

A SUMMARY OF CONDITIONS IN MINNESOTA STATE HOSPITALS
FOR THE MENTALLY ILL

A report to Governor Luther W. Youngdahl
by the Minnesota Unitarian Conference Committee
on Institutions for the Mentally Ill

Reverend Arthur Foote, Chairman
Mrs. Lawrence D. Steefal, Secretary

This represents the findings to date of the Committee, based on

- (1) a study of institutional conditions and standards by its members, and
- (2) a comprehensive tour of all mental hospitals in December, 1947, by Justin G. Reese whose services were engaged by the Conference for this purpose, with Mrs. Reese participating in the tour as co-worker. Mr. Reese former Director of Field Work for the National Committee for Mental Hygiene, is now Secretary of the Governor's Citizens Mental Health Committee.

Unless otherwise specified or implied, all observations are for December, 1947, and all operating costs, statistics or figures pertaining to Minnesota institutions were secured directly from officials and official records of the Division of Public Institutions and the hospitals.

INTRODUCTION

When the first state hospital opened its doors at St. Peter in 1866, Minnesota had no clinics with which to catch mental illness at an early stage, so that hospitalization for the patient could be either prevented or offered at a sufficiently early period to afford maximum opportunities for successful treatment. In 1866, Minnesota had none of the social work services required to permit early release of mental patients or supervision of their return to the community, a means of preventing many from breaking down again and returning to the institutions. In 1866, there were few of the techniques now known to psychiatry, which permit a high percentage of mental patients to recover.

Minnesota now has seven mental hospitals, with a population of over 10,000. But it still has no clinics, and, only a handful of social workers.

The mental patient of today would not find conditions inside the state hospital much different from those of his forebear. More likely the wear and tear on buildings and the attrition of personnel would present to him more unpleasant conditions.

Successful psychiatry is the most expensive type of medical treatment Minnesota treats its mentally ill charges at an average cost reported to be \$1.05 per day per patient. This budget covers all salaries, and costs relating to food, clothing, linen, drugs, fuel, and maintenance. This is a sum far below the \$11 daily minimum for general hospitals which treat all types of cases in the Twin Cities and the last year's \$6.52 average for the mental hospitals of the Veterans Administration.

Salaries come out of the operating budget of \$1.05 a day. They are so low that the state is unable to compete with private practice, other states, and the Veterans Administration when it tries to employ doctors and nurses who are desperately needed. The result is a shortage of personnel, which falls more than 50 per cent below minimum standards for good treatment. Because of lack of funds and consequent shortage of staff, doctors are forced to confine the practice of progressive psychiatry to a limited number of patients. The number of these depends to a large extent on the help to the state hospital by medical centers near by, such as the Mayo Clinic or University Hospitals. We observe a high percentage of patients needlessly deteriorating beyond current hope of recovery.

Only one patient out of five is discharged from Minnesota state hospitals as recovered within a year of admission. On the other hand, one out of every five admissions represents a former patient once discharged whose improvement did not last.

The reason for these conditions is not difficult to find. Science has made progress, but public opinion is still back in the Dark Ages, when mental illness was considered sinful or hopeless, and the mental patient viewed as a criminal or a brute, insensitive to his surroundings and comfort. The public has failed to demand

or support hospitals offering the kind of treatment which could restore mentally sick people to full capacity and status in society.

Were this a report designed to relieve the anxieties of those having loved ones in the institutions or to present only the favorable side of the institutions, it would not be difficult to portray positive results from the hard work of staffs and from the miracles of science for a limited number of patients.

The bad features of all seven hospitals, however, outweigh the good ones and are the direct result of decades of neglect. Until the last session of the legislature, three institutions - Anoka, Hastings, and Willmar - actually were set aside exclusively for those patients whom the four receiving hospitals failed to cure or manage. For these patients, no therapy was ever intended. Until additional facilities are erected, as already authorized at these hospitals, they will continue to carry out a basic purpose of confinement alone.

Minnesota's past failure to provide adequate operating funds, and to establish preventive social work and outpatient services is responsible for neglect and privation for the majority of the 10,000 patients in its seven institutions for the mentally ill.

The average operating cost allowed for the Minnesota hospitals is one fifth of the amount required.

No Minnesota hospital meets the minimum standards of the American Psychiatric Association, although one is sufficiently advanced to be approved by the American Board of Neurology and Psychiatry.

The hospitals fall short of meeting the minimum personnel standards of the A.P.A., by 38 doctors, 340 nurses, 591 attendants, 30 social workers and even more alarming deficiencies in other key classifications.

The minimum personal hygiene requirement of the majority of patients are neglected.

The majority of patients receive no routine physical examinations.

Restraints are substituted for treatment measures.

Food and food service are unsuited for mental patients.

Clothing is grossly inadequate.

Many patients do not receive the care and attention which the state provides livestock on the grounds of these same institutions.

TREATMENT AND STAFF

"No building ever cured a patient. Neither medicine, psychiatry, hydro therapy, occupational therapy, dietetics, drugs, electricity, music dramatics, surgery, psycho-analysis, religion, nor psychiatric social work ever cured a patient. Recoveries occur only when such techniques are applied directly and continuously to individual patients by trained people. People, not things or theories, cure patients."

George H. Preston, M.D.
Commissioner of Mental Hygiene
Maryland

Hospitals try to be treatment centers. Specific techniques include psychotherapy, shock treatment, surgery, physio-hydro therapy, general medicine, etc. As important as specific techniques in treatment are factors which create a favorable environment and a total force which brings the patient out of his private world and restores him to the world of reality. Ranking high in the process by which this is done is activity so creative that deterioration is arrested and the possibility of restoration begins. The alternative to creative activity and pleasant surroundings is further mental escape or deterioration by the patient.

Such treatment techniques and living conditions can be provided only by an adequate number of trained people. Not only are the hospitals short of selected personnel mentioned in the summary of this section, but not one has a dietitian or pathologist. Only one hospital has a psychologist. The 25 occupational therapists on duty are limited by a lack of budget for material. This necessitates confining their activities mainly to those patients - not always the ones most requiring this - who, day in and day out, are capable of turning out the same products for sale at the State Fair or at the hospital showcase. These sales do provide funds for new material and for recreation and entertainment of the other patients, but when financial considerations of this nature are involved, the work is not always therapeutic.

New patients are treated by electric shock, with the highest number of cases found at any one time in any hospital being 60. One hospital provides insulin shock treatment, Only one hospital has the equipment for the diagnosis of convulsive disorders. Brain surgery is performed by hospitals able to obtain neuro surgeons from community or medical centers.

How much active treatment is given may be determined not by accumulated statistics, but by examples such as the 81-year-old doctor whose case load la 700 patients. Routine physical examinations constitutes a means of determining whether the physical needs of the patients (much less their psychiatric ones) are met. In a

check of the seven hospitals, only two doctors were found who attempted routine physicals. These two doctors claimed it was impossible to keep up with their schedules.

The shortage of personnel is so severe that discipline and order take the place of treatment and activity. Wards of 100 may have only one or two attendants per shift, with certain wards entirely unattended during the evening shift and many wards without a nurse on duty.

If each institution could evenly divide two eight-hour shifts of nurses among the patients, the amount of time would vary from 42 seconds to one minute and 36 seconds per patient per day.

If each institution could evenly divide three eight-hour shifts of attendants among its patients, the time, permitted for personal attention would range from four minutes to twelve minutes per patient per day.

(To obtain these ratios, however, nurses would have to give up their reports, special duties, and supervisory functions; attendants could have to give up locking and unlocking doors, supervising housekeeping, taking groups of patients out to walks, and making reports. All would have to give up sick time and vacations.)

LACK OF ACTIVITIES IMPEDE RECOVERIES

A study of five out of seven institutions whose records were available at the time to corroborate personal observations showed that 75.8 out of every 100 patients are idle or occupied only by menial ward duties. Of the total number of patients, 55 out of every 100 are completely idle. The ratio of idleness for women is far higher than it is for men.

This means that the lives and activities of three out of four patients are completely, circumscribed by the walls, locked doors, and, in many cases, barred windows of the ward or cottage in which they live.

The remaining hospital population engages in activities ranging from kitchen and farm help, maintenance of grounds, work in the laundry, carpentry shop, and boiler rooms....to unloading coal cars.

Occupational therapy rates are confusing because it is often impossible to tell from the records

whether a patient assigned to this department is engaged in therapy...or uncreative maintenance activity.

No hospital claimed it had been able to take any considerable percentage of its patients out for regular walks or exercise since last fall. Some patients attend weekly movies or chapel services.

The majority of wards in the state present a common picture of unkempt patients vegetating. Few women had the use of cosmetics; few men had daily shaves. A small minority of wards present signs of activity. The majority show rows of patients sitting in chairs and benches lined against the wall, with not even pictures or curtains to relieve the monotony of bare walls. No calendars or clocks record the passing of time.

With the exception of one hospital (whose amplifying system was not in use during the visit, no hospital has radios or an amplifying system by which all patients can hear either broadcasts or piped music. In only a few wards are an appreciable number of recent books or magazines to be seen. Organized occupational therapy or recreation is observed in no ward or cottage. Pool tables are infrequent, to be seen mainly in receiving wards or liberty halls.

In some wards, even sitting is impossible because of a lack of chairs or benches. In one institution, checking revealed the following:

Ward X has 127 patients. Day room has 80 chairs and rockers and three benches. Sleeping quarters have 15 chairs.

Ward Y has 147 patients. Day room has 17 benches and 38 chairs. Sleeping quarters have one bench and one rocker.

Ward Z has 101 patients. Total ward has only 19 benches.

The receiving wards and liberty halls for working patients with ground privileges constitute the major exceptions to the kind of existence for patients described in these pages.

HOUSING

The overcrowding and dangerous physical conditions existing in the Minnesota hospitals require little elaboration here. These have been well described in the Governor's radio address of October 24, 1947, in the report of the Interim Legislative Committee on Public Institutions, and in the Eleventh Biennial Report of the Division of Public Institutions.

In Minnesota state hospitals 10,000 patients live in 123 wards or cottages. All but two of these wards were visited. Except for the smaller and generally better equipped receiving wards, the major-ity live in wards or cottages, often containing more than 100 patients. The overcrowding is so severe that many patients are able to touch the adjoining beds on at least three sides. Many patients sleep in corridors or attics. Single bedrooms contain two and three beds; bedrooms built for two or three patients contain three to five beds.

Most mental patients are not bedridden. Wards and cottages are so constructed that patients spend their daytime and early evening hours in day-rooms, with sleeping quarters closed. Even more inadequate than the sleeping quarters is this day-room space, where, in room after room and corridor after corridor, patients sit side by side without room for activity.

CLOTHING

Insufficient clothing affects appearance and self-respect. There is not only the lack of personnel to supervise dressing, but also lack of facilities for storing clothing and private articles. There are few private bureaus in which patients may keep their possessions. Each ward or cottage uses a central, locked clothing room. Clothing is hung here and private articles are kept in a small wire basket, a box, or a section of a shelf. Patients in some of the more advanced wards are permitted shoe or other small boxes for their possessions, which they must carry with them all the time. Receiving wards on occasion have dressers shared by several patients.

Many patients were seen without either underwear, shirts, socks, or shoes. Except for receiving and liberty wards, the number of male patients with non-work shirts was statistically insignificant. The nature of clothing, particularly for dress and outdoor purposes, is largely dependent on the gratuitous efforts of the superintendent to obtain clothing from the patients' relatives. Many patients either have no relatives or their relatives are without means of furnishing clothing.

In one hospital where a check of state clothing for men was made the following was found:

Coats	- 2 to every 5 patients
Socks	- 1 1/2 pairs per patient
Shoes	- 1 pair per patient
Union suits (and BVDs)	- 1 pair per patient
Drawers	- 2 for every 5 patients
Undershirts	- 2 for every 5 patients
Nightshirts (or pajamas)	- 4 for the entire male population.

With few exceptions, all clothing is for work purposes. Much of that listed, and it includes the clothing worn by the patients at the time, comprises remnants of war surplus commodity clothing. On bath or laundry days the patients in this hospital are without changes. The ratio cannot be used without qualification, since many patients receive clothing from home.

The absence of pajamas or nightshirts indicates that the patients, whether idle or working on the farm, sleep in the underwear they wear during the week.

SANITATION AND PERSONAL HYGIENE

Three of the seven institutions had soap, toilet paper, and roller towels in the washrooms of a majority of the wards. Only one had seats on a majority of its toilet stools.

Minimum personal hygiene requires that patients wash their hands and faces with soap on arising, before eating and retiring, and after bowel movement; the use of toilet paper, and the use of toothbrushes. Except for the receiving wards, such minimum needs are not set for a considerable number of patients. A majority of wards had either an inadequate supply or an unused supply of toothbrushes.

It is not certain how many patients use soap. This is a voluntary habit and dependent in many cases on whether the patient asks the attendant for it. In many wards the only means of determining the extent to which soap was used was to see how many patients carried soap in their pocket, (Fewer women use soap; although their own sanitary needs are greater, their own clothing offers no chance to carry it about). It is estimated that in the back wards a majority of the patients are no longer in the habit of using soap.

Back wards were found in which attendants estimated that only between 10 and 50 per cent of their patients used toilet paper.

These statements are made, not to highlight shortage of supplies or characteristics of patients, but to indicate the lack of personnel to supervise and encourage the use of these items.

FOOD

Most patients do not have the opportunity to leave the ward to eat in a central dining room or to have hot food from a cafeteria counter. The majority eat in the dining quarters (and in some instances the day rooms) of their wards.

In one institution the staff escort could not identify the evening meal, which appeared to be soup, coffee, and bread, served in tin plates. Unfortunately, no hospital was visited long enough to see a complete week's diet.

In other institutions the food was far superior, consisting mainly of starches such as macaroni and beans. Butter appeared to be plentiful, with one or two cups of milk a day being served.

One steward stated he was ordering dried fish to furnish relief from macaroni. Except for occasional donations of war surplus commodities, no cook recalled distributing citrus fruit.

It is difficult to ascertain the cost per meal per patient, for the hospitals serve two general diets from the same budget - a superior one to employees and an inferior one to patients. (Exceptions are food for privileged working patients and for the alcoholic patients in one institution). The average cost of meals for both patients and employees was reported by four hospitals to be between ten and fourteen cents.

The complete absence of dieticians adversely affects not only the general diet, but special diets for such as diabetics, the aged, and surgical cases.

Service for bedridden patients is particularly bad. Attendants and nurses are far too few in number to serve hot meals on time and to clean up dribblings and messes.

On Christmas Day, a bed-ward was visited at a time when the patients were served a full turkey dinner, the best meal of the year. The patients in this ward comprised elderly men, most without teeth. The meal was excellent, but the personnel on hand was too few to cut up the food so that toothless patients might eat.....or to clean up immediately the food spilled over the patients and on the bed.

Only part of the food problem is due to the quantity and quality of food. Only one institution has a kitchen equipped for normal frying, baking, or grilling, to avoid a monotonous steamed or boiled diet. Similarly, only one institution is equipped with heated food carts to bring the food hot from the main kitchen to the wards. The shortage of ward personnel is responsible for many meals getting cold while being placed on the table prior to the seating of the patients.

Brief visits were paid to the farms of four hospitals. The barns appeared clean and the livestock well cared for. One new barn and pigsty, visited at 11 p.m., were odor-free and dry, due in large measure to the modern ventilating systems which assured frequent change in air. It is reported that standards of animal care and nutrition are high, with the patients assured of tuberculin-free milk and trichinosis-free pork.

RESTRAINTS AND SECLUSIONS

The Minnesota institutions use a variety of restraints. These include the camisole (a refinement of the straight-jacket), mitts, cuffs, ankle-cuffs, sheet restraints, shoulder straps, sheets, ropes and, in one hospital, chains.

Hydrotherapy tubs are considered a humane and more effective method of curtailing disturbance. These tubs require special operators, who may be attendants trained for this purpose. Because of the shortage of personnel, the institutions are unable to use the tubs which they have on hand.

Restraints and seclusion have been banned or curtailed by law or administrative order in states such as New York and Illinois. They are considered to be an inhumane, ineffective, and aggravating method of curbing disturbed patients. There is also danger that the unregulated use of restraints may serve a punitive purpose.

The widespread use of restraints and seclusion in Minnesota is an indication of (1) shortage of personnel and (2) lack of a program of adequate treatment and activity. Recognized practice limits the use of restraints mainly to surgical cases for the purposes of self-protection. In all cases restraints must be on the prescription of the doctor and then, only for a limited time, with careful supervision of the patient.

The official records of the seven hospitals listed 778 patients in restraint, or almost one out of every thirteen. Restraints were more pronounced on the female side, in which one out of every eight women was in restraint. Significantly, idleness for women was higher than it was for the men.

Four hospitals showed a very high restraint rate; three showed a relatively low one. The rate varied from one hospital with one tenth of one percent in restraint to one which showed a rate of 18.2 percent or almost one out of every five patients.

The hospitals may be grouped in two sets relating to restraints:

The first group comprises four hospitals and 55 percent of the patient population. One out of every 8.5 patients was in restraint and/or seclusion.

The second group comprises three hospitals and 45 percent of the patient population. One out of every 37 patients was in restraint.

Two institutions showed a restraint rate in excess of what even the shortage of personnel and lack of activities would indicate. The rates of these two are being checked with sources in other states to determine whether any higher in the country exists.

On the other hand, one institution had only a negligible number in restraint, an accomplishment noteworthy for the humane administration this indicated.

In one hospital, the following was found:

Example Male Ward: A patient was found behind locked doors in a seclusion room with iron cuffs on his ankles, which were tied to the side of the bed; heavy straps around his shoulders which pinned him to bed; a belt around his waist with loops for wrists, restraining action of hands to a few inches. The shoulder straps prevented contact between mouth and restrained hands; food tray left in bed by attendant; food had slid into faeces. lying under him.

Example Female Ward: Nude girl was found behind locked doors in seclusion room with her wrists and ankles tied to side of metal cot; the cot had no mattress; a thin blanket was between her body and springs and folded over her; window wide open with outside temperature sub-zero. (Nurse stated she was without clothing and mattress because she was destructive. Observation: the girl was so completely bound it would have been physically impossible for her to tear either clothing or mattress; she was visibly suffering from exposure.)

SOCIAL WORK AND RETARDED RELEASES

An outstanding deficiency of the Minnesota state hospital system is the lack of extramural services - or activities which are carried on outside the hospital, rather than within its walls. The system has failed to provide what every other medical field is stressing - a means of early diagnosis and treatment, and follow-up services for patients who are convalescing in the community.

Until these services are provided, the state hospitals will continue to get large numbers of cases which arrive in the last stages of illness. On the other hand, there are many patients who have been in the hospital for some time who would not require further hospital care had they families willing to receive them. Such cases must stay in confinement although they would make recovery under supervised convalescence in the community...or by boarding out in foster families.

The superiority of the Veterans Administration lies not only in its higher operating budget, more adequate personnel and treatment, but in mental hygiene clinics which keep an appreciable part of their case loads - estimated at 15 to 40 per cent from requiring hospitalization. (Moreover, service organizations and officers are alerted to get known mental cases into a hospital as early as possible.) Social service staffs and agencies which can supervise the return of a patient to his community can appreciably reduce the high re-admission rate characteristic of the state hospitals.

A mobile form of clinic is needed in rural areas. These may appear at various centers on different days. The members of a mobile clinical staff are in a position to be of assistance to social agencies and courts in counties visited. No such clinics exist in Minnesota.

A psychiatric team for a clinic generally consists of a psychiatrist, psychologist, and social worker. It has been estimated that if such a team were to keep only seven or eight patients from going to a state hospital, it would pay for its own cost.

Extramural services are also handicapped by the almost complete lack of provision for social workers. One hospital had one social worker, another was reported in the process of obtaining one. There are two social workers attached to the Mental Health Unit of the Division of Public Institutions at St. Paul to take care of more than 600 cases in the Twin Cities area.

The minimum standards of the American Psychiatric Association call for one social worker for every 100 admissions, or a total of twenty-one for the seven hospitals.

The Group for the Advancement of Psychiatry recommends an even higher standard of one psychiatric social worker for every 80 admissions.... plus one for every 60 patients, on convalescent status or in family care (there were 1880 patients on convalescent status for the year ending June 30, 1947). The G.A.P. recommendations thus call for 73 social workers.

The absence of social work in the state hospital imposes a great handicap on treatment and discharge. It is impossible for doctors to have adequate social case histories of patients unless a social worker is available to serve as a liaison with the family and community. Conversely, it is difficult to prepare the community and the family for the patients release, and the patient for readjustment to the outside world.

The responsibility of the hospital to the patient does not cease when he leaves the hospital. Generally a year of successful adjustment is required between discharge and restoration to capacity. Without social work, supervision of the patient during this year is impossible; family and community adjustments are not assisted; and a possible recurrence of the disorder is not prevented or noted in time.

The value of social work is demonstrable in terms of financial savings. In a controlled test of intensive social services for 265 cases at Brooklyn (N.Y.) State Hospital, early release was responsible for a savings of 101 days of hospitalization per patient a total saving of 26,765 hospital days, and a net case saving to the state of \$15,348.

The value of another type of extramural service is under experiment in one Minnesota hospital, where a number of male patients are permitted to work in local industries during the summer, many earning appreciable sums of money. This is under close supervision. The project has been reported to have aided morale of the institution, prepared patients for discharge, and to have improved the relations of the hospital with the community.

ANALYSIS OF PERSONNEL PROBLEMS

The failure of the state to provide training and salaries competitive with other services, as shown in appended charts, is the major reason for personnel shortages and for conditions depicted here. Salaries must approximate those of the Veterans Administration and of industry. Three basic weaknesses must be corrected before there will be any appreciable change in the characteristics of the hospitals:

1. Training of Medical Personnel as a Means of Filling Staff

Only one hospital in the state has facilities for the training of recent graduates of medical schools who require residencies in approved institutions to qualify for certification as specialists by the American Board of Neurology and Psychiatry. This not only illustrates the advantage this hospital has in acquiring staff, but the contributions such residents and the superintendent have made in raising standards of patient care and treatment to the highest in the state.

The creation of a neuro psychiatric institute at the University of Minnesota, in liaison with the state hospitals, has been recommended as one way of acquiring alert young medical men.

Attendants: Training and Pay for More Than Menial Service

The attendant, who is with the patient throughout the day and nights plays an extremely important role. Because of the present custodial nature of the institutions, his function is menial, and he is paid accordingly. The attendant still retains the same title he had when the first institution opened in 1866. He has never been acknowledged as having a key role in the psychiatric team.

State hospitals in other states are developing programs intended to furnish the attendant with the training and recognition of a psychiatric worker. Pilot programs under Civil Service have been initiated in Minnesota mental hospitals, with too little time having elapsed to evaluate their effectiveness. This program will not meet its potentialities because salary scales are much too low to attract or hold attendants of a superior caliber.

Living conditions for attendants are inadequate, with many sleeping in cottage attics without private sanitary facilities. The salary is inadequate to permit a single person to live in the community or a family man to support dependents.

(An exception is found in one hospital, in which a combination of local housing conditions and far-sighted administration secures and maintains single attendants and couples with roots in the community.)

But for the eight-hour day, which permits attendants to work in the community after hospital hours, the attendant supply would be lower. In one hospital, attendants supplement their income by being blood donors. In another, it is estimated that half of the able-bodied men with dependents are additionally employed in the rail-road yards. One attendant drives a garbage truck; one is a grave-digger; another is a saloon-keeper.

5. Social Therapists; Need for a New Classification.

A major weakness of state institutions - of which Minnesota, is no exception - is that the hospital table of organization depends either upon highly trained staff, such as doctors and nurses, who are in short supply, or upon completely untrained help for whom there are no selective qualifications. The conditions described in this report result.

A new classification above the present attendant level is required for individuals without prior professional experience but who would, after intensive training, be able to carry out social and occupational activities with the patients. These psychiatric

workers would act as companions for small groups of patients, would be able to interpret the behavior of patients to psychiatrists, under whose supervision they would then carry out therapeutic functions.

The basis of such classification would be not only the technical work performed but the extent of intensive-training - of at least several years - given to men and women whose background on entering the service is at least as high as that of student nurses.

Various states and institutions are developing such programs. The outstanding one in a state hospital situation is that of Saskatchewan, which is able to attain a high ratio of staff to patients by a vigorous recruitment program mainly of high school graduates and college students, with a three-year training program leading to certification and increased pay.

The establishment of such a classification would even help recruitment at the attendant level. Except for a limited number of supervisory posts, the attendant today is faced with a dead-end on promotions. Qualified attendants should be eligible to apply for training under the new classification.

PHYSICIANS - DECEMBER 1947 APA

Standards: One Physician for Every 150 Patients

Hospital	APA	State Quota	Empl oyed		Short APA Standards	
			No.	Ratio	Number	Per Cent
Rochster (1535*)	10	8	6.5	1:236	3.5	35
St. Peter (1987)	13	7	6	1:351	7	54
Moose Lake (947)	7	5	3	1:332	4	57
Hastings (1054)	7	3	3	1:351	4	57
Anoka (1318) Fergus	9	4	3.66	1:359	5.33	59
Falls (1850)	12	6	5	1:370	7	58
Willmar (1595)	9	4	2	1:698	7	78
TOTAL	67	35	29.16	1:348	35.83	56

* Fellows and residents listed as full time.

** Fractions show part-time doctors.

Anoka	1318
Fergus Falls	1860
Hastings	1054
Moose Lake	997
Rochester	1635
St. Peter	1937
Willmar	1395

SUMMARY OF RESTRAINTS FROM OFFICIAL RECORDS FOR ONE DAY (GENERALLY DAY OF VISIT)

Hospitals	Total		
	Total	Male	Female
1	.182	.083	.283
2	.122	.092	.178
3*	.111	.041	.141
4	.058	.027	.095
5	.032	.027	.047
6	.019	.004	.033
7	.010	.009	.019
Total	.075	.038	.114

* Not day of visit

Hospital	APA	State Quota	Employed		Short APA Number	Standards Per Cent
			No.	Ratio		
Rochester (1535)	64	30	21	1:73	43	67
St. Peter (1907)	83	26	26	1:76	57	69
Fergus Falls (1850)	77	19	15	1:123	62	81
Anoka (1850)	55	14	9	1:146	46	84
Moose Lake (997)	42	8	4	1:249	38	90
Willmar (1395)	58	12	4	1:349	54	93
Hastings (1054)	43	6	3	1:351	37	93

Note: Supervisory grades excluded.

Student nurses are included in the ratio of three to one graduate nurse.
Practical nurses included in full.

SUMMARY OF PERCENTAGE OF TOTAL PATIENT POPULATION EITHER IDLE OR ENGAGED IN MENIAL WARD DUTIES
 December, 1947, for Day of Visit - Based on Official Records

Hospitals	% Completely Idle Patients			% Patients on Ward Duty ¹			Total	Male	Female
	Total	Male	Female	Total	Male	Female			
A ²	.619	.400	.673	.196	.179	.804	.815	.668	.887
B	.565	.528	.610	.265	.271	.259	.851	.799	.870
C	.562	.478	.626	.174	.208	.148	.736	.637	.775
D	.534	.356	.691	.215	.277	.154	.759	.634	.845
E	.504	.487	.596	.220	.328	.174	.734	.716	.770
TOTAL	.554	.460	.653	.213	.241	.185	.768	.701	.837

1 Ward duties consist mainly of housekeeping activities.

2 Not day of visit.

	I and II	
	Basic	\$ 90 - \$145
	Adjusted Cost-of-Living	\$130 - \$187
Minnesota Prison Attendant-Guard I and II		
	Basic	\$135 - \$190
	Adjusted Cost-of-Living	\$177 - \$238
Veterans Administration	.	\$163 - \$218

COMPARATIVE SALARIES - PHYSICIANS AND NURSES

	Basic	Adjusted Cost-of-Living	Veterans Administration
isns	\$2520 -	\$6000	\$3240 - \$7008
		<u>State Hospital</u>	
	\$1500 -	\$3240	\$2004 - \$3960

Veterans Administration provides an automatic 25 per cent increase in pay to any cian, regardless of grade, who has or receives his certification as a specialist American Board of Neurology and Psychiatry.

TOTAL NURSING PERSONNEL - DECEMBER 1947
NURSES AND ATTENDANTS

APA Standards: One Nurse or Attendant for Every 6 Patients in the Ratio of One Nurse to 4 Attendants

Hospital	APA	State Quota	<u>Employed</u>		<u>Short APA Standards</u>	
			No.	Ratio	Number	Per Cent
St. Peter (1987)	551	174	171	1:11.6	160	48
Rochester (1535)	256	139	124	1:12.4	132	52
Hastings (1054)	176	82	78	1:13.5	.98	56
Willmar (1395)	335	117	101	1:13.8	132	57
Fergus Falls (1850)	300	136	129	1:14.3	179	58
Anoka (1510)	220	104	88	1:14.9	132	60
Moose Lake (797)	166	72	67	1:14.9	132	60
TOTAL	1690	824	758	1:13.4	932	55

Note: Supervisory grades not included.
Student nurses included in the ration of three to one graduate nurse
Practical nurses included in full.

Hospital	APA	State Quota	Employed		Short Number	Standar Per
			No.	Ratio		
St. Peter (1907)	248	148	145	1:13.7	103	42
Hastings (1054)	132	76	75	1:14	57	43
Willmar (1395)	174	105	97	1:14.4	77	44
Moose Lake (997)	125	64	63	1:15.8	62	50
Fergus Falls (1350)	231	117	114	1:16.2	117	51
Anoka (1316)	165	90	79	1:16.5	86	52
Rochester (1535)	192	109	103	1:17.8	89	46
TOTAL	1267	709	676	1:15	591	49

Supervisory grades I and II have been eliminated from this chart.

Note: Shortages have been estimated in terms of those employed rather than in terms of the deficient state quota.