

An address by Governor Luther W. Youngdahl to be delivered before the public meeting of the American Psychiatric Association convention in Detroit, Michigan, on May 4, 1950, at 8 p.m. in the Music Hall.

THE NEW FRONTIER IN MENTAL HEALTH

I speak of the mentally ill.

I speak of the mentally ill as a group of people who cannot speak for themselves, cannot act, cannot vote, and cannot testify -- either in court or in the arena of public opinion.

I speak of the mentally ill as a group of people whom we have shunned, feared, ridiculed, or just ignored.

I speak of the mentally ill as the weakest group in society.

Yet I speak of the mentally ill -- of the hundreds of thousands of mental patients in this group....I speak of the mentally ill as a group that has the greatest power of all -- the power to pull on our conscience.

What manner of people are these that are so weak on one hand, but who have this power on the other hand?

They are all people in trouble....people with a problem so costly to solve and so time-consuming in its solution that these people unaided cannot take care of themselves. And because they are so weak and have become social responsibilities, what happens to them constitutes a barometer of just how civilized we are.

And how civilized we are, in turn, is the answer to that totalitarianism that holds the individual to be insignificant, particularly when that individual is weak and helpless.

Perhaps this has no more meaning to you than it had for me for a long time. Perhaps you think of this problem as mere statistics, in which one health field competes with another in proclaiming the large number of people affected.

I went to school in a community having a state hospital. I proposed to my wife on a lake in view of that hospital. I served for sixteen years in various legal and judicial positions having contact with mental patients -- and my municipal court many long years ago was one of the first in the country to use the services of a psychiatrist.

When I became Governor and had gone through my first legislative session, I, too, had the concern of any thoughtful citizen about the institutions in his state. And before visiting any of the hospitals I sought the best professional advice available and formed a Governor's Advisory Council on Mental Health, composed of leading psychiatrists in our state, plus two well-informed and strongly motivated lay persons. I even sought more information by cooperating with the Minnesota Unitarian Mental Hospital Committee in a ward by ward survey of hospital conditions. And the Unitarians in my state measured up well as spiritual descendants of Dorothea Lynde Dix, that great crusader of the 19th century, who was herself a Unitarian.

But nothing -- no predisposition, no expose, no plain talk from my professional advisers -- could possibly prepare me for what I was to find, to see, to hear, and to feel.

Perhaps this shock would not have been so bad if I had not visited the barns and the farms, too. The cows were clean, tuberculin-free, well-fed, well-bedded, and provided with so much attention that it would make the standards of the American Psychiatric Association for human beings seem ridiculously low.

The same could not be said of the patients.

I saw the barns and I saw, of course, the "show wards". But I also saw the "back wards" -- the rows upon rows of unattended human beings, figures created in the image of God whom we were desecrating by plunging them into this inferno with the word "hospital" on its gate.

Yes, I saw ward after ward of men and women -- fathers, mothers, brothers, sisters, and sweethearts -- sitting on crude benches, eyes downcast, herded into overcrowded sleeping quarters, hope gone from their eyes, vegetating in that most fiendish state of all -- idleness -- while hope left, too, the faces of the few who were entrusted with the welfare of so many.

I ask you to put yourself in the places of these patients -- you who are dressed up and carefully groomed now....I ask you women to picture yourselves without makeup and a hair-do, with hair washed once a week -- if at all -- with laundry soap, with an old burlap dress and no shoes, no stockings, and no girdle -- and you men without a shave for a week, without a toothbrush or comb, with an old sweatshirt and not even a belt for your decrepit pants, and shoes -- if you had shoes -- that were several sizes too small or too large, and without shoelaces at that.

I ask you to picture the lineup at meal time -- the lineup caused by the lagging of hours that made even a trip to an otherwise rejected meal far preferable to the emptiness of the wards. And I ask you to picture ~~these~~ conditions so overcrowded that even if you had a change of clothing, you'd have no place to hang it -- and not even space to put those personal items which might distinguish your quarters from those next to you.

And without all those things that you feel are so vital to social relations and personal comfort, imagine that you were also forced to sit in complete idleness in the same position hour after hour, and day after day, without even a clock or calendar to mark the passing of time....just the falling shadows of the end of day to mark the moment when you would be herded up to your sleeping quarters -- and put to bed and ordered to stay there at 5:30 or 6:00 p.m. just because there is nothing else to do... and to stay awake in this air of unwashed bodies until such time as sleep overcame you....and then to sleep, not in darkness, but often with a light glaring above you.

How long, ladies and gentlemen -- how long, before you, too, would become mentally ill? And how long before many of the relatives of these patients would become mentally ill under the helplessness of visiting their loved ones in these conditions?

I remember that we substituted for psychiatric treatment -- yes, I have 1,000 reminders of 1,000 patients in strait-jackets, cuffs, and manacles in every one of our hospitals except the one at Hastings.

You may say that I am presenting the worst side of the picture -- that I am not telling of the good things that our hospitals did during this period -- or even referring to the good that most hospitals do do. But I do not believe that in the interests of these patients it is valid to judge any social institution by the best. Any institution, like society, is no stronger....is no better than its worst. And these are the conditions in which a majority of our patients lived.

Of course, these conditions exist because of shortage of personnel, because of shortage of trained personnel, due to inadequate salaries, inadequate incentives, and lack of appropriations.

To say that, however, is to make a co-existing statement. But it does not furnish the answer.

To understand the characteristics of the state hospital we have to understand the characteristics of the old asylum -- and the social purpose for which the old asylum came into being.

The logic behind the asylum was (1) patients were incurable and destined to be in the hospital the rest of their lives; (2) these patients had neither feelings nor human attributes.

The asylum-builders acted on only one premise -- that these people whom we call patients and whom we describe in terms of a sickness were dangerous people who must be put away in order to protect society. Actually, they aren't particularly dangerous. They're strange and a little out of step with the world....and because we don't understand their strangeness, we get afraid and call them dangerous. (And let me say right here that I would often feel far safer in the back wards of our state hospitals than I would at certain political meetings.)

The asylum builders didn't believe that a patient could either be cured or made more comfortable. They didn't believe that mental patients respond to treatment and kindness. No, they kept on building more buildings -- institutions to keep the patients in and the public out. Today we are reaping the inevitable result of a custodial approach in an ever-increasing backlog of patients. Problems of overcrowding are still being solved by the expensive procedure of building more buildings. The truth of the matter is not that we have too little bed-space; but because of the absence of prevention, early detection, active treatment, and follow-up activities we do not have a balance between admissions and discharges.

The asylum was designed for a pre-psychiatric era. All our efforts to date have been an attempt to superimpose 20th century psychiatry -- a recently refined art -- on the asylums of the past several centuries.

It won't work until we get to the point of giving up the asylum and our attempts to obtain budgets in terms of what we have had in the past rather than in terms of what our patients really need.

I'll come back in a few minutes to what our patients need and to some of the chords binding us to the asylum that must be cut. But at this point I want to express the fact that no scapegoat can be found for these conditions. No one individual or group is responsible -- we are all responsible. Particeps criminis -- due to lack of understanding or due to lack of citizenship, we have all participated in a social crime against these sick people.

Nor is the care of the mentally ill a political issue. Republicans and Democrats alike share in the guilt, and Republicans and Democrats alike share in the responsibility for improving conditions.

We must recognize from the beginning that there is no such thing as a Republican patient or a Democratic patient; a Catholic patient, a Protestant patient, or a Jewish patient. There is no such thing as a rich patient or a poor patient. There is no such thing as a black patient or a white patient. There is only one type of ~~as~~ patient -- and that is a sick patient.

There is no place in this program for politics. The moment politics enters the sick room, medicine goes out the nearest window. The real victim will be the patient.

Our first concern must be to fight for everything the patient requires -- and let me say here, I sincerely believe that the only true economy is to help the patient get well, and anything short of that is the false extravagance of penny-pinching. This really is not spending, but it is

an investment in our society's future, in a returning flow of participants in the social and economic life of the community. For if one thing has not been made clear so far, it is this: above and beyond the considerations of humaneness to which sick human beings are entitled, there is the very practical one that we are failing to discharge as high a number of patients as the application of total psychiatric techniques has made possible. And it is economy of the falsest order to base a program on how cheaply ~~xxxxxxx~~ we can operate a hospital bed, instead of on how many times, through active treatment, that same bed can be used for successive numbers of patients.

At this point I want to stop to say ~~xxxxxxxxxxxx~~ ^{one very important thing:} you can't cure every patient. But there isn't a patient whom you can't activate. And I caution here against any consideration of fiscal policy that confines its attention solely to those who under present levels of scientific knowledge are deemed curable. You don't expect us to do that with victims of cancer, tuberculosis, heart disease, or any of the other more socially accepted illnesses. And you should not expect us to do that with mental illness -- for even the most hopeless patient in our hospitals represents something to someone on the outside -- something that hurts -- and has within himself something so precious that he cannot be judged in values other than human and divine.

Upon returning from my first tour of mental hospitals -- a period considerably in advance of the legislative session -- we were determined to do two things: first, we were going to improve the hospitals to the utmost of our administrative ability. Secondly, we were going to let the public know what the conditions were and to carry on a campaign to get support to put the asylum system where it belonged -- back in the history books.

There is one element of administrative reform that I can announce now as being virtually complete, subject to a few finishing touches. I referred earlier to the 1,000 reminders of the asylum that will burn forever in my memory -- and that is the 1,000 patients in mechanical restraint. As of today, there are less than five patients in the State of Minnesota in mechanical restraint -- and within a week I expect that every single one of these patients will be out of mechanical restraint for behavior purposes.

We are not the first state to eliminate the use of mechanical restraint for non-surgical purposes. Illinois preceded us 35 years ago. And our own state hospital at Hastings was free of these barbaric devices even prior to the mental health drive.

If we have established any one thing in Minnesota, it is this: there is no place in a state hospital for mechanical restraints.

I am not speaking theoretically. I am speaking practically. The elimination of restraints has done more than any other single thing to improve the morale and tone of employee and patient alike.

You may question this, if you wish. You may talk like the farmer who saw a giraffe for the first time and said, "There ain't no such animal." You may claim that it's impossible, that patients will hurt each other or themselves, that employees will leave, that you will have to substitute drugs for restraints, that accidents, fights, and furniture breakage will occur, and that you cannot remove restraints without additional personnel.

But the truth is that you can remove restraints and operate a better hospital. I refer you to Albert Deutsch's article in the current WOMAN'S HOME COMPANION and will vouch for the accuracy of his descriptions of the elimination of restraint in Minnesota, as I will to his account of the

situation at Manteno, Illinois, which I personally visited, and as I will vouch for the elimination of restraint in certain of the veterans' hospitals, particularly those at Winter General in Topeka and at Saint Cloud in Minnesota.

The elimination of restraints is not a side issue. It is a major symbol of where we stand in regard to the patient. It is the burning symbol of enlightened treatment as against confinement and the grave possibility of abuse.

The restraint device is a symbol of intellectual restraint on our part. It is the symbol of the Salem witchcraft days. We burn these patients at the stake every time we place one in a strait-jacket....we burn them at the stake every time we give them inadequate food, too little personnel, and penny-pinching appropriations.

Removin' restraints is not easy at first. But once it is accomplished, you find far less tension among both patients and employees. You find fewer fights, less destruction, less noise, and less untidyness. And you find increased public support that you will not get when the public has a stereotype in its mind of a maniacal patient who has to be kept in ^{a strait-} ~~restraint~~ jacket.

Before I mentioned that there are no scapegoats. And I particularly don't want the public to be made the scapegoat for our hospital conditions -- that is, once the public knows the facts. We got our appropriations because of the public. And we will be able to project the program into the future because public support and understanding today is stronger than it ever was before.

We organized a second Governor's Committee in Minnesota. The first one, the Advisory Council, was responsible for professional programming. The second committee was the Governor's Citizens' Mental Health Committee

of 50 civic leaders, mainly lay persons, who were entrusted with the job of mobilizing public opinion and of getting the letters written from the folks back home that they wanted the legislature to appropriate every cent the program called for. The fifty-member state-wide committee soon became too small, so county after county organized local citizens' mental health committees. And it was on the basis of local level activity that sprung up spontaneously from the grass-roots that the program was put over -- that coupled with the complete support of the press and broadcasting industry of the State.

I don't think we ever had a legislative session like that one. And I know that Dr. Daniel Blain, Medical Director of the American Psychiatric Association, who came out to help us at a critical time -- who actually spoke in behalf of the program during tax reduction week -- never sat in on such an unusual hearing as he did that night in Minnesota.

Since this audience is not confined to residents of Detroit, but includes professional representation from many states, I should like to state that the hardest things we had to contend with were: first, attempts to subdue our drive because it would make us look bad in the eyes of other states; and second, attempts to compare us with other states -- that we were as good as any other. The Minnesota hospitals were typical of the national average -- not as good as Michigan perhaps, but representative of most states. Our case was based on the fact that this was a nationwide problem in which every state in the country was involved -- and that no reform could come if we were content with mediocrity, ~~xxxx~~ rather than preeminence.

A great deal of publicity has been given the appropriations we obtained from the recent session of the legislature. We almost doubled appropriations of the preceding session and perhaps precedent was established in this.

Our per diem in one session jumped from approximately \$1.50 to \$3.00 per day. But in terms of the past neglect and in terms of future needs, we never claimed that this was anything but the bare minimum -- the bare minimum that we could absorb administratively and execute in one biennium. We said that it was the first step -- and only the first step -- necessary to start us on the long road ahead leading eventually to a modern mental health system embracing prevention, training, and research.

However, I think two things were far more important in this session than the funds alone. In the first place, our major bill was not appropriations, but a non-appropriations bill to determine policy. And this bill -- now a statute -- declares that the official policy of the State of Minnesota recognizes "mental illness as a sickness with respect to which there should be no stigma or shame....and the necessity of adopting a program which will furnish dignity and hope for the patient, relief from anxiety, for the patient's relatives, and recognition for the psychiatric worker."

While the bill did not embody appropriations, it declared the things for which appropriations shall be made: a single standard of food for patients and employees alike, diagnostic services, clinics, research, training, personnel, social work, a Commissioner of Mental Health, etc.

The second significant thing was not necessarily the amount of the appropriations, but the place of order in the budget held by the mental health program. Up to now in Minnesota -- and I am sure this occurs in other states, the mental hospitals were the last to receive appropriations. After everybody else came in and got his, the patients were left the scrapings at the bottom of the barrel. This time they came in first. After their turn, the other departments came in. Care of our mental patients was fixed as the first responsibility of state government.

Our appropriations covered more things than I can detail now. But appropriations alone will not sever our ties with the asylum -- it is how we use these funds and how we use the opportunities given us administratively that will determine whether or not we do this.

The first thing we did was to select a Commissioner of Mental Health through professional channels. A three-man screening committee, representing the State Medical Association, the Medical School of our University, and the May o Clinic combed the whole country. And we are proud that its choice fell to Dr. Ralph Hossen of the Hastings State Hospital in Minnesota, who demonstrated that even on asylum appropriations you can run a patient-oriented, restraint-free hospital and acquire a staff on the basis of research, training, and patient-oriented programs.

We in Minnesota know that we have a sound fighter in Dr. Hossen, who as a superintendent had to fight public apathy, red-tape, administrative inertia, and politics.

We now come to the reason why I have been so harsh on the asylum system. It is something that can comfortably be discussed in a city where the American Psychiatric Association meets and in a state whose state hospital doctors are esteemed throughout the country.

All this program is is an attempt to introduce medical procedures into every corner of our state hospital system. All we are talking about is the extension of a meaningful physician-patient relation -- with the hospital and auxiliary workers being only extensions and reinforcements of the basic physician-patient relationship.

I know what it is for superintendents to attempt to administer psychiatric programs and at the same time to worry about potatoes, politics, red-tape, and lack of funds.

I know what it is for doctors to attempt to practice medicine in a setting in which everything seems to act to negate their efforts -- lack of help,

too heavy a patient load, unfavorable ward conditions, and a thousand and one routine factors that make the patient wonder whether the institution exists for him or he for the hospital.

I know what it is for doctors to be without their basic tools -- to be without laboratories, research equipment, and even time with which to take advanced professional work.

And I submit that in view of all the therapy-negating influence of the old asylum -- in view of the restraints, and the double standard of food, and the patient-labor forced because of shortage of help, and the lack of training in many instances for ward personnel....I submit that until we eliminate these influences that work against giving the patient the feeling that everything we do is for only one purpose -- to help him get well -- try otherwise as we may, all we are doing is laying the superstructure of psychiatry on the base of the old asylum.

The recent session of the legislature was generous with its appropriations. And here are some of the steps we are taking during the forthcoming biennium to use these funds to develop medical programs.

From my lay point of view it seems to me that we must introduce an entirely different concept from the one we have had -- and this is the concept of a trained psychiatric team in relationship to a single individual.

And this is the only way I can see us projecting the program into the future -- to determine what the patient needs in terms of diagnosis, what he needs in terms of treatment, what he needs in terms of activation, what he needs in terms of food and clothing and the physical essentials of life.

Having determined these needs in the individual instance, the program resolves itself to 14,000 -- that is the number of patients in our institutions -- to 14,000 times one program.

But the crux of this is the psychiatric team in which every hospital staff member plays a vital role -- the psychiatrist, the nurse, the psychologist, the social worker, the attendant, the farmer, and everyone who comes in contact with the patient or influences his behavior in any way.

We need to make one fundamental change in the functions of personnel as we have inherited these functions from the asylum. The attendant of today is only the guard of the asylum. He is recognized as a menial and paid as such, without any regard for his present or potential usefulness on the psychiatric team.

We consider this person the most important individual in the hospital. We changed his name from attendant to psychiatric aide, raised his salary, reduced his work week from 48 to 40 hours, and provided the beginnings of training, both pre-service and in-service. And this one step alone, along with the educational experience of ward personnel removing restraints, has done more to change attitudes toward patients than anything else. I am proud of our psychiatric aides and I am proud that one of our aides won the Psychiatric Aide of the Year Award, just as I am sure that Michigan is proud that its system was able to produce two psychiatric aides in the top six of the entire country.

The trained aide must be a part of the psychiatric team. But above and beyond this I am convinced that there must be a level above the present aide -- the graduate psychiatric aide -- such as are emerging from the first training school in the country under the Menninger-sponsored program at the Topeka, Kansas, State Hospital.

But there are other members of the psychiatric team that are required. We have several thousand children in our institutions with mental deficiency and convulsive disorders, and we will have a few more when we open our

forthcoming unit for the emotionally disturbed child. I feel these children are entitled to the same rights as so-called normal children. And we hope to pioneer a little further in the near future by bringing into our system pediatrics and qualified pediatricians.

Similarly, we look forward to residency programs not only in psychiatry and pediatrics, but medicine, surgery, public health, and neurology, with the opening of one, if not two, neurological centers in our system.

We are very fortunate in having in our state two great training centers in the Mayo Clinic and the Medical School of the University of Minnesota. We already have started an in-service training program for doctors through the cooperation of the psychiatric section of the Mayo Clinic. And before this distinguished audience I wish to acknowledge the appreciation of the people of my state to Dr. Francis J. Braceland and his colleagues at the Mayo Clinic. A second phase of our professional training program starts later in the year in cooperation with the University of Minnesota.

Since we are all faced with grave shortages of personnel, we are forced to adopt residency and in-service training along with introducing the advanced psychiatric aide concept. In this connection, you should know that Dr. Rossen has introduced two additional training steps. One is bi-weekly continuing institutes for heads of all services in each hospital in which clinical case material is presented. The second step, and one with which we have had much success, is the use of total psychiatric teams making weekly rounds of each hospital for training and demonstration purposes.

But if we are to introduce sound medical procedures into our systems, there is one major step that must take place -- and that is research. In that state hospitals have 85% of the patient population in the country, they comprise the richest single reservoir of clinical material for investigative purposes in the country. It is a reservoir that has gone untapped except for isolated instances. And I am sure that I will meet with professional

support if I state that we are not going to attract the best in the medical profession until we develop an investigative attitude and make research a standing function of every member of the psychiatric team.

There are numerous other things that must be done to break the backbone of the asylum, the most important of which is to destroy the isolation existing between the hospitals and the community -- to establish links with the home, the school, the church, the courts, and the social agency. These links are through clinical services, social work, and rehabilitation programs.

But the keystone on which the mental hospital of the future will stand as a community-linked, patient-oriented training-research-and-therapeutic center is the field of public education. State hospitals have enormous resources in terms of personnel, with rich backgrounds for purposes of public education and consultative services to the people and agencies of the community.

The state hospital if it wishes to succeed as a community-linked therapeutic center cannot stay out of the field of education, for it is in this area that we cultivate social acceptance of the patient -- and without social acceptance of the patient there can be no meaningful social acceptance of programs in public psychiatry, whether they be in the fields of prevention and/or treatment.

The mental health program of the future will not be confined to institutions alone -- the institutions must be but one phase of a comprehensive program. State governments have responsibilities in the broad area of prevention and have resources in their departments of education, health, welfare, and labor which, when integrated with the community-linked therapeutic program, can bring about a complete transformation in the future hopes of today's children.

I believe a new day is coming for Americans who develop mental illness. And I believe a new day is coming for America in developing new attitudes toward the mentally ill.

This battle, however, calls for a new approach. It calls for public recognition of the role of the staffs who are desperately attempting to bring modern psychiatry to our patients -- and I speak of these staffs fondly, for I know from our own program that you don't just take concepts and wave them at will....they must be executed and put into practice within the hospitals....and that's just what our people did do in the most thrilling fashion. And it calls for recognition by those of us connected with the Administration of these programs, both on state and hospital levels, of the fact that these are the people's hospitals and without the support and understanding of the people the job cannot be done. It calls for teamwork -- between a super-psychiatric team of hospital workers and the public.

Together we will solve this problem. Separated we will be defeated.

This is a challenge such as we have never had before -- it is the challenge ~~of~~ not of destroying, but of building....a challenge to explore not yesterday's wilderness, but today's plateau of human welfare and dignity.

The pioneering of the wilderness and of geographical frontiers is over for us. But a new frontier awaits -- a frontier whose boundaries are only limited by our imagination and good will.