50 CMI-LWY

A new philosophy in

Caring for the mentally ill

A modern and humane viewpoint is voiced by a responsible, far-sighted public official who shows that false economy is ruinous

by LUTHER W. YOUNGDAHL
Governor of Minnesota

THE day is quickly coming to an end when we could incarcerate the mentally ill in a barbaric "out-of-sight—out-of-mind" fashion; when we could plunge helpless human beings into asylum-oriented infernos whose programs are characterized by overcrowding, under-staffing, and penurious appropriations; and for the patient and his relatives alike, stigma, derision, shame, and ridicule.

Instead of the hopelessness of yesterday's mental institution and its multitude of patients *needlessly* deteriorating beyond current hope of recovery because of lack of personnel for treatment programs . . . instead of this, we are coming to the "house of hope"—the therapeutic center in which an enlightened society will provide enlightened attitudes and enlightened treatment for sick human beings.

A prophetic document has been presented to this Conference It is the report on the mental health programs of the forty-eight states prepared by the Council of State Governments. It was prepared by this agency at our unanimous request of a year ago—a request we made to furnish us guidance on steps we each can take in our own states.

The data collected in the report—official data submitted by each one of our states—represent the conditions of more than a year ago. Despite this, and despite differences in reporting techniques that make comparisons difficult, the report signifies that the long-standing neglect of the mentally ill is nation-wide. Neither North nor South, East nor West, Republican nor Democratic state administration has a monopoly on this neglect—or exclusive rights in correcting it.

There is little comfort to be found in the statistical tables The differences are relative; the difference between the states on top and the states on the bottom is too insignificant to provide comfort either for the patients or for us. No state meets minimum standards prescribed by standard-setting bodies such as the American Psychiatric Association.

Behind the statistical tables is a background of human misery—perhaps not as bad as during the war years—but still deplorable enough. . and viciously so. . . to shock the conscience of the nation in supporting corrective measures that must be taken

For the patients this misery is made up of sub-standard food, shortages of personnel, overcrowding so severe that patients often sleep on the floor or in beds so close together that each touches the next, and a lack of treatment and activation programs that force many to vegetate needlessly in the institution until they are cruelly forgotten and destined to spend the rest of their lives behind bolted windows and locked doors.

For the patients the present system means straight-jackets, herding, unthinking attitudes, the regimentation of so-called hospital life, and the denial of optimum opportunities for recovery

For the discharged patients, the lack of follow-up and public educational services spells the lack of social acceptance and the increased possibility of being returned, their brief return to community life marred by stigma and the ridicule of terms such as "nuts," "crazy," "balmy," and every other vicious thing that unthinking people will use to characterize their sickness and their past residence in a mental hospital.

For the psychiatric worker this means strenuous work-loads, inadequate pay, and lack of job incentive and inducements.

For us this constitutes one of our most difficult administrative and fiscal problems.

But if these conditions exist or have existed, the recommendations of the Council—re-inforced by the thinking of outstanding consultants in psychiatry and psychiatric administration—spell out a course to which we each can subscribe—and already have started to.

I will not detail the sound and wise recommendations of the Council which have already been distributed They spell out a basic change in approach that explains why we have done what we have in the past and why we will do what we must do in the future

We have tried to build the superstructure of modern psychiatry on the asylum base of the past. And the custodial non-therapeutic characteristics of so many state hospitals can be understood only in terms of the asylum. The logic behind the asylum was (1) patients were incurable and destined for life-long institutionalization, necessitating the lowest possible expendi-

Remarks from an address made by Governor Luther W. Youngdahl of Minnesota before the panel on Care and Treatment of the Mentally Ill in the Forty-eight States at the Governors' Conference at The Greenbrier, White Sulphur Springs, W. Va , June 21, 1950.

ture, (2) patients had neither feelings nor human attributes.

Psychiatry, on the other hand, is a medical specialty that has arisen since most early asylums and hospitals were established. Its findings have upset these assumptions, and in upsetting them have also upset the justification for low asylum appropriations.

Psychiatry states that mental patients in many, many cases can be successfully treated and [illegible] in many, many cases prevented. Even under present conditions many patients *are* returned home. And plain decency and brotherhood, to say nothing of psychiatry, claim that mental patients do have feelings and are influenced for better or for worse by their surroundings.

With this change in knowledge and attitudes, we no longer have the justification for low expenditures. It no longer is a question of asking if we can afford what seem to be increased costs for personnel and treatment programs.

Since we know that in the long run we can reduce hospital populations through active treatment, it is a question not of whether we can afford the bill; it is a question of whether we can afford *not* to pay the bill and *not* to engage in the programs recommended by the Council and its professional advisers.

We have our choice of only two things: either we are going to spend for treatment to send patients home; or we are going to have to spend millions upon millions for expensive buildings to confine a needless percentage of patients who otherwise might go home.

Either we spend for treatment to reduce our hospital population and the amount of time each case spends in the hospital, or we are going to inflict on future generations an enormous tax liability for the continuance of an ever vicious cycle of building an ever-increasing number of expensive buildings for an ever-increasing backlog of what in many instances would be curable patients

At the beginning this will not be cheap, but we cannot place materialistic values above human values. We must place people ahead of dollars. In the long run, the conservation of our human resources is the only true economy we have, and I speak here not only of programs in treatment, but of those in prevention, training, and research.

Fortunately, many of the improvements recommended by the Council do not require much, if any, additional appropriation. I refer here to administrative procedures and certain changes in hospital techniques, such as the elimination of that carry-over from the Dark Ages, the strait-jacket and other forms of mechanical restraint.

Governor Youngdahl

Even with the recommendations of the Council, the millenium for the mentally ill will not come easily, and it won't come overnight. Many long years are required to hoe the long row ahead and to recover from the deficiencies of the past century.

In company with quite a few others here, I can speak from personal experience of the need for such a program, the results from it, and the time-consuming factors that go into it.

As a result of action by the last session of the Minnesota legislature, and by administrative action prior to and since then, our state is embarking on the first step of a program leading eventually to modern mental health services.

The State of Minnesota committed itself by statute to the official policy of recognizing mental illness as a sickness. The legislature almost doubled appropriations over the past, and provided for more personnel, a single standard of food for patients and employes alike, the change in classification from attendants to psychiatric aides, training, research, clinics, and for a Commissioner of Mental Health, who must be a doctor trained in both psychiatry and psychiatric administration.

The last—a Commissioner of Mental Health—is extremely important. These programs must be under medical leadership and protected by civil service and administrative procedures from interference and politics.

This is vitally important. We must recognize from the beginning that there is no such thing as a Republican patient or a Democratic patient or, for that matter, a Catholic patient, a Protestant patient, or a Jewish patient. There is no such thing as a black patient or a white patient. There is only one type of patient—and that is a sick patient.

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

On July 1st we will have completed the first year of operation of this program. We cannot report that our hospitals in this short a period of time have become psychiatric paradises or that we are satisfied—in fact we'll never rest satisfied until the last patient is either discharged, cured, or if that is not possible, receives the maximum of comfort, sympathy, and care.

There have been numerous improvements. The difficulties that many said we would have in getting personnel have not been experienced. Through higher salaries, a work week reduced to 40 hours, and the dignity in his calling that the average ward employe now has, we either have filled or have waiting lists in most classifications.

Although we acquired and are in the processes of acquiring more doctors, the universal shortage of trained psychiatrists works against us, as it will you, too. But the long-range answer to this—and it is not something demonstrable for some time—is to train doctors in our own hospitals, and to conduct research into the causes and more effective methods of treating emotional and mental disorders. However, we have compensated for the present shortage to no small extent by enlisting the part-time services of private practitioners and the facilities of our two medical centers, the Mayo Clinic and the University of Minnesota.

There is one very gratifying thing that we have experienced. That is the

virtual elimination of strait-jackets and other forms of mechanical restraints. At the beginning of the mental health drive in Minnesota, we had up to 1,000 patients in these barbaric devices. Practically all have been removed. The few left—less than you can count on one hand—are for temporary surgical or operative purposes.

I review these steps—as I can review many others—to testify personally to the recommendations of the Council's report and to the effectiveness of such recommendations as we already have instituted.

The results to date of our program bear out every justification for these recommendations. There is no room for us to say that they cannot be put into effect or to throw up our hands because of universal shortages in certain professional classifications.

Most recommendations can be put into effect, even if they do represent great effort: restraint elimination, improved food, better clothing, reduced work week, higher salaries, training, research, out-patient clinics, administrative changes, change in statutes pertaining to terminology, etc

While we have not in one short year eliminated all deficiencies, we have made improvements all along the line, improvements that critics originally said could not be made, and there are improvements in the patients that you can see with the naked eye. When the new building program is completed these will be even more evident.

For us as Governors this report furnishes a common ground for cooperation and action. Never before has any group had the opportunity to assume leadership in a human resources program of such magnitude.

I am confident that the report will be taken back, studied carefully, and incorporated to the fullest extent possible in our next legislative messages

Much more than the welfare of our patients is involved in this. The care of these voiceless and lobby-less patients is our moral answer to totalitarianism—to the totalitarianism that holds the individual, particularly the weak individual, meaningless.

It is our democratic affirmation of the dignity and rights of man. It is the most accurate barometer I know of our real concept of human values It is a challenge that totalitarianism cannot meet.

Half of hospitalized chronics can be rehabilitated, is claim

AT least half the patients now filling hospital beds because of the disabling aftermaths of chronic diseases could be rehabilitated and discharged, able to care for their personal needs, and in many cases to earn some sort of living, it was announced July 25 at Goldwater Memorial Hospital, New York City. The figures were revealed by hospital and medical authorities upon completion of the first year of operation of a project described as the first mass attempt to rehabilitate patients in a hospital devoted exclusively to chronic diseases.

The announcement of these findings concerning the effectiveness of modern medical and rehabilitation techniques when used in connection with persons disabled by chronic diseases, and their significance in view of the aging population of the country, was released jointly by Dr Marcus D. Kogel, New York City commissioner of hospitals, and Dr Howard A. Rusk, professor and chairman of the Department of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center.

The data upon which the announcement was based were compiled at Goldwater Memorial Hospital, a municipal hospital on Welfare Island in the East River, devoted solely to the care of persons with chronic diseases. The hospital's Department of Physical Medicine and Rehabilitation is staffed by faculty physicians of New York University College of Medicine.

These findings, Dr Kogel pointed out, emphasize the importance of a rehabilitation service in a hospital planning program. "In the department's plans for current and future hospital construction, the Rehabilitation Service will form a very important unit," Dr Kogel said "Each hospital, whether for general care or for a special service such as tuberculosis or long-term illness, or for custodial care only, will have associated with it a large and active rehabilitation unit This unit will serve not only the inpatients, but also clinic patients and those on Home Care

"The ultimate in any form of therapy, especially in conditions which leave some form of defect, physical or emotional, is to restore the individual to the greatest possible physical, social and economic usefulness," Dr. Kogel said. "In the general hospitals such attempts will be made early—during a period of dynamic convalescence in order to prevent the development of a chronic condition. If the treatment is to be continued over a long period of time the patient will receive his rehabilitative care in a specialized institution, such as Goldwater Memorial Hospital.

"Rehabilitation of the handicapped is a paying medical investment. It raises the individual's morale, generates a feeling of independence, restores him to some form of economic usefulness and in general provides a new incentive for life. The cost of the service to the taxpayer is more than repaid by earlier discharge from the hospital and the reduction in cost of hospital care for the individual patient, increased industrial productivity, removal from relief rolls and unemployment insurance, and the intangible benefits which flow from the addition of a useful citizen to the community," Dr Kogel stated

Speaking of the over-all medical significance of the project's findings, Dr. Rusk said, "The program at Goldwater Memorial Hospital has demonstrated that rehabilitation training, with its related physical therapy techniques, is one of the most valuable tools available for successful management of the country's chronically ill and aged. The employment and development of these techniques are badly needed by the medical profession for we are experiencing in the United States a growing epidemic of chronic diseases, and it can be expected that this country's aging population will increasingly suffer from physical and mental disabilities.

"In 1900, only one person in 25 was 65 years of age or older," Dr Rusk said, "but in 1980 the ratio will be one in ten." He said that 30 years from now our need for medical service will have expanded in a similar ratio and we will need double the amount of medical service that is available today

Reproduced from the original in the
Governor Youngdahl Records

of the Minnesota State Archives in the
Minnesota Historical Society
110 . E . 12 . 3 (B)
Box