Minnesota

MENTAL HEALTH SURVEY

A CITIZENS PROFESSIONAL COMMITTEE:

- **Studies our mental health program**
- **Recommends *immediate* and *long-range* goals**

St. Paul, Minnesota
December, 1956

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Hon. Orville L. Freeman
Governor
State of Minnesota

The attached report on Minnesota's mental health program was initiated in September 1954 at the request of former Governor, C. Elmer Anderson, and was carried out under the aegis of the Mental Health Medical Policy Committee. It is an attempt to determine the present status of the total mental health program in the state as well as to recommend immediate and long range goals.

The undersigned committee urges that the report be given careful study by your office as well as by legislative and citizens' committees. Although marked progress has been made in the state mental hospital program in recent years, there remains serious limitations of staff and facilities.

There can be no marking time in this program. If patients are to benefit from new developments in the field, there must be a planned, continuous moving ahead.

In this cause, we urge your informed leadership.

Sincerely,

Robert Challman, Ph.D.
Malcolm Farrell, M.D.
Mrs. Ruth Knee
Mr. Clifford Lobel
Rev. Frederic Norstad
Howard Ottinger (State Representative)
Harlan L. Paine, M.D.
Howard Rome, M.D.
Magnus Wefald, (State Senator)
Donald W. Hastings, M.D. (Chairman)

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MENTAL HEALTH SURVEY
STATE OF MINNESOTA

INTRODUCTION

Minnesota's more than 3,000,000 citizens can look back on 1949 as the year of a bright beginning.

That year marks the enactment of a modern, forward-looking mental health act which made possible substantial improvements in the state's mental health program.

It began, as in other states, with a rush of interest and a demand for profound changes from citizens, individually and in groups.

It was made possible by a responsive legislature which, with the mental health act of 1949, formally recognized that new attitudes and new treatments could vastly improve the care of the mentally ill.

In that beginning year, the annual per capita expenditure per patient went to a record $765.

Few will claim, however, that it was more than a beginning.

The backlog of needs was too great.

The skilled hands were far too few.

The years of public indifference, harsh economy and general unawareness of treatment possibilities were too many.

But the new program did release the flood of fresh ideas, knowledge and hopes that had been restrained for more than a decade by meager budgets and restrictive superstitions.

A single food standard for patients and employes was established, one of the first in the nation.

Modest training and research programs were started. Some of the many, needed skilled workers were hired. New buildings began going up to replace outmoded, worn-out structures and to provide adequate treatment facilities.

The importance of community clinics as part of a total approach to fighting mental illness was recognized, and during 1949-51 a follow-up clinic was opened in Minneapolis and out-patient clinics were developed in Albert Lea and Fergus Falls.

And most significantly, the old and stultifying system of maintaining several state hospitals to provide mere custody for the "incurables" was declared obsolete.

Every hospital was to become a treatment center.

The Years Before

But this beginning—and it is no more than that—can be fully valued only if it is placed in perspective with the long years before.

Minnesota's care of the mentally ill goes back at least as far as 1866 when the first hospital was opened at St. Peter. Even before that time, however, records show that Minnesota "boarded out" its mentally ill in other states.

A second institution, originally for alcoholics, was built at Rochester in 1879. During the same year, a Faribault institution was taken over to house mentally deficient patients. A hospital specifically built to care for these patients was not provided until 1882.

During the next 20 years, buildings could scarcely keep pace with need. Three hospitals for the mentally ill were built at Fergus Falls, Anoka, and Hastings. The Anoka and Hastings facilities were constructed solely for transfer patients from other hospitals, the "incurables" for whom it was believed there was no recovery possible.

From the turn of the century to 1938, three more institutions were built and promptly filled:

At Willmar, a hospital for alcoholics was opened in 1912. Five years later, that hospital opened its doors to include the "chronic mentally ill."

At Cambridge, a hospital for epileptics began operations in 1925.

At Moose Lake, the state's newest mental hospital was built in 1938 to ease serious overcrowding in other institutions.

In July 1950, the continued overcrowding influenced the state to lease from the federal bureau of prisons the unused prison buildings at Sandstone.

During these same years, the state also provided several special units on the grounds of existing mental hospitals. These special buildings are eloquent monuments to the fact that too often the mentally ill are aflicted with other problems as well.

At St. Peter, for example, an annex was provided in 1908 for the "dangerously insane."

More recently, in 1951, a building at the Anoka hospital was converted into the Burns Memorial to segregate and treat mentally ill patients with tuberculosis. Before that time, each hospital tried to deal with its TB problem. But they had neither facilities nor equipment and this disease spread dangerously in the crowded institutions. Even as recently as 1953, a state commission to study the tuberculosis problem pointed out that TB death rates in state mental hospitals ran 180 per 100,000 or more than 20 times the rate in the general population.[1]

[1]For further discussion, see Report of Tuberculosis Facilities Commission, submitted to the governor in January, 1955.

Capacity use of the Burns unit already has begun to cut this death rate and undoubtedly will cut it sharply in the future.

The growth of the whole state hospital system reflects clearly the steady pressure for more facilities for the mentally ill, as well as for the mentally retarded. This growth, however, should not be interpreted as showing a corresponding increase in the incidence of mental illness and mental retardation. Instead, the pressures for more mental hospital beds were created by a general population increase, significant changes in family living, the growing complexity of the social and economic structure along with an increasing recognition of the problems of the mentally ill.

Around 1900, there were 3,600 mentally ill patients in 5 state hospitals and 727 mentally retarded in one institution. By 1930, the hospital population had jumped to 9,958 mentally ill in 6 hospitals and 2,202 mentally retarded and epileptic in 2 institutions. In 1954, there were 11,362 patients in 8 mental hospitals and 4,180 mentally retarded and epileptics in 2 institutions. An additional 700 mentally retarded were at institutions at Owatonna, the St. Cloud Annex for Defective Delinquents and in 2 emergency units. Another 518 were being cared for in state mental hospitals.

While the number of hospitalized patients went up and up, annual per capita costs rose only slightly until 1949. In 1900, the average per capita expenditure was $155. This went up to $243 immediately following World War I, reflecting primarily an increase in the cost of living. Increased cost of food, supplies, etc., also was responsible for the moderate rise in per capita expenditures during the mid-1940's. During the 1930's, per capita expenditures averaged around $222, but hospitals could compete for workers more favorably than in the past because of the great depression. As a result, these depression years were ironically, in some ways, the best years the state hospital system had known.

Then, in 1949, with the greatly-increased interest in improving the mental health program, the legislature provided $738 a year for each patient. A second sizeable increase followed in 1951, sending per capita expenditures to $1,032, which is approximately the present level. This amount provides about $3.00 a day per patient and must cover the cost of food, clothing, heat, maintenance of buildings, laundry, medicines, equipment and the salaries of all personnel concerned with the housing, care and treatment of these sick men and women.

As the hospital system grew, administrative problems became more complex, and there was considerable shuffling and re-shuffling of the administrative structure. A board of trustees initially ran each of the hospitals for the mentally ill. In 1900, however, the State Board of Control was given responsibility for the directing of operations in all state institutions, including schools for the blind, deaf, dependent children, penal and correctional institutions, the hospital for crippled children as well as the institutions for the mentally ill and mentally deficient.

Again in 1939 a shift was made and the state reorganization act abolished the Board of Control and established the Division of Public Institutions as a separate unit.

The most recent change was in 1953 when the Division of Public Institutions and the Division of Social Welfare were merged to become the present State Department of Public Welfare.

Today, the mental health program, having passed through the "beginning," requires sound, long-range development.

Other sections of this report will make specific recommendations. But three areas at least should be mentioned here as particularly in need of carefully-planned development. These are:

1. The public mental health program which will offer preventive services, early diagnosis and treatment as well as follow-up care for those who have been discharged from an institution.

2. The training program which should provide eventually a steady, valuable source of skilled personnel, from psychiatrists to psychiatric aides, for the state hospital system.

3. The research program which, while helping to attract topnotch personnel, holds out the only real hope for ultimate solutions.

It should be emphasized here, too, that for its continued, enlightened progress, the mental health program must depend on sound professional guidance and on the two groups which gave it a beginning: interested citizens and their elected representatives in the state legislature.

MINNESOTA IN THE NATIONAL SCENE:

A COMPARISON

The problems of mental illness in Minnesota are only a reflection of the national scene. In this perspective, their seriousness can be measured more accurately.

In the spring of 1955, the Hoover Commission on Government Organization called mental illness the greatest single health problem in this nation. The Hoover report stated that perhaps as many as nine million persons, almost 6 per cent of the population, suffer from some form of mental disorder. It said further that:

1. About 10 per cent of these persons, or slightly fewer than 900,000 are considered in need of mental hospital care.

2. About 650,000 "prolonged care" psychiatric patients are being treated in state and federal tax-supported mental institutions.

3. A large number of persons suffering from mental disorders are being cared for at home, in private sanitariums, nursing homes and general hospitals where patients are not included in the psychiatric hospital statistics.

4. About 250,000 new patients will have their first admission to a mental hospital this year.

The report emphasized that the number of patients requiring prolonged care is steadily increasing at the rate of 10,000 a year.

In Minnesota, the question is asked frequently by interested persons and groups, "How does Minnesota compare with other states in its attempt to fight and control this serious public health problem?"

The answer should be in human terms rather than in dollars and cents. It should be in terms of the number of patients treated, the average length of treatment, the number of patients recovered or improved and the number of patients restored to happy, productive lives. Unfortunately, this kind of comparative data is not available.

The best statistical answers available are provided from information gathered by the Council of State Governments Interstate Clearing House on Mental Health. It shows total costs of operating the mental health program in Minnesota as compared with the United States in general and nine other midwest states in particular. Here are some of the pertinent facts and figures:

In 1953, Minnesota had a civilian population of 3,053,000 or 1.9 per cent of the total United States population. Its annual per capita income averaged $1,547 or 1.8 per cent of the total national income.

Among the 48 states, $320,553,000 was spent on mental illness in 1953. Minnesota's share in this was $12,647,000 for the mental hospitals and $4,345,930 for the institutions for the mentally retarded. An additional $50,000 was devoted to mental health clinics.

In terms of the patient, these figures mean that $3.00 a day was spent for each patient in Minnesota mental hospitals and $2.62 a day for each patient in our institutions for the mentally retarded.

This $3.00 per diem for mental hospital patients is slightly higher than the United States' average of $2.71 (range from $1.12 to $4.96), and the average of nine midwest states which is $2.81 (range from $2.09 to $5.22).

The $2.62 per diem expenditure for the state's hospitalized mentally retarded patients compares with a national average of $2.69 (range from $.86 to $4.26) and the nine midwest states' average of $2.41 (range from $1.49 to $3.89).

Translated into terms of the individual citizen, these figures reveal that in 1953, each man, woman and child in Minnesota contributed in taxes an average of $4.14 a year for hospitalization of the mentally ill; $1.42 for the mentally retarded and $.02 for clinics or community services. This is a total of $5.58 a year or $.01½ a day.

In the nation as a whole, the individual citizen paid an average of $3.16 a year for the hospitalized mentally ill. In the nine midwest states, the average per capita cost was $2.99.

For the hospitalized mentally deficient patients, the average per capita cost to the United States citizen was $0.97. In the nine midwest states, the average was $0.83.

While the individual Minnesotan spends substantially more than the average United States or Midwestern citizen on the mentally ill and mentally retarded, the actual expenditure per patient is much less than some nearby states. The explanation for this lies in the fact that Minnesota has a relatively high proportion of patients in hospitals.

Surveys reveal that 380 persons per 100,000 population are in mental hospitals in Minnesota. The United States average is 320 per 100,000 and the nine midwest states', 290 per 100,000.

There are 105 patients per 100,000 in Minnesota's institutions for the retarded compared with an average of 71 per 100,000 for the United States and 65 per 100,000 for the nine midwest states.

In summary then, the figures reveal that Minnesota ranks sixth in population and seventh in per capita income among the 10 midwest states surveyed. It ranks second in percentage of population in mental hospitals and first in percentage in institutions for the mentally retarded.

In the amount of money spent per citizen, Minnesota ranked second. In per diem expenditures per patient, however, Minnesota ranked fifth for the mentally ill, third for the mentally retarded and sixth for community services or clinics among the 10 states studied.

General Conclusions and Recommendations

Among the numerous, specialized sections in this report, there are many, detailed recommendations and conclusions. The survey committee attempted to list these in terms of immediate and long-range objectives. The conclusions and recommendations which follow are intended only to indicate major areas of the total study. They do not, by any means, represent all or even a majority of the suggestions and findings of the committee, nor should they be interpreted as representing all of the most important recommendations in this report.

Increased Personnel:

To give medically-adequate treatment and care, there is need for additional personnel in all categories of employes in the state mental hospitals and for the establishment of a number of new positions. In some hospitals, aides are so scarce that no one is on duty at certain times on certain wards. Because psychiatric social workers are in such short supply, one whole phase of the mental hospital program—that which has to do with the patient returning to the community—has been virtually neglected. Because expert workers in the psychiatric field are hard to find, special inducements such as competitive pay scales, research programs and opportunities for training must be offered. In addition, civil service job classifications must be revised to permit greater flexibility, more room for promotion as well as more realistic salary schedules.

Higher Salaries:

Most of the men and women employed to treat and care for the mentally ill must be highly-trained, skillful workers. Because the emphasis on treatment for mental disease has been growing rapidly, their services are at a premium. In Minnesota's mental hospitals, salary increases are needed for all groups of employes working directly with patients.

Opportunities for Training:

One compelling method of attracting topnotch people to the state hospital system is to offer a variety of training programs. These include stipend plans as well as opportunities for on-going training. The survey committee wishes to call particular attention to its recommendations for training programs for psychiatrists and psychiatric aides.

Outpatient Services:

Most psychiatric services available in Minnesota are concentrated around the Twin Cities, Duluth and Rochester. This means that large sections of the state are without psychiatric resources. The survey committee urges that more outpatient clinics be established in Minnesota with special emphasis on the "have-not" areas. A matching-fund plan, similar to that which exists under the New York Community Services Act, would be highly desirable.

County welfare boards can and should play a bigger role in the mental health program, particularly in the follow-up of discharged hospital patients. County welfare boards, too, should act as co-ordinating agencies for mental health services. Perhaps under the leadership of these welfare boards—or even voluntary citizens groups—community mental health self-surveys should be made in all the larger population centers. These self-surveys should put special emphasis on rehabilitation resources available to the returning patient.

Research:

The importance of research in providing ultimate answers cannot be denied. Therefore, it is recommended that a fund of $400,000 to $500,000 be established by the state legislature without any time limit on its expenditure. A research director should be employed to direct the program.

Construction:

A thorough report on construction needs, both immediate and long-range, should be prepared by a competent committee. Ideally, this committee should include specialists in hospital construction as well as hospital employes and legislators.

Among all the priority construction needs, there is an imperative requirement for a facility for emotionally-disturbed children. This state provides almost nothing for these unfortunate sick ones, a fact starkly highlighted recently when a 14-year-old boy was committed to the Asylum for the Dangerously Insane at St. Peter.

MINNESOTA'S MENTAL HEALTH PROGRAM

IN-PATIENT SERVICES

General Statement

This committee based its study and conclusions on these three basic premises—

EACH PATIENT who entrusts himself voluntarily or involuntarily to a state hospital has the right to expect and get every help toward recovery that modern medicine and its allied disciplines has to offer.

STAFF with sound, professional training is the core of any first-rate treatment program.

STATE HOSPITALS should be encouraged to continue their development as comprehensive treatment centers.

This committee also attempted to focus its recommendations for an inclusive psychiatric program around the needs of the individual patient. To do this, it was necessary to divide the patients into two general groups: the acute, recently-ill man or woman who has been sick less than a year, and the patient who has been ill for more than one year. This is an arbitrary division and there will be exceptions. It is useful, however, because experience shows that the mentally ill patient who does not improve within a year's time probably will need a relatively long period of hospital care while the patient who has been ill a short time usually recovers or shows substantial improvement within a year of the time proper treatment is begun.

This division is important for a second reason: Staff needs are different for the two groups of patients. The committee's recommendations reflect this fact.

For the patient just recently ill—

Thorough diagnosis and intensive treatment by highly trained specialists in a number of medical fields is essential. There must be accurate case history and interpretation of that history. There also should be physical and neurological examinations followed by any necessary laboratory work; diagnostic psychological tests, and careful psychiatric examination and diagnosis. On the sum total of all this work, the treatment program for each patient should be based.

To do this essential work, the skills of a psychiatric team are needed. This team includes the psychiatrist, the clinical psychologist, psychiatric social worker, psychiatric nurse as well as the laboratory technicians, psychiatric aides and other hospital staff members.

Actual treatment for a recently-ill patient usually combines several therapies. A recently-ill schizophrenic patient, for example, may require simultaneously:

PSYCHOTHERAPY with the psychiatrist or clinical psychologist.

INSULIN or electro-shock treatment which involves heavy nursing responsibilities.

INTERPRETATION of his illness and the hospital program to his family and community by the psychiatric social worker, and

OCCUPATIONAL and recreational activities with personnel trained in these fields.

For the patient who has been ill a year or more—

There will be times when he will continue to get the intensive therapy usually prescribed for the newly-ill. No program which would eliminate this flexibility should be permitted. By and large, however, treatment for the long-term patient usually consists of activities which involve less of the psychiatrist's time and more of the other hospital services.

For example, occupational and recreational therapies may be needed more, along with social work and chaplain services, various work and training plans, and the "total push" program which combines all the specialties in an all-out attack on the patient's problem.

In Minnesota's mental hospitals the number of recently-ill patients is small. Unfortunately so, for experience has shown that these patients, by and large, respond best to treatment. It seems probable, however, that as state hospitals provide more comprehensive treatment—and as families come to know this through education programs of out-patient clinics and community groups—more patients will seek state hospital services during the early phase of their illness.

As of June 30, 1954, however, only 14.3 per cent or 1,611 patients had been hospitalized for a year or less.[2] Since a number of these 1,611 men and women undoubtedly were ill for a substantial period before entering the hospital, the committee estimated that the actual number of recently-ill patients most amenable to intensive therapy would be 1,000 to 1,200. That would put the number of long-term care patients at approximately 10,000.

It goes without saying that all patients should get the best available treatment and care, but the committee believes that particular emphasis in each hospital should be on the development of an intensive diagnostic and treatment program for those patients who have been ill a short period of time. If every effort is made to treat this group with all known therapies and return them to their communities as quickly as possible, the number of patients requiring long-term hospital care eventually can be reduced.

With this background information, then, we turn now to the special reports and recommendations.

[2]See tables VI A, B, C in the appendix.

The Consultants:

Mentally ill patients suffer from a wide variety of other diseases. Their mental condition often makes the diagnosis of other ailments unusually difficult. Further, the problem is complicated by the lack of full-time medical staff in the hospitals and in some instances, a shortage of specialized consultants.

In Minnesota mental hospitals, the overall picture of the availability of consultant medical specialists is a spotty one. All state hospitals have some consultation staff, but those close to medical centers are, of course, better supplied than those in other areas. Thus, the patients in some of Minnesota's mental hospitals, like many other Minnesota citizens, are at considerable distance from medical consultants in many specialty fields.

This has complicated the development of a program that will assure adequate, general medical care for the mentally ill patients.

This committee particularly wishes to commend the development of the survey for pulmonary diseases, including tuberculosis, that is made twice annually. This survey should be a guide for at least annual examinations in the field of cancer, diseases of the special sense organs such as eyes and ears, and in the field of internal medicine and dentistry.

The committee also wishes to commend the Mayo Clinic and the University of Minnesota for their generosity of time and talent in providing consultation services in many instances, gratuitously, in some of the state hospitals. The numerous private physicians who have provided contractual consultation services, often at considerable inconvenience to themselves, also should be cited.

Recommendations:

1. A survey should be made by each of the state hospitals to determine what additional local consultation services and facilities may be available to them.

2. A specific program for consultants' attendance at all hospitals not now having a complete program in this field should be formulated. The services of specialists should be available at regularly planned intervals—daily, weekly, bi-weekly or monthly—depending on the need. All major medical specialties should be included in the program.

STAFF NEEDS

The Psychiatrist:

As chief of the psychiatric team, the psychiatrist is directly or indirectly in charge of all treatment within the hospital. It is on his prescription, after consultation with other members of the hospital team, that specific therapies are used.

In Minnesota's mental hospitals, there are 14 psychiatrists, 7 of whom are superintendents. Of this total number, 8 have passed exami-

nations of the American Board of Psychiatry and Neurology and 3 or 4 are eligible to take these examinations. The others fulfill state civil service requirements at a lower level.

Well-trained psychiatrists are hard to find. National demands far exceed the supply. State hospitals particularly find it hard to attract psychiatrists because the obvious advantages of private practice are so compelling. Yet the committee firmly believes that Minnesota has to compete for the available psychiatrists in these several ways:

1. Offer a residence training program and the opportunity to teach.[3]

2. Provide facilities and staff that will permit good service to patients.

3. Provide opportunities to do research and to follow up leads on improved methods of treatment and prevention of mental illness.

4. Provide good working conditions that will include professional opportunity and advancement; decent living arrangements and adequate, but not exorbitant, salary.

Current pay scales for physicians, including psychiatrists, in the state system are too low and must be raised substantially to put Minnesota in a better competitive position with neighboring states and Veterans Administration.

Recommendations:

1. One psychiatrist to every 20 patients with a recently-developed illness should be the long-range goal. For an estimated 1,200 acutely-ill patients each year, a total of 60 staff psychiatrists would be needed. (When the committee refers to a "long-range goal," it means a reasonable length of time, say 8 to 10 years.)

Immediate goal (for the next biennium) should be the addition of at least 1 to 2 qualified psychiatrists to the staff of each mental hospital.

2. For the estimated 10,000 long-term patients, the long-range goal should be 1 psychiatrist to 500 patients or an additional 20 psychiatrists.

Immediate goal should be the adding of clinical directors to the staffs of hospitals currently without them.

3. A training program for fellows in psychiatry should be established as soon as possible at three hospitals. A beginning for this program was authorized by the 1955 legislature.

4. This committee endorses the pay scales recommended by the medical policy committee of the Department of Public Welfare. While the 1955 legislature increased moderately the salaries of superintendents, the following schedule is recommended:

For mental hospital superintendents—$14,000 to $16,000 a year, plus $4,500 maintenance.

[3]See special section on Training.

Mental hospital clinical director—$12,000 to $14,000, minus $2,200 maintenance. The same range should be available to directors of mental health clinics and chief of state mental health out-patient services. (The job of clinical director should also provide a training ground for future superintendents.)

Psychiatrists III or chief of a a large psychiatric service at a mental hospital—$9,780 to $10,956 minus $1,020 for maintenance. (Present range is $9,012 to $10,956.)

Psychiatrist II or senior psychiatrist — $9,480 to $10,536, minus $1,020 maintenance. (Present range is $8,664 to $10,-536.)

Psychiatrist I or staff psychiatrist—$9,180 to $10,140 minus $1,020 maintenance. (Present range is $8,328 to $10,128.)

5. There should be increased use of medical specialists, particularly psychiatrists, who are in private practice but who could spend some regularly-assigned time at a state hospital. (For example, a private psychiatrist who could spend 1 to 2 days a week at a hospital could supervise the psychiatric care in one section.)

6. Every effort should be made to attract outstanding professional people who hold full-time university appointments around the nation to spend a sabbatical year at one of the hospitals doing teaching and research. One or two such people would give an impact and stimulus far beyond the cost involved.

The Neurologist:

Neurological services in Minnesota's mental hospitals fall far short of any acceptable standard.

Present statistical information shows that about one-third of the state hospital patients are known to have organic diseases of the nervous system. (This figure does not include patients at Cambridge State School and Hospital for epileptics and mentally retarded or the Faribault State School and Hospital for the mentally retarded. At both these institutions, almost all patients have organic involvements of the nervous system.)

It is entirely possible that some of the remaining two-thirds of the state mental hospital patients may have neurological disturbances that would be recognized if adequate evaluation and diagnosis were possible.

In recent years, the field of neurological diagnosis has expanded greatly. Many highly specialized procedures, such as the spinal tap with studies of the spinal fluid, electroencephalography, electromyography, air encephalography and angiography have been developed. These procedures require fairly elaborate equipment and specialized skills to use them. Their importance, however, is of such magnitude that they should be available for all state hospital patients suspected of having organic illnesses. These procedures are important for routine clinical diagnosis as well as for the setting up of a proper clinical research program.

Recommendations:

1. An attempt should be made to provide for each of the state hospitals the services of one full-time neurologist. Two neurologists should be employed at Cambridge and Faribault where almost all the patients have neurological problems.

2. One state hospital should be designated as a special diagnostic and treatment center for patients with neurological problems. This hospital should be equipped with facilities to carry out the most complex work and should be well-staffed with trained personnel. (It is contemplated that neurological cases from other state hospitals, including the institutions at Faribault and Cambridge, would be brought to this center for special diagnostic and treatment procedures and then returned to the original hospital for continued care, if necessary.)

3. This special diagnostic and treatment center also should provide training for neurologists in association with the University of Minnesota. At this center a selected group of neurological cases could be treated and observed for special training purposes and for clinical experience. Training in basic neurology would be offered primarily at the University.

The Neuropathologist:

Closely related to the neurologist's work is the field of neuropathology. This field is concerned with the study of organic lesions of the central nervous system. It is extremely important that all such lesions be correlated with the symptoms exhibited by the patient so there can be a better understanding of the pathological processes involved. This is one of the first steps in clarifying the clinical picture in mental and neurological illnesses and can be done only if there is a well-equipped, well-staffed neuropathology laboratory available.

At the present time, there is a well-equipped neuropathology laboratory and a part-time neuropathologist at the Anoka State Hospital. This laboratory, properly staffed, could do the following:

1. Make routine studies on all central nervous system tissues obtained from patients in the state hospitals.

2. Provide research material for various phases of study in mental illness.

3. Organize clinical pathology conferences to aid hospital staffs.

4. Offer training in neuropathology as part of a total training program in psychiatry and neurology.

Recommendation:

1. All state hospitals should be encouraged to use the facilities of the neuropathology laboratory at Anoka. Personnel of this laboratory should be increased to include additional technical help and a full-time neuropathologist.

The Clinical Psychologist:

Minnesota's mental hospitals have done better in recruiting psychologists than specialists in any other field. Unquestionably, the most significant reason for this is a salary scale that permits the state to compete favorably with other states and the Veterans Administration.

Still, much remains to be done. From July 1, 1949, to July 1, 1954, the number of psychologists employed in institutions and clinics expanded from 1 to 31. Therefore, the problem is not one of starting from scratch but rather of maintaining, improving and expanding a program of proven value. To bring the state mental hospitals only within standards set by the American Psychiatric Association (APA) would require another 42 psychologists. In addition, of the 31 presently employed, only 5 have the desired training, a Ph.D. degree.[4]

The job of the psychologist is many-sided. (The committee emphasizes the scope to support its conviction that an immediate increase of 11 psychologists is a wise investment.) The job covers far more than the testing program popularly identified with the profession. It includes testing, of course: the giving and interpreting of a wide variety of intelligence, aptitude, ability and personality tests which contribute to the diagnosis of the patient's mental ills. But because of his knowledge of personality structure, the psychologist also is responsible for recommending certain parts of the treatment program, particularly as it involves a work assignment for the patient, recreational and occupational therapy. He also helps carry out some individual and group therapeutic procedures and may assume responsibilities for the administration of certain ward programs. The Veterans Administration is using specially-trained clinical psychologists for ward administrative duties, thus freeing trained psychiatrists to work more intensively with individual patients. The Fergus Falls State Hospital is making a somewhat similar use of psychologists in their praiseworthy "total push" program. At Willmar State Hospital, a program of group therapy with alcoholics has been helpful in encouraging patients to talk through problems and allaying some of the feeling of "aloneness" so common to this illness. More of this work needs to be done with selected patients.

Still another highly important facet of the psychologist's role is the contribution he can make in research. Psychologists tend to be "research-minded" and well-versed in research methods. At several of the state hospitals, the psychologists already are participating in studies, such as the significant research into Huntington's Chorea now being directed from Rochester State Hospital. More research under proper conditions should be undertaken.

With this background in mind, then, the committee emphasizes that a most crucial need is recruiting well-trained psychologists in a better-balanced job classification structure. Under civil service specifications at the time of this survey, only two salary grades are allowed which make it difficult to recruit the proper quality of psychological personnel.

[4]For training recommendations, see section on Training.

Under this classification schedule, there are two salary ranges, $580 to $650 a month, which does not permit the recruiting of competent Ph.D. level persons for supervisory positions, and $370 to $420. This second salary range has become progressively less competitive until at present there is urgent need for salary increases and for the addition of an intermediate salary range.[5] Further, because there is little room for promotion, the civil service specifications also contribute to a relatively rapid turnover among state psychologists. This situation should be remedied as quickly as possible.

Recommendations:

1. To meet immediate needs and to come up to approximately 70 per cent of the standards set by the American Psychiatric Association, the following psychologists are needed:[6] (Listed in first, second and third order of priority.)

Priority Hospital	*Present Staff* (including vacancies)	*Additional Staff*
1. Sandstone	0	1 clinical psychologist
2. St. Peter	2	3 psychologists
3. Moose Lake	1	2 psychologists
3. Fergus Falls	4	1 psychologist
3. Rochester	2	2 psychologists
3. Willmar	3	2 psychologists

2. Civil service titles should be changed from the present ones of Psychologist, Clinical Psychologist, Clinical Psychology Supervisor to Clinical Psychologist, Grades I, II, III and IV. (This was done as of January 1, 1956.) These new grades would relate to the present ones as follows:

Clinical Psychologist I (previously Psychologist)—approximately $5,500 to $6,800. (Range as of January 1, 1956, $4,440 to $5,400.)

Clinical Psychologist II (new position) — approximately $6,800 to $8,500. (Present range, $4,992 to $6,072.)

Clinical Psychologist III (previously Clinical Psychologist) —approximately $7,500 to $9,000. (Range now is $6,564 to $8,004.)

Clinical Psychologist IV (previously Clinical Psychology Supervisor) — approximately $8,000 to $9,744. (Range now is $7,104 to $8,664.)

3. Within the next 5 years, psychologists with training and duties similar to those employed by the Veterans Administration as "Counseling Psychologist" should be recruited. These persons would use psy-

[5]An intermediate psychologist position was added as of January 1, 1956. Salaries were increased as of January 1, 1956, too.
[6]For recommended long-range goals, see chart following this report.

chological skills in the evaluation, job counseling and placement of patients, including follow-up work. This would be a comparatively new field for Minnesota mental hospitals but it is one which needs development.

4. Each psychologist should be encouraged to develop research ideas and to request funds and/or personnel needed for carrying out approved projects.[7]

5. A plan should be worked out within the next year to decentralize the work of the psychological staff of the Bureau of Psychological Services to help the state mental health clinics. (This committee does not recommend that *additional* psychologists be recruited for mental health clinics until, as suggested in the special report on Out-Patient Clinics, a study is made of staffing needs. It does suggest, however, that mental health centers at Fergus Falls and Albert Lea each be assigned a full-time psychologist from the staff of the Bureau of Psychological Services.)

6. A rotating psychological internship program should be developed with central office training funds. This internship, of one year duration, should be designed to attract persons who have finished the major portion of work for the Ph.D. degree. To allow sufficient time for recruiting, the number of interns for the coming biennium should be restricted to two. Central office funds also should be made available for the employment of interns for the summer months. This program should be tried for two or three summers after which a comparison should be made of its value with that of longer internship.

[7]See section on Research.

CLINICAL PSYCHOLOGY

Long-term Personnel Requirements

Present total—including vacancies	Modified V. A. Standard			American Psychiatric Standard		
	Active Treatment	Continued Treatment		Active Treatment	Continued Treatment	
	1:50	1:500	Total	1:100	1:500	Total
3 Anoka	2.4	2.1	4.5	1.4	2.1	3.5
4 Fergus Falls	5.4	3.9	9.3	2.7	3.9	6.6
3 Hastings	3.6	1.9	5.5	1.8	1.9	3.7
1 Moose Lake	4.8	2.5	7.3	2.4	2.5	4.9
2 Rochester	5.8	3.4	9.2	2.9	3.4	6.3
2 St. Peter	6.4	5.1	11.5	3.2	5.1	8.3
0 Sandstone	0.6	.9	1.5	0.3	.9	1.2
3 Willmar	2.4	2.5	4.9	1.4	2.5	3.9
Willmar Inebriate (200)	4.0	.....	.....	2.0	.....	.....
			57.7			40.4
18						

Research Psychologists—now 3 at I level.
Since psychologists tend to be research oriented and well versed in research methods, each psychologist should be encouraged to develop research ideas and to request funds and additional personnel needed for carrying out such projects.

Nursing Services:

Nursing services in Minnesota's mental hospitals include the largest group of employes in the system, the professionally-trained nurses and the psychiatric aides.

Together, they must provide complete, 24-hour care, seven days a week for the patient. The quality of care and treatment in any given hospital necessarily depends heavily on the number of well-trained, competent nursing service personnel. In Minnesota's hospitals, the lack of professionally-prepared nurses to care for the mentally ill is an acute problem. The situation varies from hospital to hospital. But not one institution approaches even remotely what can be considered a safe ratio of nurses to patients. Even in the Twin Cities area, Anoka State Hospital has only 30 professional nurses for 1,129 patients, 400 of whom have tuberculosis in addition to mental illness, and Hastings has a scant 12 nurses for 982 mental patients.

The hospitals have done far better in the recruiting of psychiatric aides.

But it must be emphasized that inasmuch as the aides' work should be under professional nursing supervision, the present shortage of nurses cannot help but affect adversely the quality of aide service.

This committee found that because of the acute shortage of nurses, whole wards and cottages are, at times, without adequate supervision. This is a potentially dangerous situation which requires immediate attention.

In making its recommendations, the committee took a number of factors into consideration. These included:

1. The rambling, diverse building plan of most of the institutions which complicates problems of supervision.
2. The necessarily varied clinical activities being carried on within the hospitals.
3. The around-the-clock service which nurses and aides must provide.

The committee also gave careful consideration to the fact that some type of patients require more professional nursing care than others. For example, the greatest concentration of professional nursing skill is required for the receiving units, acute medical and surgical wards, the wards for severely-disturbed patients and those wards where chronically ill and infirm patients must remain in bed. In the receiving units, particularly, much of the insulin shock therapy, electro-shock therapy and other complex treatments are given to newly-admitted patients. All these programs require a substantial number of professional nursing personnel.

For patients on general ambulatory and open wards, less professional nursing service is needed. Aides can perform most of the duties with direction from a nurse supervisor.

Aides also can assume much responsibility for the direct care of the "continued-treatment" type of patient, including the untidy, feeble but ambulatory and regressed patients. It is necessary, however, that sufficient number of professional nurses be available to give assistance and supervision to the aides in caring for the physical and emotional needs of the patient.

Recommendations:

1. A registered nurse, preferably with preparation in nursing service administration and special training in psychiatric nursing, should be employed by each hospital to be director of nursing. She should assume responsibility for the overall supervision of the entire nursing service. As nursing director, she should be responsible administratively to the clinical director.

2. The nursing director should have at least two principal assistants—one to help in directing the nursing service and a second to assume direction of the education program for professional nurses, professional student nurses and psychiatric aides.[8]

3. Well-qualified nurses, preferably with special training in psychiatric nursing, should be employed as shift supervisors in order to cover adequately the various clinical and geographical areas within the institution.

4. For receiving units, acutely-disturbed patients' wards and other sections requiring a concentration of nursing skill, *the immediate goal* in each hospital should be a ratio of 1 registered nurse for every 15 patients. Present ratio is 1 to 43. The *long-range goal,* in accordance with APA standards, should be 1 nurse for every 5 patients in intensive treatment units.

For these same units, the *immediate goal* should be 1 aide for every 6 patients and the *long-range plan* should be 1 aide for every 4 patients. Present ratio is 1 aide to every 6 patients.

5. For patients on regressed, untidy and closed wards, every effort should be made to establish an *immediate ratio* of 1 nurse to 60 patients. The *long-range goal* should be a ratio of 1 to every 40 patients. Present ratio is 1 nurse to every 279 patients.

For these same wards, the *immediate goal* should be 1 aide for every 9 patients; the *long-range goal* should be 1 aide to 6 patients. Present ratio is 1 aide to 11 patients.

6. For tidy, ambulant patients who are in open wards and require the least constant care and supervision, a ratio of 1 nurse to 100 patients should be the *immediate goal* while the *long-range goal* should be 1 to 40. Present ratio is 1 nurse to 249 patients.

An *immediate ratio* of 1 aide to 15 patients would provide minimal care in these wards. A ratio of 1 aide to 10 patients should be adopted as the *long-range goal.* Present ratio is 1 aide to 16.9 patients.

[8]For further recommendations on education and training for nurses and aides, see special report on Training.

Social Work Services:

Social work services in Minnesota's mental health program are far below any acceptable standard. The situation can be summed up in a phrase: far too few trained social workers for the job that must be done.

The importance of the social worker, whether working within the hospital, the outpatient clinic or in some other community agency, cannot be overestimated. The social worker can be the vital link between home and hospital, hospital and community, ex-patient and employer. He, or she, also should be the painstaking recorder of the patient's pre-hospital history, the events and the patient's response to events that may have been significant in the development of the illness. These events, too, must be considered in making a suitable plan for the patient's eventual discharge.

Yet, for several reasons—most of which can and should be remedied immediately—the social work program has not kept up with other vital services within the hospitals.

These are the statistics:

1. As of July, 1955, there were a total of 14 budgeted social worker positions among the 8 state mental hospitals, of which 9 were filled. The 9 filled positions were distributed among 6 hospitals: Anoka, Fergus Falls, Hastings, Rochester, Moose Lake and St. Peter. Only 4 of these workers had completed their training in psychiatric social work. There remained 5 vacancies for social workers among the hospitals. But even if these positions were filled, there still would be an urgent need for additional trained social workers. The preceding year, 1954, only 4 hospitals had social workers.

2. Four social workers are employed by the schools for the mentally retarded at Faribault and Owatonna and the institution for retarded and epileptics at Cambridge. Only 1 is trained.[9]

3. As of January, 1956, there were 8 full-time social work positions at state supported clinics in Minneapolis, Willmar, Fergus Falls and Albert Lea, of which 4 were filled. There also were 2 social workers in the clinics at Duluth and Rochester which are supported in part by state funds. All but 1 of the entire group are professionally-trained workers.

The survey committee states flatly that the biggest obstacle in recruiting trained social workers has been civil service regulations governing classification, advancement opportunities and salary.

The job classifications prior to January 1, 1956, for Psychiatric Social Workers I and II, for example, were totally inadequate and did not reflect the six years of college training and experience required nor

[9]Further comment on staffing of these institutions is in the special report on the Mentally Retarded.

the complexity of job responsibilities. The classification pattern did not allow for promotion except to the position of chief social worker. The salary scale put the state in a distinctly unfavorable competitive position.

Changes should be made to permit at least 3 steps in job classifications with the intermediate step being used for workers doing supervision or carrying responsibilities for groups of patients who demand special skill or concentration.[10] This intermediate classification should apply also to a person who needs only a minimum of supervision and can function as the only worker in a small clinic or hospital. As the program develops, social workers at the intermediate level should be available for research and training projects. The University Hospitals classification plan should be studied in connection with this whole problem.

The title of psychiatric social worker should apply only to those who have completed graduate training in social work. The positions of senior worker and chief worker should require previous supervisory experience in a psychiatric setting. If persons employed have not completed graduate training, they should be given a job title other than psychiatric social worker. (This committee believes it is misleading and confusing to permit persons who have not completed formal training in any of a number of special fields to be given civil service titles which indicate professional accomplishment. This applies in the field of psychiatry as well as in social work.)

In making its recommendations, the committee was guided by the knowledge that the number of social workers needed to give maximum service in hospitals and clinics would be staggering. Estimates of personnel based on hospital population or on the APA or VA standards would be beyond hope of fulfillment anytime in the near future because of lack of funds and recruitment difficulties.

Therefore, these recommendations are based on an immediate goal of providing only minimal social services to acutely-ill patients and to patients who are ready for discharge from the hospitals. A ratio of 1 social worker to 50 acutely-ill patients (those hospitalized a year or less) and 1 social worker to 80 provisional-discharged patients is the long-term goal used by the committee.

In other words, the committee believes that, with the limited services available, priority should be given to newly-admitted and to discharged patients. If at all possible, there should be complete social work coverage of all patients upon admission to the hospital. For patients being discharged, there should be individual planning. At both these particularly critical points, admission and discharge, the social worker also must work closely with the patient's family.

[10]As of January 1, 1956, this was done by adding the job of Hospital Social Service Director and making Psychiatric Social Worker II an intermediate position. As of that same date, Psychiatric Social Workers I got $329 to $400 monthly as compared with a range of $290 to $330 previously; Psychiatric Social Workers II got $356 to $433. Hospital Social Service Directors received $416 to $506. A position of Institutions Social Service Consultant at $468 to $569 was established at the state level and is now filled.

It must be emphasized that the immediate goal recommended provides no additional staff necessary for social work with chronically-ill patients nor for research or training responsibilities. As an immediate goal, social workers should be provided for services to chronically-ill patients at a minimum ratio of 1 social worker to 500 patients. Based on present figures, this would mean at least 21 additional positions.

It is obvious, too, that under present recommendations, social workers will not be able to give extensive pre-admission or follow-up services. These essential services will have to be carried by social work personnel in the community clinics and in the county welfare boards.[11] Other community health and welfare agencies may be additional resources for these needs.

The committee is keenly aware that its recommendations will permit very few research assignments for social workers. Every effort should be made, however, to establish a uniform system of preparation and collection of statistics of social work activity. These data would be available for study projects which are necessary to evaluate the present program and to plan for the future. Special study projects might be started also in individual hospitals which would contribute to the establishing of priorities for social work services and the selection of patients for intensive help. When possible, social workers could participate in research projects with personnel in other specialties.

At this time, a state psychiatric social work consultant has just been employed to give leadership in the development of the program within the state hospitals and clinics. The need for a trained worker with responsibility for planning, developing, directing and co-ordinating services is unquestionable. A major part of his duties also will be in staff development and in-service training.[12]

Recommendations:

1. A total of 21 new social work positions should be added to the staff of the 8 mental hospitals. This is an *immediate goal.* These workers are needed to provide minimum services for newly-admitted patients and patients about to be discharged.

2. Civil service job classifications must be revised to permit greater flexibility, more room for promotions and a reasonable, competitive salary scale. There should be at least 3 levels of social work positions in the state hospital system: (As indicated earlier, this was done as of January 1, 1956.)

Psychiatric Social Case Worker I — Proposed salary range, $4,200 to $5,092. (Range as of January 1, 1956 — $3,948 to $4,800.) He, or she, should have a master's degree including field training in psychiatric social work, or 1 year of advanced

[11]Further discussion of the social worker in the clinics is in the special section on Outpatient Clinics.

[12]Recommendations for a social work training program are in the special section on Training.

training and several years' experience in a psychiatric setting. The job would include the handling of social work problems of some group of patients.

Psychiatric Social Casework Supervisor — Proposed salary range, $5,000 to $6,044. (See footnote 10. Present range is $4,272 to $5,196.) This worker should have a master's degree plus 1 or 2 years of experience under supervision. He would work with the more difficult patients, supervise social workers I. He might work on a research project independently or be the only social worker in a clinic. (Salary range as of January 1, 1956—$4,272 to $5,196.)

Chief Psychiatric Social Worker — Proposed salary range $6,000 to $7,392. (Range as of January 1, 1956—$4,992 to $6,072.) He should have a master's degree plus 2 or 3 years experience, at least 1 year of which is in a supervisory capacity. He would have the overall responsibility for the social work program in the mental hospitals.

3. A psychiatric social work consultant should be employed for the mental health and related service programs in the department of public welfare. (This has been done. See footnote 10.) The salary should be $6,300 to $7,692 annually. (As of January 1, 1956, it was $5,616 to $6,828.) The person in this position would be staff adviser to the state medical director, mental hospital superintendents and the chief psychiatric social workers in the institutions. He would be responsible for the development of the psychiatric social work program.

4. Whenever possible, under the limited staffing proposed, social workers should develop and cooperate in research.

Assistance in planning for research and in the procurement of personnel for projects might be available from the University of Minnesota school of social work.

Doctoral students from the University should be encouraged to base their studies on research done within the state mental health program.

5. A review of social work services in the state mental health program should be made in 1958 and further immediate and long-range recommendations made at that time.

Rehabilitation Therapies:

All eight state mental hospitals have patient activities departments. The institutions at Faribault for the retarded and at Cambridge for the epileptic and retarded also have this department. But much remains to be done in the development of the program.

The value of providing a well-rounded schedule of therapeutic activities for mentally ill and retarded patients is accepted as sound psychiatric procedure. These activities are an invaluable part of the total

treatment plan to give the patient an opportunity to learn to get along with others; to provide outlets for hostile feelings; to make use of existing skills; to develop new vocational and avocational skills; to redirect unhealthy thoughts into constructive work and play and to provide activities which help the hospital staff to make contact with the patient for other treatment purposes. These activities should be prescribed by the physician and under his continuous guidance.

At the present time, the program of patient activities is limited because of staff shortages, inadequate budgets for purchasing supplies and equipment and lack of suitable space in the institutions. However, the attitude of employes in this field is most encouraging. Their interest and initiative is responsible for maintaining a program that makes the most of available facilities.

At each hospital, the patient activities department usually consists of three units—*industrial therapy, occupational therapy* and *recreational therapy*. In some instances, hospital employes who are classified as barbers, cosmetic therapists, librarian I or tailor shop foreman also are included in the department. The department administrators, who are responsible for planning the program, are classified as Patient Programs Supervisor I in most hospitals. All mental hospitals except Willmar had this position filled at the time of this study. Cambridge does not include this position within its hospital organization.

Overall consultation on the patient activities program is provided by a Patient Programs Supervisor II in the medical services division of the State Department of Public Welfare. Throughout the eight mental hospitals there are 105 budgeted positions, plus 20 for Faribault and 6 for Cambridge.

The Industrial Therapy Program is organized to teach work habits and new skills which the patient can use when discharged and to provide help with hospital work. The employe who supervises this program in the hospital usually is promoted from the nursing service where, as a psychiatric aide, he has broad experience in working with patients. Some training in the vocational field undoubtedly would be desirable in this position which calls for placing a patient on a job, evaluating the patient's adjustment to the work as well as making verbal and written reports to the psychiatrist in charge.

The hospitals at Anoka, Fergus Falls, St. Peter, Willmar and the Minnesota School and Hospital at Faribault have employes who supervise an industrial therapy program. The others do not. St. Peter hospital has two positions for patient placement agents, one who assigns patients in the hospital and one who arranges work for patients outside the hospital. Hospitals which have no patient placement agent or his equivalent do not maintain as complete an industrial assignment program. Arrangements are made for patients to work, but few or no records are kept, follow-up is minimal and frequently the treatment planning for the patient, which should be an essential part of industrial therapy, does not exist.

The Occupational Therapy Program develops activities for patients along the avocational and in some cases the pre-vocational interests, making use of the arts and crafts and other special activities in a shop setting or in scheduled classes on the wards. Approximately 15 to 20 per cent of the patients use the "O.T." program on a regular basis.

Under civil service, there are Occupational Therapist I and Occupational Therapist II positions. Anoka, Fergus Falls, Rochester, and St. Peter have employes in the Occupational Therapist I group who supervise the program. Budgeted positions in this classification are vacant at Hastings and Moose Lake State hospitals. At Sandstone, Willmar, Faribault and Cambridge, the hospitals do not have budgeted positions for these supervisors.

Employes in Occupational Therapist I group usually have responsibility for a section of the hospital. The activities they offer to patients may be on the ward or in the shop or both. Anoka and Rochester State Hospitals each have one such employe. None of the other institutions have budgeted for this position.

Besides Occupational Therapist I and II, the program usually has one or more handicraft instructors in order to "reach out" to more patients. There now are three handicraft instructors at Anoka; five at Fergus Falls; one at Sandstone; four at St. Peter; two at Willmar, and five at Faribault. There are no vacant positions. Hastings, Rochester and Cambridge do not use this classified position in the patient activities department.

The Recreational Therapy Program provides a schedule of social and athletic-type activities for patients. The auditoriums, outdoor areas and the day rooms of the wards are used for these activities.

The civil service title of Patient Activities Leader II usually is given the employe supervising the program. Only Hastings and Faribault do not have an employe in this position. To assist with the program in the largest hospitals, there is a Patient Activities Leader I. Thirty such positions have been budgeted. In addition, there are 42 Patient Activity Workers who assist in the recreation program. Moose Lake does not have a classified position for patient activity workers.

Some Problems: (Organization)

At present, there are no fewer than six different titles to designate what in this report is called the rehabilitation therapies department. In several instances, the budget roster for patient activities personnel is headed "Miscellaneous Department." Unquestionably, there is need for a uniform, appropriate department name. Further, it would avoid confusion if each division of the overall department had the same name in all institutions. Currently, one hospital calls occupational therapy "arts and crafts" while another may designate it "handicrafts." Recreational therapy is variously known as "sports program," "social activities" or just "recreation." Industrial therapy often is referred to as "patient work."

There are, too, considerable differences among hospitals on the department's place in the hospital organization. One or two departments are responsible to the principal lay administrative employe, usually the assistant superintendent. Others report to the superintendent and some get little or no medical supervision. In each hospital, all employes are responsible ultimately to the superintendent but his many duties require that he delegate a number of functions. In the committee's opinion, the rehabilitation therapies department should be under the direct guidance of the clinical director who, in cooperation with other staff members, prescribes the therapeutic activities for patients.

It must be emphasized that the whole purpose of this department is lost if it is not provided on a prescription basis like other therapies. The Anoka and Fergus Falls State Hospitals are the only two institutions which are using a prescripition form which permits adequate outlining of an activities program. Most hospitals require only verbal reports about the patient's progress. Only infrequently are written reports requested, and little or no information is filed in the patient's medical record folder.

The committee wishes to stress, too, that the modern practice of treating mentally ill patients centers around a team approach. All personnel who work directly with the patient must be encouraged to present their part of the program, to learn what other staff members are doing and to receive help from the physician in the treatment plan for each patient. Unfortunately, few employes concerned with patient activities are invited to participate as "team" members. Medical advice and guidance must be extended to them and their suggestions sought.

Personnel

The Minnesota Civil Service Department has 16 classified specifications for positions relating to duties of employes working in rehabilitation activities. These are far too many positions to allow good organizational control or for local adaptability in meeting program needs. Many of these specifications have not been revised within the last 5 years and many no longer describe current duties. Salary ranges for both trained personnel and the assistants are much too low to attract persons with special skills. Compared with nationally-accepted salary standards, these classes are $40 to $50 a month too low.

There is wide variation among hospitals in the ratio of activity workers to patients. The average ratio is 1 employe to 114 patients with the highest ratio at Moose Lake and Rochester State hospitals where there is only 1 employe for 161 patients. Needless to say, these ratios are a long way from American Psychiatric Association recommendations.[13]

Every effort should be made to establish training programs for workers in the rehabilitation therapies departments. The committee suggests three areas:

[13]For immediate and long-range personnel recommendations, see chart following.

1. In-service training of recently-employed personnel.

2. Affiliation program for occupational therapy and recreation students from universities and colleges.

3. Continuous training, through workshops and the like, of all personnel in the latest advancements in treatment techniques in this area of patient activities.

Anoka and Fergus Falls State hospitals are the only institutions which have programs for clinical affiliation of students from occupational therapy schools. A few limited orientation sessions are being conducted for recreation students. More hospitals provide time for a weekly or bi-weekly discussion period for rehabilitation personnel. But the training program needs to be developed both in scope and content.

Supplies, Budget and Sales

Budget planning and spending of money for patient activities has been irregular and uncertain although some funds have been provided. A number of the departments do not know from one fiscal quarter to the next what they will get. This makes long-range planning impossible. To carry on a continuous meaningful program, funds must be available for purchase of items such as athletic equipment, craft supplies, instruction booklets, etc. Maintenance and repair must be considered also.

The practice of selling articles made by patients still exists at some hospitals. This procedure is administratively unsound under present circumstances because the amount of staff time needed to price articles, catalog them, make sales transactions, etc., is quite extensive. There is no financial gain. Treatment of the patient must be the main concern. Staff time required to handle such business matters might more productively be applied to the treatment program.

Recommendations:

1. There should be one name by which the rehabilitation therapies department is known in all hospitals. The committee suggests Rehabilitation Therapies Department. This department should include three units: Industrial Therapy, Occupational Therapy and Recreational Therapy. It should be responsible to the clinical director or senior medical physician at each hospital.

2. Thorough study must be made of all job classifications in patient activities. Some titles must be changed, and others must be combined to describe more precisely the present duties of employes. Salaries must be increased in order to compete with other states and to recruit the best personnel available.

3. There should be immediate initiation of an in-service training program for all new employes. Weekly study sessions should be organized at each hospital. Affiliation programs in occupational therapy should be set up in hospitals where they do not now exist.

4. Within the next 2 to 4 years, every effort should be made to bring the total number of occupational therapists up to 43 and other workers in rehabilitation therapies to 144. This would provide a ratio of 1 employe to each 85 patients. As a long-range goal, the number of registered occupational therapists should be increased to 86 and other workers to 178. The ratio would then be 1 employe to every 60 patients or the minimum personnel standard recommended by the American Psychiatric Association.

5. A recruitment program should be developed to attract new personnel not only for direct work with patients but to participate in educational and research programs.

6. A budget for the proposed Rehabilitation Therapies Department should be established in each hospital to purchase needed equipment and to provide funds for maintenance and repair of equipment used in this program. The budget should be pro-rated on the basis of $.04 a day per patient.

7. The sale of articles made by patients should be discontinued.

RECOMMENDED INCREASE IN PERSONNEL FOR REHABILITATION THERAPIES DEPARTMENT

	No. of Patients	Present Reg.	Present O.T.	Present Other	2-4 yrs. Reg.	2-4 yrs. O.T.	2-4 yrs. Other	4-7 yrs. Reg.	4-7 yrs. O.T.	4-7 yrs. Other	7-10 yrs. Reg.	7-10 yrs. O.T.	7-10 yrs. Other
Anoka	1,135	3		16	5		16	7		15	9		15
Fergus Falls.	1,952	1		21	5		21	7		23	10		23
Hastings	994	2		10	3		11	4		12	5		12
Moose Lake .	1,290	1		7	4		9	5		11	7		15
Rochester ..	1,771	3		8	5		12	7		17	10		23
Sandstone ...	451	0		4	1		7	2		6	3		6
St. Peter	2,485	0		17	6		17	9		24	13		30
Willmar	1,505	0		13	5		16	7		18	9		20
Cambridge ..	1,100	0		7	2		9	4		10	5		11
Faribault ...	3,192	0		22	7		26	10		29	15		32
	15,875	10		125	43		144	62		165	86		178

The Volunteers:

No dollar sign can estimate properly the true value of the volunteer program in Minnesota's mental hospitals.

The volunteers bring not only services, gifts and special entertainment to the hospitals, they bring the helpful interest of the community into the hospital wards and they take the important story of the hospital program into the community. But perhaps their most significant contribution is the magnanimous gift of friendship to the individual patient who so often feels lost and isolated from the world outside the hospital.

At the time of this report, there were well over 1,000 volunteers working in state hospitals on a regularly-assigned basis. From July, 1953, through June 30, 1954, a total of 25,722 hours of volunteer

services were given on a regular basis in institutions for the mentally ill. (This figure does not include the hours given by hundreds of volunteers who visited hospitals occasionally to sponsor a party, dance or special program.) During this same period, about 300 special shows were brought into the state hospitals. For these same 12 months, approximately $51,500 worth of gifts and merchandise were donated to the eight mental hospitals. (This figure is exclusive of the gifts given to the Minnesota School and Hospital at Faribault or the Cambridge School and Hospital. The Faribault institution alone received 12,000 gifts plus 5 television sets for Christmas, 1953.)

Besides bringing in special programs, parties, dances and gifts, the volunteers are performing these other services; in some hospitals, they help feed bedridden patients. At Anoka, they built a miniature golf course for patients. At Willmar, they are helping discharge patients re-orient themselves to community living.[14] They write letters for patients, do clerical work, take patients for walks and, in some instances, work in hospital libraries, do social service and nursing duties.

Responsibility for planning and developing the total volunteer program is under the supervision of a state volunteer coordinator, a comparatively new position in the mental hospital field and one which has proven its value.

Yet, productive as it is, the volunteer program could be vastly expanded and improved. In many hospitals, the surface merely has been scratched. The best volunteer programs are in hospitals that employ a full-time coordinator of volunteers. This is not a criticism of the individuals responsible for these activities in hospitals which do not have a full-time coordinator. On the contrary, employes who are handling the volunteer program in addition to other responsibilities are to be commended. The committee believes, however, that a full-time volunteer coordinator is needed in each hospital if the program is to be developed to its full potentiality.

No hospital would consider employing a group of workers in any field without a supervisor specifically trained to direct them. It is unreasonable to assume that a meaningful volunteer program, which may involve from 20 to 200 persons, can function well without a full-time supervisor. The selecting, training and job placement of volunteers is an important factor in the success of the program. Orientation of volunteers and staff is a continuing and time-absorbing job. The continuous evaluation of hospital needs as they relate to the use of volunteers, award ceremonies, recruitment of volunteers are among the many activities that require a full-time coordinator of volunteers at the hospital level.

The committee believes there are many ways in which greater use could be made of volunteers. With the tremendous demands made on the time of the professional staff, plus the shortage of these professional workers, it is unfortunate that many of them still handle duties

[14]See outpatient section for other aspects of volunteer program.

and details which could be handled by carefully-selected, well-trained volunteers. Some of these duties include conducting tours, scoring less complex tests for psychologists, staffing reception desks, certain social service activities, etc.

Recommendations:

1. Each hospital should have a full-time volunteer coordinator to develop, expand and coordinate the program at the hospital level. There are now but 3 full-time coordinators in state hospitals. Part of the coordinator's job would be to consult with other members of the staff to broaden the use of volunteer services both in and out of the hospital.

2. Salary increases should be considered both for the state and hospital coordinators. Amount of free services and gifts alone more than justify these increases. At the present time, the salary scale is a handicap to recruitment and is not in keeping with the responsibilities carried by workers in these positions. Salary scale for the state coordinator is $3,600 to $4,080. Salary scale for the hospital coordinator is $3,120 to $3,600. The committee recommends that the scale for state coordinator should be $5,500 to $6,500 and for hospital coordinator, $3,500 to $4,500.

3. There also should be additional job classifications for volunteer coordinators. At the present time, there are only two job classifications set up under civil service, one at the state level and one in the hospitals. As the program continues to grow, an assistant to the state volunteer coordinator probably will be necessary to handle many of the details.

OUTPATIENT SERVICES

General Statement

Minnesota has concentrated its resources during the past several years on raising the standards of treatment and care offered within its mental hospitals and institutions for the retarded. This task is by no means at a stage where employes, citizens and legislators can relax their efforts. On the contrary, these efforts should be enlarged to include not only the inpatient services provided by the hospitals but the outpatient program in the community. A sound, well-planned, comprehensive outpatient program is now overdue in Minnesota. It is, after all, at the community level that many cases of mental illness can be prevented from developing or can be controlled to such a degree that the patient never need spend years in an institution. It is at the community level, too, that follow-up work with a patient can help re-settle him with his family, his employer, his friends. This follow-up work can be the difference between staying well and returning to the hospital. Public education about mental health and mental illness also can be done best at the local level.

This report only touches on the need for and scope of a good outpatient program. The committee suggests that more study should be done in this field. If these studies are participated in by local com-

munities, the results will be far more meaningful. At the present time, these are among the big drawbacks in the out-patient mental health program:

1. Minnesota does not have enough local psychiatric services available to mental patients. Services which do exist are unequally distributed around the state.

2. Most communities lack centralized planning to integrate existing services. The state should take immediate steps to explore and develop recommendations for the cooperation and integration of agencies working in and around the field of mental illness, probably through the county welfare boards.

3. Trained personnel for the outpatient program is scarce.

Outpatient Clinics

Outpatient clinics should be an essential part of the state's total care of the mentally ill. The 4 state clinics now in operation (Fergus Falls, Albert Lea, Willmar and Twin Cities) represent a substantial, significant service in spite of the serious handicaps under which they operate, not the least of which is inadequate staffing both for volume and type of service. In addition, the geographical distribution of existing clinics leaves large areas where service is unavailable.

Outpatient clinics should provide these specific services:

1. Diagnosis and early treatment of patients of all ages for whom hospitalization is not necessarily considered. The clinic helps prevent unnecessary hospitalization and may make it possible for an individual to remain in his home and community.

2. Case work-up and social history, psychological testing, guidance to individuals and families in the commitment process before a patient must enter a hospital.

3. Rehabilitation services for patients convalescing from a psychiatric condition for which they were hospitalized. Continued "supportive therapy" may be required for a long period of time.

4. Informational and education services to the general public and to both lay and professional groups.

5. Consultation services to schools, health and welfare departments, courts and other public or private agencies with the purpose of conserving mental health through the application of mental hygiene principles to the basic work of such agencies.

In addition, outpatient care is the best type for some patients and frequently may be provided on a more economical basis than hospital care. Experts suggest the ratio of one clinic team to 50,000 persons. For Minnesota, this would mean a total of about 60 clinic teams. A clinic team usually consists of 1 psychiatrist, 1 clinical psychologist, 1 or 2 psychiatric social workers and 1 clerk.

Staffing of Clinics:

Clinics here and elsewhere usually employ at least one clinic team as indicated above. Nurses trained in psychiatry also may be on the staff, although this is not the case in Minnesota. There may be variations in this pattern, of course, depending on the size of the clinic and its locality. Unquestionably, it will be difficult if not impossible to get professional staff for clinics in remote parts of the state. Where this is true, some plan of service, perhaps in the form of a traveling clinic team, will need to be developed.

This committee does not offer any specific staffing pattern in its report but does make these comments:

1. The assignment of mental health nurses to clinics should be considered to extend prevention and follow-up services to patients.

2. The pilot program now in effect in the Rochester State Hospital and Rochester-Olmsted County Health department, can serve as a suitable guide for establishment of mental health nursing services in urban areas, particularly in regard to case finding and follow-up services for discharged patients. The establishment of a comparable program in a rural area should be discussed with the Minnesota Health department toward the end of utilizing public health nursing services throughout the state.

3. It is not recommended that additional psychologists be recruited for the clinics at present. But clinics at Fergus Falls and Albert Lea each should be assigned a psychologist from the staff of the Bureau of Psychological Services. This psychologist could do essentially the same job he does now but would have more time for service since travel time would be cut to a minimum, i.e., he would travel on occasion only to towns at the periphery of the clinic's area. Administrative supervision of this psychologist would continue to be the responsibility of the supervisor of the Bureau of Psychological Services. Professional guidance and direct supervision would be the responsibility of the clinical psychologist at the clinic.

Private and Community Psychiatric Resources

The need for outpatient clinics located strategically throughout the state becomes most apparent when studies show the location of private or community psychiatric facilities. In Minnesota, these facilities are located primarily in the Twin Cities area, Duluth and Rochester. The burden of providing an adequate mental health program—both inpatient and outpatient—falls heavily on the state as a result of this geographic arrangement.

At this time, most of the approximately 100 psychiatrists in private practice in Minnesota are located in the areas mentioned. (In Rochester, most of the psychiatrists are associated with the Mayo Clinic and therefore, see very few patients from the local community.)

Private psychiatric hospitals or general hospitals with psychiatric sections are located in Duluth, Mankato, Rochester and the Twin

Cities. The only community psychiatric clinics in the state are in the Twin Cities, Duluth and Rochester area. These clinics are not supported by state funds.

Unquestionably, a large number of people get help from the private psychiatrists and the community clinics, where they are available. The number of these resources could be multiplied many times without filling the need. State clinics, however, are needed also. They are particularly needed in those localities where there are no other resources. And it must be remembered that state clinics, by and large, serve those who cannot afford to pay all, or in many instances, even part of the high cost of psychiatric services.

The committee repeats, then, a large part of the state is without any local psychiatric resources. The obvious result is that state hospitals are getting a large group of patients who never had a chance to get early treatment and thus, possible cure for their illness.

One of the most hopeful sources of help in providing a better distribution of mental health services lies in the administrative structures of county welfare boards. These agencies, located in each of the state's 87 counties, can provide a wide variety of aid to the pre-hospitalized patient, the discharged patient and his family. Every effort should be made to develop further the relationship already existing between the mental health program and the county welfare boards. In larger centers, the county welfare boards also should serve as the coordinating, integrating agency among the various units and organizations which have a role in the total mental health program. (These might include organizations such as the Minnesota Association for Mental Health as well as certain sections of the state Health Department.)

Recommendations:

1. Outpatient clinics should be increased in the state with particular emphasis on those areas now without such service. These include the northwestern, central and southwestern sections of the state.

In the establishing of new clinics, special consideration should be given to some adaptation of the New York plan whereby the local community, state voluntary agencies such as the Minnesota Mental Health association and the State Department of Public Welfare share responsibility. The New York plan, known as the Community Services Act, provides matching state funds of up to $1.00 per capita. A similar matching-funds plan should be part of any Minnesota program. This type of cooperative support, which requires local administration with a minimum of state supervision, is far superior to the superimposing of a clinic on a community that may not be ready to accept it or make the fullest use of its facilities.

2. County welfare boards should be encouraged and helped to participate directly in certain, well-defined segments of the mental

health program, particularly the follow-up of discharged hospital patients. They should act as the coordinating agency among groups and organizations which provide a service in the mental health field.

3. Follow-up and evaluation work should be a part of the program of all outpatient clinics.

4. Specific discharge plans should be prepared by the hospitals in collaboration with the family and community agencies before the patient is discharged. These plans should be forwarded to the outpatient clinic, the welfare board or other involved agencies or professional persons so that the process of care can be continuous.

5. The commitment procedure should be examined with consideration of the role that may be played by outpatient clinics and other agencies in making the procedure less upsetting to the patient.

6. The Department of Public Welfare should make a special study of the staffing patterns of outpatient clinics in Minnesota and other states in order to determine the best and most feasible pattern.

Social Services

Mental illness, because of its symptoms, the disruption it causes in family life, the community attitudes toward it and the expense and duration of treatment, requires a considerable amount of skilled social work. This social work must be both community-based and hospital-based. It should be available to the patient and his family during the entire process of the illness and rehabilitation—that is, before, during and after hospitalization. Moreover, social services provided by health and welfare agencies and by hospitals must be adequately staffed and efficiently coordinated. It is apparent, however, that if community social services, limited and comparatively unused as they are at present, are to be exploited and expanded in the mental health program there must be also a substantial increase in hospital social service staff. The hospital social workers are the connecting links between hospital and community. This state is seriously deficient in the number of inpatient social service staff. While the number of social workers in private agencies, county welfare boards and clinics are minimal, they could, with proper planning, be a considerable source of help to mentally ill patients and their families.

The role of the social worker, as well as community social agencies, frequently is misunderstood. The committee suggests the following areas in which their services are invaluable:

1. Helping the patient and his family get appropriate diagnostic service and select other treatment facilities if hospitalization is not indicated. These other facilities might include outpatient clinics, nursing homes, etc.

2. Facilitating hospitalization (when needed) by preparing patient and family, by preparing adequate referral data.

3. Helping the family or the patient with economic and social problems arising out of the patient's illness.

4. Helping the patient understand and make full use of hospital facilities and psychiatric treatment.

5. Contributing in understanding and evaluating of the social and familial factors related to the patient's illness and the resources available for the rehabilitation.

6. Helping the family understand the patient's illness, hospital procedures and treatment plans.

7. Helping the patient plan for leaving the hospital and return to the community.

8. Preparing the family and community for the patient's discharge through casework services, home-finding, if necessary, and job-finding.

At the present, the shortage of social workers in the total mental hospital program has resulted in a number of problem situations. For example, many patients now suffer unnecessary fear and shock upon being admitted to a state mental hospital. There is inadequate community social service to prepare him or his family for the experience of a commitment hearing and admission to the hospital. At the hospital itself, there is inadequate social service to permit an effective job of reception and intake. In addition, discharges from the hospitals now are fewer and later than they need be because of inadequate hospital social service staff and poor planning with available community resources.

There are other problems, too, which could be sharply limited if more social work staff were available:

1. Some patients, particularly in the aged senile group, are in state mental hospitals but they could be cared for elsewhere if facilities were available and families knew of them. A foster home program might be suitable for some of these elderly patients, if such programs could be developed. Referral to nursing homes might also be an alternative, although there is, at present, a shortage of good nursing homes.

2. At the time of commitment, large numbers of patients are admitted with little information other than their name and the committing county. Adequate referral data, prepared by community social workers, should describe the patient's background, his relationship with his family, the development of his illness. This information would facilitate earlier diagnosis and appropriate treatment.

3. Some patients are discharged to families ill-prepared and ill-equipped to deal with problems resulting from the patient's return. Adequate family casework could prevent this situation and help on such placements to the end that the rate of returns to hospitals would be reduced.

4. Family life is seriously disrupted by the hospitalization of a father or mother. Economic and social services such as public assistance grants, foster care of children, etc., must be made known to patients and their families to keep the illness from having even further bad effects.

Recommendations:

1. Legislative and administrative encouragement should be given to the continued expansion of already-existing community social services, particularly to the county welfare boards which provide the only state-wide system of social welfare services.

2. Efforts should be made, with the help of county welfare boards, to develop a foster home program for discharged mental hospital patients.

3. The inservice training programs begun recently for county welfare workers by the Department of Public Welfare should be expanded.

4. More specialized consulting staff within the Department of Public Welfare is necessary if counties are to have the help needed to develop their social services in a way that will permit them to participate more meaningfully in the mental health program.

Rehabilitation Services:

One of the obvious deficiencies in Minnesota's care of the mentally ill is the field of rehabilitation outside the hospital. Approximately 1 in 10 of the patients presently under commitment to the Department of Public Welfare is at any given time on provisional discharge from one of the hospitals. Follow-up work of a rehabilitation nature is tragically limited. In 1953, 40% of the total number of patients provisionally discharged were returned to the hospital. An important reason for this rate is that while many of these patients were ready to leave the hospital, they failed to maintain themselves outside the institution because of a lack of even minimal rehabilitation facilities. There comes a point at which a patient may no longer profit by continued hospitalization. Discharge of such a patient, however, does not imply that he can maintain himself outside the hospital without special help.

This survey committee believes there is a great need for rehabilitative facilities in local communities. The absence of these facilities is a tragic and expensive waste.

Questions have been raised concerning the difference between outpatient clinic services and rehabilitation facilities. In brief, clinics provide social, psychological and psychiatric diagnostic treatment and supportive services. Rehabilitation services include vocational training; sheltered workshops with short-term and/or long-term goals; recreational activities; hobby and craft programs and programs of organized visiting (to places of local interest, business firms, etc.).

Recommendations:

1. The whole area of rehabilitation of the mentally ill represents a problem of such magnitude that it requires a separate, long-range study. The committee urges such a study be undertaken within the next two years.

2. It is recommended that community mental health self-surveys be made in all our larger population centers in order to determine the existing resources for a rehabilitation program, the needs of the community, and the potential support for a rehabilitation center. This information would supplement the larger study.

Community Volunteer Services

Comment:

Far greater use can be made of both the lay and professional person as volunteers at the community level, particularly with the discharged patient who requires some follow-up services. In Minnesota, this program is just being developed. Clinics and county welfare workers should attempt to make use of carefully-selected, trained volunteers to assist with the rehabilitation and integration into the community of former patients from state hospitals. To a limited extent, several of the hospitals now are trying this plan. At Willmar, for example, volunteers are helping discharged patients readjust socially through "kaffee klatches" and similar gatherings. A group from the Minneapolis Junior Chamber of Commerce is exploring the possibility of helping former patients from the Anoka State Hospital find and keep appropriate employment. In Minneapolis, too, a volunteer worker at the Anoka State Hospital became aware of the lack of social opportunities often experienced by discharged patients. With his help, a social club was formed.

Where they can be helpful, volunteers might also be assigned specific tasks with patients who have not been in hospitals but who are being seen in clinics or by professional staff in the community. These assignments may have the volunteer working directly or inderectly with the patient.

Recommendations:

1. A specific program for volunteer participation at the community level should be worked out by the state volunteer coordinator in cooperation with citizen groups, clinic staffs and county welfare workers.

2. Community mental health councils should be organized in counties over the state to provide a core of interested, informed citizens who would help plan to meet community mental health needs as well as provide volunteer services.

THE TRAINING PROGRAM

Its Importance:

Good treatment and care for patients depend largely on the diagnostic and therapeutic skills of a hospital staff. This is the simple, but undeniable justification for training programs in state mental hospitals.

It has been demonstrated time and again that an ongoing training program in itself assures an immediate improvement in the care given to patients. In addition, it serves to attract already-qualified persons since it promises a high standard of professional interest, a vital factor in recruitment. While an attractive salary schedule, adequate working and living facilities and similar prerequisites are important elements in attracting and keeping a capable staff, these actually are secondary considerations. The primary one is the opportunity to be affiliated with a professional group whose high standard of excellence carries with it prestige, the possibility of professional advancement and personal satisfaction from work well done.

Thus, the spending of time, money and effort in creating good training programs is sound and necessary. It buys practical as well as academic rewards. The fine record of university hospitals throughout the nation over the past 50 years rests on the particular emphasis placed on higher education.

Training in Psychiatry:

The treatment of the mentally ill, is first of all, a medical problem. The hard core of that treatment rests upon psychiatry as a specialty field in medicine. The better trained the doctor is in psychiatry, the more likely it is that patients will get the treatment they need and thus their optimum opportunity for recovery. At this time, however, there are far too few trained persons available for service in Minnesota's mental hospital system. There is, the committee believes, only one direct method to ease the present shortage and that lies in a two-pronged training program. This program would offer the formal psychiatric training of physicians in a trainee status and also on-the-job training of physicians currently employed in the treatment of the mentally ill. At the time of the committee's investigation, there was no complete training program in psychiatry in the state hospitals

A growing number of recently-graduated physicians are seeking the opportunity to get specialized training. Many medical schools offer this training. Indeed, there are more residencies than there are residents. But most physicians seeking specialty training look for the school that has been approved by the national professional societies. This approval indicates to them that the training institution maintains high standards. In Minnesota, there are only two centers approved for complete training in the specialty field of psychiatry. These are the medical school of the University of Minnesota and the Mayo Foundation (the graduate school of medicine of the University). These centers are approved

to give resident physicians the three year minimum training required for eligibility for examination by the American Board of Psychiatry and Neurology. The Rochester State Hospital is approved to offer the first year of training only. Hastings State Hospital formerly had the same approval, but recently, as a result of personnel changes, this status was withdrawn.

The committee is of the unanimous opinion that in planning for an over-all training program for the state hospital system, there should be close affiliation with the University and the Mayo Foundation. It heartily approves the negotiations already undertaken with these institutions by the state medical director.

Briefly summarized, the following plan is contemplated in association with the University's psychiatry department and the psychiatry section of the Mayo Clinic

A number of resident training opportunities will be made available at several of the state hospitals and at the University and the Mayo Foundation. Resident physicians will rotate through the state hospital program and that of either the University or the Mayo Foundation during a three-year period. Responsibility for the content and supervision of the program will be shared by the state hospital staffs and the faculties of the two teaching centers. They will set up appropriate courses designed to give physicians employed by the state complete graduate training in psychiatry. In return for this opportunity and in partial repayment of the stipend earned during this three-year period, the resident physicians will be obligated to "pay" a period of two years service in the Minnesota hospital system while receiving a "salary" less than that paid physicians under regular civil service status. In all, then, these trainees will spend a total of five years in the program. At the end of that time, it is assumed that a percentage of these psychiatrists will remain in the employ of the state.

Obviously, there are many details to work out in establishing and operating this program. It is believed, however, that the presence of these young men and women residents will benefit present hospital staffs. The need for their supervision will demand greater concentration of interest in clinical problems of patients, better cooperation among related hospital services and the development of research projects. It also seems likely that the presence of these students will help break down the professional insularity so common to state hospitals since by chance and design, the residents will be in contact with all phases of the modern practice of medicine.

This training program should add to the attractiveness of permanent job opportunities in the state system. It also should sharpen the focus upon individual patients and their problems which is a real need in state hospitals. (If there is one indictment of state hospital care in contrast to private psychiatric care, it is the lack of time and opportunity for individualized care. While this has been dictated in large measure by factors over which the staffs have no control, it is also true that in some

instances, opportunities have been overlooked because the size of the task seemed so overwhelming. The presence of inquiring residents with their many questions tends to offset this.)

It is hoped that training responsibilities will be shared by as many members of the permanent hospital staffs as possible. But the best job will be done if ultimate responsibility is in a single physician-teacher on the full-time staff. The committee recommends that this position of teacher be on a par with the clinical director and be established in several of the more strategically-located hospitals. It is contemplated that this teacher not only will organize the training program, but will conduct many of the formal seminars and also provide some first-hand supervision of residents on the wards of the state hospitals.

On-the-job training for members of the permanent staff of the hospitals is the second important phase of a comprehensive training program. To stand still in medical practice inevitably means to go backward. There must be a planned effort to keep up with advancements in psychiatric and related fields, to keep informed of newer methods and procedures and to know what is going on in other medical centers and state systems.

The gain is greater and the enthusiasm longer lasting if the physician carries on his "self-training" with fellow workers. There are many well-established methods for doing this: staff seminars and discussion groups; literature survey study sessions; special conferences and medical forums. Obviously, these can be integrated most effectively into the complex hospital schedule if they are under the direction of one person.

The committee emphasizes that training must be extensive in scope and concept as well as intensive. A member of a psychiatric team has the obligation to be familiar with the practices of his team members—the psychiatric nurse, the aide, the psychiatric social worker, the clinical psychologist, the occupational, industrial and the recreational therapists, the dietitian, the chaplain and the affiliates of these persons in the patient's home community. In this broad concept, therapy moves forward on all possible phases and levels. The treatment and rehabilitation of the psychiatric patient is everyone's job. This is a practical philosophy and pays dividends in terms of staff morale and in the total improvement of the patient.

Recommendations:

1. Resident training programs in psychiatry should be established at two state hospitals initially. These programs should be organized and operated in close affiliation with the appropriate departments of the University of Minnesota and the Mayo Foundation. They should be started by the fall of 1955 with an enrollment of 10 students. Every effort should be made to expand the program each year until it enrolls a total of 40 students. These students should get 3 years formal training in psychiatry. During or at the end of their 3-year training, they should

serve two years in the state hospital system. Stipend levels for the five years should be $5,000 in the first year with annual increases of $500 so that $7,000 will be received in the fifth year.[15]

2. On-the-job training for members of the permanent staffs is essential, too, and should be organized on a continuing basis. It should include such activities as staff seminars, discussion groups, medical forums, etc.

3. Responsibility for the training program, both formal residency and in-service training for present staff, should be the job of a physician-teacher whose salary as a full-time, permanent staff member should be equivalent to that of the clinical director.

Training for the Clinical Psychologist:

No intern training program is now available for clinical psychologists at Minnesota mental hospitals. There is some inservice training, but it is not as well coordinated or planned as it should be to offer maximum effectiveness. Nevertheless, this state has done well in recruiting psychologists, but the years ahead undoubtedly will bring keener competition for skilled personnel in the mental health field. The needs of the state mental health program itself will demand a steady source of highly competent men and women who, in turn, will seek a professional climate that includes the stimulation of continued training.

In 1949, 1950 and 1951, it was possible to recruit psychological interns who had received an MA degree and desired supervised clinical training and experience in a hospital setting. A total of 15 persons were trained in state institutions under these conditions. Thirteen of them remained as psychologists in the state program which demonstrates the value of training activities in the recruitment of personnel. During recent years, however, it has been difficult to recruit interns because training standards in clinical psychology have risen rapidly until, at present, most universities recruit only Ph.D.-calibre students for their clinical psychology programs and encourage them to by-pass the MA degree. (The importance of this advanced training to the professional worker can be seen in the fact that of the 13 former interns employed by state hospitals, 10 have left to work for Ph.D. degrees. If the state mental health program had an intermediate salary range for psychologists, it might be possible to induce some of these people to return at the completion of their training.)[16]

It is imperative, in the committee's opinion, that an intern training program for clinical psychologists be established at one of the state hospitals for persons who are embarked on a Ph.D. level of training and who desire a high quality of supervised clinical experience. This program should be set up with central agency funds to expedite recruiting and to facilitate a system of rotation of assignments. Such rotation

[15]The 1955 Legislature provided a beginning for this program. Six positions for psychiatric residents are now available.

[16]See recommendations in report on "The Clinical Psychologist."

among the various institutions and clinics would provide a broad training experience for the intern. The committee believes that the Rochester State Hospital would, at this time, be the best location for an intern training program for these reasons:

1. It has an excellent supervisory staff in psychology.

2. It is near the Olmsted County clinic which could provide non-state hospital experience.

3. It is adjacent to the Mayo clinic, and a plan might be worked out whereby psychology interns would be allowed to attend psychiatric seminars.

This program should be tied in with and meet the standards of an accredited clinical psychology training program leading to a Ph.D. degree, preferably at the University of Minnesota. As soon as possible, a state hospital near the University should be considered as a second training center for psychologists.

Still another source of psychologists might be a special summer internship program for clinical psychology students in university Ph.D. programs. This was tried successfully at Rochester State Hospital in 1954 with two interns from Pennsylvania State college. Obviously, there are limitations in scope and completeness of training which is offered only for a three-month period. This disadvantage is counterbalanced, however, by the ultimate recruiting value this type of program offers.

The committee also believes that staff psychologists should participate in many of the in-service training programs in their respective hospitals as well as outside the hospitals.

Recommendations:

1. An intern training program for clinical psychologists affiliated with a university program leading to a Ph.D. degree should be established by 1956 at the Rochester State hospital. This program, which will require one year of advanced work, should offer a stipend of $200 a month to trainees. It is contemplated that the program will begin with one or two interns and be expanded in the future to include larger numbers of interns in several state hospitals.

2. A clinical psychologist, preferably at a new civil service grade III level, should be employed in the central office. He would relieve the clinical psychology supervisor of routine duties in the Bureau of Psychological Services so that the supervisor will have more time to develop the training programs and provide more consultation service to the psychologists now employed. (The present supervisor now is responsible for direction of 6 psychologists in the bureau itself. The increase from 18 to 34 psychologists in institutions and clinics during the last two bienniums has added to his job responsibilities.)

3. To provide more effective in-service training, special full-day meetings should be held at least on a quarterly basis for all state psychologists. These meetings should be devoted to study and discussion

of recent advances in clinical psychology and should be under the leadership of a recognized authority in the field. It is assumed that psychologists will be encouraged to attend pertinent programs at the University of Minnesota.

4. Two recognized clinical psychologists should be appointed as consultants to the medical policy committee and the clinical psychology supervisor. These psychologists would provide expert assistance needed in planning the new intern training program, in advising on research matters and in overall planning of mental health services.

Psychiatric Training for the Nurse

The acute shortage of nurses in Minnesota's mental hospitals has been discussed in the section on nursing services. But the committee commends steps already taken to recruit more, competent personnel through the offering of several training programs. These training programs are aimed primarily at three groups:

1. There are the graduate nurses who want the additional training to qualify as full-fledged psychiatric nurses. Minnesota currently has a stipend program which annually offers $175 to $200 a month to six selected nurses. These nurses are taking a year's training in psychiatric nursing in a qualified university in return for which they agree to serve at least one year in a Minnesota mental hospital. To date, all nurses who have completed their training are employed except one who fulfilled her agreement and now is inactive because of family responsibility. There is no question about the success of this program. The number of applicants exceeds the number of available scholarships indicating, too, that the program fills a need of the graduate nurse. Inquiries are received even from nurses in other states who are willing to work in a Minnesota state hospital if they can qualify under the stipend program.

2. The student nurse affiliate program provides 12 weeks of clinical experience in psychiatric nursing. Currently, there are 200 undergraduate nurses each quarter in this program receiving training not provided by the home nursing schools in which the girls are enrolled. Students come not only from Minnesota but from North and South Dakota and Iowa. It is likely that with the progress planned for North and South Dakota mental health programs, students from their three-year diploma schools of nursing may be withdrawn soon to take their training in their local institutions.

3. The third group includes students enrolled in a college school of nursing. These students get their field training at the Anoka State hospital and come from Hamline university in St. Paul, St. Olaf college in Northfield, and Jamestown college in North Dakota.

These three training programs mentioned above provide state hospitals with a source of excellent nursing care that otherwise would be impossible to hire. The programs also provide hospital administrators with the opportunity to recruit permanent nursing staff from a well-qualified group. In view of the extremely limited number

of professional psychiatric nurses available throughout the country, as well as in Minnesota, the committee urges strongly the continuation and expansion of all three programs. Expansion of the stipend program, particularly, is urgent.

Recommendations:

1. Every effort should be made to expand immediately the current stipend program for graduate nurses from 6 recipients annually to 12. The long-range goal should be 25 a year until the need for specially-trained nurses is satisfied.

2. Steps should be taken immediately to extend the use of state hosiptals as field experience for graduate professional nurses enrolled at the University of Minnesota as well as at other colleges and universities. This type of arrangement would assist materially with the recruitment of qualified professional nurses for administrative and teaching positions as well as improving the level of nursing service to patients.

3. The training program at Anoka should be expanded so that affiliation could be offered on a regional basis to colleges and universities in addition to the three now participating.

4. A well-qualified person should be employed at each hospital as educational assistant to the director of nursing. This assistant would be responsible for the education of professional nurses, student nurses and psychiatric aides.

5. Experienced instructors of psychiatric nursing should be employed in each state hospital to implement the present training and in-service programs. There should be at least one instructor for every 25 professional nursing students or psychiatric aide trainees.

Psychiatric Aide Training:

The psychiatric aide is a key member of the psychiatric team. No other hospital employe spends as much time with individual patients. For this reason, alone, training for aides cannot be a voluntary, hit-or-miss program. It must be well-planned and it must be uniformly good in all state hospitals.

It is the committee's opinion that the program for aides in Minnesota state hospitals is better in many ways than similar programs in other states, although at the time of this study it was limited to on-the-job training. Not all hospitals have done equally well in setting up these programs, however. The best programs appear to be under the direct supervision and responsibility of an educationally-prepared, professional nurse.

The nursing skills of the aide group could be greatly improved by extending the present training to include available programs in practical nursing. The results of this additional training undoubtedly would be reflected in improved patient care. Since there are several practical nurse schools in the vicinity of state hospitals, it would be worthwhile

to set up a pilot program to integrate instruction between the state hospitals and the practical nurse schools. The additional training not only would benefit the patient but it would provide the aide with eligibility for practical nurse licensure, thereby giving him increased status in this state as well as in others.

Recommendations:

1. A pilot project should be set up immediately by several state hospitals with practical nurse schools to work out a combination program which includes major subject matter of the practical nurse training program and the present in-service training for psychiatric aides.[17]

2. Each hospital should appoint at least one professional nurse who has the proper educational qualifications to be responsible for the present in-service training program for aides. This nurse, or nurses, should have no other duties.

3. The present in-service training program for psychiatric aides should be improved so that each hospital is offering at least 100 hours of instruction to these employes.

Training for the Psychiatric Social Worker:

No acceptable in-service training is available for social workers in Minnesota mental hospitals. This lack becomes particularly disturbing when figures reveal that only 4 of the 9 social workers employed in the hospitals have completed their graduate training. A continuing program of in-service training is important for social workers, as well as for other staff members, and results in more effective service for patients. An on-going training program should include siminars, institutes, attendance at professional conferences and special courses. Some of these activities are carried on irregularly, but more should be done on a scheduled basis. To plan this training and for general staff development, a state psychiatric social worker consultant should be employed on the central office staff. This consultant should be responsible for the growth of the entire social work program, including the training plans, within the state hospitals and clinics.[18]

It is certainly as true in social work as in other professions that outstanding opportunities for training will help attract outstanding personnel. If at least two Minnesota mental hospitals could gain a reputation for providing excellent case work supervision and training along with the opportunity for collaboration with psychiatry in treatment and research, they would be powerful factors in recruiting.

At the present time, there is a stipend program available to those who wish to complete graduate training. There now are 5 persons in the program which provides $175 a month for those who attend the

[17]A pilot project involving three aides was started in November, 1955, at the St. Peter State Hospital.

[18]For further explanation of the role of psychiatric social work consultant, see recommendations in report on "Social Work Services."

University of Minnesota and $200 a month for the student who attends an accredited school of social work out of state. For every year of training under the stipend program, the student "owes" the state a year of work in one of the institutions. To date, 3 of the 4 who completed training under the stipend program are working in state hospitals. Careful consideration should be given to expanding the stipend program within the next two years. At this time, the shortage of competent, qualified candidates for the stipend has permitted the filling of only 6 of the 7 vacancies available.

Until a greater number of trained social work personnel becomes available, it is likely that the state will employ a few persons who do not have the desired training. These untrained persons should be employed, however, only where there is at least a trained social work supervisor available, and there should be definite planning for completion of their social work training. It should be recognized, too, that the hiring of untrained persons is only a stopgap measure to be used in an emergency situation.

Recommendations:

1. The present stipend program should be expanded from 7 persons to 12 within the next two years. Preference in selecting candidates should continue to be given to workers now employed in state hospitals or clinics who wish to complete their graduate training.

2. In-service training for social workers must be improved and expanded. This program should include inter-disciplinary training which cuts across professional lines and promotes greater understanding of the role each specialty plays in the mental hospital. To be effective, in-service training must be continuous and compulsory.

3. A state psychiatric social work consultant who, as part of his responsibility, would plan a program of staff development and in-service training, should be hired as soon as possible.

THE PROGRAM FOR THE MENTALLY RETARDED

The Problem:

In recent years, the problem of the mentally retarded has aroused increasing attention. The reasons for this are many and not the least of these include the growth and prominence of interested organizations, the steady pressure for more institution beds for the retarded and the related growth of interest in mental illness.

In Minnesota, as in many other states, there are no accurate statistics available on the magnitude of the problem of mental deficiency. Authorities in this field, however, estimate conservatively that between two and four per cent of the population are mentally retarded. If the lower figure of two per cent is used then Minnesota has approximately 60,000 retarded persons among its population of 3,000,000. The committee regards this as a very conservative estimate. Recent reports show that 4,885 retarded patients are in six state institutions: at Faribault, Cambridge, Owatonna, the St. Cloud Annex for Defective Delinquents, and emergency units at the Shakopee Reformatory for Women and the Sauk Centre Home School for Girls. An additional 518 mentally retarded patients are being cared for in state mental hospitals.

Authorities believe that 10 to 15% of the total number of mentally retarded in the population require institutional care. If this is true, and again using the lower figure, Minnesota should provide adequate facilities for about 6,000 retarded children and adults. It does not even approach this goal. The emergency units at Shakopee and Sauk Centre house 117 retarded children, but they should be closed as soon as possible not only because they are substantially more expensive to maintain, but because they cannot provide many needed services, such as occupational and recreational therapy. In addition, present facilities at Faribault are overcrowded by 64% and at Cambridge by 56% (as of June, 1955) according to minimal state health department standards. Add to these facts the list of 884 retarded persons (as of April, 1955) waiting for placement in one of the now-crowded facilities and the need for a new institution is self evident.[19] Estimates show that by July, 1957 the waiting list will include 1,310 persons.

The Institution Program:

The program for the mentally retarded in Minnesota began 73 years ago. Traditionally, the purpose of the schools has been to provide care, training, education and treatment and to provide opportunity for maximum development in all these areas, either in preparation for return to the community or as the basis for as happy and useful a life as possible within the institution. With the gradual development of communtiy facilities and a more enlightened public attitude, the institutions have been called on increasingly to provide care and protection

[19]See report on "Construction."

for the more severely mentally handicapped, many of whom have gross physical deformities, and also to care for mentally deficient infants. With the improvement in medical techniques and the development of new drugs, the survival rate of these children has increased markedly and their life expectancy lengthened. Demands on the institutions have increased proportionately with the marked jump in the birth rate following World War II.

The result has been serious overcrowding in all institutions, as previously mentioned, as well as the use of "emergency units," facilities which never were intended for the care of the mentally retarded and are not suitable for this function. There are some community facilities provided for the educable and trainable among the retarded, but there remains a relatively large group with emotional and other difficulties who will continue to require institutional care. These "emotional problems" complicate the establishment of an adequate program for the retarded, but much can and should be done in the education and training of all groups—even the increasingly prevalent custodial type.

Needless to say, mental retardation is a cause of much unhappiness and mental conflict among those who have retarded children in their families. Because of the psychiatric problems involved, as well as the nature of research needs and the change in the type of care provided by institutions, the committee believes the problem of mental retardation is primarily a medical one. As such, it should be under medical supervision. Currently, the program for the retarded is under the child welfare and guardianship division of the state welfare department. (See Footnote 21.) The committee recommends, however, that the magnitude and importance of the problem in Minnesota requires a strong, separate administrative unit within the Department of Public Welfare and under the medical director. This unit would have total responsibility for both institutional and community-wide programs provided by the state. The person heading this unit would be responsible for the promotion, development and administration of a unified program for the mentally deficient. Since conservative estimates show there are 60,000 mentally retarded persons in the state, there is great need for a qualified person in a position of authority to coordinate the many facets of a well-rounded program. The committee believes that the weaknesses evident in the state-wide program are in large measure due to the fact that there has been no individual with sole responsibility for the program or authority to take necessary action. Particularly close cooperation will be necessary with the Department of Education which is in charge of meeting the educational needs of all those not in institutions. The committee also recognizes that any new unit must maintain close ties with the state child welfare and guardianship division as well as with local welfare offices in order to provide maximum social services to those in need of them.

Staff Needs

Comment:

The committee was surprised that so much is being done for so many with so little. Given adequate personnel and facilities the program could be one of which the state might well be proud.

Nursing Services:

The shortage of professional nursing personnel and hospital aides is perhaps even more acute in institutions for the retarded than in the mental hospitals. Nursing care for the retarded is a never-ceasing, around-the-clock job because of the inability of this lower intellect group to care for basic body needs. Yet there are many wards where professional nursing care is almost non-existent. Whole wards and cottages are, at times, without any nursing supervision. Some of these wards are not even covered by an aide during parts of the day. In case of an emergency, such as fire, it would be impossible for many of the more retarded patients to be removed, particularly during the evening and night hours.

At the institution at Faribault, for example, which has a hospital population of 3,245 (as of June, 1955), there now are 15 professional nurses, exclusive of the nursing director and the nurse-instructor. This provides a ratio of 1 nurse to 218 patients. There are 365 aides which provides a ratio of 1 to about 9 patients. With a total of 380 nursing personnel, it is not possible to provide 1 employee on each of the three shifts for all wards. An immediate increase from this 380 to 471 nursing care personnel is recommended. The practice of hiring competent aides when a professional nurse position cannot be filled should be continued until more nurses are available.

Social Services:

There are now in the institutions and schools for the mentally retarded 4 social workers, only 1 of whom is trained. More, well-trained workers are needed to do case work with families at the time of admission and discharge and during any crisis period which may occur during the time the patient is under care. Arrangements should be made to permit workers now on the staff to complete their training.

Clinical Psychology:

Long-term staff needs in psychology at state institutions for the mentally retarded depend not only upon the size of the institution population but also on the specific goals and the general nature of the program. The committee makes no recommendations for long-term personnel needs in psychology at this time. There is a need now, however, for a type of psychological service besides the testing being done. Many of the children suffer from reading or arithmetic disabilities as well

as from mental retardation. It is recommended, therefore, that a school psychologist be employed to do diagnostic and remedial work in reading and arithmetic as well as in intelligence testing. The committee believes, too, that additional psychologists are needed both at Cambridge and Faribault. There now are 3 psychologist positions at Faribault and 1 clinical psychologist at Cambridge. The position at Cambridge is unfilled[20] and 1 at Faribault similarly is vacant.

Community Facilities

Comment:

The question of special education for retarded children in Minnesota has been neglected and consequently, has trailed behind accepted practices elsewhere. There appears to be a division of opinion within the state as to where responsibility for special education rests—with the state, the local communities or private agencies.

It has become common practice to divide the mentally retarded in 3 main groups: the educable, the trainable and the custodial. In the committee's opinion, the education of the first two groups—the educable and the trainable—is clearly the responsibility of educational authorities in local communities working with the cooperation and assistance of those charged with the responsibility for the mentally retarded at the state level. State laws require that all children *shall be* educated. The mentally retarded child is first of all a child. He is entitled to the same consideration as other children. He is, secondly, a handicapped child and therefore is entitled to every aid that can be given him to function within his handicap. Public education must be geared in accordance with the child's needs and capacities. It would be folly, for example, to expect a retarded child to grasp the principles or experiences offered a normal child.

The Educable Retarded Child:

Special classes for the educable retarded child must be directed toward enabling him to make a satisfactory economic and social adjustment. In the ordinary classroom situation, this child cannot compete with his normal mates. If compelled to do so, he may become a behavior problem. He can profit only from a program tailor-made to his special needs and one which permits successful achievement for him. Given this chance, he can become a useful member of society.

The Trainable Retarded Child:

This is the child who is retarded to such a degree that he will not be able to direct his own life. While he needs supervision, he does have the capacity to develop the capability for living in a community situation. Special education should be extended unequivocally to this trainable group by the home and the local community. Such classes have been very successful in many communities.

[20]The Cambridge position was filled in January, 1956.

The committee emphasizes the concept that the place for a child, whenever possible, is in his own home. It is the duty of the community to make this possible. The assumption for too long has been that because an afflicted individual is different, he is a hazard to his family and other citizens. There is no doubt that many children in institutions could be trained to live acceptable lives with their families in local communities. It should be the right of parents to keep their severely retarded children at home if they can.

Although some of the trainable retarded children may need institutional care eventually, an extended period of home and community experience will result in a better evaluation of the child's true potential. He may have to spend some of his days in an institution but why all of them? Some of the severely retarded could spend their whole lives within the shelter of their families if the community made an effort to accept them.

From a practical point of view, it is cheaper to conduct a public school program for the trainable retarded then to place them in an institution and provide total maintenance.

The Program Now:

In Minnesota, there were 560,773 children in public schools at the end of the 1954 school year. Again, using the figure that 2 per cent are mentally retarded, there should be 11,215 in special classes. If an estimated 6 per cent who have I.Q.'s from 74 to 79 are added, there is a total of 8 per cent or 44,862 who need the specialized or individual attention of special classes. In fact, only 2,834 are in special, public school classes for the mentally retarded. The conclusion that must be drawn is that many retarded children are being neglected educationwise, or they are attending ordinary classes with children of higher intelligence. They may hold back the normal group from greater accomplishment or, what is more likely, they are merely sitting in a class which has no meaning for them. For the retarded child, the result is constant frustration and failure. Every child needs interest and recognition. If he cannot get them in ordinary ways, he may develop emotional or behavior problems. He may turn to delinquent behavior. The special class is one important means of preventing abberant behavior among the retarded and influencing them toward becoming useful citizens.

Conclusion:

If the various communities accept their responsibilities for providing special education for the educable and the trainable mentally retarded, then demands for admissions to institutions for the mentally retarded could be reduced noticeably. There always will be the need for institution care, however, among all categories of the mentally retarded. Not every family is capable of coping with a mentally retarded child even under good circumstances. In addition, some retarded children have no families and for others, there are still other complicating factors. This

report should not be construed as suggesting that the state reduce its rightful share of responsibility in caring for the retarded but rather that other levels of government assume their fair portion.

Recommendations:

1. A separate administrative unit should be set up immediately within the Department of Public Welfare to assume total responsibility for all phases of institutional and community-wide programs for the mentally retarded. This unit should be under medical supervision.[21]

2. Vigorous steps should be taken to expand the special class program in local communities for both the educable and trainable retarded. A stipend program has been organized to help recruit properly-qualified teachers. This whole area of special classes, recruiting and training of teachers should be worked out with the State Department of Education under whose jurisdiction the classes should be. In-service training programs for teachers should be established at Faribault and at the new institution at Brainerd when it is completed.

3. There should be every effort to provide immediately a ratio of 1 nurse to 100 patients in order to give adequate, direct professional care to patients and to give on-the-job assistance and supervision to aides. The present ratio is 1 nurse to 218 patients. Thus, an additional 17 nurses are needed. The long-range goal should be 1 nurse to 40 patients.

4. The number of psychiatric aides should be increased to provide a 1 to 7 ratio as soon as possible. Present ratio is 1 to 9. The long-range goal should be 1 aide to 5 patients.

5. A continuation and expansion of the present on-the-job training program for aides is necessary in order to assure good bedside care. An in-service type of professional nursing education program should be developed in each institution in order to attract nurses to the field of nursing for the mentally retarded and to assist them in attaining a higher degree of skill in caring for this group of patients.

6. There should be immediate development of a nursing administrative staff in institutions for the retarded. More than one-half of the employed personnel are in the nursing service. It is wasteful and uneconomical not to provide leaders for this large group of workers, particularly for the semi-skilled aides.

7. A well-organized research program should be developed in any new institution for the retarded as well as in those already established.

8. New construction, as recommended in the special report on building, is needed urgently. The proposed new building at Brainerd, as well as other units, are required to remedy dangerous situations.

[21]The program for the mentally retarded was transferred to the Medical Services Division of the Dept. of Public Welfare October 1, 1955. As yet no medical person has been recruited to give his full attention to the program.

9. Besides the need for increased staff in the nursing services, many new workers are needed as soon as possible.

Inasmuch as almost all patients at Cambridge and Faribault have neurological problems, there should be *2 neurologists* at each of these institutions. At least *11 new social workers* should be employed: 3 at Owatonna, 5 at Faribault and 3 at Cambridge.

A new position of *school psychologist* should be created at the Clinical Psychologist II level so that the institutions for the retarded can employ persons trained in mental testing and in remedial work in reading and arithmetic.

Three persons should be added to the psychological staff of the Faribault institution. The *clinical psychologist* position at Cambridge should be filled as soon as possible,[22] and *2 additional psychologists* or school psychologists should be employed, thus increasing the staff from none to 3. These psychologists should be qualified in the use of projective techniques and psychotherapy as well as in psychometric testing.

[22]Filled in January, 1956.

THE ALCOHOLIC

The Problem:

In recent years, public attitudes toward alcoholism have been undergoing a slow change. To an increasing extent, alcoholism is regarded as an illness, a kind of mental illness, with a few physical disturbances adding to the complexity of the problem.

Minnesota has begun to meet the challenge this problem presents. Of its 80,000 citizens who are among the approximately 4,000,000 Americans directly affected by alcoholism, 5 out of 6 alcoholics are men, most of them between 30 and 35 years of age. In dollars and cents, the cost of alcoholism is a huge burden. A 1953 report of the Interim Commission on Alcoholism in Minnesota has this to say:

"In Ramsey county alone, in the year ending March 30, 1950, the direct costs of the community for individuals or families in which inebriety was a problem was between $100,000 and $135,000. Of this sum, $35,000 was the cost of maintaining inebriates committed to the workhouse or jail; $16,000 went for payment by voluntary social agencies for relief to inebriates and their families or for the payment of boarding home care of children of inebriates, and $84,000 was provided by the welfare board for relief grants. *None of this expenditure was directed at rehabilitation of the individual or solution of the problem.*"

The report also estimated that $1,700,000 is the annual cost of traffic accidents caused by alcoholics in the state. Another $625,000 is the estimated cost of jail stays; $11,000,000 the annual wage loss and $3,900,000 the cost of crime. The report does not include the cost of hospitalization at Willmar state hospital, but it is estimated at a minimum of $222,460 a year.

These statistics, shocking as they are, do not reveal the terrible toll alcoholism takes of human beings, the disintegration of personalities, the separation or neglect of children, the anxieties, tensions, humiliations inflicted on families, the break-up of homes.

The problem is complex and compelling. It requires careful treatment, and treatment for the alcoholic is a long and often-discouraging process.

The Treatment Program:

Treatment facilities for the alcoholic in Minnesota consist of the Willmar and Sandstone state hospitals (state-supported); Hazelden Foundation at Center City (private); the Salvation Army (community-supported); Pioneer House (operated by the Minneapolis Welfare department); the St. Paul Information and Treatment Center (community-supported), and the Willmar Follow-Up clinic (state-supported).

Even with these facilities, however, Minnesota's program fails to meet minimum needs and lags behind many of the 30 states which now have alcoholism programs.

The public program for the care and treatment of the alcoholic is under the supervision of the Department of Public Welfare and is centered largely at the Willmar State hospital of which Dr. Nelson J. Bradley is superintendent. This committee wishes to emphasize that the remarkable growth and community acceptance of the program for alcoholics at Willmar is due primarily to the efforts and interest of Dr. Bradley. This committee agrees with the report of the Interim Commission on Alcoholism that he is "an important asset" to the state's program.

The institution at Willmar was established in 1907 as a hospital for inebriates and opened in 1912. In 1917, the legislature expanded its duties to provide care for the "chronic insane" but for some years, the emphasis was on providing a place for alcoholics. As time went by, however, the emphasis shifted to mental hospital activities for non-alcoholics. At first, alcoholics were limited to one 75-bed ward. Currently, this has been expanded to a 200-bed ward.

Since June, 1950, when the present alcoholism program began, there has been a steady increase in the number of alcoholic patients. Between 1950 and 1954, the increase was 300%. The hospital has about 1,200 psychotic patients and between 200 and 250 alcoholics. Between June, 1953, and June, 1954, the average daily population of alcoholics was 208; total first admissions, 690; and total readmissions 457. (There is some duplication in these figures. An unduplicated count was not available.)

The primary purpose of the alcoholism program of the state hospital is rehabilitation—to help the alcoholic get a better understanding of himself, under psychiatric supervision, in the period following a drinking spree or at a time when his emotional tension is mounting and he feels unable to refrain from drinking.

It should be mentioned that by the time the alcoholic reaches the state hospital life appears bleak and worthless. Very often, he has lost family and friends, job and money. He may enter the hospital as a voluntary patient—about 45% do—or he may be one of the 55% who are committed by the courts. Usually he is suffering from a number of medical complaints commonly associated with alcoholism, such as malnutrition, dehydration, avitaminosis and cirrhosis of the liver. The hospital uses the broad approach to treatment of the alcoholic as recommended by the Yale Center on Alcohol Studies. This includes medical care, psychological and social rebuilding and reorientation of the individual. Alcoholics Anonymous (AA) also plays a large part in the hospital program both as a treatment factor and later in follow-up-work. Hospital treatment usually requires 6 weeks to 2 months. During the first week, the patient gets a physical examination, drug and vitamin therapy and attention for his physical ailments. In later weeks, the hospital has a program of mental hygiene lectures, movies, group therapy sessions, religious counseling, etc., for his often-confused thinking and emotional problems.

When the acute stage of illness is over, the patient is encouraged to attend AA meetings at the hospital and to familiarize himself with steps he can take toward more complete rehabilitation. At the hospital, too, the patient may attend psychological seminars on alcoholism, take psychological tests as well as get individual and group psychotherapy. Work therapy is planned to meet the patient's interests, needs and former experience. It is designed primarily to improve the patient's mental and physical health and work habits and not merely to get hospital work done.

The whole job of treating and rehabilitating is slow and tedious, and because it is a comparatively new field, it must, of necessity, be somewhat flexible and experimental.

The committee notes here that Minnesota, like many other states, has a problem within a problem in the treating of women alcoholics. At the present time, Willmar is the only available facility for them in the state. But because of space difficulties, women inebriates are kept with psychotic patients. About 120 women alcoholics a year are admitted. Average age: 35. Their average stay at the hospital is longer and follow-up results are not as good as with the men. Unquestionably, something more in the way of facilities needs to be provided on a statewide basis.

The Follow-Up Program:

Follow-up work begins while the patient still is in the hospital. A psychiatric social worker from the follow-up clinic interviews patients from the Twin Cities and Duluth areas who are ready to leave the institution. In this way, patients are informed about local facilities for help and the social worker gets to know the patients. The relationship between the clinic and the patient continues for as long a time as necessary. The psychiatric social worker has a lot to contribute in the after-care of the alcoholic. Social work needs to begin with first things first, recognizing that the patient is not going to solve his deeper emotional conflicts on an empty stomach, without a job or with his family in a turmoil. There may be referral to relief or family agencies; referral to employment service or a "reapproachment" with the employer. When his immediate needs are cared for, then reconstruction can begin in other areas.

The follow-up work also may include helping the alcoholic revamp his entire vocational life. There have been numerous cases of young alcoholics who were not doing well vocationally because of the disparity between their intelligence and interests and the menial jobs they held. For these men, a program of vocational testing and guidance is essential.

Recommendations:

Comment: The recommendations of the survey committee coincide closely with those made by the Minnesota Advisory Board on Problems of Alcoholism in its annual report to the 1955 legislature.

1. Services of the Willmar State hospital should be expanded. The survey committee believes the personnel recommendations of the Minnesota Advisory Board on Problems of Alcoholism in its 1955 report are reasonable for Willmar. It does not agree, however, that the alcoholic unit should have a separate budget. It would be cumbersome to administer and would destroy some of the present budget flexibility.

2. The services of the Sandstone State hospital should be expanded to include a 30-bed unit for the treatment of alcoholism.[23] Personnel recommendations as outlined by the aforementioned committee in its report are concurred with by this survey committee.

3. A follow-up service for alcoholics in Duluth area should be made available. If possible, it should be integrated with existing mental health facilities in that area.

4. There should be an increase in funds for research in alcoholism but it should be part of a general increase in research funds for work in the field of mental illness.

5. A treatment center for women is needed. Although the ratio of women to men alcoholics is 1.5:5, treatment resources do not exist in this proportion. The only resource available to the women alcoholic is the Willmar State hospital, and the present physical facilities there are considered inadequate for this purpose. Other costly problems are those created by the chronic drunkenness offender and by the incorrigible, criminal and tuberculous alcoholic.[24] Tremendous sums of money are being spent for the incarceration or custody of these persons with few, if any, being permanently rehabilitated.

6. The survey committee agrees with the advisory board on alcoholism that an interim commission be appointed to study the problems of the woman alcoholic and the chronic offender.

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[23]The 1955 legislature permitted Sandstone to designate 30 additional beds for alcoholics. On March 10, 1955 the first alcoholic patient was admitted to the Inebriate Section at Sandstone. As of June, 1955, 22 inebriates were at Sandstone and 183 at Willmar.

[24]A unit is being established for the psychotic and recalcitrant tuberculous patients at the Anoka State hospital. The tuberculous alcoholic can be treated there also when the new unit is finished.

THE AGED

The Problem:

The nation as a whole is confronted with many difficulties arising from the increase of an aging population. As part of the total question, the problems of senility and mental illness among the aged are significant. No one who has seen these elderly men and women sitting despondent and without hope on benches in a mental hospital can fail to ask the questions: "Must they be here? Can anything be done for them?"

This committee could not attempt to answer these questions believing, instead, that recommendations should come in the near future from a committee that will examine this problem only. The 1955 report of the State Commission on Aging refers but briefly to this problem of the aged in mental hospitals.

There are available, however, revealing statistics which show what is happening to our population and what can be expected. In 1950, Minnesota had 269,300 citizens who were 65 years of age or more—9.5% of the total population. By 1970, estimates show that 402,416 persons or 11.2% will be in that upper age range. For Minnesota's mental hospitals, the figures are more startling. As of June 30, 1954, 2.2% of the patients were 25 years of age or less; 22.5% were 25 to 44 years; 39.4% were 45 to 64, and 35.7% were 65 years of age or more.[25] A closer examination of the 35.7% who are in the oldest age group reveals that: only 17.3% actually have been diagnosed as senile; 9.8% have some other type of brain damage; 48.7% are schizophrenic; 12.3% are classified "early psychotic"; 8.1% are mentally retarded and 2% are diagnosed "unknown." A total of 1,200 of these "over 65" patients are in the 4 geriatric buildings provided since 1948 by the state at Fergus Falls, St. Peter, Moose Lake and Rochester State hospitals.

Studies indicate that 40% of all *first* admissions and 35% of *all* admissions to state mental hospitals are 65 years and over. Most of these men and women are sufficiently disturbed and confused to require the help of workers trained in the field of mental illness. That a substantial number (no exact figures are available) could be released after a short period of care if there was a place for them to go has been demonstrated in special projects at Fergus Falls and other state hospitals. The committee believes it is important to state that, contrary to frequent comments, a majority of the aged are in the mental hospitals because they need to be there. When an elderly person becomes so confused that he cannot get along in his home or community, he needs care in a hospital where the personnel are especially trained to understand not only his physical symptoms but his mental condition as well. Chronic care hospitals usually have the medical facilities for treating

[25]See Table VI-B in Appendix.

physical ailments but not the mental. Nursing homes frequently have neither. A chronic care hospital or a nursing home may be, however, the proper place for the aged patient *following* treatment in a mental hospital. They can be of particular value because they help keep the patient near his family and they can bring in specialized volunteer services from the community in which they are located.

It should be stressed, however, that nursing home care is unlikely to be cheaper than mental hospital care. Figures indicate that care of the aged patient in a state hospital costs about $90 a month. For public and private nursing home care, the figures range from $45 to $278 a month, with an average cost of $135.

At the present time, there are approximately 52,000 persons receiving Old Age Assistance (OAA) grants in Minnesota. Of this number, about 4,500 are in nursing homes and approximately 650 are in boarding care homes. In both instances, they continue to get OAA. If they should need mental hospital care, however, OAA is discontinued. The committee believes that a total study of the aged in Minnesota mental hospitals should include particular attention to this situation and what changes might be made. It appears to the survey committee that these grants, which include federal money, could help substantially in providing a high standard of care and treatment for the aged patient in the mental hospital.

Nursing Homes:

There has been a substantial growth in the number of public and private nursing homes in Minnesota during the past five years. Yet the need for additional beds continues to be acute. Only Hennepin county, and particularly Minneapolis, approaches a sufficient number of beds. There are about 6,200 nursing home beds available throughout the state. The State Health department estimates that an additional 12,392 beds (based on a calculation of 4 beds per 1,000 population) are needed.

It is believed that a sizeable number of mental hospital patients, particularly among the aged, could be cared for closer to home if some of these additional beds were available. Not only would these beds help take some of the pressure off state mental hospitals, but they would be beneficial to the patient for reasons already mentioned.

The need for these facilities is recognized by all workers in the field, but the survey committee emphasizes again that local nursing homes should not be regarded as substitutes for state hospital care of the aged senile patient. Oftentimes, the patient is under better medical supervision in the state hospital and he can get a consistent type of care that could help him re-establish an adequate pattern of living. There should be, however, alternate facilities so that the "right patient can be cared for in the right place."

Recommendations:

1. It is imperative that a committee be appointed to consider the problems of the aged in Minnesota mental hospitals. There should be an anlysis of the patient load to determine how many patients could be discharged if there were places available. What these "places" should be—boarding homes, nursing homes, foster care facilities—also is a logical part of such a study. The possibility of extending OAA to mental hospital patients should be examined, too.

2. Expanded foster home and nursing home facilities undoubtedly are a need in this state. Every effort should be made to provide these facilities as quickly as possible. Day care centers for the aged also are a need and would appear to be good projects for local community groups.

a. County government units should be encouraged to develop additional nursing home facilities. This "encouragement" should be both financial (through some matching funds plan) and administrative.

b. All such facilities should continue to be carefully regulated as to standards. Their programs, in addition, should be integrated with local and state hospital programs and facilities, where these are available.

3. Efforts should be made to provide some psychiatric training, probably through the schools of practical nursing, for the practical nurses employed in nursing homes.

RESEARCH

Present Status:

Any hospital system devoted to the treatment of the mentally ill should have a well-developed research program. Where it exists, a good research program raises the level of staff interest, improves the hospital standing and facilitates the recruitment of more and better personnel. It is implicit, of course, that in research designed to gain new knowledge about the causes, diagnosis, treatment and prevention of mental illness lies the hope for reducing ultimately the tremendous burdens carried by state mental hospitals. Only through carefully-controlled research will some of the basic questions about mental illness eventually be answered.

A small amount of research currently is being conducted in state mental hospitals supported largely by a 1953-55 legislative grant of $110,000 and a 1955-57 grant of $150,000. All research projects must be approved first by the state mental health medical policy committee. At the time of this report these were among the projects supported by legislative funds:

1. Study of brain physiology which utilizes a system of recording deep brain waves to learn more about the function of different parts of the brain in relationship to one another. At Rochester State hospital.

2. Study to discover what factors work favorably or unfavorably in the satisfactory social adjustment of discharged patients. At Fergus Falls State hospital.

3. Study of the relation of certain hormonal functions to epileptic seizures. At Cambridge School and Hospital for Epileptics.

4. Study of the relation of nutrition to hardening of the arteries. At Hastings State hospital.

5. Study of the relative effectiveness of 3 different methods of psychotherapy in the recovery of alcoholics. At Willmar State hospital.

Only the limitation of funds prevents a number of other worthwhile projects from being undertaken. It must be emphasized, too, that even with the present amount of research, the state mental health program does not have even one person working full-time in the field of mental illness research.

Nature of Research:

There are two types of research which the committee wishes to explain before presenting its recommendations for a stepped-up research program in Minnsota mental hospitals and out-patient clinics. The first type is *clinical research* which requires for its success not only highly-skilled professional personnel but also large groups of patients and, therefore, is ideally suited to a state hospital and clinic system. Such research would include some of the following studies: the development and evaluation of new therapies; the effectiveness of current thera-

pies; better procedures for patient care; better hospital administration techniques; the effectiveness of preventive techniques, and improvements in diagnosis and classification of mental illness. This type of research lends itself to more rapid development than the second type which is basic research. *Basic research* requires highly-skilled personnel generally working with fairly elaborate and expensive equipment. In the field of mental illness, basic research would include studies in:

1. The neuropsychological and neurochemical alterations occurring in the aged and mentally ill or the changes resulting from the various therapeutic procedures used in this field.

2. Metabolic changes in the mentally ill.

3. Neurophysiology.

Basic research currently is being carried out primarily at university centers because of staff and equipment requirements. Some basic research also is being conducted in the state hospitals. This should be developed slowly and on a limited scale in a state hospital system with emphasis on the type of research that requires substantial numbers of patients. As interest in basic research arises, however, it should be encouraged and coordinated with similar or related work at the University of Minnesota and the Mayo Foundation.

Some Problems:

It must be appreciated that research inevitably is a long-term program and cannot be hurried into producing results. The reasons for this slow development are determined in part by the lack of availability of adequate personnel as well as the nature of research itself. The lack of personnel for research in state mental hospitals is due to many factors:

1. Research workers often are discouraged from entering the field because of financial insecurity.

2. Clinical personnel interested in research find little time for research because of their heavy responsibilities for the daily care of patients. Good research can rarely be done while an individual is burdened with clinical and other responsibilities.

3. To do adequate research requires long periods of training. Often, a research worker will have to discontinue a project while he learns new techniques to complete his work. Too few workers are offered the opportunity for special training possibilities because of financial and other responsibilities.

4. Research in the field of the nervous system has so expanded in scope that it is very difficult for a single individual to carry out adequate work without access to a large variety of associated skills for consultation. For this reason, young workers prefer to be associated with university centers where such consultation is available. This emphasizes the importance of joint state hospital and University of Minnesota research projects.

Recommendations:

1. A research fund of $400,000 to $500,000 should be made available without time limitations for expenditure. This fund would be spent as the program develops and should be renewed when the fund is partially depleted. There is no doubt that a most important factor in setting up an adequate research program in the availability of these continuing monies. The fund should be expended under the supervision of the medical policy committee with relative freedom from administrative procedures. There should, of course, be strict accountability for the way in which the fund is spent. The fund would permit the following developments:

   a. Creation of research positions in psychiatry, neurology, psychology, social service and administration without imposing additional responsibilities.

   b. Sending of research workers to centers where they can develop best or learn techniques of importance to the areas of their research.

   c. Support of related studies in other centers if such studies may be helpful or necessary in the research being carried out in the field of mental illness.

2. A state research director should be employed to dircet the program.

3. The medical director, with the advice of the medical policy committee and the research director, when he is employed, should attempt to employ a few additional, competent research workers about whom new programs will be developed.

4. Research projects should be reviewed annually by the medical policy committee with the collaboration, if necessary, of special consultants in research in order to determine any changes needed in the program. This review also would help coordinate research among the state hospitals.

CONSTRUCTION

The Situation:

For at least the past 8 years, the Minnesota legislature has expressed its concern about mental hospital facilities by granting large appropriations for needed new buildings. These appropriations, since 1947, total more than $25,000,000. For the Rochester State hospital alone, the legislature appropriated $5,000,000 in 1947 and $1,500,000 in 1949. Among other grants, the legislature appropriated $400,000 in 1953 in an effort to eliminate some of the worst fire hazards in the institutions and to provide the surveys to assess the need for additional fire protection controls. Money has been provided for improvement of the power plant at the Anoka State hospital, for a new power plant at Hastings (where a part of the facilities were condemned) and a turbine generator at Willmar.

The committee was favorably impressed with much of the new buildings. But the obvious facts cannot be denied: Minnesota's state hospitals still are overcrowded, even by minimal state health department standards, and the millions of dollars spent since 1947 have been swallowed easily by the accumulated years of neglected needs. A glance at the following figures will reveal the extent of overcrowding: (Figures are from 1953-54)[26]

Hospital	Average Population	Health Dept. Standard (Minimum)	% of Overcrowding
Anoka	1,134	933	21.5
Fergus Falls	1,876	1,448	29.6
Hastings	943	761	23.9
Moose Lake	1,259	1,160	8.5
Rochester	1,782	1,760	1.3
St. Peter	2,469	1,820	35.6
Sandstone	439	445	—1.3
Willmar	1,460	1,040	40.0
Faribault	3,125	1,986	57.4
Cambridge	1,065	713	49.4

For the 8 state mental hospitals, then, there is 21% overcrowding —and that percentage is based on absolutely minimal standards! The institution at Faribault is appallingly overcrowded as is the Cambridge facility.

According to federal standards, there should be 5 beds per 1,000 persons for the mentally ill. By this guide, Minnesota will need about 18,000 beds for its mentally ill by 1970. It is immediately apparent that more construction will be necessary and it is equally apparent that some orderly plan of development and priorities should be established. The plan should be based on the sound precept that each hospital, except Sandstone,[27] should provide up to and no more than 2,000

[26]See Table III in Appendix.

[27]Sandstone is a former federal prison which is leased to the state by the federal government.

acceptable beds. At this time, Rochester is the only state hospital that has the beginning of a site plan to carry out this program. The survey committee believes that architects should be hired to assess existing facilities (including wiring, plumbing, etc.), and to develop plans for the expansion or reduction of each hospital, except Sandstone, to approximately 2,000 beds each. (Note that this plan still will leave the state 4,000 beds short of the 18,000 anticipated by 1970.) It has been estimated that architects' fees to perform this essential task would require an initial appropriation of about $700,000 to $1,000,000. This assessment would provide, however, the most sensible—and in the long run, the most economical—method of developing an orderly building plan that should establish priorities. It is the opinion of the survey committee that this assessment should be made before any new hospitals for the mentally ill are constructed. (Development of the plants at Hastings and Anoka should proceed, however. Because these two hospitals are located so close to the Twin Cities, there is no doubt that they will be called upon to give continued, even expanded, service to large numbers of patients.

A Hospital for Children:

Among the many needs in Minnesota's mental health program, nothing is more urgently required than an adequate hospital for mentally ill children. At the time of this survey, there was no adequate facility within the entire state program for these unfortunate boys and girls. No one can dispute the fact that an effective program of treatment must include this youngest group of patients for whom the prognosis is often most hopeful. Approximately 185 children a year are being seen in various public, mental health clinics for whom treatment in an in-patient facility is needed. Because the present state hospitals have neither staff nor appropriate space, only 20 of these children have been placed in the various institutions.

A special committee should be established as quickly as possible to study and recommend what is needed—the size, location, staffing, etc., of such an institution.[28] It appears to the survey committee that this hospital should provide intensive treatment facilities for a period of 18 months to 2 years for about 120 children between the ages of 5 and 16. In this type of unit, the staff ratio to patient should be at least 1 to 1. It would be advisable to place this hospital on a site which would allow expansion if necessary. It is likely that a continued treatment unit for children who do not respond to the intensive therapy will have to be established eventually.

Housing for Staff:

There is great variation in housing facilities for all employed personnel, including physicians. As a general rule, it is better for employes to establsh residence in the local community than to live on hospital grounds. There are some smaller communities, however, where it is

[28]An ad hoc committee of the state's Medical Policy Committee has been working on such a study.

difficult for staff to find adequate housing. When this is the situation, acceptable housing will have to be provided and a reasonable charge made for it. At the present time, there is no hard and fast rule regarding staff housing. One suggestion from survey committee members was to permit doctors and other department heads to live on the grounds for a year to give them time to decide whether they want to remain. The best suggestion for housing of permanent staff might be to provide housing on the grounds for personnel required for emergency calls. It is preferable in most instances, however, to pay staff a salary that will permit the buying or rental of a home in the community, where the community is large enough to offer some choice.

Facilities for the Mentally Retarded:

As already mentioned in this report, institutions at Faribault and Cambridge are severely overcrowded. Emergency units have been set up in other state institutions but even so, there remains a lengthy waiting list of patients who require institution care. To complicate the situation further, the Faribault institution is much too large and the hospital population should be reduced to 2,000 or, at the most 2,500. New facilities for the retarded in this state are long overdue. Although progress is being made, the situation will remain acute for some time.

The survey committee makes these recommendations:

1. Older and more dilapidated buildings at Faribault, such as the administration building, should be replaced. More recreation, warehouse and dormitory space for older, more infirm patients is needed.[29]

2. Facilities at Cambridge should be expanded to provide 2,000 beds.[30]

3. Another 2,000 bed hospital is needed urgently to relieve overcrowding at Faribault and Cambridge.[31]

Other Needs:

The survey committee did not pretend to attempt a thorough-going survey of construction needs either immediate or long range. But certain deficiencies are so glaring they cannot be overlooked. These are among them:

1. New service buildings are needed at Willmar and Anoka. Completion of these 2 buildings will satisfy major service building needs for the institutions. (Authorized by the 1955 legislature.)

[29]Some of this construction was approved by the 1955 legislature but none of the authorized building will reduce the institution's overcrowding.

[30]The 1953 legislature provided another 400 beds which will be available soon. The 1955 legislature provided construction for another 500 beds which will bring Cambridge up to about 2,000 beds. Some of the old sections of the institution will still be crowded.

[31]The 1955 legislature allowed $1,675,000 to erect an administration building at Brainerd. It will eventually be the site of a 2,000 bed hospital for the retarded, but appropriations for additional beds must come from future legislatures.

2. Replacement of existing hospital buildings is necessary since some of the old buildings cannot be remodeled economically to assure fire protection and adequate facilities. Several new hospital buildings are needed at Rochester to replace the unacceptable space in the old Main building which now is a real fire hazard. Buildings known as North and South Detached at St. Peter should be torn down and replaced. New hospital buildings are needed at Anoka to evacuate the third floors of existing cottages.

3. There is an immediate and continuing need for elimination of serious fire hazards at most of the hospitals. Correction of these fire hazards involves such things as rewiring, installation of sprinkler systems, enclosure of open stairways and elevators, improved water supply and water distribution, availability and adequacy of fire-fighting equipment, access roads, etc.[32]

4. Repair of the roof and parapet of Sandstone hospital is essential in order to maintain the condition of the buildings in accordance with the state's contract with the federal government. About $50,000 is needed for this job.

5. Revamping of space in the Receiving Wards East and West is needed at Moose Lake State Hospital to provide dining and serving room services for patients who are unable to use the three flights of stairs to the nearest dining area. More dayroom space as well as treatment area for newly-admitted patients are urgently needed at Moose Lake too.

6. Power plant facilities at Fergus Falls State Hospital should be enlarged at an estimated cost of $275,00.

The survey committee emphasizes that these are by no means all the construction needs at the state hospitals, nor are those listed necessarily the most urgent. But they do represent a kind of cross-section of the work that must be done.

Recommendations:

1. A thorough report on construction needs, both immediate and long-range, should be prepared by a competent committee.[33] Ideally, this committee should include specialists in hospital construction as well as hospital employes, interested citizens, and legislators. The committee should concern itself with, among other things:

a. Inadequacy of present power plants and the changing over from the present obsolete, expensive DC electricity to AC.

[32]The 1953 Legislature appropriated $400,000 for elimination of the worst fire hazards and to make surveys of what more was needed. The 1955 legislature was asked for $1,000,000 to implement the program, of which $375,000 was granted.

[33]The 1955 legislature appointed an Interim Commission on Buildings to survey all state building needs, including those of the mental hospitals.

b. Plumbing and wiring, which are in bad condition in many state hospitals.

c. Need for staff housing.

2. Special consideration must be given to providing a facility for emotionally-disturbed children as quickly as possible.

3. Architects should be employed within the next 2 years to assess existing facilities and to develop plans for the expansion or reduction of each hospital, except Sandstone, to provide approximately 2,000 beds each. To employ these architects would require an estimated appropriation of $700,000 to $1,000,000.

4. Population at the Faribault institution for the retarded should not exceed 2,000 or, at the most, 2,500. This institution is dangerously overcrowded at present. The Cambridge institution should be expanded to provide 2,000 adequate beds. A new 2,000 bed hospital for the retarded is essential just to relieve present overcrowding.

5. Every effort should be made to carry out the many recommendations made over the years to make the institutions fire resistant and to eliminate actual fire hazards.

EXPLANATORY NOTES

MENTAL HOSPITAL STATISTICAL TABLES

TABLE I. Minnesota Population by Age Groups

This table shows the increasing proportion of persons aged 65 and over in Minnesota's population. In 1900 only one in every 26 persons in Minnesota's population was aged 65 or older. By 1940 one in every 13 persons was 65 or older. By 1950 the proportion had increased to one in every 11 persons and by 1970 it is expected that one in every nine persons in the state will be 65 years of age or older.

The mental hospital populations have increased more rapidly than the general population of the state. Of every 100,000 persons in the state's population, 206 were in mental hospitals in 1900 compared with 357 in 1940. Between 1940 and 1950 there was little change in the mental hospital population so in 1950 there were 351 mental hospital patients per 100,000 population. This proportion had increased to 368 per 100,000 in 1955 and is expected to total 385 per 100,000 in 1970.

The mental hospital population aged 65 or over has increased greatly over the period for which figures are available: from 796 patients per 100,000 persons 65 or older in the state in 1940 to 1,169 per 100,000 in 1950 and 1,366 per 100,000 in 1955.

TABLE II. Minnesota State Hospital Populations and Per Capital Costs

Mental hospital expenditures per patient showed little change between 1920 and 1940, averaging $227 in 1930-40. During the war years the increased cost of living necessitated an increase in hospital expenditures which, combined with additional appropriations for better care, brought the average per capita cost for the mental hospitals to $1,101 during 1953-54. Costs per patient vary from hospital to hospital because of the differences in types of patients, physical lay out and available personnel, with Anoka particularly high because of the necessarily higher cost of maintaining the tuberculosis unit.

TABLE III. Minnesota State Hospital Population Compared with Designed, Budgeted and Health Department Standard Capacities

While most of the hospitals have been able to keep populations at or below the designed or budgeted capacities, most have many more patients than they should have to stay within the Health Department standard of 60 square feet of dormitory space per patient. Space has been made for extra patients by marked crowding of beds in rooms and dormitories, reducing day room space and using hall, etc. for sleeping room.

TABLE IV. Number of Medical Employes and Number Needed to Meet APA Standards

The American Psychiatric Association has worked out a standard ratio of employes to patients based on the amount of care needed by patients, number of admisssions, etc. This standard was used to determine the number of employes in each classification needed by each hospital.

TABLE V. Number of Nursing Employes Needed to Meet APA Standards

These figures have been computed on the basis of reports from hospitals classifying patients in the various wards and nursing personnel assigned thereto. The immediate recommended standard represents the number of such employes the Medical Director and superintendents believe to be available over the next two years if funds were available and also the number needed to provide for minimum safety standards and the beginnings of an intensive treatment program.

TABLES VI-a, VI-b, and VI-c. Comparative Figures—Minnesota State Mental Hospitals

There is considerable variation among hospitals in the distribution of patients by sex, age, mental disorder, length of stay, etc., and also in the amount of turnover in the hospital population. Table VI-a shows the number of patients in the total mental hospital population and in each hospital in each of these population groups.

Table VI-b shows the percentage distribution of patients in these various groups within each hospital and also shows population turnover in relation to total population so that hospital to hospital comparisons may be made. For example, of all patients on the hospital books, only 6 percent of Willmar's patients were on provisional discharge compared with almost 15 percent at Fergus Falls. Part of this difference may be the result of hospital policies. However, at Willmar 79 percent of the resident patients had been hospitalized 10 years or more compared with 50 percent at Fergus Falls. Also, 41 percent of Willmar's patients are 65 or older compared with 33 percent at Fergus Falls. On the other hand, at Moose Lake 13 percent of the patients on the books were on provisional discharge although 41 percent of the resident patients were 65 years old or older. However, only 32 percent of Moose Lake's patients had been hospitalized as long as 10 years. Also, Moose Lake had 233 admissions per thousand patients on the books compared with 194 per thousand at Fergus Falls and only 154 per thousand at Willmar. Other comparisons and at least partial explanations of differences between hospitals can be made by study of this table. Special note should be taken of the fact that Willmar, in addition to its mentally ill patients had about 1,200 inebriate patients entering and leaving the hospital during the year, while Anoka had an average of 417 patients, more than one-third of its population, in the tuberculosis unit.

Table VI-c shows what proportion of all patients in each designated group are in any particular mental hospital. Another comparison between Willmar and Moose Lake, for instance, shows each has 11.4 percent of the total mental hospital population and both have about 13 percent of the patients aged 65 or over. However, Moose Lake has 21 percent of the patients diagnosed as senile and Willmar less than 6 percent, while on the other hand, Moose Lake has only 7 percent of the patients hospitalized 10 years or more and Willmar has 18 percent of these long time care patients.

TABLES VII-XIV. Individual Hospital Tables

To make information for individual hospitals more readily available, data taken from preceding tables has been grouped in a separate table for each of the eight mental hospitals.

TABLE XV. June 30, 1954 Resident Population—Distribution by Sex, Age, and Mental Disorder

This table shows both in actual numbers and percentagewise the distribution of the total mental hospital resident population and indicates the groups of patients which make up the greatest part of the case load in all mental hospitals.

TABLE I

Minnesota Population by Age Groups

Age Group	1900	1910	1920	1930	1940	1950	1955 (est.)	1960 (est.)	1970 (est.)
Total	1,751,394	2,075,708	2,387,125	2,563,953	2,792,300	2,982,483	3,088,000	3,224,000	3,593,000
Under age 15	637,801	661,475	743,954	741,540	689,151	823,411	.....	.....	.....
15–24	330,851	431,818	437,528	454,378	502,941	421,202	.....	.....	.....
25–34	279,662	340,633	403,424	383,174	429,408	433,674	.....	.....	.....
35–44	221,839	252,868	303,893	365,914	379,648	395,213	.....	.....	.....
45–54	129,938	193,399	227,643	269,314	345,456	347,088	.....	.....	.....
55–64	80,430	104,460	157,264	185,185	233,078	292,586	.....	.....	.....
65 and over	66,771	86,057	110,766	163,480	212,618	269,309	294,000	325,000	402,416
Unknown	4,102	4,998	2,653	968	.....	.....	.....	.....	.....
Percentage distribution									
Total age known	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Under age 15	36.4	32.0	31.3	28.9	24.6	27.7	.....	.....	.....
15–24	18.9	20.9	18.4	17.7	18.1	14.1	.....	.....	.....
25–34	16.0	16.4	16.9	14.3	15.4	14.5	.....	.....	.....
35–44	12.7	12.2	12.7	15.0	13.6	13.3	.....	.....	.....
45–54	7.4	9.3	9.5	10.5	12.4	11.6	.....	.....	.....
55–64	4.6	5.0	6.6	7.2	8.3	9.8	.....	.....	.....
65 and over	3.8	4.2	4.6	6.4	7.6	9.0	9.5	10.1	11.2
Average number of persons in mental hospitals per 100,000 population:									
Total population	205.6	229 6	255.6	302.9	356.6	350.7	368.0	375.0	385.0
Total age of 65 or older	.....	.....	.....	.....	796.0*	1,169.1**	1,366.3	.....	.....

*Estimated from 1939 survey of hospitals.
**U. S. census.

TABLE II

Minnesota State Hospital Populations and Per Capita Costs

Fiscal Year	Total all hospitals	Total Ment. hosp.	Anoka	Fergus Falls	Hastings	Moose Lake	Rochester	St. Peter	Sandstone	Willmar	Faribault	Cambridge
Average population												
1900–01	4,327	3,600	118	1,323	123	.....	1,102	934	.....	.....	727	.....
1909–10	5,958	4,766	459	1,613	471	.....	1,208	1,015	.....	.....	1,192	.....
1919–20	7,811	6,102	848	1,472	902	.....	1,312	1,326	.....	242	1,709	.....
1929–30	9,967	7,765	1,042	1,687	1,003	.....	1,414	1,758	.....	861	1,950	252
1939–40	13,457	9,958	1,432	1,780	1,089	503	1,542	2,179	.....	1,433	2,432	1,067
1949–50	14,330	10,459	1,022	1,950	1,026	1,062	1,603	2,345	.....	1,451	2,794	1,077
1951–52	15,016	11,110	1,142	1,950	917	1,213	1,694	2,351	430	1,413	2,838	1,068
1953–54	15,552	11,362	1,134	1,876	943	1,259	1,782	2,469	439	1,460	3,125	1,065
1957 (est.)	.....	11,900	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
1960 (est.)	.....	12,100	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
1970 (est.)	.....	13,800	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
	Average all hospitals	Average mental hospitals										
Per capita costs: (annual)												
1900–01	$ 155	$ 155	$ 165	$ 141	$ 173	.....	$ 151	$ 176	.....	.....	$ 154	.....
1909–10	152	152	105	146	122	.....	167	187	.....	.....	155	.....
1919–20	243	239	163	249	220	.....	249	263	.....	$ 337	256	.....
1929–30	222	211	143	241	182	.....	249	239	.....	146	251	$ 343
1939–40	226	227	165	232	210	$ 467	246	246	.....	159	220	233
1949–50	738	765	988	736	906	807	664	700	.....	735	630	747
1951–52	1,032	1,075	1,483	975	1,258	919	916	991	$1,176	1,007	887	967
1953–54	1,049	1,101	1,600	1,106	1,285	942	990	999	1,177	1,008	878	996

TABLE III

Minnesota State Hospital Populations Compared with Designed, Budgeted and Health Department Standard Capacities

	1953-54 average population	Designed capacity	Average population over Des. cap.		Budgeted capacity	Average population over Budg. cap.		Health Department Standard	Average population over H. D. standard	
			Number	Percent		Number	Percent		Number	Percent
Total, all hospitals	15,552	15,932	−380	−2.4	15,780	−228	−1.4	.....	.....	.....
Total, 8 mental hospitals	11,362	11,688	−326	−2.8	11,565	−203	−1.8	9,546	+1,816	+19.0
Anoka	1,134	1,200	−66	−5.5	1,225	−91	−7.4	933	+201	+21.5
Fergus Falls	1,876	1,890	−14	−0.7	2,000	−124	−6.2	1,448	+428	+29.6
Hastings	943	1,100	−157	−14.3	950	−7	−0.7	761	+182	−23.9
Moose Lake	1,259	1,160	+99	+8.5	1,300	−41	−3.2	1,160	+99	+8.5
Rochester	1,782	1,600	+182	+11.4	1,760	+22	+1.3	1,760	+22	+1.3
St. Peter	2,469	2,748	−279	−10.2	2,400	+69	+2.9	1,999	+470	+23.5
Sandstone	439	480	−41	−8.5	480	−41	−8.5	445	−6	−1.3
Willmar	1,460	1,510	−50	−3.3	1,450	+10	−0.7	1,040	+420	+40.4
Faribault	3,125	3,136	−11	−0.4	3,115	+10	+0.3	1,986	1,139	+57.4
Cambridge	1,065	1,108	−43	−3.9	1,100	−35	−3.2	713	352	+49.4

TABLE IV

MINNESOTA STATE MENTAL HOSPITALS

Number of Professional Employees and Number needed to meet APA standard, July, 1954

(Nursing employees on separate tables)

		Physicians*	Dentists	Dental Hygienists	Clinical Psychologists	Registered OT's	Other activity therapy workers	Psychiatric Social Workers
TOTAL:	Budgeted positions	57.0	8.0	5.0	7.0	14.0	80.0	11.0
	APA standard	156.4	11.6	23.0	37.1	57.9	137.1	82.5
	Shortage	−99.4	−3.6	−18.0	−30.1	−43.9	−57.1	−71.5
ANOKA: (incl. Tb. Unit)	Budgeted positions	11.0	1.0	1.0	1.0	3.0	7.0	2.0
	APA standard	20.3	1.2	2.3	3.4	4.3	10.0	5.4
	Shortage	−9.3	−0.2	−1.3	−2.4	−1.3	−3.0	−3.4
FERGUS FALLS:	Budgeted positions	6.5	1.0	1.0	1.0	2.0	18.0	1.0
	APA standard	24.0	1.9	3.8	5.8	9.7	22.8	12.6
	Shortage	−17.5	−0.9	−2.8	−4.8	−7.7	−4.8	−11.6
HASTINGS:	Budgeted positions	7.0	1.0	.....	1.0	1.0	11.0	3.0
	APA Standard	11.5	1.0	1.9	2.6	4.9	11.6	7.2
	Shortage	−4.5	.....	−1.9	−1.6	−3.9	−0.6	−4.2
MOOSE LAKE:	Budgeted positions	4.0	1.0	1.0	1.0	2.0	7.0	2.0
	APA standard	16.0	1.3	2.6	4.4	6.3	14.5	9.0
	Shortage	−12.0	−0.3	−1.6	−3.4	−4.3	−7.5	−7.0
ROCH-ESTER:	Budgeted positions	11.5	.....	1.0	1.0	3.0	7.0	1.0
	APA standard	25.2	1.8	3.6	6.3	9.7	23.1	10.4
	Shortage	−13.7	−1.8	−2.6	−5.3	−6.7	−16.1	−9.4
ST. PETER: (excl. ADI)	Budgeted positions	9.0	2.0	1.0	1.0	2.0	14.0	1.0
	APA standard	29.7	2.5	5.0	6.9	11.9	28.6	13.6
	Shortage	−20.7	−0.5	−4.0	−5.9	−9.9	−14.6	−12.6
SAND-STONE:	Budgeted positions	2.0	1.0	.....	.....	.....	4.0	.....
	APA standard	6.8	0.4	0.9	1.8	2.6	6.1	2.2
	Shortage	−4.8	+0.6	−0.9	−1.8	−2.6	−2.1	−2.2
WILLMAR:	Budgeted positions	6.0	1.0	.....	1.0	1.0	12.0	1.0
	APA standard	22.9	1.5	2.9	5.9	8.5	20.4	22.1
	Shortage	−16.9	−0.5	−2.9	−4.9	−7.5	−8.4	−21.2

*Excludes superintendents, clinical directors and consultants.

TABLE V

MINNESOTA STATE MENTAL HOSPITALS

Number of Nursing Employees (Nurses and Aides) needed to meet APA standard, July, 1954
By Type of Service

	Total*	Anoka	Fergus Falls	Hastings	Moose Lake	Rochester	St. Peter	Sandstone	Willmar Ment. Ill
Total patients:	10,890	728	1,893	986	1,287	1,776	2,288	433	1,499
I Rec., bed, disturbed patients	2,828	260	428	187	280	500	544	146	483
II Feeble, regr. untidy, closed wards	3,730	114	714	468	219	628	1,001	139	447
III Ger. amb., regr. clean, open wards**	4,332	354	751	331	788	648	743	148	569
Current number of nurses and aides:	1,374.9	101.5	250.0	112.5	147.1	263.0	275.4	44.5	180.9
I Rec., bed, disturbed patients	702.8	52.0	112.3	52.6	71.5	153.0	138.6	22.1	100.7
II Feeble, regr. untidy, closed wards	406.6	10.0	89.5	41.2	32.8	70.4	101.8	11.7	49.2
III Ger. amb., regr. clean, open wards	265.5	39.5	48.2	18.7	42.8	39.6	35.0	10.7	31.0
Total needed under APA standard:	2,957.5	197.1	504.8	268.2	292.2	498.6	643.5	127.0	426.1
I Rec., bed, disturbed patients	1,285.5	118.2	194.5	85.0	127.3	227.3	247.3	66.4	219.5
II Feeble, regr. untidy, closed wards	1,130.4	34.6	216.4	141.8	66.4	191.3	303.3	42.1	135.5
III Ger. amb., regr. clean, open wards	541.6	44.3	93.9	41.4	98.5	81.0	92.9	18.5	71.1
Difference current from APA:	−1,582.6	−95.6	−254.8	−155.7	−145.1	−235.6	−368.1	−82.5	−245.2
I Rec., bed, disturbed patients	−582.7	−66.2	−82.2	−32.4	−55.8	−74.3	−108.7	−44.3	−118.8
II Feeble, regr. untidy, closed wards	−723.8	−24.6	−126.9	−100.6	−33.6	−119.9	−201.5	−30.4	−86.3
III Ger. amb., regr. clean, open wards	−276.1	−4.8	−45.7	−22.7	−55.7	−41.4	−57.9	−7.8	−40.1
Total immediate recommended:	1,698.9	124.6	282.0	142.9	173.2	288.4	357.0	76.0	254.8
I Rec., bed, disturbed patients	943.7	86.7	142.6	62.3	93.3	166.7	182.4	48.7	161.0
II Feeble, regr. untidy, closed wards	466.4	14.3	89.3	58.5	27.4	78.5	125.1	17.4	55.9
III Ger. amb., regr. clean, open wards	288.8	23.6	50.1	22.1	52.5	43.2	49.5	9.9	37.9
Difference current from recommended:	−324.0	−23.1	−32.0	−30.4	−26.1	−25.4	−81.6	−31.5	−73.9
I Rec., bed, disturbed patients	−240.9	−34.7	−30.3	−9.7	−21.8	−13.7	−43.8	−26.6	−60.3
II Feeble, regr. untidy, closed wards	−59.8	−4.3	+0.2	−17.3	+5.4	−8.1	−23.3	−5.7	−6.7
III Ger. amb., regr. clean, open wards	−23.3	+15.9	−1.9	−3.4	−9.7	−3.6	−14.5	+0.8	−6.9
Ratios, recommended and actual:									
	APA standard	Immediate recommended							
I	1:2.2	1:3.0	1:4.0	1:5.0	1:3.8	1:3.6	1:3.9	1:3.3	1:3.9	1:6.6	1:4.8
II	1:3.3	1:8.0	1:9.2	1:11.4	1:8.0	1:11.4	1:6.7	1:8.9	1:9.8	1:11.9	1:9.1
III	1:8.0	1:15.0	1:16.3	1:9.0	1:15.6	1:17.7	1:18.4	1:16.4	1:21.2	1:13.8	1:18.4

*Excludes Anoka Tb. Unit and St. Peter ADI.
**Anoka figures did not separate feeble and bed patients from ambulatory geriatric patients.

TABLE VI-a
Comparative Figures—Minnesota State Mental Hospitals (excl. Willmar Inebriates)

	Total	Anoka	Fergus Falls	Hastings	Moose Lake	Rochester	St. Peter	Sandstone	Willmar Ment. Ill
Total patients on books June 30, 1954	12,809	1,274	2,224	1,132	1,492	1,989	2,859	477	1,362
Patients on provisional discharge	1,432	116	329	149	186	192	337	40	83
Patients on other leave	125	7	6	17	22	18	44	7	4
Patients in residence	11,252	1,151	1,889	966	1,284	1,779	2,478	430	1,275
Age:									
Under 25 years of age	249	31	34	34	19	50	55	7	19
25-44 years	2,529	214	488	234	320	402	607	96	168
45-64 years	4,434	485	748	391	419	644	1,016	166	565
65 years of age or older	4,017	415	619	307	521	683	795	160	517
Unknown	23	6	.....	.....	5	.....	5	1	6
Mental Disorder:									
Senile	1,952	110	327	191	415	341	417	40	111
Other brain syndromes	1,098	103	148	104	126	210	234	58	115
Schizophrenic	5,483	714	1,014	544	481	695	1,093	197	745
Other Psychotic disorders	1,387	89	200	64	127	346	349	42	170
Mentally deficient	908	106	150	47	77	132	229	73	94
All other	424	29	50	16	58	55	156	20	40
Sex:									
Male	5,712	547	939	573	642	666	1,289	430	626
Female	5,540	604	950	393	642	1,113	1,189	.....	649
Time since most recent admission:									
Under 6 months	1,091	100	206	112	160	193	208	16	96
Under one year	1,611	141	269	180	243	285	322	32	139
Under two years	2,444	204	398	233	364	463	553	49	180
Under five years	4,078	290	640	335	649	868	959	112	225
Under 10 years	5,592	366	936	409	873	1,182	1,371	186	269
10 years or more	5,660	785	953	557	411	597	1,107	244	1,006
25 years or more	1,875	327	211	199	45	171	242	131	549
Order:									
Voluntary	497	26	63	59	51	114	136	12	36
Other	10,755	1,125	1,826	907	1,233	1,665	2,342	418	1,239
Type of admission of resident patients:									
First admissions	9,071	935	1,394	793	1,019	1,401	1,982	380	1,167
Readmissions	2,181	216	495	173	265	378	496	50	108
1953-54 population movements:									
Total admissions	3,118	253	540	346	446	539	646	104	244
Total discharges	1,802	122	337	206	216	399	376	63	83
Total deaths	1,138	94	198	54	188	218	264	25	97
Total provisional discharges	1,477	117	355	168	196	228	282	43	88
Total returns from prov. discharge	534	49	97	72	66	77	129	14	30
Total discharged from prov. discharge	804	42	193	62	124	186	165	10	22

TABLE VI-b
Comparative Figures—Minnesota State Mental Hospitals (excl. Willmar Inebriates)
Percentage Distribution within Hospitals

	Total	Anoka	Fergus Falls	Hastings	Moose Lake	Rochester	St Peter	Sandstone	Willmar Ment. Ill
	Percent	Percent	Percent	Percent	Percent	Percent	Percent	Percent	Percent
Total patients on books June 30, 1954	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Patients on provisional discharge	11.2	9.1	14.8	13.2	12.5	9.7	11.8	8.4	6.1
Patients on other leave	1.0	0.6	0.3	1.5	1.5	0.9	1.5	1.5	0.3
Patients in residence	87.8	90.3	84.9	85.3	86.0	89.4	86.7	90.1	93.6
Patients in residence	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Age:									
Under 25 years of age	2.2	2.7	1.8	3.5	1.5	2.8	2.2	1.7	1.5
25-44 years	22.5	18.6	25.8	24.2	24.9	22.6	24.5	22.3	13.2
45-64 years	39.4	42.1	39.6	40.5	32.6	36.2	41.0	38.6	44.3
65 years of age or older	35.7	36.1	32.8	31.8	40.6	38.4	32.1	37.2	40.5
Unknown	0.2	0.5	.....	.....	0.4	.....	0.2	0.2	0.5
Mental disorder:									
Senile	17.3	9.6	17.3	19.8	32.3	19.2	16.8	9.3	8.7
Other brain syndromes	9.8	9.0	7.8	10.8	9.8	11.8	9.5	13.5	9.0
Schizophrenic	48.7	62.0	53.7	56.3	37.5	39.0	44.1	45.8	58.4
Other Psychotic disorders	12.3	7.7	10.6	6.6	9.9	19.5	14.1	9.8	13.3
Mentally deficient	8.1	9.2	7.9	4.9	6.0	7.4	9.2	17.0	7.4
All other	3.8	2.5	2.7	1.6	4.5	3.1	6.3	4.6	3.2
Sex:									
Male	51.0	47.5	49.7	59.3	50.0	37.4	52.0	100.0	49.1
Female	49.0	52.5	50.3	40.7	50.0	62.6	48.0	0.0	50.9
Time since most recent admission:									
Under 6 months	9.7	9.7	10.9	11.6	12.5	10.8	8.4	3.7	7.5
Under one year	14.3	12.3	14.2	18.6	19.0	16.0	13.0	7.4	10.9
Under two years	21.7	17.7	21.1	24.1	28.3	26.0	22.3	11.4	14.1
Under five years	36.2	25.2	33.9	34.7	50.5	48.8	38.7	26.0	17.6
Under 10 years	49.7	31.8	49.5	42.3	68.0	66.4	55.3	43.3	21.1
10 years or more	50.3	68.2	50.5	57.7	32.0	33.6	44.7	56.7	78.9
25 years or more	16.7	28.4	11.2	20.6	3.5	9.6	9.8	30.5	43.1
Order:									
Voluntary	4.4	2.3	3.3	6.1	4.0	6.4	5.5	2.8	2.8
Other	95.6	97.7	96.7	93.9	96.0	93.6	94.5	97.2	97.2
Type of admission of resident patients:									
First admissions	80.6	81.2	73.8	82.1	79.4	78.8	80.0	88.4	91.5
Readmissions	19.4	18.8	26.2	17.9	20.6	21.2	20.0	11.6	8.5
No. per 1000 total on books during 1953-54:									
Total admissions	198	154	194	239	233	202	182	177	154
Total discharges	114	74	121	142	113	149	106	108	52
Total deaths	72	57	71	37	98	82	74	43	61
No. per 1000 total residents pts. during 1953-54:									
Total provisional discharges	103	76	142	129	114	94	90	77	57
Total returns from prov. discharge	37	32	39	55	39	32	41	25	20
Total discharged from prov. discharge	56	27	77	47	72	77	52	18	14

TABLE VI-c
Comparative Figures—Minnesota State Mental Hospitals (excl. Willmar Inebriates)
Percentage Distribution Among Hospitals

	Total	Anoka	Fergus Falls	Hastings	Moose Lake	Rochester	St Peter	Sandstone	Willmar Ment. Ill
	Percent	Percent	Percent	Percent	Percent	Percent	Percent	Percent	Percent
Total patients on books June 30, 1954	100.0	10.0	17.4	8.8	11.7	15.5	22.3	3.7	10.6
Patients on provisional discharge	100.0	8.1	23.0	10.4	13.0	13.4	23.5	2.8	5.8
Patients on other leave	100.0	5.6	4.8	13.6	17.6	14.4	35.2	5.6	3.2
Patients in residence	100.0	10.2	16.8	8.6	11.4	15.8	22.0	3.8	11.4
Age:									
Under 25 years of age	100.0	12.4	13.7	13.7	7.6	20.1	22.1	2.8	7.6
25-44 years	100.0	8.5	19.3	9.2	12.7	15.9	24.0	3.8	6.6
45-64 years	100.0	10.9	16.9	8.8	9.5	14.5	22.9	3.7	12.8
65 years of age or older	100.0	10.3	15.4	7.6	13.0	17.0	19.8	4.0	12.9
Unknown	100.0	26.1	.....	.....	21.7	.....	21.7	4.4	26.1
Mental disorders:									
Senile	100.0	5.6	16.7	9.8	21.3	17.5	21.4	2.0	5.7
Other brain syndromes	100.0	9.4	13.5	9.5	11.5	19.1	21.3	5.3	10.4
Schizophrenic	100.0	13.0	18.5	9.9	8.8	12.7	19.9	3.6	13.6
Other psychotic disorders	100.0	6.4	14.4	4.6	9.2	24.9	25.2	3.0	12.3
Mentally deficient	100.0	11.7	16.5	5.2	8.5	14.5	25.2	8.0	10.4
All other	100.0	6.8	11.8	3.8	13.7	13.0	36.8	4.7	9.4
Sex:									
Male	100.0	9.6	16.4	10.0	11.2	11.7	22.6	7.5	11.0
Female	100.0	10.9	17.1	7.1	11.6	20.1	21.5	.....	11.7
Time since most recent admission:									
Under 6 months	100.0	9.2	18.9	10.2	14.7	17.7	19.0	1.5	8.8
Under one year	100.0	8.7	16.7	11.2	15.1	17.7	20.0	2.0	8.6
Under two years	100.0	8.4	16.3	9.5	14.9	18.9	22.6	2.0	7.4
Under five years	100.0	7.1	15.7	8.2	15.9	21.3	23.5	2.8	5.5
Under 10 years	100.0	6.6	16.7	7.3	15.6	21.2	24.5	3.3	4.8
10 years or more	100.0	13.9	16.8	9.8	7.3	10.5	19.6	4.3	17.8
25 years or more	100.0	17.4	11.3	10.6	2.4	9.1	12.9	7.0	29.3
Order:									
Voluntary	100.0	5.2	12.7	11.9	10.3	22.9	27.4	2.4	7.2
Other	100.0	10.5	17.0	8.4	11.4	15.5	21.8	3.9	11.5
Type of admission of resident patients:									
First admissions	100.0	10.3	15.4	8.7	11.2	15.4	21.9	4.2	12.9
Readmissions	100.0	9.9	22.7	7.9	12.2	17.3	22.7	2.3	5.0
1953-54 population movements:									
Total admissions	100.0	8.1	17.3	11.1	14.3	17.3	20.7	3.4	7.8
Total discharges	100.0	6.8	18.7	11.4	12.0	22.1	20.9	3.5	4.6
Total deaths	100.0	8.3	17.4	4.7	16.5	19.2	23.2	2.2	8.5
Total provisional discharges	100.0	7.9	24.0	11.4	13.3	15.4	19.1	2.9	6.0
Total returns from prov. discharge	100.0	9.2	18.2	13.5	12.4	14.4	24.1	2.6	5.6
Total discharged from prov. discharge	100.0	5.2	24.0	7.7	15.4	23.1	20.5	1.3	2.8

TABLE VII

ANOKA STATE HOSPITAL

Fiscal Year 1953-54: Expenditures $1,814,458 Per Capita Cost $1,600

	Number	Difference	Percentage Overcrowding
1953-54 average population	1,134		
Designed capacity	1,200	−66	−5.5
Budgeted capacity	1,225	−91	−7.4
Health Department Standard	933	+201	+21.5

	1953-54 Budgeted Positions	Needed to meet APA standards	Difference	Immediate Recommended	Difference
Staff:					
Physicians	11.0	20.3	−9.3		
Nurses and aides—Total	101.5*	197.1	−95.6	124.6	−23.1
Rec., bed, disturbed patient	52.0	118.2	−66.2	86.7	−34.7
Feeble, regr.. untidy, closed wards	10.0	34.6	−24.6	14.3	−4.3
Gen. amb., regr. clean, open wards	39.5	44.3	−4.8	23.6	+15.9
Dentists	1.0	1.2	−0.2		
Dental assistants	1.0	2.3	−1.3		
Clinical psychologists	1.0	3.4	−2.4		
Registered occupational therapists	3.0	4.3	−1.3		
Other activity therapy workers	7.0	10.0	−3.0		
Psychiatric social workers	2.0	5.4	−3.4		

June 30, 1954 resident population:	Number	Percentage of patients in Anoka State Hospital	Percentage of all patients in state mental hospitals
Total population:	1,151	100.0	10.2
*Rec., bed, disturbed patient	260	22.0	9.2
*Feeble, regr. untidy, closed wards	114	9.9	3.1
*Ger. amb., regr. clean, open wards	354	30.7	8.2
*Tb unit (*July, 1954)	424	36.8	100.0
Senile	110	9.6	5.6
Schizophrenic	714	62.0	13.0
Mentally deficient	106	9.2	11.7
Other	221	19.2	
Under 45	235	21.3	8.5
45-64	485	42.1	10.9
65 and older	415	36.1	10.3
Age unknown	6	0.5	26.1
Admitted less than 6 months ago	100	9.7	9.2
Admitted less than one year ago	141	14.3	8.7
Admitted less than five years ago	290	36.2	7.1
Admitted ten years or more ago	785	50.3	13.9
Admitted 25 years or more ago	327	16.7	17.4
Voluntary patients	26	4.4	5.2

	Number	Number per 1000 on books during year	Percentage of total for state mental hospitals
1953-54 population movements:			
Total admissions	253	154	8.1
Total discharges	122	74	6.8
Total deaths	94	57	8.3
		Number per 1000 in residence during year	
Total provisional discharges	117	76	7.9
Total returned from prov. disch	49	32	9.2
Total disch. from prov. disch	42	27	5.2

TABLE VIII

FERGUS FALLS STATE HOSPITAL

Fiscal Year 1953-54: Expenditures $2,074,997 Per Capita Cost $1,106

	Number	Difference	Percentage Overcrowding
1953-54 average population	1,876	.....	.....
Designed capacity	1,890	−14	−0.7
Budgeted capacity	2,000	−124	−6.2
Health Department Standard	1,448	+428	+29.6

	1953-54 Budgeted Positions	Needed to meet APA standards	Difference	Immediate Recommended	Difference
Staff:					
Physicians	6.5	24.0	−17.5	.....	.....
Nurses and aides—total	250.0*	504.8	−254.8	282.0	−32.0
Rec., bed, disturbed patients	112.3	194.5	−82.2	142.6	−30.3
Feeble, regr. untidy, closed wards	89.5	216.4	−126.9	89.3	+0.2
Ger. amb., regr. clean, open wards	48.2	93.9	−45.7	50.1	−1.9
Dentists	1.0	1.9	−0.9	.....	.....
Dental assistants	1.0	3.8	−2.8	.....	.....
Clinical psychologists	1.0	5.8	−4.8	.....	.....
Registered occupational therapists	2.0	9.7	−7.7	.....	.....
Other activity therapy workers	18.0	22.8	−4.8	.....	.....
Psychiatric social workers	1.0	12.6	−11.6	.....	.....

June 30, 1954 resident population:	Number	Percentage of patients in Fergus Falls State Hospital	Percentage of all patients in state mental hospitals
Total	1,889	100.0	16.8
*Rec., bed, disturbed patients	428	22.7	15.1
*Feeble, regr. untidy, closed wards	714	37.7	19.1
*Ger. amb., regr. clean, open wards (*July, 1954)	751	39.6	17.3
Senile	327	17.3	16.7
Schizophrenic	1,014	53.7	18.5
Mentally Deficient	150	7.9	16.5
Other	398	21.1	13.7
Under 45	522	27.6	18.8
45-64	748	39.6	16.9
65 and older	619	32.8	15.4
Admitted less than 6 months ago	206	10.9	18.9
Admitted less than one year ago	269	14.2	16.7
Admitted less than five years ago	640	33.9	15.7
Admitted ten years or more ago	953	50.5	16.8
Admitted 25 years or more ago	211	11.2	11.3
Voluntary patients	63	3.3	12.7

	Number	Number per 1000 on books during year	Percentage of total for state mental hospitals
1953-54 population movements:			
Total admissions	540	194	17.3
Total discharges	337	121	18.7
Total deaths	198	71	17.4
		Number per 1000 in residence during year	
Total provisional discharges	355	142	24.0
Total returns from prov. discharge	97	39	18.2
Total discharged from prov. disch.	193	77	24.0

TABLE IX

HASTINGS STATE HOSPITAL

Fiscal Year 1953-54: Expenditures $1,211,631 Per Capita Cost $1,285

	Number	Difference	Percentage Overcrowding
1953-54 average population	943	.....	.....
Designed capacity	1,100	−157	−14.3
Budgeted capacity	950	−7	−0.7
Health Department standard	761	+182	+23.9

	1953-54 Budgeted Positions	Needed to meet APA standards	Difference	Immediate Recommended	Difference
Staff:					
Pysicians	7.0	11.5	−4.5	.....	.....
Nurses and aides—total	112.5*	268.2	−155.7	142.9	−30.4
Rec., bed, disturbed patient	52.6	85.0	−32.4	62.3	−9.7
Feeble, regr. untidy, closed wards	41.2	141.8	−100.6	58.5	−17.3
Ger. amb., regr. tidy, open wards	18.7	41.4	−22.7	22.1	−3.4
Dentists	1.0	1.0	.....	.....	.....
Dental assistants	.....	1.9	−1.9	.....	.....
Clinical psychologists	1.0	2.6	−1.6	.....	.....
Registered occupational therapists	1.0	4.9	−3.9	.....	.....
Other activity therapy workers	11.0	11.6	−0.6	.....	.....
Psychiatric social workers	3.0	7.2	−4.2	.....	.....

June 30, 1954 resident population:	Number	Percentage of patients in Hastings State Hospital	Percentage of all patients in state mental hospitals
Total population	966	100.0	8.6
*Rec., bed, disturbed patient	187	19.0	6.6
*Feeble, regr. untidy, closed wards	468	47.4	12.5
*Ger. amb., regr. clean, open wards (*July, 1954)	331	33.6	7.6
Senile	191	19.8	9.8
Schizophrenic	544	56.3	9.9
Mentally deficient	47	4.9	5.2
Other	184	19.0	6.3
Under 45	268	27.7	9.6
45-64	391	40.5	8.8
65 and older	307	31.8	7.6
Admitted less than 6 months ago	112	11.6	10.2
Admitted less than one year ago	180	18.6	11.2
Admitted less than five years ago	335	34.7	8.2
Admitted 10 years or more ago	557	57.7	9.8
Admitted 25 years or more ago	199	20.6	10.6
Voluntary patients	59	6.1	11.9

	Number	Number per 1000 on books during year	Percentage of total for state mental hospitals
1953-54 population movements:			
Total admissions	346	239	11.1
Total discharges	206	142	11.4
Total deaths	54	37	4.7
		Number per 1000 in residence during year	
Total provisional discharges	168	129	11.4
Total returns from prov. discharge	72	55	13.5
Total disch. from prov. discharge	62	47	7.7

TABLE X

MOOSE LAKE STATE HOSPITAL

Fiscal Year 1953-54: Expenditures $1,186,138 Per Capita costs $942

	Number	Difference	Percentage Overcrowding
1953-54 average population	1,259	.....	.....
Designed capacity	1,160	99	8.5
Budgeted capacity	1,300	−41	−3.2
Health Department standard	1,160	99	8.5

	1953-54 Budgeted Positions	Needed to meet APA standards	Difference	Immediate Recommended	Difference
Staff:					
Physicians	4.0	16.0	−12.0	.....	.....
Nurses and aides—total	147.1*	292.2	−145.1	.....	.....
Rec., bed, disturbed patient	71.5	127.3	−55.8	93.3	−21.8
Feeble, regr. untidy, closed wards	32.8	66.4	−33.6	27.4	+5.4
Ger. amb., regr. tidy, open wards	42.8	98.5	−55.7	52.5	−9.7
Dentists	1.0	1.3	−0.3	.....	.....
Dental assistants	1.0	2.6	−1.6	.....	.....
Clinical psychologists	1.0	4.4	−3.4	.....	.....
Registered occupational therapists	2.0	6.3	−4.3	.....	.....
Other activity therapy workers	7.0	14.5	−7.5	.....	.....
Psychiatric social workers	2.0	9.0	−7.0	.....	.....

June 30, 1954 resident population:	Number	Percentage of patients in Moose Lake State Hospital	Percentage of all patients in state mental hospitals
Total population:	1,284	100.0	11.4
*Rec., bed, disturbed patient	280	21.8	9.9
*Feeble, regr. untidy, closed wards	219	17.0	5.9
*Ger. amb., regr. clean, open wards (*July, 1954)	788	61.2	18.2
Senile	415	32.3	21.3
Schizophrenic	481	37.5	8.8
Mentally deficient	77	6.0	8.5
Other	311	24.2	10.7
Under 45	339	26.4	12.2
45-64	419	32.6	9.5
65 and older	521	40.6	13.0
Age unknown	5	0.4	21.7
Admitted less than 6 months ago	160	12.5	14.7
Admitted less than one year ago	243	19.0	15.1
Admitted less than five years ago	649	50.5	15.9
Admitted 10 years or more ago	411	32.0	7.3
Admitted 25 years or more ago	45	3.5	2.4
Voluntary patients	51	4.0	10.3

	Number	Number per 1000 on books during year	Percentage of total for state mental hospitals
1953-54 population movements:			
Total admissions	446	233	14.3
Total discharges	216	113	12.0
Total deaths	188	98	16.5
		Number per 1000 in residence during year	
Total provisional discharges	196	114	13.3
Total returns from prov discharge	66	39	12.4
Total disch. from prov. discharge	124	72	15.4

TABLE XI

ROCHESTER STATE HOSPITAL

Fiscal Year 1953-54: Expenditures $1,764,994 Per Capita Costs $990

	Number	Difference	Percentage Overcrowding
1953-54 average population	1,782	.....	.....
Designed capacity	1,600	+182	+11.4
Budgeted capacity	1,760	+22	+1.3
Health Department standard	1,760	+22	+1.3

	1953-54 Budgeted Positions	Needed to meet APA standards	Difference	Immediate Recommended	Difference
Staff:					
Pysicians	11.5	25.2	−13.7	288.4	−25.4
Nurses and aids—total	263.0*	498.6	−235.6	166.7	−13.7
Rec., bed, disturbed patient	153.0	227.3	−74.3	78.5	−8.1
Feeble, regr. untidy, closed wards	70.4	190.3	−119.9	43.2	−3.6
Ger. amb., regr. clean, open wards	39.6	81.0	−41.4	.....	.....
Dentists	.....	1.8	−1.8	.....	.....
Dental assistants	1.0	3.6	−2.6	.....	.....
Clinical psychologists	1.0	6.3	−5.3	.....	.....
Registered occupational therapists	3.0	9.7	−6.7	.....	.....
Other activity therapy workers	7.0	23.1	−16.1	.....	.....
Psychiatric social workers	1.0	10.4	−9.4	.....	.....

June 30, 1954 resident population:	Number	Percentage of patients in Rochester State Hospital	Percentage of all patients in state mental hospitals
Total population:	1,779	100.0	15.8
*Rec., bed, disturbed patient	500	28.2	17.7
*Feeble, regr. untidy, closed wards	628	35.3	16.8
*Ger. amb., regr. clean, open wards (*July, 1954)	648	36.5	15.0
Senile	341	19.2	17.5
Schizophrenic	695	39.0	12.7
Mentally deficient	132	7.4	14.5
Other	611	34.4	21.0
Under 45	452	25.4	16.3
45-64	644	36.2	14.5
65 and older	683	38.4	17.0
Admitted less than 6 months ago	193	10.8	17.7
Admitted less than one year ago	285	16.0	17.7
Admitted less than five years ago	868	48.8	21.3
Admitted 10 years or more ago	597	33.6	10.5
Admitted 25 years or more ago	171	9.6	9.1
Voluntary patients	114	6.4	22.9

	Number	Number per 1000 on books during year	Percentage of total for state mental hospitals
1953-54 population movements:			
Total admissions	539	202	17.3
Total discharges	399	149	22.1
Total deaths	218	82	19.2
		Number per 1000 in residence during year	
Total provisional discharges	228	94	15.4
Total returns from prov. discharge	77	32	14.4
Total disch. from prov. disch.	186	77	23.1

TABLE XII

ST. PETER STATE HOSPITAL

Fiscal Year 1953-54: Expenditures $2,466,169 Per Capita Cost $999

	Number	Difference	Percentage Overcrowding
1953-54 average population	2,469	.....	.....
Designed capacity	2,748	−279	−10.2
Budgeted capacity	2,400	+69	+2.9
Health Department standard	1,999	+470	+23.5

	1953-54 Budgeted Positions	Needed to meet APA standards	Difference	Immediate Recommended	Difference
Staff:					
Physicians	9.0	29.7	−20.7	357.0	−81.6
Nurses and aides—total	275.4*	643.5	−368.1	182.4	−43.8
Rec. bed, disturbed patient	138.6	247.3	−108.7	125.1	−23.3
Feeble, regr. untidy, closed wards	101.8	303.3	−201.5	49.5	−14.5
Ger. amb., regr. clean, open wards	35.0	92.9	−57.9	.....	.....
Dentists	2.0	2.5	−0.5	.....	.....
Dental assistants	1.0	5.0	−4.0	.....	.....
Clinical psychologists	1.0	6.9	−5.9	.....	.....
Registered occupational therapists	2.0	11.9	−9.9	.....	.....
Other activity therapy workers	14.0	28.6	−14.6	.....	.....
Psychiatric social workers	1.0	13.6	−12.6	.....	.....

June 30, 1954 resident population:	Number	Percentage of patients in St. Peter State Hospital	Percentage of all patients in state mental hospitals
Total population:	2,478	100.0	22.0
*Rec., bed, disturbed patient	544	23.8	19.2
*Feeble, regr. untidy, closed wards	1,001	43.7	26.8
*Ger. amb., regr. clean, open wards (*July, 1954-exc. ADI)	743	32.5	17.2
Senile	417	16.8	21.4
Schizophrenic	1,093	44.1	19.9
Mentally deficient	229	9.2	25.2
Other	739	29.9	25.4
Under 45	662	26.7	23.8
45-64	1,016	41.0	22.9
65 and older	795	32.1	19.8
Unknown	5	0.2	21.7
Admitted less than 6 months ago	208	8.4	19.0
Admitted less than one year ago	322	13.0	20.0
Admitted less than five years ago	959	38.7	23.5
Admitted 10 years or more ago	1,107	44.7	19.6
Admitted 25 years or more ago	242	9.8	12.9
Voluntary patients	136	5.5	27.4

	Number	Number per 1000 on books during year	Percentage of total for state mental hospitals
1953-54 population movements:			
Total admissions	646	182	20.7
Total discharges	376	106	20.9
Total deaths	264	74	23.2
		Number per 1000 in residence during year	
Total provisional discharges	282	90	19.1
Total returns from prov. discharge	129	41	24.1
Total disch. from prov. discharge	165	52	20.5

TABLE XIII

SANDSTONE STATE HOSPITAL

Fiscal Year 1953-54: Expenditures $516, 598 Per Capita Costs $1,177

	Number	Difference	Percentage Overcrowding
1953-54 average population	439	.....	.....
Designed capacity	480	−41	−8.5
Budgeted capacity	480	−41	−8.5
Health Department standard	445	−6	−1.3

	1953-54 Budgeted Positions	Needed to meet APA standards	Difference	Immediate Recommended	Difference
Staff:					
Physicians	2.0	6.8	−4.8	.....	.....
Nurses and aides—total	44.5*	127.0	−82.5	76.0	−31.5
Rec., bed, disturbed patient	22.1	66.4	−44.3	48.7	−26.6
Feeble, regr. untidy, closed wards	11.7	42.1	−30.4	17.4	−5.7
Ger. amb., regr. clean, open wards	10.7	18.5	−7.8	9.9	+0.8
Dentists	1.0	0.4	+0.6	.....	.....
Dental assistants	.....	0.9	−0.9	.....	.....
Clinical psychologists	.....	1.8	−1.8	.....	.....
Registered occupational therapists	.....	2.6	−2.6	.....	.....
Other activity therapy workers	4.0	6.1	−2.1	.....	.....
Psychiatric social workers	.....	2.2	−2.2	.....	.....

June 30, 1954 resident population:	Number	Percentage of patients in Sandstone State Hospital	Percentage of all patients in state mental hospitals
Total population:	430	100.0	3.8
*Rec., bed, disturbed patient	146	33.7	5.2
*Feeble, regr. untidy, closed wards	139	32.1	3.7
*Ger. amb., regr. clean, open wards (*July, 1954)	148	34.2	3.4
Senile	40	9.3	2.0
Schizophrenic	197	45.8	3.6
Mentally deficient	73	17.0	8.0
Other	120	27.9	4.1
Under 45	103	24.0	3.7
45-64	166	38.6	3.7
65 and older	160	37.2	4.0
Age unknown	1	0.2	4.4
Admitted less than 6 months ago	16	3.7	1.5
Admitted less than one year ago	32	7.4	2.0
Admitted less than five years ago	112	26.0	2.8
Admitted 10 years or more ago	244	56.7	4.3
Admitted 25 years or more ago	131	30.5	7.0
Voluntary patients	12	2.8	2.4

	Number	Number per 1000 on books during year	Percentage of total for state mental hospitals
1953-54 population movements:			
Total admissions	104	177	3.4
Total discharges	63	108	3.5
Total deaths	25	43	3.2
		Number per 1000 in residence during year	
Total provisional discharges	43	77	2.9
Total returns from prov. discharge	14	25	2.6
Total disch. from prov. discharge	10	18	1.3

TABLE XIV

WILLMAR STATE HOSPITAL

Fiscal Year 1953-54: Expenditures $1,471,717 Per Capita costs $1,008

	Number	Difference	Percentage Overcrowding
1953-54 average population	1,460	.....	.....
Designed capacity	1,510	−50	−3.3
Budgeted capacity	1,450	+10	+0.7
Health Department standard	1,040	+420	+40.4

	1953-54 Budgeted Positions	Needed to meet APA standards	Difference	Immediate Recommended	Difference
Staff:					
Physicians	6.0	22.9	−16.9	.....	.....
Nurses and aides—total	180.9*	426.1	−245.2	254.8	−73.9
Rec., bed, disturbed patient	100.7	219.5	−118.8	161.0	−60.3
Feeble, regr. untidy, closed wards	49.2	135.5	−86.3	55.9	−6.7
Ger. amb., regr. clean, open wards	31.0	71.1	−40.1	37.9	−6.9
Dentists	1.0	1.5	−0.5	.....	.....
Dental assistants	.....	2.9	−2.9	.....	.....
Clinical psychologists	1.0	5.9	−4.9	.....	.....
Registered occupational therapists	1.0	8.5	−7.5	.....	.....
Other activity therapy workers	12.0	20.5	−8.4	.....	.....
Psychiatric social workers	1.0	22.1	−21.2	.....	.....

June 30, 1954 resident population:	Number	Percentage of patients in Willmar State Hospital	Percentage of all patients in state mental hospitals
Total population: (ment. ill only)	1,275	100.0	11.4
*Rec., bed, disturbed patient	483	32.2	17.1
*Feeble, regr. untidy, closed wards	447	29.8	12.0
*Ger. amb., regr. clean, open wards (*July, 1954—incl. inebriates)	569	38.0	13.1
Senile	111	8.7	5.7
Schizophrenic	745	58.4	13.6
Mentally deficient	94	7.4	10.4
Other	325	25.5	11.2
Under 45	187	14.7	6.7
45-64	565	44.3	12.8
65 and older	517	40.5	12.9
Age unknown	6	0.5	26.1
Admitted less than 6 months ago	96	7.5	8.8
Admitted less than one year ago	139	10.9	8.6
Admitted less than five years ago	225	17.6	5.5
Admitted 10 years or more ago	1,006	78.9	17.8
Admitted 25 years or more ago	549	43.1	29.3
Voluntary patients	36	2.4	7.2

(mentally ill only)	Number	Number per 1000 on books during year	Percentage of total for state mental hospitals
1953-54 population movements:			
Total admissions	244	154	7.8
Total discharges	83	52	4.6
Total deaths	97	61	8.5
		Number per 1000 in residence during year	
Total provisional discharges	88	57	6.0
Total returns from prov. discharge	30	20	5.6
Total disch. from prov. discharge	22	14	2.8

TABLE XV

MINNESOTA STATE MENTAL HOSPITALS

June 30, 1954 Resident Population
Distribution by Age, Sex, and Mental Disorder

Mental disorder	Total	Under 25	25-44	45-64	65-84	85 and over	Unknown
Total resident patients	11,252	249	2,529	4,434	3,613	404	23
Senile	1,952	.....	3	123	1,479	342	5
Other organic brain disorders	1,098	18	206	554	308	11	1
Schizophrenic reactions	5,483	124	1,697	2,568	1,054	30	10
Other psychotic disorders	1,387	8	155	652	558	11	3
Mental deficiencies	908	52	325	389	140	2	.....
All other	424	47	143	148	74	8	4
Male resident patients	5,712	138	1,338	2,228	1,817	175	16
Senile	1,009	.....	.....	77	781	148	3
Other organic brain disorders	726	14	119	358	226	8	1
Schizophrenic reactions	2,758	66	871	1,289	517	9	6
Other psychotic disorders	438	2	51	202	177	4	2
Mental deficiencies	506	31	198	211	65	1	.....
All other	275	25	99	91	51	5	4
Female resident patients	5,540	111	1,191	2,206	1,796	229	7
Senile	943	.....	3	46	698	194	2
Other organic brain disorders	372	4	87	196	82	3	.....
Schizophrenic reactions	2,725	58	826	1,279	537	21	4
Other psychotic disorders	949	6	104	450	381	7	1
Mental deficiencies	402	21	127	178	75	1	.....
All other	149	22	44	57	23	3	.....
	Percent	Percent	Percent	Percent	Percent	Percent	Percent
Total resident patients	100.0	2.2	22.5	39.4	32.1	3.6	0.2
Senile	17.3	.....	a	1.1	13.1	3.0	a
Other organic brain disorders	9.8	0.2	1.9	4.9	2.7	0.1	a
Schizophrenic reactions	48.7	1.1	15.0	22.8	9.4	0.3	0.1
Other psychotic disorders	12.3	0.1	1.4	5.8	5.0	0.1	a
Mental deficiencies	8.1	0.5	2.9	3.5	1.2	a	.....
All other	3.8	0.4	1.3	1.3	0.7	0.1	a
Male resident patients	50.8	1.2	12.0	19.8	16.1	1.6	0.1
Senile	9.0	.....	.....	0.7	6.9	1.3	a
Other organic brain disorders	6.5	0.1	1.1	3.2	2.0	0.1	a
Schizophrenic reactions	24.5	0.6	7.7	11.4	4.6	0.1	a
Other psychotic disorders	3.9	a	0.5	1.8	1.6	a	a
Mental deficiencies	4.5	0.3	1.8	1.9	0.5	a	.....
All other	2.4	0.2	0.9	0.8	0.5	a	a
Female resident patients	49.2	1.0	10.5	19.6	16.0	2.0	0.1
Senile	8.4	.....	a	0.4	6.2	1.7	a
Other organic brain disorders	3.3	a	0.8	1.7	0.7	a	.....
Schizophrenic reactions	24.2	0.5	7.3	11.4	4.8	0.2	a
Other psychotic disorders	8.4	0.1	0.9	4.0	3.4	0.1	a
Mental deficiencies	3.6	0.2	1.1	1.6	0.7	a	.....
All other	1.3	0.2	0.4	0.5	0.2	a	.....

a—Less than .05 percent.