

# The Minnesota Mental Health Program

JANUARY 1951



A Report to the Director of Public Institutions

**MR. CARL J. JACKSON**

From the Office of the Commissioner of Mental Health and  
Mental Hospitals

**RALPH ROSSEN, M. D.**

**MINNESOTA**  
HISTORICAL SOCIETY

# The Minnesota Mental Health Program

*To the Director, Mr. Carl J. Jackson, Division of Public Institutions:*

The following is a report of the office of the Commissioner of Mental Health for 1949-50. Since this is the first report from this office and covers a rather large scope, it will be more comprehensive and detailed than in the past,

The Commissioner of Mental Health of the State of Minnesota is charged with the development and administration of the Mental Health Program of the State. The broad outlines of the Program, and some important details, were written into the law by the 1949 Legislature which created the position of the Commissioner of Mental Health. But many specific problems and operating mechanisms remain to be analyzed and set forth. These will be examined here as they can be seen in the first year of the office of the Commissioner of Mental Health.

The Mental Health Program embraces all aspects from preventive hygiene to rehabilitation after hospitalization, but the most obvious and immediate problems are those of the state hospitals. In all parts of the United States, and particularly in Minnesota, the people are demanding new standards of understanding and medical care for the patients in our mental hospitals. The days of the custodial insane asylum are gone; the new day of the mental hospital, with standards equal to those of any general hospital, is rising. This is clearly the "Will of the People" and is a mainspring of the mental health movement

The essential human fact is the patient; there are nearly fifteen thousand patients in the Minnesota State Hospitals, comprising a tremendous catalog of varieties of misery and medical problems. But the real issue is not a mass of patients; the vital consideration begins with "One Patient" who was born, who had a childhood, who has all the bodily and emotional needs—and more, in the most cases,—of any human being. Examine *all* the needs of care and treatment of the one patient and the necessary ramifications of the program are revealed. The development and operation of the program starts from this one patient,

The bases of the Mental Health Program, and the responsibilities of the Commissioner of Mental Health, are indicated by excerpts from the Mental Health Bill, Minnesota Mental Health Policy Act, Chapter 512, Laws of 1949:

## MINNESOTA MENTAL HEALTH PROGRAM

"The State of Minnesota recognizes the necessity of adopting a program which will furnish dignity and hope for the patient, relief from anxiety for the patient's relatives and recognition for the psychiatric worker. ....

"Sec. 3 Subd. 7. At Hastings and Rochester, the Director shall establish training centers for the training of personnel and may require the personnel of the other institutions to attend such training centers from time to time in order that the personnel may be better equipped to carry into effect modern mental hospital treatment.

"Sec. 4. Subd. 1. There is hereby established in the Division of Public Institutions a Commissioner of Mental Health and Mental Hospitals .....

"Sec. 4. Subd. 3, The Commissioner, subject to the direction and control of the Director of Public Institutions, shall supervise the care and treatment of mentally ill or nervous persons and persons within those specified in paragraph (11) of Section 3 hereof. Within the limits of the appropriations available, the Medical Commissioner may provide consultative services for courts, and state welfare agencies, supervise the placement and aftercare of patients provisionally or otherwise discharged from a state hospital or institution, promote and conduct programs of education for the people of the state relating to the problem of mental health and mental hygiene. The Commissioner shall administer, expend and distribute Federal funds which may be made available to the state for mental health and mental hygiene purposes.

"Sec. 7 ..... The Director of Public Institutions is hereby constituted the "State Agency" as defined by the social security act of the United States and the laws of this state for all purposes relating to mental health and mental hygiene."

Obviously, these legal provisions call for the closest cooperation and the fullest degree of mutual confidence between the Director, of Public Institutions and the Commissioner of Mental Health. They must be in complete agreement on all matters of broad policy. The special province of the Commissioner would seem to cover all professional aspects of the Mental Health Program-medical care and treatment, training of professional and semi-professional personnel, and research. This means training of all employees from the psychiatric aide to the psychiatrist. Since in mental disease the total environment and living conditions of the patient are necessarily important in the psychiatric management, the Commissioner must also give close attention to these questions.

## MINNESOTA MENTAL HEALTH PROGRAM

. Other branches of the state government have responsibilities which are intimately related to those of the Division of Public Institutions and of the Commissioner of Mental Health. Moreover, there are other organizations in the state which are concerned with those problems. The Mental Health Program, then, must involve many agencies and it is important that effective interrelationships be developed between these several sources of aid and cooperation. Such a body as the Governor's Mental Health Advisory Board, which is primarily made up of leading psychiatrists who are not employees of the state, brings a wealth of wisdom and aid to the state officials, and they, in turn, bring knowledge of the problems of the state to the community at large. But on a less formal basis, it is believed that all persons who have official responsibilities in the Mental Health Program, must constantly seek to give and to receive aid from the courts and the judges, the city and county welfare agencies, the schools and churches, the medical and mental hygiene societies—everyone, in short, who can aid in the program.

On matters of public education and consultative services regarding mental illness and hygiene, there is in operation the Interdepartmental Council which serves as a coordinating body. This is composed of representatives of the State Divisions of Education, Social Welfare, Youth Conservation, the State Board of Health, and persons who bring the views of all other agencies in the state which have interest in these questions.

It is proposed to foster such cooperation and coordination to the end of achieving the highest degree of efficiency and effort in the Mental Health Program. Special mention must be made of the two great forces in medical work in Minnesota—the University, of Minnesota and the Mayo Clinic and Foundation. With both of these institutions increasingly active and cordial relations have been established in recent months. They bring to the Mental Health Program outstanding learning in the medical arts and sciences and extremely valuable assistance in the training of persons who are in, or who may enter, official positions in the hospital system.

### *Organization of the Commissioner's Office:*

The work of the office of the Commissioner of Mental Health is concerned with patients in hospitals and after discharge, with research and with mental hygiene, with the attitudes and education of the public at large. This work should be done very largely in the hospitals and out in the communities of the state. It is not proposed, therefore, to establish a large central bureaucracy. Besides a minimal central administrative office, the work falls in four major operating divisions which deal directly with the

problems where they exist. The office of the Commissioner is mainly a central reference point for the staff personnel working primarily in the hospitals and in the communities in four divisions; Hospital administration, training; mental hygiene, and research. The program of the central office is to coordinate the work of these four divisions and to develop a statistical control section for the service for all of the divisions and all of the state hospitals. Those functions, together with the programs of the four operating divisions, form the program.

The business aspects of the Mental Health Program should be operated from the office of the Director of Public Institutions in close conjunction with the other administrative offices of the state government. The professional aspects of the program, however, should be operated in close proximity to patients and to professional personnel at work. It is proposed, therefore, to place the professional office of the Commissioner at Hastings State Hospital which has the special advantage of maximum proximity to the University of Minnesota, the Mayo Clinic and Foundation, and to the great metropolis of the Twin Cities. Here also should be the center for in-service training and some special facilities for this should be provided.

*Hospital Administration:*

The purpose of this program is: 1) Improve existing conditions in all state hospitals in regard to care and treatment of the individual patient. This means a change in philosophy that can only be brought about through training and education; 2) shorten the period of hospital stay by earlier diagnosis and modern methods of therapy. This means good hospital administration plus research and training; 3) study the causes of unknown types of mental illness, in order to treat them correctly. This involves the study of research; 4) prevent re-admissions and admissions to state hospitals through good follow-up rehabilitation and out-patient care. This includes a public education program, the help of the medical profession and good follow-up and rehabilitation clinics; 5) the staffing pattern should be the same for each hospital. There should be one aide or nurse for every six patients with a ratio of one graduate nurse for each five aides. The Psychiatric Aide I position should be abolished and the Psychiatric Aide II position should be the lowest grade. This would be a greater incentive for people to work as aides. A graduate nurse with psychiatric training should be in charge of each ward,

The improvement of the organization, operation, and services of the state hospitals is a major objective of the Mental Health Program. The bas-

ic aim, in brief, is to develop these hospitals into a medically coordinated system made up of hospitals in the best sense of the word, fully equal to modern centers for the care and treatment of physical disorders. The operation of the individual hospitals, and the development and maintenance of high professional standards in them, is the responsibility of the individual superintendents. The task of the office of the Commissioner is to coordinate the work of the several hospitals, to establish uniform policies, and to aid the superintendents in all professional problems. While it is proposed to place the continuing responsibility for dealing with problems of hospital administration in the hands of a senior psychiatrist, the problems are so large and so numerous that all personnel in the office of the Commissioner must contribute to the work in this area.

*Admissions end Subsequent Work-Up:*

Patients must be seen on admission, having a primary physical and history within twenty-four hours and a complete neurological and psychiatric work-up within ten days. From then on there should be regular progress notes and re-evaluations of the patient at three, six, and twelve months and at six month intervals thereafter.

*The Environment:*

Aside from the medical and psychiatric treatment of the patient another important aspect is his environment. This has a powerful influence on his attitude, his mental and emotional status and on the tendency for his disorder to progress or regress. Beyond his environment of persons, all features of the environment must be considered. It is generally recognized that pleasant and restful surroundings are beneficial to patients and that ugly, unharmonious and noisy atmosphere should be avoided. Both the grounds and the inside of buildings should follow this theme. Overcrowding may be unavoidable without additional funds but by attention to color, drapes, light and bed arrangement, the wards can be made more cheerful and beneficial to the patient

The clothing of other patients and especially his own is important to developing emotional associations with the patient's picture of himself and his relationship to other people. Each hospital should have a place where patients might do a limited amount of shopping, of picking and choosing such clothes that are available.

On a more elementary level is the insistence that adequate clothing and mittens be provided for inclement weather and that outdoor workers have straw hats when they are working in the hot sun.

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aides and nurses are, as in other questions, of the greatest importance in the recreation program. These points must be stressed in the training programs within the hospitals. Recreation is the first step in a total push program. There must be recreation for the unoccupied as well as the occupied. The unoccupied number several thousand people especially in the younger age groups; and these patients must be included in the recreation program. This by itself explains the need for a very great number of recreational specialists.

*Occupational Therapy:*

It is recognized that the distinctions between occupational therapy, recreation, vocational training and just plain work are not always easy to make. The distinctions are psychiatric and psychological; they exist in the minds of both patient and doctor and must be established for each patient in the prescription of his treatment. It is insisted that this concept be accepted and adhered to so there is no possibility that over work, and possibly "slave labor," is disguised as occupational therapy. As in other areas of professional work in the state hospitals, the principle must be established that the occupational therapist is by no means the only person concerned with occupational therapy—doctor, nurse, aide, psychologist, must also be concerned. Moreover, every ordinary work assignment must be considered as at least potentially a therapeutic aid. To this end it is urged, that members of the non-professional staff—cook, painter, farmer and the like—be brought into staff meetings to learn that they too, are occupational therapists in their way. There must be insistence on a four hour work day for the patient and only longer if prescribed by his doctor. There is no objection to an eight hour work day if the patient works under a medical directive written by his doctor. The purpose of the four hour work day is to occupy more patients under supervised working conditions. When the condition arises that the patient can work a full eight hour day but yet is unable to leave the hospital because of his mental condition or the environmental situation at home, a percentage evaluation of his eight hour day as compared to that of a normal person's work should be determined. This evaluation should be done by the union covering that particular trade. In this manner we may eventually be able to pay the patient in proportion to what he does to keep up the institution and to recognize in writing that they are self sustaining and are helping to run the institution in the place of regular paid employees.

*Vocational Rehabilitation and Placement:*

For every patient the goal is eventual discharge and this means the necessity for the ability to earn a living. There are always patients who are



psychiatrically so improved that discharge would be possible but no suitable job can be found outside. It must be insisted that this question of vocational rehabilitation be considered early in the course of treatment of every patient. Attention to this point will also re-enforce the attitude of hope which should be brought to every patient. It is believed that more attention to vocational preparation for discharge and to placement outside will be rewarded by more discharges, more human happiness and a smaller hospital burden. In spite of efforts in this direction, however, it is evident that there are large problems to be solved. Accordingly, it is believed that intensive study and conferences by social workers, vocational specialists, psychologists, and representatives of employer groups are needed to provide realistic recommendations from the office of the commissioner.

#### *The Education of Patients;*

The question of patient education in the state hospitals involves both children and adults. The requirements for education of retarded children are obvious and increasing efforts should be made in this direction. There are also to be considered the educational needs of emotionally disturbed children and of children with neurological disorders. Clearly, presence in a state hospital should not preclude a child from all the advantages that ordinary education can bring. But the question is not so simple for adults. Vocational rehabilitation necessarily involves some education and there seems to be no valid reason why this must always be limited to the lowest level of simple skills. Moreover, in some adults it is likely that remedial defects in education may be involved in the production or maintenance of the mental illness. Insofar as education may contribute to the restoration to the community of the most acceptable and useful type of rehabilitated citizen, just so far must education be provided. It seems proper at this time to ask for joint consideration of all of these educational problems with the State Department of Education and with other experts in the field.

#### *Psychological Services:*

The value of trained clinical psychologists in the state hospitals is increasingly clear; but, as is true of other professional workers in the state hospitals, the jobs to be done are more numerous than the workers.

It is urged that the psychologists can perform many valuable services other than their own work with patients. For example, they should be able to develop and institute the use of simple but systematic behavior records which can be kept by the nurses and the aides. Another area of service is in evaluating the team work and inter-personal relationships be-

tween the different categories of employees. Advantage should also be taken of the fact that the psychologists have all had at least some training in statistical methods so they should be able to bring these techniques to bear on problems of the evaluation of various activities, including research in the several hospitals. In order to attract and retain the highest caliber of psychologists in the hospitals it is considered that attention be given to the frequent desire of these specialists to engage in research. In many cases it is believed that a psychiatrist-psychologist team on a research project in the hospital will create mutual stimulation and satisfaction and will benefit the operations of the whole hospital.

The functions of the Bureau for Psychological Services were expanded during the biennium by the addition of psychologists to the staffs of many institutions. The total number of psychologists and clinical psychologists in the Division of Public Institutions at the end of the biennium was 22 including six in the central office, two engaged in the training of psychiatric aides, one temporary appointment for a research project, one in the Fergus Falls Mental Hygiene Clinic, and ten assigned to various institutions. One position for a clinical psychologist remained unfilled. This total of 22 represents an increase of 17 over the number of psychologists employed in the previous biennium.

The central office staff has continued to extend psychological services—chiefly intelligence and personality testing—to public and private agencies throughout the state. During the biennium 7,772 individuals were examined. Charges were made to all private and some public agencies at the rate of \$8 per diem for these services and the total amount of \$11,908.50 was collected and deposited in the General Revenue Fund.

The bureau has initiated and directed several research projects including major efforts in the psychological evaluation of the long term effects of pre-frontal lobotomies, the selection of psychiatric aides, and the evaluation of electric shock therapy.

In-service training for psychologists has progressed through the media of the Anoka Center for Continuation Study, established by the Commissioner of Mental Health, regular psychological staff conferences, and seminars conducted by authorities from other states and agencies.

An internship program has been organized to go into operation in the next fiscal year. Seven psychological interns will be employed in six of the mental hospitals. These persons who hold the master's degree in psychology will gain practical on-the-job experience. The institutions will profit from the service performed by the intern and in having at hand personnel of known qualifications to fill staff positions.

*Recommendations:* A staffing pattern has been suggested with regard to psychological services for all institutions which would provide a ratio of one psychologist to each 600 patients or major fraction thereof. The chief of the psychology services at each installation should be a clinical psychologist who holds the doctor's degree. The central office clerical staff should be increased by one Clerk I to facilitate handling of records—particularly with regard to inter relating our work with that of the Youth Conservation Commission, the Division of Social Welfare, and other agencies.

*Psychiatric Social Services:*

The social services represent a principle contact between the hospital, the patient and his relatives, the potential employer, and the community. Since a prime factor in the commitment of the patient to a mental hospital is the wish of the community and/or the relatives for protection, the great importance of the social worker is evident. Moreover, the social worker obtains information about the background of the patient and this is essential for the doctor who has charge of the case. When discharge is contemplated, the social worker is a key person whose advice on the prospects of the patient for a job and for family and community acceptance is crucial. Properly done, such work is necessarily time-consuming and it is urged that the staffing pattern of the hospitals must recognize this fact. But even a considerable increase in social workers will not fully discharge the obligations of social service. Social agencies outside the hospitals, must, together with volunteer agencies and public spirited individuals, take a large burden. The problem in the social services, then, is partly one of supplying trained social workers and partly one of public education to assure full cooperation and help from outside the hospitals.

In this biennium, to June 30, 1950, the social services in the state hospitals increased several fold even though on a limited scale and each independently of the other. Because of the difficulty of filling the positions of Psychiatric Social Worker I, a substitute classification of Social Worker I was approved by Civil Service. It is in this latter group the additional staff was recruited. Of the ten hospitals, four do not as yet have a social service department. With the appointment of a State Supervisor of Psychiatric Social Services on April 19, 1950, the first steps were taken in the coordination and extension of the social services. Their functions in the hospitals were defined, and the creation of two new positions proposed: Psychiatric Group Worker and Psychiatric Social Worker II, the latter to be on a supervisory level. Statistics were gathered nationwide correlating recruitment problems with low salary schedules. Pending the establish-

ment of the supervisory position in each hospital, this function was discharged in so far as possible by the state supervisor on monthly visits to each institution. The basis of an evaluation of the extent and quality of the social services in the state hospitals was laid by requesting that copies of hospital records be sent to the central office for comparative purposes. Through the group meetings at the Center for Continuation Study at Anoka State Hospital a small beginning was made toward a larger program of in-service training. The discussions served to develop a feeling of unity among the social workers of the several hospitals.

The interest of the professional psychiatric social workers throughout the state in evolving the state hospital program has been maintained through service on an advisory committee to the state supervisor. The question of Foster Home Care as a therapeutic procedure was broached and will be studied.

The ratio of psychiatric social workers to patient population recommended by the Group for Advancement of Psychiatry, the American Psychiatric Association, and the American Association of Psychiatric Social Workers is one to every eight new hospital admissions, plus one for each sixty patients on provisional discharge. The proposed staff for the next biennium is based on those findings. Data used are those of the fiscal year June 30, 1947, to June 30, 1948, at which time there were 13 social workers. At present there are 16 and eventually a total of around 90 will be needed.

No basis for the determination of the number of social workers needed in relation to the epileptic and mentally deficient has ever been defined. As follow-up care is provided by the county welfare boards, the institutional social worker's responsibilities are almost wholly intra-mural. Because of the great number of wards to be served in the hospital, it is known the present staff is too small and should doubtless be doubled at least.

It is becoming more apparent that in order to attract social workers, a higher wage scale—compatible with what the veteran's hospitals pay is desirable. The same is true for aides, nurses, psychiatrists and others. In the meantime in order to help increase the discharge of patients ready to leave the hospitals, it is recommended that a position as Placement Officer and Rehabilitation Officer be established at each hospital. These people working under psychiatric directive can be of national aid to the program.

#### *Nursing Services:*

It is apparent that there is a great need for an intensive recruitment program in the nursing field. The recruitment program should be com-

prehensive in order that all areas of nursing care are adequately covered in the state hospital system. There is a need for a larger number of psychiatric nurses from the ward to the supervisory level. Each hospital should have on its staff a public health nurse trained in mental health who will be able to function in public health techniques as well as the mental health aspects. There is a need for trained pediatric nurses as well as nurses trained in geriatric care.

With the opening of the tuberculosis therapy center, nurses trained in tuberculosis care will be required.

It will be necessary to provide better living and recreational facilities if we are to make our positions attractive and in order to recruit qualified personnel in this field as well as all others.

Added to the central office staff, either full-time, part-time or on a consultant basis in the field of neuro-psychiatry and medicine are Dr. Gordon Kamman of St. Paul, Dr. L. E. Gowan of Duluth, Dr. Richard Anderson, Dr. Louis Flynn, Dr. James Garvey, Dr. Francis Barnes, Dr. Reader, Dr. Berkwitz and Dr. Lieberman. Dr. Barnes will be in charge of pediatrics at Hastings and a consultant to Cambridge and Faribault.

There is also in effect a Governor's Mental Health Advisory Board headed by Dr. Francis Braceland, Chief of Psychiatry at the Mayo Clinic, and many other well known men in the field of psychiatry and mental health in Minnesota. Included on this board are Dr. Burtrum Schiele, Dr. A. Challman, Dr. Walter Gardner, Dr. Ernest Hammes, Dr. L. E. Gowan, Dr. Howard P. Rome, Mr. Frank Rarig, of the Amhurst H. H. Wilder Charity, and Rev. Arthur Foote. This board meets once a month in an advisory capacity. They have been of great help in advising the office of the Commissioner of Mental Health.

Consultants are available in all fields of medicine; some on a part-time basis and some on an honorary basis. These men are all very well known and respected in their fields. Dr. Ancel Keyes, of the University of Minnesota, and Dr. Lawrence Kolb, of the Mayo Clinic, are co-consultants in the research and training program. As mentioned before, the research and training program is a very important part of the improved mental health program and is elaborated under the section of research and the section of training in this manuscript. Dr. George Fahr is in charge of the newly organized medical center at Anoka. All cases of mental illness with heart disease or diseases of the blood vessels, which present particular problems to the doctors of the state hospital system, can be transferred to Anoka where heart consultants and special equipment are avail-

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MINNESOTA MENTAL HEALTH PROGRAM    15

able. Dr. David Sharp and Dr. A. E. Krieser are the tuberculosis consultants who are to direct the new tuberculosis center to be opened soon at Anoka. A more detailed report on the important subject of tuberculosis control will be found in a separate section. There is a neurological center open at Anoka and one is to open soon at Hastings and Rochester State Hospitals. All special neurological cases associated with mental illness can be referred to these hospitals where they will be under the supervision of Dr. A. B. Baker, who is an outstanding neurologist and head of neurology at the University of Minnesota. Dr. Baker will also supervise a neuropathological laboratory to be opened shortly at Anoka State Hospital. This laboratory is at the present time operating at the University of Minnesota. State paid neuro-pathological technicians that have been university trained are at present working at the University and will soon be transferred to Anoka. All neuro-pathological material from any of the state hospitals can be shipped to this laboratory for special examinations, diagnosis and a report. This should greatly stimulate work in pathology in all of the

Part of the Center for Emotionally Disturbed Children was opened at Hastings on an emergency scale. Although the law states that there shall be such a center, no funds were appropriated to staff or furnish it.

The ultimate plan is to take over 4 cottages which will each house 30-40 children. The fifth cottage will furnish educational and dining facilities.

One cottage houses all children deemed psychotic by law under sixteen who have been housed in various state hospitals with adults. All future patients under sixteen who are committed as psychotic will go to this facility.

One cottage will be opened up shortly and house 30-40 children who are emotionally disturbed in addition to being mentally retarded or epileptic. The other two cottages will eventually house other emotionally disturbed children and neurotic delinquents in need of observation, care and treatment

It is important that funds be allotted by the Legislature to staff this facility properly. The need for additional beds for the mentally retarded is imperative and should be given number one consideration in our program, as there are many siblings, fathers and mothers who are becoming or are emotionally disturbed as a result of living in a home with a retarded child for years because there are not enough beds available to house these children. Geriatrics has become increasingly important in the past few years. In August of this year a National Conference on Aging was held in Wash-

## MINNESOTA MENTAL HEALTH PROGRAM

ington, D.C.: Dr. Ancel Keyes our consultant in research attended for the State of Minnesota and was on the committee for research. Mr. Oscar Ewing, head of the Federal Security Agency, later wrote Dr. Keyes stating that he and the other delegates to this conference were interested in our entire Mental Health Program and in particular our geriatrics problem.

At the present time, we have new geriatric buildings in use at Rochester, St. Peter, Moose Lake and Fergus Falls State Hospitals. In the section on new construction, below, we will discuss further plans for proposed units including geriatrics. The care of the aged is becoming an increasingly important nation wide problem. We can expect in the future to have more and more of this type of person admitted to our state hospitals. In Minnesota the percentage of patients first admitted to the seven state hospitals, age 65 or over, increased from 17.6% in 1938 to 35% in 1948.

### *New Construction:*

Other new construction this past year consists of the completion of receiving hospitals at Willmar and Hastings and one started at Anoka. Recommendations for needed new construction by the Commissioner's office are as follows: (A) A five hundred bed facility for the mentally retarded with an attached diagnostic center that will be located in the northern section of the state, at least 150 miles north of the Twin Cities. (B) A larger facility which would be within thirty minutes of driving from the University and within fifteen minutes of the Veterans Hospital, and which would not be over forty-five minutes from Faribault. This facility would contain: 1. A large common power-plant. 2. A common infirmary. 3. Three hundred geriatric beds for Ramsey County, three hundred geriatric beds for Hennepin County. 4. A five hundred bed facility for the mentally retarded, which will include a diagnostic center. 5. A 50 bed facility for emotionally disturbed children needing short intensive periods of therapy, with an attached diagnostic center. All units under (B) except 1 and 2, to have no relation with each other and to have their own respective campus. By having a common power plant and a common infirmary there should be a saving of several millions of dollars in building this type of facility.

The reason for the location of the facility mentioned in (B) is: 1. Proximity to the University and Veterans Hospitals which would make it possible to incorporate a medical and nursing residency program in pediatrics, psychiatry, neurology, geriatrics, genetics, and education. 2. To make it easier for old people to visit their relatives in the Twin City areas.

3. Facilities in this area would attract good doctors, who are retirement age, and who have their homes in south Minneapolis or St. Paul, and who would be available to work in the geriatric centers for both Ramsey and Hennepin Counties. This would insure the practice of good medicine in the geriatric field and offer a future in this specialty.

It is realized other units of new construction will be presented through the various state hospitals.

Follow-up and rehabilitation clinics are functioning at Fergus Falls, Hastings and, Minneapolis. There will also be a clinic in operation at Albert Lea. These clinics are important in helping former state hospital mental patients in their readjustments. At this time there are plans for a follow-up clinic at Willmar and Minneapolis for people addicted to drugs and alcohol. The Alcoholics Anonymous should be recognized for their excellent work and be incorporated in the state's mental health program if at all possible.

In the state hospitals themselves some of the most outstanding advancements are the equalization of one diet for both personnel and patients under the supervision of trained dietitians.

Virtual elimination of mechanical restraints in seven of the nine hospitals has been accomplished. One hospital still has a considerable number in restraint up to date. A "total push" program has resulted in recreation for many of the formerly unoccupied patients with the resultant relative improvement in the patients' mental and physical well being. The training of the hospital personnel also should be included its one of the primary outstanding advancements in the state hospitals.

#### *Staffing Pattern:*

A definite pattern must be established in regard to the ratio of patients to personnel. Considering good administration and looking ten years ahead, we suggest the following optimal staffing pattern for each of the state hospitals, full well realizing that this is impossible to fulfill at the present time, but yet presenting the anticipated needs of a program, to give the best care and treatment which in the long run will be the most economical:

A Clinical Director (Psychiatrist)

An Assistant Superintendent; or a non-medical administrative assistant.

Director of Laboratories

Psychiatrists and Physicians; in the ratio of 1 per 150 patients. One physician should be responsible for public health, sanitation and health education.



Dentists and Dental Hygienists; 1 per 800 patients or major fraction thereof. It will be necessary that equipment requests be coordinated with this request.

### Laboratory Workers

**1 Laboratory Technologist per 500 patients**

**1 X-ray Technician**

**1 Electro-encephalograph Operator (where equipment exists or is requested in budget) or a Research Scientist I.**

Psychologist:

**1 Clinical Psychologist and**

**1 Psychologist for each 1000 patients**

Psychiatric Social Workers:

**1 Psychiatric Social Worker II**

**1 Psychiatric Social Worker per 500 hospital patients and 1 for each operating out-patient or rehabilitation clinic.**

Chaplains:

**2 Chaplains (unclassified service) per 1000 bed hospital.**

Barbers;

**1 Barber per 200 male patients**

Cosmetic Therapists:

**1 Cosmetic Therapist per 200 female patients.**

Nurses and Aides:

**1 of either per 6 patients but in a ratio not to exceed 1 graduate nurse for each five aides. These include all levels of nurse and aide except surgical nurses and nursing school principal and nurse instructors. One of the nurses shall be a public health nurse. trained in public education and shall assist the medical staff member in all phases of sanitation and public education including teaching sanitation and public health to staff and others. This nurse shall be designated as the nursing sanitation and public health officer.**

Surgical Nurses:

**2 Surgical Nurses for each operating room may be requested.**

Nursing School:

1 Nursing School Principal, regardless of whether or not an affiliate program is to be operated. Under either condition the nursing school principal shall be charged with the responsibility of teaching aides, nurses and other staff.

1 Nurse Instructor or Psychiatric Aide Instructor (use level of Psychiatric Aide III (for salary purposes) for every 500 patients. These employees are to devote full time to teaching and training • of aides and other employees.

1 Nurse Instructor for each 25 affiliates.

Librarian:

1 Librarian II 1  
Librarian I

Patients' Activities:

1 Patient Program Supervisor I 1

Occupational Therapist II 3

Occupational Therapists I 1

Recreational Leader II 3

Recreational Leaders 1

1 Handicraft Instructor or 1 Recreational Worker for each 150 patients.

Art Therapists, Music Therapists, placement officers or vocational rehabilitation counselors may be substituted for either handicraft instructors or recreational workers.

Physiotherapists;

2 Physio or hydro therapists may be proposed.

Food Preparation and Service:

1 Dietitian II (Covers the basic first 500 patients.)

1 Dietitian I for each additional 500 patients or major fraction thereof above the basic first 500 patients.

1 Cook IV

3 Cooks III per kitchen having a 500 or more patient capacity. Cooks II and I; 1 per 150 patients at a ratio of 3 Cooks II for each Cook I,

Custodial Workers I (main kitchen) 1 per 500 patients.

1 Baker II (Covers basic first 750 patients.)

Baker I 1 for each 750 patients above the basic 750 patients.

- 1 Custodial Worker I (bakery)
- 1 Food Service Supervisor and 1 Custodial Worker 1 for each 100 patients.
- 1 Meat Cutter or Butcher for each 1000 patients or major fraction thereof. 1 Pasteurizer for each 1000 patients or major fraction thereof

Laundry:

- 1 Laundry Supervisor
- 1 Laundry Worker II (washing unit)
- 1 Laundry Worker II (finishing unit)
- Laundry Workers I and Custodial Workers I to represent an increase of not to exceed 30% more than present total laundry staff.

Housekeeping:

- 1 Hospital Housekeeper
- 1 Housekeeper per nurses' dormitory
- 1 Maid
- Custodial Workers I for janitorial and cleaning needs will be considered and determined at preliminary hearing on basis of need.

Pharmacy:

- 1 Pharmacist

Miscellaneous Services:

- Mattress Maker—not to exceed 1 per institution
- Shoemaker—not to exceed 1 per 1500 patients
- 1 Tailor Shop Foreman
- 1 Seamstress per thousand
- Truck or automobile driver—not to exceed 2 per hospital except where special needs are presented and approved.
- Night Watch (estimate as Custodial Worker I) not to exceed 2 per hospital.
- Psychology Interns, Recreational Interns or Trainees, Occupational Therapy Trainees, and Psychiatric Social Work Trainees or other trainees may be included if desired.

Business Management and Clerical Staff:

- 1 Executive II or III (Business Manager)
- 1 Accountant or Executive I

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MINNESOTA MENTAL HEALTH PROGRAM

2 .Account Clerks  
1 Medical Records Librarian  
2 Stores Clerks  
5 Switchboard Operators I (or equivalent number of Clerks I  
or Clerk Typists I where switchboard does not warrant a  
switchboard operator.)  
2 Clerk Stenographers III  
4 Clerk Stenographers II  
Clerk Typists I                      1 per 300 patients to be distributed  
Clerk Stenographer I              according to the hospital needs.

Clerk I

Personnel for power, buildings, grounds, farm, garden, to be apportioned to the needs of the individual institutions.

We should attempt to shift and synchronize our efforts in every way in preparing the budget, to emphasize the institution as a place for care, treatment and rehabilitation for the total personality of each patient. The institution should have a budget that can integrate a program for each patient on admission, complete neuro-psychiatric work-up, recreation therapy, occupational therapy, vocational rehabilitation, education or work with anticipated discharge and follow-up in the shortest possible time.

There can be no question that all of us have directed our thinking toward the objective of rounding out the program for successful patient rehabilitation. It is evident that we agree that our requests must be realistic in their recognition of the present and anticipated economic manpower conditions and must present a substantially uniform pattern, differing from hospital to hospital only where the deviations can be supported by clearly established and easily understood conditions or needs. Under the plan adopted by the last Legislature in distributing the addition of the authorized fifty-five per cent of our requested personnel over a period of time, the full financial effect of the added staff will be felt only during the last six months of the biennium. This means that our personnel services appropriations will be substantially larger during the next biennium regardless of whether or *not* additional staff is authorized. In view of the present cost of living trend and the manpower shortages, it would appear that an upward adjustment in wages may be anticipated during the next biennium. To insure the necessary number and quality of personnel, we recommend an increased pay scale for all hospital personnel in order to compete with the veterans' hospital and other state, federal and private psychiatric facilities. We do not anticipate that the training and research budget will need to be ex

panded to any appreciable extent for the coming biennium. The central

office budget, that portion of which comes under the Commissioner of Mental Health, needs considerable revamping, and each position under our office will integrate with one of the four main sections; Hospital Administration, Training, Research or Mental Hygiene. In this way each position will synchronize with a similar position in a similar section at each state hospital. It is imperative that there be appropriations established to staff the Center for Emotionally Disturbed Children.

### *TRAINING*

The success of the Mental Health Program depends, to a large measure, on the skill and the morale of personnel administering and operating the program. Consequently, a proper training and indoctrination of the hospital personnel is of crucial importance. The training program, at the present time, includes everybody in the state hospital system, from the aides to the superintendent. The care and treatment of mentally ill patients is a complex matter and it *is* carried out by a team of workers—the psychiatrist, the nurse and the aide, the psychologist, the recreation worker and occupational therapist, the chaplain and the social worker. The energies of this team must be focused, in an integrated manner, on the patient. It is not enough to train every member in his particular specialty. It is necessary, also, to train the individuals for the demanding but rewarding task of working as members of a complex team. Particular attention has been devoted to the clarification of the duties of closely allied and partly overlapping groups, particularly the nurses and psychiatric aides, and recreational workers and occupational therapists. The psychologists in several meetings sought to define more clearly their job in the framework of the mental hospitals.

An active, dynamic mental health program must involve a change of attitude and philosophy in the care and treatment of the mentally ill in state hospitals. The basis of this program is aimed at the individualization of the patient and at doing away with care and attempt at treatment en masse. Because of lack of psychiatric personnel and the great number of patients assigned to one psychiatric aide, unproductive custodial care had consisted of quieting the actively disturbed, while the equally ill, but relatively quiet, mute, regressed individual was ignored. When there were more disturbed patients than the overworked attendant could handle, he resorted to the use of restraints. Thankful that the patient was causing no added difficulty, he allowed the mute catatonic to sit quietly in his corner, having no time to attempt to activate him. No recreation facilities or occupational therapy were available for the unoccupied regressed individual, and the personnel

available for the handling of the actively disturbed was insufficient. This led to the development of the "back wards," with increasing numbers of people, who by virtue of their presenting symptoms were neglected medically and sociologically.

The psychoanalysts and psychotherapists spend as long as a year or more seeing one patient for one hour daily, several times a week, or weekly—this is done to diminish or cause the disappearance of, or prevent the recurrence of the symptoms of emotional disturbance in one patient.

We now turn to our aim: What can be done to rehabilitate one mute, regressed catatonic who becomes the recipient of the persistent energies of a unified psychiatric team consisting of a psychiatrist, psychologist, social worker, recreational worker, occupational therapist, nurse, psychiatric aide, and other interested individuals or groups. How can this be done? The answer lies through persistent "on-the-ward" in-service training and teaching, beginning with the psychiatric aide. Thus, if there are two aides on an eight hour shift, one aide watches the group, while the other divides his time, individualizing each patient daily, giving about five minutes to each one. For each person, on two shifts, this becomes ten minutes of individual attention. The recreational worker adds five minutes of individual attention, as does the social worker, the occupational therapist, the psychologist, the nurse, the doctor, and others. The doctor's office is on the ward, and if assigned three wards of 100 patients each, he would spend two hours daily on each ward, and give at least five people individual therapy for a minimum of fifteen minutes each. His team will operate in a group always in his proximity, thus psychiatric directive for any member of the team will always be available. This method or procedure need not interfere with any other existing programs of therapy involving groups in the field of the volunteer worker, recreational and occupational worker, or any other progressive endeavors.

The above-described method of treatment has never before been attempted in state hospital systems because of insufficient personnel. We have been forced to think in terms of one attendant for every 75 to 100 patients, or in terms of one doctor for every 300 to 500 patients. Total push methods have been tried with groups of "back ward" patients, but no state hospital system has ever tried directing the energies of unified psychiatric teams toward *ONE* "backward" patient in a sustained manner over a period of years. An expanded mental health program will therefore emphasize total push, care and treatment of one "back ward patient" utilizing all available psychiatric team energies. The improvement of *ONE* psychiatric patient, multiplied 15,000 times is the core of our program. However, by placing

the emphasis on one patient we learn from his psycho-biological behavior and we institute a doctor-patient relationship where therapy, through medical directive, utilizes all available energies of hospital personnel. We must get away from treatment en masse.

Much attention has been paid to the training of psychiatric aides. Significantly, changing the title of "attendant" to that of "psychiatric aide" was one of the first steps in the inauguration of the mental health program. Changing labels, obviously, achieves little or nothing. It must be accompanied by a change in attitude and increased competence. The psychiatric aide—or the nurse, if she serves as a ward worker—spends more time in intimate contact with the patient than any other member of the hospital team. He can be curt, impatient, irritable, and cold; or he may show understanding of the mentally ill patient; being kind, infinitely patient, always reassuring, and radiating personal warmth. The psychotherapy carried on by the best psychiatrist can be counteracted by the wrong handling of the patient by an unfit aide. The aide may use cold packs as a threat or punishment rather than as a treatment. He may insist on the letter of the hospital rules in the same spirit of malice and revenge. The aide alone can make sure that the patient gets his food warm and that he eats it or that the patient's refusal of food is reported. The aide can change the location of the bed on which the patient sleeps, if the patient is disturbed when sleeping next to a patient who "gets on his nerves." The aide can make the patient feel more or less secure, more, or less hostile, and either further interfere with the patient's rapport with the psychiatrist. At night he can report an illness immediately when the symptoms, such as high temperature, are discovered or he may wait until morning, when it may be too late. Often he can prevent serious accidents by an early separation of patients who are apt to get into a fight. The aide can change occupational therapy and work, beneficial to the patient, into slave labor.

As far as the physicians in the state hospitals are concerned; the absence of provisions for the specialty boards has been a serious limitation to their recruitment and professional advancement. The goal should be to make each of the state hospitals acceptable for board training in neurology and psychiatry. In addition, it is desirable to have several of the state hospitals acceptable for board training in other areas, such as internal medicine and pediatrics. The Office of the Commissioner has directed determined efforts toward these ends. At this time it is very likely that the hospitals at Hastings and Rochester will be certified for board training in Neurology and Psychiatry.

In this connection the working relationships with the Mayo Clinic



and the University of Minnesota are of particular value. In the past two years members of the following university departments participated in some phase of training: psychiatry, neurology, radiology, pediatrics, surgery, social sciences, and the School of Public Health.

The overall training program now in action involves several phases:

- 1) Continuation Center
- 2) Training program at individual hospitals
- 3) Visiting psychiatric training team
- 4) Hospital conference (consultation) team
- 5) The training center at Rochester
- 6) The central training school at Hastings
- 7) Research training

These will be briefly discussed in their turn.

*Continuation Center:*

in the past, the individual mental hospitals were largely autonomous and isolated. The new mental health program demanded raising the overall standards of care and treatment, necessitating a greater uniformity of policy and practice. It raised technical and professional problems the solution of which demanded pooling of resources and brain power. It called for a demonstration of the importance of team work and clarification of the implications of a psycho biological approach to the personality of the patient

These needs were met by establishing regular continuation center meetings. The program was initiated in March, 1950, and the meetings were held twice a month until July, 1950, when their frequency was reduced to once a month. Frequent meetings were needed initially in order to provide for an intensive indoctrination in the general policies and methods of the mental health program. Because some of the participants have a long way to drive, it is planned to alter the schedule and provide for two-day meetings to be held at intervals of two or three months. Interested professional groups may meet in the interim to discuss their particular problems. In 1950 the meetings were held at the Anoka State Hospital except for one meeting which took place at the Moose Lake State Hospital. It is planned to transfer the meetings to the Hastings State Hospital which, together with Rochester, has been designated by law as one of the two training centers. The transfer is dependent on the completion of facilities for holding the meetings and housing of the attending personnel.

The meetings are attended by heads of all departments of each state hospital. The professional staff of the office of the Commissioner provides

the leadership for those groups represented on the central office staff (psychiatrists, psychologist, social workers, recreational workers, and dietitians). Other groups attending the meetings included nurses, psychiatric aides, laboratory technicians, chaplains, dentists, and business managers.

The mornings are devoted to clinics illustrating the focusing of energies of all members of the hospital team on one patient. The case presentation is directed by the psychiatrist but it is carried out with the direct participation of a panel consisting of the members of the hospital team who have anything to contribute to the review of patient's life history or the program of care and treatment. Occasionally, the panel may include personnel who has a direct and important contact with the patient, such as the individual who is in charge of the laundry or the carpenter, but whose potential role in the total treatment of the patient frequently does not receive adequate attention.

The procedure usually followed is to have the summary of the case history presented by the psychiatrist. Relevant aspects of the social history are presented by the social worker. The psychologist interprets the results of mental measurements. The ward worker—which is at times a nurse, at times a psychiatric aide—contributes information relative to the behavior of the patient on the ward. The dietitian discusses the feeding problems, if any are present. The recreational worker and occupational therapist describe their contact with the patient. The patient is then brought in and interviewed by the psychiatrist, if possible. Following this the diagnosis of the patient is considered in the light of available information and a further program of care and treatment is outlined. The morning clinic is concluded by questions from the floor and by group discussion.

In the afternoon the several specialty groups meet separately. The case of the patient presented in the morning is discussed by the separate groups from the point of view of each specialty and its function in the total program of care and treatment. In addition, attention is given to professional problems faced by the particular group. For this purpose, at times, outside lecturers are brought in. These have been for the most part, members of the faculty of the University of Minnesota. At the end of the day, all groups meet again and their representatives summarize the main topics and conclusions of the group discussions for the benefit and information of all participants.

The continuation center meetings hold an important place in the over\* all training program. They show, by means of an illustrative case, how the energies of the psychiatric team can be directed toward one patient. Emphasis is placed on the total personality of the patient and his function\*

ing on the highest level, of which he is capable is set as a goal. If this means the possibility of returning as a productive member to the society, so much the better.

The value of the continuation center as an instrument of training has been recognized by persons prominent in psychiatry and in the mental hygiene movement who served as lecturers at the continuation center meeting, such as Dr. Karl Menninger (Kansas) and Col. Edmund Bullis (Delaware).

*Training Program at Individual Hospitals:*

The responsibility and opportunity for an intensive in-service training of all groups of employees rests on individual hospitals. Regular and effective staff meetings provide the best medium of training. Provision has been made in the majority of the hospitals for conferences of the medical staff as well as for administrative meetings which include the technical service staff.

Of particular importance has been the pre-service orientation and continued in-service training of psychiatric aides. The aides come to their exacting and important job with little or no preparatory training. Consequently, the orientation and indoctrination of the aides is one of the crucial phases of the whole training program. In the past two years considerable attention has been devoted to this problem at the individual hospitals. After some experimentation with different types and lengths of the pre-service training, a general agreement has been reached that each new aide must have at least 80 hours (10 work days) of systematic instruction, covering all aspects of the job, before he can be entrusted with relatively independent work on the ward.

The state hospitals at present employ some 1400 psychiatric aides and this number will be increased in 1951. Many of these persons are relatively new employees, and from recent experience, it must be expected that a continuing high turnover will call for training 300 to 500 new aides each year. This is a serious problem because of the numbers of wholly untrained persons involved, and because of the great importance of the aide to the physical and mental welfare of the patient

The psychiatric aide, particularly the new appointee, obviously needs a basic guide—regulations, instructions as to duties and procedures—for private study and reference. There is no such manual provided in the Minnesota State Hospitals and, in fact, nothing really suitable of this nature exists anywhere. Several of the Hospitals have assembled sets of rules and there are in print a few books which attempt to explain the work

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sub-professional medical care of the patients. However, their approach is limited in that the teaching is essentially expository, didactic. This refers not so much to the technique of training, which does include on-the-ward work, but to the general approach. The training team operates on the basis of a critical evaluation of the individual patient's needs. It attempts to teach not so much what a good aide does but how he can improve in what he is doing as a member of the hospital team.

The inclusion of supervisors in the groups assigned to the training team, instituted during the summer of 1950, as well as the activation of administrative channels of information and supply and their orientation to the individual patient's needs is also a distinctive feature of the approach of the psychiatric training team. Another feature is the combination of practical demonstration by the team members of concrete procedures and the active participation of the trainees. The contact of the aides with the training team is limited in time but it is intensive. The "teacher-pupil" ratio is much larger than can ever be hoped for in orientation classes of the more traditional type.

The training program is based on the plan of approaching the overall problem of care and treatment of an individual patient, both in reference to his physical environment and his interpersonal relationships. For an effective operation of the training program two patients are selected—one male and one female.

The minimum personnel needed to insure the proper functioning of the team includes a psychiatrist, three psychiatric aides, a recreation worker, and a psychiatric nurse. For most of the visits, no psychiatric nurse was available. The team spent a week at each institution it visited, except for emergency periods during which the team helped with converting Sandstone into a mental hospital and with the setting up of the central training school at Hastings.

### ***Hospital Conference (Consultation) Team:***

The team consists of the heads of the departments in the office of the Commissioner of Mental Health. It began to function in May, 1950. Each month the team visits all the state hospitals where the individual members meet for a conference with the divisional heads of the particular hospital. They serve primarily in a consulting capacity. Obviously, training, consultation (and inspection) are difficult to separate.

: It has been felt that at the present time shorter and intensive visits, rather than longer and extensive visits, are desirable due to the need for a close follow-up on suggestions for improving patient care, made by

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be individualized and requires, as teachers, experts actively engaged in investigative work. Research training in various specialties of the medical sciences is being provided in the several research units in the hospitals.

In addition, as a part of the activities of the division of training in the office of the Commissioner, a research seminar is being established at Hastings. The seminar is organized around the Hastings Research Center as a nucleus but is open to all qualified personnel within the mental hospital system concerned with the planning, executing, and reporting of research.

*Chaplains:*

The provision of religious counsel and comfort to the patient in the mental Hospital requires at least some training of the ministers, priests and rabbis who provide such services. In parallel with the establishment of regular positions of chaplains as hospital employees, a training program for chaplains has been started and will be further developed. This program provides that appointees who have not had special training for work in mental hospitals shall receive systematic in-service instruction and shall be, from time to time, sent elsewhere for limited periods of organized special education. These provisions will aid recruitment of good men as well as assure progress in the effectiveness of their work.

A Chaplains Advisory Committee consisting of 7 members appointed by the Director of Public Institutions has been formed. The appointments are for the length of 4 years and include chaplains of all denominations. The number of chaplains will be determined by state institution population and the faith represented according to the church census of the state.

*Other Training Problems;*

The unique character of mental hospitals means that all employees must have at least some measure of indoctrination and training so as to achieve full understanding of the patient and the dependence of his welfare on the combined efforts of all of the staff. For this reason there have been brought into the continuation center and other meetings employees whose responsibilities may not seem at first sight, to have much direct connection with the treatment of the mental disorder of the individual patient. But the experience of widening the circle to include business managers, dentists, and maintenance workers, is encouraging and it is planned to develop

further the training of all classes of employees in the state hospital system.



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tions. Proposals were received and approved, from the Divisional Office, St. Peter, Faribault, Willmar, and Hastings State Hospitals; and provision was made for prospective proposal from Rochester State Hospital. From this and further meetings in the fall and winter of 1949-'50, the general pattern of research expenditures was established on the following principles:

- 1) Research support, within budgetary limitations should be available to competent experts in any of the state hospitals.
- 2) Each of the hospitals should be considered a potential research center and every professional employee a potential research worker.
- 3) The allocation of research funds should be made by the Commissioner of Mental Health, with the advice of a committee representing each of the hospitals, on the basis of proposals for research projects.
- 4) Experts from the University of Minnesota and the Mayo Clinic should be asked to give continuing advice on various phases of the research program,
- 5) The research program is necessarily related to some aspects of the program of professional training in the hospitals and this fact should be recognized in plans and operations.
- 6) At present, limitation of both funds and trained personnel will make it necessary to specialize research activities in several hospitals. A suitable arrangement would be to develop general research centers at Anoka, Hastings and Rochester State Hospitals, where University and Mayo Clinic help could be expected most readily, and to concentrate at the other hospitals more specialized activities appropriate to their facilities. This would mean for example, work on convulsive disorders at Cambridge, on problems of addiction at Willmar, and on problems of the aged at Fergus Falls.

Since February, 1950, when the position of Commissioner was filled by Dr. Ralph Rossen, these general arrangements have been crystallized and the research program has begun to operate. The major items of progress to be recorded at present are:

- 1) The establishment of sound policy as indicated above,
- 2) Construction of a research laboratory and installation of basic equipment for physical and chemical analyses and measurements at Hastings State Hospital. An ultracentrifuge and spectrophotometer, for **example**, are major items,

- 3) Establishment within the State Civil Service of three classes of Research Scientist positions to allow employment of experts in any of the scientific disciplines which may contribute to research on mental and nervous disorders.
- 4) Enlistment of part-time and voluntary help on research activities of experts from the Mayo Clinic and the University of Minnesota departments of neurology, surgery, pediatrics, anatomy, biochemistry and physiological hygiene.
- 5) Recruitment of a nucleus of full-time workers and assistants for research.
- 6) Initiation of dietary and metabolic studies under controlled conditions on 21 patients' resident at Hastings. The first 3 months' study, arranged partly to train staff and patients and to gain experience with the procedures, was devoted to cholesterol in the blood as related to the fat and cholesterol content of the diet. Cholesterol metabolisms are of importance because cholesterol is one of the major constituents of brain and nervous tissue. Already this work is indicating that the fat in the diet has more effect on the blood cholesterol than does cholesterol itself in the diet. This and other work on metabolism is being expended.
- 7) Studies on the preparation and tenacity of plant and animal nucleic acids which may be suitable for oral or intravenous administration to man. The nucleic acids are of great interest in view of their reactions in neutralizing various viruses and their high concentration in the nuclei of living cells, notably the brain, About 120 different nucleic acids have been prepared from plant and animal tissues and some of these have been tested for toxicity, This work is being continued in the hope of obtaining an active preparation which will be safe for use.
- 8) Studies on the possible use of malononitrils injections in patients with schizophrenia showed, on animals, evidence of toxicity. While it is hoped to continue this work directed toward modification of cerebral function in schizophrenia, the problem of toxicity must be solved before it can be used with man. This type of investigation should be extended using other nucleic acids, pentnucleotide, adenine, other purines and pyrimidines.
- 9) Technical methods have been, and are being developed and applied to the chemical analyses and microscopic study of brain tissues, particularly tissues removed during surgery on the brain, It is believed that work of this nature is essential to the recogni-

tion of physical disorder in the brains of persons with mental disease.

- 10) At Fergus Falls, clinical research is in progress on the results of "total push" in the treatment of mental patients. Such evaluation studies of treatment should be constant progress in all of the hospitals.
- 11) The familial factor in mental deficiency is being studied from family and case records at Faribault State School and Colony. The findings so far are giving valuable data on the relative role of heredity in mental deficiency.
- 12) A careful study has been completed on the clinical results in 100 patients of pre-frontal lobotomy. The findings are of great interest and value and have been presented at several national meetings of psychiatrists. The combination of brain surgery and "total push" holds high promise for suitably selected patients. Some side effects, however, appear in some patients and efforts must be made to discover why this occurs.
- 13) A detailed study has been made on the long-term effect of pre-frontal lobotomy on the flicker-fusion frequency of light. This work at Willmar State Hospital definitely refutes the belief that pre-frontal lobotomy reduces the ability to discriminate flashes of light
- 14) Abnormalities in the function of the autonomic nervous system in schizophrenia have been suggested frequently without proof. What seems to be definite proof of such abnormality now seems to be shown in a study on patients from Anoka and Hastings State Hospitals. The abnormality is in the rate and character of skin temperature response to local (but distant) thermal change. This finding controlled by parallel studies on many normal individuals, indicates that more attention for diagnosis and prognosis should be given to the study of autonomic function in mental patients.
- 15) A research program in the field of Electro-encephalography "brain waves" has been in operation and has involved studies (a) before during, and after frontal lobotomy; (b) before, during and after histamine therapy; (c) correlation of EEG findings, and seizures following lobotomy; (d) E.E.G, and studies in genetics.

The foregoing list of research operations is not exhaustive but will indicate that already an active and sound research program is beginning to

operate and to yield results. At this early stage of development the lack

tion of physical disorder in the brains of persons with mental disease.

- 10) At Fergus Falls, clinical research is in progress on the results of "total push" in the treatment of mental patients. Such evaluation studies of treatment should be constant progress in all of the hospitals.
- 11) The familial factor in mental deficiency is being studied from family and case records at Faribault State School and Colony. The findings so far are giving valuable data on the relative role of heredity in mental deficiency.
- 12) A careful study has been completed on the clinical results in 100 patients of pre-frontal lobotomy. The findings are of great interest and value and have been presented at several national meetings of psychiatrists. The combination of brain surgery and "total push" holds high promise for suitably selected patients. Some side effects, however, appear in some patients and efforts must be made to discover why this occurs.
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The foregoing list of research operations is not exhaustive but will indicate that already an active and sound research program is beginning to operate and to yield results. At this early stage of development the lack

ample as to how buying one instrument and studying one chemical in a patient leads to learning more about the whole person note the following. The ultra-centrifuge was purchased and the study of cholesterol was carried out. Cholesterol was then found to not only play an important part in the brain and nervous tissue but also in the function of the heart and was related to hypertension. We thus find that in studying one part of the patient we are discovering and treating the patient as a whole. A real hospital system is based on medical science and the life blood of medical science is research. Mere contacts with research develop a forward-looking and analytical approach.

*Expenditures for Research:*

The very nature of research precludes detailed anticipation of many needs for new tests and measurements, and thereby new items for purchase suddenly become critical. While basic items and large pieces of apparatus can be planned for, many purchases must be made only when the need is "apparent from the actual findings of the day-to-day work or from the publication of new information from other laboratories. It is imperative therefore; that appropriations for research be kept as fluid as possible and those ordinary purchase requirements for long anticipation of needs be removed or reduced to the minimum. By the same token, long delays in processing requisitions for many research items are very expensive, in terms of time lost and of frustration of the research staff. The office of the Commissioner hopes that suitable adjustments of purchasing routine to the special character of research needs can be made,

One patient is made up of many millions of cells. These cells can be studied individually, or as groups by using methods known to chemistry, physiology, anthropology, cytology, biology, electro-physics, neuro-surgery, psychology, sociology, psychiatry, and other sciences. How can we begin a training program that will individualize one patient? This can be done only by intensifying, increasing, or introducing carefully planned programs in all aspects of neuro-psychiatric research and training. Thus, when clinical therapy has been shown to be of no avail in the individual who does not respond, we continue through research methods in a sustained manner to discover *why* he or she did not respond, and the "back ward" then changes to a laboratory where medical science will seek the answers to psychiatry in the future.

***Mental Hygiene Services***

As with all other diseases, the prevention of mental disease is the final goal of medical work. It must be recognized that the science of mental

hygiene is as yet in the most rudimentary stage of development and there is a dire need for research to discover elementary principles as well as to develop methods of application. However, there is an important body of knowledge which can be applied now and the Minnesota Mental Health program must utilize this to the fullest possible extent.

Any statewide program on mental hygiene must stress the following:

- 1) The provision of facilities to aid patients discharged from state hospitals, with a view to the prevention of relapse or recurrence of mental illness and to aid in rehabilitation; 2) the provision of facilities to give advice to patient and relative alike, where commitment to a state hospital may be avoided and where private psychiatric help cannot be provided; 3) special education of the general medical profession regarding the recognition of mental illness, the estimation in individual patients of its character, severity and prognosis, the understandings of currently available methods of care and treatment, and the responsibility of the general practitioner in these matters; 4) public education on the nature of mental illness, its treatment, and the general principles of *its* prevention so far as these are known.

The role of a well-integrated out-patient and follow-up rehabilitation clinics is a link between the state hospital and the community. It is also the essential connecting link between the incipient psychotic patient and the deteriorated individual mentally sick for a long time on a back ward; the focal point of the efforts of both lay and professional people to help the person whose marginal adjustment to remaining normal hangs always in delicate balance. Here those who need help to avert state hospital care meet those discharged patients who need help to take their place again at home and in society; thereby, in many instances to be able to support at least themselves if not their families. There are many facets to the adjunctive services of an out-patient clinic. With the state hospitals it carries on a public education program directed toward the professions of law, medicine, and ministry; public and private welfare agencies; schools; law enforcement authorities; and lay groups which represent cross-sections of community thought and attitudes. It is right and proper of course, that the private physician or clinic should have all the possibility of responsibility up to the moment of commitment. But there are many intermediate problems where the private physician or the community may need competent psychiatric help short of actual commitment to a state hospital. It is not proposed that the State Mental Health Program seek out patients to receive expert psychiatric advice; the load of the state service is already large. But if the individual community and the local medical practitioners



agree that state out-patient help is needed, and then this program should provide for such cooperation. An out-patient clinic is now functioning in Fergus Falls on this basis.

A cardinal rule for the operation of any such out-patient clinic must be insistence that every patient, if referred by his or her physician, will be received and that no patient will be received without such referral. Referral to a private psychiatrist will be made if the person is financially able to pay. With proper safeguards, and with full assurance of the interest and cooperation of both the general public and the medical community, it seems obvious that the out-patient clinic can do effective work in mental hygiene and can actually prevent some cases of mental disturbance from progressing to the point where commitment to a state hospital is necessary.

There is not enough understanding about mental illness and emotional disturbances by the laity and even some of the medical profession. Likewise the fuller purpose and services offered by the state mental hospital system are not adequately recognized. Some say that out-patient mental hygiene clinics should not be in a state hospital or in a town where there is a state hospital, because it will not be patronized by new patients or even patients who have been at the hospital. There is no question but that this is true in many communities. However, the very essence of a well sustained mental health movement is a public education system arising from the community in the vicinity of the state hospital, the local school system, and actually from the state hospital personnel and patients themselves. Only in this way can we ever hope to eliminate the stigma of mental disease, one of the great aims and hopes of the Minnesota Mental Health Program; which the people of Minnesota have established through legislation by the Minnesota Mental Health Act,

It is to the point to tell briefly about the new well-established Mental Health Out-Patient Clinic which was established at Fergus Falls toward the end of last year, (November, 1949). One-hundred and eighty-six patients in all have already been seen and treated at this clinic. There have been over thirteen-hundred contacts with patients having various types of mental illness. This includes, as well as the examinations and interviews by the psychiatrists, also testing and treatment by the psychologists, and taking of patient's histories by the psychiatric social worker. In addition, this worker makes home visits where indicated to study the environment in which the patient lives and to meet the family. Those coming to the clinic included some forty children. Seventy of the patients were psychoneurotic, of these thirty-eight are much improved and doing well in their communities. It has been shown that a psychiatrist, a psychologist, a psychi-

atric social worker and a nurse are needed in order to have a well-run follow-up and rehabilitation clinic and in addition, of course, adequate clerical help is necessary.

Two very practical factors need be emphasized here. First of all, that the doctors in an area of a couple hundred miles from Fergus Falls have been referring patients to the clinic, which indicates without question not only the value of this service to the people to whom they minister, hut at the same time recognize the clinic as in no way indicates with their private practice of medicine, but rather as a significant help to them in the care of patients with neurotic and even psychotic manifestations. The second factor is the very fine improvement shown by a high percentage of patients treated. A large number of letters have been received from patients who have so greatly improved as a result of the care and treatment of the clinic that they do not find it necessary to return.

It must be emphasized again and again that the aim for every patient in the state hospitals is his improvement and discharge to take a satisfactory place in the community. Provisional discharge, however, cannot end the interest and responsibilities of the hospital and the mental health program. Too often provisional discharge has been only an unhappy trial of "freedom" to be followed by return to the hospital with a greater discouragement and a more serious psychiatric problem. Realization of the likelihood of such failure has moreover, prevented many patients from being discharged even though their status in the hospital might appear to warrant it. The patient on provisional discharge is still convalescent and complete rehabilitation often is not achieved without periods of great difficulty. The patient must have readily available advice, periodic check-ups and re-enforcement of his returning mental vigor. Without proper provision for these services, the stay of patients in the hospitals will tend to be prolonged and the percentage of recommitments will be high.

It is proposed therefore, to establish a system of follow-up and rehabilitation clinics to maintain close contact with every patient who is discharged from the Minnesota State Hospitals. Within recent months it has been possible to set up such follow-up clinics at Fergus Falls, about which considerable information is given above, and at Minneapolis, the latter serving both Anoka and Rochester State Hospitals, and supported by funds from these two hospitals, A clinic is now in operation at Hastings State Hospital and the area served is essentially that of Ramsey county, including patients and provisionally discharged patients from St. Peter State Hospital and from Hastings. Of course, the Utter clinic will serve patients who live in this area, but may have been in other of the state's mental hospital



als. Patients are also seen other times by the full time psychiatrist who is on the staff of the central office of the mental health program.

But additional clinics are needed if all of the State is to be served and arrangements for several of these are now under study. Under study at present is the establishment of a Mental Hygiene Out-Patient Clinic in the southern part of the state at Albert Lea, by request of the County Medical Society. This clinic should start soon. It must be noted, however, that the present complement of trained personnel is not equal to the obvious needs. These clinics should serve many purposes besides being a source of advice for the former patient in his moments of discouragement. There is continuing talk of interpreting the patient to his family (and vice versa) and to the community. There are jobs to be obtained for the patients—and the protection of the patients from exploitation in these jobs. There is aid to be given in the cultivation of new interests, and new friends. And, should the patient prove unready for continued discharge, there is the necessity for providing the hospital psychiatrist with full details on the problems of the patient which are still to be solved by active treatment.

For these reasons, then, the follow-up and rehabilitation clinics must be increased in number and accessibility, and improved in the quality of their work. The question of the proper location of these clinics is still not settled. The state hospitals themselves would be most convenient for the staff but more urban locations would be more convenient for the former patient. Moreover, the former patient is often unhappy about "reporting" to the scene of his severe illness. On the other hand, possibly the rehabilitation clinic at the hospital might serve to break some of the isolation of the hospital. In any case this is an important area for real effort in the mental health program.

The follow-up and rehabilitation clinic, if located in the community or near the community in which the state hospital is located, can in most part be staffed by professional persons from the hospital staff. This has an added advantage both to the patient and doctor, of being seen by the doctor who treated the patient while the latter was in the hospital. We strongly recommend that each state hospital have one psychiatrist and one social worker to take care of follow-up rehabilitation and public education in their area. Further needs such as office equipment, dictaphone, medical instruments, and supplies are needed to complete a clinic set-up.

Just as at present, the Fergus Falls Mental Hygiene Clinic serves patients discharged from the hospital as well as people referred to it by private practicing physicians, so will the additional clinics planned for, and expansion of service by the follow-up and rehabilitation clinics in Hastings

and Minneapolis serves their adjacent hospitals and areas. The Minneapolis clinic is at present serving the Anoka and Rochester State Hospitals' discharged patients or patients out on a visit. This clinic must be expanded to include for example, patients from Willmar State Hospital.

The Hastings clinic, now serving St. Peter and Hastings State Hospitals should be expanded to include service to patients from Cambridge State School and Hospital. With the establishment of a clinic in southern Minnesota, patients from Faribault, as well as some from St Peter State Hospital could be seen there.

Particularly in locating mental hygiene out-patient clinics, the local county medical societies are consulted with to gain their full understanding, agreement, and cooperation. Thus far, this has been obtained, even welcomed. Actually, it is a projection of the thinking of the community, the lay person as well as the professional, that such clinical services round out the proper and more complete care of the mentally ill.

It should be obvious that the major responsibility for mental hygiene work in the communities cannot be assumed by the state hospitals, though they should play an important role in the work. The hospitals have a specific responsibility in regard to the patients discharged from them and should contribute to the work in public education. Every visitor to a state hospital is a potential learner who has a personal interest in mental disorders which may be cultivated. Every state hospital employee has a circle of friends, relatives and numerous casual contacts to which some knowledge may be imparted. This assumes, as seems reasonable to insist, that every state hospital employee is educated to an extent compatible with his responsibility in regard to mental disease.

The larger job in mental hygiene however, must be carried out by agencies, groups, and individuals who are not a part of the hospital system. Education on mental hygiene must reach every member of the community beginning with school children, and must use all available devices of lectures, forums, and the mass media of newspapers, magazines, radio, television and motion pictures.

By now it is reasonably clear that in order to accomplish the fine goals in the field of mental hygiene as has been outlined above, the establishment of further out-patient and follow-up rehabilitation clinics will require an increase in appropriations. It is felt that the finer results already obtained are well showing the way, that money appropriated at this time will be very well invested in the greater vigor of mental health for the people of Minnesota. Such facilities make possible earlier diagnosis and treatment. Not only is this beneficial to persons who have been in the

state mental Hospitals, but to as great an extent in the prevention of many persons having to be committed or otherwise entering mental hospitals.

*Public Education:*

The public educational work of the Office of the Commissioner of Mental Health should aid and reinforce the larger long term educational program which is conducted by other agencies of the State Government. Three expert consultants have helped in the analysis of the problems and in the preliminary organizations of the program. They are Dr. Roger Howell, Associate Professor of Psychiatry of the University of Minnesota who is an expert on radio techniques and group programming, and Dr. Howard Rome of the psychiatry section of the Mayo Clinic, who is also a consultant to the National Mental Health Film Board, and Mr. Justin Reese, who developed a project in public education in mental health which has received national recognition and which he discussed at the St. Louis meetings of the American Psychiatric Association's Second Mental Hospital Institute.

A first step in the educational program of the office of the Commissioner is the insistence that each of the state hospitals serve as a public education center for the adjacent community. To this end, each of the hospital superintendents has been asked to designate an "Educational Officer" in his hospital and to instruct his staff and to participate himself, to stimulate public discussion of mental hospital problems and services, and of mental health and hygiene generally. The hospital educational officer should coordinate the activities of all hospital staff members in services to educational and social agencies, lectures, and study-group programs, and should act as the representative of the hospital who maintains contact with the commissioner's office on all matters of public education. The objectives to be stressed by the individual hospitals are similar to those promoted by other operations in the educational program: social acceptance of mental illness and mental patients, and understanding of the principles of prevention and the relationship between prevention, treatment and research.

Another activity originating from the commissioner's office is a pilot radio program. This has been so successful that arrangements have been completed, in cooperation with the University of the Air, Radio Station KUOM, and the State Department of Education, for the production, recording and distribution of these radio programs to schools, other radio stations and to community groups.

Other educational work in progress includes the distribution of printed materials, the provision of motion picture programs at the state hospitals,

the preparation and release of special articles and news items to the public press, and the presentation of public lectures and discussions in all parts of the state.

*Summary Conclusions and Recommendations for the Office of the Commissioner of Mental Health:*

These will be presented under four divisions which are namely, Hospital Administration, Research, Training and Mental Hygiene. It should be emphasized that it is impossible to treat a mass of patients. One patient is treated and he is not reached by dividing the population in the hospitals by 15,000; the total population of the hospitals is accounted for by 15,000 times one patient.

## DIVISION OF HOSPITAL ADMINISTRATION

I                    A center for Emotionally Disturbed Children has been established at the Hastings State Hospital. This facility will provide care and treatment for all children deemed psychotic by law, less than sixteen years of age, emotionally disturbed children that are mentally retarded or suffer from a convulsive disorder and other types of emotionally disturbed children. No funds have been appropriated for this facility as yet, and it is now functioning with a skeleton staff on an emergency basis. It is important the funds be allotted by the Legislature to staff this facility properly.

II                    The need for additional beds for the mentally retarded is imperative and should be given number one consideration in our program. (Ref. p. 15)

III                    A cardio-vascular center has been established at Anoka to study mental cases with heart disease and diseases of the blood vessels. (Ref. p. 14)

IV                    A neurological center to study mental cases with associated neurological conditions has been established at Anoka State Hospital. Two more centers are to be established at Hastings and Rochester State Hospitals.

V                    A neuro-pathological division for all state hospitals has been established. (Ref. p. 14)

VI                    One diet has been established for both patients and staff at the hospitals. (Ref. p. 6)

VII                    There has been virtual elimination of mechanical restraints. In the future disturbed and violent wards should be placed in the proximity of the superintendent's office. This is to insure a sustained program of non-restraint measures.

VIII           The general esthetics of all back wards must be improved; otherwise there will be great discrepancy at each institution in caring for a patient in an old building as compared with the new buildings. Money must be provided for interior decorating, and replacement of old plumbing in many back wards. This problem is present in hospitals that house many of the aged and do not have any or insufficient of the new geriatric facilities.

IX           Patients should not sleep in attics. These should be re-modeled and used for recreational rooms and sitting rooms. Sleeping quarters should be on the first and second floors as much as possible, especially for the aged until such time as there is more new construction. Six geriatric buildings have been completed thus far. The other two are nearing completion. This will help to alleviate the over-crowding of the aged and has already helped improve the care and treatment of the senile population. New geriatric buildings should be used to house the untidy, the feeblest and the sickest of the aged as well as those who are best able to care for themselves. (Refer, p. 15)

X           The Sandstone facility has been opened on a temporary basis to help alleviate over-crowding and fire hazards. This facility will eventually house 450 patients. Money must be allotted by the Legislature to staff and operate this facility.

XI           There has been a marked expansion of recreational facilities for the unoccupied as well as for the occupied patients through addition to the recreational staff and volunteer services.

XII           The pediatrics services have been expanded at Cambridge and Faribault with an affiliation with the pediatrics department of the University of Minnesota. A pediatrics residency program was inaugurated at Cambridge. Good pediatrics nursing and medical care must be emphasized for our infant and child population.

XIII           There has been an intensification of neuro-psychiatric treatment in all hospitals in the fields of psychotherapy, group therapy, insulin shock therapy and neuro-surgery,

XIV           Consultative services have been expanded in all fields of medicine. (Ref. Pages 13-14)

XV           The tuberculosis therapy center at Anoka State Hospital has been completed. This will be for patients of all the state hospitals who, because of tuberculosis, need special care. Competent consultants are heading this division. (Ref. p. 14)

XVI           There has been an increase in the medical staff, both full-time and part-time, and the establishment of a residency program in several



hospitals. Since the entire seven mental hospitals house essentially the same type of patients, the staffing patterns should be alike and not autonomous. Therefore, a refinement of the staffing pattern is indicated in most hospitals. (Ref. p. 17-20)

XVII           The position of Psychiatric Aide I should eventually be eliminated and the beginning salary should be that of an aide II. There should eventually be only one class of aide working on the wards in addition to the supervisors. The people in charge of all medical, surgical, pediatrics, geriatric and neuro-psychiatric wards should be graduate nurses. A Psychiatric Aide Trainee position should be provided as the initial position for the Psychiatric Aide to begin at.

XIX           An overall sanitation and public health program must be intensified in all of the state hospitals with a well-trained physician and nurse delegated to carry out this function in close cooperation with the State Board of Health.

## DIVISION OF TRAINING

The overall training program now in action involves the following phases:

- A) Continuation center. (Ref. pages 24, 25, 26)
- B) Training programs at individual hospitals. (Ref. pages 26, 27, 28)
- C) Visiting psychiatric training teams. (Ref. pages 28, 29)
- D) Hospital conference (consultation) team. (Ref. p, 29)
- E) The training center at Rochester. (Ref. pages 29, 30)
- F) The central training school at Hastings. (Ref. p. 30)
- G) Research training. (Ref, 30)       These are fully discussed on the pages referred to.

H) The state hospitals must be actual hospitals for medical treatment, with cure and discharge being the goal for every patient. Every person who has contact with the patient is a part of his psychiatric environment and has a responsible role in his psychiatric treatment. Hence, every employee must be trained with this in mind.

I) Constant improvement through training, is essential for every employee; the alternative of merely attempting to maintain the status quo, actually results in regression.

J) The patient never represents simply a problem of one deranged function; the whole psychological personality must be treated and all training programs must emphasize this.

## DIVISION OF RESEARCH

A) A research program is now in progress in the fields of lipid and nucleic acid metabolism, psycho-surgery, electro-encephalography, geriatrics, psychology and genetics, (pages 32-38)

B) Research support, within budgetary limitations, should be available to competent experts in any of the state hospitals.

C) Each of the hospitals should be considered a potential research center and every professional employee a potential research worker.

## DIVISION OF MENTAL HYGIENE

A) Follow-up clinics have been established at Fergus Falls, Hastings and Minneapolis. There will also soon be a clinic operating in Albert Lea. These clinics are helping former state hospital patients in their readjustment. (pages 39-44)

B) Public education officers have been appointed in each of the state hospitals. The hospital staff, from the superintendent down, participates in public discussions of mental hospital problems and services. The hospital education officer coordinates the activities of the staff members in services to educational and social agencies by lectures, study-group and acts as the representative of the hospital who maintains contact with the Commissioner's office on all matters of public education, (pages 44-45)

## ACKNOWLEDGEMENT

Dr. Royal C. Gray resigned in the summer of 1950 after working for the State of Minnesota since 1937. His loss will be distinctly felt by the system, as he was an outstanding neuro-psychiatrist and it is significant that he persistently presented the needs of the state hospitals, especially in regard to additional bed space and staffing and the needs for increased salaries, training, and research in his biennial reports of 1944, 1946, and 1948.

RALPH ROSSEN, M.D.

Commissioner of Mental Health

## NUMBER OF EMPLOYEES

The care and treatment of the patients in the State Hospitals is primarily dependent upon the employees in the Hospital system. In the present Statement it has been emphasized repeatedly that the progress of the Mental Health Program is limited by the number and character of the professional and senior professional personnel available. The following tabulation shows the total numbers of employees in the major categories just before the inauguration of the expanded Program (June 1, 1949), four months later (November 1, 1949), and at the time of preparation of this Statement (Aug. 31, 1950).

Class of Position	June 1, 1949	November 1, 1949	August 31, 1950
Physicians _____	37	54	68
Medical Residents _____	0	0	2
Dentists _____	9	9	8
Nurses _____	102	125	142
Psychiatric Aides** _____	1064	1374	1429
Dietitians _____	1	8	9
Psychologists*** _____	0	7	10
Social Workers _____	9	11	14
Recreational Workers _____	0	20	64
Occupational Therapist T _____	10	14	15
Research Scientists _____	0	1	10
Cosmetic Therapists _____	6	7	8
Barbers _____	10	12	12

\* Does not include 5 Residents serving part time. \*\* Includes Attendant Guards at St. Peter State Hospital (A.D.I.) \*\*\* Does not include 5 Bureau of Psychiatric Services Psychologists, those constant during 3 periods shown above.

† Reduction in this group due to re-allocation of non-professional worker positions in this field to Recreational Worker or Handicraft Instructor

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