60-TFM-FSS

Ira. Krafve

TASK FORCE MEETING, FARIBAULT STATE SCHOOL & HOSPITAL

January 5, 1960

Mr. McGuire: . . . . . several people connected with the school and hospital here and I have been a little bit concerned about the hesitancy on the part of some of the people to discuss the operation of the hospital and different things that have occurred at the hospital and that they think might be important for fear that in doing so there may be some recrimination against them and I thought perhaps that it might be well at the beginning of this meeting if we could clear the ground on that. I am certain that both Dr. Engberg and Mr. Wangensteen could assure not only our committee but all people connected with the hospital that they should feel perfectly free to bring anything before our committee that they think would be helpful to us without having to fear any recrimination or any possible problems as a result of doing so from the administration.

Mr. LaVelle: Well I can speak for Mr. Naftalin, Commissioner of Administration, that this has been his view through the first phase of the task force. And certainly it is true with the present phase of the task force that by all means employees or public members or public advisors very freely come in and voice their comments. Absolutely no recriminations of any sort will be heaped upon any person that shall we say is old enough to open his mouth.

Mr. McGuire: It would certainly seem to me that if we are going to perform a worthwhile function here we are going to have to operate on that basis. It is not going to do us any good to spend our time here and if people who do have what they feel are suggestions to improve the operation of the hospital in one way or another and if they are not going to feel free to present them to us, we are not going to be able to do the kind of job that we should be doing.

Dr. Engberg: Well, I might say that so far as I am concerned, as administrator, certainly I would welcome the discussion of any matter. I think the important

thing is that there be full information so all of the facts are known on any issue that comes up. That's my only concern.

Mr. Wangensteen ?: The other task forces employees and public members and Mr. LaVelle knows that have felt free to speak on those things that are of concern to the institution and this is no different in my thinking, and certainly, if this contributes to better operation and better management and to the welfare of the patients, this is certainly something that should be discussed with the task force. So far as recriminations are concerned, I'm sure the Commissioner of the Department of Public Welfare would never employ such tactics.

Mr. McGuire: Well, I didn't intend to imply that that was the situation. The only thing I wanted to set across that apparently there are some people connected with the institution that fear that that might be the situation. While I realize it's not, I thought perhaps that if they were assured also that it was not by you people it might be a little easier for them to speak out if they had some suggestions in regard to the operation of the hospital.

Dr. Engberg: I think in that connection it might be well to make mention of this: that Mr. Endres together with one or two members of the Union meet with Mr. Krafve and with me each month regularly and there certainly is no reason why any matter then that Mr. Endres or the Union would know of whether it was a Union member concerned or one who is not where it could not be brought up for consideration.

Mr. LaVelle: Mr. Greene, would you like to make your comments?

Mr. Greene: If I might. . . .I think what I have to say is of most importance primarily for the patients, secondarily for the operation of the school, third, for the personnel, the effective carrying out of the duties for which they were placed here and hired. I feel, gentlemen, that above all and primarily you must be thoroughly familiar with the task and function of the psychology department in an institution of this type, an institution for the mentally retarded. I do not

think that there will be any doubt in your mind but what, when I have finished, you will understand fully and agree with what I have to say. If I may, first, describe the function of a psychologist in an institution for the mentally retarded, which I think is not covered here. I say, gentlemen, that the psychological services are the heart of an institution for the mentally retarded. When I'm through, I would like to go through this paper that was prepared, and I repeat, gentlemen, of the utmost significance and importance. Why? ~~My wife is from Minnesota. I am from the East~~. We came here, I fell in love with the state, and wanted to come here because of that, and on the other hand, because of this. Up to some years ago the psychological services in this state were second to none in the world—they led. You had the greatest psychology you could ever want coming from here,—Kuhlmann, Terriman (?), quite a few others. Your psychologists, gentlemen, being the heart of the institution, by reason of his training—not that of a psychiatrist or anyone in here—but by reason of his training is in a position to evaluate if an individual is truly mentally retarded and to what extent this individual is retarded, if retarded at all. A psychologist is not, as some people state, a tester where he gives a test, he comes up with a few numbers and this is an IQ and, therefore, this individual is mentally retarded. There are ramifications to that. I can speak unequivocably—it has been proven through the profession, and I state profession, of psychology that an individual's IQ can't very according to his emotional state, his physical makeup, his physiological functioning and many other factors, in part or related. You can see that a psychologist is needed to commit, in a general sense, an individual to an institution of this type. Further, he is equipped to diagnose emotional problems that interfere with proper functioning, that interfere with intellect, which interfere with the results on an intelligence test. He is also equipped by reason of his training to diagnose to a great degree and understand and treat, gentlemen, individuals with emotional problems.

Important, yes. In terms of re-evaluation of patients, which there are not periodic re-evaluations and there is no excuse for it in this hospital despite what is said in re-evaluation of patients because a great many here, come here by reason of getting trained so that they can be partially or self-supporting on the outside or placed on the outside. The re-evaluations through tests, not through plain interviews, gentlemen, but re-evaluation at times to see how they have improved. Your psychologist is also important, gentlemen, to the extent that upon final consideration for discharge or placement, as the case may be, he again is called in to evaluate. One other function of your psychologist, gentlemen, being the heart of an institution of this type is to evaluate this individual for placement, for occupational training, to place him in a certain aspect of training within this institution so he will benefit optimally from it. This is not done here. Despite what is said on this sheet-that group psychotherapy was in effect in 1955, this is not so. That is taking a group of patients and treating them with similar interests, age groups, intelligence, personalities. For there are emotional problems so we will benefit most, if they can't profit by psychotherapy. Gentlemen, I initiated that here, one month after I started. To the best of my knowledge, this has never been done here.

I don't know what this psychological services sheet says. ~~I'm proud of my profession.~~ I've worked hard and a long time for it as such to be recognized as a profession. When I see a psychologist and the only psychologist in view of what I've said before, in this institution, being made a public information officer and a lack of judgment putting such things down here as to what the function of the psychologist here is, it's an abomination. 3200 patients are in here. Any psychologist or any professional station will tell you you need at least one psychologist for 500 patients. I'll state one thing further. Now this I am saying in defense of myself and in defense of the position in which I found myself when I was discharged. To put a professional man and to condone such a thing in

an institution or anywhere, a psychologist as a public information officer, editing a daily bulletin,. coordinates schedules of other staff, that's none of his business. Why was it permitted? Writes special features, liaison agent between the press, radio and TV and what have you? This is an insult, and I resent it. What time does this man have left, being the heart of this institution, to do the job for which he was hired. I'm not dealing in personalities; I'm making this straight now, gentlemen, but I'm stating facts. When my supervisor had told me I would not accept supervision. For many years, now, gnetlemen, for many years, this psychologist has spent a fractional part of his time within his office and in the institution and testing patients. Why is it condoned? That he was allowed to spend as many, many hours every day throughout the year outside of his office working as an officer in the United Fund, having United Fund, sort of town meetings right here in his office, as an officer going around putting up posters for the Civic, what is it, Civic Music organization here or what have you, and meeting thereof in there. Why was this condoned? Now, sir, you state that anyone that states something about the operation will not have his job jeopardized. It's too late for me. I hope it's not too late to be reinstated in some way, shape or form. But I've been blacklisted throughout the state through this . . .(and I'll prove it . .?). Those are a few things. I'd like to go through here.

I think, and as I touch upon psychological services, I am in a position to answer any other questions not related to me directly, and I'd be happy to do so, but I feel that ethically I must confine myself in my talk to this. This to me is a tangential, ubiquitous, nebulous, vacuous, concept of psychological services here. I think that you as a task foce self-survey group should want to know what are they doing for patients. I might add through here too, this institution was devised for patients, not for personnel, not for anything else. How many patients has this man seen? How many patients has he evaluated? How many patients has he

treated? What recommendations were made for psychological services? What percentage of patients seen were discharged or placed? How many patients were recommended for occupational training? These are the things I would like to know. These are the things you should know. Looking through this sheet of psychological services, Mr. Madow states, the supervisor,--in the past 38 months the senior clinical psychologist has had four different assistants giving a total of 13 months service. Let's figure out why. Because of recruiting difficulties these psychologists were employed even though their availability was only temporary. Gentlemen, my availability was permanent. There is another psychologist, a James Daniels, who was permanent. What kind of whitewashing is this? Now, I'm happy to know that as a head of a department, as a supervisor, this individual,--and I say it reflects great lack of judgment not only on his part but from up above for allowing this even to be shown to you. . .and if that will reflect upon my demise as a psychologist in this institution. Can you imagine a professional man, a psychologist now maintain at state the heart of the institution and I might state at this time, gentlemen, you're going to find many, many, many, many institutions for mentally retarded in this state without a psychiatrist who might be used on a consult basis. But your psychologist is the one who does your diagnostic testings, your therapies, your evaluation and your recommendation. I'm happy to know he obtained financial support for a pamphlet. Mind you with one psychologist here, gentlemen, and the overwhelming need. I'm happy to know he's editing the institution's daily bulletin for employees. I'm happy to know all these things because I state this with a salary close to $10,000 you cut that in one-third and hire a glorified clerk to do these things. For a public information officer, hire one. Not prostitute my profession, or his profession. I won't elaborate on this. I think I've made it clearly understood.

My position,--I was hired as a professional man to do a job, this is outlined, I

won't go into detail. My job is with the patients. I was reproved, gentlemen, on the morning that Senator Al Quie spoke before combined Rotary and Lion's Club meetings, because besides trying to crowd, I don't know the exact number, 10 to 14 patients newly admitted into a workup conference for placement to be done in less than two hours with a comment, "All right, let's hurry it up, we want to be through by twelve". They brought in a little spastic child of five years old who could not move, gentlemen, who was on a bed,-you know what a spastic is, who can't move a muscle, who can't move their eyes, who can't speak-in a crib. We were hurried through. Mind you, this boy's future, this child's future, we were hurried through to get this over with. He was labeled by a medical officer, who I might add at this time have on many occasions for hours spoken with me stating, "Why do we have to diagnose, we are equipped for medical practice, that is your job". He was labeled the lowest type of mentally retarded, an idiot. I don't think you have to be a psychologist or psychiatrist, I don't think you have to have more than average intelligence to know you cannot put a label on an individual, particularly a spastic child, of idiot. I raised my voice at that time. I was censured, telling them not to put such a label on him. This is not one isolated instance, gentlemen, but I had a professional obligation to do, to do the job for which I was hired. I could go into a lot more detail but I think your time is valuable. If you want to know, I'll tell you if you are interested further about . . .Not only was I censured, gentlemen, but within a couple of days, the chief psychologist who had censured me, became increasingly upset with me. (Grievance ?) what have you, on the basis of trying myself to iron over frictions within the department and having told the chief psychologist these things in the utmost confidence, he had called down to state consultant in psychology. Resultantly, well I have this in black and white here, a copy of a memo to you, Dr. Engberg. State consultant wrote down that knowing the reputations of both of us and the way in which I conducted myself when he came down to interview us, he could not recommend

my staying here. I had spoken to Dr. Engberg at the time; he was gracious enough to listen to me and did not, as Madow wanted, the chief psychologist, fire me on the spot. I must give him credit for that. Here is the crux. I had started psychotherapy with patients. We have psychiatric facilities, gentlemen. This is known to be the only institution for the mentally retarded with psychiatric facilities. Our psychiatrist, clinical director, one of our psychiatrists, let us say, is so up to his neck in paper work in that office he can't see patients. Suddenly, one day, and this particular girl is no more than 25 yards from us, my supervising psychologist, in flagrant violation of professional ethics, called in my patient to question her about what was going on in psychotherapy and upset her greatly, to the point where a great deal of what effective therapy I could do was broken down a bit to the point where this patient did not trust me and it took some time to bring back that rapore. I mentioned this to Mr. Madow. One week later I was accused of disturbing my patients and meddling in administrative affairs. I was brought into Dr. Smith's office, the clinical director, and accused of disturbing patients and upsetting doctors, Dr. Lende. Also accused of upsetting Dr. Lende so Dr. Lende had called in, one of our medical officers, to complain about me and subsequently found out this was not so. Dr. Smith, who believe me had never at no time ever refused to see a patient of mine, where I thought there was medical, physiological and neurological involvement attached to the emotional disturbance that they found. . .A wonderful man, by the way. And as is known, a brilliant psychologist. He stated that I could investigate, to see if that were so, which I doubted, and it was not. I found out, gentlemen, and can substantiate that psychiatric aides in one of the buildings in which some of the patients I were treating resided were calling in my patients one after another asking them what I spoke about in psychotherapy and upsetting them. Further, that none of the patients that I was treating were upset or disturbed. Why this was

done, I leave it to your consideration. I walked into, after having found out these things, into Dr. Smith's office to tell him the results of my investigation. Mr. Krafve, our director of administrative services, our assistant superintendent, who by the way, is not or should not be in a position of hiring or firing professional personnel and I think that on your outline here, if you will look, you will find that the professional services are under Dr. Smith, the clinical director, psychiatrist III. I went back to Dr. Smith's office with the result of my proven (?) investigation. Mr. Krafve was in there. I said he might as well hear this too, that his own aides and one of his nursing supervisors were not only violating professional ethics by questioning my patients or anyone's patients, but did it in such a manner as to disturb these patients. Mr. Krafve said this will have to be stopped. I said "Halleluia". He said, "You're through". I think this was about the 25th or 26th. I don't know exactly when. I was through at the end of the pay period on Tuesday. Two days. Dr. Engberg by the way was not even in the institution at that time. Mr. Krafve would not answer me. I stated, "Aren't you going to investigate the charges, welfare of patients and improper use of patients by personnel?" He did not answer me. I demanded to speak with Dr. Engberg. He said he would be in the next morning. I asked him again if this were final. He said, "Yes, you're through". "Are you going to investigate this?" He did not answer. To the best of my knowledge, this has not to this day been investigated. And these people who are responsible have not been even censured. I spoke with Dr. Engberg, finally. And for the first time told him some personal things between the chief psychologist and myself. Dr. Engberg did not budge. He did not even investigate this as the administrator of the hospital. I threatened to take all of this plus many other things to the governor's office. I owe a $1,000 in town. I've been blacklisted in the state. I've got two infants, my wife is pregnant. Said, no, this will

have to stand. I saw Dr. Engberg in an evening and took him from his home. Almost begged and pleaded with him. The next thing I know, gentlemen, and you add this up for yourself. I got a call from the state consultant in psychology stating I would be working out of the St. Paul office as a traveling psychologist for the remainder of my probation period. But mind you, gentlemen, I was paid by the school. My last check will come in next week. I felt, and I went through channels, gentlemen, I felt I should see Morris Hursh about this, go right to the top. I made an appointment on a Saturday and I went to see him. Mr. Hursh seemed pretty much unconcerned. He drew (?) quite a bit of chores (?) in writing on his desk. When I said I want nothing for nothing, I don't want something for something. I've been rated and (?) I can give you 150 people around here who can say I've been the best psychologist they have ever had at the school and the first one they feel is doing something for the patients. The first individual who has been aggressive in his attempt to do an honest job. I stated this to Hursh. I said because of that I must maintain my family. The answer Hursh gave me, "No one asked you to come here and we're not responsible for your family, period." I talked to Tom Hughes on the phone. He spoke to Morrie Hursh. The answer to me was, "You better find employment elsewhere, they don't want you." Many other things. If you wish to question me in the realm of professional ethics, and particularly as regards my position in relation to the operation of the school, I'd be very happy to do so.

Mr. Kucera: Now, Mr. Greene. . . Mr. Greene: Yes, sir. Mr. Kucera: You mention that the psychologist here wasn't performing the functions for which he was hired. Are there—does he evalue each patient as he comes in or does he evalue. . . ?

Mr. Greene: No patients are re-evaluated periodically here.

Mr. Kucera: But is every patient in this institution - is he or she evaluated at one time or another? Mr. Greene: Just when they came in except for other

times. When? Perhaps the county, and this can be borne out, when the county welfare board pressures someone to the point of wanting information is the only time they are ever evaluated. Except for one other time. We went through, supposedly, re-evaluations for 200 patients or so was mentioned back here. This is a farce. Five out of six or seven out of eight of the patients, people sitting around the table evaluating these patients, did not even know what the heck they looked like and the patient wasn't even at the table. I'm sorry for my ...temper, gentlemen, but this touches me. . .As far as re-evaluation is concerned, I've noticed this. I think, representative, you're leading up to this. There was an article in the paper saying, quoting Dr. Engberg, saying he would like to see every patient re-evaluated every two years but by reason of shortage of staff this cannot be done. Now, certainly everyone in this room has a more than average amount of logic. Prior to that I might state I've seen people here 40, 50 years; 10, 20,25 years, and more than you can shake a stick at, whose last evaluation was 40 years ago. People who are in the high grade moron classification who are educable and who could be at least partially self-supporting, I have seen, who are still here, but, I'm sorry, when we have a psychologist who is busy with all these things, plus the United Fund, plus the Civic Music Organization, hardly ever in his office, when you have another group of professional people, gentlemen, of social workers. I might say by the way over and above all you've got one of the finest staffs that you could ever want here, if they were allowed to do their job. Your social workers are assigned to duty as glorified guides. Sightseer guides for visiting groups that come in here, wasting hours upon hours of professional time. We have a psychiatrist who is so up to his neck in paper work. Where is the shortage of staff, gentlemen, for re-evaluating these patients? There are many times I have been sitting around my office with 32 patients here, twiddling my thumbs wondering who to do or what to do for fear that I might get

reprisal from my supervisor for sticking my nose where it doesn't belong when I knew I could be busy 35 out of 24 hours each day. Where is your shortage of staff for re-evaluation? Mr. Kucera (?): Dr. Greene, ... Do you say that there are patients here who need not be institutionalized? Mr. Greene: I would say this, that upon the original commitment, that there was something there that interfered with optimum intellectual functioning. It's a well known fact today that we cannot accurately differentiate or give a differential diagnosis between an individual who is severely, emotionally disturbed and a retarded individual. There is a great deal today of research being done, trying to differentiate between the schizophrenic child and a retarded child. I will give you one example. Would it be all right to mention patients' names; I don't know within the realm of [illegible]? Dr. Engberg: Why don't we mention them by his first name. Mr. Greene: Well let's take patient X, an Indian girl whom I had in psychotherapy. At that time I noted that there was something above and beyond the degree, above recognition there. Came from a reservation, gentlemen. Her parents were killed, one in 1925, one in 1927. . . . . .She hardly spoke English. By reason of sub-social behavior she was examined to be committed as mentally deficient, mentally retarded I meant to say--a better term. Gentlemen, she was given a standardized test, Stanford-Binet, which was standardized upon about a middle class high white population. She got a 46. But to give you a little idea as to the means of diagnoses. We know for a fact that if we get a hostile individual coming in, someone suddenly flopped in the psychologist table, questions asked them, they are hostile. They don't give a darn. . . .This particular individual could not speak English. She got a 46 which places her within the upper limits of imbecile classification. That was 12 years ago. She had not been re-evaluated since. She hadn't even been tested when she came here. I gave her a test by reason of her environmental depriva-

tion, her educational deprivation, a test that does not call for language ability and educational ability, ...point scale of performance test, which correlates very highly with a Binet. . . . . .This girl got a 112 I.Q. She was above average. But potentially, gentlemen, her I.Q. was still even higher. That was four months ago. She's still here. That's one of the few. Now, therefore, representative, there are so many ramifications, which are involved in diagnosis for the mentally retarded individual, that at times it's extremely difficult, extremely difficult. Therefore, I would say,and I think Dr. Engberg would agree with me, that there are a few in here who could estimate to be of at least average intelligence, who are not improperly diagnosed. . . . . There are individuals in here that are committed epileptic. One boy I had in psychotherapy. A measured I.Q. of 90 within the average range. I didn't mean to go around in circles but I can't pointedly answer your question, the way you have put it. Mr. McGuire: Mr. Chairman, I might say that following our last meeting after I got back home I sat down and read through the information that we had been given at our meeting and I was a little bit concerned, or surprised, I don't know which, about the report of psychological services. When I began reading through this report, I was quite impressed with the record the institution apparently had had. I came down into the third paragraph where it was stated that in 1950 full time psychological services were re-established, indicating that diagnostic testing remained the basic duty of the psychologist. Then as I read farther down in the report, I learned that apparently the institution has had great difficulty in securing psychological personnel, indicating that there were only four assistants to the chief clinical psychologist giving a total of 13 months service in the last 38 months, which means for a period of over two years we had only the chief clinical psychologist. And then, in reading further on down the report I find that the chief clinical psychologist here was the

public relations officer and apparently a considerable part of his time was taken up with the activities that were outlined in this report. I had intended to ask Dr. Engberg or Mr. Madow if he were here whether or not they felt there should be some change made in the psychological department or just what the need was for psychological treatment of the patients here--what might be done about this. Dr. Engberg: You're directing the question to me? Mr. McGuire: If you could explain this a little bit further, Dr. Engberg, I'm certain it would be helpful to me and I think to the rest of us. Dr. Engberg: I think first of all that the thing we have to recognize is that there is very definite understaffing particularly in the professional areas. Now there are some of these other services that I feel are important as a matter of public education. I think it is extremely important. You've got to delegate it to some person who is competent to handle it I feel, and much of that work is done. Now mention is made about the Bell-Ringers....Well most of that work is done by clerical help except for the matter of somebody to see what information should go in. We have some of these copies here today. I think it might be well to circulate them so that you see what they mean. And then the matter of public education. There are a good many talks. There are requests made for them by, for instance, the Association for Retarded Children, luncheon clubs, other groups, and Mr. Madow, then, those matters are channeled through to him, because in one instance one member of the staff may be better qualified, For instance, the chaplain may be better qualified to handle it. To set it up in such a way that some selection is made of the proper person and much of that work is in overtime work for which there is no compensation. So it isn't a matter of the work day being used entirely for those purposes. Now it is true that there is this difficulty of getting psychologists. Other institutions are having the same problem. And I think that here, unfortunately, a situation developed wherein Mr. Greene did not fit into our picture. We've

continued to carry him as long as it was possible for him to be carried. He was a provisional employee and the provisional employee can be carried for a six months period, but in the meantime, it is expected that they will be on Civil Service lists and the appointment can then be made as a probationary employee. I don't want to go into all of the details. --be glad to answer any further questions in regard to it,--but the situation ultimately had reached the point wherein Mr. Krafve, who is responsible for the business management, that is he has to do with overseeing the personnel officer,--and Dr. Smith, both said that the situation had reached the point where they did not see how it would be possible to continue Mr. Greene's services here. Well, I felt that Mr. Greene had the--I respect professional people; I don't want to embarrass them; I realized he had the matter of family responsibilities here and I think the responsibility of two daughters in California--is that not correct? And, naturally, I was sorry that a situation of this kind had developed. I then asked Dr. Smith to set up the program wherein in order to make it possible for Mr. Greene to be continued here, to set up the situation where he would do nothing except testing. This decision was reached in conference with Mr. Krafve and Dr. Smith and I thought that that plan would work out all right. Dr. Smith came back to me. He said, "It's absolutely hopeless; we just simply cannot work out such a plan". Well I said, "Then, there's nothing that we can do except terminate the employment here" and the matter then was taken up with central office and arrangement was made then whereby Mr. Greene was continued in employment. He was carried as on detached duty from us but we paid him during the remainder of the period of time, and I think that was through December 28. Mr. Krafve is out and he can confirm this. I don't think that the record shows a discharge. I believe it simply shows a termination of provisional appointment, and it would not be possible for--we'll say that Mr. Greene's service had been entirely satisfactory. We could not continue him in employment beyond

December 28 unless Civil Service rendered another provisional appointment. Naturally, under the circumstances, we could not make that sort of a recommendation. If there was nothing to prevent the central office, the psychologist there from making such a recommendation if he saw fit to do it. I do not know whether that has been done or not because I haven't . . . . .Mr. Greene: I have that in writing, sir. Dr. Engberg: Pardon me? Mr. Greene: I have that in writing. . . Dr. Engberg: The discharge? Mr. Greene: No, stating that it would be up to you entirely to continue me. Dr. Engberg: Yes--to make--but to make--no, no, I think--let's see the letter. You might just read that portion of it. Mr. Greene: "If Mr. Greene should be terminated which will be automatic after a total of six months service, unless he re-applies to Civil Service and passes the oral examination, I'm sure you will give him liberal time to locate something else for himself and his family. It is certainly conceivable that you will not agree with my recommendation, either in view of more complete observations you have now, or characteristics Mr. Greene may demonstrate in ensuing weeks. Naturally, I'm sure that if that should be your feeling it would be based on sound reasons, and I would give whatever support requested by you."

Dr. Engberg: Yes, but, naturally, in view of the developments that occurred, I could not take that action. Mr. Greene: Sir, I'm stating this, and I'm repeating it as I said before. I was charged with something extremely serious. I vindicated myself. I made further charges that my supervisor, and I'm strongly repeating this, had disturbed my patients, had disturbed other patients. Now, why did you not see reason to investigate that to see if it was so and why did I take the ax? Why is this not been investigated to this day? Those were your patients involved, Dr. Engberg. Dr. Engberg: Those matters were taken up with Dr. Smith and. . . . Mr. Greene: I'm not stating who they were taken up with, sir. I'm saying why were they not investigated? Dr. Engberg: Well, I presume they were investigated.

Mr. Greene: By whom? Dr. Engberg: Yes. I know Dr. Smith well enough so that he made an investigation of those matters. . . . .Mr. Greene: Sir, I've spoken to Dr. Smith just this last week prior to his entering the hospital for removal of a polyp from his vocal cords. He stated he did not and it was not investigated to the best of his knowledge. Dr. Engberg: Well, I think on some of these matters, naturally, the. . . .Mr. Greene: Dr. Engberg,. . . . . patients' welfare. If there is an outside chance, sir, if there is an outside chance I can be reinstated somewhere else, I have to fight, and I'm stating again, I'm bringing you truth and what is right now and to this committee. These are patients' welfare and I repeat the question to you, not for tangential, vacuous answers, "Why was that not investigated?" Dr. Engberg: What are you referring to now? Mr. Greene: I've repeated it three times. Dr. Engberg. These patients were disturbed by the supervising psychologist, aides, in violation of professional ethics, had been investigating what went on in psychotherapy in my office. Dr. Engberg: I think the only way to get that answer if you wish to go into it. . . . . Mr. Greene: You are the superintendent, sir, why was this not investigated to this day? Patients were disturbed. Mr. Wangensteen (?): This matter has been brought to the attention of the task force and I think it's appropriate for the task force to pursue it further if you so desire but I don't think we're going to get any place, this sort of procedure right now. I think the point has been made and certainly the task force will be interested in it and will want to follow it further. But I don't think we're making any progress at this stage. . . . . Mr. LaVelle: No, especially with Dr. Smith not being present. There is this general area that Mr. Greene has referred to and Dr. Engberg also, and there's been the comment about the problem of not only the psychology department but certain other departments where professional people are tied down with paper work or other duties which wash out their time to the extent that they are not fully

performing the real functions for which they were hired. I think this is of vast importance. We've run into this in one of the other institutions where they are having a similar problem, not exactly at the same level but where people that are hired for one duty actually are performing another sort of duty primarily because of limitations of staff. I think this is something that the task force might very well make note of in their final report. I'm quite certain that if, for example, you have the position of a public information officer that this could be fully utilized here and at the same time relieving the chief psychologist of these other duties. I believe there was some mention made of paper work in some of the other areas.

Dr. Engberg: From an administrative standpoint, there is a total job to be done. You've got an insufficient number of people to do it and you then try to do the very best total job that you can. Now that may mean a neglect of certain areas, not areas that we feel are essential, however. I think that one thing that should be mentioned is this, that every patient that comes here has had psychological study before coming here. Every patient is seen in Case Conference where I am present, where there is a report of the psychologist, of psychological findings at least. The psychologist is present and other members of the psychology staff if we have others and when the psychologist many times will have to determine if this patient is one who requires further study. In others it's perfectly apparent that maybe there would be some value in a re-evaluation but it would be minimal at most and sometimes of no value at all. So there has to be discretion in that. When we finish with the review of the newly admitted patients, there is a question asked if there are any matters which have come up for consideration. Any person on the staff there has the right to bring to the attention of the staff any matter that they feel requires special study, and then the machinery will be set up for that special study. I just want to mention that so that the impression

which I think was left was that there is no psychological on a great many of these, none at all, which, of course, is not true. I'm sure Mr. Greene does not intend to leave that impression. Mr. Greene: Here is an impression I give describing the function of my profession. I stated there are a lot of ramifications attached regarding diagnosis of mental retardation; it's not just a matter of cut and dried intelligence testing. When these patients come to us, the only psychological testing that is done is an intelligence test. There are personality tests to be given to determine emotional content; there are tests that can detect subtle, neurological, possible neurological involvement. The psychologist can pick up work even a medical man cannot pick up. I might state this. Dr. Engberg, on two distinct occasions, in a one so called review conference and another in a staff conference, when I started to read my psychological report said, "That's enough, that's enough, that's enough". I've been told also by Mr. Madow when I first came here, "You don't read psychological reports; just give a brief I.Q., whatever it is." But I have been specifically told, where in one meeting where Dr. Thorsten Smith, the psychiatrist, was in charge of this review, I was reading my psychological report; finally Dr. Engberg came in. I started to read another one to them. Mr. Walsh: Mr. Chairman, it would seem that much of the problem that we're talking about has to do with the fact, and everybody knows this, really no need to be repeated, the fact that we don't have enough psychologists in any of the state institutions in Minnesota to do the job. I know that in California where they have an institution of a similar size, they have 13 psychologists where we have had one or one plus. Many of these things relate to this. I think that it is perfectly in order for any professional person to be involved in all community affairs; I'm sure you will agree, United Fund, these other things, it is a part of being in a community and doing your job so that it would be a matter of criticizing the degree to which. . . . . .Certainly I know

that our Minnesota Association for Retarded Children meeting with various committees of the legislature pointed out that Faribault needed at least five additional psychologists to meet just the average of the United States taking into consideration the average state and southern states who don't have any institutions or any psychologist. And I think this will be true with other problems, certainly, that you grapple with. The staff problem is so great that the other problems occur as a direct product of the staff shortage.

Mr. Greene: Are you Mr. Berglund? Mr. Walsh: No, Walsh. Mr. Greene: Mr. Walsh, I was a psychologist. . . . . .(?) so when a psychologist spends upwards of six hours of a working day for the United Fund. I say working day. I have spent, with due respect to Dr. Engberg, many an evening here and it will be borne out, working nights. I've never seen Mr. Madow.

Mr. McGuire: Mr. Chairman, I wonder if Dr. Engberg might give us in brief his own feeling on the value of psychological treatment for the patients in the school and hospital and probably the function that he feels the psychological department should play. I'm not familiar enough with this problem to know exactly how important a role a psychologist does play in an institution, how great the need is for psychological treatment. Dr. Engberg: Well, this is an area where there are some differences of opinion, psychologists, certain ones, feeling that psychology alone should take care of it. I think the general feeling is that if this work is carried out it should be under medical supervision and that was the part of the difficulty that we had here. Dr. Smith said that he just was not able to keep control of the situation, and Dr. Smith is here so that if any of you want him to be present this afternoon, we can arrange for him to be here. Naturally, much of the detail of this I can't, as you can readily understand, keep all of it in mind. I try to evaluate to be sure that there is not prejudice that's entering in and that there is fairness in dealing with the situation. But Dr. Smith could

be here this afternoon. My own feeling is this. The psychologist can play a part in the treatment of mentally ill or of mentally retarded but then that it should be under psychiatric guidance. Mr. McGuire: How many psychiatrists do you have on the staff here, Dr. Engberg? Dr. Engberg: Dr. Smith and myself are the only ones who are here. Mr. McGuire: May I assume then from the discussion we've had so far that Mr. Madow is the only psychologist on the staff. Dr. Engberg: At the present time, yes. Mr. McGuire: In the future, what are the prospects of increasing either the, let me say, are you authorized to have more than the two psychiatrists on your staff? Now how many psychiatrists are authorized for the institution? Dr. Engberg: I think that Mr. Krafve could give that. I believe there are two additional ones at least and we have vacancies in those positions. Mr. McGuire: How long have those positions been vacant, can you recall, doctor? Dr. Engberg: It's been a long, long time. Dr. Smith was the first one that we could add. He came in '55. Until that time I was the only one and my administrative work is so heavy that there is very little personal attention that I can give to psychiatric treatment. Mr. McGuire: Apparently, that's about the same situation with Dr. Smith also. Dr. Engberg: Yes and I think what Mr. Greene says is true. He's had a tremendous amount of paper work. The reason for that is this, that we have been in the process of transferring patients to Lake Owasso. That has not presented a particular problem or great problem to Dr. Smith, but in the transfers to Brainerd there is a good deal of time that has to be spent in making the selection of patients that are suitable for the vacancies that will occur up there and then the planning for the admission of replacements for those patients here. The transfers to Brainerd are of older patients, many of them ambulatory patients. The ones that are coming to us are young, children, many of them very helpless children so that there is a tremendous amount of time that has to be spent on that. And no one on our staff really

could do that job right now intelligently except Dr. Smith. He ought not to be doing this work but there is no one else to do it, and it's absolutely vital that that work be done properly. Mr. Wangensteen: We have many professional vacancies in the state service, psychiatrists, psychologists, etc. We haven't been able to fill the position allocated or allowed us by the legislature. Mr. McGuire: Is that difficulty primarily with the shortage of people in the profession, or related to the situation and circumstances here in Minnesota,-institutions' pay scales,-things of that sort--? Mr. Wangensteen: . . .shortage of personnel and inadequate salaries. Dr. Engberg: Mr. Greene, I thought when Mr. Krafve was back I would ask him:-Does your Civil Service form show a termination of provisional appointment? Mr. Greene: My Civil Service form shows failure to pass oral examination. Mr. Krafve told me some time ago... Dr. Engberg: The point is this, that there was not a discharge in the ordinary sense of the word so far as we were concerned. It was a termination of provisional appointment. We carried him purposely as long as it was possible. Had that not been possible, we then would have indicated a termination of provisional appointment. This matter of blacklisting is something that. . . Mr. Greene: Sir? Dr. Engberg: This matter of blacklisting,-what do you infer in that? Mr. Greene: I will state it bluntly. Tom Hughes stated they do not want me,--to find employment elsewhere outside the state. I had been offered a position for consideration in Aitkin. They turned awfully cold after. . .when I got back there. St. Peter,--Madison,--Faribault Public Schools. I do not want to bring in personalities, I won't. Even as you remember and respect me for it. . .in defense of my family (?). Dr. Engberg: Well, I want to make perfectly clear. I have said nothing that in any way could react against you. I want to make it clear. Mr. Greene: I want that clear too. I never stated any such thing. But, lastly and logically if I may just add a few more words. This. First, I had been, no

matter what fancy words you give it, discharged. So, I've been discharged. Next. Even as Senator Sundet mentioned to me a few days ago,--What's going to happen to you if you do go up there to testify? No one, even if there were an open road, no other superintendent would take you by reason of the fact that the assumption that I was maybe a trouble maker or something of that sort. I'm fighting for my professional life right now. I must be vindicated on truth and right and fact. Let's face it. I have been discharged. Period. I can't get another job in the state and I was told not to apply any where in the state. Dr. Engberg: Mr. Krafve, is there a discharge record here or a termination of provisional appointment? Mr. Greene: Whatever it was, I was discharged, Dr. Engberg, I left here. Mr. Krafve: Termination of provisional appointment. Dr. Engberg: Yes. Mr. Greene: I was discharged from a state hospital. Whatever fancy word you use, I was working out of St. Paul. Now I cannot get another job here. Dr. Engberg: Might I ask, have you taken the Civil Service examination? Mr. Greene: I have reapplied. Dr. Engberg: I see. Mr. Greene: I was told in so many words it would be folly for me to reapply. Mr. Kucera (?): Dr. Engberg, maybe I shouldn't ask this question but is it a matter of professional incompetence or just a clash of personalities? Dr. Engberg: It's a clash of personalities. I think that Mr. Greene is very competent in his work, but he just did not fit into our picture here. Mr. Kucera (?): Then if that is true, then there should be no reason why he may not fit in in some other employment at some other institution, if it's not a matter of competence. Dr. Engberg: Well, of course, I could not answer that because each person makes his own decisions. Mr. Kucera: That's true, but what I'm getting at is that if he's been told not to apply anywhere else in the state, I was just wondering what's behind that. Dr. Engberg: Well, I think that Mr. Krafve is more familiar with this than Mr. Wangensteen would be because I don't know all of the details. I presume here that if he passed the

Civil Service examination, he then when a vacancy was reported, his name would be reported to the institution or whatever agency it was that submitted that sort of a requisition. The department head there would make the determination whether to employ or not. Mr. Kucera: He does that on his own merits without any directive from the state office? Dr. Engberg: Just what do you mean? Mr. Kucera: Well, . . . ____?____: Civil Service exam. Mr. Kucera: Yes. Dr. Engberg: Yes. I think the record is, and Mr. Greene can correct me if I'm wrong in this, that you had taken the Civil Service examination and had failed it so that the provisional appointment had to continue here, is that not correct? Mr. Greene: Not necessarily if I understand the Civil Service workings,—I failed the orals. I was asked such questions as why I came to Minnesota, what do I like about Faribault,—what do I assume is the main cause of mental retardation, how many do I think are—approximately how many are mentally retarded,—and describe any individual I know. I flunked that. Dr. Engberg: So that you did fail the Civil Service Examination? Mr. Greene: I failed the oral examination. Dr. Engberg: Yes. Mr. Kucera: Well is that what the oral examination consists of? Mr. Greene: The entire examination is recorded on tape to be found at the Civil Service Department. Dr. Engberg: Now that examination, I just want to clarify, that examination occurred, I'm not sure, but did it occur after your employment here; it was very early after your employment here. Mr. Greene: That's right. Dr. Engberg: So it was not because of any prejudicial. . . Mr. Greene: I didn't say that, Dr. Engberg. Dr. Engberg: No, I'm just saying that to clarify it because with the statements that have been made here the question would come up in the minds of some of you that possibly Civil Service had received such unfavorable reports. ____?____: Mr. Greene, in the Civil Service examination, do you recall how much weight is given to the oral portion of the exam? Mr. Greene: One must attain the score of 70. ____?____: That's overall?

Mr. Greene: The reason given. . .I was up to Civil Service; I went through all my papers. They told me they considered I had an unstable personality. ___?___: Civil Service told you that? Mr. Wangensteen: The examination process, I should point out, is independent of the hospital or the school or the state department. The examining for all positions whether it be social worker, or steno, is outside of the individual department of the State. . . Mr. McGuire: Who gives gives the oral phase of the examination? Mr. Wangensteen: That's arranged by Civil Service Department. I don't know who does it. Mr. McGuire: Normally people from other departments of state service or someone outside of state service? Mr. Wangensteen: Both, I think. I at times have served oral interview boards years ago and I know in the examination I've taken they have had outside people as well as people within state service. Mr. Kucera: Mr. Wangensteen, as long as you served on those boards, is that oral exam, that isn't limited to questions like that, is it? Mr. Wangensteen: I'm not familiar at all with the. . .I'm a social worker by training.--I'm not familiar at all with the psychological examination. Mr. Kucera: Well, it's inconceivable to me that they'd give an oral examination solely on that sort of a oral questionnaire. Mr. Wangensteen: With Civil Service classifications, there is a written examination and oral exam; both of those coupled with the rating of training and experience, constitute your final score. But as I understand it, I may be wrong,--failure on one part of the examination may fail. . .(?) Maybe Mr. LaVelle knows more about that; I don't know. Mr. Walsh: I don't think the oral exam is meant, in the same way you think of oral exam for a doctor's thesis or master's thesis,--is not a question of a person's technical ability. This comes in the written part, I think, doesn't it? In the oral exam there's a group of people selected,--were they from the area of psychology, this examining board?--I think that the thing there probably is related more to what we think of a personnel interview being perhaps. The

questions you might ask in a personnel interview when you're sitting across the desk from somebody trying to hire, trying to make a judgment, an oral judgment, after which you talk back and forth, whether you think he would fit into your organization. Some of the questions might be entirely unrelated to psychology, but again trying to get this overall general impression of the person. Something about how he thinks perhaps, what he thinks a little bit, things like this.

Mr. Kucera: More apt to his personality rather than competence or education.

Mr. Walsh: Probably, yes personality. Dr. Engberg: Mr. LaVelle will be back in a moment. I might mention that we plan to have a recess beginning at 12:15 in time for lunch and then Mr. LaVelle, I presume, will have the group assemble following lunch. Now the members of the task force are guests, Senator Sundet would be a guest, of course, and Representative Kucera. Mr. Endres had sent a message yesterday of certain ones that you would be taking care of. That you had invited especially to be here. I think Mr. LaVelle will be back shortly.

Mr. McGuire: Dr. Engberg, I don't know what Mr. LaVelle has planned for the balance of our meeting today. If he doesn't have anything that would conflict with this suggestion, I thought perhaps it might be, I know it would be to me and I think to the rest of them, if Dr. Smith is available this afternoon, and perhaps also Mr. Madow was on the grounds, that they could appear briefly and give us some indication of what they feel the problems are in the psychiatric and psychological work of the institution, so that we might have a little better picture of what problems there may be in that field and what we might be able to do constructively to be of assistance in that area. Dr. Engberg: Yes, Senator. I've made mention about the luncheon so that's been taken care of. And then the question was raised whether Dr. Smith and Mr. Madow could meet with us. From our standpoint, we'll be glad to arrange it. Mr. McGuire: I didn't know if you had anything on the program that might conflict with that. Mr. LaVelle: No . . . .

possibly tour a few of the buildings today but the weather as it is, I think that next time it will be a little bit warmer. Mr. McGuire: I though that perhaps as long as we had gotten into this phase of the institutional operation this morning, we might continue it this afternoon. See whatever information we might be able to get in regard to that particular aspect. Mr. LaVelle: Then we do want to get into the work manual that Dr. Engberg and his staff have prepared. We also have this report from the Union and if at all possible we should review the items today which we feel are of primary importance for the task force to review. Dr. Engberg: At what time do you want us to assemble here? Mr. LaVelle: By one o'clock or so. Dr. Engberg: 1:15, , ,Mr. Krafve, would you arrange for someone to call Mr. Madow and Dr. Smith.

AFTERNOON SESSION

Mr. McGuire: Mr. Chairman, if I might start. Dr. Smith, this morning in our task force meeting Mr. Greene appeared before the task force and discussed some of the problems that he had encountered in connection with his employment here in the institution, Following his presentation we got into a discussion of the psychological and psychiatric services that are offered here, a discussion of the problems that you experience as a result of shortage of manpower and I thought it might be helpful if we had a little more information about the manner in which the patients are handled professionally in the institution, about what type of testing they receive, about what type of professional care they are getting, if they can use it if it's needed. Do you feel that the care is adequate or could there be something done to improve the care and treatment the patients are getting? Most of us being outside of the institution are not familiar with the problems of dealing with patients, the type that you have here; it is most difficult to understand just what these problems are. I wonder at the outset if you might just basically outline the professional services offered to the patients here at the

hospital, the psychiatric care that is offered to them. Dr. Smith: Well our patients on admission are evaluated from several points of view. That is, first of all, they're evaluated from the physical, biological point of view by a physician, our physicians, and various physical disorders are noted,--state of health,--evaluated by our psychology department, by means of various tests and interviews, predetermine the mental status and any deviations on behavior, conduct which indicate some mental disturbance. They are evaluated from the social point of view by our Social Service Department. They're evaluated by our teachers, as to their educational achievement, and indications for their learning and training. ...for each patient,-each patient is an individual and all these evaluations made here (?) and brought together in Case Conference, where plans for the patient are made as to his placement, as to his capabilities and future programs. We all put together and intend to work more and more. . .team. . .and. . .We respect one another professionally and accept the other team members' opinions and where we can't follow through absolutely on . . .ideal, at least we try to compromise in providing what we feel is the proper program for the patient. That in the nut-shell is just what we try to do for the patient. Now the older patients, of course, require re-examination from time to time. So there are four points of view, the biological or physical, psychological, social, cultural and the educational, not forgetting the chaplain. Mr. McGuire: What's your official position here, doctor; I think if I heard it or it's in the information I have here somewhere. . .Dr. Smith: My Civil Service classification is Psychiatrist III and my institutional position is that of Clinical Director in charge of the clinical services. Mr. McGuire: Clinical, does that include both the,--all the medical facilities, as well as the psychological, psychiatric facilities? Dr. Smith: Yes, Social Service is also a clinical facility. Mr. McGuire: Dr. Smith, this morning in our discussion Dr. Engberg was telling us about the problem presented by the shortage of personnel and indicated that because of his administrative

duties he has very little time for anything else and he also indicated that for the most part, it is my recollection at least, that you are pretty well tied up with administrative duties at the institution also. Is that correct, or do you have some time to work with patients? Dr. Smith: We must have integration. We can't split ourselves out purely in administrative duties. Neither can Dr. Engberg. You're interested in the total operation, of the individual and of groups and of the whole institution. There is a combination of administrative and clinical duties involving all of us. It would be awfully hard to separate. You've got to accept it....They're inter-related. Administration affects the clinical services and vice versa. Mr. McGuire: How much time, I suppose it's most difficult to estimate these, talking in generalties? Is there any way that you can tell us about approximately how much time you have available for work with the patients? Are you able with your administrative duties to work individually with the patients in treatment? Are you able to test them or is that part of your duty here at the institution to be active in testing the patients or is it primarily concerned with the treatment after they have been tested? Dr. Smith: Primarily concerned with treatment of the group, treatment of the patients. Mr. McGuire: In other words, you do, your primary work is not individual. Dr. Smith: Individual or not, we're all concerned; Dr. Engberg is concerned with each individual problem that comes up. Mr. McGuire: We understand that, doctor. Dr. Smith: . . .things of that sort. Very important problems,--but all the overall individual problems of 3300 patients, of course, must be handled at patients' level. Mr. McGuire: The point I was making I think probably is answered by that that it's almost impossible with the shortness of staff to do much of a job with any individual when you have 3300 to be concerned with. Apparently you and Dr. Engberg. . .(?) Dr. Smith: . . .(?) We must pay attention to problems which are extreme, that have to be cared for, day or night.

Mr. McGuire: Are most extreme problems on an individual basis, doctor? Say within the past month or so, can you give us any idea how many patients here at the hospital you had an opportunity to deal with individually? Dr. Smith: Well, I deal with a great many individually, but I don't deal with them in terms of a case load. Mr. McGuire: Do you deal with any of them in terms of a case load? Dr. Smith: No, I deal with the whole institution, that is, a certain patient is in trouble. . .I give my . . .(?) but I can't see every one of them. Mr.McGuire: That would be obvious with the number of patients you have here.

Dr. Smith: . . .supervisors, or nurses,--or in working areas, laboratories.

Dr. Engberg: Or I may ask that you to check on a patient. Dr. Smith: Yes, and then not just myself but Mr. Madow, psychologist, and social workers, teachers, rehab people, activities people, we're all concerned because the patient has many programs. Each patient is involved with more than one person, with more than one department. Mr. McGuire: The point I was trying to make and it becomes more and more obvious as we go along,--it seems to be almost a hopeless task I would think. Apparently, on the staff at the present time people that are qualified to either treat or test mentally retarded are only three of you, yourself, Dr. Engberg and Mr. Madow, the psychologist. Dr. Smith: No, there are physicians; we have four physicians. Mr. McGuire: But the physicians I assume are general practitioners, doctors who are more concerned with the medical physical aspect than they are with treatment of the mind. Dr. Smith: They handle individual problems, too. When a behavior problem comes to a peak, becomes--emergencies, then they are referred to me, to Mr. Madow and consult with all the other departments, patient activities, work areas, wherever these problems may hinge (?)

Mr. McGuire: Doctor, what percentage of the,--just in real rough figures,--what percentage of the patients here at the hospital do you think can be helped by treatment, by training programs, educational programs, things of that sort? How

many patients can you help and how many of them are such a low mental stage that just nothing can be done for them except custodial care? Dr. Smith: I'm sure that we all agree that all of them can be helped to some degree. All of us can improve, even us. I'm sure that we all agree that everyone of our patients can be helped in one manner or another--physically, psychologically, social point of view, learning. Mr. McGuire: How many patients here at the hospital are attending what I as a layman would consider normal school classes? Dr. Smith: Pure academic classes? Mr. McGuire: Yes. Dr. Smith: I believe about one-tenth? Dr. Engberg: That would include the trainable. Dr. Smith: Include trainable classes, that is patients with I.Q. below 50. Where the training is not academically such, concentrating on learning to get along in groups, public schools, patient activities, etc.--social training. I would say. . .Purely academic classes, I believe we have less than 250. Dr. Engberg: Yes. Dr. Smith: About 200. I wish to explain that situation in that Owatonna provides the program for the educable academic type of brighter patient, I.Q. over 50, between 8 and 21 years old, are at Owatonna. We get patients in that age range and I.Q. range if they have other problems, severely diabetic, severely epileptic or sick in some other way. Then, of course, they come here. So we have very few academic patients as such. We must have the program because we do have some. . . . recent severe behavior problems. Mr. McGuire: One of the things that stands in my mind and it was just re-emphasized following our lunch and I certainly don't mean this in the way of any criticism because I realize that with the number of patients that you have here, it's most impossible to treat, to give treatment that you would like to give every one here. It can't humanly be done. Following the lunch as I was walking by the door to the kitchen, I had an opportunity to visit with the girl who was standing in the doorway whose name was Kathy. I talked to her for a minute and at first thought she was an employee and then found out that she was a

patient here in the institution. I assume that she is an exceptional patient but the question I would have is from talking to her apparently there is something that doesn't meet the eye but she seems to have at least normal or average intelligence. She was able to carry on a conversation, she is working in the kitchen and she appears to be a bright sort of a person to a layman but for someone like that, there must be some type of treatment that she could be getting which probably would help her to be released from the institution. I asked her and she said she had been here for a, my recollection was a year and seven months. I don't know if you're familiar with the patient I am referring to.

Dr. Smith: Well, the patient may have physical problems or other psychological problems in addition to the general mental deficiencies; may have social problems at home that have to be solved before she can return. We have a program whereby our brighter patients--need not be brighter patients--or all our patients. . .(?) are reviewed and then the procedure that the home county makes plans to have the patient home or be placed in a suitable boarding home. Mr. McGuire: In this class of patients that have the potential to be released, is there any such schedule how often they are reviewed, how often their cases are considered? Dr. Smith: Well we try to maintain a schedule of review cases every Tuesday. . .at least try to. . . weekly. Mr. McGuire: In other words in the written material I remember reading something about the review committee. . .once a week. Dr. Smith: Yes.

Mr. McGuire: My question, originally, doctor, does this committee have any particular schedule they try to follow as far as patients in the institution are concerned? How often do you try to review a particular patient? Dr. Smith: Well, that's a schedule we've been trying to achieve. We have a tremendous backlog. We want to consider every patient in the institution no matter how physically handicapped that patient is, or how low mentally the patient may be. We want to consider every single patient in the institution so we have worked on the backlog

using the admission dates of the patients, trying to arrive at a date about two years from today so that when we arrive at. . .backlog we will be reviewing every patient automatically after a period of two years. Mr.McGuire; What information is available to your review board when you re-evaluate these cases? Dr. Smith: Well, all the records and all the department heads are there--psychologist, social worker, physician. Mr. McGuire: Is it possible with the staff you have at the present time to have detailed reports of recent testing of the patient and things of that sort, or isn't that necessary if you have your original admittance information and reports? Dr. Smith: No, it is necessary to have recent testing and that, of course, isn't possible with the case load we have. With one psychologist, we're simply unable to have recent tests completed on every single patient. But what happens when these patients do come up and a test hasn't been done for quite a while, in the opinion of the psychologist if he feels another test is warranted, he will repeat it or do another test, a different test, to see what changes have occurred in this patient. But with one psychologist it is simply impossible to do as much testing as we'd like. Mr. McGuire: Doctor, insofar as your own position and duties are concerned here at the hospital and recognizing the extreme shortage of psychiatric help that you have, is there anything that you might suggest to our task force in the way of possible recommendation by us that might help to relieve you of some of these administrative duties? Is there anything along that line that might be done or do you feel that there is just nothing that can be done to improve the situation as it exists today without having additional professional help which, apparently, you aren't able to get? Dr. Smith: I think there's a misunderstanding. I'm not asking to be relieved of any administrative duties. I'm an administrator. Mr. McGuire: Well, I realize that, doctor,. . . Dr. Smith: We need more physicians on the staff to see the individual patient. We need more social workers. We need more psychologists.

Mr. Kucera: If I may interject here. I think what Senator McGuire is getting at is, he's wondering what could be done so that you could spend more of your time seeing patients rather than doing paper work or is that. . . Dr. Smith: Well, it isn't all paper work. It isn't just seeing individual patients. We must spend time in programs and in planning, long-range planning. We have been in the process of changing our buildings about. We've converted female buildings to male buildings. We transferred females to Lake Owasso. We've been constantly and gradually changing our facilities over to a different type of patient. This institution is becoming more and more neurological. We have to spend time on planning, on programs. Mr. Kucera: In other words the paper work that you are doing. . . Dr. Smith: I think we all have to work with paper. Mr. Kucera: I sense,--I don't use the word in a derrogatory sense,--it has to be done but it has to be done, apparently, then by the clinical psychologist rather than some other person who could do the menial part or the more or less routine aspect of keeping records. Dr. Smith: Well, no--there are different kinds of paper work. Some kinds of paper work can be given to a high school graduate to prepare. All that she needs to do is type in copy. There are other kinds of paper work that require analysis, synthesis, compiling tabulations and understanding the significance of what these tabulations mean. For instance, I could have given the waiting list to one of the clerks. Just tabulate the waiting list. It doesn't mean a thing until we see who those patients are on the waiting list, what the waiting list is composed of. The terms on the waiting list would indicate cerebral spastic, hydrocephaly or something like that. You can't expect the clerk to interpret the terms.

Mr. Kucera: In other words the work that you are doing in your office is the work that is necessary within your staff position. Dr. Smith: Yes, it's analytical. Mr. Kucera: Yes, well the reason for the question was the remark was made earlier that instead of you spending your time with patients you're engrossed with routine

paper work. Dr. Smith: Oh no, that isn't true, that isn't true, I spend my time with patients too and so does Dr. Engberg. We can't split ourselves off into an ivory tower and then say this is all we've got to do. There are a thousand and one things to do. Mr. Kucera: We realize that. Getting back to this patient that Senator McGuire was referring to. Apparently, she's in here not because of mental retardation but for some other reason or did I understand that correctly? Dr. Smith: I'm sure she's been duly committed as a mental defective. Dr. Engberg: I think that it might be well to bring out this. I remember a statement made a good many years ago that always comes back, and that is this. The patients are not here because they are mentally retarded. There is what we call a plus factor. 90% of the mentally defective are in communities. They're not in the institution. It's when some plus factor comes up. They get into difficulty at some time or they cannot get the care that they need or if a school child, there are no school facilities available for them. Then that plus factor makes it advisable for them to be committed and to be handled then through the resources that are available for mentally retarded who need special attention. Mr. Walsh: Would it be well, I wonder, for everyone to understand the commitment process, how it's done through the court, etc. Certainly it isn't a matter of somebody saying this child is retarded, therefore, he should be in an institution, but it's an orderly procedure that starts with the county welfare board and whereby the probate court judges this person mentally deficient. And there must be certain people there to testify; there has to be psychological examination; and then they must wait, usually two or three years in Minnesota, before there is space available so there is a two or three year waiting period when the circumstances could change. If the person improved, they wouldn't come in, so there is a long period. Dr. Engberg: In fact, on our waiting list now, there's about what percentage that decline space when it's offered to them? Dr. Smith: About

25%. Usually the declinations are in cases of patients that have adjusted fairly well and probably even attending special classes in school so they need not come in and what we have been getting in are sicker patients, patients that require nursing care, neurological types, more and more of those. They don't decline because they are a burden at home, of course. We're getting in much more neurology. Rev. Van Kirk: It's been my understanding and I don't know whether it's correct or not but anyone who comes into the school has a mental age of 13 or less. Is that right? Are there any with a mental age over 13 years of age?
Dr. Engberg: Your epileptics might. Dr. Smith: Yes, that's true. There may be some. Mr. Madow: Maybe one or two, very rarely. Dr. Smith: Very rarely.
Mr. Madow: Since we are now an institution that includes epileptics.
Rev. Van Kirk: If they were over age 13 in mental capacity, they would be in one of these special classifications like the epileptic. Is that correct?
Mr. Madow: Generally speaking there would be some unusual circumstance. The patient would have been committed as mentally retarded sometime earlier before they came to us and. . . and their social adjustment has broken down to the point where there is just one other. . .to be made for them. Rev. Van Kirk: But they would be mentally deficient to the point of 13 years of age. Mr. Madow: Diagnosis of mental deficiency is not a clear cut demarcation. There is no point where you say this person is mentally defective, this person is not. The social factors go into a good deal to determine the diagnosis. Dr. Smith: There's a upper limit. In New York State, the upper limit is 70. They'll admit patients with I.Q's of 78. In Sweden the upper limit is 60. They feel anyone with an I.Q. over 60 should be able to adjust. Here, I think we agree it's somewhere between 70 and 80.
Dr. Engberg: We carry the group between 70 and 80 as borderline where there's question as to whether they should be regarded as mentally retarded or not.
Mr. Madow: The difficult points to determine are a matter of judgment, really.

When a person has failed to get along--has made a miserable adjustment over a long period of time. . . Dr. Smith: . . .except some of them are on the verge of leaving I'm sure and others. . . Mr. Greene: I might offer the most recent criteria adopted by (?) American Association on Mental Deficiency. There are three factors involved. One is learning ability, second is I.Q., third is social behavior. And all of these three entities must be considered at once or in part. Therefore, any individual who may be considered mentally retarded today, tomorrow may not be according to this definition which has been universally accepted throughout the United States. Mr. Kucera: Mr. Madow, regarding your remarks, then apparently the person's inability to adjust socially is not due to mental deficiency or that phase of it. Then that person should not be in this institution according to that or is my statement substantially correct? Mr. Madow: I would say. . . that if the committing authorities. . . ascribe the intellectual deficit as part of the factors making for social maladjustment then. . . person of definitely average intelligence and also average capabilities making a hodge-podge of his life and here we very rarely get this type of person. . . it is not uncommon at all to get a person of definitely superior intelligence into an institution for the retarded. Mr. Kucera: Well once such a person is in here, do you in your position take any steps to see if that person can be. . .

Mr. Madow: Yes, yes, I immediately report he's competent. He's discussed with the superintendent. . . very often and most frequently his. . . taken up with the state office. In other states the commitment as mentally retarded is to an institution. When the institution feels the person is no longer in need of care or is no longer defective, the person is discharged. In Minnesota the commitment as retarded is a life long commitment to the Commissioner of Public Welfare. Admission to the institution and discharge from the institution is taken. . . at the state level. The commissioner is the guardian of the person who has been

committed. We, therefore, type. . . the attitude of the state office has been that the person who was committed as defective. . . and who is now for some reason or another not regarded as mentally defective. . . their feeling was that they had a responsibility towards these people. . . to arrange the best possible situation for them. . . Mr. Kucera: Well, Dr. Smith was saying that you try to re-evaluate every patient every two years--well using such a patient as an example if he or she have to wait two years or they get another chance at it, so to speak, isn't that delaying it or postponing it too far into the future or are such persons placed on some kind of a list where they are reviewed a little more often? Mr. Madow: Well, that's part of it, the fact that they are placed on a list. For example, . . . a girl of Mexican descent who was committed,--and she tests fairly high and with her history I have a strong suspicion that. . . she was at the very lowest rung of the social ladder and that perhaps with the stimulation that the institution can provide for her she will improve therefore. . . Mr. Walsh: Mr. Chairman, could I ask Mr. Madow a question. There were questions about the services of the psychological department. Do you have a record which would show say for the last year, whatever the year would be, the number of psychological examinations made of this particular type? You don't have it with you, do you? Would you be able to quote this off hand--roughly in a year, would you say 300 were examined. . .400 or ? Mr. Madow: I would think that in a year we would. . . Mr. Walsh: A psychological examination would take how long? Mr. Madow: This varies considerably. In some cases examination would roughly take an hour. . . most frequently you have to read the record on the patient, you have to contact those people who have immediate contact with the patient, the aides, the teachers, the work supervisors, etc. and question. . .others. . .on the staff. . . patients who have a battery of tests it might take 8, 10, 12 hours. Mr. Walsh: In other words it's different for each patient. Mr. Madow: For each

patient one has to select those tests which are most appropriate and to derive the information. . . and the test cannot be a cure-all by any means,--neither infallible or tell you all that you want to know. . . Mr. Walsh: Testing certainly isn't the entire role of a psychological department by any means. Mr. Madow: No, it's not. . . a good deal of the other time is spent in counseling. . . programs, treatment for patients. . . getting a brief on patient so that the psychologist will know him the next time he sees the patient, etc. Mr. McGuire: Mr. Madow, are all of the patients tested by your department upon admission to the institution? Mr. Madow: No, they are not all tested. Mr. McGuire: Which ones aren't tested? Mr. Madow: Those where. . . Those who aren't tested are those who have posed special problems,. . .personality disturbances, those who haven't been tested in the past; those where no recent psychological test has been done. . . Many of the patients we get have been tested 3; 5, 10 times before they ever came here. And depending upon the nature of the case. The school child for example, one who is likely to be placed in our school department and where we don't have a recent test, we will do one in order to be able to more properly advise the school department where they might begin to take their place in the . . . school program. There are many, many number of patients who are not tested. They don't respond. . . and there are many patients who come here who have been tested in the last month or so and there is no point in giving the examination over. One of the things that I should bring to your attention is the fact that there is--I mentioned the test is not infallible. . . will repeat a test. . . Mr. McGuire: Well upon admission to the hospital you either have the advantage of the test taken before the patient was admitted here or test taken after his admission. I assume at that time some decision is made as to whether the patient should be placed in the hospital or what category (he should (?) be put.) Mr. Madow: In the case of each new admission. . . I review the records. . .to determine what the patient's problems

are. . . review and dig out of the record all the previous testing results--look for educational factors, etc., try to form some opinion of what this patient is like and what additional procedure might be necessary. . . . at the Case Conference, bring them to attention at that time. At the Case Conference decisions are made as to where the patient is going to live, what the initial program will be for that patient, etc. Mr. McGuire: Assuming that we have a patient who is admitted now to be in some type of a educational or training program, whose primary obligation is it to supervise the program and see that this patient does get the care that the Board has determined he should have upon admission. Mr. Madow: This is a shared responsibility. Technically, the way we are organized here, the physician is the first responsible, the physician in charge . . . responsible for his total program. In the case of a specific . . . to attend school, etc., the physician orders work or what have you. In actuality beyond that most of the attention is given by the school principal and the teachers and they discuss whether . . . can contribute something to the child. For example, at the end of each school year, they will draw up a roster of those that they feel probably should not return the following year to school. This is based usually on their observation of the child. . . Then they meet with the social service staff and psychologists to get their confirmation . . . and we at that time express our views. Mr. McGuire: How many physicians are there on the staff here, Mr. Madow? Mr. Madow: Well we just added one. That makes five in addition to Dr. Smith and Dr. Engberg. Mr. McGuire: Roughly than, each physician would have an average of 650. Mr. Madow: That's right. That's why I say that they obviously cannot give the immediate attention. In fact in many cases there is not the individual attention that one would desire, but it's about the way an institution constituted as we are, staffed as we are has to operate. Mr. McGuire: How long have you been on the staff here, Mr. Madow? Mr. Madow: Since July, 1951. Mr. McGuire: I notice

in this report that was given us at our last meeting, apparently, during the period since the last task force survey of the institution, you have only had assistants for about 13 months out of the three year period. What was the experience from the time you came here in 1951 up until 1955? . . . Mr. Madow: No we had more and it so happened that at the time that I came here, very shortly afterward, a young fellow came here as a psychological intern and worked here for a year. Then he left and returned a couple of months later and stayed on the staff an additional four years, I believe. In the meantime a woman who had preceded me had left for a leave of absence to travel abroad, came back and so we had three at that time. Largely we maintained three up til July or so of '56, I believe, when one of the psychologists transferred to another institution on a promotion in doing this and the other returned to school and is now completing his doctorate. Mr. McGuire: How long have you been the senior clinical psychologist here, Mr. Madow? Mr. Madow: Since 1951. Mr. McGuire: Where were you before coming here, Mr. Madow? Mr. Madow: Immediately before I was at the Columbus State School in Ohio which is a similar institution with a population of about 2300 and there incidently I was one of eight staff members, I believe, and now I think they have 12. Mr. McGuire: Where did you get your education, Mr. Madow: Mr. Madow: Indiana University. Mr. McGuire: What degrees do you have, Mr. Madow? Mr. Madow: I have only a Bachelor's Degree. I am a candidate for the Doctor's Degree. Mr. McGuire: Apparently, there are additional psychologists authorized in the makeup of the institution. Mr. Madow: Just one at present. Mr. McGuire: There are just two psychologists authorized for employment here? I thought this morning Dr. Engberg said there were more. ___?___: I believe that was psychiatrists. Mr. McGuire: Psychiatrists, excuse me. Mr. Madow: I had made a request back in either '53 or '55 in which I had asked for four psychologists. The standard or suggestion made by the American Psychiatric

Association for psychologists is, I believe, one for every 500 patients for psychiatric type institutions. And in my request I specified what I think we would be able to do with that staff and what their various roles would be. Mr. McGuire: At the present time there is only one vacancy in the Psychology Department. I would assume then from your remark that you feel there should be a couple of additional psychologists authorized for the institution. Mr. Madow: I would feel so. I recognize and I know--let me put it this way--I feel that there is much that psychologists can contribute to the institution, that a good deal of the indivudualization for patients that I know that we need to give them can come through the efforts of psychologists. Mr. McGuire: Mr. Madow, in going through the information that was given us at the last meeting which was discussed briefly this morning, I know from the psychological services sheet here that you are in addition to being the senior clinical psychologist the public information officer in the institution. Do you feel that the additional work that you must necessarily do as the chief informational officer is compatible with your work as the senior clinical psychologist? Mr. Madow: Yes, I most certainly do. The giving of information about the institution, about mental retardation to the public requires somebody who knows something about mental retardation, and it so happens that in addition to knowing something about mental retardation I have a flair for writing and perhaps a little flair for speaking, not much, and I'm able and I think they're useful in communicating with the various groups what the functions of the institution are, what the problems of mental deficiency are. Mr. McGuire: In percentage of your time here at the institution, Mr. Madow, approximately how much of your time is spent in duties that would generally be considered the duties of the senior clinical psychologist and how much of your time is spent in duties normally considered duties of the public information officer? Mr. Madow: I would say about 70 - 30. 70 as senior clinical psycholigist, 30 as public information officer,

which is off the top of my head and varies from time to time with whatever is pressing at the time. Mr. Kucera: Mr. Madow, do you have occasion to see a number of patients every day, that is, individuals? So that you're not immersed in these other duties to such an extent that your position as a psychologist is suffering as a result. Mr. Madow: I don't feel so, recognizing, of course, that one has to balance off various values of what one feels one can contribute. As I pointed out I feel I can contribute something by acquainting the public, and professional groups, etc. of the problems in this particular area. I also feel that I have something to contribute, and apparently other staff members do, in our various staff conferences where we're either discussing the long range planning in terms of the institution or planning for particular patients, either one, and conference time consumes a good deal of time. Now, there are some institutions that do less than we do and there are some I know that do a lot more in terms of conference time. Mr. Greene: As a psychologist, do you consider this 30% of time that ordinarily would be spent for testing patients, particularly when you're so short staffed, is as important as the public information work . . . (?)
Mr. Madow: I do my work as I see it. Mr. Greene: Could the answer to that be you do your work as you see it, don't you . . . (?); well that's not answering my question. Do you think that the public information office work is just as important as the task for whichyou were hired--for testing patients?
Mr. Madow: There is a false assumption in the question and that is that I was hired to test patients. Mr. Greene: Let's take the duties of a psychologist—let's phrase it that way. Mr. Madow: This is one of the duties of a psychologist.
Mr. LaVelle: I think that we are getting into the realm of personal beliefs. I don't know how the members of the task force feel about this particular thing. Ordinarily the problemsthat the task force review are those that affect the operation and administration . . . I think we're probably getting into the area--

I have one opinion, you have another--I don't think the task force could resolve one way or another. Mr. McGuire: Mr. Chairman, again we seem to be--I certainly don't mean this to be critical at all, it's something we discussed earlier, that not only this institution but at all of our institutions again we are faced with this problem of people that are trained professional people necessarily having to spend a portion of their time with administrative duties of one type or another and we discussed this with Dr. Smith and in his explanation at least it helped me to know what part his administrative duties were and they at least to a great part necessitated professional background he had and his professional training. I wonder if I might ask Mr. Madow whether he feels that there might be someone within the institution that does not have the professional background that he has that might be able to handle the present duties of the public information officer. Mr. Madow: Oh, I'm sure that there are, I'm sure that there are people who are equally well qualified in terms of their knowledge of deficiency and of the institution . . . Mr. Wangensteen: Maybe I can help, senator, simply by stating that the Medical Division, Department of Public Welfare,--we've discussed the possibility of obtaining a public information officer for all the state schools and hospitals. We have none at the present time. We have one person in the state office who has the responsibility that way and the administrative setup in the hospitals varies. In some instances a volunteer services coordinator acts as a public information officer. But this is simply because we don't have a particular person on our staffs and the point is that state planning whether or not an additional psychologist or psychiatrist or psychiatric aide would probably be of more value to the institution than public information officer. We're in the throes of wrestling with this thing now as to whether or not we will present this to the governor as a request for presentation to the next legislative body. But there is a great need for public information, as you're probably aware, and

whether or not it is feasible in an economic sense to have a separate staff person for that purpose-is something that we are not ready to recommend as yet to the legislature but it might well be in the next session that that may come up. Mr. McGuire: Well I'm glad to know that there is some setting to be made up because while I don't have enough information to know whether it's good or bad, it does seem to me that not only in public information field but perhaps there may be other fields, too, where we are using trained professional personnel for particular jobs that are actually outside of their training and we are short of those type people. If we can utilize them to the fullest extent for the job that they have been trained for and delegate some of the other duties they may now be doing to people that have training in those particular fields but not professional training that the first individuals have, we may be able to get more professional use out of the professional people that we have on our staff. Mr. Wangensteen: This is an administrative problem really for each individual hospital as to which comes first. There are many things in all our hospitals which remain undone and it's just a question of juggling personnel almost to accomplish the overall which seems to be most desirable for that particular hospital. Certainly I agree with you it leaves room for question as to whether this shall be done or this shall be done. It turns out that administrative judgment really is the final authority when you finally determine staff. Mr. Walsh: Everything always seems to come back to staff. You're so short of not only trained aides and people on the lower level but we're so shallow on the professional level. And I referred a short time ago, California which is way out in the Pacific Ocean but the state of Wisconsin South Southern Colony has the same population about as here at Faribault. They have twice as many employees, if you can imagine it, than you do have here. The staff situation is critical and still when you go to the legislature and try to get additional staff people you're faced with many pro-

blems, not only in institutions but throughout the whole state. So it's difficult for them to say well, we'll put a hundred people down there, we realize that. Still it is so critical that something must be done about it and the fact that some people are doubling up on duty there's either a choice to make, one, we eliminate certain things they're doing such as cutting all public information from the institution or have somebody to do it. This presents many problems.

Dr. Engberg: I think one of the other areas where this same thing comes in is with reference to clerical help. We have professional people who are doing writing longhand where they should be dictating something or have some clerk take care of it, and Mr. Endres will remember the discussions we had with reference to supervisors of the divisions where there's no one to answer the telephone, for instance, and a lot of detail work that might be done, purely clerical work, that a clerk could do if a clerk were available, but there is no one. I have this record on this Kathleen.--I thought possibly you would be interested in it. She had been at Cambridge, then had been placed out and this is a copy of a letter from the University to the caseworker in the Medical Division of Hennepin County. Kathleen, I'm not giving the whole name, then age 24 is at present time under our care for her third pregnancy. A review of the previous hospital chart (I'm omitting some, just bringing out the essential things) reveals, the previous hospital chart reveals, that this patient was admitted to this hospital on April 2, 1957, at which time she delivered spontaneously and without complications a living male infant weighing 2475 grams. A postpartum course had been uneventful. She was again seen in the Obstetrical Out-Patient Clinic on July 10, 1957 for her three month postpartum examination at which time an impression of a normal three months recovery was gained from the examination. Our hospital records also indicate that in 1953 she delivered her first pregnancy uneventfully at the University of Minnesota Hospitals. The past history also

mentions that this patient had an operative closure of the patient's ductus arteriosus (that is a heart operation) performed at the University Hospital in 1953. That is the summary that they sent. Then she was admitted here June 5 in pregnant condition and on August 3rd was delivered of a living . . . Mr. Greene: That was my patient. Dr. Engberg: Yes. Mr. Greene: Very valuable information. The qualifying there has been neglected. Kathy has been institutionalized all her life. She's an illegitimate child, foster parents till the age of 5, Cambridge, then Owatonna, then here or Owatonna, Cambridge, then here. She's been environmentally, culturally and educationally deprived. I carried her for psychotherapy for four months almost. I found that her intellectual level was far above and could be at least within the average range. Mr. Walsh: Her trouble seems to be that evidently some place along the line she lacks the judgment necessary to live outside in the community, whether it's environmental or training or whatever it is. At this point she seems to lack this. Mr. Greene: Sir, I would say this. Judgment is lacking primarily by total lack of proper training. Mr. Walsh: Well, that's what I said. Mr. Greene: This girl by going out--I could mention one thing which might be just of curiosity, Mr. Chairman--This girl has never been given sex education. The first time I had seen her--this school does not give sex education here either prior to discharge--however, here is a girl in first initial interview of psychotherapy, she asked if she could speak to me. She said, Mr. Greene, I know I've done wrong. She showed such amazing insight I'd think it was psychotherapy. She said, I was starved for love and affection. It might be stated too that when she was discharged from Owatonna, gentlemen, where she was an illegitimate child, the social worker from Hennepin County told her where her mother was. She subsequently went to her mother. This was not mentioned. Dr. Engberg, which I think is important in qualifying this girl and the whole case. She found out where her mother was after 25 years. She

found out she was illegitimate. She was rebuffed because her mother had married and had a son. She met a family she'd never known before. Then she proceeded to have three illegitimate children. I think that should be the qualification. Rev. Van Kirk: I have a question in a case of a person like this. I don't understand the mental level there but I was wondering now if a child or a person like this, how a person like this happens to be here rather than in say the state school at Rochester if this person's mental level. . . Dr. Engberg: Owatonna you mean? Rev. Van Kirk: No. . . Mr. Walsh: State hospital at Rochester. Rev. Van Kirk: Yes, I think of this as an institution and this may require my re-education but I think of this and the school at Owatonna as for the retarded. Now if this girl is not retarded at this point, then how does she happen to be here? Dr. Engberg: Well, possibly we are getting into an area of argument. She is committed as mentally retarded. The last I.Q. test we have on her is 70. I think we will have to recognize that she is socially inadequate, whatever the reasons for it may be, and a girl that requires course planning. Rev. Van Kirk: Now, last year there came out with quite a story and I suppose it made a good story, about a condition in Iowa where a person who had an I.Q. of up around 100. What possibility would there be for such a person to be in any one of our retarded institutions today, and not be found and set out again into society. That case was, of course, a dramatic situation or written up so. Now what are the possibilities for that kind of thing happening in Minnesota? Dr. Engberg: I think they'd be rather remote. I happened to have surveyed that institution and it doesn't surprise me. A situation like that might exist in that particular institution. Mr. Walsh: It might interest you to know this man was let out and later it was found he had diabetes also, had a leg amputated and my report says that he had other difficulties out in the community, which may have been because he was in. But I think that this was probably dramatized far beyond what it should have been.

The person who did the dramatizing, a lay superintendent, later turned out was flying under the colors of a doctor when he didn't have a doctor's degree and he evidently was the kind of a person who wanted to dramatize things. But certainly even if the fellow did have a high I.Q. but you see there are other things involved, diabetes, . . .I'm not trying to justify it at any means. Mr. McGuire: Doctor, pursuing this individual case, this is just to give me a little background, how long ago was the last test made to determine that this girl has an I.Q. of approximately 70? Dr. Engberg: Yes, Mr. Greene's got a 71. Mr. Walsh: Mr. Greene had a 71. Mr. McGuire: When was that test taken? Dr. Engberg: That was taken on September 23, 1959. Previous test there was an 83 in 1935. She was born in '27, so she was eight years old at that time. Then in '47 a 58, in '51 a 70. There were several tests done. On the Stanford Binet, Form L, there was a 70, on the Wechsler-Bellevue, there was a verbal of 74, performance of 83 or a net of 77, and then on September 5, 1954 a 78, performance of 81 and a verbal of 78, and then Mr. Greene's test was 71. Mr. McGuire: When this girl was admitted to the hospital here, what was done with her, how was she classified, where was she placed, was particular training prescribed for her, what was done? Dr. Engberg: Well, of course, she was taken care of for her pregnancy first. Mr. McGuire: yes. Dr. Engberg: And then the child would be returned to the community in her county, and then she has been here for the purpose of training and observation since then. Mr. McGuire: What type of training has she been receiving while she's been here, doctor? Dr. Engberg: Well, in the sense of a work assignment. Mr. Endres: Mr. Chairman, I can't quite see the justification of placing these patients in a mentally retarded institution like this as we all know people acquire knowledge by their environment. That's one reason I'm happy to be here today; I'm gaining much information. I have also noted through the progress of a patient from the 10 years that I have been here, particular person .

. . . town, I don't know how long he has been here but he was a wonderful detail. Because of the lack of being with educated people and being helped, he had retarded to the point where he is almost now useless in the building, and when I started here he was a wonderful detail. We could send him almost any place and trust him on almost any job and we can't depend upon him to do a thing now. Possibly it is something that goes on automatic. Sometimes I feel it's because of the environment. In my particular building, there are many in the very low state mentally and by having to live with these possibly that affects their mentality too. I don't know, I'm not a psychologist or psychiatrist. I couldn't make these statements as accurate. I have seen patients retarded constantly throughout the different buildings but I was wondering the reason for it.

Dr. Engberg: Well, it would be difficult to say in a particular instance. There are the deteriorations that occur. I'm sure that you can think of your own friends who are out and around who today aren't what they were ten years ago.

Mr.. Endres: Or including myself. Dr. Engberg: There are these and than there are certain types of mental deficiency where a deterioration occurs. I think the thing that drove this home especially to me was a mother who came just to discuss matters with me. She had three children that were at one of the private institutions. Now all of these are retarded. The first child appeared to be normal of intelligence. They are normal, apparently, during the early months of life and then very early a deterioration occurs and here now she has three severely retarded children that have to have institutional care. The first child seemed to be perfectly normal. They had their second child and those children seemed to be perfectly normal. They had their second child and those children seemed to be normal. By the time the third child was on its way they recognized the defect had occurred so that we can't speak about mental deficiency, we have to speak about a patient who is mentally defective. What the reason for it is

and your prognosis and your whole program is going to be determined by that. Mr. McGuire: Doctor, in classifying these patients as they come into the institution, I assume first of all in the various buildings they are broken down according to sex. You have men in one building and women in another. Dr. Engberg: Yes. Mr. McGuire: Are they broken down further then by their, assume taking out the epileptics, the people with physical defects, are the other broken down by ages, by mental ability or how are they classified? Dr. Engberg: Yes, there is what we call a classification. Now the epileptics will be grouped with them. They are not kept separate. Mr. McGuire: They aren't. Dr. Engberg: No, no, but they're broken down into classifications and, of course, one of the problems that we have here is this,—that with the overcrowding that we have and the tremendous pressure of the waiting-list, we have a breakdown in our classifications which makes for a great many problems. You take if you have in a building one patient that does not fit in well with the others in the group and they live together 24 hours of the day, you can see it becomes a source of irritation on both sides. Mr. Endres: Also this is a must because of the understaffing of people to care for them. We must have the brighter detail patients living right in the building with the lower type patients because they have to assist the aides in their duties. The aides couldn't possibly do the work. We have details in each building to assist the aides. That is one of the reasons for having the mixed groups. Dr. Smith: Mixtures aren't always bad either. Sometimes it is better to have two different kinds of people together than to make it completely homogeneous. You need stimulation, you need a little anxiety, you need a little push. Dr. Engberg: But in any event a thought is given to the best possible placement for the individual to meet whatever the needs of that person may be. Mr. Kucera: Dr. Engberg, I think this Kathy, whatever her name is, in that regard her problem is probably a moral problem or inability to determine right from wrong . . .

In her training program, is there anything done specifically to remedy that problem of hers or is this just a general . . . Dr. Engberg: No, it's more general . . . type of therapy. Here I think that if we had the adequate staff, we would want to spend more time with a girl of that type, of course. But I'm sure we have others where it's equally true so that it becomes many times a question of where you're going to devote the time. Mr. Kucera: Actually, then with your limited staff, then there really is not a great deal that you can do to remedy her specific problem or the problem . . . Dr. Engberg: That raises an interesting question. We know the normals where they have this same situation and so that it's not what it is that accounts for behavior is something we might spend a tremendous amount of time on. I think that here there are the religious services, the attitude of proper behavior, proper relationship to others and all. It's indirect but I think it has a value and probably just as much value . . . She knows how pregnancy occurs certainly. Mr. Kucera: In that regard, does her chaplain know or the chaplain, whoever he may be, know her problem and does he attempt to do anything about it. Dr. Engberg: Well, I'm sure that he knows of her problem and what his attitude is, I couldn't say for him. Mr. McGuire: Well, Mr. Chairman, it seems we're right back where we started. I assume that probably Dr. Smith and Mr. Madow would like to get back to their work. I wonder before we leave this particular phase if either Dr. Smith or Mr. Madow would have any suggestion or recommendation to our task force that might help the situation, other than additional personnel. Now apparently we're going to have serious problems with additional personnel realizing the problems that we have as members of the legislature; that alone doesn't seem to be the problem. Apparently, we've authorized additional psychiatrists for many years and they just have not been available. Dr. Engberg: But we're in competition with other states and even in our own state where they can get better pay rather than in an institutional setting. Mr. McGuire: Well, I

assume then that one possibility would be more adequate compensation for professional personnel or to increase the staff. Is there anything that might be done within the staff that we have to help the situation any. I was wondering before they leave if either one of them might have any suggestion to our task force; is there anything that we might be able to do to help the situation any as it is at the present time; is there anything that we might recommend that could or would be done to help your situation as it now exists at the present time? Dr. Engberg: You mean in addition to personnel? Mr. McGuire: Yes, assume that we can't get additional personnel today, is there anything that can be done with the personnel we have . . . Dr. Smith: Only other thing that can be done to improve our facilities, to get our new buildings, to get an out-patient department to the hospital so that we can streamline our programs and carry out the programs that we wish to follow. If we can't manipulate personnel, if we can't manipulate buildings, then we manipulate programs. If you have good personnel and good buildings, then you've got a good program. Mr. Kucera: In other words you're satisfied that the most efficient use is being made of staff as it now exists. Dr. Smith: Oh yes, absolutely. Mr. Wangensteen: The Building Commission meets here next Friday. Mr. Walsh: Is this a regular meeting of the Building Commission they will hold here or are they having a special . . . Dr.Engberg: They're having it here. Mr. Walsh: These are open meetings, aren't they? Mr. Wangensteen: The Building Commission hasn't opend them. They've invited all the local legislators; this is very much of a work Commission. Dr. Engberg: And the mayor and the president of the Chamber of Commerce have been invited. Mr. Wangensteen: Mr. Burdick is the Executive Secretary of that Commission. Probably a request could be directed to him if any of the non-legislative members would like to attend. I know they encourage local legislators to attend . . . Mr. Greene: . . . It would seem the DPW is competing with itself. They're pushing all these public county clinics

and offering psychiatrists $18,000 to start. They can't build their own hospital. They're offering psychologist $9,000 to start where they can't get that within an institution. It just doesn't add up logically. Mr. Wangensteen: This is true in part. Of course, we're always competing with ourselves. I suspect that some of the good people leave the central office for the institutions, some of the institutional people for the central office . . . Mr. Walsh: These people must not be under Civil Service . . . Mr. Wangensteen: The out-patient clinic,as set up by the statute, are community clinics. There is 50% reimbursement from state funds for a clinic. The rest of the money has to be raised locally. Mr. Walsh: State governs the salaries. Mr. Wangensteen: No, they're governed by a local board and, of course, the law and so far we haven't the out-patient clinic,-to my recollection-they-haven't-stolen any psychiatrists from our state hospitals but there is this danger. Mr. Greene: . . . who might ordinarily have been given a place in a short-staffed institution . . . Mr. Wangensteen: That's entirely possible, Mr. Greene. The other thing is it may be that the individual psychiatrist or psychologist prefers not to work in an institution. He rather work in an out-patient clinic. This is true. This has been discussed too and there is pro and con to both. By offering better salaries, all you do, as you know, Mr. Greene, there's competition between public agencies and Veterans Administration on salaries. Veterans Administration raises their salaries on social workers. Social workers will come to the VA clinic or VA hospital. The public agency raises theirs again and they might come back and they might not. There's always this going on and in areas of professional competence where there aren't enough people to go around and this is cannibalism really. But it does exist; I have to admit that. Mr. Endres: Because the time is limited and it's getting late I don't want to read this word for word but I do want to express my sincere gratitude for being allowed the privilege to be here. The first two items that

we have covered are the patients' basic wardrobe and centralization of dining rooms. I believe these are self-explanatory. I don't think they have to be discussed. Mr. Walsh: One question, very briefly. You mention state purchased clothing, How about patients' parents who furnish clothing. Does anything happen to them? Mr. Endres: They seem to withstand the shrinkage much, much better. Mr. Walsh: They do. Mr. Endres: Yes, definitely. Why I couldn't tell you but one thing I have noticed although it's a known fact that the J. C. Penney Company overalls is one of the best work overalls there is will stand the laundry far better than ours, our state purchased overalls. Why it is I don't know. They don't seem to shrink the way ours do. They will, because of the terrific temperature, the pressures, in the steam cleaning and laundry they will shrink a little but not too much because they are sanforized. Dr. Engberg: Could I interrupt just a moment? I think one thing that isn't considered here in this matter of the inventory or wardrobe inventory is this: We feel that there should be the wardrobe inventory--it will vary from building to building--so that we can know for instance that in Building A, in that building the patients need so many shirts, and other articles of clothing, and we can then arrange so that we can know that that supply is on hand and available for them so that it is an orderly manner of pruchasing. One of the problems that comes up with reference to state purchasing is this: The purchasing is done by the State Purchasing Department so that if this situation does exist, it is a matter that would have to be discussed with them. I want to mention one other thing and that is this. I had hoped that we would get a substantial increase in the amount of money that we could have to purchase clothing, especially for our men. I think our women are dressed pretty well. Wouldn't you feel so too? But our men are not dressed nearly as well as are the women or girls and we had hoped we could correct that. The money is not sufficient for us to do it so part of it is purely a budgetary

problem. Mr. Endres: Doctor, we have always kept more or less of an inventory on clothes in the building in the past years. Prior to this basic wardrobe setup, we used to keep count of the number of overalls, etc. and as soon as so many were discarded, we would reorder that many more and we had a standard number of overalls. Now in the process as it used to be we would order larger sizes for bigger boys. They would get the new ones all the time. As they would shrink they were put on the little guys. The poor little guy was always wearing old overalls. That is what the basic wardrobe was set up to change so that he would get new overalls once in a while too. But as it is set up now, as this explains, it is a terrible waste because when they don't, the patient gets mad and tears them or they have to be remarked or reissued. Things that the aides have to do because of the shortage of custodial workers. They can't do it. We have to sacrifice time, patient care, to mark clothes. Mr. Walsh: What happens then, basic wardrobe, if a parent brings down say three pair overalls, 6 shirts, 10 pair of sox, two pair of pajamas. I mean if it were changed. Mr. Endres: Each individual building has two separate sets of clothes. They have the patient's private clothes that are always marked with his name and issued to that patient. At least that is the way it is in my building. I can't account for all of us. I'm sure that's the way it is supposed to be in all buildings. Mr. Walsh: Then, you're just talking about the state purchased clothes. Mr. Endres: Yes. Dr. Engberg: The point that we feel is important in basic wardrobe is this, that if the family is providing, certainly the state does not need to, but they should have the same amount of clothing whether the clothing comes from one source or the other. That's the basic purpose of the basic wardrobe and it has not worked out so far simply because one has not been available to keep up with the program. But we have for instance on the women's side, certain girls who have more dresses than they can possibly wear. Well, it's important to know that that condition exists and maybe

they're going over here and they're making dresses for themselves. They've already got all that they need. Then if that is true, they should be making dresses, if they make them at all, for some other patient . . . This is just a sidelight of this but I felt it important to bring this in at this particular point.

Mr. Endres: Getting back to nursing supervision. That's on page 3. I'd like to give you a brief rundown of the history of it. When I became vice president, because I was elected an officer of the Union, not knowing my authority or my position, I took it upon myself to make an individual trip to central office. I was received very coldly and I left. Something like a dog with his tail between his legs. Several years later, I was elected president of the local and I took a committee. We had a meeting with Mr. Hursh, Dr. Cameron, Mr. Estlund, who is present now, was there, and I believe Ray Lappegaard, I'm not sure. Anyway a similar situation of the problem was brought up then. Dr. Cameron stated emphatically, he said the reason they have disregarded the Aide III and Aide IV supervisory positions and placed nurses in charge of the divisions was for one purpose and that was to give better care, medical care, to the patients, better supervision to the patients. Fine, we wholeheartedly agree as this brochure will state, we agree. We want better supervision and better medical care but under the present setup, as it states here, we'll go down a little ways here, for example. In Dakota building, according to an article in the Minneapolis paper dated October 6, 1949, was supposedly to be in terrible condition, lack of proper care, etc. I think you all remember reading that article by Mr. Clark. Mr. Walsh: Is this 1959? Mr. Endres: Yes, 1949. That's '59, that was a mistype here. That was just recently he had presented that article in the Minneapolis paper out of the section of reviews that the Minneapolis paper put out. We have checked the day book records and have actual proof to show Mrs. Goodwin, nurse supervisor, from November 12-- from October 8 through November 12, we just checked for a period of a few weeks, has made rounds only five times. In our estimation, a building

of this type needs constant nursing service. We do not feel that is the fault of the nurse because she has so much book work and meetings to attend. The nurse's desk is filled with papers, time sheets, reports of all different kinds, that any clerk could do. I would like very much to see the Aide II and Aide IV position reinstated as division supervisors and place the nurse back in charge of supervision of the training program and actual patient care, helping to supervise the aides that need the training on the job. We still have aides that are not properly trained, I'm sorry to say. And that is where the nurse being a professional person would fit in beautifully. Not sitting answering a telephone and doing paper work. We don't need them there for that. Example No. 2. In the past years it has been the custom when the shots have been given to complete wards and this was years ago, I remember distinctly. The nurses would take their instruments and equipment and come to the building but on November 5, in a snowstorm, patients from Glen cottage, Lind cottage, and from some of the other buildings in Sunnyside Division had to walk through a snowstorm, take off their outer clothing to get their shot. The question we ask now, are the nurses working for the benefit of the patients, or are the patients in the institution for the benefit of the nurses? And again, just the other day, groups of patients were brought to Osage building, it's an infirmary type building, and they even went so far as to have patients brought in wheel chairs there, rather than have the nurses take their equipment and hop into a car and go to another building. I'm not interested in going over what happened to me here but that's on your next page. I would like to state now we have a nurse supervisor who has a Nurse V rating, Mrs. Blomquist. It is my feeling that it is mostly a title, a desk, and a pay check. I have gone to her in many, many cases, and she says she does not have the authority to make any decisions. There are many things, in fact, I would like to have Mrs. Blomquist asked to be present at this meeting, ask her a few questions,

on some of these nursing conditions. Mr. Walsh: Are nurses in charge of all divisions in the hospital? Mr. Endres: Yes sir, at the present time they are. Mr. Walsh: Some of these divisions, are some of the divisions completely bed patients, almost. Mr. Endres: The divisions aren't but certain buildings are of very lowly retarded, like Osage is one ward that they either lay on the floor or they lay in a bed. The other ward is hyperactive that are running around, scooting around the building. Mr. Walsh: Do many of these patients have medications? Mr. Endres: Definitely, the medication at Osage is terrific. The aides are doing all the medications, giving the shots and everything. We have a class of people here in the aide category, they are about the most wonderful people there are, they are doing a terrific job. They're dedicated to their job even though they are underpaid and underprivileged. As far as underpaid is concerned, right here in the records, a game keeper gets $270 to start to feed animals, a psych aide trainee gets $240 or $250 to start for one year and then moves up to $260 as Psych Aide I. Mr. Walsh: I think that $260 was moved to $270. Is that the July, 1959, schedule? Mr. Endres: The trainee starts with less though than the Aide I. The Aide I classification is from $260 to $316. The trainee gets less money for the first year training program. Less than the game keeper. We're dealing with human beings. As far as myself. I haven't seen my nurse, well, as it states back here, I was relieved of charge duty from Springdale quite a few months back and I haven't seen my nurse except on payday when I go to get my check. I haven't seen her on rounds through my building. I've been on duty five days a week constantly. Most of the time she never even made rounds in our buildings. I know she's busy on paper work but in the old system the charge III used to take care of that. Of course, under the old system we didn't have nurses assigned to the divisions. The doctor used to make his rounds instead of the nurse but I would like to see the nurse assigned to the divisions just to the medical end of

it. Mr. Walsh: Are there any state laws governing who should be giving medication to patients? As long as the doctor prescribes it anybody can give it? Dr. Engberg: Yes. Mr. Endres: There's a law against narcotics. Dr. Engberg: Yes, well no narcotics are administered here except in the hospital. Mr. Endres: From what I understand the Aides I over there are administering all medications; they have no assistance from the nurses there. Dr. Engberg: That may be but there are no narcotics administered there except in the hospital. Mr. Endres: Do you suppose we can get Mrs. Blomquist to come over and give us the highlights. She is more in a position to explain the excellent nursing care that is going on in here. Mr. Walsh: What did the nurses do before they were in charge of divisions? You said they were doing training . . . Mr. Endres: No, this program started, I believe, about eight years ago. . . . Actually, years back the nurses used to do most of the nursing work directly in the hospital itself. Then they increased the staff of nurses and as they could get the nurses to come to work here, they put them in charge of the divisions, as the Aide III's retired or quit. Aide IV, John Burnett is the Aide IV, is the last one retired in Sunnyside. Mr. Erickson was the last Aide III retired. . . . Mr. McGuire: Mr. Chairman, I wonder perhaps if Dr. Engberg would give us a little rundown again on the organization of the hospital, now I'm getting fuzzy again. We've discussed, apparently, the top level, the superintendent, psychiatrist and psychologist . . . Dr. Engberg: I think it's all in the report that I made. It shows the organizational breakdown. Mr. McGuire: Where will I find that, doctor? Do I have the right sheet here? Mr. Walsh: Yes. Mr. McGuire: Now in looking at this, where do we come into this division thing. This morning we were talking about the formerly four and currently five positions that somehow or other are given duties with the patients in the hospital or in the institution. . .how is that determined?. . . Dr. Engberg: I think possibly that it might be well if I covered this in just a general state-

ment. In a sense we operate almost as the base hospitals operated in a base hospital center. We have four main divisions. Each has between 700 and 800 patients and each of those divisions is under a graduate nurse. Then in the various buildings there are charge aides who are in charge during a tour of duty. The senior . . . Mr. McGuire: Are the charge aides nurses, doctor? Dr. Engberg: No, they are psychiatric aides, or attendants is the common word. An Aide II who is in charge of the building at the time, and then under the Aide II are aides at the I level, that's the beginning level, and in that group will be certain trainees during whatever time they're spending in the building. This institution is becoming more and more medically oriented and one having medical needs, and you see originally when I came here, we had the Owatonna type patients as well as the patients we have now. Now the Owatonna type patients do not come to us at all unless they have some additional handicaps as Dr. Smith has mentioned. We felt that we needed a nurse who would have the judgment of what the nursing needs of patients in her division would be. We did not institute this change until Psychiatric Aides IV, that was the top level of aides, Psychiatric Aides IV were retired. Then we would place a nurse in charge of the division and Mr. Endres and I have discussed this in the past. We disagree on it, but I feel definitely that at the top level there should be a nurse in charge of a division. I feel that there should be clerical help. It's one of the things I mentioned earlier. There should be clerical help so that the nurse supervisors would not be required to spend time on a good deal of the paper work that they do now. The senior aide in the building is looked upon as the one who correlates the total program for the building but the aide who is on duty at the time, the Aide II who is on duty at the time, has the full responsibility during his or her work assignment. Does that answer the question? Mr. McGuire: Well, it does to a certain extent, doctor. Where do the physicians at the institution fit into this organizational...

Dr. Engberg: The physicians are assigned usually, well it may be to a certain division or it may be to specific building. Mr. McGuire: So actually the physicians are in almost a totally separate classification in the divisions that are headed by nurses; the physicians aren't necessarily assigned to the same divisions that nurses are. Dr. Engberg: Ordinarily the physicians would report to supervisor of the division if there were any matter that needed special attention. Ordinarily, it would be to the Aide II who happened to be on duty at the time but if he was particularly concerned about a matter, he would discuss it with the nurse supervisor of the division and she in turn would communicate with Mrs. Blomquist who is the nurse supervisor, that is she has overall supervision of nursing services. Mr. McGuire: Among the physicians on the staff, doctor, is there one physician that is the chief physician or senior physician or something or are all the physicians responsible directly to Dr. Smith or to you? Dr. Engberg: They're all responsible directly to Dr. Smith. Ordinarily, if Dr. Smith is not here, then the one who is the physician on duty for the day acts in his absence. Mr. Kucera: Doctor, I notice in the diagram that the nurses are under the direct supervision or indirect supervision of the assistant hospital superintendent. Shouldn't they be under the supervision of the psychiatrist? Dr. Engberg: The two work together. That's primarily on the basis of work assignments. Mr. McGuire: Who did you say the chief nurse was, Mrs. . . Dr. Engberg: Mrs. Blomquist. Mr. McGuire: Who is her immediate superior? Dr. Engberg: Dr. Smith would be. There again there may be some matters she would take up with Mr. Krafve, but ordinarily if it had to do with patient care, it would be taken up with Dr. Smith. Mr. Walsh: Who is the Assistant Hospital Superintendent? Dr. Engberg: The Civil Service title is Mr. Krafve's, the Director of Administrative Services. Mr. Walsh: Well, then Business Manager is something different then. Dr. Engberg: Yes, Mr. Thurber is the Business Manager

under Mr. Krafve. Mr. Endres: Dr. Engberg, possibly, maybe it's because I'm dense, it doesn't quite sink in. You know there is a shortage of nurses in the State of Minnesota; that's the reason our legislation set up scholarships so that underprivileged girls with the ability could go to school and be nurses. And to me I still can't see the valuation of having nurses in the offices doing book work. . . Dr. Engberg: That isn't all they do. Mr. Endres: I know, but that's all they're doing at the present time. Dr. Engberg: Oh, no, no, no. Mr. Endres: I see them day after day. Dr. Engberg: Well, I see them too. Mr. Endres: I have yet to see them working on the grade or helping. Dr. Engberg: They don't work on the grade, no; the supervisor, she would not work on the grade. She would supervise the work that's being done. Mr. Endres: Well, the supervision of the divisions in the past has been for years and years, was done by the Aide III and or Aide IV. They got along beautifully and still we have taken a professional person that can give professional medical care to a patient, put him in the position of a supervisor and taking a non-professional person that should not be giving professional care and they are still giving the shots and the pills and administer the drugs. Dr. Engberg: Well, are you making a point that there should be nurses in those areas too? Mr. Endres: Well, possibly we need nurses to work with the patients too. At the present time I can't see the feasibilities of a nurse doing the book work where an Aide III and an Aide IV in the past have done it and they could still continue to do it, and relieve the nurse so she could do the medical part. Dr. Engberg: Yes, but she wouldn't be a supervisor then. We differ radically on this. I think it might just as well be known. Mr. Endres feels very definitely that there should be unprofessional aides in charge of divisions. I feel that with the type of patients that we have that we need a professionally trained nurse in order to make the decisions that are necessary. A patient becomes ill. The question comes up, should the doctor be notified immediately or not. Well, the nurse certainly is in a better position to make

that determination than is a lay person. Mr. Endres: From 2 o'clock in the afternoon until 6 o'clock in the morning, you can't get a nurse in my division, sir. There is a night nurse but she has resigned just recently but she wasn't there too long on the night shift. But from two until she would come on at 10:15 there was not a nurse. It was impossible. The decision was left up to the aide and in many cases was left up to an Aide I. We didn't have even Charge II's in the building. An Aide I would take the temperatures, if the temperature had risen. He would call the doctor, make the report or his immediate supervisor, making the report, who would possibly be an Aide III. Dr. Engberg: But that was only because of lack of personnel, wasn't it? Mr. Endres: Well, because of the lack of personnel, so we can have nurses around the clock for the medical part. As it states here. Return the nurses to their nursing duties, place them in charge of on-the-job training and for work with the patient. They can be entirely in charge of the medical end of it. We don't want to take that part away from them but I don't think it is feasible for a nurse to go around checking the dust in the building or see if the basic wardrobe is up or whether all your boys ate their breakfast. I think those are things the lay people like myself can do very, very well. Dr. Engberg: Those are the things that if we had a housekeeper, the housekeeper would be doing. Here again we get into a situation where with inadequate staff, there are certain things that individuals will do that may be is not, shouldn't be a part of their duties but somebody's got to do it. They're available and they can do it.

I'd like to speak on this matter of automatic merit increases. I do not believe that merit increases should be automatic but I do believe this and this is the policy that we follow. I think merit increases should be merit increases. The policy we follow is this, that through personnel and Mr. Krafve's office the

question comes up when merit increases are given who are to receive them. The recommendations are made for merit increases. And I expect that the merit increase is going to be recommended unless there is some specific reason why it's not recommended and the records should show the employee has known that his work was not satisfactory, they have been given an opportunity to improve it and if they don't improve it, I don't think that person deserves a merit increase. Now I think that there are very few merit increases we do not grant, very few, but I think it would be entirely improper to give a merit increase to a person who is just tagging along enough so that you know that Civil Service would not approve of dismissal if you took that action. Now, I'm speaking very frankly but that's my honest conviction that that's good administration. But I do think that if a person does not get their merit increase, they should know why they are not getting it, and should have been given an opportunity to bring their work performance or their whole attitude up to a normal standard. I do not feel that in order to get the merit increase that the individual should be doing superlative work but they should be doing satisfactory work. Now that's my attitude and I'm always going to take that attitude, Mr. Endres, and I'm never going to favor the matter of automatic merit increases. Mr. Endres: We feel the same way. We feel that there should be additional incentive for merit increases, for anyone that does a superb job but when a person starts here, the first thing he is told, he starts at a given range and he moves up to this given range. In other words, that is more or less a verbal contract that this is the job and this is your pay scale. And yet I've had different aides come to me and complain bitterly. In fact, several years ago, you remember, we were in your office with 13 people who had been refused to be given merit increases. Many of those people felt that it was not because of their duties but because of other personalities, the general feeling of the people themselves. Dr. Engberg: I don't remember that particular

instance and it may be that the approach has been different since that time. Now if Mr. Krafve would report to me that this person had not been recommended for a merit increase, the record doesn't show that that person has been notified that their work has not been satisfactory, I would over-rule the one who had indicated they would not approve the merit increase. Mr. Walsh: Isn't there a legislative committee studying the whole problem of merit increases? Mr. McGuire: Employer-employee relationships. Mr. Walsh: I sat in on both the Senate and House money committees when they talked about this and both committees practically unanimously voted not to give merit increases until the thing could be studied, because they felt it was becoming too automatic and they felt that it should be as it was intended to be for meritorious service. And then, of course, as you know . . . 18 month. Mr. McGuire: That was both the merit increase and cost of living increase that was involved for the state employees' pay. Mr. LaVelle: It was the cost of living that was provided for July 1, 1959, but no further cost of living adjustments for this biennium. Merit increases can only be given between January 1st and June 30th of each year in the current biennium. Mr. McGuire: Dr. Engberg, how many registered nurses are employed at the institution at the present time? Dr. Engberg: How many do we have all together, Mr. Krafve? Mr. Krafve: 27, two vacancies. Mr. McGuire: Is this guide that we have here correct? Can I just total up the . . . Mr. Walsh: 27, less two instructors. Mr. McGuire: What do the balance of the nurses do then? Apparently, there is a chief nursing supervisor and one nurse in charge of each of the four divisions. Dr. Engberg: Well, in the hospital you see you have a different situation. Mr. McGuire: Are all the other nurses employed in the hospital? Dr. Engberg: Well, there are two nurses that give the in-service training program. Mr. McGuire: What does that involve, doctor? Dr. Engberg: That's the training as aides. Mr. McGuire: Oh, I see, the training of the employees. . . Dr. Engberg: All of

aides now or those who go into the aide classification come now as trainees and they then receive their in-service training and that is carried out by the two nurse instructors. Mr. Walsh: Well, then it would take approximately 12 to 16 nurses to give service on the four divisions, wouldn't it on three shifts ... Dr. Engberg: We don't have. . . Mr. Krafve: We have two. Well we have one that just resigned. In East Grove, we have 2 nurses, we have two in . . . Dr. Engberg: It's not around the clock. Mr. Walsh: Oh it isn't around the clock. Mr. Krafve: Around the clock you would need at least five in each division. Dr. Engberg: Yes, so what we have is really just minimal coverage, that I feel there should be for the divisions. Mr. McGuire: Do you have more than one nurse in each division, doctor? Mr. Krafve: In two divisions, we have two. Dr. Engberg: In two divisions, we have two. Mr. McGuire: The other two there is just one. Dr. Engberg: Yes. Mr. McGuire: The nurse is on duty I suppose 40 hours per week. Dr. Engberg: Yes, that's true. The remainder of the time the aides then would be functioning. Mr. McGuire: Prior to the time when the nurses were put in charge of the divisions were there more nurses available in the various positions or nursing care then. Dr. Engberg: No, I think they had this difference, Mr. Endres, that they would have a nurse from the hospital who would go out to do certain nursing services but we have not had that and I don't think that there would be advantage in that plan. I think they're of more value in the hospital than they would be circulating through the various divisions. Mr. Walsh: What do the seven psychia-aides III's do now. Dr. Engberg: They're reliefs for the nurses. Mr. Walsh: This is a plan that used at Canbridge and Brainerd also. The nurse has charge of each division . . . Dr. Engberg: I'm not sure. . .Mr. Walsh: Well, Canbridge, I think has it. Dr. Engberg: They have the overall nurse supervisor, I know. Mr. Walsh : But whether they have one in each division? Dr. Engberg: I wouldn't know,-no. Mr. Endres: When I visited some relatives in Rochester. I under-

stand Rochester instead of having divisions have units. The nurse,-well it was my wife's aunt we were visiting,-the nurse was very busy with her little medicine cart with an Aide II assisting her taking care of the patients and they had an Aide I and a clerk in the office. They had the wings spreading out. The Aide I and the clerk in the office were doing the clerical and the book work. That is the type of setup that they have in Rochester. Dr. Engberg: They have a different setup too in that they're divided into just a male and female section rather than into divisions as we have them here. Mr. McGuire: The head of the division is she called a charge nurse? Dr. Engberg: She's a supervising nurse. Mr.McGuire: Supervising nurse. What basically are her duties and functions? What is she doing, what is she supposed to do? Dr. Engberg: Well, she has overall supervision of all of the nursing care. She would have the charge aides of the various buildings meet with her and work out with them the program that would be in effect and she would be the contact person with the physician on any special matters that it would come up; otherwise, the physician would deal directly with the charge who was on the duty at the time he made his rounds. And then it becomes a matter of discretion on the part of the charge aide as to what matters are important enough to be brought to the attention of the nurse supervisor. She or he, as the case might be, would not bring it to the nurse supervisor's attention unless there was something unusual about it. Mr. McGuire: I might ask Mr. Endres then what you feel the charge nurse is doing or should be doing that they aren't doing now?
Mr. Endres: Well in the older years when I started, we had aides doing charge work. We had the Aide III and Aide IV positions. They were doing what the nurse is doing now--answering the phone, taking care of the employees' time sheets, payrolls, the records of the patients. In fact, the nurse in my division is so busy on her records that she very seldom gets out to any of the buildings. The patients she very seldom gets to see the patients. When Mr. Erickson was supervisor, he

never failed, every day without fail, he would always make the rounds and yet we very seldom see our charge nurse. Dr. Engberg: But there is this difference. The present nurse has much larger area to cover than did Mr. Erickson. Mr. Endres: Well from the records I have acquired from the testimony of the aides in Sunnyside-Sunnyside isn't much larger than it was when Mr. Burnett was there. Dr.Engberg: No but I was only speaking of your division. Mr. Endres: Mr. Burnett never failed to make his rounds and sometimes twice. He always answered a call to a building whenever anything came up and he would make the decision whether the patient should go to the hospital or whether to just call the doctor and get an order verbally for the patient or whether the doctor should come to the building. I don't know what's going on in Sunnyside, but I know that it's very hard to get the nurse to come out to our buildings. She will ask what is wrong, she will call the doctor and a few minutes later we will get a verbal order what to do and still we don't have the nursing supervision. Dr. Engberg: Well, I think maybe you're correct in that there isn't the immediate but on the basis of report and her general knowledge, she can report the matter to the physician and the physician then can make the determination, and the physician will either see the patient directly or will leave an order for the patient. Mr. Walsh: How many buildings would there be in a division? It would vary of course. Dr. Engberg: Well, let's see. Mr. Endres: Nine buildings in my division. Dr. Engberg: Nine buildings and that ground covers, the last building would be what, half a mile away? Mr. Krafve: At least half a mile. Dr. Engberg: At least, it's better than a half a mile, so you can see that there is this element of distance that enters into it as well. Mr. LaVelle: I was wondering, you're speaking of four divisions. How are these divisions determined. There would be the physical buildings, of course, but are they different types of patients . . . Dr. Engberg: Well, to a degree that would be true, but for instance the Skinner Hall division and Sunnyside division would

be essentially the same. One is females and the other males, that would be the only difference. The Colony group as it is now is not materially different from what the Sunnyside would be. Mr. Kucera (?): Mr. Endres, do you know how the nurses themselves feel about the situation as compared to . . . Mr. Endres: Well, Mrs. Heskett, the nurse who just left, stated to me she was leaving because all she was doing was paper work and she did not have a chance to practice her profession and she was forgetting her training and that is the reason she applied for a transfer to Rochester Hospital. That is in her own words. I think some of the other nurses feel the same about it. Mr. McGuire: Was she a supervising nurse? Mr. Endres: She was the night supervisor. She would make rounds from 10:15 in the evening until 6:15 in the morning. Mr. McGuire: Your division is the one that had two nurses. Mr. Endres: Yes, we have one on the early shift and one on the night shift but none on the afternoon shift. Mr. Kucera: Well, has this lack of adequate supervision caused any hardship or is it a detriment to the care of the patient. I assume that it is but is there a specific case . . . Mr. Endres: Well, I don't want to state a specific case but since the Mental Health Program had started we have created many, many new positions. Each one of these positions has to have information to compile paper work and records and basically every bit of their information concerns the patient and eventually it comes right down to the aide who must prepare the information. When I started here 10 years ago, I used to sign the day book, make my medical record in it; it would be a paragraph about that long. The balance of the time I was just like a father and mother to the patients, see that they got fed, see that they were clothed, entertain them, show them a good time, take care of their medications, entertain them, whatever their wants were, counsel them wherever I possibly could. As a charge aide when I was at Springdale, I would be along 90% of the time, very seldom without relief. I was spending two and three hours continuously at that

desk just on paper work that I could not give to the patient because of the immense amount of paper work because of all these offices. We have to supply information to the head housekeeper. We have to supply information to,-well, practically every department. Mr. Welsandt will call up, patient placement supervisor, he wants information on the action of a certain patient, how he is doing in his job. We have to compile that. Mr. Roach or Mr. Endres in recreation will call up. They want the information. It's continuously answering the phone and giving information. Actually you almost have to be a clerk to be an aide now. Dr. Engberg: Yes, I think that Mr. Endres has made a point here that comes into this picture of the change from charge aides to charge nurses. If the Aides IV had had to keep the records that the nurses do today, they wouldn't have any more time than the nurses have today for their work, so it's just a question of what level you're having your supervision at. Mr. Kucera: I suppose the determining factor is how does the patient best get served, I presume. Dr. Engberg: Mr. Endres makes mention about these reports of Mr. Welsandt who is the patient placement officer. I urged very strongly that that particular position be created, that's several years ago now, and I think our was the first place where they established it after discussion with the Department of Administration and representatives from the Department of Welfare (I guess it was the Division of Institutions at the time). There were two reasons that entered into it. One was this, that we are having an ever lessening number of patient workers that really can do anything. Our population has changed so that they are more helpless or more severely retarded and for that reason we knew that we would be confronted with the situation of finding enough patient helpers to serve in the various areas. So that part of it was to see that the areas that needed it most would be the ones at least who would be getting it. Those who did not need it as much would be getting less help. That was one aspect of it. The other aspect and the thing that concerns me more than anything

else was this. Theorectically the doctor made the assignment of the patient to the laundry we'll say. As a matter of fact, the supervisor of the division, the aide in charge, would pick somebody and would send that person over to the laundry. Now if that person didn't learn quickly, the laundryman would send him back say so and so, John, is no good, send us somebody else. Well maybe they hadn't given the instruction, maybe they hadn't helped this person to learn how to do his work, or if we found a person who was a good worker, we'd never hear about him and maybe he was an individual who could be considered for return to the community so that there were the two factors that entered into it. Now it does mean, of course, that Mr. Welsandt has to get reports if he is going to intelligently function as a patient placement officer. So that there is more in the way of reports that are required but it's necessary because of improved programs. But that does mean that you need more help and this matter of the increased clerical help that I mentioned before is a very important one and it's likely to be lost sight of when we thing of staffing. Mr. Walsh: Is there a clerk in each division office, as well as the nurse? Dr. Engberg: No. Mr. Walsh: It might be helpful than if there were enough clerks, to have a clerk in each division office. Mr. Krafve: We plan to include that in the biennial request for personnel,-a clerk for each division. Dr. Engberg: I think that is one of the values in a task force approach to this because during a legislative session there isn't time to go into some of these matters and still they are of extreme importance in determining what increased help should be considered at least. If we don't get it, we'll have to, of course, continue to carry on and do the very best job that we can. Mr. Endres: In comparison with ten years ago, doctor, do you feel that there is work being done that is not necessary? I do know that . . .
Dr. Engberg: I think possibly there is some. We have a self-survey committee. I can answer that better after Mr. Thurber and his committee have functioned on

this. We're in the process of studying it. I think that will be extremely helpful to us. I think to some extent immediately possibly there are certain reports that are no longer necessary. For instance, one report, an additional report, that was not formerly required was one by Dr. Smith in which he makes a report of his departments to me. Mr. Krafve has always participated in a report that I made to the department office, but it is rather important that I get that information from Dr. Smith because he'll point out certain conditions that need special attention and he is the only one who is going to know about it quickly. Mr. Walsh: Has the population of the Faribault institution changed significantly in the last 10 years, that is, are you getting more patients that need more medical care or treatment than you had 10 years ago? Dr. Engberg: Yes, that's true. Mr. Walsh: I mean would this be 10% . . . Dr. Engberg: It would be quite an appreciable percentage, yes. Mr. Walsh: Do you anticipate this will continue? Dr. Engberg: It will continue, I'm sure. Mr. Walsh: You'll have more helpless patients than ever before. Dr. Engberg: More helpless. We're going to need more and more help and I think there are some of these wards that in addition to... where we should increase the nursing services. Certain buildings where you have totally bed patients where I would feel that we would need,—that doesn't mean that we would replace charge aides in all areas,—but in a building for instance, one of the new buildings now the population of a 100 is divided into one-third heart and diabetic patients where a great deal of medical attention is needed. A third of them are total bed patients, are in bed the whole time. A third of them are wheel chair patients. I'm sure that the medical staff would feel a little more confortable if there were a nurse who was actually in charge of that building but we know that with the present situation, we shouldn't be planning on that today. Maybe 20 years, 25 years from now, possibly so. Mr. Wangensteen: Recent admissions do indicate in all hospitals for mentally retarded that patients being

admitted are people with multiple handicaps requiring a great deal of attention. Those people on the waiting list who are turning down admission to any of the state hospitals or schools are the ones who are being taken care of in the community and this is good. It's better that they live at home with their own family and go to school locally, if those facilities are available, but it does mean that the institutions for the mentally retarded are going to be faced with a more serious problem in future years and this is already evident. Then too the lack of patients who through work therapy, in quotes,—sometimes we wonder if therapy's enough. There are fewer and fewer patients who are able to work in the institutions and these have to be replaced with employees. There is no question that the lack of employees is becoming an ever increasing problem. We know this from the other task forces at Cambridge and Brainerd too, and this is a terrific problem that is going to have to be considered with the central office and legislature. Mr. Walsh: Maybe there is some system that would be worthwhile breaking divisions down into say a big division into two units but that would bring a problem in staff. . . Dr. Engberg: Well, I think that may be but with what difficulty we have in staffing now, we have got to try to staff even though we know that it's skimming the surface in many areas. We've got to staff as adequately as we feel is possible. Mr. Endres: Dr. Engberg, four times a year I attend the Council meetings where all the representatives of all the locals of the 22 institutions meet and we have a chance to discuss our problems. From what I understand talking to these employees approximately about the same time that we set up divisions with division nurses in charge, the other institutions disregarded divisions and put the nurses in as workers and they have created more Aide III and Aide IV positions. Until just recently Rochester just lost an Aide III position but until just recently, most of them had increased the psych aide positions to do the clerical work, to do the supervision of the housekeeping and other

records and the nurses were working more with the patient. In other words, it was a teamwork affair where the nurse was on the ward more of the time than she was actually in the office. Dr. Engberg: Of course, I think, in that connection that they have a relatively larger number of nurses than we have. I think you would find that that would be true. Mr. LaVelle: I know at one of the institutions they have made a survey of what the psychiatric aides were doing. They discovered that a large percentage of their time was performing duties that more appropriately could be performed by custodial workers. They felt that this was the thing that diminishes the value of a psychiatric aide to such an extent that they feel that in their next biennial budget they will request custodial workers rather than psychiatric aide positions. I was wondering if a situation like this existed here where the psychiatric aide was actually performing more or less housekeeping functions that more appropriately could be performed by custodial workers? Mr. Wangensteen: Custodial workers and food service supervisors. So much of the time was being taken in preparation of getting people ready to eat. Mr. Endres: That is very true and by the same token we have people in the higher echelon doing work the psych aides could do. From the top down the whole pattern fits right in there perfectly. Everybody seems to be working out of category doing things they shouldn't be doing. Dr. Engberg: Well, of course, Civil Service, you see, provides for that. If they're working within their class, if they work more than 50% of the time in their class. . . Mr. Endres: If they work more than 50% in a position over and above . . . Dr. Engberg: No, no, in their class. In their proper classification. Mr. Endres: Yes, but . . . Dr. Engberg: Theoretically, this would be, of course, a situation that wouldn't develop, but you might have a position who is working 51% of the time there and 49% of the time is on the farm but,-you wouldn't have the situation,-but he still would be properly classified by Civil Service. That wouldn't mean that it would be approved as an organization-

al setup by the department, I am sure. Mr. Kucera: Well, is the solution to get more nurses then, in regard to this, or is it a matter of reshuffling them or . . . Dr. Engberg: Well, I think it is a matter that we have to study pretty carefully and that's one of the reasons where this self-survey because I think when we go in we should show justification for every single job that we are indicating as an additional job and you've got to know pretty definitely where they are going to work and you'll have to know why they are placed there then if you're going to justify it. Now we are increasing the number of food service supervisors, haven't we? You are familiar with it in a general way, at least. For this reason, that if you do not have an adequate number of food service supervisors, then an aide has to go in to fill in part of the time. Well that presents problems too because they maybe ought to be in the ward area taking care of the work there rather than in the dining room giving the supervision that you want. Mr. McGuire: Dr. Engberg, I noticed in this information that you gave us that you requested in your budget requests for last year three additional nurses and they were granted by the legislature. Do you feel that under the circumstances the nursing component now is reasonably adequate here at the institution? Dr. Engberg: No. Mr. Walsh: Was that the original request to the department? What did they start out at? Dr. Engberg: Three. Mr. Walsh: Three, all the way through. Dr. Engberg: What we had in mind there was that we would set a charge nurse on each floor in the hospital; that was the purpose of that, feeling that there should be a nurse in charge of each floor rather than just a floating nurse that really wasn't in charge. Simply working on the floor. Mr. McGuire: Well, it's difficult for me, not being more familiar with the operation of a hospital institution, to know how much nursing assistance is needed in the various buildings that you have. It would seem, however, from the discussion we've had so far, that again we have a situation where we are dealing with trained professional personnel

and at least in part their time is taken up to some extent with keeping time records of employees, and payroll records and things of that sort. Perhaps we might explore a little bit further to see if there is something that we can work out to relieve them of that obligation so that they can spend all their time with their nursing duties and supervisory duties which require nursing training and experience. Dr. Engberg: Yes, that would be desirable. Mr. Walsh: Certainly a clerk in each office of the division would be a big help I would think. Dr. Engberg: You see in the past we've had patients who were smart enough so that they could be there and take care of those matters. Today we haven't got them. That's just an illustration of the difference in type of population that we have. Mr. McGuire: Generally speaking, in this division level that you operate out of hospital or at the institution when the supervising nurse is off duty is there an aide in her place? Is there always someone on duty in the division? Dr. Engberg: Oh yes, there is someone on who always has the responsibility. Mr. McGuire: And if the supervising nurse is off duty that would be a . . . Dr. Engberg: Ordinarily an Aide III would be the one who would be relieving. Mr. Endres: That is also the reason we recommended that the Aide III take charge of the division. In that way the nurse could come later in the morning and be with the group of aides on the early shift, work later through the day and be with those on the late shift and to utilize the nurse better in her own ability, and that is the reason we recommended more Aide III and IV positions be re-created. That would relieve them of the paper work, the payroll, all these minor things they are doing. I don't think that's in their classification. Mr. Walsh: Do the nurses fill out payroll records? Mr. Endres: My nurse takes charge of my time sheet and she checks over the patient's time sheet. . . Mr. Walsh: Does she fill it our or do you fill it out? Mr. Endres: Well, it's duplicated and triplicated. We have a little book we fill out at the ward or at the building; that book goes

up and she checks it with the main book that she has; then they both come back and the charge has to refigure it to check; and then it goes back again and goes in to Mr. Johnson's, PersonnelOffice. Same way with many of our reports. We make identical reports that are recorded in five, six or seven different places and the need for it I can't understand. When a patient goes or come it gets on five or six different places. We keep it on the patient's private medical chart at the ward level; it's on the daily report that goes in; it's in the day book, and it's also in the population book along with other records. Prior to that it used to be just in the day book, and the day book would be checked by the supervisor and he kept all records. Mr. McGuire: Are there any other functions that these supervising nurses are performing; Mr. Endres, other than the keeping of time payroll records, you feel they wouldn't necessarily have to be doing? Mr. Endres: Well the patient records are all kept in their office. Mr. McGuire: What are the patient records involved? Mr. Endres: Accident reports, conduct reports, escapee reports, there are stacks of them. Also the nurse checks all medical reports going and coming; she checks all requisitions on drugs; she checks the requisitions on clothes. Mr. Walsh: It would seem that some of the requisitions on clothes might not fall under nursing but I'm sure drugs, medications would certainly and accidents would fall under nursing, generally, so that it would seem to be a combination of things. Mr. Endres: I can state she has a terrific job and I can understand why she never gets out of the buildings. Dr. Engberg: Well, that isn't true that she never gets out. Mr. Endres: Well, I've seen her in years and very seldom does she get out when the charge aide is out. It's in our book. Dr. Engberg: I'm sure that she gets into your buildings at times. Mr. LaVelle: Mr. Walsh mentioned to me earlier today that the Minnesota Association for Retarded Children has made a survey and is in the process of preparing a report of the hospital here and thought it might be advisable if we obtained

copies of that report and use that as one of our items for our next meeting. I'm sure that the report would be . . . Mr. Walsh: Actually we could mail it out in advance so you could read it before the meeting. Mr. McGuire: If we could have it ahead of time, it would help I think. Mr. LaVelle: And we could use that as one of the items. Another item that I personally am interested in, and I'm not certain about the other members of the task force, would be to go to a group of the buildings here in comparison with some of the older buildings and some of the later buildings that have been built. I found it very useful when we were at Cambridge. We were discussing patients and until you actually see patients you're not always certain what you're really discussing. We got into a hyperactive ward in Cambridge and this was very enlightening, and but if the rest of the members would like to, I would suggest that as another item for our next meeting. Maybe have a chance to see any or all of the hospital. We wouldn't want to make an extensive tour but at least see typical sort of buildings, some of the older and some of the newer ones. Mr. Walsh: Will the task force come up with recommendations? Mr. LaVelle: Well this was left more or less open ended to the task force. They could prepare a report, they couldmake recommendations, they could indicate that certain areas are problem areas, appropriate action should be taken but not actually recommendations as such. It's more or less left up to each individual task force to come up with a report or they could come up with several reports. . . I wonder if I could suggest a date for our next meeting. Dr. Engberg: At the next meeting then you would review this manual. . Mr. LaVelle: Yes, review this manual that Dr. Engberg and staff have prepared and you could think of any questions you might have pertaining to any material in there. And also review the material that Mr. Walsh will make available to us. Dr. Engberg: I think if I might--there's one other matter. I had listed certain things if we made the tour today, the laundry, the kitchen, dairy, tailor shop and about 14 buildings in addition to the hospital. I'm just bringing this up at this point because it could be

thought through before the next meeting. Might it be better to divide this up into certain groups because certainly I doubt that you are going to have the time to go through all of these buildings and would you rather that we try to break this down into certain areas and then that the individuals could indicate what group they would want to be with. Mr. Walsh: If they all went to the hospital . . . Dr. Engberg: There are certain things that you would want to see. We would want you all to see the hospital for instance, the ward there with the very severely disabled patients and the research laboratory. I think that it would be well if all saw the laundry and thekitchen and then I think that we could pick certain buildings that are typical of the oldest type of buildings, the newest type of buildings, so you have a chance to make a comparison on that basis. And then we could plan on certain of our staff members being available and we could discuss it so that those things that were particularly pertinent could be discussed. Mr. Wangensteen: I think that would be very well if we could see some of the older buildings and some of the new. Would it be possible to follow one division, Dr. Engberg? Dr. Engberg: Well, it's a little difficult to do that because there are, well, for instance, in certain buildings we'd like to show the floors that ought to be replaced where for sanitary reasons it ought to be done even aside from having the good floor and then in other buildings--there are buildings which we would feel should be replaced at as early a date as possible. There are other buildings that are going to present serious problems when the time does come to make a replacement. And in the work areas, I think in the kitchen you should see the underground type of delivery and why we're anxious to get away from that and to provide for an overland delivery entirely. We've made some good advances in that but there still is some of that that ought to be corrected. Mr. Kucera: Well we shouldn't infringe on what the Building Commission will be doing this week. Dr. Engberg: Well, this wouldn't be

because this is more for information to see the difficulties in working in a building of that type, don't you see. Mr. Kucera: Oh. Dr. Engberg: Yes. Mr. Wangensteen: Hopefully it would be supported to the Building Commission's recommendations. Mr. Walsh: See the Building Commission didn't last time recommend replacement of any of these old buildings. Maybe the task force would. . well, they should be replaced. Mr. Kucera (?): Well, they'll be here this week-end so our next meeting will be after that so. . . Mr. LaVelle: I was wondering if we could set a meeting for Friday, January 29. Any conflicts there. Mr. Wangensteen: I can't meet that date but that shouldn't hold up the rest of the task force. Mr. LaVelle: Is that agreeable with everyone? Mr. McGuire: I'm not certain whether I can. I've got a commitment to speak at the Minnesota Association of Public Schools some-time that week. I've forgotten what day it is. I know it's the last week in January, I'm not sure of that date. . . It would be better for me the first week in February. Mr. LaVelle: Should we make it the first week in February? The first Tuesday in February, the 2nd? Well, let's make it Tuesday, February 2. Is 10:00 a convenient time for everyone? Well, then shall we adjourn? I thank all of you again for attending and participating. Mr. McGuire: I might ask, Mr. Chairman, if a record or transcription is going to be made of the meeting today. . .? Dr. Engberg: The recording has been made and we can arrange for. . . Mr. McGuire: It will be a lot of work but if you were going to do it for use of the institution, maybe you could od that on duplicating paper and make copies for the rest of us. I wouldn't want to ask you to make copies if you haven't planned on it but if you're going to make a record of it perhaps you can duplicate it so that we can have it. Dr.Engberg: We can do that. Mr. McGuire: If you don't plan on doing it, I certainly wouldn't want to ask you to do it, DR. Engberg: We felt that the determination could be made here as to whether you wanted it or not. We've made the recording and we can have a -

transcription made of it. Mr. Estlund: It's a tremendous job though. Dr. Engberg: Yes. Mr. Wangensteen: If someone could review the tape and take notes from the tape and then outline the points that came up for discussion. Dr. Engberg: Well, I know it was a tremendous job last time. The way it was done,—my secretary heard the recording and made---put it down in stenographic notes because it was the only way that she could do it because one person speaks distinctly and another person, it's hard to make it out. She maybe would have to run a certain thing over a couple of times in order to get it. Then, unfortunately, one of the tapes was defective so that the second tape was really blank, but we can handle that and we would be glad to do it and we can mail it out to each of the members of the task force. Mr. LaVelle: Another thing I might suggest is that either through the Bell-Ringer or some other means that Dr. Engberg make the information available as to when our next meeting is and if there are any employees and other persons that have any comments or suggestions to make, they could come forward at that time. Dr. Engberg: Yes. Mr. McGuire: We probably could plan our next meeting to meet in the morning and make our tour in the afternoon or vice versa so that anyone who was interested could be advised in advance if they could meet at 10:00, 1:00 or whatever time would be best. Mr. Walsh: Is it better to tour in the morning or in the afternoon? Dr. Engberg: Well I would think probably it is a little safer to plan on the afternoon for the tour. Then it depends upon how much discussion there is and all, and if the weather is very, very bad you wouldn't want to make the tour. And then the members of the task force could invite anyone they wish to.