separation was clearly established to prevent prisoners from working with patients at HSC. Although the minimum-security units were instrumental for prisoner vocational skill development at HSC, these two aspects were not the only connection between mental illness and the Department of Corrections at Yankton’s facility.

The Yankton Parole Services was another significant section of the Department of Corrections connected to HSC. In the mid-1970s, Yankton’s parole office originally opened in the basement of HSC’s Administration Building in the far east wing. This department opened with one parole officer in charge of parole services for seven counties, including Union, Clay, Yankton, Bon Homme, Hutchinson, Douglas, and Charles Mix. The goal of Parole Services was to reintegrate juveniles and adults released from the state correctional facilities into society. The department supervised adults and juveniles that

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10 Mark Katterhagen, interview by author, Yankton, South Dakota, June 9, 2019.
11 Ibid.
the South Dakota Board of Pardons and Parole released from incarceration, and
transitioned those individuals to the community-based supervision of parole officers.
Parole officers from across the state also managed suspended sentence cases by the
district judges. The last critical function of the parole unit was to supervise all probation
and parole cases through interstate compact with the other forty-nine states. Parole
Services worked in conjunction with HSC for treatment of paroleses with mental illness.
The parole officers transferred paroleses with mental illness requiring hospitalization to
HSC for supervision until deemed mentally competent to live in the community.

The early sole Yankton parole officer worked as the liaison between Parole
Services and HSC for mental health treatment for all paroleses in the state of South
Dakota. Upon initial service development at HSC and during the early years of parole in
South Dakota, in-patient chemical dependency treatment was very limited. HSC was the
only state facility in South Dakota that provided an in-patient treatment unit for chemical
dependency. HSC was also the only facility utilized for in-patient mental health treatment
for paroleses.\(^{13}\) Mark Katterhagen, retired Yankton Parole Officer noted,

> I was the second parole officer of the Yankton District Office. I served as the
liaison to HSC for parole services across the state for inmates who were receiving
treatment at HSC. When I started as a parole officer, there was no Jameson Annex
[current psychiatric mental health prison unit for South Dakota prisoners] which
is now located in Sioux Falls, South Dakota. Every parolee requiring mental
health treatment was transferred to the Yankton office at HSC.\(^ {14}\)

Because new medical facilities were established in Sioux Falls inside the prison walls,
paroleses and inmates no longer receive treatment at HSC. Throughout the advancement
of hospitalization, the understanding of psychiatric treatment expanded to accommodate

\(^{13}\) Mark Katterhagen, interview by author, Yankton, South Dakota, June 9, 2019.

\(^{14}\) Ibid.
patients, which impacted parolee services and connections to HSC for the Yankton Parole Office.

Some individuals hospitalized for mental illness may also face legal charges but are declared mentally incompetent to stand trial.\textsuperscript{15} Psychiatric hospitalization for those individuals focuses on restoration to competency. This modern-day focus brings forth an even stronger connection between those hospitalized and those incarcerated. The understanding of insanity as a legal defense advanced greatly, through the deprivation of wrongful mental state of the person charged with the crime. Even police officers’ approach to responding to calls with people possibly suffering from mental illness had an impact across the nation. Many police stations adopted educational programs known as Crisis Intervention Teams (CIT) to improve officer responses to situations involving those with mental illness. Statistics indicate that “In over 2,700 communities nationwide, CIT programs create connections between law enforcement, mental health providers, hospital emergency services and individuals with mental illness and their families.”\textsuperscript{16} Residents of Yankton, South Dakota are proud theirs is one of the communities promoting the CIT program that supports educational contact between law enforcement officers and the providers of mental health treatment.

Statistics of inmates with mental illness, the physical location of the Department of Corrections at the HSC facility, and the current CIT programming available today support the connection between mental health and legal systems. As the approach to

\textsuperscript{15} NAMI, Jailing People with Mental Illness.
\textsuperscript{16} NAMI, Crisis Intervention Team (CIT) Programs, NAMI, accessed December 29, 2019, https://www.nami.org/.
mental health changed greatly throughout history, the stigma decreased as well.\textsuperscript{17} The community approach toward mental illness demonstrated increasing compassion. Yankton and many communities positively affected the lives of people seeking treatment for mental illness.

CHAPTER THIRTEEN

Wollmann Incident

On June 23, 1989, the Charboneau family of Yankton did not expect their world to be torn apart by the end of the day. The sense of safety was ripped away from many Yankton residents that day. HSC patient James Verlyn Wollmann enjoyed a leisurely ride, a much-desired break from the confining walls of the mental institution. However, this ride provided Wollmann the means to escape from the facility, murder two people, and shatter the feeling of security in Yankton.

Wollmann’s criminal history initially led to his hospitalization at HSC. In 1984, Wollmann was sentenced to the South Dakota State Penitentiary, where he served about two-and-a-half years for forgery. In 1986, “After prison officials diagnosed him [Wollmann] as a schizophrenic…he was involuntarily committed to the Yankton center by Minnehaha County officials.” While at the hospital, Wollmann claimed staff mistreated him, fueling his desire for revenge. However, “Wollmann’s frequent misbehavior as a patient at the state HSC forced staff members to take disciplinary action against him, said Bill Podhradsky, a secretary of the state Human Services Department.”

Restraint and seclusion were the typical means to control aggressive and inappropriate

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1 Brian Hunhoff, “James Wollmann’s competency trial may cost county $100,000,” *The Missouri Valley Observer*, September 29, 1989, 3.
behavior. Through patient records analysis, Podhradsky concluded that there was no mistreatment of the patient, who caused such difficulty for the HSC staff. While the rumor of mistreatment fled from HSC, so did patient Wollmann while on a typical outing.

On June 23, 1989, “Wollmann, seven other patients and two staff members left the center grounds Friday night to go for a van ride.” While the group stopped to use a restroom near Lewis and Clark Lake around 7:45 p.m., Wollmann walked away from the site without staff pursuing him. At 8:33 p.m., the staff reported Wollmann missing, originally stating that the patient was not considered dangerous. Twelve hours later, after a review of Wollmann’s case file, the authorities were notified that Wollmann was “potentially dangerous.” Potentially was an understatement, as Wollmann “reportedly ripped the screen off an unlatched window and entered the Charbonneau home.”

Wollmann broke into the Charbonneau family home and discovered the family’s shotgun and rifle.

The events continued to unfold for the Charbonneau family. Forty-year-old Colette Charbonneau and her twelve-year-old daughter Chantal were asleep in the basement bedrooms. Colette’s husband Kim was out of town for the weekend, while Colette’s sister, Jessica Schoenfelder, was asleep in the upstairs bedroom. Schoenfelder worked the night shift and returned home.

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5 Ibid.
6 Deselms and Lively, “Patient held in Yankton slayings,” I.
7 Ibid.
8 Ibid.
9 Ibid.
10 Ibid.
11 Ibid.
late that night, around midnight. She told authorities, “she heard noises downstairs, but was too scared to investigate.” The scene of the crime appeared to be a robbery gone wrong. Several of the Charbonneau’s neighbors reported seeing or interacting with a man of Wollman’s description. On Saturday, June 24, 1989, the police arrested Wollman “at 9:20 a.m. Saturday, one-half mile from the house where Colette Charbonneau, 40, and her daughter, Chantal, were found dead.”

In the trial, Wollmann noted, “I went for a van ride that night and I made a run for it… I went through an old river bed and a slew [slough] and hid there until dark… I went downstairs. I saw a shotgun in the closet and I loaded it and took the shotgun and shot the woman and her daughter… twice.” During the trial, the testifying psychologist noted that Wollmann was in touch with reality to proceed with the case. While psychologists questioned whether Wollmann’s thoughts were based in reality, the facts of the case proved a tendency toward violence. Even though the police arrested Wollmann, some in the community of Yankton felt their sense of security ripped away.

Following the murders, citizens had varying opinions on whether patients receiving treatment at HSC should be allowed trips outside the facility. A portion of the town supported trips, as long as HSC staff supervised the patients and utilized proper travel procedures. Others believed, “the patients at HSC should never be allowed outside the institution on outings or otherwise because of possible danger to area residents.”

Several even believed that a large fence was necessary around the facility to prevent

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12 Ibid.
13 Ibid.
patient escapes.\textsuperscript{17} The city of Yankton hosted a public meeting for local citizens to voice their concerns and recommendations about patient interaction with the general public and outside the facility. Confusion ran rampant around the town about the policies of travel allowed for HSC patients: “Yankton Mayor Don Buehrer…said he asked state Human Services Secretary Bill Podhradsky to suspend off-campus group outings until security measures were reviewed. The request did not include individual supervised leaves.”\textsuperscript{18}

Trips reached nearly an immediate stop after the Wollmann incident.

Travel activities of patients were severely limited to only specific locations due to the concerns of the public. Prior to the Wollmann incident, HSC had allowed planned outings to the Lewis & Clark Shrine Circus in Yankton, the Czech Days Parade in Tabor, and locations of the employees’ and patients’ choosing. Spontaneous outings, such as the brief road trip to the lake area that Wollmann walked away from, were also permitted prior to the shootings. The outings came to an abrupt stop for all patients after the horrendous actions of one HSC patient. Only trips for medical, legal, and other required appointments were allowed following the deaths of the two innocent victims.\textsuperscript{19} After review and approval of the off-campus patient outings policy by the Yankton Mayor’s HSC Advisory Committee, HSC staff resumed patient outings, but with stricter regulations for travel. In compliance with the policy, HSC staff obtained permission to escort patients to local establishments. Staff determined pre-approved routes with directives to not deviate from those travel plans. Portable hand-held radio use was

\textsuperscript{19} Ibid.
mandated for each route to maintain contact with HSC in the event of an emergency.\textsuperscript{20} The treatment team reviewed each patient proposed for participating in the outing, and paperwork was prepared. Each patient’s past conduct was reviewed, and their potential threat for violence considered, before being allowed along on outings.\textsuperscript{21} Notations described patients’ clothing to ensure an accurate description in the event of a walk away. In an interview following the trial, grieving father and husband Kim Charbonneau stated, “I will never understand why the state virtually delivered a murderer to the doorstep of my home.”\textsuperscript{22} The state accepted responsibility and a settlement, which was initially confidential, was secured between the state and the Charbonneau family.\textsuperscript{23}

The lawsuit was settled, but comfort did not return to the grieving family or concerned citizens of Yankton. Prior to the settlement of the case, the court required an initial hearing to establish if Wollmann was competent for trial and conviction. Dr. Eugene Engen, a psychologist from Yankton’s Lewis and Clark Mental Health Center, testified that Wollmann “does not think like most people do. He was psychotic. He tends to be autistic and somewhat bizarre.”\textsuperscript{24} As Dr. Engen and multiple psychiatrists found Wollmann to understand right from wrong, he was considered competent to withstand trial; the proceedings began on September 25, 1989, in Brule County following the defendant’s request for a venue change.\textsuperscript{25} Wollmann pleaded guilty, but with a defense of insanity during the criminal proceedings.

\textsuperscript{20} Ibid.
\textsuperscript{21} Ibid.
\textsuperscript{22} Tia Swift, “Victims’ family assails ‘system’,” \textit{The Sioux City Journal}, June 27, 1989, 1.
\textsuperscript{24} \textit{Argus Leader}, “Wollmann is in his ‘own little world,’ psychiatrist says,” \textit{Argus Leader}, September 30, 1989, sec. A.
Wollmann’s insanity defense could not protect the state of South Dakota from a civil lawsuit. The Charbonneau civil suit settled for $950,000, which did not repair the devastation the Charbonneau family felt. Steve Johnson, the attorney for the Charbonneau family stated, “The governor [George S. Mickelson] accepted moral responsibility on behalf of the state of South Dakota for the tragedy…I am pleased that the state followed through and accepted its share of the financial responsibility as well.” The loss of loved ones was felt most strongly by the Charbonneau family, but no one won in the Wollmann incident.

The event drastically affected everyone in the small town of Yankton. The state transferred James Wollmann, who was already previously declared mentally ill, from HSC to a prison. Questions arose whether the HSC facility should relocate further from the main city population. However, Robert Kean, the Director of South Dakota Advocacy Services, reminded citizens, “The purpose of the Human Services Center is not to incarcerate people…Mental illness is not a crime in South Dakota.” The new regulations bound the remaining and future HSC patients by requiring adherence to a strict outings policy, limiting their interaction with the community. Many in the Yankton business community, who had welcomed HSC patients, missed both the business and the compassionate interaction with those hospitalized for mental illness. HSC staff lost the freedom to take recreational outings for a significant time period. HSC also lost two leaders after Administrator John A. Henderson and Medical Director Frank Johnson,

27 Ibid.
28 Argus Leader, “Psychiatrist: Wollmann in touch with reality,” sec. A.
M.D. were fired following the Wollmann incident.\textsuperscript{31} Most importantly, the community lost the feeling of innocence as guns were now placed in cabinets, doors suddenly locked, windows strongly secured, and some people now looked at those with mental illness with increasing stigma and fear of their potential for violence.

CHAPTER FOURTEEN

New Hospital Construction

To appease the concerned citizens of Yankton, HSC constructed a new facility to contain the patients. The tragedy of the Wollmann incident sparked review of safety measures. Further review indicated the best method for ensuring safety and transformation of mental health services was through construction of a new hospital. Throughout the wear and tear of daily use at HSC, the once pristine facilities became outdated and in-need of attention. Because of the necessity of extensive repair and updates needed at HSC, word from the Department of Human Services (DHS), the organization that then supervised the facility, reached the governor of South Dakota.

After observation of the aging hospital incited thought that the facility desperately needed updates, the discussion arose throughout the legislature as to how to improve the state hospital. With the leadership of South Dakota Governor George S. Mickelson, the legislature reached a decision about the facility that impacted HSC’s staff, patients, and Yankton’s future. Because of research about the facility, design of the new organization, and work from Governor Mickelson, HSC constructed the new hospital, designed for updated and improved care for patients.

Governor Mickelson spearheaded and guided the investigation on the best method to improve the HSC facility. In 1991, Governor Mickelson noticed the desperation for updated facilities, as the following year he toured HSC after hearing the Department of Human Services’ desire to refurbish the hospital tunnels system and treatment areas for
patients.\textsuperscript{1} Concerns arose about the safety of the facility, the inadequate psychiatric treatment, the buildings’ lack of compliance with fire safety codes, and the facilities’ failure to meet the standards of the Americans with Disabilities Act.\textsuperscript{2} Mickelson ordered a study about the safety and effectiveness of the existing HSC campus.\textsuperscript{3} The staff of the Office of State Engineer conducted research to compare the cost effectiveness of updating the buildings in use from the 1900s in contrast to the cost of building new treatment facilities for patients.\textsuperscript{4}

The results of the study led to the decision to build a new hospital at HSC. The study concluded that the cost of upgrading buildings was similar to the cost of a new facility. The legislature decided that a new facility, which supported the advancements in mental health treatment and compliance with new disability and fire codes, was the best course of action.\textsuperscript{5} An initial estimate of the cost to refurbish the existing buildings was close to $22 million, which would be the equivalent of nearly $40 million in 2019.

Governor Mickelson signed legislation for construction of a new treatment facility, and construction began in 1992. Notes from the groundbreaking of the facility states that, “Governor Mickelson advanced bills proposing design and construction of a new psychiatric facility which passed by an overwhelming majority of the 1992 Legislature.”\textsuperscript{6} The projected expenditures were estimated at nearly $33 million: “The consultant’s report included the usage of many existing buildings, including: the food

\textsuperscript{1} Travis Cooke, “Mental Health Care in South Dakota,” Master’s thesis, University of South Dakota, 2005, 28
\textsuperscript{2} Ibid.
\textsuperscript{3} HSC, The George S. Mickelson Center for the Neurosciences Dedication and Ground Breaking, (Yankton, SD: HSC, 1994).
\textsuperscript{4} Ibid.
\textsuperscript{5} Ibid.
\textsuperscript{6} Ibid.
service, activities center, laundry, power house, heating plant, warehouse, garages, and other support buildings.”

As nearly all the funding for the new facility came from taxes, legislative support was crucial to the improvement or construction of the hospital. Fortunately, 104 out of 105 South Dakota Legislators approved the project, and the architects initiated the planning stage. With the preplanning activities complete at HSC, designing the new facility was the next step for progress.

The architects designed the facility to maximize space for staff and patients. The state selected Dana, Larson, Roubal, and Associates as the architects for the new hospital. That company still operates today building functional and elaborate facilities throughout the nation. The facility constructed on the northeast corner of the HSC land; “The building project’s master plan was developed and provided for the separation of patient areas from those accessible by trustees and new construction for 331 total beds consisting of 60 acute, 36 adolescent care beds, 125 extended/geriatric beds, and 110 psychiatric rehabilitation beds.” The facility’s design included housing for patients with closely located treatment units for convenience of staff and patients. The facility utilized several buildings already on the campus and expanded around the current structures. The architects designed the buildings to be a single-story, to prevent unnecessary stairs and hazards for patients and staff and to support Americans with Disabilities accessibility.

The design of the buildings planned to remove possible restrictive features, commonly associated with prisons, to prevent the connections and beliefs that people

7 Cooke, “Mental Health Care in South Dakota,” 29.
9 Ibid.
with mental illness are criminals. The facility’s goal included the elimination of bars and fences to corral and imprison patients.\textsuperscript{11} Instead, the focus relied on buildings encircling each other to allow for center courtyards, where patients gained access to fresh air and sunshine with the view of building’s windows instead of restricting images of fences. The facility took precautions to allow patients as much freedom as possible, but staff utilized locked doors and other safety precautions to prevent those seeking treatment at HSC from walking away from the facility. After establishing designs centered on the safety of the facility, the ground-breaking for construction was the next step toward completion.

Many prominent South Dakotans attended the groundbreaking ceremony for the facility, a public event located in the activities center. The ceremony occurred on April 28, 1994, in memory of Governor Mickelson, who died in a plane crash on April 19, 1993.\textsuperscript{12} Speakers at the groundbreaking included: HSC Administrator Steve Lindquist, Yankton Mayor Terry Crandall, Director of South Dakota Alliance for the Mentally Ill Donna Yocom, Governor’s Chief of Staff Frank Brost, South Dakota Governor Walter Miller, and Linda Mickelson, the widow of Governor Mickelson.\textsuperscript{13} These speakers focused on the memory of Governor Mickelson and the future of the facility and the hospital. The groundbreaking ceremony led to the construction of the new building, which began in phases.

\textsuperscript{11} Merritt and Hunhoff, “‘New’ HSC Mickelson Center should open next month,” 4.
\textsuperscript{13} Ibid.
The construction of the phases of the new building coincided with the 115th anniversary of HSC’s service. Phase I of the project required clearing of trees and leveling the land at the west corner of HSC, which Slowey Construction began on May 4, 1994. Another construction company worked with the hospital to clear the area next to the activities center, which remained operational in the new section of HSC. The contractors arranged the building as one continuous circle, with different pods for the various treatment units. In the warm months the construction crews worked tirelessly to complete outside sections allowing them to complete interior work during the winter seasons.

Spanning nearly two years, following the completion of the construction, the designs changed slightly for the facility, but generally the facility remained consistent with the legislators’ and HSC’s objectives. Throughout the construction of the facility, the contractors decided “Each ward…[would] hold 15 to 23 patients and include meeting rooms, common areas and entertainment centers.” The facility focused on improving psychiatric milieu, a common term referring to treatment environment. Construction ended in the fall of 1996, and in October of the same year patients moved into the Mickelson Center.

The new hospital facility is the George S. Mickelson Center for the Neurosciences, in memory of the late Governor. While traveling to Cincinnati, Ohio, “The state’s 28th governor was killed April 19, 1993 at about 4 p.m. when a twin-engine, eight-seat airplane encountered engine trouble from a broken propeller blade

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14 Merritt and Hunhoff, “‘New’ HSC Mickelson Center should open next month,” 4.
15 Ibid.
and crashed into a farm silo about 10 miles south of Dubuque, Iowa, killing everyone on board." Governor Mickelson was a highly respected man throughout South Dakota. In order to reflect his support for improved mental health treatment, HSC received approval from the Mickelson family to honor his legacy by naming the new facility in his memory. Governor George S. Mickelson’s commitment to improving mental health treatment for the patients at HSC significantly and positively affected the lives of many across the state of South Dakota.

The impact of Governor Mickelson’s work to provide a new facility to improve mental illness continues to this day, as HSC currently utilizes the building named in his honor. With currently nearly two-and-a-half decades of service, the facility continues to make important strides in providing treatment. HSC is recognized as a regional leader in providing progressive mental health services. Throughout the struggle and diligent efforts to improve treatment across South Dakota, this facility achieved Governor Mickelson’s goal of creating a haven to help people with mental illness achieve the best possible treatments. As Governor Mickelson stated, we’re “doing the right thing for the right reason.” Because of Governor Mickelson’s impact, the facility transformed the lives of patients, staff, family, the Yankton community, and South Dakota. The project far exceeded the goal as the building was the right thing to do to help improve treatment of mental illness for the right reason.

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17 Inside HSC, “Mother Nature’s Surprise Did Not Hamper Dedication & Ground Breaking,” 2.
18 Ibid.
CHAPTER FIFTEEN

National Alliance on Mental Illness (NAMI)

A national movement began in the 1970s to reduce the stigma surrounding mental illness and improve support for family members and those seeking mental health treatment. The purpose of the National Alliance on Mental Illness (NAMI), founded in 1979, is to advocate for patients, their families, and other organizations supporting treatment of mental health. Through the creation of the organization, efforts to reduce stigma, lobbying for legislative action, and continued advocacy work, NAMI reduced misconceptions and stigma about mental health and worked to improve treatment across the nation. Active NAMI membership – around the world and in South Dakota – reminded mental health providers that others were advocating for quality care and treatment for those with mental illness.

NAMI was a grassroots effort that spearheaded advocacy for those with mental illness. The non-profit NAMI organization began with the original purpose of removing the stigma surrounding the term “mentally ill” and mental health treatments. Through educating, advocating, listening, and leading, the organization achieves success in assisting families and individuals facing mental illness. NAMI leaders quickly expanded their organization beyond its Midwest roots initially based in the rural state of Wisconsin to an international scope.¹

Several mothers, seeking support to cope with family members suffering from mental illness, spearheaded the life-changing initiative. Each

mother had an adult child suffering from severe mental illness and found themselves with no support network for guidance. Through their suffering “[a]gainst the forces of stigma and discrimination, they channeled their fears and frustrations to bring about positive change for their loved ones and others.” NAMI developed four common areas of focus, referred to as the cornerstones: Support, Education, Advocacy, and Research. From small roots, the constantly growing organization strives to improve all four areas of knowledge about mental illness.

The parent organizers developed the NAMI program in 1979, originally titled the National Alliance for the Mentally Ill, to provide the encouragement that the mental health systems lacked for those seeking services around the Wisconsin area. The organization changed its name to the National Alliance on Mental Illness, in 2005 to reflect first-person language and emphasis on action. The initial title of the National Alliance for the Mentally Ill hindered membership. While there were classifications for family, member, and consumer membership, prospective members may have feared the stigma of others believing they were mentally ill. A professional may have hidden membership and not boldly list the organization on their resume for fear that prospective employers may believe that the applicant was mentally ill. The new title, the National Alliance on Mental Illness, allowed membership by all, removing the potential stigma.

Eventually the NAMI program spread across the nation to promote improvements in mental illness research, education, and advocacy. The program reached South Dakota

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2 Ibid.
3 Ibid.
4 Ibid.
5 Ibid.
6 Ibid.
in 1987, with Brookings residents as the first to introduce the program in the state.\(^7\)

Shortly thereafter, Sioux Falls residents joined in the initiative to provide support networks for people suffering with mental illness. Yanktonians then developed a NAMI program to serve individuals and families seeking assistance from the multiple treatment facilities for those with mental illness.

Every year South Dakota encourages improvements in mental health treatment, even hosting a NAMI conference for education of professionals, family members, and those with mental illness. The NAMI South Dakota conference has secured nationally recognized leaders in the field of mental health to educate providers across the state on new and improved mental health treatments.\(^8\) The gathering of professionals, consumers, and their families builds an alliance of those dedicated to improving treatment and the quality of life for those with mental illness. The organization sponsors NAMIWalks to raise funds for programming to serve the one-in-five individuals who experience mental illness in their lifetime.\(^9\) NAMI is the support system for those otherwise lacking support. Through NAMI’s work with advocacy, the negative connotation some people associated with mental illness became more apparent, improving acceptance and understanding for those suffering with mental illness.\(^10\)

Although the reduction of stigma was a noteworthy accomplishment of the organization, another pivotal action was NAMI’s involvement with lobbying for legislative changes revolving around mental illness. NAMI supported the federal Mental

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\(^8\) Ibid.


Health Parity Act of 1996. This act “provided that large group health plans cannot impose annual dollar limits on mental health benefits that are less favorable than any such limits imposed on medical/surgical benefits.” In summary, this act required that insurance companies must cover treatment for mental illness, just as they would cover any physical disorder. While the policy on this act changed slightly throughout the years, NAMI was instrumental in the success of this legislation, ensuring that individuals throughout the nation have insurance coverage to access neurobiological treatment when necessary.

The success of NAMI continues through ongoing support for mental health legislation and advocacy for those with mental illness and their families.

The impact of NAMI lives on today through work to improve the lives of those with mental illness. Through support, education, advocacy, and research, NAMI succeeded in reducing the stigma related to mental illness and psychiatric treatment. Due to the NAMI program, people with mental illness became more accepted into society, instead of ostracized in insane asylums. During May Mental Health Month, NAMI provides thought-provoking quotes to spark discussion about the impact of mental illness to reduce stigma. NAMI advocate Paula Cayer reminded individuals that there is “no difference between my brain not being able to make correct levels of serotonin [usually the cause of depression] and my pancreas not being able to make the right amount of insulin [the cause of diabetes].” Following this mindset, NAMI supporters encourage individuals and society to ignore previous misconceptions about mental illness.

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13 NAMI South Dakota, About NAMI South Dakota.
NAMI provides classes, resources, and programs to assist patients and families through the process of mental health treatment. South Dakota is a very rural state with limited resources and support groups. The toll-free NAMI telephone line provides a resource for mental health support, advocacy, and education in all locations.\(^\text{15}\) Those in recovery with mental illness and family members of those with mental illness lead classes to assist individuals cope with the stigma of mental illness.\(^\text{16}\) Through their You Are Not Alone movement, NAMI promotes success stories of patients’ recovery journeys. The successful approach serves to remind individuals of the support surrounding them and to inspire them by sharing similar experiences of others. These programs emphasize how NAMI and mental health treatment allow individuals to regain control of their life, transitioning to a better future for themselves and their loved ones.

The NAMI program grew from its original grassroots to become recognized internationally for improving the lives and services for families and people suffering from mental illness.\(^\text{17}\) Through the creation of the organization, efforts to reduce stigma, legislative action, and the continued work today, NAMI South Dakota successfully increased support systems and education surrounding mental health treatment. Similarly, other nationwide initiatives worked to assist individuals with mental illness in the creation of support systems through community-based facilities.

\(^{15}\) NAMI South Dakota, About NAMI South Dakota
CHAPTER SIXTEEN

Individualized Mobile Program of Assertive Community Treatment

Following the creation and application of psychotropics medication, care for patients progressed to include community-based facilities for individuals with manageable forms of mental illness. With the substantial decrease in hospitalized psychiatric patients across the nation between the 1950s to the 1970s, the need for community facilities increased for patients. Establishment of community mental health centers was key to successful community-based transition. A movement established in the 1980s and 1990s, known as the Individualized Mobile Program of Assertive Community Treatment (IMPACT), assisted in the transition between full-time psychiatric care to out-patient treatment. Through the creation of the program, the growth of the project, and the success of the community-based services, IMPACT supported the trend of deinstitutionalization and transition to out-patient treatment in South Dakota.

In order to improve the connection and reintegration process of patients from the state hospital into Yankton and other communities, the state of South Dakota established IMPACT. In November 1992, Yankton officials launched this program to assist with the transition of patients from HSC who did not require twenty-four-hour care, back into the community.¹ The IMPACT program sought to provide community-based supervision. The original location of IMPACT was on the HSC campus, with relocation to the corner of 4th and Broadway, in Yankton. Based on East-Coast club house models, Yankton’s

¹ South Dakota Human Services Center, Overview of Programs, (Yankton, SD: HSC, n.d.) 4.
IMPACT program was the first of its kind in South Dakota, serving as a model for other communities.

Originally IMPACT started small, with “seven clients, all former patients from the SDHSC [South Dakota Human Services Center] who had an average length stay of 4-1/2 years.”\(^2\) Over the past few decades, the IMPACT program expanded to include additional centers across the state. The other locations are in Rapid City, Huron, Sioux Falls, Aberdeen, and Pierre.\(^3\) Although the program expanded throughout the state, the focused remained on community-based treatment for people with mental illness.

The IMPACT program allowed previously institutionalized patients access to independently based supervision from the comfort of their own residence. The staff at IMPACT “provide support and assistance with medication, money management, transportation, housing, and other needs.”\(^4\) IMPACT continues to improve the lives of patients with mental illness, to provide support when options are limited. The program utilized a team approach as “[p]sychiatrists, substance-abuse specialists, mental-health professionals, nurses, and employment specialists work together to give consumers the wide array of ongoing, individualized care that they need.”\(^5\) The service offers continuous care to provide patients assistance for as long as necessary. The objective of the program includes that “IMPACT helps consumers struggling with mental illness to get back on their feet.”\(^6\) The IMPACT program continues to create life-changing services as they seek recovery for mental illness for many people throughout the community of Yankton.

\(^2\) Ibid.
\(^3\) South Dakota Department of Social Services, Community Behavioral Health Services, accessed February 29, 2020, https://dss.sd.gov/behavioralhealth/community/.
\(^4\) South Dakota Human Services Center, *Overview of Programs*, 4.
\(^6\) Ibid.
The Yankton IMPACT program made award-winning strides to improve the lives of those they served. During the month of October, 1993, the South Dakota Chapter of the National Alliance for the Mentally Ill awarded IMPACT the “Outstanding Service Award” for “exemplary efforts at providing community services for persons with severe mental illness.”7 Another award that IMPACT received was the South Dakota “Governor’s Employee Excellence in Teamwork Award” for “improving the lives of people with mental illness in this State.”8 These exemplary honors reflect the strong community ties developed through this program and the increased advocacy for those with mental illness.

IMPACT complemented HSC by allowing the community to have another resource for mental health treatment, specifically for patients not requiring constant supervision. In 2002, the IMPACT program increased its capability to serve nearly fifty-five patients through relocation to a larger facility at 301 Capital Street, Yankton, SD.9 This move allowed fifty-five individuals to no longer be confined to an institution. The relocation served a dual purpose in that it accommodated a Department of Transportation highway expansion plan. The program continues to operate today allowing for twenty-four-hour support.

The IMPACT program provided positive treatment, especially for many former HSC patients throughout the years of operation. Former HSC Administrator Cory Nelson

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7 South Dakota Human Services Center, *Overview of Programs*, 4.
8 Ibid.
9 Ibid.
stated, “HSC is grateful to the citizens of Yankton for supporting this community-based mental health program…. The success of the IMPACT program reflects positively on the work of the staff and the clients. IMPACT’s success also reflects the Yankton community’s genuine concern for persons with mental health disorders.”

The development of IMPACT improved the care and support systems provided throughout the community, allowing for better services for those with mental illness. Eventually, the program expanded to receive patients who did not have prior hospitalization at HSC. The IMPACT program continues to touch the lives of many seeking assistance and shapes the community’s interaction with people with mental illness. However, possibly the largest impact this organization created involved reducing the long-term patient census at HSC. This organization reduced the number of patients hospitalized at HSC and improved the lives of individuals suffering from less severe symptoms of mental illness. After the creation of IMPACT, people with well-managed symptoms of mental illness had a place to seek assistance with out-patient support, instead of readmittance into HSC.

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CHAPTER SEVENTEEN

Mental Health Legislation

Historically, legislation focused on individuals with mental illness was limited, possibly due in part to the stigma surrounding psychiatric treatment. However, with increases in understanding and support of those with mental illness, lobbying for legislation ensuring rights to those receiving care rose as well. With assistance from South Dakota Codified Law Section 27A, HSC commitment hearings, and the Least Restrictive Environment Legislation, the state adopted legal mandates in the 1960s to assist those receiving treatment for mental illness throughout the state, and thus transformed the facility.

Currently, mental health and chemical dependency are the only types of illness for which courts regularly mandate treatment. Through court-ordered commitment hearings, individuals are legally mandated to remain hospitalized and required to seek treatment for a mental illness. However, with any other illness, such as cancer, an individual has the right to refuse treatment or check out of any hospital against medical advice (AMA). Few people understand that mental health is one of the few illnesses in which the legal system potentially controls the involuntarily admitted patient’s treatment and legal rights. As one example, following involuntary commitments to HSC or other mental illness in-patient treatment facilities, patients no longer have the right to own firearms. Patients, who believe their constitutional rights were violated in losing their freedom through involuntary commitment, have defenses to contest such decisions regarding loss of their rights.
A legal defense developed over time to prevent mental illness commitments and suppression of individual rights for patients who did not need such intensive services. One of the original defenses to unnecessary involuntary commitments to mental institutions was a Writ of Habeas Corpus.¹ This action allowed individuals to contest their involuntary commitment to mental health facilities in the presence of a judge, if they believe they were unconstitutionally detained. In order to prevent unnecessary commitments into HSC and other facilities, the South Dakota government enacted the South Dakota Codified Law Section 27A.

The state identified the characteristics for involuntary commitment to a mental health facility. Legislators initially passed this law in 1966, to solidify the requirements for involuntary commitment into HSC and other mental health facilities throughout the state of South Dakota.² The law stated, that a “person is subject to involuntary commitment if: (1) The person has a severe mental illness; (2) Due to the severe mental illness, the person is a danger to self or others or has a chronic disability; and (3) The person needs and is likely to benefit from treatment.”³ This section supports the process for commitment into HSC’s treatment facility.

Section 27A assists mental health professionals in understanding the requirements necessary for involuntary treatment into an in-patient facility. Prior to commitment, this act requires a petitioner, who is a witness to the individual’s behavior, to file a Petition

³ Ibid.
for Emergency Commitment to the chair of the Yankton County Board of Mental Illness. Following the Petition, individuals placed under a mental health hold are then taken into physical custody, varying from jail to other treatment facilities. A Qualified Mental Health Professional (QMHP) conducts a psychiatric evaluation of an individual placed under the hold. The QMHP, based on statue-set education and credentials, conducts an assessment indicating whether an individual is treatable in the local community, requiring the individual to remain in the least restrictive environment for out-patient mental health treatment. In-patient treatment is generally not the least restrictive option. The other conclusion that the QMHP could reach is whether an individual has mental illness that is too severe to be successfully treated in the community, requiring in-patient treatment at HSC or other mental health facilities. This process precedes the involuntary commitment hearing conducted at HSC for admittance into the facility.

If the QMHP’s decision requires treatment, the Yankton County Board of Mental Illness conducts an involuntary commitment hearing at HSC. To ensure accuracy and provide a legal record, a court reporter transcribes the hearing for future reference, in case a patient appeals the board’s decision. After an individual receives notice of the hearing, he or she is assigned an attorney or allowed to hire their own attorney. The Chair of the Board of Mental Illness swears in a QMHP for testimony and presentation of the psychiatric history of the patient, providing a recommendation if the individual should be committed to the mental health facility or released into the community. Then, the patient’s attorney has the opportunity to cross-examine the QMHP. Next, the defense

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5 Ibid.
6 Ibid.
attorney could call the patient, if he or she is willing to testify. The state’s attorney may cross-examine the patient, if he or she testified. Occasionally additional witnesses, especially family, may testify at the hearing. To conclude the hearing, the Board of Mental Illness deliberates in a separate room, reviewing all facts presented and deciding whether the patient needs further treatment or meets criteria to be released into the least restrictive environment.⁷

The Least Restrictive Environment (LRE) Law supports the concept that individuals with mental health challenges should be placed in the least confining and restraining environment able to meet their required level of care. Legislation defines LRE as “Persons with mental health disorders should be provided with healthcare which is the least restrictive.”⁸ This law requires that individuals who are not suicidal, a danger to themselves, or homicidal, a danger to others and are able to maintain appropriate self-care, are released into the least restrictive care environment. This act supports the release of patients who meet the required conditions from in-patient mental health treatment facilities into out-patient centers, that do not require constant supervision.⁹ The LRE law affects HSC through removal of patients who do not require constant supervision. The act allows individuals to find care in facilities that support their required level of need, reducing unnecessary hospitalization at in-patient facilities, such as HSC.

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⁷ Ibid.
⁹ Ibid.
CHAPTER EIGHTEEN

Leadership and Administration

As American businessman S. Truett Cathy stated, “A business, successful or not, is merely a reflection of the character of its leadership.”¹ HSC operates in a similar manner, as the agencies in charge of the facility reflect the variances in success of operation and treatment. The variances during the shifting eras of administration sparked changes in the facility. Throughout the eras of the Board of Charities and Corrections, Department of Human Services, and Department of Social Services, HSC experienced changes in budgets and focus that affected the success of the facility.

During HSC’s early days of operation, the leading government department in charge of the facility’s organization was the South Dakota Board of Charities and Corrections. As South Dakota established the Board of Charities and Corrections in 1890, the hospital experienced approximately eleven years of early operation without guidance from this organization.² Unfortunately for the early era at HSC, the number of “prisoners,” now referred to as patients, increased exponentially with the influx of immigrants searching for gold in South Dakota’s Black Hills during the early 1870s.³ The Board of Charities and Corrections oversaw both mental health treatment and prisons, with its limited budget.⁴ The initial budget allowed only limited expansions throughout

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³ Ibid.
⁴ Ibid.
the facility. However, the initial limitations did not restrict HSC from achieving many influential changes under the Board’s direction.

Under the direction of the Board, HSC constructed the initial hospital and the Mead Building, accommodating the necessary expansions of the facility. The Board supported advancements to improve the safety of the facility, applying the available funds when the demand was urgent. However, the leadership by the Board of Charities and Corrections ended, following Constitutional Amendment D, which dissolved the agency in November 1988. Following the dissolution, the state of South Dakota created two agencies to control the areas previously under the Board of Charities and Corrections: the Department of Corrections (DOC) and the Department of Human Services (DHS). Governor George S. Mickelson created DOC in March 1989 to oversee matters in South Dakota regarding prisons, jails, parole, and juvenile correctional facilities. DHS, created in 1988, facilitated organizations involving patient care, such as hospitals, nursing homes, and mental health facilities. The separation provided budgets to improve both facilities for inmates and patients, instead of commingling funds.

Following the governmental changes, HSC was now under the watch and support of DHS. With supervision by DHS, HSC staff sought to accomplish the department’s mission: “We are committed to providing accurate, impartial and timely disability [which includes mental illness] decisions for South Dakota citizens.” Upon adopting the mission, the organization supported and directed attention toward improving behavioral

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5 Dorothy Jeneks, “The Dakota Hospital for the Insane 100 Years Ago,” *Humanist* 2, no. 4 (1979): 7.
6 South Dakota Department of Corrections, Historic Timeline.
7 Ibid.
health services throughout the state. Only three years later, construction on the George S. Mickelson Center for the Neurosciences began, supporting the expansion and improvement of the facility.\textsuperscript{10} Compared to the long-term administration under the Board of Charities and Corrections, the DHS era spanned twenty-two years of operation.

Following the era of DHS, the state government transitioned to a new agency in charge.

In 2011, the state designated DSS as the organization in charge of HSC, as the state budget provided greater support for mental health treatment under this department.\textsuperscript{11} The mission of DSS is “Strengthening and supporting individuals and families by promoting cost effective and comprehensive services in connection with our partners that foster independent and healthy families.”\textsuperscript{12} HSC applied this mission, in conjunction with the center’s specific mission, to support improved treatment for individuals and family assistance throughout the facility. The DSS budget supported operation of the facility and similarity services. DSS leadership introduced a redistribution of executive power throughout the facility.

Throughout the eras of the Board of Charities and Corrections, DHS, and DSS, HSC experienced changes in budgets and focus, which affected the success of the facility. As healthcare is a business, finding the financial and administrative balance was key to the success for HSC. The state hospital encountered changes based on the many agencies mandating standard of care for the facility. The trials and tribulations of the various agencies in charge of HSC mirrors the structure of a business, reflecting the leadership of each department.

\textsuperscript{10} Department of Social Services, HSC History.
\textsuperscript{11} Department of Social Services, Key Resources, accessed December 31, 2019, https://dss.sd.gov/.
\textsuperscript{12} Ibid.
CONCLUSION

The aim of this thesis has been to recap the noteworthy events in the history of the South Dakota Human Services Center (HSC). By utilizing short essays, the project emphasizes the historical milestones throughout HSC’s 140 years of operation. Researching transformative trials, trends, and tragedies allowed for analysis of the critical moments in HSC history, including how each occurrence affected the facility.

Understanding the history of HSC is imperative for the facility’s future success, as similar events occurred overtime. Researching how historical events, often repetitive, sparked historical changes in the facility assists future leaders and employees in understanding the results of past and present occurrences. There are opportunities for growth by learning from past tragedies to prevent reactive behaviors and promote proactive transformations. Analysis of the past often provides a potential starting point when preparing for the future.

This project includes the potential for expanded research and analysis of additional events during HSC’s past and present operation. Through the researcher’s continued education in administrative actions, legislative proceedings, and many more areas, the operation of HSC provides further topics for analysis. Additionally, as the facility remains in operation, HSC will experience more noteworthy instances for continued reflection and opportunities for transformation throughout the hospital.

However, the research aspect of this thesis presented several limitations. The requirement of confidentiality limited thorough availability for research on multiple topics. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires confidentiality of patient records. My research, knowledge, and thesis comply
with patient confidentiality requirements, by utilizing sources that are classified as public record. The access to information was limited due to restriction for any psychiatric hospital’s ability to share personal accounts. Additionally, as my research encapsulates 140 years of operation, the length of this thesis limited the historical moments to research and address. However, through my analysis and review of publicly accessible archives, I uncovered what consistently indicated the most substantial events for research to accurately depict the transformation of the facility.

From my research, I uncovered significant connections between similar events at the facility. As the subtitle of this thesis reflects, the trials, trends, tragedies, and ultimately triumphs led to various transformations of the facility, including the procedures, treatments, patient care, and many more aspects of HSC’s operation. These four recurring themes impact mental health, both in South Dakota and across the nation.

The largest trial during the HSC history reflects the difficulties of treating mental illness. Throughout HSC and psychiatric history, a serious challenge was the lack of treatment options for mental illness. The symptoms of the devastating diagnoses are typically treatable, but too seldom curable. Even with mental health treatment advancements and improvements, there remains a need for increased psychiatric research. Along with the trial of limited treatment options, the challenge of reducing stigma and negative opinions of those with mental illness was an obstacle for many providers across the nation. Dr. Mead’s early work of educating the public about mental illness was a precursor for grassroots efforts, such as NAMI’s organizational objective of reducing

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1 As much of the public information accessible within HIPAA guidelines is filtered through the administration of the state and HSC, official histories rarely offer full disclosure of treatment. As this thesis only includes verified or published sources, the information is often presented from the administrative or journalist’s point of view.
stigma. These educators attempted to overcome the view that mental illness is connected to criminality, immorality, and dangerous behaviors. While false information remains prevalent, these anti-stigma resources worked – and serve to continue to educate others – to reduce the negative beliefs surrounding individuals with mental illness.

Trends throughout history stemmed from the different options of treatment methods and their varying popularity over time. Throughout multiple chapters, readers learn of common historical treatments, including lobotomies, shock therapy, and psychotropic medications, especially Thorazine. These historical treatments were initially hoped to be miracle cures, but some efforts were deemed unsuccessful and inhumane. A common trend with psychiatric treatment, much like other medical specialties, included trial and error. The earliest uses reflected the limited knowledge of mental health treatment throughout the years but guided the way for progress. Some of the methods have been refined over the years, with significant success in modern times. Experimental treatment options arose throughout history, such as Dr. Mead’s aesthetic stimulation, vocational therapy with patient jobs in the facility, and therapeutic recreation as utilized at the patient activities center. While vocational therapy, therapeutic recreation, and electric shock therapy remain as currently accepted treatment methods, the early applications reflect medical professionals’ capability to assist patients, even with the limited support and few treatment options available in early years.

Unfortunately, the limited treatment methods contributed to the multiple tragedies that occurred at HSC. Throughout the operation of HSC, the need for improved facilities was a consistent theme. As my research reveals, construction of new hospital buildings consistently followed tragedies. Often, needs were evident, but solutions were not
addressed until after tragedy occurred. The construction of the Mead Building and the George S. Mickelson Center for the Neurosciences both followed the death of patients or citizens of Yankton. The early fires during HSC’s early years resulted in the tragic loss of over twenty-two patients at the facility. After these events, funding was allocated to construct the Mead Building, providing increased safety procedures. The Wollmann incident resulted in additional evaluation of safety procedures for the future Mickelson Center. Other tragedies resulted in the loss of lives of employees including the murder of Dr. Baum and the drowning of Larry Pillard.

Mental healthcare and HSC rallied from the tragedies of deaths and insufficient early psychiatric treatment to experience many triumphs. The construction of several new buildings at HSC were triumphs, which developed from tragedies. The movement toward community-based treatment provides alternative options to in-patient treatment. Descriptions of IMPACT and Cedar Village educate readers on community-based care and the developments in mental health treatment to promote these opportunities. As revealed by HSC’s 140 years of operation, the facility’s staff persisted throughout the ages to remain as South Dakota’s state operated psychiatric facility. Advancements in legislation and treatment practices revealed triumphs through established patient rights and improved procedures for care.

Researching the history of the South Dakota Human Services Center and mental health in general provides substantial value, due to the significant number of individuals that are affected by mental illness. As the Centers for Disease Control notes, “1 in 5 Americans will experience a mental illness in a given year.”

of mental health treatment, utilized in South Dakota and that are consistent throughout the nation, readers become better educated about psychiatric medication, treatment practices, and advancements to provide quality care for patients. Many of the challenges HSC faced are not unique to South Dakota. Reviewing mental health procedures increases understanding of current and historic treatments and advancements. While this thesis is not a manual on the process of mental health treatment, sharing this information will hopefully assist families with individuals struggling with mental illness to understand the resources available.

As my research could be offered to the Mead Cultural Education Center to assist with the creation of the Yankton State Hospital/HSC exhibit, my thesis will substantially contribute to discussion and education on the impact of HSC. In addition, the design of my thesis includes mini essays, essentially in the format of newspaper stories. Following prospective discussion with a potential local newspaper, my research could be published as a multi-week column, emphasizing the critical events of HSC across the 140 years of the facility. Through public emphasis of my research, my thesis strives to increase understanding of the history of mental health treatment at HSC and in South Dakota. Understanding helps to reduce the stigma surrounding mental health, exemplifying that “When ‘I’ is replaced by ‘we’ even illness becomes wellness.”

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