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REPORT

of the

Interim Commission

ON

Youth Conservation

and

Mental Health Programs

Relating to the

Mental Health Programs

Submitted to

THE MINNESOTA LEGISLATURE

OF 1953

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STATE OF MINNESOTA

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FOREWORD

In their first annual report the Board of Trustees and officers of the Minnesota Hospital for the Insane made this statement:

> "At an early period in the history of our State the wants of the insane appealed to the deepest sympathy and philanthropy of our people. Most earnestly they asked that suitable provision be made for their proper care and treatment. As our population increased this appeal became more pressing. Something must be done for their relief.
>
> "Correspondence was opened by our State officials with the Superintendents of hospitals in Wisconsin, Illinois and Iowa, asking if arrangements could be made to receive our insane patients until we were able to erect suitable buildings for this purpose. The only favorable response was from the Superintendent of the Iowa hospital, stating that the trustees thereof were willing to accommodate a limited number, and then only so long as their own patients did not require the full capacity of their building.
>
> "This was a great favor conferred by our sister state. The result, however, was that as a State we did not feel the high necessity of making provision for them at home. The history of all our states shows that the first great charity demanding legislative action is the proper accommodation for the safety and medical treatment of the insane."

This report was issued in the year 1867 when Minnesota, as a state, was not yet ten years old. From that early period until the present time the needs of the mentally ill and physically handicapped have had, "the deepest sympathy and philanthropy of our people".

From that time on there has been continual expansion of the state's facilities to provide for the growing needs of our growing population, and each legislative session has been called upon to give consideration to the need for new institutions as well as for the expansion and improvement of those already established.

The following list of our hospitals and schools for the handicapped in the order in which they were established is convincing proof of the interest of the people of Minnesota in these problems:

School for the Deaf	Established in 1863
St. Peter Hospital	Established in 1866
Braille and Sight Saving School	Established in 1874
Rochester State Hospital	Established in 1879
Minnesota School and Colony	Established in 1882
Owatonna State School	Established in 1886
Fergus Falls State Hospital	Established in 1890
Gillette State Hospital for Crippled Children	Established in 1897
Anoka State Hospital	Established in 1899

SUMMARY—of Major Recommendations Mental Health Programs

(Supporting information and recommendations follow in the body of the REPORT)

This printed report is an assembled condensation of previously released more detailed reports on each section. In the condensation much material is only summarized and considerable supporting material is omitted. A limited number of detailed reports on each section are available.

ADMINISTRATION OF MENTAL HEALTH

★ The Director of Public Institutions should be entirely responsible for administration:

Establishing and maintaining professional practices in institutions;

Enlisting the assistance of all professional teaching institutions to improve the staffing, training and professional standards in the Mental Hospitals;

Integrating and maintaining uniform and adequate standards of patient care and treatment, and,

Integrating administration of all institutions on a uniform basis.

★ A Medical Policy Directional Committee on Mental Health should be established.

This Committee should be composed as follows:

Not less than 5 nor more than 7 persons, each of whom is a recognized expert in a separate field of medicine or a related science.

Appointments to be by the Director of Public Institutions for staggered terms and with adequate compensation.

Purposes of the Committee should include responsibility for advising the Director as to all phases of professional policy and standards, including the approval and guidance of research projects and distribution of research funds.

★ The Committee recommends that a careful study and analysis be made of the potentialities of Central Warehousing for all State institutions.

★ A trained hospital administrator, holding a master's degree in Hospital Administration, should be appointed superintendent of at least one Mental Hospital with complete administrative operational responsibility.

★ In such institutions as a trained hospital administrator is appointed as superintendent, the position of Medical Director should be established.

★ Neither the superintendent or medical director should be in the classified service.

★ Central administration should institute and enforce proper standards, patterns, and rulings for all Mental Hospitals.

★ In the ensuing biennium some agency accountable to the Legislature should investigate the various institutions and should determine the extent to which there may be failure to remedy present deficiencies of administration.

RECORDS AND STATISTICS

★ The Legislature should require that an adequate and appropriate system of records and statistics be devised, installed and operated. All basic record forms including medical record forms and manner of their use should be required to be precisely uniform.

★ The Legislature should require that competent expert assistance be retained for the purpose of devising a record system.

ADMISSIONS, DISCHARGES AND SCREENING PROBLEMS

★ Each commitment of a person as mentally ill should be subject to the following conditions:

1. The court should be required to find specifically that commitment is necessary.
2. Each commitment should be provisional until 60 days after the entry of the patient into a State Mental Hospital.
3. Sixty days after a patient has entered, the mental hospital should be required to file a certificate with the committing court and a copy with the Director of Public Institutions setting forth the condition of the patient, and a statement as to whether the patient needs to be further confined.

4. Upon the completion of the certificate just described, the patient shall be:

   Returned to the jurisdiction of the committing court if the patient does not need to be further confined, or,

   Remain in the mental hospital under a commitment which becomes final unless there is an extension to the provisional commitment.

5. Upon return of any patient to the committing court as not needing further confinement, the civil rights of such patient shall be immediately restored.

6. Except as herein provided, the patient while under provisional commitment, shall be considered as if the commitment were final.

★ Legal safeguards to the rights of any patient, such as are found in the State of Wisconsin regarding the right of jury trial if requested, are commended to the attention of the Legislature.

★ The Director of Public Institutions should establish a screening staff or panel of three or more qualified persons to supervise the policies of the various mental hospitals as to both the admission and discharge of patients.

STAFFING PROBLEMS—(Psychiatric Staffing)

★ To continue and improve training and staffing measures.

★ The administration of the Mental Health Program and the State Department of Education should consult and study the possibility of using Federal funds under the Smith-Hughes Act to aid and develop a vocational training program at each mental hospital.

(Proposed Integrated Training Program to Improve Psychiatric Staffing)

★ The Director of Public Institutions should be authorized to work out with the University of Minnesota and the Mayo Clinic an integrated program of psychiatric training to the extent of not more than 5 trainees each year.

(Patient Care Staffing)

★ The number of authorized positions for recreational and occupational therapists should be approximately one worker for each 150 patients or more. The costs saved should be expended to increase the number of aides.

(Patient Help In Institution Operation)

★ The central administration should make a careful study of unnecessary use of operational employees at the various institutions.

★ Patient participation should be increased in institutional operation.

★ The payroll liability of the operational employees made unnecessary by better use of patient help, should be used to increase the number of aides, nurses, etc.

RESEARCH

★ All research funds should be appropriated to the Director of Public Institutions to be allocated in accordance with the direction of a Director's Medical Advisory Committee, as recommended under the Administrative Section of this report.

★ Provision for a State Research Fund should include proper legal authority to accept contributions from individuals or organizations to be allocated and controlled along the lines similar to public funds.

★ For the next biennium a research fund should be appropriated by the Legislature to provide:

$75,000 for the first year of the biennium, and
$100,000 for the second year of the biennium.

★ Individuals and organizations interested in Mental Health are urged to accept the responsibility of raising funds toward Mental Health Research.

PROGRAM FOR MENTALLY DEFICIENT AND EPILEPTICS

★ The Committee recommends that at Faribault there should be a better distribution of patients within present facilities.

★ Sandstone State Hospital should be converted on a temporary basis to the use of mentally deficient.

★ All mentally deficient that are in need of institutionalization should be admitted as soon as the mentally ill can be transferred from Sandstone.

★ Steps should be taken to obtain more uniformly satisfactory supervision of mentally deficient in the local communities by the various County Welfare Boards.

★ All committed mentally retarded in need of institutionalization should be admitted and no waiting list permitted to again develop.

★ It is recommended that Cambridge be enlarged to the extent of 400 patient housing facilities to provide for the patients now committed and on the waiting list.
Note: The subject of a new institution at Brainerd is noted.

★ The Committee further recommends that a substantial portion of the saving, due to enlarging Cambridge rather than building a new institution, be devoted to the more necessary improvements at both Cambridge and Faribault.

★ The Legislature should adopt a definite program for expansion of facilities for the mentally retarded.

★ Each session of the Legislature should re-evaluate the need for institutionalization and provide such additional facilities as experience will demonstrate are necessary.

★ Charges for care of mentally deficient persons should be revised by the Legislature.

★ Legislation, relative to training severely retarded, should be strengthened.

★ The Department of Education should be directed to waive arbitrary requirements as to class size and required teachers' training until after further experience.

CHARGES TO PATIENTS, RELATIVES OR COUNTIES (For Mentally Ill)

★ A receiving unit rate of charge should be established for receiving units to be comparable to the charge rate of the University of Minnesota Hospitals.

★ A schedule of hospital and clinical charges similar to that in use by the University of Minnesota Hospitals should be established to be used by all Receiving Units.

★ For committed patients the county of residence should be billed for the total of these two charges and should be liable to the State for the payment of any amount collected on an ability to pay basis from the patient or responsible relatives plus one-half of the remaining uncollected balance.

★ Voluntary patients referred by a physician as unable to pay for private hospitalization and physician's services, may be accepted provided:

The County Board of the county of residence has accepted liability for the county share of the charges on the same basis as committed patients,

or

The voluntary patient or responsible relatives guarantee and are able to pay the full amount of charges during the period of hospitalization in a Receiving Unit.

★ Provision should be made that in cases of voluntary patients, without county certification, the patient should be examined by a hospital staff physician to determine whether or not the case is an emergency and, if so, procedure for necessary care and treatment is provided.

★ The Director of the Division of Public Institutions should be required each year to establish a rate of per capita cost for patients in the various State Mental Hospitals.

★ Voluntary patients in the Mental Hospitals, except in Receiving Units, should be required to pay the full per capita rate and in addition, hospital and clinic charges, except that if unable to pay the full rate plus charges, then upon county certification, provision for a lesser payment is recommended.

The following should be the required procedure concerning charges to patients, responsible relatives or counties for costs due to care of patients committed when less than 65 years of age:

★ The Director of Public Institutions should be required to collect from the patient or responsible relatives up to the full per capita cost whenever possible.

★ When patient or responsible relatives are unable to pay the full per capita cost, the Director should collect that portion of the per capita cost that is reasonably possible.

★ If the Director finds the patient or responsible relatives unable to pay one-half or more of the per capita cost, he must bill the county of legal settlement of the patient in the amount of one-half of the per capita cost.

★ The county of legal settlement shall be responsible to collect from the patient or responsible relatives such portion of the amount billed as their ability to pay may warrant. The county shall be liable to the State for the amount so collected plus one-half of the difference, if any, between the amount billed by the State and the amount collected from the patient or responsible relatives.

★ Local Welfare Boards should be made responsible to give discharge or provisionally discharged mental patients supervision or, if necessary, financial assistance in order that the patients may adjust to living "outside" of an institution.

(For Mentally Deficient and Epileptics)

★ The Director of Public Institutions should each year determine a per capita cost rate for mentally deficient and epileptic patients based on the average cost of the institutions at Faribault and Cambridge.

★ The charge to persons responsible for mentally deficient or epileptic patients in any State facility should be 25% of the per capita cost rate.

★ Whenever the person or persons responsible are found unable to pay the charge, this charge should be levied against the county of legal settlement of the patient.

★ Legislation should be enacted so that the Director of Public Institutions may accept from persons responsible for mentally deficient or epileptic patients payments in excess of the minimum rate to be used by him for the benefit of mentally deficient and epileptic persons in the State, including those in institutions.

★ Owatonna State School, being primarily an educational institution, the charge to responsible relatives or counties should be the same as at other institutions for mentally deficient and epileptic persons.

(Out-Patient and Follow-up Clinics)

★ State Out-Patient Clinics (accepting referred new patients) should be limited to State Mental Hospitals in order that they be adequately equipped with laboratory, x-ray, etc. facilities.

★ Because psychiatric out-patient clinics should be part of completely equipped medical facilities, communities are urged to include psychiatric out-patient provisions in their local medical facilities.

★ Out-patients (not follow-up patients discharged from mental hospitals) should be charged according to ability to pay up to the full cost of service received. For patients unable to pay, the county should be required to pay $5 to cover the first visit and examination. The patient should be required to pay a fifty cent registration fee for each visit.

(For Aged Patients)

★ The Director of the Division of Social Welfare shall prepare for each county of the State an average county nursing home charge rate and he shall set forth the amount which represents the county's share per person of such average nursing home payments.

★ For patients entering any mental hospital after attaining the age of 65, the patient, responsible relatives or counties of legal settlement should be charged as follows:

While in Receiving units, as outlined previously.
For voluntary patients, as outlined previously.
For committed patients not in Receiving Units charges should be:

To patients or responsible relatives the average county nursing home charge rate of the county where the patient has legal settlement or a portion according to ability to pay, except that;

For each patient who is or whose responsible relatives are unable to pay as much as one-half of the average county nursing home charge rate, the Director will bill the county for one-half of such rate.

The county so billed will remit to the State for each patient an amount equal to the county's share of the average county nursing home charge rate for

that county plus one-half of such amount as the county may recover on an ability to pay basis from the patient or responsible relatives.

★ Churches and other non-profit charitable organizations are urged to continue and expand their efforts toward providing rest home and nursing home facilities for older people.

★ Local communities are urged to take steps to provide adequate facilities for care of the aged.

★ The Legislature is urged to consider the desirability of providing State assistance to local communities toward the establishment of facilities for the aged.

★ High standards of safety in facilities for the aged are desirable but progress toward these standards must be gradual and realistic because of the over-lying need to provide for old people who are in need of care.

★ Greater emphasis in the regulation of public and private nursing and rest homes should be placed on care of the patient.

★ The function of licensing and enforcing rules and regulations for the control of rest and nursing homes should be placed under the Division of Social Welfare instead of the State Board of Health.

★ Legislation should be enacted providing for restriction on sale or transfer of property of wards of the State over 65 years of age whether by operation of law or otherwise to the same extent as may exist from time to time with respect to recipients of Old Age Assistance.

(General Recommendations Relative to CHARGES)

★ All collections should be centered in the Division of Public Institutions.

★ Provision should be made for the Director of the Division of Public Institutions to have legal services for the purpose of enforcing collections.

★ Legislation should be enacted requiring the courts to notify the Director of the Division of Public Institutions whenever any proceedings for guardianship or proceedings under guardianship take place as to patients in State institutions.

★ The Civil Service requirements for employees of the Collection Department of the Division of Public Institutions should be made appropriate to the duties of the employees.

★ The superintendent of each institution should be required to send each month to the Division a record of all patient welfare accounts.

★ It would seem wise to consider some legislation whereby a responsible relative liable for the keep of a ward of the State could not disinherit a ward and place the future burden of the ward's keep wholly on the counties and the State.

THE PROGRAM FOR INEBRIATES

★ The treatment for alcoholism should be separated from the Mental Health Program.

★ Local facilities should be encouraged as the most effective and economical means of rehabilitating alcoholics.

★ The State should establish a separate facility devoted to the following purposes:

> Long range treatment of the patient who has not responded to local Alcoholics Anonymous type of treatment.
>
> Provide custodial care for the deteriorated patient.

★ Voluntary patients should be required to pay the entire per capita cost of the institution.

★ Through commitment procedure (perhaps revised) local communities should accept a measure of financial responsibility for alcoholics.

★ The discharge patient should be subject to provisional discharge control.

★ All alcoholics, except those found to be with psychoses, should be admitted only to the State Facility for Alcoholics.

★ Separate provisions should be made for a tubercular alcoholic to be treated:

> First, as a tubercular patient with the costs to the counties, the patient, or his relatives in accordance with the rules for tubercular patients.

Second, the tubercular alcoholic on discharge from the tubercular hospital should be returned to the State Facility for Alcoholics and thereafter the charges and the rules of supervision for alcoholic discharges should be followed.

★ Provision should be made to the effect that selection of personnel for a State Facility for Alcoholics should not be required to conform to the rules of Civil Service as now constituted.

BUILDING NEEDS OF THE MENTAL HEALTH PROGRAM

★ The Legislative Research Committee should be required to add to its staff a competent person to examine and study building requirements, and to report to each session of the Legislature in respect to all building needs.

★ It is recommended that until many phases of the Mental Health Program as to admissions, discharges, type of patients and ultimate patient load can be more accurately determined, the construction of elaborate or expensive new buildings be subordinated to the more immediately obvious needs to improve and repair present structures.

★ The inequities as to staff housing should be remedied by more adequate and fairly determined charges or by a monthly allowance to staff members not occupying staff residences. Similar action in regard to employee housing should also be taken.

★ Particular recommendations for new buildings are:

New buildings to add 400 bed capacity for mentally deficient at Cambridge contingent on which is a further recommendation for a medical, surgical and infirmary building at Cambridge.

Also contingent on the additions at Cambridge, improvements or necessary replacements should be started at Faribault and Cambridge.

Remodeling to a condition of adequacy of the present medical-surgical hospital at Anoka is recommended.

Note: Subject of new institution at Brainerd is covered in Mentally Deficient Section.

★ A thorough analysis of the space at Anoka State Hospital, now devoted to a swimming pool and gymnasium, should be made.

★ This Committee visited the United States Government Indian School at Pipestone, Minnesota. It appeared to this Committee this institution would be suitable for those alcoholics requiring long term treatment.

THE MENTAL HEALTH PROGRAM

INTRODUCTION:

Webster's dictionary defines **a program** as **"an outline of work to be done; a pre-arranged plan of procedure; as the program of the administration."** If that definition is to be applied we have not had a real Mental Health Program in Minnesota.

The Legislature has authorized a considerable increase in personnel and expenditures. Mental Health has been a subject of such emotional concern that many citizens groups have advocated unwise expenditures just to show interest in the program. Public officials have been condemned as anti-mental health, if any proposed activity in the name of Mental Health was questioned. Laymen and others have excused waste, extravagance or mismanagement as being in a sacred cause. During this time there has been an apparent reluctance on the part of many State administrative officials to enforce sound principles of business management, adherence to Legislative purpose or strict adherence to administrative rules and policies of the State.

The conclusion is unavoidable that Webster's definition of a program, if strictly applied, would rule out the use of **program** in regard to Mental Health up to this date.

The following material represents a small portion of the total material gathered by this Committee and by the Legislative Research Committee, which was made available to this Committee. Justice and accuracy require that attention be called to the fact that this Committee gathered some of its material 15 months ago, that it has been very gratifying to note that current administrators have remedied some of the administrative deficiencies. These steps were good and should be supported. Nevertheless this report will set forth the situation as found because much more remains to be done. We believe this will amply demonstrate that strengthened administrative structure and procedure is essential. In fairness it must be noted that the mental hospitals once were completely separate units governed by separate boards and show many of the lingering traditions of this autonomy. A great portion of the criticism of administration would apply for a considerable period in the past.

PRELIMINARY APPRAISAL

Accomplishments of the last eight years as **supported by the** Committee's findings:

From the standpoint of the patient:

Better food, clothing and housing of all patients.

Better treatment for the treatable.

Better nursing and medical care for all patients.

Legislative. The Legislature has given considerable support and made increasingly generous provision for the mentally ill. This

is shown by the more than triple increased rate of appropriations for operations alone:

Biennium 1946-1947 appropriated	$ 8,061,548.00.
Biennium 1948-1949 appropriated	10,551,823.00.
Biennium 1950-1951 appropriated	19,629,990.00.
Biennium 1952-1953 appropriated	26,084,423.00.

These appropriations include contingent appropriations but are for operational expenses only and **do not include the tremendously expanded building program** for which the Legislature has likewise provided appropriations from 1941 through 1951 totaling nearly **$21,000,000.** Also not included is the very material current cost of the Division of Public Institution's office, including the Commissioner of Mental Health staff, as there is no breakdown available of the portion of Division office expense attributable to Mental Health.

From the standpoint of administration progress has lagged considerably.

THE ADMINISTRATION OF MENTAL HEALTH

THE FUNDAMENTAL PREMISE OF THIS REPORT IS:

Unless there is sound administrative machinery and procedure, no public function will consistently work well—stabilize on a high level—or offer a sound base for the support of progress.

Unless there is considerable improvement of administrative structure and procedure:

> The public will never receive a reliable and accurate evaluation of the present or future State Mental Health Programs.
>
> The present gains due to public concern, Legislative support and administrative enthusiasm will rest on a temporary and varying foundation.

OVERALL ADMINISTRATION OF THE MENTAL HEALTH SYSTEM TO DATE:

As pointed out the administration of the Mental Health Program has been a series of contradictions, confusion and lack of coordination with divided responsibility to the extent that no one individual can be held accountable for its operation. **The confusion attendant upon a Director of Institutions and a Commissioner of Mental Health, both appointed by the Governor, in addition to the traditional autonomous operation of each mental hospital all contribute.**

Operationally there has been no "program."

There has been a condition of confusion with division office personnel and Commissioner of Mental Health personnel issuing conflicting orders but neither enforcing department-wide policies on patient care, institution management, accounting or use of equipment.

No division manual as to policies and procedure exists. No standardization exists as to medical records, personnel records or operational records.

Medically there has been no "program."

Substantially each hospital has been autonomous as to treatment. There is no standard policy on or adequate records and statistics concerning admissions, readmissions or discharges. This deficiency of the "program" is so important that a separate section on Records and Statistics is included.

There is no system-wide control of narcotics, barbiturates and other drugs—each hospital being left to its own devices.

The Legislative Research Committee reports a good portion of $616,656 training appropriation made by the Legislature has been used for hospital staff.

Some typical examples of the lack of administration medically are set forth in the detailed reports of this Committee and also those of the LRC.

Some improvements have been made recently but so many are needed that legislation, good administration and the time to effect the changes are all essential.

ADMINISTRATION OF INDIVIDUAL HOSPITALS

Administration of each individual hospital is vested in the superintendent, who may or may not delegate authority, but who is responsible for the medical and treatment program as well as operation of the institution.

Operationally there is no "program."

Control of supplies, inventories, etc. varies with each hospital according to the superintendent's wishes.

No two hospitals have the same pattern of organization of internal administration. The efficiency of administration varies considerably. Systems of patient, personnel and accounting records all vary.

To cite all additional instances of administrative confusion, abuses or inefficiency found in some institutions would in itself require a long report.

Medically there is no "program."

No two hospitals follow the same policies as to voluntary admissions. Treatment of patients in each hospital is according to judgment of the superintendent rather than to a statewide departmental medical policy.

Medical records vary so much as to completeness and form that they are of little value as a basis of department statistics or for the evaluation of the care and treatment of patients in some of the hospitals.

Training of personnel has varied to a considerable extent.

ADMINISTRATIVE REQUIREMENTS OF A MENTAL HEALTH PROGRAM

We assume the premise that the purposes of a Mental Hospital System are two-fold:

> To effect the early recovery and return to society the maximum number of mentally ill patients.
>
> To provide humanitarian care and custody for those mental patients not rehabilitated.

ANALYSIS OF ADMINISTRATIVE NEEDS AND PROPOSALS WILL BE MADE IN ACCORDANCE WITH THREE MOTIVATING OBJECTIVES

TO MAKE THE MENTAL HEALTH PROGRAM WORK—TO STABILIZE GAINS MADE TO DATE—TO ESTABLISH A SOUND BASIS FOR FUTURE PROGRESS.

To accomplish these objectives the administration of a Mental Health Program should include many factors:

> The advice, counsel and assistance of recognized experts in a number of the fields of medicine and related sciences are extremely important in respect to many phases of a Mental Health Program. Specialists in most fields of medicine are extensively used in the Mental Hospitals.
>
> The causes of those mental illnesses afflicting most of the patients are not known and may ultimately be found, if ever, in many of the fields of medicine.
>
> Research should be encouraged under the leadership and guidance of experts in many fields. (See Research Section.)
>
> The assistance of recognized authorities in all fields of medicine can greatly facilitate the coordination of the Mental Health System with other medical facilities in the state such as the Mayo Clinic and the University of Minnesota.
>
> Expert professional advice and guidance to the operational administration of the Mental Health Program is necessary so that administrative policies and procedures will be thoroughly sound from a professional point of view.

A Mental Health Program must have responsible, competent and determined operational administration to make a Mental Hospital System out of eight semi-autonomous hospitals:

> Sound administrative policies and practices as determined with the advice and assistance of recognized professional experts must be instituted and enforced.
>
> Policies as to treatment, patient care, professional and non-professional personnel, etc. must be enforced uniformly throughout the system.

An adequate and uniform medical and patient record system coupled with a good divisional statistical department must be established,

So that the Legislature and the public may be accurately and reliably informed.

So that the accomplishments of each hospital can be evaluated.

So that administrative and treatment deficiencies will be likely to be revealed.

So that valuable statistical research can be pursued. Efficiency of operation must be enforced to eliminate waste or extravagance so that the maximum amount of Mental Health funds can be devoted to patient care and treatment.

CONCLUSION:

One of the most essential basic needs to establish a Mental Health Program on a sound basis is one competent and determined administrator backed by the firm support of the Governor and the Legislature. He will need highly competent assistance and direction in the various fields of medicine and related sciences.

RECOMMENDATIONS:

1. **The Director of Public Institutions or such other person as subsequent legislation may place in charge of the institutions of the State should be entirely responsible for the administration of the Mental Health Program including:**

   a. **Establishing and maintaining the best possible professional practices in all mental institutions.**

   b. **Enlisting the assistance of all professional teaching institutions, including the University of Minnesota, the Mayo Clinic and others to improve the staffing, training and professional standards in the Mental Hospitals.**

   c. **Integrating and maintaining uniform and adequate standards of patient care and treatment.**

   d. **Integrating administration as to business and operational functions of all institutions on a uniform basis.**

2. **A Medical Policy Directional Committee on Mental Health composed of specialists in those fields of medicine and related sciences most appropriate to the Mental Health Program should be established:**

   a. **This Medical Policy Directional Committee on Mental Health should be composed as follows:**

(1) Not less than 5 nor more than 7 persons who are recognized experts in their various fields of medicine or related sciences.

(2) Not more than one member of the Committee should be from any one field of medicine or related sciences.

(3) Each member of the Committee should be appointed by the Director of Public Institutions for a term of years. Initial appointment should be for varying terms so that the expiration of the various members' terms would not coincide.

(4) The Committee should be required to meet not less than once in every month.

(5) Each member of the Committee should be adequately compensated for services rendered. Note: As examples only and not all inclusive, recognized specialists appropriate to the Mental Health System, include besides psychiatry, the following fields: neurology, physiology, biochemistry, internal medicine, pediatrics, pharmacology, psychology, etc. Advice of experts in such fields is essential for the best care and treatment of patients and for research.

b. Purposes of the Committee should include responsibility for advising the Director as to all phases of professional standards including patient care, training of personnel, establishment of treatment programs, obtaining of adequate staff, establishment of medical and statistical records and operational practices in order that they be compatible with professional requirements. In addition such a Committee is essential for the approval and guidance of research projects and distribution of research funds.

c. It is suggested that at least a fair proportion of the experts appointed to the Medical Policy Directional Committee should be men primarily engaged in private practice.

3. The Committee received testimony and considered the subject of Central Warehousing for all State Institutions. It appears that there are many details which should be carefully examined with an evaluation of the cost of such an operation as contrasted with potential efficiency and economy.

The Committee recommends that in the ensuing two years a careful study and analysis be made of the potentialities of Central Warehousing for all State Institutions.

ADMINISTRATIVE REQUIREMENTS OF THE INDIVIDUAL HOSPITALS

The administration of a Mental Hospital, like any other hospital, consists of two sets of functions:

Operational Administration

The general management of the institution, including the problems of personnel, purchases, inventory, farming, maintenance, power plant, accounting and all other problems of operation.

Medical Administration

The direction of and the professional leadership in the treatment and care of patients, the professional direction of the medical, nursing and other "patient care" staff.

These functions are combined in the superintendents of the Mental Hospitals with the result that the following situations generally exist:

No superintendent of a State Mental Hospital so far as can be learned has had any training in the management of any type of institution or business enterprise.

Each State Mental Hospital superintendent is a trained doctor of medicine and in addition is a psychiatrist.

The Committee found hospital superintendents so burdened with administrative duties that some saw very few patients while others neglected administration.

In some State hospitals the only specialized psychiatrist available was the superintendent. It has often been impossible to keep all psychiatric positions filled.

ALTERNATIVE POSSIBILITIES OF HOSPITAL ADMINISTRATION DESIGNED TO INCREASE ADMINISTRATIVE EFFICIENCY AND TO IMPROVE MEDICAL CARE AND TREATMENT.

Thirteen colleges and universities in the United States, including the University of Minnesota, now conduct a graduate course in Hospital Administration leading to a master's degree.

INSTANCES WHERE TRAINED HOSPITAL ADMINISTRATORS ARE HOSPITAL SUPERINTENDENTS

It has long been the general practice in Europe for hospitals to be administered by trained lay administrators. The European practice was described by one of the specialists consulted. He stated, "......So I think it is wasting the time of a specially trained man to go into administration after he has spent years in developing his knowledge of medical problems."

The University of Minnesota Hospitals are under a trained lay hospital administrator, Mr. Ray M. Amberg.

The Superintendent of Minneapolis General Hospital, Mr. Kenneth Holmquist, is a graduate of the University of Minnesota course in Hospital Administration.

The operational management of the Mayo Clinic at Rochester has for many years been under Mr. Harry Horwick, recently retired.

At Rochester, the Kahler Hospital, the Colonial Hospital and Worrall Hospital are managed by non-medical men.

The University of California Administration of Hospitals is under Mr. R. J. Stull, Director of Hospitals and Infirmaries, who is also a lecturer in the course of Hospital Administration at the University of Minnesota.

The following conclusions appear warranted:

> In general, medical hospital trained lay administrators are proving increasingly successful.
>
> In institutions using trained administrators, conflicts between these administrators and the medical directors of the institutions appear to be extremely rare.
>
> Where trained administrators are used, the professional leadership is able to concentrate on professional policies and practices.
>
> The State of Minnesota Mental Health Program is extremely short of psychiatrists.
>
> Administration duties at each institution deprive the patients of the best psychiatric attention available at the institution.

RECOMMENDATIONS:

The Committee recommends that the following procedure be adopted:

1. **A trained hospital administrator, holding a master's degree in Hospital Administration, be appointed superintendent of at least one Mental Hospital with complete administrative operational responsibility for the institution.**

2. **In such institutions as a trained hospital administrator is appointed as superintendent, the position of Medical Director should be established. Such Medical Director should have complete authority and control of medical administration in the hospital including treatment of all patients and direction of all medical policies.**

3. **Neither position should be in the classified service.**

4. **Central administration should institute and enforce proper standards, patterns and rulings for all Mental Hospitals so as to reduce the operational complications of the Superintendents. Such functions as can be advantageously centralized in the divisional office should be so consolidated.**

5. **It is recommended that in the ensuing biennium some agency accountable to the Legislature should investigate the manner in which funds are expended and functions performed in the various institutions and should further investigate to determine the extent to which administrative practices and procedure are improved and the extent to which there may be failure to remedy present deficiencies of administration. Note: A number of instances were encountered where it appeared legislative intent had not been followed. In addition much of the value of the studies made the past biennium might be lost if there is no follow-up.**

COMMENT

It is essential to emphasize again that unless there is firm enforcement of administrative rules and policies, which may be established, no structural organization will function satisfactorily.

If steady progress toward a considerable total of administrative improvement and enforcement takes place, Minnesota can attain the position where we can rightfully refer to our MENTAL HEALTH "PROGRAM."

RECORDS AND STATISTICS
THE SIGNIFICANCE OF MINNESOTA MENTAL HEALTH RECORDS AND REPORTS

Few persons would advocate and certainly very few owners would finance the expansion or extension of any business enterprise without the answers to three basic questions:

1. How well has the enterprise done in the past?
2. How well is it doing now? Improved? Slipping? Well managed?
3. What are the prospects of improved results if extension and expansion are financed?

Considering the Minnesota Mental Health System as an enterprise for the care and treatment of patients, the **BOARD OF DIRECTORS** (Legislature) and the **STOCKHOLDERS** (Public) could seek the answer to these three questions in either of two ways:

1. By the general impression method.
   Accepting unsupported figures and reports or listening to promising allegations and prophecies from

persons connected with the system. Accepting hopes and wishes as if they were already accomplished results.

2. By analysis of actual facts.
   By studying the records and statistics of the enterprise **first as to reliability of the records themselves** then the past and present results.

   By analyzing what the records indicate as to probable future success.

This Committee presumed that the second method was the only means by which the Mental Health Program could be accurately evaluated and a responsible and reliable report prepared.

FIRST REQUIREMENTS FOR A STUDY OF THE MENTAL HEALTH PROGRAM

Proceeding along this line the Committee in its first meeting on July 20, 1951, as its first witness, asked Dr. Donald W. Hastings, Professor of Psychiatry at the University of Minnesota, to advise the Committee as to the essentials of a study of the Mental Health Program. He advised the Committee as follows: **"First, I would think is the possibility of orienting yourself as to WHAT IS IN THE MENTAL HOSPITALS—what kind of patients, what the prognosis is for these patients, the outlook for them, the most modern type of treatment, what is involved professionally in giving all of the newer types of therapy,** and what **can logically be expected from the point of view of recovery or non-recovery and anything that medical science knows how to do today.** In passing, I would just like to mention one point that I feel fairly strongly on—**that from time to time there have appeared in the papers,** statistics, which to my mind, are utterly fantastic with regard to what **one can expect by way of recovery."**

Proceeding along the line of Dr. Hasting's advice, the Committee, by letter dated December 10, 1951, asked the Division of Public Institutions for the following information:

> "Will you please prepare tabulations of the population of State Mental Hospitals starting with all patients in the hospital June 30, 1946, then listing by years the records since that date basing the statistics on the individual identity of the patient and giving for each year the admissions to the hospital:
>
> a. Voluntary.
>
> b. Court committed.
>
> c. Sex.
>
> d. Age by age groups as used in your own monthly tabulations.
>
> e. Diagnosis according to the American Psychiatric Association condensed classifications of mental

disorders with full data as to removal through discharge or death for each.

f. The data as to tenure on the books of the institution and in the institution.

The reports should be by hospital and should show the number of people by the above classifications who have been admitted more than once by number of admittances and the same for discharges."

The Division of Public Institutions advised the Committee that **most of the information requested was not in existence and never had been. The Committee insisted such information as was requested was as basic and vital as a complete and accurate set of books is to a business** and were assured an attempt would be made to answer some of the Committee's questions. Four months later after the appointment of Mr. Jarle Leirfallom as Acting Director of the Division of Public Institutions, it was discovered that only a few preliminary steps had been taken to assemble any of the information requested.

In April, 1952, Mr. Leirfallom advised the Committee—**"Your Committee has been trying to get information which is almost a complete void."** Mr. Leirfallom ordered his department to proceed as best they could. Questionnaires were sent to the various Mental Hospitals. In Dcember, 1952, some of the results of the questionnaires were tabulated and a small amount of the information requested was supplied to the Committee as "preliminary figures." **Inaccurate** and **subject to error as these first figures are, it must be realized that they are the first step toward an attempt to provide records which could become worthwhile if made accurate and thereafter kept up to date. These figures were gathered by means of clerical workers and patients at the various Mental Hospitals** checking the medical records and attempting to answer questionnaires sent out by the Division of Public Institutions. When it is realized that the **medical records were interpreted by untrained persons, that the medical records are not uniform as between hospitals, that some medical records are poor and incomplete,** it can be seen that the statistics resulting are **gross approximations.** They do, however, serve as the first gross approximations of **facts that should always be accurately and completely available.**

These "preliminary figure" statistics, as the best available approximation of **what kind of patients are in the Mental Hospitals,** are of value as examples of the kind of information that should be accurate and basic. They serve likewise to prove the serious deficiencies in reports that have from time to time been issued purporting to indicate results under the Mental Health System.

THE SERIOUS DEFICIENCIES OF THE PRESENT SYSTEM OF MENTAL HEALTH RECORDS AND STATISTICS ARE WELL ILLUSTRATED

As of June 30, 1951 there were in the Mental Hospitals 10,496 patients and **"on the books"** (in patients plus those on visits and provisional discharge) 12,161 patients.

The "preliminary figures" as of the same date cover 11,319 patients—close to neither figure.

No two hospitals followed the same pattern.

WHAT KIND OF PATIENTS OF WHAT GENERAL PROGNOSIS ARE IN THE MENTAL HOSPITALS?

The Committee took these **gross approximations** represented by the "preliminary figures" of the Division of Public Institutions because **inaccurate as they are** they still represent the only approximation available of what is in the hospitals and thus serve as an example of some of the **information which should be accurately available at all times.**

Dr. Donald W. Hastings, Head of the Department of Psychiatry, University of Minnesota, complied with the Committee's request for a general prognosis of the various diagnosis categories of mental patients.

The following four points must also be kept in mind if an indicative evaluation of the subsequent material is to be obtained:

1. The group deals with 11,319 patients presumably reporting all of the 10,496 patients in the seven institutions plus some of the 1,665 that were on the books of the institutions but not in the hospitals.
2. Most of these patients have been in the hospitals a number of years.
3. Many of these patients have already had every treatment known either before entering a State Hospital or since.
4. 43.1% of this group are reported as over 60 years of age.

A summary of a breakdown of the "preliminary figures" is included here to show that unless and until **accurate** and **reliable records** and **statistics are established** and our illustrative **laymen's breakdown** (made on the general advice of a psychiatrist) can be more precisely made from adequate records by qualified experts, the question **WHAT KIND OF PATIENTS OF WHAT GENERAL PROGNOSIS ARE IN THE MENTAL HOSPITALS** can not be accurately answered by anyone.

The detailed report of this section includes a breakdown of the total number of patients into the various diagnosis categories along with Dr. Hasting's prognosis for each diagnosis. (Available on request.)

1,289 patients constituting 11.3% of the total were reported in a miscellaneous group including victims impaired by infectious diseases etc. plus undiagnosed psychoses. Impossible to evaluate. An indication of poor and incomplete medical records.

From the breakdown we note the following indications:

1. With a good outlook for recovery, 11.9% or 1,357 patients.
2. With a fair outlook for recovery, 2.4% or 275 patients.
3. With a poor outlook for recovery, 47.9% or 5,428 patients.

These three groups are the patients most benefited by new psychiatric therapies but all three groups have little prospect of further benefit after two years treatment. Consequently even in these groups as found in State Mental Hospitals, the major portion in numbers are care and custody patients.

One obvious exception to the above statement is extremely significant and should be noted here. IF PEOPLE PLACED IN MENTAL HOSPITALS ARE NOT SUFFICIENTLY ILL SO AS TO BELONG IN MENTAL HOSPITALS (notwithstanding a diagnosis used to commit them) **THEN APPARENT RECOVERIES CAN BE ALLEGED BY RELEASING THESE PATIENTS.** See Section on Admissions and Screening.

Some important conclusion are inescapable:

1. No realistic staff ratio indicating a number of psychiatrists, psychiatric nurses or other specialists can be made until the type of patients involved are evaluated accurately.
2. Data to this extent, even if entirely accurate, would not be a basis of determining needed professional staff ratios until additional data as to how many of these patients have been mentally ill for several or more years is determined.
3. Staff ratios advanced as desirable by various groups cannot possibly be caused to be accurate by the statement they are for typical mental hospitals since different States have different policies as to who they will accept in mental hospitals and who they will keep.

"Preliminary figures" do not include and hence there exists no adequate estimate of such essential material as the following:

1. The yearly changes beginning in 1946 which were requested in order to indicate what the trends might be.
2. The "preliminary figures" include no information sufficiently based on the identity of the individual patient so as to show the number of patients in the hospitals the second, third, etc number of times.
3. Voluntary patients are not indicated in any categories reported.
4. Committed patients are not indicated in any categories reported.

5. Sex distribution of patients is not included.

6. Patient tenure in mental hospitals is in no way indicated.

This information should be a minimum requirement for an adequate record system and in addition the following information should, as a minimum requirement, be accurate and reliable:

1. Admission records and reports must be accurate as to diagnosis, status as to voluntary or committed, status as to first admission or readmission, not in just a particular hospital, but in the Mental Health System.

2. Discharge reports and records must be equally accurate, complete and reliable. The diagnoses of the dischargees and tenure in the hospital before discharge is essential.

3. Records should be available as to treatment of patients by various methods and the results as to improvement, discharge, further regression, etc. indicated.

4. Each patient's medical record should be required to include a diagnosis by the Mental Hospital Staff. All data and statistics should be on the basis of this hospital diagnosis. (At present in some cases the diagnosis used by the courts to commit is allowed to remain as the diagnosis of record even though not concurred in by the Hospital Staff. Obviously data based on such a record will be worse than none because it will misinform.)

Unless sound and accurate information appropriately defined is available, statements, publicity releases or alleged statistics relative to many phases of the Mental Health Program will be either unrealistic or actually misleading.

DIVISION REPORTS ON ADMISSIONS AND DISCHARGES FAIL TO CORRECTLY INFORM

For the last fiscal year reports of the Division as to hospital populations, admissions and discharges give apparent support to conclusions which may not be true. Considering admissions as receipts and discharges and deaths as disbursements, the records would indicate the following for seven Mental Hospitals: (Willmar data is irrelevant due to large number of alcoholics included in its reports.)

Total patients on hand in 7 institutions July 1, 1951	9,529
Total admissions for one year up to July 1, 1952	2,761
Total patients in 7 hospitals during the year	12,290

Less:		
Direct discharges	810	
Provisional discharges	1,559	
Deaths reported	900	
Total reported disbursements of patients	3,269	3,269
Based on these reports the total patients in hospitals at the end of the year would appear to be		9,021

BUT, THE POPULATION REPORTED BY THE DIVISION FOR JUNE 30, 1952 is 9,835 patients in these seven hospitals.

It is thus apparent that published reports, if not analyzed or explained, would lead the public and legislature to believe that the Mental Health Program was successful in regard to over 800 patients more than was the actual result. Such factors as "return from provisional discharge", "extension of provisional discharge" (counting the same patient as a discharge in two separate years), "gone on visit", "return from visit", etc. are not included or explained when statements of admissions and discharges were released.

We indicate by way of illustration some of the inadequacies of the present system of records used to collect admission and discharge figures:

1. **The increase in the number of discharges last year over previous years may be no indication of improved care or treatment.** Besides the fact that there is no breakdown of prior years discharge figures, the following factors, which are unrevealed, prevent accurate evaluation:

    a. Voluntary patient neurotic discharges are not indicated.

    b. Alcoholic patients are not segregated in the discharge report.

    c. Voluntary patients of any diagnosis are not indicated. (They can leave the hospital at pleasure, be classed as discharge, re-enter and be credited as admissions.)

    d. Patients who are on provisional discharge from previous years have frequently been listed as new discharges when the previous years discharge was extended.

    e. Of 810 direct discharges credited, 140 are listed as unknown relative as to whether the patients were voluntary or committed.

It would be perfectly possible under present methods to issue reports indicating a large number of discharges when in fact poor results were being accomplished. Please note this is not a statement that poor results are being accomplished. There are no adequate records to show whether or not the results are good or poor.

2. **The increase in voluntary patients in recent years may not be any indication that more psychotic patients are being rehabilitated or even treated.** There are inescapable indications that at least some of the increased voluntary admissions are either patients not primarily hospital type of cases or represent conditions which do not indicate either improved or poorer results. Some examples:

    a. Neurotics who could well be "out-patients" but enter the hospitals simply because it is more convenient when hospital charges are free or $10 per month.

    b. Alcoholics entering voluntarily for free treatment and perhaps to avoid jail confinement. It is well known that this group has increased considerably but the extent is not a matter of record. Success or failure in regard to alcoholics is irrelevant to evaluation of the question of psychotic patients.

    c. Readmissions of previously discharged patients voluntarily re-entering state hospitals. **Factors which tend to increase this admission figure but indicate neither success nor failure of the program** are improved food and care in mental hospitals, the policy of encouraging voluntary admissions, and ability of voluntary patients to leave at will as a discharge. A number of instances were encountered where patients returned voluntarily for a few months (usually the winter) being employed the balance of the year. There are no records to show the extent of such practices but it is obvious each person following this practice will average at least one admission and one discharge per year.

Probable needs for future building requirements and the type of buildings needed cannot be accurately estimated without establishing trends through the comparison of accurate and precisely comparable data for several succeeding years. This data must include the information requested by the Committee and must be based on uniform and adequate records.

Success or failure as to treatment of patients in the various Mental Hospitals cannot be indicated until all of the data requested is accurately kept. Until then the good hospitals (treatment-wise) can appear to have poor records and the poor hospitals can appear to have good records.

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VERY IMPORTANT AND VALUABLE STATISTICAL RESEARCH WILL BE IMPOSSIBLE UNTIL THERE IS A UNIFORM, ADEQUATE AND ACCURATE RECORD AND STATISTICAL SYSTEM

One of the most valuable features of a sound and adequate record and statistical system is its **immense importance to adequate research.** Obviously for this purpose inaccurate or misleading data would be worse than none. The Committee asked Dr. Donald W. Hastings to comment on its request for information which the Committee had made to the Division of Public Institutions as reported earlier. He wrote the Committee as follows:

> . . . "With regard to your second question relating to the importance of the data you requested in the letter of last December, it would seem to me that it is important that there be available at a central place data of this type. **It has obvious importance with regard to administrative planning, research, follow-up programs, and statistical trends. This whole question of the keeping of records in a form that makes them meaningful statistically and in a form that lends to accessibility for research purposes is such an important one that if I may I would like to suggest it might be made a project for special study by some group of experts.** I believe this would be a much sounder method of approaching a problem of this magnitude. As you may be aware, the American Psychiatric Association Mental Hospital Service came out recently (1952) with a new manual "Diagnostic and Statistical Manual of Mental Disorders" which involves rather major changes in the psychiatric nomenclature. Hence I believe this would be a rather appropriate time to review the current record system practices."
>
> Note: The bold face in the above quotation is the Committee's.

The Committee received considerable information as to the value of an adequate system of records and statistics but Dr. Hasting's reply is an excellent summary of the subject.

PRESENT CONDITIONS RELATIVE TO RECORDS AND STATISTICS IN THE MENTAL HEALTH SYSTEM

At present Division of Public Institution's statistics are based on reports from the Mental Hospitals with little machinery for checking or making uniform the manner of preparation and the content or accuracy of the hospital reports. There is very little control or supervision from the Division office. **Control or supervision would be very difficult unless uniform record forms and policies as to entries were to be established.**

The Division of Public Institution's Statistical Unit, as now constituted, had been in existence only a little over a year when in December, 1951, this Committee requested basic data as already described in this report. Since April, 1952, there have been three

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occupants of the position of unit statistician. The present statistician began duties in November, 1952 and appears to be doing as well as could be expected under very unsatisfactory circumstances. No criticism of this person's performance is in any way intended.

A medical records librarian has recently been added to the Division staff. Her authority and facilities for checking hospital records appears as limited as is the case of the statistician.

IBM tabulating equipment was rented as of July, 1952. This was the first mechanical tabulating equipment in the Division. Whether or not this equipment is correct or sufficient for the purposes of an adequate statistical system can only be determined after a satisfactory system of records and statistics is devised.

CONCLUSION AND COMMENT:

1. **Without an adequate and accurate record and statistical system it is difficult to conceive how any administration, even with the best professional advice, can accomplish what should be the basic objectives of a Mental Health Program.**

   a. Uniform and high standards for treatment of patients cannot be adequately maintained by inspection tours and other superficial observation, even if done by experts, any more than a business expert could determine operating efficiency of a business enterprise without adequate accounting records.

   b. Enforcement of division or legislative policies cannot be accomplished as to many vital factors such as, admissions, discharges, rights and privileges of patients, treatment policies for all patients, the use of professional staff and many other vital factors.

   c. Determination of the value by measured results of various treatments and therapies cannot be made without adequate records.

   d. Determination of the professional proficiency or the diligence of the staffs of the various institutions by record rather than salesmanship or superficial impressions.

2. **If the Minnesota Mental Health Program is to have an adequate and reliable system of records and statistics some factors are absolutely essential:**

   a. **Unvarying and thorough enforcement of a complete and specific set of rules** governing all phases of records and statistics.

   b. A system of records and statistics **appropriate to the needs of the Mental Health Program** which is **specifically designed** to accurately develop the necessary information.

   c. A divisional staff sufficient in number, authority and ability to operate and enforce the system.

d. Recognition by the Legislature and the administration that an **accounting system relative to the care, treatment and disposition of the patients, is at least as important as is accounting relative to expenditure of funds.**

3. **Some possible obstacles to the establishment and operation of a satisfactory record and statistics system must, if encountered, be overcome:**

    a. Such a system will restrict the autonomy and assumed power of various units limiting their ability to do as they please by evading division instructions.

    b. If there are deficiencies in some staffs they will be revealed by adequate records.

    c. A record and statistical system will increase the difficulty at various institutions of carrying out unnoticed "pet projects" or "special arrangements."

    d. Such a system will decidedly limit the possibility of any unit obtaining extra or favorable consideration by means of propaganda or "pseudo-statistics."

4. **Some desirable results may be expected if a good record and statistical system is installed and operated:**

    a. **The Legislature and the public will be able to evaluate the Mental Health Program more accurately.**

    b. **Patients and the public will be protected.**

    c. **Statistical research may very likely contribute to the prevention**, determination of the cause of, or the care for mental illness.

A gesture toward the installation of a record and statistical system or the adoption of a make-shift system would be misleading to the public and the legislature and would instill false confidence.

To expect the present operating divisional medical record and statistical staff to devise and install an adequate record and statistical system would be as unfair and unrealistic as to expect an operating accountant to devise and install a complete accounting system in a complicated enterprise.

Recommendation 35 of the Council of State Governments in its report "The Mental Health Programs of the Forty-Eight States" is —"This study has demonstrated the need for adequate and standardized general medical records and statistics in state hospitals for the mentally ill. **Record-keeping processes should be improved and standardized in order to have accurate and current information relative to patients and to the operation of mental health programs".**

RECOMMENDATIONS:

1. **The Legislature should require by legislation and otherwise that an adequate and appropriate system of records and**

statistics be devised, installed and operated throughout the entire Mental Health System.

All basic record forms including medical record forms and manner of their use should be required to be precisely uniform throughout all hospitals for the mentally ill.

Essential to such a record and statistic system would be a manual explicitly covering every phase of the installation and use of all basic records, defining the nature of each type of entry, the reports to the Division office and the handling of all records, data and statistics at both the Hospital and Division levels. The record system and statistical procedure should be so designed as to minimize the probability of conclusions and reports that would be likely to be misinterpreted by professional people, the public or the legislature.

Within the limits of reasonable expense the record and statistical system should include that material which would be most valuable for the purpose of statistical research.

2. **To devise and install an adequate system of records and statistics is a more difficult task than would be the installation of a good accounting system. The Legislature should require that competent expert assistance be retained for the purpose of devising such a system. Expert advice as to medical records and statistics should be required. Adequate funds should be provided for this purpose.**

   It is suggested that if the recommendation of this Committee as to creation of a "Medical Policy Directional Committee on Mental Health" is enacted by legislation, it might be well for the Director of Public Institutions to appoint as one of the members of that Committee a recognized expert in biometrics.

ADMISSIONS, SCREENING AND DISCHARGES

Other Sections of the report of this Committee, reports of the Legislative Research Committee and considerable additional information indicate that one of the principal problems of the Mental Health Program is to develop policies and procedure as to admissions, and discharges together with methods of screening to make them effective.

Screening as to admissions is needed to uniformly implement policies designed for three purposes; the admission of all persons in need of the care and treatment of a Mental Hospital; the protection from commitment of those not in need of such care and treatment; the protection of the mentally ill patients in State Hospitals from overcrowding and the dilution of the services of the available staff through admission of persons not in need of Mental Hospital care and treatment.

Screening is likewise needed as to discharges to implement on a uniform basis policies designed for three related purposes; the return to their home communities and to the civil rights lost on

commitment, such persons as need care but not that of a Mental Hospital; the return to society with liberty and civil rights all of those persons sufficiently improved or stable to adjust to society with perhaps some assistance; the concentration of the staff and facilities of the State Mental Hospitals upon the care and treatment of those patients sufficiently mentally ill to need such specialized services or custody.

PRESENT COMMITMENT PROCEDURE IS AN INTEGRAL PART OF THE PROBLEMS

In recent years, changes which appear to be decided improvements, have been made in some of the phases of commitment procedure in the State of Minnesota:

1. A petition for commitment of a person believed to be mentally ill is filed in the probate court of that person's residence or presence by any relative or reputable person.
2. The court then appoints two examiners, who must be licensed physicians, to advise the court as to the patient's mental condition.
3. The court, after notice to all interested parties, conducts a hearing.
4. The person believed to be mentally ill may retain counsel or the court may appoint counsel for those persons unable to pay the cost of their own counsel.
5. The court, after considering reports of the examiners and the testimony at the hearing, may determine that the person is mentally ill and commit that person to a Mental Hospital.

FAVORABLE FEATURES OF MINNESOTA COMMITMENT

1. No person is deprived of liberty and other civil rights without a legal hearing.
   The Probate Judges' Legislative Committee in a report prepared in 1951 points out the considerable value of such hearings:

   > "In prompt, informal hearings as conducted under the present law, it is very often found that the proceedings were instigated as a result of domestic troubles and quarrels. The disgruntled spouse may sincerely believe the other is psychotic probably being herself or himself likewise that way. Relatives with selfish designs are often balked and exposed at a court hearing. Proceedings without hearing might deprive the patient of his inalienable rights and such proceedings might be very dangerous and unjust."

2. The hearing is in the patient's community where witnesses and the patient's counsel are readily available.

3. Since 1947 the court can send the patient for observation to an available hospital before making a determination as to commitment.

4. Since 1947 restoration to civil rights and capacity is generally automatic one year after a patient leaves a mental hospital.

5. Hearings are generally prompt and quiet with no publicity given and the public not encouraged to attend.

6. The patient usually has benefit of counsel of his own selection or as provided by the court.

7. Voluntary admission to a State Mental Hospital is available to the patient.

UNFAVORABLE FEATURES CLAIMED AS TO MINNESOTA COMMITMENT PROCEDURE

1. **There are no uniform standards as to who should be committed.** The requirement is simply that the patient be found mentally ill and the procedure is not designed to carefully select mental patients:

   a. Commitments arise from 87 different probate courts throughout the State. (Hennepin and Ramsey County have court commissioners who function in this respect.)

   b. Commitment is made by a probate judge under the advice of two physicians. Most counties do not have available the services of a psychiatrist.

   c. **Psychiatric standards of diagnosis are not accurately followed at commitment.**

   d. **Many patients are committed to a mental hospital without a thorough physical examination to determine physical ailments, if any.** Dr. Hastings of the University of Minnesota told the Committee that the University considers a physical examination absolutely essential in diagnosis of mental illness.

2. Commitment by the court is final subject to subsequent discharge by a State Hospital superintendent.

3. **Patients are not sufficiently protected from commitment in case of an illness of short duration of a physical ailment or a mistake in diagnosis:**

   a. There is no general use of machinery for temporary commitment, diagnosis, medical examination and short term treatment before a permanent commitment takes effect. This is not true in every county. For instance, in Hennepin County over a period

of 10 years, persons named in 7,315 petitions were studied in a local hospital with the result that in 1,061 cases proceedings were dropped. In addition, of the 6,254 cases that did go to hearing, 404 were discharged.

These figures indicate the very considerable importance of hospital and medical attention to a person before the determination of commitment which leads to loss of liberty and civil rights.

b. **Many apparently mentally ill persons recover upon correction of a physical ailment or after a short period of medical care.**

4. Patient's rights are not required to be sufficiently protected. **Many of the courts appear to extend considerable more protection to the patient than they are actually required to do:**

   a. Notices of hearings as to mental illness, which are sent to "interested parties" often result in notices only to relatives who want the people committed or to local welfare workers.

   b. Immediate loss of civil rights and the patient's lack of any right to initiate discharge proceedings is too drastic.

   c. **The State of Wisconsin gives to each person** alleged to be mentally ill or to his relatives for him, **the right to demand a trial before a six person jury.**

   Where a jury trial is requested, the court is required to fix the date of trial in not less than 30 or more than 40 days from the request. The patient may, meanwhile, be detained for study and observation in a designated public institution.

   Further, a **patient already committed, may petition and require a jury trial,** provided that a jury trial cannot be required by a patient oftener than once a year. (Wisconsin departmental literature says this right is not often abused.)

5. At the present time persons with psychopathic personalities without psychoses can legally be committed to mental hospitals and be subject to discharge as improved mental patients. Dr. Ralph Rossen, in a letter dater May 24, 1952, addressed to Mr. Jarle Leirfallom, Acting Director of the Division of Public Institutions, pointed out that some persons of this type seek such a commitment to avoid a prison sentence or commitment as criminally insane.

6. **The superintendents and staff of the State Mental Hospitals are not held responsible for the review and diagnosis of a committed patient from the standpoint of the appropriateness or the need for the patient to be committed.**

The committed patient even though by a mistaken diagnosis, must be accepted and retained until discharged under the same procedure as a severely or long term mentally ill person.

7. **Wisconsin attempts to increase the protection and the rights of the patient by requiring the court to specifically find** that not only is the patient mentally affected but that he likewise **needs to be committed.**

IN MINNESOTA VOLUNTARY PATIENT ADMISSIONS ARE NOT IN ACCORD WITH ANY ESTABLISHED POLICY OR RULES

1. Voluntary patients are admitted subject to approval of the individual hospital superintendent.

2. There is no uniform State policy on who is admitted. **Last year the distribution between voluntary and committed patients admitted varied between hospitals to such a degree that it is apparent no policies exist.** The range is from 55.7% of all new patients being voluntary patients at Hastings to 15.4% at Moose Lake.

3. One result of no policy as to voluntary admissions is that **the administration has no real knowledge or control of what type of patients the superintendents admit,** whether they are mentally ill or not in a medical sense. The LRC pointed out a retired employee admitted as a voluntary patient for several months each year and thereby receiving board and room for $10 per month. The LRC reports he was diagnosed as senile. Excluding Willmar there were 756 voluntary admissions last year.

A NUMBER OF PATIENTS IN STATE MENTAL HOSPITALS DO NOT NEED PSYCHIATRIC TREATMENT AND COULD BE CARED FOR IN NURSING OR REST HOMES WHILE AT LEAST SOME COULD GET ALONG IN THEIR HOME COMMUNITIES WITH A LITTLE SUPERVISION OR HELP.

1. In October 1951 this Committee by questionnaire asked the superintendents of the eight State Mental Hospitals **how many of their senile patients in their opinion "are sufficiently stable to receive adequate custodial care under a family type program, a welfare home program or in a nursing or convalescing home."**

   Six superintendents representing hospitals with 7,080 patients sent in **replies** that a total of **440 of their senile patients met the qualifications of the question.**

   Two hospitals with 4,011 patients, not answering, but if 6.2% of their senile patients are rest home type would add 248 to the 440 of the other six hospitals.

Thus at least 600 to 700 patients are in State Mental Hospitals deprived of civil rights who could be free citizens subject to rest home care.

2. **The Committee received considerable evidence** from superintendents and doctors that patients whose relatives do not accept responsibility for assisting them were kept in Mental Hospitals because the local welfare boards refuse to accept responsibility to help them. **Note:** Recommendation of this Committee in another Section of this report requiring Welfare Boards to accept such responsibility.

THE PROBLEM OF ESTABLISHING UNIFORM SYSTEM-WIDE POLICIES OF ADMISSIONS HAS NOT BEEN MET IN MINNESOTA MENTAL HOSPITALS.

Minnesota policy of separate receiving units at each Mental Hospital has complicated establishment of a uniform policy of admissions due to dispersal of this function. Since 1945 the State has built four new receiving buildings at Anoka, Hastings, Rochester and Willmar costing a total of $3,415,730. Separate receiving units previously existed at Moose Lake, Fergus Falls and St. Peter.

No screening machinery exists to coordinate admissions from the 87 counties. For example, the Youth Conservation Commission, receiving commitments of delinquent youth from 87 counties, is a screening panel to establish uniform policies governing the admission or retention of delinquents in institutions.

Lack of a requirement for good and uniform medical records and the resulting lack of reliable statistics at Division level is an additional handicap to the establishment or enforcement of any policy.

MINNESOTA'S MENTAL HEALTH PROGRAM HAS NO ESTABLISHED POLICY OR SYSTEM TO DETERMINE WHO WILL BE DISCHARGED FROM STATE MENTAL HOSPITALS

1. The discharge of patients is theoretically by the Director of Public Institutions but in fact is determined by the superintendent of each hospital.

2. Hospital superintendents are reluctant to release patients where relatives do not request the release and accept responsibility for the patient.

3. **Minnesota has no machinery whereby a patient can initiate procedure looking to discharge. As already noted Wisconsin's right of jury trial rehearing enables a Wisconsin patient to initiate the question of his own discharge not oftener than once a year.**

CONCLUSIONS:

1. Present commitment procedure has failed to prevent many people from being unnecessarily committed to a Mental Hospital.
2. The loss of civil rights and liberty upon commitment is too severe and drastic to be brought about without study, observation and a thorough physical examination of the patient.
3. The present Mental Health Program is deficient as to machinery for insisting that counties retain or accept back persons who:

   Should not have been committed or,
   Those who have responded to physical care and medicine and apparently were not primarily mentally ill.
4. There is no machinery whereby a provisional commitment can be made providing Mental Hospital diagnosis, care and treatment of a patient on a short term basis before a final determination is made as to the need for long term confinement, and the attendant obstacles to the regaining of liberty and civil rights.

RECOMMENDATIONS:

1. **Each commitment of a person as mentally ill should be subject to the following conditions:**

   a. **The court should be required to find specifically that commitment is necessary either for the protection of the public or the welfare of the patient.**

   b. **Each commitment should be provisional until 60 days after the entry of the patient into a State Mental Hospital.**

   c. **Sixty days after a patient has entered a State Mental Hospital, the chief medical officer of the hospital should be required to file a certificate with the committing court and a copy with the Director of Public Institutions setting forth the condition of the patient, his diagnosis as determined at the Mental Hospital, a statement as to whether the patient, for his or society's protection, needs to be further confined in a Mental Hospital or does not need to be further confined in a Mental Hospital.**

   d. **Upon the completion of the certificate just described, the patient shall be:**

      (1) Returned to the jurisdiction of the committing court if the chief medical officer of the Mental Hospital has found the patient does not need to be further confined, or,

(2) Remain in a Mental Hospital under a commitment which becomes final unless the Chief Medical Officer of the Mental Hospital and the committing judge concur in writing to an extension to the provisional commitment. Not more than one extension of provisional commitment may be allowed.

e. Upon return of any patient to the committing court as not needing further confinement in a Mental Hospital, the civil rights of such patient so returned shall be immediately restored to precisely the extent that existed prior to the filing of the petition for commitment which resulted in the patient's commitment.

f. Except as herein provided, the patient while under provisional commitment, shall be in all other things, including relative and county responsibility, considered as if the commitment were final.

2. Legal safeguards to the rights of any patient under consideration for commitment or in a mental institution such as are found in statutes in the State of Wisconsin regarding the right of jury trial if requested, are commended to the attention of the Legislature as being worthy of study and consideration.

3. The Director of Public Institutions with the advice of such professional experts as the law may provide should establish a screening staff or panel of three or more qualified persons to supervise the policies of the various mental hospitals as to both the admission and discharge of patients, to examine the records of all patients admitted, to examine personally all patients who from the records appear to justify a reasonable doubt as to the need of commitment or the need of continued confinement in a mental hospital and to further examine all patients in each mental hospital first by record and second by examination of the patient in all instances where the examination of the record indicates reasonable doubt as to the patient's need to continue in a mental institution.

PSYCHIATRIC STAFFING PROBLEMS OF THE MENTAL HEALTH PROGRAM

Probably no phase of the Mental Health Program has been more generally confused or misunderstood than the subject of professional staff for Mental Hospitals. The American Psychiatric Association published standards of psychiatric staffing for Mental Hospitals which was last revised as of November 4, 1951. It has been difficult for casual observers to understand why these standards may not be particularly applicable to Minnesota's Mental Hospitals or why even if they are they may be unattainable at this time.

Considering these standards as at least an indication of desirable direction of progress we analyze initial factors involved.

THE PROSPECTS OF PSYCHIATRIC STAFFING ON THE AMERICAN PSYCHIATRIC ASSOCIATION LEVEL APPEAR REMOTE IN THE FORSEEABLE FUTURE

The State has been unable to secure psychiatrists for existing authorized positions. It has been necessary to use general physicians in some psychiatric positions.

Sufficient qualified psychiatrists do not exist in Minnesota to staff just the State Mental Hospitals to "recommended" standards. Dr. Hastings stated, "Certainly you could use up all the psychiatrists in Minnesota handling that group." The University of Minnesota and Mayo Clinic are turning out an average of only approximately six psychiatrists per year. Dr. Hastings estimated it would be 15 or 20 years at the least before there was any prospect of enough psychiatrists.

The shortage of psychiatrists is nationwide with equally poor prospects of early attainment of sufficient numbers. For the United States and Canada the American Board of Psychiatry in the last two years examined only 1,227 candidates and certified only 652 psychiatrists, 53 neurologists and 5 specialists in both fields. The shortage in Wisconsin Mental Hospitals is practically identical with the situation in Minnesota.

At this time the military situation further retards the development of more psychiatrists. Many young doctors are drawn into the service in lieu of preparing for all specialities of medicine. The Veterans Administration is absorbing a large number of psychiatrists.

The Minnesota State Mental Hospital System is not in a favorable position to compete for psychiatrists.

A stable and high quality administrative condition is necessary to attract top grade professional men.

Many State Mental Hospitals are too remote from medical centers to be served by part-time consultants engaged in private practice or to attract ambitious young specialists.

The chronic nature of a large proportion of State Mental Hospital patients does not offer a compelling professional appeal to many medical men. Many State patients are the residue left after all known treatments. Many other State patients were of a chronic or unpromising group treatment-wise when admitted to State Hospitals. It was pointed out to the Committee by a number of specialists consulted that the **high proportion of patients over 60 and in the chronic categories is a handicap in the recruiting of professional personnel.**

PSYCHIATRIC NURSES ARE IN SHORT SUPPLY

The supply of registered nurses is insufficient for all types of nursing in Minnesota. Many steps are being taken to improve psychiatric nursing. State Hospitals are stressing training of

nursing staff. Moose Lake, Fergus Falls, St. Peter and Rochester State Hospitals are conducting affiliate nurse training programs. Three months psychiatric training is now required in all registered nurses training programs including the University of Minnesota.

THE SHORTAGE OF PSYCHIATRISTS AND PSYCHIATRIC NURSES HAS NEVER BEEN ACCURATELY DETERMINED AND DOES NOT APPEAR TO BE AS GREAT AS IS SOMETIMES REPRESENTED

Not enough is known statistically about the patients in Minnesota State Mental Hospitals to allow precise evaluation of the need for staffing of psychiatrists or psychiatric nurses.

Published ratios of generalities for Mental Hospitals of necessity are only approximations for any specific hospital or State system.

Minnesota Mental Institutions contain many types of patient who need little or no psychiatric attention. (See Section on Records and Statistics.)

Until more accurate diagnostic analysis can be made not even experts can advise except in approximate terms.

THE STATE MENTAL HEALTH SYSTEM IS TAKING SOME STEPS AND PLANNING OTHER STEPS TOWARD ULTIMATE SOLUTION OF THE SHORTAGE OF PSYCHIATRIC STAFFING

Rochester State Hospital and Hastings State Hospital are now approved teaching institutions for one year residency toward training specialists in psychiatry for board examinations. Nursing in-service programs are being expanded.

Research is being pursued and is recommended for expansion to attract top grade professional graduate students.

Many prospective steps are planned to improve psychiatric staffing through increased collaboration with the Mayo Clinic and the University of Minnesota, expansion of research, and the qualifying of more State Hospitals as teaching institutions.

In addition, recommendations of this committee for administrative revision and improvement, are designed to free psychiatrists from administrative duties.

The recommendation and creation of the Medical Policy Directional Committee on Mental Health is intended to improve medical and psychiatric standards, treatment and research with the thought of attracting more professional personnel.

RECOMMENDATIONS:

1. **To continue and improve training and staffing measures now under way.**

2. **Adopt the prospective steps for improvement of staffing and training described herein particularly the establishment of the Medical Policy Directional Committee on Mental Health to conceive, propose and evaluate such measures.**

3. **The administration of the Mental Health Program and the State Department of Education should consult and study the possibility of using Federal funds under the Smith-Hughes Act to aid and develop a vocational training program at each Mental Hospital.**

A PROPOSED INTEGRATED TRAINING PROGRAM TO IMPROVE PSYCHIATRIC STAFFING

The committee discussed this subject a length with Dr. Donald W. Hastings, Head of the Department of Psychiatry, University of Minnesota, and Dr. Ralph Rossen, until May 1952, Commissioner and Acting Commissioner of Mental Health. The committee likewise requested Dr. Leslie Osborn, Director of Division of Mental Hygiene of the University of Wisconsin, to outline a similar integration, now being instituted in Wisconsin. Dr. David Boyd, Secretary of the American Board of Psychiatry and member of the Mayo Clinic staff also discussed this with subcommittees of this committee as in general did most of the expert scientists who are mentioned in the detailed report of the Section on Research.

The requirements of a program of training for graduate medical students working toward certification by the American Board of Psychiatry, must include several essential factors.

1. At least three years in residency in approved teaching institutions.

2. Experience with psychotic patients such as are found in the University psychiatric ward, psychiatric wards of general hospitals and in state mental hospitals.

3. Approximately one year training on out-patient patients predominately neurotics and less disturbed psychotic persons.

4. A short term of training with mentally deficient persons such as are found in state institutions for the mentally deficient and to some degree in out-patient practice.

5. Various other requirements which can only be met in Minnesota at the University of Minnesota or the Mayo Clinic.

COMMENT:

It can thus be seen that the state mental hospital system of Minnesota has not within itself all of the necessary attributes to a complete training course. The only large out-patient psychiatric clinics are now those of the University of Minnesota and

the Mayo Clinic. Potential out-patient clinics, which must be in conjunction with a complete general hospital facility, including laboratory and general medical facilities, are such clinics as St. Paul, Minneapolis and Duluth may some day afford in conjunction with their general hospitals.

On the other hand, the state can contribute to an integrated training program, the psychotic patients in the mental hospitals and the mentally deficient patients in Cambridge and Faribault.

A POSSIBLE PLAN OF INTEGRATION

Dr. Donald W. Hastings outlined to the committee an integrated program similar to the program being started in Wisconsin. Dr. Leslie Osborn, Director of Mental Hygiene of Wisconsin, sent the Committee a description of the Wisconsin program of psychiatric training. Under such a program the State would support a combined teaching and residency fellowship that would result in financial support to the trainee over a five-year period and result as follows to the state system:

1. One of the three years' training in an approved teaching institution would be in a qualified state hospital (Rochester and Hastings are now so qualified.)
2. Two of the three teaching years would be elsewhere (University of Minnesota or Mayo Clinic, etc.) at State expense.
3. The two additional years of residency experience would be at state hospitals. These last two years would not necessarily have to be at one of the qualified teaching hospitals.

Thus the State would receive three of the trainee's five years of service under this program.

RECOMMENDATION:

1. **The committee recommends that the Director of Public Institutions, or such person as subsequent legislation may designate to be in charge of mental hospitals, along with members of his staff as selected by him, (see note below) be authorized to work out with the University of Minnesota or the Mayo Clinic or both of them such an integrated program as outlined above to the extent of not more than 5 trainees each year to be started on the program.**

Note: Here again the Medical Policy Directional Committee of experts as recommended in the Section on Administration is an excellent medium for establishing liaison with the University of Minnesota and Mayo Clinic as well as for professional guidance on setting up such a plan.

PATIENT CARE STAFFING AT MENTAL HOSPITALS

By patient care we refer to the aides and various recreational and occupational therapists who do not give treatments but customarily have charge of patients either in the wards or while engaged in activities around the institution.

To some extent many of the employees at a mental hospital can be said to be indirectly involved in patient care due to the fact that many functions of the hospital such as farming, gardening, etc. are performed with the assistance of patients.

PSYCHIATRIC AIDES

Every superintendent interviewed expressed the sentiment that good psychiatric aides are the backbone of patient care. Under the supervision and charge of nurses and professional people these are the employees who supervise and operate the wards, assist the patients and administer to their routine needs. Prior to the recent innovation of considerable staffs of patient activity workers such as recreational therapists and occupational therapists, the aides conducted the bulk of the recreational and occupational programs in the hospitals.

Factors which are important in the Psychiatric Aide Program are:

1. In-service training is of vital importance in developing and maintaining a competent staff of aides:

   A two weeks' indoctrination training program for new aides appears to be general throughout the State system.

   Continuation in-service training from time to time has been conducted at some of the hospitals but has not been systematically pursued as a rule among the State hospitals.

2. Advancement incentive to aides is limited:
   After attaining the rank of Psychiatric Aide II further opportunities for advancement are practically non-existent.

   Several hospital superintendents expressed the belief that a third classification for aids should be established which would be attainable only by aides of considerable experience and exceptional proficiency in handling patients and who perhaps had taken additional training.

   Prior to the creation of recreational and occupational therapists some aides developed exceptional proficiency at conducting patient activities of a recreational-occupational nature.

   The superintendent of one State Hospital has recommended that aides of this type should be able to progress to a supervisory patient activity classification.

3. Every superintendent questioned stated that among his most desired improvements was an increase in the number of aides at his institution.

4. If recommendations of this committee designed to reduce the use of mental hospitals as custodial homes for the aged are adopted, the patient population in the hospitals should diminish and the present staff of aides would be adequate.

PATIENT ACTIVITY THERAPISTS

Therapists in this class are recreational, occupational and industrial therapists as distinguished from hydro-therapists, etc. who administer treatment to patients. The following table of data collected by the LRC is of interest.

COMPARISON OF PATIENT ACTIVITIES STAFFS TO HOSPITAL CAPACITY (1)

Hospitals	Staff Leg. Apprvl.	Staff Organ. Chart	Hospital Capacity	Ratio-Patient Activity Employee - Cap.	Rank
Anoka	19	21 (2)	1281	1: 61.0	1
Fergus Falls	19	19	2086	1: 109.8	5
Hastings	15	14	993	1: 70.9	2
Moose Lake	7	7	1258	1: 179.7	8
Rochester	12	12	1796	1: 149.7	7
St. Peter	17	18	2538	1: 141.0	6
Sandstone	4	5.5	458	1: 83.3	3
Willmar	18	17	1487	1: 87.5	4
Totals	111	113.5	11,897		
Average				1: 104.8	

(1) As of June 30, 1952.

(2) Includes one Psych. Aide I assigned to Patient activity work with tuberculous patients.

It can be seen from the above table that there is considerable variation between mental hospitals as to the ratio between personnel devoted to patient activities to total patients.

Factors which appear of consequence in considering the recreational and occupational therapists are:

1. The committee observed as did the LRC investigators, a considerable portion of recreational therapists' time was used conducting such patient activities as going for walks, teaching shuffle board, taking patients to the beauty parlor, conducting simple handicraft such as weaving of rag rugs, etc., which was formerly conducted by aides.

2. The table shows that Anoka has about three times more patient activity staff per patient than Moose Lake and two and one-half times more than Rochester, yet,

   LRC reports as active and well distributed a patient activities program at Moose Lake as at Anoka.

   A subcommittee of this committee observed, if anything, a better and more equitably distributed patient activity program at Rochester than at Anoka.

3. A large portion of the patient activities now conducted by recreational-occupational therapists could be taught or conducted by most aides.

4. The pay scale for aides is materially less than the pay scale for these activities workers, many of whom are college trained.

5. Some hospital superintendents, some aides and other institution officials indicated that adverse results have followed the expansion of the recreational and ocupational therapy programs as conducted:

   Aides resent these therapists being paid at a higher rate for performing functions which the aide could conduct just as well and formerly did.

   It was generally reported that many aides refused to be interested in promoting recreation in the wards on the ground that "this is no longer my job."

   The new therapists often were resentful toward those aides who did continue to promote ward recreational activities.

   Considerable evidence was found that many of the recreational and occupational therapists:

   (1) Frequently conducted programs in interference with patient work schedules such as kitchen, laundry, housekeeping, etc.

   (2) Took patients away from purposeful and useful tasks to engage in trivial recreation.

   (3) Conducted the bulk of their programs during normal "working hours" **leaving the patients to the aides and to boredom during normal leisure hours.** This system is convenient for the therapists who thereby have weekends and evenings off duty.

THE QUESTION OF EXPANSION OF THE AIDE AND RECREATIONAL AND OCCUPATIONAL THERAPISTS STAFFS

Each hospital superintendent interviewed was asked this question: "If you could have a limited number of additional employees at your institution, would they be recreational and occupational therapists or aides?" **Without exception the answer was aides.**

Dr. Magnus Peterson, who has in his institution next to the lowest number of patient activities workers per patient, stated in effect, that good activities workers, used to supervise and stimulate recreational programs conducted by the aides plus general programs are valuable, but that he had **sufficient patient activities workers until such time as he had a considerable increase in aides.**

One of the first chaplains to be added to the Mental Health System was emphatic in his belief that if the patient activities personnel were kept to such proportions as would be necessary to supervise activities carried on by the aides, and to train the aides in these procedures, then the patient's welfare would be considerably improved. **He stated that if the money, saved by this reduction in the number of activities workers, were spent for additional aides, the patients would be the benefited persons.**

RECOMMENDATIONS:

1. The number of authorized positions for recreational and occupational therapists for the State Mental Hospitals should be cut to a ratio no greater than that found at Moose Lake and Rochester where there is approximately one worker for each 150 patients or more. The cost of operation saved thereby should be expended to increase the number of aides throughout the Mental Hospital System. Note: This would reduce the patient activity workers by approximately 33 persons and because of lower salary scale would allow an increase of more than 33 aides.

2. Data gathered by the LRC points out that there is a considerable variation between hospitals in the number of non-patient care employees such as laundry workers, groundkeepers, etc. in relation to the number of patients. Improved use of the therapy of patient participation in institution operation (see Section on Patient Work) should result in a reduction of the number of non-patient care personnel for some hospitals. This saving could be distributed throughout the Mental Hospital System to finance employment of additional aides.

3. Recreational and Occupational therapists should be competent people whose duties should be confined to:

> **Conducting large group special activities requiring special proficiency.**
> **Conducting special therapies as art therapy and those few occupational therapies requiring considerable skill.**
> **Principal duties of most recreational and occupational therapists should be:**
>
> **a. Conceiving programs for the leisure not working hours of the patients.**
>
> **b. Training all aides to conduct these programs.**

PATIENT HELP IN INSTITUTION OPERATION

The assistance of patients in performing necessary tasks in the operation of Mental Hospitals is of material value in the economy of the institutions. Because of that fact some persons have assumed and proclaimed that patient work was evil and was "slave labor."

The following factors are perhaps worth noting:

1. It is easier administratively to operate a hospital with paid full time employees than with the assistance of patients.
2. More "non-patient care" employees and likewise more recreational therapists and occupational therapists are required if patients are prevented from performing useful work in the hospitals.
3. The LRC indicates that the average hours worked per week by those patients doing any work is only 23.26 hours. They state this is probably an overestimate.
4. Dr. Ralph Rossen, Dr. Donald Hastings and others advised this committee that doing useful work at an institution is one of the best therapies for many patients provided the work is done subject to the approval of the attending physician.
5. The value of patient work is well set forth by Reverend Roy E. Burt, Chaplain at Anoka State Hospital. He told a subcommittee—"I think the activity should not just be recreation, I think it ought to have very definite functional value and, I think, doing work around the institution. In the first place the purpose of the activity in my judgment is to help socialize the patient, to help to do things in cooperation with other people, and I think the work offers an opportunity to do something in that nature."
6. The effective use of patient participation in the operation of a Mental Hospital frees a larger portion of the total number of employees to be engaged in the "patient care" classifications such as aides and nurses. This results in better care and treatment for the patients.

RECOMMENDATIONS:

1. **The central administration should make a careful study of unnecessary use of operational employees at the various institutions.**
2. **Patient participation should be increased at those institutions which are not giving patients full benefit of the therapy of assisting in institutional operation.**

3. **In order that those institutions already making considerable use of patient help will not be penalized for doing a good job, the payroll liability of the operational employees made unnecessary by better use of patient help, should be pooled on a divisional basis and used to increase the number of aides, nurses, etc., at all hospitals according to need.**

RESEARCH IN THE MENTAL HEALTH PROGRAM

The subject of research was discussed by the Committee or by Subcommittees or by correspondence with a considerable number of qualified experts in many fields of medicine and science.

The Committee is indebted to these men for a considerable amount of valuable information and advice not only on the subject of research but on many other phases of mental illness.

PRESENT RESEARCH PROGRAM

The 1951 Session of the Legislature approved of the inclusion of research in the Mental Health Program by appropriating $50,000 for each year of the current biennium toward financing research. In addition considerable research is state supported at the University of Minnesota. Some research is being pursued at nearly every State Mental Hospital although the greatest amount is being carried on at Hastings and Rochester State Hospitals. Hastings State Hospital is, among other things, pursuing research on electroencephlography and virus effects. For some types of research, the Hastings State Hospital laboratory has excellent and adequate equipment. In the field of lobotomy the greatest amount of research is being carried out at Rochester State Hospital in collaboration with the Mayo Clinic. At Anoka State Hospital, Professor Darzins, formerly at the University of Riga, and considered by many to be the world's outstanding scientist in the field of tubercle bacilli, is engaged in research in connection with the tubercular unit of the State Mental Health System, which is located there.

MOST OF THE CAUSES OF MENTAL ILLNESS ARE NOT KNOWN

The Committee was advised by every authority consulted that the causes of mental illness, to a very considerable extent, are not known. This is best summarized by Dr. Maurice Visscher of the University of Minnesota, in a letter dated May 9, 1952: **"Our knowledge today as to the causes of mental disease is so deficient that it can rather fairly be compared with knowledge about infectious diseases before Pasteur's and Koch's discoveries. In the management of the psychoses the conventional and the dynamic psychiatric approaches have as yet yielded nothing of startling value. Shock therapy has not been proven to increase greatly long-term cures over the spontaneous cure rate according to recent studies. Psychosurgery is palliative but seems scarcely to offer promise, as at present conducted, of being a generally useful therapeutic procedure. In short we are at present not in possession of any satisfactory therapeutic tools. This is undoubtedly related to our comparable ignorance of the pathogenesis and pathophysiology of the major psychoses."**

ANY CONSIDERABLE FURTHER IMPROVEMENT IN THE TREATMENT AND PROSPECTS FOR MENTALLY ILL MUST AWAIT MORE KNOWLEDGE AS TO CAUSES

Mentally ill persons are now subject to treatment procedure which is not entirely understood by experts as to why in some instances improvement appears to result and in other instances no appreciable improvement is obtained.

There are few measures that are of established value toward the prevention of mental illness and yet prevention is the only means by which any medical problem can be said to be controlled and contained. Dr. Hastings best described this situation when he said, "The analogy of typhoid fever is a good one. You don't stop typhoid fever by curing people sick with typhoid fever. You can stop them from getting sick by regulating the water supply and the milk supply." He continued to the effect that until the causes of mental illness are established, measures aimed at prevention are primarily based on the opinion of those few experts who may be called on for advice.

RESEARCH OFFERS THE MOST LIKELY MEANS OF LEARNING THE CAUSES AND HENCE PREVENTION AND CURE OF MENTAL ILLNESS

It is notable that compared to other types of illness, the total amount of research that has been done on mental illness, is very small. Dr. David Boyd, Secretary American Board of Psychiatry and Member of the Mayo Clinic, expressed the opinion that the limited amount of research in the field of psychiatry is due to the fact that this "specialty of medicine" is so new and the number of psychiatrists is so small that research has been neglected.

MENTAL HEALTH RESEARCH SHOULD BE PURSUED IN MANY FIELDS

There is no way of knowing in what field or fields of medicine causes of mental illness may ultimately, if ever, be found. In general all experts consulted agreed with Dr. Maurice Visscher, when he outlined the fields in which he considered research is likely to be most fruitful. "I would advocate the setting up of a committee of experts including not only a psychiatrist, a neurologist, a psychologist, but a physiologist, biochemist, internist, pediatrician, pharmacologist, and pathologist, drawn either from within or without the State of Minnesota, selected with a view to obtaining the most creative scientists in these fields."

RESEARCH IS COSTLY AND UNCERTAIN AS TO RESULTS

Dr. Hastings advised the Committee, "that subsidizing basic research is playing the same kind of game as betting on the horses. You will spend 90% of your money and have nothing to show for

it—that's immediately utilizable or practicable." He explained that apparently unusuable results of research from many sources when assembled may "finally develop a pattern that is pliable and utilizable treatment wise." All experts consulted agree that there is no measure of a specific amount needed for research.

THE STATE SHOULD PARTICIPATE IN RESEARCH

The risk of research is considerable. The benefits of a given project may relate to many phases of human welfare.

The state mental hospitals contain the only numerous groups of psychotic persons in the State—as Dr. A. B. Baker told the Committee by letter, "There is, however, a definite place where the state institutions can play an important role and that is particularly in those phases of medical research which involve that type of material which is available only in the state institutions."

FINANCING OF RESEARCH SHOULD BE BOTH PUBLIC AND PRIVATE

The State may appropriate public funds and promote research through grants to private research projects for public use, through the University of Minnesota Research Program, and through the Mental Health Program.

Funds from private and voluntary contribution sources should also be available:

1. Grants by foundations such as Rockefeller, by bequests of individuals and other endowed agencies.
2. Voluntary contribution organizations such as are encountered in other fields of medicine. Notable instances are the Tuberculosis Association, National Foundation for Infantile Paralysis, various Cancer Foundations, Heart Foundations, etc. It would appear that voluntary contributions as a means of financing research in the Mental Health field have been neglected.

PROVISIONS SHOULD BE MADE FOR INTEGRATION AND GUIDANCE OF RESEARCH

Since research in all fields of medicine may relate to mental health, guidance of research pursued under the Mental Health Program should be by a Committee of experts representing the various fields of medicine and related sciences rather than one specialist in any field. The advantages of such a Committee acting as a single coordinating authority on research are many.

1. Research allocations should be approved only where appropriate facilities for the individual project are available.

2. Unnecessary duplication of expensive equipment should be avoided.

3. The necessary advice and skills of experts in all fields of medicine and related sciences should be available to the staff primarily engaged in any research project.

4. Proposed projects should be evaluated by outstanding scientists in accordance with total funds available.

5. Research should be channeled into all fields of medicine for projects which may relate to mental health.

6. All projects should be under guidance and control of trained scientists appropriate to each project.

CONCLUSION:

The requirements of this section can be met only if the patient material and the staff of state institutions are closely coordinated with the expert personnel and research programs of the University of Minnesota and the Mayo Clinic. Every expert consulted concurred in this conclusion.

It is in the best interests of research of the entire Mental Health Program that the greatest possible participation in research by members of the professional staff of all state institutions be encouraged under competent coordinating authority.

RECOMMENDATIONS:

1. **All research funds should be appropriated to the Director of Public Institutions to be allocated in accordance with advice and direction of an advisory committee, which should be made up of expert representatives of major fields of medicine and related sciences. Mental Health Research funds should not be solely confined to any single specialty of medicine until the causes of mental illness are found to lie in a single or limited number of fields. If a Director's Medical Advisory Committee, as recommended under the Administrative Section of this report, is established, that Committee should be the Research Advisory Committee, otherwise a separate Research Committee constituted as is recommended for the Administrative Medical Advisory Committee, should be established.**

2. **Provision for a State Research Fund should include proper legal authority to accept contributions from individuals or organizations to be allocated and controlled along the lines similar to public funds.**

3. **For the next biennium a research fund should be appropriated by the Legislature to provide:**

a. $75,000 for the first year of the biennium, and,

b. $100,000 for the second year of the biennium.

Note: These amounts are recommended because the Committee was advised they are close to the amounts the Committee's advisors estimated can well be used during the first two years of the establishment of such a program.

4. Individuals and organizations interested in Mental Health are urged to accept the responsibility of raising and contributing funds toward Mental Health Research as volunteer organizations in other fields of health now do in respect to those fields.

PROGRAM FOR MENTALLY DEFICIENT AND EPILEPTICS

INTRODUCTION

Minnesota's institutional population of mentally deficient and epileptics is approximately 3,200 at Minnesota School and Colony at Faribault, nearly 400 at Owatonna State School, 1,100 at Cambridge State School and Hospital, of whom approximately 900 are mentally deficient as well as epileptic, and 120 at Shakopee and Sauk Centre with 42 in Sandstone Mental Hospital.

CONDITIONS SURROUNDING PRESENT INSTITUTION POPULATION

Mentally deficient patients in all State facilities are receiving very good care. Institutional housekeeping is very good; morale and attitude of employees appear excellent; patient morale appeared surprisingly good. Both Faribault and Cambridge Institutions appeared to be making excellent use of patient participation in institutional operation which is considered very good therapy.

Since 1942 Minnesota has increased its patient capacity for Mentally Deficient and Epileptic persons by 1,342 bed capacity while the number of patients has increased by 1,127 persons. Total present bed capacity 4,850 and total patients 4,779.

Housing of patients is improved although there is some overcrowding at Faribault and Cambridge if judged in accordance with theoretical standards. This condition is at least partly remediable with present facilities and by proper administrative measures.

The extent of the overcrowding such as exists consists of extra beds in dormitories although all beds observed are still accessible to attendants through passable aisles.

No instances were discovered at either institution wherein any ward failed to maintain sitting room or recreational areas. **At Faribault** in some wards, extra beds were put up at night in day room space and taken away each day.

At the same time new wards and new buildings were not filled even to theoretical recommended capacity. When new buildings are filled to theoretical capacity they will still have considerable room

for additional patients without serious overcrowding from a practical patient comfort standpoint.

New buildings containing duplicate medical rooms, extra recreation rooms, etc., could accommodate considerably more patients before even approaching the extent of crowding in old buildings.

At Faribault there are 24 separate dining rooms. Approximately 2,500 of the 3,200 patients are ambulatory so that using fewer dining rooms—some on a two shift meal basis—would release considerable space for other use.

Some wards at Faribault were considerably more crowded than others which could be remedied. Some wards populated with predominantely helpless patients included recreational space that was more than ample for the few patients able to use such space.

RECOMMENDATIONS:

The Committee recommends that at Faribault there should be better distribution of patients within present facilities. It appears an injustice to some patients to house them in overcrowded wards while extensive new facilities are kept less than theoretically full and far less than for practical purposes would be adequate and comfortable. This is an administrative responsibility.

There are also possibilities of reducing overcrowding with present facilities at Cambridge. For years Cambridge has requested a new medical-surgical infirmary hospital. This would release the present infirmary of 55 bed capacity with isolation rooms, etc. The space released would accommodate considerably more than 55 beds on a patient living basis. If second floor dormitories are deemed overcrowded from a realistic patient welfare basis, parts of the first floor, now entirely devoted to day rooms, could be used for dormitory space leaving the balance of the first floor and basement for recreational and day room space. Each cottage has a separate dining room for approximately 100 patients. Consolidating dining rooms and using some space for other purposes, if necessary, holds possibilities. **Other facilities at Cambridge** consist of an excellent auditorium with 800 patient seating capacity as contrasted with an old non-fire resistant 300 seating capacity auditorium at Faribault. Buildings **at Cambridge** are relatively new and modern, the oldest building having been built in 1919. **At Faribault** the buildings range in age back to the 1880's. There is ample nurses' dormitory accommodation at Cambridge provided in a new building.

LIST OF MENTALLY RETARDED AND EPILEPTICS WAITING FOR ADMISSION TO STATE INSTITUTIONS

The waiting list is supposed to consist of mentally deficient and epileptic persons committed by the courts and under the supervision of local County Welfare Boards until needed institutionalization is actually provided. The list is not supposed to include those committed and not in need of institutionalization. This waiting list

has been a focal point of discussion at the Legislature in recent years. It has grown and shrunk and has been used in attempts to prove various contentions.

The committee started with a waiting list of 799 persons as of March, 1951 and found that new provisions for 460 patients have been provided since that date, yet the list remained 474 as of July 15, 1952.

The Committee checked with County Welfare Boards and discovered the waiting list exceeded county board records of "the number, if any, for whom admission to an institution is desirable but not now available." **The Committee discovered that administrative policies of the Department of Public Institutions were of a nature that would tend to inflate the list.**

THE COMMITTEE FOUND:

> A realistic approximation could be said to be that as of October 31, 1952, there were approximately 250 mentally deficient in need of immediate institutionalization plus approximately 50 additional with epilepsy in need of immediate institutionalization.

The Legislative Research Committee reported that as of June 30, 1952, there were 688 available beds in the various mental hospitals of the State.

RECOMMENDATIONS:

1. **Sandstone State Hospital, which has a capacity of nearly 500 beds, including approximately 40 mentally deficient, should be vacated as to mentally ill persons and be converted on a temporary basis to the use of mentally deficient. This would make available approximately 450 beds for mentally deficient.**

2. **All mentally deficient that have been committed and are in need of institutionalization should be admitted as soon as the mentally ill can be transferred from Sandstone to other mental hospitals.**

3. **The Department of Public Institutions and the Legislature, if necessary, should take steps to obtain more uniformly satisfactory supervision of mentally deficient in the local communities by the various County Welfare Boards so that the standards of supervision in all counties be increased to a level comparable to that obtained in those counties providing good supervision of mentally deficient.**

4. **The State should construct additional bed capacity for mentally deficient to the extent of 400 beds.**

5. **All committed mentally retarded in need of institutionalization should be admitted and no waiting list permitted to again develop.**

BUILDING NEEDS OF THE PROGRAM FOR MENTALLY DEFICIENT AND EPILEPTICS

For the purpose of this report, building needs for mentally deficient and epileptics are considered to be, necessary repairs, replacements or rehabilitation for the institutions at Faribault and Cambridge plus the construction of facilities to provide for 400 additional patients as recommended herein.

At Faribault and Cambridge the superintendents have outlined their recommendations for additions, repairs, replacements or rebuilding. Some needs are urgent, some highly desirable, and some subject to careful analysis as to desirability.

AT FARIBAULT—The institution is spread over a considerable tract of ground. Future additions or replacements should be so located as to consolidate rather than disperse the institution in the interest of efficiency and economy of operation. The superintendent requests repairs and replacements for the institution as now populated as follows:

1. Replacement or rebuilding of present administration building, which includes replacing inadequate auditorium, housing for 200 patients, employee housing and service facilities, which the Department of Administration estimated to the Committee would cost approximately $2,732,000.
2. Replace old boilers, increase generating capacity, provide a new well required by the Board of Health and miscellaneous additions, estimated by the Department of Administration to cost $603,000.

Thus the superintendent requests repairs and replacements to improve facilities for the 3,200 patients at Faribault totaling approximately $3,335,000.

AT CAMBRIDGE—The superintendent listed repairs, replacements and additions now necessary as follows:

1. A medical-surgical and infirmary hospital which has been requested for years to replace present 55 bed infirmary. The Department of Administration estimates the cost at $1,000,000.
2. Miscellaneous other repairs, improvements and an increase in staff residence, including small expenditures to comply with the request of the State Fire Marshal and Board of Health, totaling $264,000.

These are the needs given by the superintendent and estimated by the Department of Administration, for the institution as now populated, to cost $1,264,000.

The foregoing estimated costs of improving Faribault and Cambridge as they now stand do not include provision for the 400 additional bed capacity herein recommended. **The Commissioner of Administration estimates the provision for 400 additional bed capacity at these institutions, including necessary alterations or additions to present facilities, as follows:**

1. At Faribault the estimate is $2,038,000.
2. At Cambridge the estimate is $2,227,000.

Note: The Committee questions the cost of enlarging the power plant at Cambridge given as $280,000 in view of the availability of REA standby power available in consideration of a minimum purchase of $62.50 per month of electrical current.

ENLARGEMENT OF FARIBAULT OR CAMBRIDGE VERSUS A NEW INSTITUTION FOR MENTALLY DEFICIENT

The Legislature has approved by specific action the proposal for a new institution for mentally retarded to be located in Northern Minnesota. The question of site has been controversial. The 1951 session referred this problem to the Executive Council which was directed to acquire land and proceed with plans.

Under this authority the Executive Council has recommended that the new institution be located at Brainerd, Minnesota.

A new institution for mentally retarded in the northern part of the State recognizes the distance factor in visiting patients by relatives.

While the Governor's Advisory Council on Mental Health indicates a new institution should be near a medical center, there is evidence to show that custodial patients are not especially dependent on specialized medical treatment.

A new institution would cost over $4,302,000 before the first bed would be ready for use. (Estimated cost by Department of Administration) A new institution would lack many important facilities such as auditorium, class rooms, farm, farm buildings, etc. unless these were added at additional cost of approximately $450,000. While the Committee is inclined to recommend enlargement of Faribault rather than a new institution, they believe that the advisability of enlarging Cambridge State School and Hospital is so much greater that for practical purposes the question of Faribault versus a new institution does not arise.

Factors that determine the recommendation that Cambridge State School and Hospital be enlarged are numerous:

1. It would cost over $2,450,000 more to provide adequate facilities and 400 beds at a new institution than it would cost to add 400 bed capacity to Cambridge.
2. The saving of over $2,450,000 would go a long way toward improving the welfare of all mentally deficient institution populations in the State through improvement of both Faribault and Cambridge.
3. Considerable delay required to build a new institution would be avoided.
4. Construction of duplicate facilities would be avoided.

5. The duplication of non-patient care personnel required to operate a new institution would be avoided allowing more patient care personnel.

6. Cambridge, being over 90 miles north of Faribault, would better serve the northern part of the State.

7. Cambridge State School and Hospital was originally intended to be at least a 1,500 patient population institution.

8. The available employee supply for aides and other patient care personnel appears very favorable at Cambridge.

9. The Committee is informed there is no medical or administrative reason why mentally deficient patients without epilepsy should not be housed in the same institution with mentally deficient patients with epilepsy as is done in many States.

RECOMMENDATIONS:

1. **It is recommended that new buildings be constructed at Cambridge State School and Hospital with 400 patient housing facilities. If the 400 beds are added to Cambridge, a medical-surgical hospital and infirmary should be constructed, as has long been requested.**

2. **The Committee further recommends that at least a substantial portion of the saving in capital outlay, due to enlarging Cambridge rather than building a new institution, be devoted to some of the more necessary improvements at both Cambridge and Faribault so that the final result will be betterment of facilities for all of the 4,700 patients that will be in the two institutions.**

PROBABLE FUTURE NEEDS OF THE MENTALLY RETARDED PROGRAM

The number of mentally deficient needing institutional care appears to be increasing at the rate of approximately 100 per year, that is, new commitments needing institutionalization exceed deaths and discharges at the rate of approximately 100 per year.

Factors which contribute to this needed increase in institution capacity are:

1. Improvement in institution care and medicine is decreasing the death rate in institutions.

2. The same factors encourage parents to have children committed.

3. Modern practice of living in smaller quarters encourages institutionalization of mentally deficient.

Factors which may offset this tendency to at least a partial degree are:

1. Adoption of more equitable rates of charge to counties or relatives will have at least some tendency to reduce the demand for institutionalization. Present rates of $40 per year per patient were adopted in 1885 and have never been increased. The effect of higher rates cannot be forecast until the rates are established and experience is accorded under new rates.

2. Legislation enacted at the 1951 session designed to further training of severely retarded in the public schools it is hoped will reduce the need for institutionalization for a portion of the severely retarded.

3. Development of the training school at Owatonna for retarded children of less retardation than those called severely retarded and an expansion of public school training of the same type of retarded children is a material factor in reducing the need for institutionalization.

While the trend of an increasing number of mentally deficient in need of institutionalization appears marked as to the near future, the variables herein outlined indicate that it would be unwise to attempt to rigidly chart increasing needs for an extended period into the future.

Factors and facilities required to meet likely future needs are illustrated:

1. Adding 1000 bed capacity to Cambridge would cost approximately $6,630,000. (This includes the 400 beds recommended for immediate addition.)

2. Adding 2000 bed capacity to Cambridge would cost approximately $12,178,000.

3. To build a separate institution of 2000 bed capacity would cost approximately $16,239,000 plus cost of site.

4. A new institution would duplicate operating expenses and non-patient care personnel.

5. A new institution would duplicate facilities such as auditoriums, storage and inventory facilities and service facilities.

6. If enlarged by 2000 additional bed capacity Cambridge would still be only a 3100 patient institution.

RECOMMENDATIONS:

1. **The Legislature should adopt a definite program for expansion of facilities for the mentally retarded. After pro-**

viding for the present waiting list, there will still be the problem of taking care of approximately 700 additional mentally deficient persons in the next 5 years; which now appears to be a likely estimate of the increase in number of mentally deficient patients of approximately 100 per year, plus provision for the 160 patients now provided for temporarily at Sauk Centre, Sandstone and Shakopee.

2. **Each Session of the Legislature should re-evaluate the need for institutionalization and provide such additional facilities as experience will demonstrate are necessary. Comment: If the recommendations heretofore listed relative to admission of those on the present waiting list and more accurate and realistic determination of such waiting list, as may occur, is followed in the future, a more reliable basis for determining exact need for additional facilities will result.**

3. **Charges for care of mentally deficient persons should be revised by the Legislature as will be pointed out further in the section dealing with charges for institutional care.**

TRAINING OF SEVERELY RETARDED CHILDREN IN THE PUBLIC SCHOOLS

What is meant by trainable severely retarded is best defined by the Bulletin No. 11 of the Federal Security Agency, Office of Education, entitled "The Forward Look, The Severely Retarded Child Goes to School." This definition is "those who can achieve a limited degree of personal social adjustment under sheltered conditions."

This problem involves children too retarded for traditional type of school work but seeks to train a severely retarded child with the following objectives: Adequate habits of personal behavior, efficient communicative skills (speech), useful physical coordinations, acceptable habits of work, adjustments to social situations (rights of others and cooperation with others), willingness to follow direction of others.

Minnesota Legislation provides:

1. Increased special school aid per child in training classes, $150 per child increased to $240 per child. M.S.A. 128.13.
2. Increased transportation aid per child in such classes to $160 per child, M.S.A. 128.07.

Minnesota Legislation provides that the Department of Education shall set standards of:

1. Size of permissible classes:
   a. The Department of Education requires class size of not less than 5 and not more than 8 children per teacher.

b. The Federal Bulletin recommends flexible class of 10 to 15 children as best size. Reason given—it is not good to have too small classes as social adjustment to others is a big objective of training.

c. The Department of Education has established a number of other requirements pertaining to class room adequacy, special equipment, length of school day, etc.

2. The Department of Education may require specified qualifications for teachers permitted.

a. Minnesota Department of Education requires specialized training of teachers plus other qualifications.

b. Federal Security Agency recommends:

(1) Educational institutions have not had an opportunity to establish specialized training classes, hence the requirement of specialized training limits the field to an unrealistic degree.

(2) The program should be started with best available teachers. The expansion of the field will lead educational institutions to establish training.

(3) Three school districts in Minnesota qualified for State Aid for severely retarded classes in the school year 1951-52. They are Minneapolis, Pipestone and South St. Paul.

For the school year 1952-53 four school districts are conducting classes for severely retarded and will get State Aid if they meet the Department of Education requirements.

Minnesota Legislation establishes training of severely retarded and other handicapped children as a separate function of public schools.

1. Federal Security Agency, Office of Education, recommends classes for severely retarded should be integrated with the program for educable retarded as some children should be transferred from one type of class to another.

2. Federal Security Agency, Office of Education, recommends that the school program should be integrated with the other public agencies such as recreation departments, etc. and private agencies such as Scout groups and agencies for parents.

3. Public School training of severely retarded should be integrated with sheltered work agencies such as Goodwill Industries, Vocational Rehabilitation Agencies, etc. to assist the trained severely retarded to remain in his home community.

GENERAL COMMENT:

The Federal Security Agency, Office of Education, throughout Bulletin No. 11 makes the following points:

1. Training severely retarded has valuable possibilities for diminishing the number needing institutional care.
2. Development of this field is in the pioneering and experimental stage and should not be hampered by rigid patterns which may be unrealistic and retard adaptation to the needs of the community.
3. Training severely retarded by its nature must be a local function, as the object is the retention of the retarded child in the community.
4. Slow steady progress as experience develops will be of more lasting value than excessive experimentation along unsound lines.

RECOMMENDATIONS:

1. **Legislation, relative to training severely retarded, should be strengthened and amended to further integration of these training classes into local programs for all retarded children and to facilitate coordination with other local agencies.**
2. **The Department of Education should be directed to waive flexible requirements as to class size and required teachers' training until further experience and establishment of appropriate teachers' training courses has indicated more rigid requirements.**

CHARGES TO PATIENTS, RESPONSIBLE RELATIVES OR TO COUNTIES FOR COSTS OF CARE OF PATIENTS IN STATE MENTAL HOSPITALS

When we approach the subjects of admissions and charges we encounter an area of confusing inconsistency.

Many professional and lay persons interested in Mental Health tell us the **modern philosophy of Mental Health is**:

1. It is essential that mental illness be recognized to be as truly a form of illness as are physical ailments.
2. The stigma of insanity being "different" must be broken down and the subject of Mental Health approached and handled with the same attitude as any other phase of health.

However, when we come to the subject of payment and relative and local government responsibility, we encounter from some of the same persons, an attitude to the effect that admissions, basis of

payment, patient and relative responsibility must be different than would be the case if the illness were tuberculosis or any other physical ailment. We are urged that everything must be free or nearly so. (Free means at State Expense.)

Perhaps the following factors, each to some degree, have contributed to this inconsistency:

1. Perhaps in the minds of many, unconsciously the old time attitude of "take care of 'em" by minimum standard custody still lingers, even though treatment and rehabilitation are the objectives today.
2. Perhaps many still feel there is a stigma to mental illness and it is "different".
3. Perhaps few realize the considerable factor of physical medicine in modern care and treatment of the mentally ill.

The Legislature has very definitely adhered to the modern philosophy of Mental Health for many years. This is proved by the millions appropriated for new buildings at mental hospitals and by the steadily increasing appropriations for operating expenses that have made possible the very considerable increases in personnel and standards of care and treatment.

NEWLY ADMITTED PATIENTS WHILE IN RECEIVING UNITS

Comparative examples are based on the following factors:

1. The University of Minnesota Hospitals are a State supported medical agency including every variety of ailment from physical to psychiatric.
2. University of Minnesota Hospitals admit only patients referred by a private physician. "This rule avoids the criticism that the hospitals or its clinics are taking patients away from private practitioners."
3. The psychiatric section of the University of Minnesota Hospitals **is a receiving unit** for diagnosis and intensive treatment of mental patients.
4. **The new Receiving Units attached to the various State Mental Hospitals are identical in purpose patient-wise with the University of Minnesota Psychiatric Unit,** i. e., they are for the diagnosis and intensive treatment of mental patients. These units have all been built within the last few years at costs ranging from approximately $10,000 per bed to $20,000 per bed except St. Peter receiving unit, which is adequate, but was completed in 1937 at considerably less cost per bed.
5. State mental hospitals receive patients entirely by medical referral:

a. Directly by local physician as volunteer patients.

b. Indirectly by commitment on advice of at least two physicians.

Note: Reference in this section is covered in "Bulletin University of Minnesota Hospitals and Minnesota Medical Foundation Hospitals report 1950-1951" from University of Minnesota Hospitals "Rates and Charges" July 1, 1951. For a complete and detailed description of present State Institution charges and policies herein mentioned and for data on similar charges and policies of other states, see LRC report issued pursuant to proposal No. 47 (1951 Session) entitled "Relative Responsibility for Costs of Care in State Institutions."

COMPARING UNIVERSITY OF MINNESOTA HOSPITALS PHYSICAL MEDICAL CHARGES WITH PRESENT STATE RECEIVING UNIT CHARGES

1. **Indigent Patient**—(unable to pay as much as hospital expense, if anything)

    a. University of Minnesota—**County Board must certify responsibility for county share of charges:** University of Minnesota daily charge rate is $12.50 per day plus a schedule of charges for clinic and hospital costs (such items as x-ray, laboratory, drugs and materials.) The county responsible for the patient pays $6.25 per day plus one-half of the clinic and hospital costs.

    b. State Receiving Units:

        (1) Voluntary patients—(no certification of responsibility by local authorities, no investigation before admission by any agency except hospital and only referring doctor's statement of opinion that patient is unable to pay entire cost of care and treatment.) **State pays entire cost of all items, County never liable for anything.** Patient, if of some means and so determined to be able to pay something, is subject to not over $10 per month if he has a spouse or other dependent.

        (2) Committed Patients—County pays a total of $10 per month to cover board, room, nursing, clinic and hospital costs and professional services.

2. **Per Diem Patient**—(able to pay for services of hospital but not also private physician)

    a. **University of Minnesota**—(County pays nothing). Patient's physician fills out forms assuring ability

to pay—investigation of patient's resources by Hospital Social Service Department.
Patient or relative pays full charge rate of $12.50 per day plus all clinic and hospital costs.

b. **State Receiving Units**—Patients either voluntary or committed who or whose relatives can pay $10 per month but not entire cost of hospital and treatment. **County** pays nothing. **Patient** or relatives pay $10 per month. **State** pays entire balance of cost of board, room, nursing plus clinic and hospital costs plus professional service of staff.

Note: Even if the patient is wealthy or if the relatives are well to do the maximum charge is $10 per month to the patient if the patient has a dependent (spouse, minor or defective child.)

3. **"Full Pay" Patient**—(University of Minnesota classification "Private Patient")

   a. **University of Minnesota**—(referred by physician but able to pay everything). Board, room and nursing **patient** pays $14 per day. Clinic and hospital costs **patient** pays all. Professional services of staff **patient** pays all doctor fees.

   b. **State Receiving Units**—Board, room and nursing plus clinic and hospital costs plus professional service, **patient with dependent** pays $10 per month. **Patient without dependent** pays $39.38 per month. (Average 7 hospitals.) **State** pays balance of cost.

THE UNIVERSITY OF MINNESOTA PSYCHIATRIC SECTION CHARGES

Mental patients are the only exception to the above basis of charges by the University of Minnesota and even here there is considerable contrast with State Receiving Units.

At the University of Minnesota Hospitals—the county pays one-half clinic and hospital charges for indigents; the patient pays "according to ability to pay" as determined by the Social Service Department; the State pays whatever the patient cannot (except one-half clinic and hospital charges for indigents with county certification.)

The basis for this is as follows:

Section 4, Extra Session Laws 1951, Chapter 2, sets forth the appropriation for the Psychopathic Department of the University of Minnesota Hospitals as $216,956 for each year of the biennium.

This is listed under appropriations for research and teaching. **This appears to have a certain amount of justification as follows:**

1. Psychotic patients are required by the University in order to carry on their teaching and research program.

2. If the University attempted to charge the counties for psychiatric hospitalization in the same manner as all other forms of illness, they would be confronted with the situation where one of the two following situations might exist:

   a. The counties could induce the patient to go as a **voluntary admission to a State Mental Hospital** which would involve **no cost whatsoever to the county** and would further relieve the county of paying one-half of the cost for physical medical examination, surgery, laboratory, etc., which the county still would have to pay if the patient were sent to the University Hospital.

   b. If the patient were sent to a **State Hospital under commitment** because of refusal to go as a voluntary patient, the **county would still be liable for only $10 per month,** which would cover not only the psychiatric hospitalization but all physical medicine including complete physical examination which would be a liability of the counties to the extent of one-half the cost if the patient were sent to the University Hospital with county certification.

Comment:

It is apparent that in this instance the State Mental Institutions and the University are similarly suitable for, and are in competition for, at least a certain type of mental patients and it is perhaps necessary for the State to allow the University to give psychiatric hospitalization free so as to reduce any disadvantage costwise from the standpoint of the University Hospital as compared to State Mental Hospitals. This is perhaps necessary to maintain a sufficient number of psychiatric patients for the University Hospital research and teaching needs.

CONCLUSIONS:

1. State Hospital Receiving Units like the University of Minnesota Hospitals are expensive units for **diagnosis** and **intensive treatment of new and acute cases.**
2. **Patients usually remain in these units for only a relatively short period.** A very large portion of admitted patients need to remain in Receiving Units only a matter of days, if at all.
3. Normal treatment is continued after patients are transferred to less intensive treatment units of mental hospitals.
4. Mental illness should be considered as comparable to any other illness.
5. **The various agencies of the State should not be in competition or at considerable variance as to policies.**

RECOMMENDATIONS:

1. That a receiving unit rate of charge be established by the director of the Division of Public Institutions for receiving units to be adjusted by the Director of Institutions from time to time and be comparable to the charge rate of the University of Minnesota Hospitals.
   When adequate cost accounting procedure has been established throughout the Mental Health System, the Director of Institutions should thereafter determine the Receiving Unit Rate of Charge on the basis of an average of the per patient cost of operating the various Receiving Units.

2. A schedule of hospital and clinical charges similar to that in use by the University of Minnesota Hospitals be established to be used by all Receiving Units.

3. For committed patients the county of residence should be billed for the total of these two charges and should be liable to the State for the payment of any amount collected on an ability to pay basis from the patient or responsible relatives plus one-half of the remaining uncollected balance.

4. Voluntary patients referred by a physician as unable to pay for private hospitalization and physicians' services, may be accepted provided:

   a. The County Board of the county of residence has accepted liability for the county share of charges on the same basis as committed patients.

   b. The voluntary patient or responsible relatives guarantee and are able to pay the full amount of charges during the period of hospitalization in a Receiving Unit.

5. Provisions should be made that in cases of voluntary patients referred by a physician but unable to pay the full cost of Receiving Unit charges plus extras for clinical, laboratory, etc., then the patient should be examined by a hospital staff physician to determine whether or not the case is an emergency wherein danger to the public or damage to the patient would result from delay in hospitalization and treatment, whereupon:

   a. If no emergency is found to exist the patient shall not be retained in the hospital.

   b. If an emergency is found to exist, certification by the county must immediately be sought and the patient retained.

   c. If certification by the county is not received within 5 days the superintendent of the hospital or a staff member designated by him, must either institute proceedings for commitment or release the patient.

   d. The liability of the county shall arise as of the date of admission of the patient at the Receiving Unit.

IF THE FOREGOING RECOMMENDATIONS ARE ADOPTED, THEN:

1. Mental illness would not be handled as "different" from other illness by the State Receiving Units.
2. A uniform policy of admissions and retention of patients at the seven Receiving Units of the State would replace the seven varieties of policy now existing.
3. The present practice (instances of which were found) would be eliminated wherein a "nervous person" could enter a Receiving Unit and for **a total cost of $10 receive a complete physical examination, psychiatric examination, clinical and laboratory services, medical-surgical services** as well as psychiatric treatment if needed and **in addition one month top quality hospital care.**
4. No person in need of hospitalization and treatment would be denied.
5. The total cost to the counties should not be excessive, keeping in mind that many committed patients will need little, if any, stay in a Receiving Unit. University of Minnesota Psychiatric Unit is reported by Hospital Reports 1950-1951 as having an average patient "length of stay" of 34 days.
6. Receiving Unit patients would pay according to "ability to pay" for part of the cost of the very expensive treatment.

PATIENTS IN MENTAL HOSPITALS BUT NOT IN RECEIVING UNITS

This includes the vast majority of patients. It should be made clear that **treatment is not confined to Receiving Units.** As a basis for discussion, the following table is necessary:

Cost data of the State Mental Institutions as it will be used in determining the per capita cost charges for patients in mental institutions.

Collections are still made on the basis of 1948 per capita costs due to the considerable variation in cost between the various hospitals if 1951 costs were used.

PER CAPITA COST, per month, FOR FISCAL YEAR ENDING

JULY 1ST, 1951

	Average Patient Population 1951	1948	1950	1951
Anoka	1082	$35.59	$82.34	$103.54
Hastings	843	43.96	75.52	97.86
Willmar	1391	38.31	61.23	74.30
Fergus Falls	1974	33.05	61.32	70.05

Rochester	1624	39.21	55.35	67.49
St. Peter	2369	43.10	58.33	68.11
Moose Lake	1133	42.45	67.28	72.25
Sandstone	351			82.62
Average per patient per month	——	$39.38	$65.91	$ 79.53
Total Patient Population	10,767			

1948 and 1950 per capita costs are from the biennial reports of the Division of Public Institutions.

1951 per capita costs were supplied to Mr. L. P. Erickson of the Collection Department of the Division of Public Institutions by Mr. Conrad Peterson.

In approximate numbers the breakdown of the basis on which the patients or counties pay, if at all, is as follows:

1,100 Patients or their relatives pay from $33.05 to $43.96 per month. (called full per capita rate) Average $39.38 per month.

1,900 Patients or their relatives pay $10 per month.

1,500 Patients are "county charges" committed since 1947 for whom the county pays $10 per month.

5,500 are non-paying patients committed before 1947 for whom the State receives nothing or are voluntary patients without "ability to pay."
The increase in three years (1948 to 1951) was over 100% or on an average basis from $39.38 per month to $79.53 per month.

The above table shows clearly that the per capita costs of the several hospitals vary widely. Reasons for this are in some cases observable but in general, accounting systems and record and statistics systems, are too inadequate to allow accurate analysis.

RECOMMENDATION:

The Director of the Division of Public Institutions should be required each year to establish a Rate of Per Capita Cost for patients in the various State Mental Hospitals, except in Receiving Units, based on the average cost of all of the Mental Hospitals. This rate should be determined at the end of each fiscal year and should then become the basis of all collections based on per capita cost until supplanted by the rate for the following year as is now done by the Division of Social Welfare in regard to tubercular patients at Minnesota State Sanatoriums.

For the purposes of this section the patients accepted by the Mental Hospitals and not in Receiving Units will be divided into three classes:

Voluntary.

Committed.

Aged—i.e., Senile and Cerebral Arteriosclerotic.

For a detailed report on present laws, practices and basis of pay by patients, relatives, or counties, for patients in mental hospitals of Minnesota and in addition reports on similar practices of other states, see the report of the Minnesota Legislative Research Committee issued in 1952 entitled "Relative Responsibility for Costs of Care in State Institutions" issued pursuant to proposal 47 Session 1951. Data from this report is used here by summary and where specific reference is made to this report, the indication will be LRC.

As does the LRC we wish to call attention to the conclusion of the Council of State Governments in its 1950 report "The Mental Health Programs of the Forty Eight States," page 8—

"In most of the states, the amount of reimbursement required from patients or their legally responsible relatives is much less than the cost of care and treatment. In only a few states is the amount set at "actual cost" of maintenance and medical care. Much of the stigma surrounding hospitalization of the mentally ill might be averted if patients could feel that they were making a contribution toward the cost of their hospitalization, as in a general hospital for physical illness. **Patients or their legally responsible relatives should contribute to the cost of hospital care and treatment in accordance with financial ability, but such ability should not imply preference in hospital admission or treatment.**"

VOLUNTARY PATIENTS (certified by a physician as unable to pay cost of hospitalization plus physician's fees). Most states listed, who accept voluntary patients at all, require these patients to pay up to the full rate according to ability to pay. See LRC Table 12.

The following points are important in determining the question of local government responsibility for voluntary patients remaining after a short Receiving Unit stay:

1. **Voluntary patients usually are of short tenure in the institution:**
   a. They can leave at pleasure.
   b. In the year 1951-52, 21% were neurotics who rarely stay after the Receiving Unit period. Dr. Hastings advised that except for a few acute cases they should be treated "out patient."
2. **Voluntary patients should be of short tenure in a mental institution:**
   a. If the patient is dangerous to himself or others he should not be able to leave the hospital at will.
   b. If the patient is not dangerous to himself or others and could get along outside he has the right to the help of his local Welfare Board to so do. Note: **The committee found that some Welfare Boards refused help, which has the effect of keeping the patient in the hospital at no expense or trouble to the county, if voluntary, and at only $10 a month expense if committed.**

c. If the patient's condition is such that long tenure of treatment is called for he should be committed so as to be subject to provisional discharge procedure including follow-up clinic and social worker's service and regulation when ultimately released.

c. The State Hospital Staffs should be required to decide the patient's condition—his need for continued hospitalization as would be required if some official act was required to keep a patient a long time.

e. The central administration should have a required report on voluntary admissions inherent in a requirement for definite decisions by each hospital staff in order that the administration be informed on the procedure of each hospital and to maintain a uniform policy throughout the Mental Hospital System.

f. It is noteworthy that State Hospitals accepted 79 voluntary patients over the age 65 in the last year thus relieving the counties of any obligation to pay even $10 per month to say nothing of relieving the counties of any Old Age Assistance cost. 41 of these 79 were cerebralsclerotic or seniles.

RECOMMENDATIONS:

Voluntary patients in the Mental Hospitals, except in Receiving Units, should be required to pay the full per capita rate and in addition hospital and clinic charges, except that if unable to pay the full rate plus charges, then:

1. **For any patient certified by his county board, the county would be billed for the total amount but would remit such amount as it could collect on an ability to pay basis from the patient or responsible relatives plus one-half of the uncollected balance, if any.**

2. **For any patient without certification by his county, certification must immediately be sought.**

3. **If county certification is not received within 5 days the Superintendent of the hospital or a staff member, designated by him, must institute proceedings for commitment or the patient must be released.**

Because of the short stay in the hospital by most voluntary patients plus each county's right to withhold or withdraw certification, coupled with the county's right of recovery from responsible relatives, it appears unlikely that the above recommendations would materially increase county costs.

COMMITTED PATIENTS NOT IN RECEIVING UNITS

While there are no records available on the exact number of committed or voluntary patients in the Mental Hospitals, it is probably safe to say that probably 90% of the patients in the hospitals, but not in Receiving Units, are committed.

Approximately one-third of these patients or about 3,300 are over age 65 of whom about 1,500 were diagnosed as senile or cerebralsclerotic.

Points of consequence in considering local government, patient or relative responsibility to contribute toward the cost of caring for committed patients are:

1. Mental illness is a relatively long confining illness in a number of cases much as is tuberculosis.

2. Tubercular patients in Minnesota State Sanatoriums are charged $7.45 per day as per capita cost. If the patient does not pay, the county is charged $6.38 per day with right of recovering as much from the patient or responsible relatives as their ability to pay warrants.

3. The average per capita cost per patient per day for mental hospitals in 1951 was $2.50.

4. The $10 per month county charge for patients committed since 1947 is for less than:

   a. The cost to the county of relief if the patient is under age 65.

   b. The county share of Old Age Assistance if the person is 65 or over but fully ambulatory.

   c. For **chronically ill** or even ill with a long period of hospitalization in prospect, **it is of considerable financial advantage to the county to unload a patient into a Mental Hospital for $10 per month.**

5. Several superintendents of mental hospitals have stated that they had a number of patients who could just as well be "outside" except that relatives, if any, and local County Boards had refused to accept the expense and bother of assisting the released patient.

6. Local governments are in a better position to recognize ability to pay and the extent of such ability than is a State agency.

7. Since local officials commit persons to mental hospitals the **situation should not exist where there may be a financial advantage to local government to commit.**

8. It is unfair to the patient, to the State and to mentally ill persons in Mental Hospitals to crowd the hospitals with persons who, in some cases, with a little help can get along nicely "outside" and who are not in need of hospital care or treatment.

9. The quality of care and treatment and the cost therefore have increased considerably in recent years.

10. Many states charge against local governments all or a considerable portion of the cost of care of mental patients in state hospitals as shown in Table 8, LRC.

RECOMMENDATIONS CONCERNING COMMITTED PATIENTS UNDER THE AGE OF 65 AT TIME OF COMMITMENT:

The following should be the required procedure concerning charges to patients, responsible relatives or counties for costs due to care of patients committed when less than 65 years of age:

1. The Director of Public Institutions should be required to collect from the patient or responsible relatives up to the full per capita cost for the care and treatment of the patient whenever possible.

2 When patient or responsible relatives are found to be unable to pay the full per capita cost, the Director should be required to collect that portion of the per capita cost that is reasonably possible on an ability to pay basis except that:

3. If the Director finds the patient or responsible relatives unable to pay one-half or more of the per capita cost, he must thereupon render a bill to the county of legal settlement of the patient in the amount of one-half of the per capita cost rate.

4. The county of legal settlement shall thereupon be responsible to collect from the patient or responsible relatives such portion of the amount billed as their ability to pay may warrant. The county shall be liable to the State for the amount so collected, if any, plus one-half of the difference, if any, between the amount billed by the State and the amount collected from the patient or responsible relatives.

Local Welfare Boards should by law be made responsible to give discharged or provisionally discharged mental patients supervision or, if necessary, financial assistance in order that the patients may have a fair chance to adjust to living "outside" of an institution. Note: This does not imply any reduction in the functions of the follow-up clinics or mental hospital social workers.

If the foregoing recommendations relative to committed patients not in receiving units are adopted, then:

1. The possible county liability will be changed as follows:

   a. Present maximum county liability is $10 per month. The per capita rate now used is an average of $40 per month. If the foregoing recommendations were followed on the present per capita rate, the maximum county liability would be $10 per month, the same as at present.

   b. If the per capita rate is changed to the basis of 1951 costs, the rate would be approximately $80 per month. At the $80 per capita rate, maximum county liability would be $20 per month. Note: If a subsequent recommendation to change the maximum responsibility for patients or relatives with dependents from a limit of $10 per month should be adopted, the ability of the county to recover a portion of the costs from patients or responsible relatives will be considerably increased. This would no doubt materially help offset any increase in the net liability of each county.

2. The recommendation for **welfare board assistance to discharged patients** coupled with the **limited increase in county responsibility for costs** of patients in mental institutions should **increase the incentive** for the counties to **assist in making possible the release of a material number of patients** whom we are advised could "make it on the outside" with a little assistance particularly the first few months.

3. Any incentive which may exist for local governments to **unload problem people** into state mental institutions will be to **a small extent diminished.**

4. Counties, patients and relatives will be doing no more than sharing in responsibility for the increased costs of operating state mental hospitals which have accompanied the improvement in care and treatment of patients.

CHARGES TO PATIENTS, RESPONSIBLE RELATIVES AND COUNTIES FOR MENTALLY DEFICIENT AND EPILEPTIC PATIENTS

In 1885 the charge for mentally deficient persons in State Institutions was established at $40 per year and has remained unchanged ever since. This payment is collected from the persons legally responsible for an epileptic or mentally deficient person but if such person fails or refuses to pay the $40 per year, the charge is assessed against the county where the patient has legal settlement, if any, otherwise the county of commitment. Each institution collects directly from persons responsible or from the several counties.

Per Capita Cost at the Present Institutions for Mentally Deficient and Epileptics for the Fiscal Year Ending June 30, 1951

Institution	Average Population	Annual Cost	Monthly Cost
Minnesota School and Colony, Faribault	2875	$ 771.23	$ 64.27
Cambridge State School and Hospital	1099	$ 820.90	$ 68.40
Owatonna State School	353	$1,508.05	$125.67

Relevant factors for consideration:

1. The value of $40 per year compared to the operating costs in 1885 and 1952 defies comparison.
2. $40 per year is considerably less than the cost of suporting the normal child in an average home. The quality of care is good.
3. The high per capita cost at Owatonna reflects the cost of education of educable retarded children.

RECOMMENDATIONS:

1. **The Director of Public Institutions should at the end of each fiscal year determine a per capita cost rate for mentally deficient and epileptic patients in State Institutions based on the average per capita cost of the Minnesota School and Colony at Faribault and Cambridge State School and Hospital at Cambridge.**
2. **The minimum charge to persons responsible for mentally deficient or epileptic patients in any State facility should not be less than 25% of the per capita cost rate as established in Recommendation No. 1.**
3. **Whenever the person or persons responsible are found unable to pay the minimum charge on an ability to pay basis, this charge should be levied against the County of Legal Settlement of the patient or if there is no County of Legal Settlement, against the County of Commitment.**
4. **Legislation should be enacted so that the Director of Public Institutions may accept from persons responsible for mentally deficient or epileptic patients payments in excess of the minimum rate provided that the amount of such payments in excess of the minimum rate shall be deposited in a Welfare Fund to be established by the Director and used by him for the benefit of mentally deficient and epileptic persons in the State including those in institutions. This fund is to be in addition to appropriations made by the Legislature for the care and treatment of mentally deficient and epileptic persons. Research should be considered as one of the appropriate uses for this fund.**

5. **Owatonna State School, being primarily an educational institution, the charge to responsible relatives or counties should be the same as at other institutions for mentally deficient and epileptic persons. The higher rate of cost should be considered attributable to education.**

OUT-PATIENT AND FOLLOW-UP CLINICS

The State of Minnesota maintains follow-up clinics at Albert Lea, Fergus Falls, Duluth and Minneapolis. In Rochester the State contributes to a Clinic operated by the county. More clinics have been proposed.

THE TWIN CITY FOLLOW-UP CLINIC

The Twin City Clinic confines its activities to:

1. Follow-up consultation for provisionally discharged mental patients, with a psychiatric social worker and, if necessary, a psychiatrist.
   Advantages of the follow-up clinic as conducted in the Twin Cities are:
   a. The clinic substitutes an office consultation with the provisional discharge patient for a social worker home call.
   b. The morale factor on patients is considerably improved as it removes the implication of snooping into the home.
2. The Twin City Clinic has referred to it a number of wards of the YCC and the State Board of Parole. Some work is also done for county agencies.
   When the Twin Cities Clinics were formed there was considerable discussion as to whether or not they should be set up as out-patient clinics seeing all patients who might be referred by a physician. This plan was at least temporarily not pursued because of two factors:
   a. The shortage of psychiatric staff. The load for neurotics would have been overwhelming.
   b. The controversial question of socialized medicine.

FOLLOW-UP AND OUT-PATIENT CLINICS

The plan of operation of the clinics at Fergus Falls, Albert Lea and Duluth is decidedly different from the Twin City Clinic. The Fergus Falls Clinic seeks to function as a complete out-patient clinic seeing all persons referred to it by physicians. All service is free regardless of patient's ability to pay.

Psychiatric service at Fergus Falls is primarily rendered by a consultant psychiatrist from Minneapolis who devotes one day per week at the clinic and 1½ days of reimbursed time in traveling. Some of the follow-up service at Fergus Falls is performed by Fergus Falls State Hospital as was the case before the establishment of a clinic. At Rochester an out-patient clinic is operated by the State Hospital in conjunction with Olmsted County Public Health Authorities. It performs both out-patient and some follow-up service free.

FOLLOW-UP SERVICE IN MENTAL HOSPITALS

A considerable amount of follow-up work is still performed by the various mental hospitals partly by patients calling at the institution for consultation, and partly by visits to the patient on the part of a social worker attached to the institution.

OUT-PATIENT CLINICS

The question of enlarging present follow-up facilities into out-patient clinics and the establishment of additional out-patient clinics is very likely to arise from time to time. The following factors are notable:

1. Two complete out-patient clinics now exist in the State of Minnesota, at the University of Minnesota and at Mayo Clinic, Rochester.
2. The great majority of the treatment of out-patient clinics is for neurotics.
3. Neurotics, as pointed out by Dr. Hastings, do not become psychotic with any greater frequency than non-neurotics. Most neurotics should be treated on an out-patient basis, but occasionally acute cases should be hospitalized for a time.
4. Contrary to a widely assumed fallacy, the treatment of neurotics has very little, if any, value as a means of preventing psychoses.
5. The treatment of either neurotics or psychotics involves a considerable amount of physical medicine.
6. To have an out-patient clinic equipped to adequately treat referred new patients or to avoid tremendous expense of duplication of facilities, it should be established in connection with local general hospitals.
7. The University of Minnesota out-patient clinic, handling patients referred by physicians, charges the county $5 for the initial examination. Then the patient is charged 50c per visit. Patients able to pay a physician are not accepted by the University out-patient clinic.

8. At least a number of the neurotics who were voluntary patients in the State Hospitals could be treated at an out-patient clinic.

9. The treatment of voluntary patients through hospitalization at a State Hospital at the present time is considerably less expensive to the patient than would be the case if either out-patient or in-patient treatment were sought at the University of Minnesota or at the Mayo Clinic.

COMMENT:

Attention is called to the fact that the existence of an out-patient clinic taking referred patients conducted by the State at Fergus Falls, Duluth and Albert Lea and purely a follow-up clinic in the Twin Cities might appear to be inconsistent.

RECOMMENDATIONS:

1. **State Out-Patient Clinics (accepting referred new patients) should be limited to State Mental Hospitals in order that they be adequately equipped with laboratory, x-ray, etc. facilities.**
2. **Because psychiatric out-patient clinics should be part of completely equipped medical facilities, communities too far from State Mental Hospitals to use out-patient facilities at these hospitals, are urged to include psychiatric out-patient provisions in their local medical facilities, if possible. Note: The Committee is aware of the fact that compliance with the foregoing recommendations is contingent on the availability of professional personnel.**
3. **Out-patients (not follow-up patients discharged from Mental Hospitals) should be charged according to ability to pay up to the full cost of service received. For patients unable to pay, the county shall be required to pay $5 to cover the first visit and examination. The patient should be required to pay a fifty cents registration fee for each succeeding visit. Note: This is the practice of the University of Minnesota's Out-Patient Clinic.**

SENILE AND CEREBRAL ARTERIOSCLEROTIC PATIENTS IN MENTAL HOSPITALS

Almost every phase of the Mental Health Program is complicated or adversely effected by the "senile problem." **Standards of treatment, problems of staffing, building requirements, operating costs and patient care are all effected.** Justice not only to old people but to mentally ill patients requires attention to this problem. The Committee on Hospitals of the group for the Advancement of Psychiatry states the problem thus: **"Many of the aged presently admitted for care in a mental hospital show nothing more important**

than memory impairment, confusion and physical infirmity. It seems evident that many who come to the mental hospital come primarily for sociological reasons. This situation needs correction." Note: Page 1, Report No. 14, entitled, "The Problem of the Aged Patient in the Public Psychiatric Hospital," published August, 1950.

Further substantiation is found in Recommendation No. 5 of the Governor's Advisory Council on Mental Health dated January 23, 1951, wherein the Council cites that approximately 40% of patients admitted to the Mental Hospitals of Minnesota are 65 years of age or over and recommends development of local institutions for the care of the aged including many persons now committed to mental hospitals.

THE EXTENT OF MINNESOTA'S PROBLEM

As of June 30, 1951, 3,655 or 32.1% of all patients in Minnesota Mental Hospitals were 65 years of age or over. 1,546 of these had no other diagnoses other than those of senile or cerebral arteriosclerotic and in addition, 513 were listed as "other diagnosis," which includes the category "diagnosis unknown." In the last year 763 or 31.23% of all new admissions were senile or cerebral arteriosclerotic, a considerable increase from the 285 admitted in 1950.

An excellent example of the extent to which our mental hospitals are filled with older people, who could be "outside", is supplied by one hospital superintendent who wrote this committee to the effect that 238 or 16% of his patients could well be cared for outside of a mental hospital.

After describing the degrees of outside care needed by these patients the superintendent ends thus, **"The 238 that we decided could make some sort of adjustment in various facilities outside the hospital, of course, would make a tremendous difference to the functioning of the hospital. It would alleviate for probably many years our present overcrowding and assure the younger patients of a more active program . . . . . and I have little doubt it would increase our discharge rate with the younger patients . . . . ."**

REASONS FOR THE EXTENT OF MINNESOTA'S SENILE PROBLEM IN MENTAL HOSPITALS

1. The law was changed a few years ago to admit "senile and nervous persons." One reason given at the time for this change was that **too often seniles without psychoses were being labeled psychotic to get them into mental institutions.**

2. The maximum cost to a patient or responsible relative who is married or has other dependents is $10 per month for care in a mental hospital.

3. The homestead of an older person is not subject to lien if the person is in a mental hospital thus allowing the heirs to inherit the homestead clear of encumbrances. Un-

der Old Age Assistance the homestead is subject to a lien of payments received by the old person.

4. Wide publicity concerning the very attractive new geriatrics buildings built at some mental hospitals.

5. The general improvement in care of patients at mental institutions.

6. The shortage of nursing and rest homes in many communities:

   a. The steadily increasing number of old people has created a steadily expanding need for homes for the aged including rest and nursing homes.

   b. It is cheaper for counties to commit to mental hospitals than to buy or build rest homes or to pay the county share of Old Age Assistance costs for patients in private rest homes. Maximum county liability is $10 per month.

   c. The State Board of Health and the State Fire Marshal have raised the standards they require for approval of proposed additional rest homes. This has reduced the number of new facilities within recent years. The requirements are generally higher but in particular they require fire proof buildings if bedridden patients are to be kept on the second floor plus stricter standards on size of kitchen, recreation space, etc:

      (1) In 1951—of 52 applications for new rest homes only 32 were approved.

      (2) Several surgical hospitals replaced by new community hospitals were rejected as nursing homes.

      (3) Board of Health and Fire Marshal require a present home to meet the new requirements if there is a change of ownership. The result of this is that several owners and estates of owners have closed homes through inability to sell with State approval. Note: One result of the continuation of a shortage of private rest homes has been higher rates than would be the case if more competition were introduced into the field.

EFFECTS ON OLD PEOPLE IN MENTAL INSTITUTIONS

1. They are removed from their own communities, friends and relatives.

2. Mildly senile old people are mixed with more disturbed persons:

a. Security and confinement are closer than would be necessary for mildly confused or forgetful old people.

b. Older people are sometimes injured by psychotic patients.

3. Many mildly senile persons are embittered and humiliated by being labeled mentally ill and institutionalized by their relatives and neighbors.

4. Those older persons, who improve considerably through medical treatment, diet, etc. in the hospital **rarely are able to get out of a mental hospital** and **back to the community and relatives who had them committed.** Dr. Hastings, Head of the Department of Psychiatry, University of Minnesota, reports that 25% of the seniles entering the University Hospital return home after proper diet and medical treatment.

5. The presence of the seniles in the mental institutions dilutes the quality of medical care for both the seniles and the mental patients. Note: Few young doctors, seeking to progress, are willing to accept jobs primarily treating old people. Local institutions would be served medically by local physicians in private practice.

EFFECTS ON THE MENTAL HEALTH SYSTEM OF THE STATE

1. Mental hospitals become overcrowded.
2. Constant demand for more buildings is inevitable.
3. Procuring sufficient adequate quality psychiatric staff is much more difficult.
4. Mental hospitals cease to be treatment centers for the mentally ill but become mass custody institutions.
5. A tremendous increase in costs is charged to the mental hospital system instead of to old age programs.

   The taxpayers of the State lose the Federal share of Old Age Assistance.

   Patients and relatives able to pay more than present required rates escape at the expense of the State taxpayers from paying for the care and suport of older people.

The Objectives of the Following Recommendations can be Summarized as follows:

1. **Devote the mental hospitals to the care and treatment of the mentally ill.**
2. **Require those benefited to share the cost within ability to pay.**
3. **Enable the State to afford a constructive Mental Health Program.**

4. **Protect older people and others from being unnecessarily committed to mental institutions.**

5. **Remove the financial incentive from relatives and counties to commit to mental institutions.**

RECOMMENDATIONS:

1. The Director of the Division of Social Welfare shall prepare for each county of the State an average County Nursing Home Charge Rate. This rate shall be the average payment for residents of that county supported in nursing homes through the Old Age Assistance program. Accompanying this rate he shall set forth the amount which represents the county's share per person of such average nursing home payments. This average nursing home charge rate together with the amount of this rate that represents the county share of the total rate shall be furnished to the Director of the Divison of Public Institutions.

2. For patients entering any mental hospital after attaining the age of 65, the patient, responsible relatives or counties of legal settlement should be charged as follows:

   a. While Receiving Units charges should be as outlined previously for Receiving Units;

   b. Charges for voluntary patients should be as previously outlined.

   c. For committed patients charges should be:

      (1) To patients or responsible relatives the average County Nursing Home Charge Rate of the county where the patient has legal settlement or such portion of that rate as is possible according to ability to pay, except that;

      (2) For each patient who is or whose responssible relatives are unable to pay as much as one-half of the average County Nursing Home Charge Rate, the Director of the Division of Public Institutions will bill the County of Legal Settlement for one-half of such rate.

      (3) The county so billed will be responsible to remit to the State for each patient an amount equal to the county's share of the Average County Nursing Home Charge Rate for that county determined by the Director of Social Welfare plus one-half of such amount as the county may recover on an ability to pay basis from the patient or responsible relatives.

3. **Churches and other non-profit charitable organizations are urged to continue and expand their efforts toward providing rest home and nursing home facilities for older people. They are to be commended for the valuable steps already taken in this direction.**

4. **Local communities are urged to take steps to provide adequate facilities for care of the aged. Their attention is directed to legislation of the 1951 session authorizing counties or associations of counties to establish such institutions. This function is more suitable for local jurisdictions than as a State function.**

5. **The Legislature is urged to consider the desirability of providing State assistance to local communities toward the establishment of facilities for the aged.**

6. **High standards of safety in facilities for the aged are desirable but progress toward these standards must be gradual and realistic because of the overlying need to provide for old people who are in being and in need of care.**

7. **Greater emphasis in the regulation of public and private Nursing and Rest Homes should be placed on care of the patient.**

8. **The function of licensing and enforcing rules and regulations for the control of Rest and Nursing Homes should be placed under the Division of Social Welfare instead of the State Board of Health.**

COMMENTS:

The basis of Recommendation No. 8 is as follows:

1. A considerable proportion of the persons in Rest and Nursing Homes are recipients of Old Age Assistance which is under the Director of the Division of Social Welfare. Three and one-half million dollars per year is now expended under this Division's direction for this purpose.

2. The Division of Social Welfare is the State agency in continuous association with the local Welfare Boards relative to relief and Old Age Assistance.

3. The Division of Social Welfare is the State agency most in position to know the availability of facilities for the aged in each community and the needs for such facilities in these communities.

4. The Division of Social Welfare is at present represented on the Committee of Standards which determines the standards for the care and operation of Rest Homes and Nursing Homes.

5. The Division of Social Welfare is the State agency most in the position to know the requirements for adequate care and the point at which charges and facilities become excessive or extravagant.

RECOMMENDATION:

9. **Legislation should be enacted providing for restriction on sale or transfer of property of wards of the State over 65 years of age whether by operation of law or otherwise to the same extent as may exist from time to time with respect to recipients of Old Age Assistance.**

GENERAL RECOMMENDATIONS RELATIVE TO CHARGES TO PATIENT, RESPONSIBLE PERSONS, AND COUNTIES:

1. **All functions of collection should be centered in the Division of Public Institutions under the Director.**
2. **Legislation necessary to effect such recommendations as are adopted must be enacted.**
3. **Provision should be made by statute for the Director of the Division of Public Institutions directly or through the Attorney General's office to have legal services for the purpose of enforcing collections without the use of the County Attorneys of various counties.**
4. **Legislation should be enacted requiring the courts to notify the Director of the Division of Public Institutions whenever any proceedings for guardianship or proceedings under guardianship take place.**
5. **The Civil Service requirements for employees of the Collection Department of the Division of Public Institutions should be made appropriate to the duties of the employees. This does not appear to be the case at present where the employees are classed as Law Enforcement Inspector. The Public Administration Service also makes this same recommendation.**
6. **The superintendent of each institution should be required to send each month to the Division of Public Institutions a record of all patient welfare accounts at his institution. Note: The LRC cites instances where accounts of patients amounting to over $1000 have accumulated without the knowledge of the Director of the Division of Public Institutions.**
7. **It would seem wise to consider some legislation whereby a responsible relative liable for the keep of a ward of the State could not disinherit a ward and place the future burden of the ward's keep wholly on the counties and the State.**

PROGRAM FOR INEBRIATES

ALCOHOLISM IS NOT A PSYCHOTIC CONDITION

The overwhelming preponderance of evidence encountered is to the effect that inebriacy is not a psychotic condition and hence not a mental illness in the same sense as a form of insanity.

1. The patient is not psychotic, the inebriate when sober is perfectly sane.
2. This conclusion is substantiated by the considerable success of treatment by Alcoholics Anonymous and other treatments which follow the same principle, as well as by the studies of Yale University over the last 20 years.
3. The public conception of alcoholism is confused by retaining the treatment under the Mental Health Program.
4. The patient's peace of mind is not enhanced by being in a mental institution.
5. The need for different commitment laws will be furthered by a separation from the Mental Hospital system.
6. The staffing of the treatment group should be different from mental hospital staffing and it should be predominately ex-alcoholics.
7. Only the relatively few alcoholics who are psychotic or acutely neurotic should be classed as mentally ill and should be treated in mental institutions.
8. Alcoholism appears to be a form of addiction and seems to have characteristics similar to narcotic and barbiturate addiction.

THE MOST SUCCESSFUL TREATMENTS ARE NOT PSYCHIATRIC

The tremendous advances of recent years in rehabilitation of alcoholics have been found in those facilities using the treatment methods employed by Alcoholics Anonymous which are also the methods recommended by Yale University.

There is nothing of psychiatry in this treatment although a tremendous amount of "physical medicine" is required to physically rehabilitate the alcoholic as a condition precedent to treatment.

It is not appropriate to the furtherance of the Alcoholics Anonymous type of treatment that it be continued under the supervision of psychiatrists, whose skill is not needed, while the Mental Health Program itself is so short of psychiatrists.

RECOMMENDATION:

The treatment for alcoholism should be separated from the Mental Health Program.

THE BASIC LOCATION FOR TREATMENT IS NEAR THE PATIENT'S HOME COMMUNITY

One fundamental principle of Alcoholics Anonymous treatment is therapy by volunteer alcoholics who have succeeded in

becoming arrested alcoholics. This factor alone would require that the most effective program for alcoholism would be designed around local centers of population where the patient will be near his home community and where the AA members would have easy access to the patient. Pioneer House in Minneapolis is such a facility.

Economy likewise recommends local units with little professional staff but many volunteer recovered alcoholics as the most effective method of rehabilitating alcoholics.

A local treatment base removes the average patient from employment and his home community for the minimum length of time.

RECOMMENDATION:

Local facilities should be encouraged and perhaps assisted because this is the most effective and economical means of rehabilitating the maximum number of alcoholics.

THE PLACE OF THE STATE IN TREATMENT FOR INEPRIATES—LONG TERM TREATMENT

Considerable success of Alcoholics Anonymous type of treatment still leaves a residue of patients for whom rehabilitation has not taken place. There are two types of these unrehabilitated patients. They are:

1. The incorrigible, uncooperative or unwilling patient who has refused to accept or respond to treatment.
2. The patient who has deteriorated either mentally or physically and hence has limited possibilities of rehabilitation.

These people need a longer term, closer security treatment than is appropriate for local institutions and many of them should have life long custodial care. The place of the State in the alcoholics' program appears to be to supply this longer range treatment and often long term custodial care.

If nearly all of the treatment for alcoholism is attempted in large proportions on a State scale, the following adverse factors will be encountered:

1. Patients will be concentrated from the entire State and will have available only the volunteer Alcoholics Anonymous assistance that is near the State institution.
2. Serious limitations will be placed on the only type of treatment that has been markedly successful.
3. The cost per patient cannot help but be considerably greater and the average tenure in the institution longer in a large formal institution where

the patient is housed away from his home community as contrasted with the short period of institutional housing when treatmenet is at the local level with extensive use of volunteer assistance to the patient as he returns to his job and resides at home.

RECOMMENDATION:

The State should establish a separate facility devoted to the following purposes:

(1) Long range treatment of the undeteriorated patient who has not responded to local AA type of treatment.

(2) Custodial care for the deteriorated patient. This facility should be designed to provide a reasonable amount of work for the patients because:

(a) Work therapy is one of the best rehabilitating factors and one of the best means of eliminating hopeless boredom for the non-rehabilitable patient.

(b) The long range patient should be enabled to contribute to his own support through work for his own welfare and to enable the State to maintain such a facility within the means of the State.

COMMITMENT AND ADMISSIONS PROBLEM

The present commitment laws and admission rules of the State Mental Health Program are not appropriate to the inebriate program since:

1. The present voluntary admissions system encourages patients to enter Willmar where most pay nothing, the county pays nothing and only a few pay $10.00 per month. A very few pay the full per capita cost. Table I* shows that in one year 64.7% of all alcoholic patients were voluntary.

*Table I at the end of this section.

2. The fact that counties have no liability for voluntary patients encourages the use of the state institution in lieu of potentially more effective local treatment and also in lieu of jail or workhouse sentences.

3. The right of voluntary patients to leave the state institution on three days' notice often defeats the treatment program and enables the patient to escape a jail sentence but fails to effect rehabilitation.

4. The state policy of free medicine in mental hospitals encourages the voluntary patient to enter Willmar, obtain extensive medical service, effect physical rehabilitation and leave unrehabilitated as to alcoholism.
   Table I* shows that for last year 31.7% of all alcoholic patients were "repeaters."

5. Recruiting of voluntary patients for the state institutions is retarding the development of local facilities which would constitute a far more effective means of rehabilitating the greatest number of patients most economically.

6. Mental Health Program rules give the state no control of a voluntary patient who has left an institution. The released alcoholic patient should be subject to provisional discharge rules and returned to the institution in case of failure to rehabilitate before his "back sliding" has become too severe, otherwise, expensive treatment will have yielded no return to the patient or to society and will eventually have to be repeated in full. Table I* shows that of 286 "repeater" patients, 219 or 76.5% were voluntary and hence not under State control.

7. The problem of the tubercular alcoholic cannot be dismissed unless the commitment and treatment rules are changed:

   (1) Protection of the public requires that alcoholics with arrested tuberculosis should be closely checked to prevent "relighting" active tuberculosis and becoming a focus of infection in their communities.

   (2) Financial justice recommends that a tubercular alcoholic be treated first as a tubercular patient with all charges to the patient, his relatives and the counties according to TB regulation. After the tuberculosis is arrested, the patient should be committed to the State Alcoholic Facility and become subject to the rules and regulations for alcoholics.

RECOMMENDATIONS:

Laws and rules relative to commitment to the State Facility should be changed with the following objectives in mind:

(1) Voluntary patients should be required to pay the entire per capita cost of the institution.

(2) Through commitment procedure (perhaps revised) local communities should accept at least a substantial measure of financial responsibility for alcoholics sent to the State Facility with recovery from patients or relatives according to ability to pay.

Local treatment would be encouraged since it is best for most patients and also the cost of local treatment should be less than the cost in a State Facility.
Commitment to the State Facility should be for those who cannot or have not responded to local treatment. Commitment procedure can be so designated as to facilitate voluntary application for commitment by the alcoholic.

(3) The discharged patient, who has received an expensive treatment should be subject to provisional discharge control to justify the State's expense, to protect society and to reinstitutionalize cases of incipient failure as to rehabilitation.

(4) All alcoholics, except those found to be with psychoses, should be admitted only to the State Facility for Alcoholics. Any who subsequently become in need of psychiatric treatment could subsequently be referred to one of the mental hospitals. (For the year July 1, 1951 through June 30, 1952, 46 non-psychotic alcoholics and 3 drug addicts were admitted to other Mental Hospitals than Willmar.)

(5) Separate provision should be made for a tubercular alcoholic to be treated:

(a) First as a tubercular patient with the cost to the counties on the patient or his relative in accordance with the rules and laws for tubercular patients who are non-alcoholic.

(b) Second, the tubercular alcoholic on discharge from the tubercular hospital should be returned to the State Facility for Alcoholics and thereafter the charges to the county, its patient or relatives and the rules of supervision for alcoholic discharges should be complied with and perhaps in addition a stricter rule for longer term follow-up supervision should be adopted because of the danger that the discharged arrested alcoholic may revert to alcoholism and subsequently again become an active tubercular and focus of infection in his home community.

SELECTION AND RATIOS OF PERSONNEL FOR TREATMENT OF ALCOHOLISM SHOULD BE DIFFERENT FROM MENTAL HEALTH PATTERN

1. Modern treatment methods indicate it is important that therapy for alcoholics be principally conducted by recovered alcoholics. This is an inherent factor in the AA type of treatment as followed by successful facilities.

2. Civil Service makes it impossible to follow the recovered alcoholics pattern in selecting staff for a mental hospital. Aides, therapists, etc. must now be selected from a Civil Service list covering these categories without regard to the individual's history of alcoholism. All testimony before the Committee was to the effect that separate qualifications should be established.

RECOMMENDATION:

Provision should be made to the effect that selection of personnel for a State Facility for Alcoholics should not be required to conform to the rules of Civil Service as now constituted. It is important that it become possible to at least partially staff the Alcoholic's Facility with recovered alcoholics and likewise it is equally important to be able to dismiss the recovered alcoholic employee who may later on again fail to maintain his recovery.

COMMENT:

The problem of drug addiction and barbiturate addiction is at the present time small in extent even though important in the State of Minnesota. Table I* shows 39 drug addiction admissions for the year. However, such indications as the Committee has encountered are to the effect that the need for custody and physical medicine but not psychiatric treatment would indicate that the treatment for narcotic and barbiturate addiction should be included with and follow any provisions which might be made for treatment of alcoholism.

TABLE 1

Admissions and Readmissions to Willmar State Hospital for the year from July 1, 1951 through June 30, 1952, with breakdown for classifications relating to Alcoholism and Drug Addiction.

*ADMISSIONS AND READMISSIONS TO INSTITUTION

	Total	1st Admissions	Readmissions
Committed Admissions	423	346	77
Voluntary Admissions	723	448	275
All Admissions	1146	794	352

*BREAKDOWN FOR CLASSIFICATIONS RELATING TO ALCOHOLISM AND DRUG ADDICTION

	Total for Institution	With Alcoholic Psychoses	Psychoses Total Without	Alcoholic Without Psychoses	Drug Addiction Without Psychoses
Committed 1st Admissions	346	3	255	251	2
Voluntary 1st Admissions	448	5	380	365	14
Committed Readmissions	77	1	70	67	3
Voluntary Readmissions	275	0	241	219	20
Total for Year Voluntary and Committed	1146	9	946	902	39

The difference between the "totals for the institution" above and the sum of the next two columns immediately to the right, represents admission of psychotics, neurotics and those listed as "age and/or diagnosis unknown."

* Based on statistics of the Department of Public Institutions.

BUILDING NEEDS OF THE MENTAL HEALTH PROGRAM

The Legislative Research Committee in December 1952 issued a report on "Policies and Practices Relating to State Building Projects," which specifically examines and reports on specific projects and practices. This report will therefore be confined to particular building requirements needed to carry out recommendations of this Committee and general observations of past performance as a basis for recommendations rather than as a detailed report.

The $21,000,000 of new buildings in the Mental Health System, constructed in the last ten years, reduced overcrowding and resulted in a considerable improvement in facilities for both the care and the treatment of mental patients.

The building needs of the Mental Health Program should be examined with one basic fact in mind—**to the extent that the funds of the Mental Hospitals are absorbed by extra costs of operating buildings of functionally inefficient design or location or which have facilities excessively expensive as to operation—to that extent the general patient population is deprived of the care and treatment those funds could buy.**

THERE HAS BEEN NO COORDINATED BUILDING PROGRAM AT MENTAL HOSPITALS

The Public Administration Service reports issued in 1950 in conjunction with the work of the Committee for Efficiency and Economy in Government in general observations indicate the obvious fact that there is no pattern of design or building arrangement at the various State institutions. Several general conclusions can be made.

1. Many buildings have been constructed without due attention to operational or functional efficiency. A few typical instances are:

a. The Receiving Hospital at Anoka is placed so far from the kitchen that food delivery is more expedient by truck than through the communications tunnel.

b. New buildings at Faribault were placed on the circumference of the previous building area leaving an area of considerable acreage unoccupied between the power plant, kitchen, etc. and the new buildings.

c. The new Receiving Hospital at Willmar was placed in the corner of the grounds directly over the main sewer which backs water into the basement of the new building during heavy rainstorms.

2. **Observable exceptions to excessive dispersal or poor placement are:**

   a. Receiving Unit at St. Peter (built in 1937) is in the center of the grounds close to the administration building.

   b. The new Receiving Unit at Hastings State Hospital was constructed between two older buildings connecting them, saving costs of construction and operation and increasing institutional efficiency.

3. There has been a considerable variation in the cost of facilities for similar purposes but at different institutions:

   a. The LRC points out numerous instances including staff housing.

   b. The cost of Receiving Units have varied markedly ranging from $7,163 per bed at Willmar to $23,889 per bed at Hastings.

4. There was considerable duplication of facilities in new building programs such as:

   a. Duplication of surgical facilities at Rochester at the Receiving Unit and the surgical hospital.

   b. New geriatric buildings at most institutions contain examining rooms, doctor's office, etc. within a block of new medical and surgical buildings.

   c. New buildings at Faribault contain medical rooms, dental rooms at the same time that there were already sufficient dental facilities at the institution.

THERE HAS BEEN NO CONSISTENT OR PLANNED MAINTENANCE AND REPAIR PROGRAM THROUGHOUT THE MENTAL HEALH SYSTEM

1. Older buildings which need such items as pointing of brick or stone, repair of roofs, stairs, window casements, etc. were observed at most institutions.
2. Many older buildings have deteriorated to the point where it may be more economical to replace than to repair them.
3. The Legislature was not even advised of the need for repairs at some institutions while at the same time detailed exhibits urging new buildings were submitted.
4. Quite obviously no thorough survey by qualified persons has been made of the Mental Hospitals and hence no analysis is available to the Legislature of the relative need or advisability of repairs that should be made throughout the system.

CONSTRUCTION OF ELABORATE NEW BUILDINGS WHILE OLDER FACILITIES ARE ALLOWED TO REMAIN UNIMPROVED OR UNREPAIRED SHOULD NOT BE REPEATED

1. At Anoka, the new Receiving Unit with a swimming pool and gymnasium costing in the neighborhood of $500,000 and of excessive size for any possible institutional needs, was built, while the surgical hospital was allowed to remain decidedly deficient and inadequate:
   a. The present surgical hospital operating room is too small with insufficient laboratory; there is no elevator in the building and patients must be carried up and down narrow stairways on a litter.
   b. This surgical hospital at Anoka could have been remodeled to be entirely adequate for less than the approximately $500,000 cost of the swimming pool and gymnasium which can be used by very few of the mental patients.

      Dr. George Fahr, Consultant in medicine at Anoka State Hospital told the Committee—"**I have drawn up some plans which I have shown to Dr. Rossen and Dr. Miller which, I think, would only cost something around one quarter of a million dollars to make that into a first-class hospital.** It wouldn't be a beautiful hospital . . . . . but it would be a building which would do good work and increase the accuracy and reliability of the work very materially." Dr. Fahr continued, "It is hard to teach some people that it is the men not the building."
   c. Sometimes some department heads tend to seek new buildings rather than functionally adequate remodeling.

2. Other instances of expensive new construction while repair of old facilities were omitted are covered by the LRC reports.

WHETHER OR NOT THERE IS A NEED FOR INCREASED BED CAPACITY CANNOT BE DETERMINED UNTIL ADMINISTRATIVE AND PROFESSIONAL POLICIES OF THE MENTAL HEALTH PROGRAM ARE ESTABLISHED AND A STATISTIC AND RECORD SYSTEM IS ESTABLISHED TO DETERMINE THE TYPE OF PATIENTS TO BE ACCEPTED OR TO BE RETAINED IN THE HOSPITALS AND THE TREND AS TO TYPE AND NUMBER OF PATIENTS IS LEARNED

1. This is illustrated frequently in the Sections on Administration, Staffing, Admissions and Discharges and on Records and Statistics.

2. There are some indications that the Mental Hospitals may in the future require less bed capacity than at the present time:

   a. The LRC found that as of June 30, 1952 there were 688 available empty beds. These were available empty beds not necessarily desirable beds.

   b. Between 600 and 700 seniles now in mental institutions could well be taken care of in rest homes in their home communities. See Section on Admissions, Screening and Discharges.

   c. Between 200 and 400 mental patient beds will become available at Willmar in case the recommendations of this Committee relative to removing alcoholics from the Mental Hospital System are followed.

   d. Approximately 350 war veteran mental patients are in State Hospitals awaiting admission to U. S. Veterans' Hospitals.

   e. If the admission of voluntary neurotic and other non-psychotic patients is restricted to those in actual need of hospitalization, a number of additional beds will become available.

      Dr. Hastings, University of Minnesota, pointed out to the Committee that most neurotics should be treated out-patient. He also advised that treating neurotics in Mental Hospitals is of no value for the prevention of psychoses.

   f. Still further reduction in patient population is likely if various recommendations of this Commitmittee and other measures are taken to limit the admission or effect the discharge of persons who do not need to be confined to or treated in a Mental Hospital.

THERE IS FREQUENTLY POOR DISTRIBUTION OF PATIENTS MAKING OVERCROWDING APPEAR WORSE THAN IT IS

1. In Rochester State Hospital some of the old wards were seriously overcrowded at the same time that there was no apparent crowding in the new geriatric buildings or in the old receiving hospital now converted to a patient dormitory.
2. Anoka State Hospital had over 100 patients in some cottages and only 38 patients in another cottage of equal size.
3. There was no overcrowding in geriatric buildings at St. Peter but old wards were very full.
4. Similar instances could be listed at other hospitals.
5. Statements have been made that the State Board of Health has forbidden placing more patients in the various new units at Mental Hospitals thus forcing excessive crowding in the old units. This is difficult to believe. As pointed out in other Sections, it appears inhuman and unjust to crowd the poorer facilities and barely fill, if that, the newer facilities. Many of the new buildings have almost excessive provision for day rooms, recreation space, medical rooms, etc.

THE PROBLEM OF STAFF HOUSING SHOULD BE REVIEWED

The Governor's Advisory Council on Mental Health in their report issued January 23, 1951 included a Recommendation No. 10 to the effect that—"a sufficient number of new homes be constructed to provide quarters for all doctors needed by the State Hospitals in order to make possible recruitment of additional staff doctors." The Legislature had already made provision for a number of staff residences completing 25 such buildings in 1950.

The LRC devotes over four pages to this problem in their report "Policies and Practices Relating to State Building Projects in Minnesota." The LRC sets forth the wide variation in costs between residences of different institutions as well as the high cost per dwelling unit.

A STATE POLICY RELATIVE TO STAFF HOUSING AS A MEANS OF RECRUITING PERSONNEL SHOULD BE DETERMINED BY THE LEGISLATURE

Under present practices State provision of staff housing amounts to a considerable hidden salary of varying value for some staff members. A policy should be determined if justice is to be established.

Staff housing consists in the main of separate two or three bedroom dwellings occupied by doctors and some top level non-medical operating personnel.

The present practice is that the occupant of a staff dwelling pays a total charge of $85 per month and receives;

Occupancy of the dwelling,

Laundry service for his entire family,

All groceries required for the entire family, and

All heat and all utilities required.

Employee housing is also provided at equally low rates and generous benefits with similar results.

The inequity in staff housing is inherent in the fact that providing all staff housing benefits for $85 per month amounts to a subsidy in the neighborhood of $200 per month or more of hidden salary depending on size of a staff members family.

The assignment to particular dwellings causes jealousy and discontent within some hospital staffs.

A severe injustice is worked upon staff members receiving the monetary salary of their rank but who are required to provide their own housing, groceries, laundry and utility service in the local community.

Multiple dwelling staff housing would provide the same extent of living quarters at considerable lower initial cost and lower maintenance cost.

In varying degree the present practices as to employee housing contain similar inequitable features.

THE INEQUITY OF THE PRESENT STAFF HOUSING SITUATION HAS SEVERAL POSSIBLE REMEDIES

1. The establishment of a charge for staff housing more in line with actual costs and values with charges based on size of family, number and age of children, etc.

2. Increase in the salary of those persons eligible for staff housing so that the staff member not in staff housing will not be at such a financial disadvantage as compared to an occupant of a staff house.

3. Construction of sufficient staff housing to enable every professional staff member at every institution to live in a State supplied residence so that a comparable subsidy is available to all staff members.

Note: Attention is directed to the LRC report indicating variance in cost of multiple dwellings versus residence and present expensive practice of providing separate furnaces, wells, cesspools, etc. for staff houses instead of placing them so that they can be economically attached to institutional heat, sewer and water systems.

THERE IS A DECIDED NEED THAT A SOUND POLICY BE DEVELOPED TO GOVERN ALL PHASES OF BUILDING, CONSTRUCTION, MAINTENANCE, REPAIR AND USE AT ALL MENTAL INSTITUTIONS

Fundamental principles that should be followed in the development of such a policy include:

1. Every step as to new construction, repair or remodeling should be designed to improve the operating efficiency of the institution involved.
2. Until the State remedies the extensive present lack of policies as to the type of patients retained at Mental Hospitals and the lack of adequate records and statistics by which any trends can be reliably determined, no well conceived program of new buildings can be developed.
3. As to present buildings there is a very considerable need that a program be developed with the advice of qualified personnel to improve the maximum number of buildings to, but not beyond, a condition of functional adequacy. Under such a program all present buildings should be evaluated so the Legislature may be reliably informed:
    a. Some buildings should be analyzed as to remaining feasible life and use, then scheduled for replacement.
    b. Some buildings should be remodeled or repaired before further neglect renders them beyond recall.
    c. Buildings now adequate should be examined as to all repairs necessary.
    d. All new buildings should be designed to give the maximum functional use so the operational efficiency of the institutions will be improved.

RECOMMENDATIONS:

1. **The Legislative Research Committee should be required by the Legislature to add to its staff a competent person qualified to examine and study building requirements, building use, maintenance requirements of all institutions and to report to each session of the Legislature in respect to all building needs. It would be required that all requests for new building, remodeling or repairs by the various institutions be transmitted to the Legislative Research Committee for study and analysis before submission to the Legislature. Included should be a study of design and location of buildings to improve the operating efficiency of each institution involved.**

2. **It is recommended that until many phases of the Mental Health Program as to admissions, discharges, type of patients and ultimate patient load can be more accurately determined, the construction of elaborate or expensive new buildings be subordinated to the more immediately obvious needs to improve, repair and rehabilitate present structures. There should be definite planning designed to improve the functional value and efficiency of the various institutions through remodeling and repair and ultimately through design and location of those new structures which may in the future be added.**

3. **The inequities in the present situation as to Staff Housing should be remedied by more adequate and fairly determined charges for occupancy of staff dwellings or by a monthly allowance to staff members not occupying staff residences or by the application of some of both measures. Similar action in regard to employee housing should also be taken.**

4. **Particular recommendations for new buildings are:**

   a. **New buildings to add 400 bed capacity for mentally deficient at Cambridge contingent on which is a further recommendation for a medical, surgical and infirmary building at Cambridge.**

   b. **Also contingent on the additions at Cambridge it is recommended that improvements or necessary replacements be started at Minnesota School and Colony and Cambridge State School and Hospital.**

   c. **Remodeling to a condition of adequacy of the present medical-surgical hospital at Anoka is recommended unless conclusive evidence is submitted to the effect that such action is not feasible.**

   Note: The subject of a new institution for Mentally Deficient persons at Brainerd is considered in the Section on Mentally Deficient and Epileptics.

5. **A through analysis of the space at Anoka State Hospital now devoted to swimming pool and gymnasium should be made. A report should be submitted to the 1955 Legislature suggesting the best possible use of this space.**

6. **This Committee visited the United States Government Indian School at Pipestone, Minnesota. If this school is closed by the Federal Government and made available to the State, it appeared to this Committee that this institution would be suitable as an institution for those alcoholics requiring long term treatment or treatment for a chronic condition.**

REORGANIZATION

The Efficiency in Government Commission, consisted of 19 citizens of the state, chosen as leaders in business, the professions, agriculture and labor.

This commission did a tremendous amount of research and in a comprehensive but condensed report made specific recommendations to the 1951 Legislature.

One section of this report covered those agencies of state government dealing with public welfare, institutions, youth conservation and correction. Because this study and report deals directly with several agencies studied by our Interim Committee on Mental Health and Youth Conservation we wish to direct attention in this summary to section 12 of that report which proposes a reorganization of these agencies. While this section covers a broader field than was assigned to us, there is a sufficiently close relationship among the services provided by these agencies to justify their being included when reorganization is being considered.

In general our Committee subscribes to the conclusions of the Efficiency in Government Commission recommending that these related agencies be consolidated into one department to be known as the Department of Welfare. We specifically oppose the inclusion of agencies dealing with the affairs of veterans, however, and are not in agreement on all details recommended in the report.

There obviously is unnecessary duplication and overlapping of services and authority among the various agencies dealing with public welfare, relief, hospitalization, health, punishment, correction and parole. It seems reasonable to believe that reorganization could bring about an improved service at lower costs at both the state and local levels.

The Reorganization Plan providing for a Department of Welfare, as proposed by the Efficiency in Government Commission, is similar in many respects to the plan adopted some years ago by our neighboring state of Wisconsin. The reports we have had on the success of the plan in Wisconsin, after several years of experience, are generally favorable. Wisconsin officials have been cooperative in making available to our Committee information on their experience with reorganization in this field and we are certain they would be helpful to any committees that might have before them bills dealing with these problems.

Recommendations published in this report are basic to the Mental Health Program and are entirely compatable with those found in Section 12 of the report of "The Efficiency in Government Commission."

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Minnesota. Legislature.
Interim Commission on Youth
Report of the Interim

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