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Demography, Risk, and Power:  
An Examination of the Deceased Patient Population  
at the Hastings State Hospital, 1900-1978

By

Dawn T. Whitney

B.A., Hamline University, 2014

Thesis

Submitted in fulfillment of the requirements for the Degree of  
Masters of Science in the Department of Anthropology at Minnesota State University

Mankato, Minnesota

June 2019

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Demography, Risk, and Power: An Examination of the Deceased Patient Population at the Hastings State Hospital, 1900-1978

Dawn Whitney

This thesis has been examined and approved by the following members of the student's committee.

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Advisor

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Committee Member

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Committee Member

## Abstract

The purpose of this research is to investigate the Hastings State Hospital (HSH) and its cemetery (HSHC) within a multidisciplinary framework, invoking discourse analysis, demography, and critical race theory to examine how power and risk factors impact the treatment and disposal of the body at death. It incorporates perspectives from both anthropology and sociology to interpret the data, relying heavily on the ideas of Michel Foucault. Integrating these diverse analytical tools is important to this research because social and structural forces all intersect in the creation of identity, power, and inequality.

All data in this study represent patients that have died at HSH from 1900-1978. This research is unique and important because this is the first critical examination of the deceased patient population at HSH using the complete obituary records. Patient records remain locked for 75 years after death, restricting public access to patients that died earlier than 1944 at the time this study was conducted. Patients that died after 1944 could still have spouses or children that could potentially be impacted by the stigma associated with institutionalization. The lack of anthropological scholarship about institutionalization in Minnesota underscores the importance of this research. It is long overdue.

This study examines how variables like class, gender, immigrant status, age, and civil status are transformed into risk factors for commitment. I examined burial practices and treatment of the body after death by separating the HSH sample into subgroups: private burials, burial at the asylum cemetery, individuals sent to the U of M as cadavers, and unknown. No skeletal material is available from the cemetery; research was conducted through archival

methods. The results of this study suggest that the aforementioned variables do have a significant impact on risk, burial practices, and treatment of the body.

Throughout the paper I use the discourse of insanity developed during the 16<sup>th</sup>-20<sup>th</sup> centuries to enhance my discussion. The language of the time period is controversial and considered inappropriate by 21<sup>st</sup> century standards. The structure of this paper is designed to bring the audience along on a journey, one that illustrates the experience of insanity in America from the 18<sup>th</sup> to the 20<sup>th</sup> century. A strong understanding of history is necessary to interpret the results of the research. It begins with an introduction and a discussion about the history of institutionalization in Europe, America, and Minnesota. I then explain my methods and conclude with the results of my analysis and a discussion about my findings.

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## CH 1: Introduction

Early research into the history of institutionalization and treatment of mental illness in America has been largely neglected by anthropologists in the past, a problem that has recently been addressed with more intensity by bioarchaeologists and cultural anthropologists. Years of omission can be linked to the development of anthropology as a discipline and its narrow focus on non-western peoples. Most of the early work on institutionalization has been conducted by historians, sociologists, and psychologists, scholars that focused more on the study of the west.

The relationship between order and disorder, and reason vs. unreason as it applies to human behavior, has long been a preoccupation for humans throughout history (Foucault 1965; Macdonald 1985). If we explore the order of the mind and soul from a perspective that invokes humanist ideals and Enlightenment thought, the experience of 'madness' takes on different forms. For the ancient Greeks like Socrates, *Nous* (the mind and the Good) and the acquisition of knowledge, is the closest that we can come to divine perfection (Menn 1992). A departure from order in terms of the mind and soul becomes a transgressive act against perfect forms because man was the measure of all things in the universe (Plato: Benardete 1984, 152a; Macdonald 1985).

During the 17<sup>th</sup> century, these transgressive concepts expanded to incorporate other behaviors and states of being, such as: poverty, prostitution, criminality, disease, debauchery, disability, inebriation, and mental illness. Aberrant behaviors and conditions were stigmatized and served as grounds for legal commitment to institutions, forming communities of madmen. Madmen were stigmatized due to their illness, a phenomenon that needed to be removed,

isolated, studied, corrected if possible, and reorganized into the social milieu. Departures from reason were associated with bestiality, reducing an individuals' value to society and introducing the "theme of the animal madman:" "The animality that rages in madness dispossesses man of what is specifically human in him" (Foucault 1965, 74-75).

Within the earliest institutions and hospitals in Europe, patients and inmates were not separated based upon their conditions, nor was there a move towards rehabilitation or treatment. Coercive care and the use of restraints were utilized to control patients that were violent or unmanageable (Foucault 1965, 70-71). Conditions were squalid and facilitated opportunistic infections and the spread of disease. Moreover, the religious and moral dimension of total institutions promoted the exploitation of patients and their labor for profit; idleness was frowned upon by society and the church (Foucault 1965, 53). These patterns resonated throughout colonial and pre-modern America, as it was prefigured upon European models.

Michel Foucault explores institutionalization and mental illness in Europe from the 17<sup>th</sup> century onward in *Madness and Civilization*. The development of large mental institutions and the criminalization of both poverty and mental illness result from the growth and centralization of power within the state (Foucault 1965). Foucault argues that power relationships can be revealed through discourse analysis (1965; 1973). There are many different types of discourse. Discourse can be referred to as all of the complex phenomena that articulate upon and around an object, which in the case of the mentally ill, operate on the body and include all of the social forces that impact it (Foucault 1973). Discourse analysis can be used to understand how society functions; it can be conceptualized as a series of narratives (McGee and Warms 2017).

For Foucault, discourse is not limited to language. It encompasses a wide range of phenomena such as bodies, structures, practices, language, behavior, actions, and institutional policies- of which none can be separated from power (1965; 1973). Foucault argues that mechanisms of power are expressed through discourse and are often coercive and repressive, functioning as methods of total control in institutions. In the *Birth of the Clinic*, Foucault examines medical discourse and the development of the medical gaze. He suggests that with the emergence of positivist medicine, the medical gaze of clinicians became more reductive and hegemonic, revealing how discourses are created by the powerful and are closely associated with scientific observation and the hierarchical classification of patients. McGee and Warms' interpretation of Foucaultian discourse analysis suggests that "... discourses are set within power relationships and are reflective of them. Language is never neutral, never a clear window through which we can perceive the world. Discourses promote ways of understanding and interpreting the world to favor or disfavor particular individuals or groups" (McGee and Warms 2017, 492).

Social inequality has been associated with increased risk of mental illness and institutionalization, resulting in significant disparities in overall health, access to treatment, and the distribution of resources. According to the U.S. Surgeon General (2001), "... all Americans do not share equally in the hope for recovery from mental illnesses. This is especially true of members of racial and ethnic minority groups" (5). This study examines how variables like class, gender, ethnicity, age, and civil status are transformed into risk factors for mental illness and commitment. I examined burial practices by separating the HSH sample into subgroups: private burials, burial at the asylum cemetery, individuals sent to the University of Minnesota as cadavers, and unknown. I review the history of institutionalization and mental illness to understand how mental illness is constructed and culture bound, and examine these phenomena

by invoking different theoretical perspectives and analytical tools, one of which is critical race theory. Critical race theory focuses on the way that white elites use race as a vehicle to create or exacerbate existing inequalities between groups. The unequal distribution power creates a divide that often results in the allocation of more resources and opportunities to the dominant elites. This can manifest in legislation that works against minorities and subordinate segments of the population.

Funerary practices in the United States traditionally placed great importance on burial of the body; burial became an expression of social capital and the value of an individual to the family and community. During the 19<sup>th</sup> and 20<sup>th</sup> centuries, new methods for investigating health and disease through autopsy and dissection of the human body created a need for human corpses. The culture of cadaver supply emerged and the body was transformed into an instrument of science; its new purpose was to facilitate the advancement of medical knowledge. This phenomenon has long history in the United States and Europe, creating a new market economy of the dead (Buklingas 2008). Researchers can learn much about the lived experiences of the dead, but they must be contextualized within social and political relations of power. Zuckerman et. al (2014) reference a case study of individuals recovered from the cemetery associated with the Mississippi State Asylum to emphasize how social inequality is embodied in human remains, and suggest that the deceased can inform researchers "... about the effects of various processes, such as power, oppression and privilege on human well being" through evidence of trauma, activity patterns (entheses), malnutrition, and disease – a phenomenon they refer to as "material effects of power on the body" (514-515).

Through the commoditization of the corpse a new relationship developed between medical schools and state hospitals in America. This relationship is illustrated by the HSH,

which became a supplier of cadavers for the Anatomy Department at the University of Minnesota (U of M). The HSH was an ideal candidate for partnership with the U of M. Asylums typically housed deviants and paupers, people that traditionally had less social and cultural capital. Tatjana Bukligas (2008), in an examination of the politics of corpse supply in 19<sup>th</sup> century Vienna, suggests that the implementation of anatomical acts intended to prevent grave robbing increased the exploitation of the poor after death. Appropriation of cadavers identified as working class poor escalated in both Britain and the United States during the 18<sup>th</sup> and 19<sup>th</sup> centuries. Buklingas (2008) explains, “In Britain, a period of indiscriminate grave robbing ended with the 1832 Anatomy Act, which gave anatomists almost unrestricted access to the workhouse poor in exchange for their not touching the middle-and upper-class dead. In the United States, where the anatomical divide cut along lines not just of class but also of race, violent protests in the turbulent decades around the American Civil War delayed anatomical acts until the end of the nineteenth century” (1).

### **Research Questions**

Many questions were addressed through this research, questions that elucidate both the experience and risk factors of institutionalization in Minnesota during the 20<sup>th</sup> century through an examination of the HSH and HSHC. The sample in this study is taken from the HSH obituary records, and represents all patients that died in the institution. The following questions were utilized to organize this study:

1. Preliminary analysis demonstrates a disproportionate ratio of males to females in the HSHC population, where males outnumber females 9:1 (Whitney 2018). Is this pattern representative of the total deceased population? Why are there such small numbers of

women buried at HSHC compared to men? An examination of Richard Napier's case files by Michael Macdonald (1985) suggests that women experienced more mental illness than men, a trend that he suggests has continued well into the modern era. Napier was a 17<sup>th</sup> century astrological physician. Many of his patient case files have survived providing scholars with an opportunity to examine how mental disorders were treated in the past. If the ratio at HSHC is not representative of the total deceased population at HSH, then an interpretation about why this ratio is eschewed is necessary, and must be investigated by reviewing the disposal of female bodies at death.

2. What does the mortality profile of the HSH deceased population look like? I would expect the population structure to represent a population with low fertility and high adult mortality. The HSH population is not growing through the birth of new individuals, but through artificial means where only adults are integrated into the population and removed through attrition. This should be reflected in the age at death distribution.
3. What is the average age at death for HSH patients? State hospitals were renowned for functioning as continuing care facilities, which should be represented statistically by an aging population.
4. Do women live longer than men in institutions?
5. Are there differences between the mortality profiles of the HSHC group, HSH population, and the U of M cadaver population, suggesting that certain types of people had less value and were therefore more disposable to society? Social epidemiological factors such as age, sex, civil status, occupation, and ethnicity influence morbidity and mortality in human populations. I would expect the Hastings State Asylum to demonstrate the following characteristics:



A. Single, divorced, or widowed men and women were admitted at a higher rate than married individuals.

B. Patients with lower status and social capital account for a high percentage of the asylum, cemetery population, and patients sent to the U of M.

## CH 2: A History of Madness and the Rise of the Institution in Europe

### **Institutionalization in France**

Europe's institutions prefigured the development of mental asylums, poorhouses, and almshouses throughout America. In order to understand the history of institutionalization in America, it is necessary to explore the social and structural factors that contributed to the rise of the institution in Europe. Before the birth of the asylum, mental illness was paradoxically both a private affair and a public spectacle. Individuals with families were cared for at home, but those without familial support, such as madmen and the lame, wandered the streets or were incarcerated in jails. These are the village idiots, court jesters, and the fools that we read about in literary stories. In Paris, the destitute poor fared much worse: "... a decree in Parlement [Parliament] dated 1606 ordered beggars to be whipped in the public square, branded on the shoulder, shorn, and then driven from the city; to keep them from returning, an ordinance of 1607 established companies of archers at all the city gates to forbid entry to indigents" (Foucault 1965, 47). The criminalization of madness and poverty in France would have far reaching effects, ushering in a new era of confinement. Pauper lunatics represented a danger to society and the economy.

One of the first general hospitals dedicated to mental disorders in Europe was the Valencia asylum in Spain, established in 1406 (Butcher 2007, 36). This was just one of many new asylums that would soon occupy the landscape. During the 17<sup>th</sup> and 18<sup>th</sup> centuries, a time that has been referred to as "The Great Confinement," new asylums and general hospitals were established throughout Europe to accommodate the growing population of people suffering from mental illness (Foucault 1965). The proliferation of mental asylums during this time does not

necessarily mean that there was a sudden explosion in the insane population, but rather that definitions of madness and beliefs about how to manage mental illness in society have shifted. In keeping with this new tradition of reclassifying madness, narratives about mental illness must be repositioned; interpretations about the asylum should be framed as an administrative response to a public social problem. Porter (1987) suggests that “One age’s saints have been another age’s religious maniacs,” a theme exemplified in the life and death of Joan of Arc (277). Joan’s story is an example of a paradigm shift. She was found guilty of witchcraft and burned at the stake, but historical revisionism by the church later resulted in her canonization as a saint. Madness took on political dimensions, with classifications functioning to further the agendas of the powerful.

Throughout history, treatment for mental illness has always been limited to contemporaneous advancements in medical knowledge. Macdonald (1985) argues that “... early epidemiologists of mental disorder did not demonstrate any consistent link between the natural attributes and social conditions that contributed to psychological suffering and specific kinds of insanity” (34). Enduring beliefs about the etiology of mental illness were strongly linked to mystical causes, religion, and bad blood, ideas that have persisted since the Middle Ages (Grob 1994). The church exerted powerful influence in determining the fate of madmen – sitting in judgment and overseeing the distribution of charity. There were no sophisticated medical specialists comparable to 21<sup>st</sup> century biomedical specialists available to treat or cure insanity. Therapy took the form of prayer, exorcism, beatings, amulets or talismans, purgatives, emetics, bloodletting, opiate derived sedatives like laudanum, and ice-water baths to shock the body back to a normal state (MacDonald 2008; Porter 1987; Hermsen 2011; Grob 1994). According to Porter (1987), “A wide range of techniques were tried for curing or relieving insanity, including

medicines and magical means. But it was acknowledged that madness was a mysterious condition and commonly intractable” (278).

Class, status, and education were strongly linked to the development of explanatory models for health and disease. Europe’s population during this time period was predominantly illiterate and strongly influenced by religious propaganda, which associated disease with sin. Western traditions tend to locate events and circumstances in binary concepts, adding strength and legitimacy to many of these ideas. Common binary concepts were: nature/ nurture, good/evil, sane/ insane, reason/unreason, order/ chaos, normal/ abnormal, magic/science, and saint/sinner. Society was highly stratified and status influenced human responses to illness. Individuals with lower socioeconomic status, like villagers and peasants, looked to the church for answers to complex phenomena. They could not afford to consult the types of specialists elites might due to financial constraints, a situation that contributed to antagonistic feelings about the exclusivity of medical care (Macdonald 1985, 192). Elite members of society shared many of the same ideas about misfortune, but looked to other specialists like astrologers or physicians to guide them. According to Macdonald (1985), “Mental states and behavior could also be explained in purely natural terms by appealing to astrological and medical ideas. Astrologers helped their clients to relate emotional disturbances and mad behavior to astronomical events, and physicians provided their patients with diagnoses that classified mental disorders as a type of sickness” (xiii).

In France the first hospitals were established during the 17<sup>th</sup> century, beginning with the conversion of the Hospital General from a leprosarium to a house of confinement and correction (Foucault 1965). Leprosy was on the decline in France, and the transformation of leprosariums across the country soon followed to manage the deviant population. Definitions of deviance are

culture bound, and in France they took on moral, somatic, and psychological dimensions. Madmen represented a social danger, and madness was presumed to be contagious. Popular perceptions about madness and confinement focused not on helping the afflicted, but on the social impact of insanity, such as how the insane defile their surroundings. The term confinement is appropriate in conversations about institutionalization in France because state policy regarding deviant behavior stipulated that madmen, criminals, prostitutes, sick, disabled, and the destitute poor must be incarcerated. It was an absolutist response to what was considered the worst of all social problems. State hospitals were at once penal institutions, welfare establishments, and mental asylums, with no specialized care or treatment programs in place to manage the large community of deviants.

Characteristics of institutionalization include overcrowding, coercive care, abuse, dietary insufficiency, and exploitation for profit. There was no distinction between patients; criminals were placed in wards with the insane and the sick. Conditions in the hospitals were dismal, with overcrowding and sanitation issues contributing to morbidity and mortality. The wards housing individual cells have been compared to a “human stable” where madmen were treated like animals- chained to walls, barely clothed, and forced to eat their meals where they deposited their excrement (Foucault 1965, 72; Rollin and Reynolds 2018). According to Foucault (1965), “It was common knowledge until the end of the eighteenth century that the insane could support the miseries of existence indefinitely. There was no need to protect them; they had no need to be covered or warmed” (74). Moreover, poverty was criminalized, leading to unprecedented numbers of indigent and unemployed people confined to institutions. France’s state hospitals were originally considered a form of government charity, where food and housing were provided

to madmen and indigents. However, the tension between charity and idleness, along with the financial demands on the state, soon shifted the relationship between the poor and the state.

The workhouse emerged in France during a period of scarcity, and became important because an expanded labor force was necessary to support industrialization. Patients were now assessed and assigned to workhouses based upon their productive value, foreshadowing within France's institutions an economic struggle between the bourgeoisie and proletariat that Marx would later critique. Foucault argued that an inverse relationship existed between the poor and the state: "In the mercantile economy, the Pauper, being neither producer nor consumer, had no place: idle, vagabond, unemployed, he belonged only to confinement, a measure by which he was exiled and as it were abstracted from society" (Foucault 1965, 230). A number of factors contributed to the creation of policies demanding that indigents work to offset the financial burden they represented to the state. There emerged an obligation to repay the debt of food and housing, and those that were able to work were sent to workhouses for profit, including young children. However, it is difficult for modern scholars to accept this form of exploitation because commitment was compulsory. Once an individual became part of the institutionalization system, they were wards of the state and unable to leave. In addition, madmen were placed on display as a type of tourist attraction comparable to a menagerie, where citizens could view the spectacle of insanity for a small payment (Foucault 1965).

### **Institutionalization in England and a New Era of Reforms**

There were many similarities and differences between France's asylum system and England's. Like in France, houses of correction became mandatory with passage of the Act of 1575, requiring every county in England to establish at least one hospital (Foucault 1965, 43).

These houses of correction functioned like asylums in France, with inmates that exhibited a broad range of social, physiological, and psychological problems. The Bethlem Hospital, later referred to as Bedlam, opened in 1547 to admit and confine madmen. Bedlam soon developed an infamous reputation for abuse of patients, and like institutions in France, put patients on display for the amusement of citizens for a small fee attracting "... as many as 96,000 visitors a year" (Macdonald 1985, 122). This public exposure created a new rhetoric for insanity: "By the early seventeenth century the language of madness had become rich and pervasive; words and phrases about insanity were part of the common coinage of everyday speech and thought, negotiable everywhere in England and not restricted to a small circle of medical and legal experts" (Macdonald 1985, 123). An expanded vocabulary contributed to the established stereotypes and the stigma of mental illness, incorporating but not limited to the following words: Bedlam, mad, insanity, fool, lunatic, despot, debauched, moron, idiot, and abnormal. According to Foucault, it is language that gives structure to madness, and this discourse always revolves around the concept of reason: "...on language are based all the cycles in which madness articulates its nature" (Foucault 1965, 95-100).

The development of the asylum system throughout England was significantly influenced by the increasing birth rate and move towards industrialization. In essence, it was economically driven. During the late 18<sup>th</sup> century the population of England and Wales increased exponentially, rising from 7 million to 12 million, and by 1890, it had reached an all time high of 30 million (Rollin and Reynolds 2018, 74). Along with the rising population came shifting trends in demography; more people moved into the cities in search of work, adding to an already large population of indigents in need of food, work, and housing. Workhouses, bridewells, and asylums were built as a solution to the increasing numbers of pauper lunatics, establishments that

profited from this new labor force. According to Rollin and Reynolds (2018), "... in 1808 an act of Parliament (The County Asylums Act) encouraged all counties in Britain to build asylums for which they could borrow money," and in 1845 The Lunatics Act was passed, requiring every county in England and Wales to establish provisions for the mentally ill (74).

Where France established its institutions in the heart of its major towns and cities, British models separated the workhouses and bridewells from the mental asylums. A bridewell is an alternative to prison although similar in concept; it is a type of penal institution where pauper lunatics were sent. The first workhouses in England were established in 1697 as private establishments that reserved the right to turn away the sick, diseased, and infirm (Foucault 1965, 44). These were originally designed to house a few hundred patients but soon became overcrowded due to the increasing population. Workhouses and bridewells served an important function within the community; they removed the poor from mainstream society, upheld moral codes denouncing idleness, and provided vital labor that could be exploited for profits. These practices exclusively benefitted the upper classes and created new forms of structural inequality. Mental asylums, on the other hand, were often located in the countryside- a physical and symbolic removal of deviant populations from mainstream society. The more affluent members of society either kept their insane relations sequestered in private homes, or sent them to private doctors or monasteries for continuing care.

Poor conditions in mental asylums and workhouses soon became the focus of public scrutiny during the 18<sup>th</sup> century, leading to the moral treatment movement and reforms throughout Europe. Phillippe Pinel and the Samuel Tuke were two of the primary catalysts for this change, shifting existing models for therapy and custodial care. Although contemporaneous with each other, scholars suggest that their work emerged independently (Hermsen 2011). Pinel was



appointed as superintendent of the Bicêtre Hospital in France, and his contribution to the care of patients cannot be overstated. He ordered that chains and restraints be removed from the patients under his care, implemented new regimens for exercise and fresh air, and created a new type of doctor patient relationship that treated the individual and emphasized the importance of humane treatment. Like Pinel, William Tuke eliminated restraints and moved away from coercive care towards a more humane relationship with the patient. Tuke is renowned for creating the Retreat in York, England, an institution that promoted many of the same freedoms as Pinel but emphasized the importance of religious concerns. The focus was on moral treatment and religiosity, with the intent of discharge after the patient's conditions improved.

Pinel and Tuke's work were highly publicized and instrumental in changing custodial care and treatment across Europe. Although the reforms implemented by Pinel and Tuke did manifest in significant changes to the doctor-patient relationship and improved environmental conditions, Foucault argues that they were not beneficial to the patient. A critical interpretation by Foucault offers a more censorious perspective, locating the events and circumstances within an alternative but authoritative dialogue that resonates with "mythical values" existing on a spectrum of fear, guilt, and reason. Within this framework, the superintendent or keeper becomes the voice of authority, forcing the madman to acknowledge the state of his/her unreason, eventually reaching a point where madness is "... controlled, not cured" (Foucault 1965, 244). Madness must become the servant to reason within this new system of reforms. Foucault invokes the *gaze* to examine these shifting power dynamics, a concept that remakes the subject into an object of study, and argues: "We must reevaluate the meanings assigned to Tuke's work: liberation of the insane, abolition of constraint, constitution of a human milieu – these are only justifications. The asylum no longer punished the madman's guilt, it is true; but it did more, it

organized that guilt; it organized it for the madman as a consciousness of himself, and as a non-reciprocal relation to the keeper” (Foucault 1965, 247; Foucault 1994; Hermsen 2011).

Towards the end of the 18<sup>th</sup> century and into the 19<sup>th</sup>, a paradigm shift occurred with the emergence of positivist science, introducing a new generation of physicians that redefined insanity as a pathological condition, curable with the correct interventions. This new logic altered the relationship between madmen and their keepers, and a new branch of scientific medicine was conceived – psychiatry. Within this new system of thought, insanity was no longer limited to the four most common personality types (Macdonald lists them as choleric, phlegmatic, sanguine, and melancholy, but Hornsten describes them as phrenitis, melancholy, mania, and hysteria), but expanded to incorporate a broad range of new categories and types (Macdonald 1985, 186; Hornsten 2009, 9). However, the social problems that resulted in the growth of institutions and the asylum reforms movement had not disappeared by the 19<sup>th</sup> century, leaving the insane and the poor in a difficult situation where provisions of government most often resulted in chronic custodial care. The shift towards humane reforms and the intent behind this process was a bold move, but doomed to failure. Institutions that were built to serve hundreds soon housed thousands, reducing levels of care and therapy due to inadequate space, funding, and patient to staff ratios. Society was harsh and unforgiving, and although the asylum was not an ideal place for rehabilitation and recovery, it provided subsistence and housing for desperate people. Is an existence defined by reason so horrible that men and women must slip into madness to escape from it? Some might argue that social inequality and poverty, the miseries of existence for the poor during the Enlightenment and the long nineteenth century, were so great that insanity and institutionalization provided a means to escape from it.

## CH 3: Mental Illness and Institutionalization in America

Prior to the development of asylum institutions in colonial America, care for the old, infirm, indigent, and insane rested with the community, a tradition embedded in European ideas about moral responsibility. Large scale institutions were not yet necessary due to low population density. Public officials and community leaders functioned as custodians for individuals that could not support themselves and dispensed subsidies to families with dependents, an early form of welfare providing minimal provisions for their care. This civic duty extended to paupers, madmen, the violent insane, and individuals with severe disabilities, who were confined if they represented a danger to themselves or the community. The town reserved the right to appropriate their property to pay for their care. According to Grob (1994), "... the unique circumstances of a newly-settled society meant that colonial Americans would have to develop novel ways of dealing with the problems associated with insanity. The decentralized nature of colonial society and government, as well as its rural character, mandated informal solutions to the intensely human problems that involved the immediate community and – if the afflicted person had one – the family" (13).

### **Poorhouses and Almshouses**

As the size of communities grew, so did the need for a new type of facility designed to accommodate the poor and confine people with complex problems. Poorhouses and almshouses emerged in town parishes at the turn of the 18<sup>th</sup> century to help manage these diverse groups of people. Segregation based on class and disposition was customary; the poor were sent to the poorhouses, and the infirm and insane to the almshouses. These establishments were usually

small and could only maintain a handful of individuals. Proprietors were compensated by the town parishes or local government for providing basic care for dependents. However, a controversy over the quality of care in almshouses, along with mass waves of immigration and industrialization during the 19<sup>th</sup> century led to the development of large hospitals with complex infrastructures to supervise the care and treatment of deviants. Later, the growing number of aging and senile persons combined with the development of the asylum resulted in the decline of almshouses in America (Grob 1983; 180-198). The poor and the elderly often received better care in state asylums before overcrowding was an issue.

### **Fiscal Responsibility**

America's earliest asylums were located in the east in states like Pennsylvania, Massachusetts, and New York. These institutions were based upon European models in both design and function. The Pennsylvania Hospital, established in 1750, was the first institution for the insane in the colonies (Hermsen 2011, 41). The establishment of this institution marked the beginning of the Asylum Era in America, a period beginning in 1750 that lasted until the middle of the 20<sup>th</sup> century. The purpose of the institution was to care for patients that represented a burden to their families or a danger to the community. Families were expected to pay for their care if they had the financial means, but cost was determined by economic status (Hermsen 2011). For indigents, the cost of institutional care shifted to the county of residence, which was required to pay institutionalization costs if the patient had no family (Grob 1983). If the town did not have adequate facilities to manage individuals with severe disabilities or violent dispositions, they could send them to another location but were responsible for their financial support. State responsibility for the mentally ill increased during the 19<sup>th</sup> century in response to the growing number of patients confined to institutions. Insanity was again redefined to include old age and

senility – nursing homes were a 20<sup>th</sup> century invention. Grob (1983) suggests that “If senile persons were cared for in state hospitals rather than in local or county almshouses, the burden of support would be transferred to the state” (181). The Federal government later subsidized the state’s financial responsibility for the mentally ill with the Social Security Act in 1935 and the passage of the National Mental Health Act the in 1946 (Grob 1995, 210 and 265).

### **Immigration**

Mass waves of immigration had a profound impact on asylum populations, intensifying society’s preoccupation with the relationship between immigration and insanity. Eastern cities like Pennsylvania and New York experienced a sharp rise in the population, mostly due to foreign immigrants: from 1790-1830 “Philadelphia more than tripled in size, and New York experienced a more than six-fold increase, from 33,000 to 215,000” (Boyer 1993, 4). The trend towards urbanization resulted in new social problems, and the larger cities were notoriously referred to as reservoirs of vice, immorality, and crime. Massachusetts, for example, had a significant number of foreign born “incurable paupers” in their state hospitals requiring continuing care, representing a significant drain on the state’s budget for the insane (Grob 1985, 82). Legislative bodies became more critical of people entering the United States, resulting in codified discriminatory practices designed to cull deviants from the population.

These new laws foreshadowed the emergence of Social Darwinism and Eugenics, movements that focused on selective policies as a form of ethnic cleansing. According to Grob (1983), “Fear that foreign governments were using the United States as a receptacle for infirm, crippled, and mentally ill persons as well as criminals strengthened a growing desire to end unrestricted immigration. In 1882 Congress enacted one of the first statutes designed to limit

immigration by applying a principle of selectivity. Among its provisions was a stipulation that convicts, insane persons, idiots, and individuals unable to care for themselves without becoming a public charge would be excluded but deficient enforcement procedures vitiated the statute's intent" (168). In addition, sterilization laws were implemented across the nation. In an examination of 30 states, Grob's data indicate that a total of 18,522 mentally ill patients were sterilized between 1907 and 1940, and in Minnesota 379 (1985, 174). This data only includes the insane.

Immigration continued to increase, resulting in additional immigration policies designed to eliminate deviants. By 1900, many states passed deportation laws regulating incoming aliens (Grob 1985, 216). The preoccupation with identity is reflected in 19<sup>th</sup> and 20<sup>th</sup> century asylum patient logs, which contain blank spaces for data to be collected on nativity, race, and hereditary status. The quality of institutional care was biased; minority status had a significant impact on the level of care individuals received (Grob 1985). In 1936, the Public Health Service "... had been made responsible for excluding aliens" from initiatives to improve treatment (Grob 1985, 310). Immigrant status was stigmatized and prejudice was ever present in the daily lives of patients; ethical standards for patient care did not transcend race, class, and ethnicity.

Hermesen (2011) addresses the issue of status in asylums, and suggests that they "... provided more refined and cultivated accommodations for the refined and cultivated classes" (43). Class and status determined who had access to moral treatments, effective therapy, improved living accommodations, better food, music and entertainment – in summary, better quality of life and the inequitable distribution of resources. Moreover, the disposition and temperament of patients determined whether they were socially integrated into the cultivated classes or segregated in isolated buildings. Architectural design of institutions changed from

large imposing structures to smaller structures with multiple buildings, facilitating separation of patients based on disposition, diagnosis, race/ class/ ethnicity, and sex.

### **The Custodial Role of Institutions**

The explosion in the number of people confined to mental institutions presented significant problems, problems that also resonated across Europe. Superintendents found it difficult to manage overcrowding in asylums; the number of patients exceeded the number of hospital beds available. In 1880 there were approximately 41,000 patients in mental institutions, but that number rose sharply through the next decades and by 1940 there were 450,000 people in state hospitals (Foote 2018, xv; Grob 1994, 4-5). Society struggled to deal with the mounting problem of mental illness and chronic custodial care as more and more patients entered institutions for life.

Asylums went from providing more acute care to patients to serving those with chronic terminal conditions. Grob (1985) asserts that “After 1900 the proportion of aged senile persons residing in hospitals increased sharply, thus altering the functions of an institution that had been designed for entirely different purposes. The most astonishing statistic was the total number of patients retained in mental hospitals; 746 out of every 1000 first admissions and 851 out of every readmission remained institutionalized at the end of one year” (5, 197). Policy makers argued that the effort needed to provide custodial care reduced the ability to implement therapeutic programs to treat acute illness, extending the institutionalization period for curable conditions and creating chronic conditions (Foote 2018; Hermsen 2011; Grob 1985).

## **The Need for Reform**

Asylums were being constructed at an unprecedented rate across the United States. Conditions in these institutions declined as the number of patients rose, resulting in a series of reforms that resonated throughout the Jacksonian Era (1824-1840). An important feature of the Jacksonian Era is the focus on democratic ideals, and legislative efforts to improve living conditions and expand the rights of everyman (Boyer 1993). During this time period, urbanization, social inequality, moral disintegration, and the corruption of government officials became the focus of reform movements throughout the country. Religious groups and charitable organizations were instrumental in advocating for change, with women filling important roles in organizations and committees. Dorothy Dix was instrumental in the crusade to reform mental hospitals in America. During the 1850's, she visited institutions across the United States to expose the alarming conditions that asylum patients were forced to endure. Her findings were presented to the nation and demonstrated a compelling illustration of the state of the insane (Foote 2018). Inadequate nutrition, clothing, therapy, as well as excessive use of restraints represented a mounting crisis in American asylums. Dix joined forces with the Unitarian Conference and advocated for immediate changes, resulting in the construction of more than 30 new asylums and improvements in patient care (Parry 2006).

## **Mental Hygiene Movement**

The Mental Hygiene Movement was one of the most public reform initiatives implemented in the United States, an expression of the progressive optimism that characterized the time period and a reflection of the expanding role of psychiatry in mental hospitals. It was spearheaded by Clifford Beers (1876-1943) around 1908 to address the problems associated with



mental illness in America (Parry 2010; Grob 1994). Beers set out to increase public awareness about mental illness, reduce the stigma associated with psychological disorders, improve the deplorable conditions in institutions, and create outpatient programs. His experiences as an asylum patient, and personal struggle with mental illness and suicidal tendencies, fueled his determination to initiate change. Mental Hygiene focused on prevention, emphasizing the social factors that contribute to mental illness (Grob 1994; 151-162). It also focused on the need for more effective outpatient programs to avoid reinstitutionalization for rehabilitated patients. Counseling services were also necessary to provide support for discharged patients' successful reintegration into the community. The movement experienced moderate success, but lack of sustainable funding and public support stifled its progress. New mental institutions continued to be built across the country because a growing number of patients required custodial care.

### **The Great Depression**

According to Grob (1983), "Between World Wars I and II the commitment to institutional care of the mentally ill remained unchanged" (288). Spending remained relatively consistent in large mental institutions even through the Great Depression of the 1930's. Grob suggests that this is because the purchasing power of hospitals was offset by Depression Era pricing (Grob 1983, 289). Many scholars have examined the relationship between mental illness and economic hardship (Catalano et. al 1981; Granados and Roux 2009; Zivin et. al. 2011). Catalano et. al (1981) researched admission rates for a mental institution in Kansas City, Missouri and determined that economic hardship does not necessarily cause mental illness to develop within populations, but it does exacerbate existing untreated behavioral issues. In addition, a study conducted by Zivin et. al. suggests that not only do suicide rates increase during severe economic recessions, the "effects of economic crises most negatively affect the poor, less

educated, and unemployed populations (2011). This research is supported by Granados' and Roux's (2009) analysis of suicide rates during the Great Depression, which they determined did rise by 2%. Their findings present a paradox, suggesting that although life expectancy increased during the Great Depression, population health declined during periods of economic expansion in the 20<sup>th</sup> century.

## **Eugenics**

During the late 1800's Social Darwinism gained popularity in both Europe and America. Proponents of this movement suggested that humans could breed a more fit population if they selected partners with desirable characteristics (Fischer 2012). Eugenics grew out of the dominant ideas that characterized Social Darwinism, and has been invoked to justify sterilization laws, medical experimentation on 'unfit' humans, and genocide, like we saw with Racial Hygiene in Germany during WWII (Fischer 2012). The Eugenics Movement had a significant impact on medical and social perceptions about mental illness and the treatment of the immigrants in Americans. Americans became increasingly preoccupied with discovering underlying hereditary factors for the etiology of mental illness. In a report to investigate the increase of criminals, mental defectives, epileptics and degenerates in Massachusetts (1911), a commission determined "that alcohol, syphilis and heredity are among the most important factors in the causation of mental disease there can be no doubt... Some observers have seemed to trace heredity [as the cause of up] to 30 or 40 percent [of the insane population in Massachusetts]" (Fenwald et. al., 26). Sterilization laws were implemented in many states, resulting in the sterilization of 40,000 Americans (Fischer 2012). The atrocities committed under the guise of Aryan nationalism during WWII caused Americans to turn away from Social Darwinism and Eugenics.

## **The 1940's - A New Wave of Reforms**

Towards the end of WWII (1939-1945), Americans were concerned with the prolific number of soldiers returning with post traumatic stress disorder: 37% of soldiers serving in the Army were discharged due to mental illness (Rocheftort 1984). The atrocities that Americans witnessed during the war shifted public attention to consequences associated with eugenics, sterilization, and clinical diagnoses that implied hereditary explanations for mental illness. Although Eugenics predated WWII, it had long lasting implications for mental health. This resulted in greater political involvement and policy driven changes to mental institutions and treatment programs. According to Grob (1985), "Eugenicists set out to encourage the multiplication of the 'fit' and to discourage the 'unfit.' A particular version of Darwinian biology and a new interpretation of race that substituted heredity for culture as the defining element helped to rationalize the claims of Eugenicists" (167). Moreover, new developments in medicine changed how practitioners diagnosed and treated mental illness. Where in the past psychiatry struggled to earn recognition because of its association with asylums, it had now established legitimacy in the field of medicine. The immigration of European psychiatrists to America both during and after the war also began to influence how American clinicians classified, diagnosed, and treated mental disorders. Many of these psychiatrists invoked the psychoanalytic methods of Sigmund Freud to treat acute cases, with more radical treatments reserved for chronic patients with little hope of recovery, these included prefrontal lobotomy, electric shock, metrazol shock, insulin shock, sterilization, and other pharmacological interventions (Grob 1985; Grob 1994; Foote 2018).

## Deinstitutionalization

During the 20<sup>th</sup> century, the rhetoric of insanity was again transformed due to new psychiatric constructions of illness and the introduction of methods that combined somatic and psychological treatment resulting in more successful outcomes. The belief in these treatments, along with the shift towards community care, led up to the deinstitutionalization movement which gained momentum in the 1960's. Minnesota had specific goals with deinstitutionalization, and defined its residents in two categories: patients and residents (see Fig. 3.1).

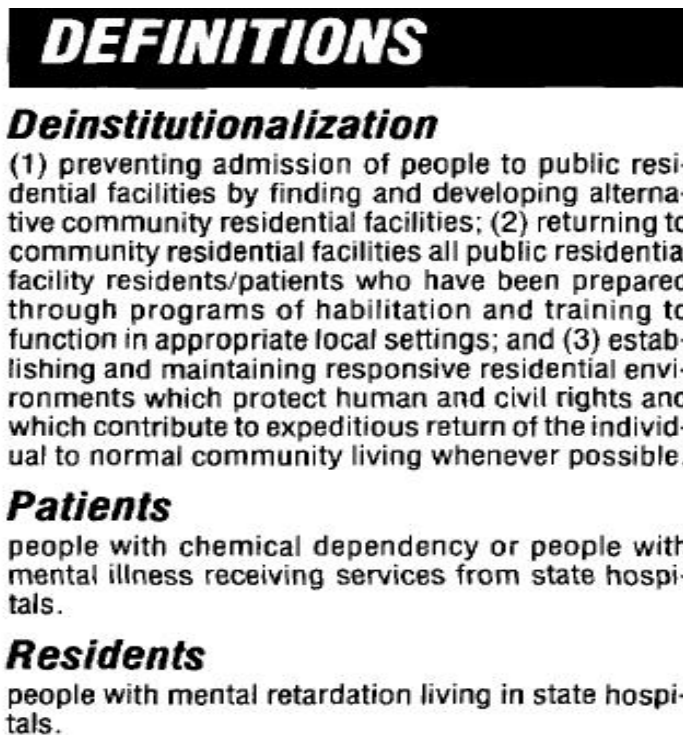


Figure 3.1 The goals of deinstitutionalization in Minnesota. Taken from a report generated by the Minnesota State Planning Agency in 1985 (see Appendix A)

Deinstitutionalization had both positive and negative consequences. On the bright side, many patients were successfully rehabilitated with community care and prescription drugs, leading normal lives after discharge. Alternatively, deinstitutionalization has been heavily criticized because many of the patients that were committed to institutions were completely unprepared to be released into mainstream society. The inability of asylum patients to assimilate resulted in a sharp increase in the homeless population, a rise in unemployment, and a phenomenon referred to as transinstitutionalization (Primeau et. al. 2013; Mechanic and Rochefort 2019).

Transinstitutionalization occurs when an individual is released from one type of institution, only to be committed to another (Primeau et. al. 2013). Primeau et. al. (2013) argues that “When a community is unable or is unwilling to support the mentally ill, the ideals and purpose of deinstitutionalization collapse. Rather than enjoying a new life full of freedoms, previously institutionalized patients [who] are unable to handle their own mental health treatment in the community are faced with the harsh realities of the world viewed through skewed lenses of their mental illness” (2). At the height of the asylum era in America (1955), there were 559,000 people institutionalized out of a total population of 165 million (Lamb et. al. 2004). One theory posits that the fewer hospital beds that are available, the more mentally ill persons are incarcerated in jails due to inadequate community support systems and mental health services (Lamb et. al. 2004; Primeau et. al. 2013). Movement between different institutions is not a new phenomenon. It existed prior to the 20<sup>th</sup> century, and is visible in hospital records that document patient transfers between different hospitals due to overcrowding or disposition/pathology. Nevertheless, the effects of deinstitutionalization and criminalization of the mentally ill continue to resonate throughout America today.

## **Mental Health and Deinstitutionalization in Minnesota**

Mental Health in Minnesota followed the same patterns and trajectories as experienced by much of the nation. Grob presents statistics about the allocation of funding provisioned by the state and federal government for state hospitals. The following data illustrates inadequacies with the distribution of resources: per capita spending in dollars between 1931 and 1940 was highest among the Mid-Atlantic States (*Location 1931 spending in U.S. \$/ 1940 spending in U.S. \$*: New York 392/398, New Jersey 495/395, Pennsylvania 310/291) and lowest in the south (Kentucky 153/147, Tennessee 219/158, Alabama 193/200, Mississippi 183/265) (Grob 1985, 219). Many scholars argue that differential allocation of funding in southern states was due to the high percentage of African Americans in the population, representing a highly racialized medical infrastructure. Minnesota had the lowest per capita expenditure on state hospitals in the West North Central region (Minnesota 203/213, Iowa 239/221, Missouri 237/267, North Dakota 282/237, South Dakota 325/241, Nebraska 231/247, Kansas 229/199), which was directly reflected in reports about the conditions of its state hospitals (Grob 1985, 219).

Minnesota's mental institutions became the focus of a very public mental health campaign during the 1940's, where various charitable organizations (most notably the Unitarian Conference Committee under the leadership of Reverend Arthur Foote) began sending committees to evaluate the conditions of the facilities, patients, and staff in state institutions (Foote 2018). The results of their findings were alarming. The following is an excerpt from "A Summary of Conditions in Minnesota State Hospitals for the Mentally Ill" (1947) to Governor Youngdahl from Arthur Foote and the Unitarian Conference Committee:

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

- The average operating cost allowed for the Minnesota hospitals is one fifth of the amount required.
- No Minnesota hospital meets the minimum standards of the American Psychiatric Association, although one is sufficiently advanced to be approved by the American Board of Neurology and Psychiatry.
- The hospitals fall short of meeting the minimum personnel standards of the A.P.A., by 38 doctors, 340 nurses, 591 attendants, 30 social workers and even more alarming deficiencies in other classifications.
- The minimum personal hygiene requirements of the majority of patients are neglected.
- The majority of patients receive no routine physical examinations.
- Restraints are substituted for treatment measures.
- Food and food services are unsuitable for mental patients.
- Clothing is grossly inadequate.
- Many patients do not receive the care and attention which the state provides livestock on the grounds of these same institutions” (2) (see Appendix B for the complete report sent to Governor Youngdahl).

In addition to the aforementioned issues, Foote brings up disturbing deficiencies in patient care and staffing. Out of the seven hospitals visited, none had a pathologist on staff. This

is problematic because these institutions treated people with serious diseases and pathological conditions, some caused by the therapies offered. For example, Foote (1947) discovered electric shock therapy was used excessively on new patients, "... with the highest number at any one time being 60" (3). Meprozol therapy was also in use, often causing convulsions that were so violent that fractures would manifest in the jaw, other parts of the skull, and the vertebral column (Endler 1988). Other therapies like fever therapy were introduced to treat syphilitic patients, along with insulin therapy that induced a false diabetic coma. Moreover, there were no dieticians employed in any of the state hospitals, leading to chronic issues with malnutrition, anemia, and bowel obstruction (data from current HSH study). Overcrowding was another serious problem, leading to the expansion of current institutions and more institutions being built. Foote (1947) states: "In Minnesota state hospitals 10,000 patients live in 123 wards or cottages... The overcrowding is so severe that many patients are able to touch the adjoining beds on at least three sides. Many patients sleep in corridors or attics" (6).

These investigations did bring about positive impacts on reforms throughout the state. Firstly, the use of restraints was eliminated from state institutions for all but the most violent or dangerous patients in 1949 (Foote 2018). More institutions were built to relieve overcrowding, and state legislature increased its funding for state hospitals and programs for the mentally ill. In addition, the Mental Health Law was passed in 1949 with the intention of providing humanitarian care with a focus on the patients and staff (Foote 2018, 188-189). However, budget cuts ultimately undermined efforts at total reform, which pushed for an emphasis on research and patient care. Concerns about the custodial role of institutions, the increasing number of elderly persons in institutions, and a new emphasis on acute patient care resonated in America and resulted in the deinstitutionalization movement. In Minnesota, the deinstitutionalization



movement resulted in the closure of 12 out of 18 state hospitals and institutions, releasing thousands of people back into the community. The issues resulting from this were twofold: communities were not ready to receive the patients and patients were not prepared to function independently, resulting in a combustible social problem of homelessness, unemployment, and transinstitutionalization.

## CH 4: Hastings State Hospital and Cemetery

### Hastings State Hospital

In 1899, the Minnesota legislature purchased 500 acres of farmland in Hastings, Minnesota to build the HSH (see Appendix C and Appendix D). HSH opened in 1900 and functioned primarily as a transfer institution during its early years of operation. The population of Hastings in 1905 was 3,900, compared to the state of Minnesota at 1,914,000 (Minnesota Historical Society Census Records). The HSH was established to help manage the growing population of inebriates, mentally ill, and physically disabled in Minnesota. It was the fourth institution for the insane established in Minnesota, designed according to a cottage plan with multiple smaller buildings to appear less imposing (see Fig 4.1).



**Figure 4.1** Image of the Hastings State Hospital, courtesy of the Minnesota Historical Society.

The first 112 patients were relocated to HSH from the Rochester State Hospital (HSH patient intake log books, MHS). From 1900-1978 the HSH served over 13,000 patients. HSH has been referred to as Asylum Number Two for the Insane at Hastings, Minnesota and Hastings State Asylum in the past, a reflection of early 18<sup>th</sup> and 19<sup>th</sup> century attitudes about mental illness and disability in Europe and America (Minnesota Department of Health and Human Services). After HSH closed, it was converted into a veteran's home.

Many social and historical forces contribute to the location of institutions and their associated cemeteries within the landscape. Asylums were historically perceived as a source of shame, and were therefore often located in remote areas of the countryside, completely isolated from urban populations. According to Powell (2011), "The loss of living identity can occur long before medical death, and 'social death' can be said to occur when the body comes to occupy certain spaces defined by its disconnection from a wider social network. They [institutions] are dying spaces" (356). This perspective was reflected in the built environment of institutions, which were typically located in remote areas of the countryside or on the periphery of city limits.

Location functioned to isolate the patients from mainstream society, and conceal the daily management and care of patients. The HSH was no exception, situated next to a rural farming community. Archival memos suggest that there were no roads to the asylum when it was first established: "These patients and their baggage were brought to Midas Mill, and they were walked across a field of a privately owned farm to their new 'home.' The 18<sup>th</sup> Street bridge, giving private and direct access to the City of Hastings, was not completed until February 13, 1903" (see Appendix E).

## Hastings State Hospital Cemetery

The HSHC was in use for just over 63 years, with the first burial in 1901, and the last burial in 1964 (see Appendix E). Institutional cemeteries were further isolated from both the larger community and the institution due to their placement at the margins of the property. The HSHC exists as a social phenomenon that is twice obscured within the landscape, hidden from the public gaze of outsiders and the private gaze of asylum patients (Whitney 2018). It is situated at the southeast corner of the property. The distance from the asylum to the cemetery is 1801.06 meters, or 1.12 miles (see Fig 4.2). This would place the cemetery well beyond the view of the patients.



**Figure 4.2** This satellite image was taken from Google Earth. It illustrates the distance between the HSHC and the HSH. The HSH was converted to a Veterans Home when the institution was closed in 1978. Residential development has pushed very close to the boundaries of the HSHC and HSH. The red arrow represents true north.

There are two distinct sections within the cemetery – the southern and northern. Both sections were arranged in a grid pattern (see Fig. 4.3). The southern cemetery is the oldest, used from 1900-1944. There are 671 graves arranged in 16 rows (see Appendix F). Graves in this section are aligned E-W. Burials face to the east, reflecting early religious concerns with death and resurrection (see Appendix E). The northern cemetery was in use from 1944-1964. There are 230 graves in this section arranged in 9 rows (see Appendix F). Burials in this section are aligned N-S and face north.



**Figure 4.3** Satellite image of the north and south sections of the Hastings State Hospital Cemetery (image created through Google Maps).

Graves were originally marked with wooden posts, but these have recently been replaced with flat granite stone tablets set into the grass (see Fig. 4.4). The Hastings State Cemetery is an

example of how marginalized groups are removed from the public gaze, reflecting disproportionate discourses of power between the disabled and the state. In death, asylum patients were stripped of their identity, which is underscored by the use of uniform numbered tablets in the place of headstones to memorialize the graves at the HSHC and in asylum cemeteries throughout Minnesota.

The presence of grave markers is a relatively new introduction to the cemetery. In 2007, the Remembering with Dignity advocacy group received grant funding to add grave markers to all of the headstones at HSHC (Burdine 2013). The grave markers are homogenous, very plain, and without individuality – reifying the construction of a collective identity for asylum patients. Identifiers on grave markers included name, date and year of birth when known, and the date and year of death. Up until 1987, there was no access or right of way to get to the cemetery, emphasizing the concept of social death that Powell (2011) discusses.



**Figure 4.4** Photo of the grave markers at the Hastings State Hospital Cemetery.

## CH 5: Materials and Methods

### **Materials**

Materials used to analyze the HSH included the HSHC, satellite imagery and aerial photos, *Find a Grave*, and archival records stored at the Minnesota Historical Society. Archival materials include- cemetery records, obituary logs (vol. 1 and vol. 2), patient intake logs (vol. 1 and vol. 2), and the patient index collection.

### **Spatial Analysis**

Spatial information is important for developing interpretations about the built environment. Research commenced with a visit to the HSHC, where I walked the grounds and assessed the spatial location of the graves in reference to the asylum. I also conducted background research utilizing satellite imagery and aerial photos to understand the relationship between the location of the institution and the cemetery, as well as the spatial relationship to urban and rural populations.

### **Data Collection- *Find a Grave***

Data were initially collected from the *Find a Grave* website to generate a database for the cemetery population (Whitney 2018). Information was limited to name and year of death for all individuals, but age and nativity were occasionally included. Gender was not provided, but had to be inferred based on name – a method that produced inaccurate results due to human error. *Find a Grave* had 115 more graves listed than cemetery records, emphasizing its unreliability as a resource. The website is an open platform like Wikipedia, where anyone can upload

information. This method for gathering data produced eschewed results; there are 901 physical graves and 1,016 records associated with the cemetery on the website. Issues that I encountered with *Find a Grave* were duplicate entries, inconsistent information, and incorrect dates.

Preliminary analysis on the HSHC population using *Find a Grave* demonstrated a disproportionate ratio of males to females, where males outnumbered females 9:1.

### **Data Collection- HSH Archival Material**

I abandoned *Find a Grave* and utilized maps, obituary records, patient registers, patient index records, and cemetery records provided by the Minnesota Historical Society Gale Research Library. Patient records are locked for 75 years after the death of each patient due to privacy laws, which function to ensure patient confidentiality and to protect their families. Restricted access to patient records presented a new set of challenges. I requested access to the locked records through the state archivist which was approved, enabling me to expand my research to consider trends during the entire time HSH and HSHC were in use. Access to these materials was contingent upon specific terms, primarily ensuring the protection of patient identity.

Information about the HSHC population was entered into Microsoft Excel. I later expanded my data sets and utilized Microsoft Access to create a database for the total deceased HSH population (see Fig 5.1). Each individual was given four markers of identification in the database for redundancy and cross referencing: the database index number (generated by the Access program), the obituary number, medical ID number/ case number, and the patient name (which is not disclosed). Due to the inconsistencies in record keeping by HSH staff, it was not possible to generate an accurate listing without each individual's name. The patient index, for



example, was alphabetized and frequently utilized to validate information for hundreds of patients.

In order to conceal patient identity in this thesis, each individual that is referenced in the thesis discussion was given a number and letter to assign identity and gender – the index ID generated by the program and M (male)/ F (female). Discussions about gender are conceptualized in binary terms. Male and female categories are used because they follow institutional conventions at the time of admission. There was no skeletal material, so all assignments of male and female must be viewed as human constructions of identity. Patient data were not entered into the Access database in chronological order (I skipped around between pages, but always kept a log of completed pages), so the database ID number for each patient does not correspond to the obituary number in the HSH reference materials.

The image shows a screenshot of an Access database form titled "Form - Search by ID # Obituary # or Case #". The form is designed for data collection and includes several search and input fields. At the top, there are three search buttons: "Search ID#", "Search Obit ID#", and "Search Case ID#". The form is divided into two main columns of input fields. The left column includes fields for ID (with a "(New)" dropdown), Book No-Page No, Obituary Number, Date of Death (Year, Month, Day), Name, Sex (dropdown), Age, Civil Cond (dropdown), Occupation, Occupational Classification (dropdown with options: Farmer, Laborer, Skilled Laborer), Nativity (dropdown), Location, County Sent, and Form of Disease on Admission. The right column includes fields for No of Attacks, No of Admissions, Case No, Case Letter, Admission Year, Admission Month, Admission Day, Period of Residence (Years, Months, Days), Duration of Disease (Years, Months, Days), Cause of Death, Disposal of Remains (dropdown), Autopsy (checkbox), and Notes.

**Figure 5.1** This image illustrates the Access database form for data collection.

The use of Microsoft Access was ideal for my research because I had the ability to organize the data, create queries, and sort by multiple fields. Back-ups were made of all files if changes were made or new data was entered. I used a versioning system which created daily copies of the database in case of corruption, then used a copy to create new forms and queries, and lastly copied them to the live database. Most of the information I gathered was fragmented and required the use of multiple sources to generate a complete profile on each patient, but there were still gaps in the data. Missing data was made explicit in the analysis of each data set. In addition, I operationalized occupation to include general categories: domestic, student, farmer, laborer, skilled laborer, clerical, white collar, other, unknown. These categories are a reflection of status, class, and education.

The broad scope of my research required the following data: age, gender, occupation, nativity, civil status, diagnosis at admission, cause of death, duration of time spent in the institution, and disposal of remains. This information was generated by referencing obituary records dating from 1900-1977 (MNHS Call Number 108.D.10.6F), the patient intake logs (MNHS Call Number 108.D.10.6F), and the patient index (MHS Call Number: 114.G.3.6F-1, 114.G.3.6F-2, 114.G.3.7B-1, 114.G.3.7B-2, 114.G.3.8F-1, and 114.G.3.8F-2).

The total number of individuals represented in the obituary records for HSH was 3,652 ( $n = 3652$ ). I was able to produce a nearly complete representation of the 901 individuals buried in the cemetery ( $n = 897$ ). Issues with administrative processes and record keeping at the HSH presented significant obstacles in generating a complete listing. There are no duplicate individuals in my data set, only duplicate case numbers or entry numbers which I will explain shortly. I cross referenced multiple sources to confirm the data I collected.

## **Data Collection – Issues, Obstacles, Limitations**

I encountered many issues with the resources I utilized to collect data about the deceased from HSH and HSHC. An inventory of the cemetery conducted in March of 1963 revealed numerous errors in the burial plot records, emphasizing not only the ineffective record keeping, but the low social and cultural capital of asylum patients. Issues encountered were duplicate graves where two graves were marked for the same individual, unmarked graves that contained a burial, graves (empty) that were assigned to individuals that were buried elsewhere, and graves (empty) marked for individuals sent to the University of Minnesota (see Appendix G). Some of the individuals listed in the full report of HSHC burials were disinterred.

Although I recorded information for each deceased individual at HSH, the totals that I have calculated are not necessarily correct due to inconsistent record keeping at HSH. For example, the aggregate data provided by MHS for the HSH population in 1963 revealed inconsistencies, listing a total of 3275 individuals ( $n= 3275$ ) (see Appendix H). However, the same document then splits the total population into subcategories: HSHC ( $n= 901$ ), U of M ( $n= 151$ ), and Home ( $n= 2226$ ). The total of these subcategories from the same document demonstrates a different total, where  $n= 3278$  (see Fig 5.2).

Obituary Book Vol. I (June 30, 1900 to 6/30/49  
Vol. II (July 1, 1949 to 6/30/63)

<u>Year</u>	<u>No. Deaths</u>	<u>Burial-HSH-U</u>	<u>of M</u>	<u>-Home</u>
1951	60	16		44
1952	62	20		42
1953	49	7		42
1954	76	6	2	68
1955	121	6	6	109
1956	130	9	4	118
1957	120	4	4	112
1958	81	1	3	77
1959	100	2	1	97
1960	102	10		92
1961	83	4	2	77
1962	81	4	1	76
*1963	69	3	2	67
1964	30	1	0	29
<b>Total:</b>	<b>3275</b>	<b>901</b>	<b>151</b>	<b>2226</b>

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**Figure 5.2** Aggregate data for patient deaths from HSH obituary books (vol. 1 and vol. 2). This report was created by Rev. J. J. Quinlan, Chaplain on 6/30/1965 (Hastings State Hospital. Cemetery Records. Minnesota Historical Society Records).

There were many different members of the hospital staff entering information in the ledgers, and much of the handwriting was barely legible. Many columns of information were left blank in the obituary records and patient intake logs, limiting my ability to generate a complete profile of the HSH/HSHC population. Data analysis is representative of these gaps in patient information, which is made explicit to the reader by defining the sample size for each data set in ‘unknown’ categories. Attempts to correct these issues were time consuming and not always successful. Patient case book records have been destroyed for all patients after 1909 without a successful replication of data to the obituary logs, patient intake logs, or index cards. Autopsy information was inconsistent, and was documented infrequently in obituary records and patient index cards.

Another issue was that large numbers of patients had no recorded diagnosis at the time of admission, which was evident by the presence of a blank space or the following terminology: not given, unknown, or undiagnosed. Many patients died before they were diagnosed, underscoring the problems with overcrowding and understaffing at the institution. Patients went for months before receiving any treatment for their specific conditions. It is difficult to imagine being institutionalized today without a complete examination and thorough diagnosis upon admission. Moreover, many individuals had duplicate medical identification numbers, necessitating additional attempts to correct the issue because the Access database was built to reject duplicate entries for this field. For individuals that I could not determine the correct medical identification number, they received a false one beginning with a 0.

Other issues were chronological duplicate entry ID numbers for patients in the obituary books. Clerks manually assigned each individual a number at death in the obituary ledgers. There were numerous errors in recordkeeping for this field, creating more than 594 duplicates that needed to be corrected. For example, in obituary book 1 pg. 46 the numbers skip from 1838 to 1939, omitting 100 numbers (see Fig. 5.3). This sequence continues through to 1986, and then resumes at 1887 on pg. 48. However, the process of renumbering the sequence to close the gap in numbers created duplicate entries for 1939-1986 (see Fig. 5.4). This is a common problem with the obituary book records. In addition, some patients were given the same ID number upon death, which is identifiable in the Access database by a decimal (ex. 3296.1, 3296.2). To illustrate the issue with numerical entry errors, the last obituary number in the ledger is 5261, but there are only 3,652 individuals in the HSH obituary logs.

1835	1944	12	29
1836	1944	12	31
1837	1945	1	1
1838	1945	1	1
1939	1945	1	14

**Figure 5.3** This image is taken from book 1, pg. 46 of the obituary records. It demonstrates a break in the sequence, where numbers the admission number skips from 1838 to 1939.

1985	45	11	3
1986	45	11	5
1887	45	11	11
1988	45	11	15
1889	45	11	19

**Figure 5.4** This image is taken from book 1, pg. 48 of the obituary records. It illustrates the record keeper correcting mistakes in the admission number sequence.

I identified significant inconsistencies in the presentation of data regarding the duration of time spent at the institution. Many of the patients transferred to Hastings State Hospital from other institutions, such as the Rochester State Hospital or the Saint Peter State Hospital. For individuals that transferred from other institutions, the duration of time spent at Hastings does not represent the total duration time that they were institutionalized in the state of Minnesota. For example, obituary records for patient ID 757 demonstrate that the individual was institutionalized for 14 years, 7 months, and 21 days. Patient ID 757 was admitted to the hospital in 1904 and died in 1919. However, this patient was transferred to Hastings from Rochester. The date of admittance to Rochester was 1897, therefore extending the institutionalization period to approximately 22+ years. This discrepancy is important for establishing a meaningful interpretation about custodial care, and the intersection between cofactors like civil status, immigrant status, occupation, gender, and age. The patient case records contained information about transfer dates that the obituary records did not, but I was not able to access all of the patient records in the case books, which ultimately biased the data to reflect shorter institutionalization periods.

Other patterns were recognizable in regards to the administrative functions of the staff and the life histories of the patients. It was evident that knowledge about mental illness, pathology, and disability was limited to psychoanalytical interpretations of illness, with a trend towards increased medical expertise about somatic pathology during the latter years that the institution was in operation. There were many consecutive records with the same cause of death, indicating two different theories about practice and pathology. Firstly, it is evident that there are time periods where epidemics resulted in high mortality at the HSH, such as lagrippe in 1918 (influenza), pneumonia, and tuberculosis. Secondly, medical personnel were not trained to properly diagnose the wide variety of patients they admitted. For example, patient ID 45 was diagnosed with alcoholism and acute mania at admission, but the cause of death was listed as syphilis and paralytic dementia.

Many entries in the obituary books also had the same improbable cause of death for consecutive patients, such as organic heart disease or cerebral arteriosclerosis, revealing a pattern where the coroner or superintendent just lists a random nonspecific condition as the cause of death. There were multiple entries in a row for cerebral hemorrhage, raising questions about why so many patients died of cerebral hemorrhage. Could this be due to shock treatments? According to Axayacalt, et al (2018), “High-voltage electric injury may induce lesions in different organs. In addition to the local tissue damage, electrical injuries may lead to neurological deficits, musculoskeletal damage, and cardiovascular injury. Severe vascular damage may occur making the blood vessels involved prone to thrombosis and spontaneous rupture” (1)

## **Data Analysis**

This research measures the relationship between many different variables within and between the subgroups in the deceased HSH population. To analyze the data, I utilized frequency analysis and life table analysis. Frequency analysis measures the number of times something occurs for the unit being analyzed. Data is broken down by disposal of the body, gender, risk factors, and time frames. Life table analysis was utilized to establish the mortality profile and survivorship of the deceased HSH population, omitting individuals that did not have an age at death provided in the obituary records. Life tables are an important component to demographic analysis, and can inform researchers about trends that occur within a population cohort. According to Ogella et. al., “Lifetable demography provides information, such as age specific survivorship, fecundity, average lifespan, generation time population growth rate and intrinsic rate of natural increase” (Ogello et. al. 2016).



## CH 6: Results and Discussion

This chapter presents the results of data analysis on the deceased HSH population. It is structured to assist the audience with transitions between topics, where I present the results for each data set followed immediately by a discussion. The first section (6.1) is a summary analysis and discussion about the total deceased HSH population, followed by results and discussion of potential risk factors, such as: civil status (6.2), immigrant status (6.3), occupation (6.4), and age (6.5). Raw data (tables) are included for cross referencing purposes.

### **6.1 Summary Analysis: Total HSH Sample**

The total number of deceased patients represented in the HSH obituary logs are 3652 (see Table 6.1). Males outnumber females 4:1, where 80% of the patients are male ( $n=2933$ ) and 20% female ( $n=719$ ). Most of the deceased patients at HSH were retrieved for private burial ( $n=2564/3652$ ; 70%). Private burial among males ( $n=1906/2564$ ; 72%) occurred at higher rate than females ( $n=658/2564$ ; 25%) expressed by a ~3:1 ratio. I combined the U of M and Mayo patients into one category ( $n=160$ ). Only one body was sent to the Mayo Clinic, whereas 159 patients were transported to the University of Minnesota's Anatomy Department to be used as cadavers in the medical school. There is a significant difference in the ratio of males to females in the U of M cohort, where males ( $n=150/160$ ; 94%) outnumber females ( $n=10/160$ ; 6%) 15:1. Only 31 individuals were listed as unknown burial type. There was no documentation in the obituary logs, patient indices, or patient intake logs about disposal of remains for the individuals included in this cohort ( $n=31/3652$ ; 0.8%).

**Table 6.1** Aggregate data for the total deceased population at HSH from obituary books examining disposal of remains and gender. The population in this study represents a complete listing of all individuals that were documented in the obituary books from the HSH.

Population Sample	Male	Female	Total
HSHC	861	36	897
Private	1906	658	2564
U of M	150	10	160
Unknown	16	15	31
Total	2933	719	3652

### **6.1 Discussion: Total HSH Sample**

When I began researching the total deceased population at HSH, one of my primary research questions focused on gender distribution because it has the potential to elucidate disparities in health and the risk factors that influence admission. Gender distribution at the HSH (based on the deceased population sample) corresponds with demographic studies of other asylums, where males were admitted at higher rates than females (Magennis and Lacy 2014; Grob 1983). Data from the 1910 “Insane and Feeble Minded in Institutions” census of institutionalized patients in America also corresponds with this trend, and reported that 34,116 males (56%) and 26,653 females (44%) were admitted to asylums ( $n=60,769$ ). In Minnesota, 1,425 people were admitted (males=866/1425; 61% and females =559/1425; 39%) (24). The 1910 census report differentiates between the existing institutionalized population, admissions, and deaths. Therefore, it is necessary to examine the HSH data against census data for deceased asylum patients, because the HSH sample represents patients that have died, rather than those that lived. Census data for deceased patients in American institutions ( $n=381$ ) also demonstrates

a higher representation of males ( $n=248/381$ ; 65%) to females ( $n=133/381$ ; 35%) at a ratio of ~2:1.

Preliminary analysis of the HSHC population revealed a disproportionate ratio of males to females (Whitney 2018). Data collected from the obituary ledgers supports my initial findings from the HSHC where males outnumber females, although instead of the 9:1 ratio from the cemetery records, the total HSH sample presents a ratio of 4:1. There is a simple explanation for the gendered distribution of patients at HSH. Female patients were admitted to HSH for four years from 1905-1909, but from 1900-1905 and 1909-1943, institutional policies prohibited the admission of females and the population became segregated. According to the Minnesota Historical Society, policy changes allowed for women to once again be admitted to HSH in 1944 (MHS Library Guide Hastings State Hospital). However, data collected from the obituary logs suggests that there were exceptions to rules governing the presence of female patients at HSH.

To confirm this new information about female segregation at HSH, I ran a query against the Access database searching for females that were admitted between 1900 and 1944. The results of the query confirmed that 8 females were admitted between 1905 and 1906, data that correlates with policies allowing female entrance from 1905-1909. This search also revealed that 6 other females were recorded in the obituary logs, with admission dates between 1925 and 1943. I rechecked the data against the obituary ledgers to ensure that I had not entered the admission dates incorrectly. Not only does the data confirm that females were admitted to the HSH during this time period, it implies that more women were indeed admitted than my data can support because this study only represents a small portion of the asylum population. One of the major limitations in this research is that we will never know if the deceased population is

representative of the living population of men and women that were discharged from HSH because the obituary logs only represent individuals who died while institutionalized.

According to the World Health Organization (WHO), “Gender is a critical determinant of health, including mental health. It influences the power and control men and women have over the determinants of their mental health [and their bodies], including socioeconomic position, roles, rank and social status, access to resources and treatment in society. As such, gender is important in defining susceptibility and exposure to a number of mental health risks” (WHO 2000). Meaningful discussions about gender can only take place by incorporating an analysis of the time period from 1944-1978, because gender-based discrimination due to admissions policies resulted in the significant underrepresentation of females before 1944 (see Table 6.2). During these 34 years, there is almost a 1:1 ratio of males (n=790/1480; 53%) to females (690/1480; 47%) in the population sample, compared to 4:1. Between 1944-1978, 690 of the women (n=690/718; 98%) in the total deceased HSH population were admitted. In 1944 alone, 70 women were admitted compared to 17 men at a ratio of ~4:1, but admissions rates for women declined in successive years.

**Table 6.2** Aggregate data for the total deceased population at HSH from obituary books examining disposal of remains and gender between 1944 and 1978.

Population Sample	Male	Female	Total
HSHC	54	32	86
Private	707	639	1346
U of M	15	9	24
Unknown	14	10	24
Total	790	690	1480

By narrowing this summary discussion about HSH to the 1944-1978 time frame, a more balanced representation of males to females emerges. For example, private burials occur at almost a 1:1 ratio between males and females. In the HSHC, only 86 total individuals were interred from 1944-1978 compared to 897: 54 men (63%) and 32 (37%) women at a ratio of ~3:2 (see Tables 6.1 and 6.2). Moreover, the ratio of males ( $n=14/24$ ; 58%) to females ( $n=10/24$ ; 42%) sent to the U of M shifts dramatically from 15:1 to 1.4:1. In an examination of the Colorado Insane Asylum from 1879-1899, Magennis and Lacy determined that males were more likely to die in the institution, a trend that we do see at the HSH even when we adjust for female admission, although the difference is not as pronounced (2014, 268).

Gender bias occurs frequently in studies about mental health; scholars argue that the primary determinants of poor health outcomes are structural inequality and women's subordinate status to men, factors that illustrate how power exacerbates existing risk factors (WHO 2000; Yu 2018; Pinillos-Franco and Kawachi 2018). In order to effectively discuss gender bias in terms of risk and cofactors, such as civil status, occupational status, immigrant status, and age, the rest of the results section in this paper will consider the entire time period the HSH was in operation, and the time period from 1944-1978 as different data sets to adjust for differential admission policies.

## **6.2 Data Analysis: Civil Status**

### **Total Deceased HSH Population**

An examination of civil status from 1900-1978 demonstrates that single patients dominate the total deceased HSH population ( $n=1629/3652$ ; 45%). Married patients ( $n=1072/3652$ ; 29%) have the second highest representation, followed by widowed

( $n=733/3652$ ; 20%) and divorced patients ( $n=143/3652$ ; 4%). Separated patients ( $n=38/3652$ ; 1%) and individuals with unknown civil status ( $n=37/3652$ ; 1%) exhibited the lowest numbers (see Table 6.3). When compared to data for patients from 1944-1978 to adjust for the inclusion of women, this trend totally shifts and married patients ( $n=557/1480$ ; 37%) exhibit the highest representation followed by widowed ( $n=526/1480$ ; 35%) (see Table 6.4).

Among women, widows ( $n=339/719$ ; 47%) presented the highest prevalence from 1900-1978, followed by married ( $n=206/719$ ; 29%) and single ( $n=127/719$ ; 18%) patients (see Table 6.7). This pattern is reproduced in the 1944-1978 HSH sample: widows ( $n=336/695$ ; 48%), married ( $n=198/695$ ; 28%), and single ( $n=117/695$ ; 17%) (see Table 6.8). Men, on the other hand, exhibited different patterns, where the highest concentration of patients from 1900-1978 were single ( $n=1502/2933$ ; 51%), then married ( $n=866/2933$ ; 30%), and widowed ( $n=394/2933$ ; 13%) (see Table 6.5). From 1944-1978, these results change and married men are most prevalent ( $n=359/792$ ; 45%), followed by widowers ( $n=190/792$ ; 24%) and single men ( $n=176/792$ ; 22%) (see Table 6.6).

### HSHC

There are significant differences between males and females within each category for disposal of remains. Within the 1900-1978 HSHC cohort, males ( $n=861/897$ ; 96%) outnumber females ( $n=36/897$ ; 34%) 17:1. Single males appear in higher frequencies in the HSHC cohort ( $n=596/897$ ; 66%), followed by married ( $n=127/897$ ; 14%) and widowed men ( $n=77/897$ ; 9%). This pattern shifts for males in the 1944-1978 HSHC cohort, where single men dominate ( $n=22/55$ ; 40%), then widowed ( $n=15/55$ ; 27%) and divorced men ( $n=8/55$ ; 15%). Among women, widows ( $n=23/36$ ; 64%) had the highest representation from 1900-1978, with equal

numbers of single ( $n=6/36$ ; 17%) and married ( $n=6/36$ ; 17%) patients (see Tables 6.5 and 6.7). This pattern is reproduced in the 1944-1978 HSH female sample: widows ( $n=22/32$ ; 69%), single ( $n=5/32$ ; 16%), and married ( $n=4/32$ ; 13%) (see Table 6.8).

### Private Burial

Private burials among men account for the greatest percent of the HSH population from 1900-1978 ( $n=1906/3652$ ; 65%). Within the private burial cohort, there were 775 single men (40%), 728 married men (38%) and 306 widowed men (16%) (see Table 6.5). From 1944-1978, these categories shift and married men ( $n=350/708$ ; 49%) exhibit the highest prevalence, then widowed ( $n=172/708$ ; 24%) and single men ( $n=135/708$ ; 19%). Women in the private burial category exhibit the greatest numbers in the widowed ( $n=309/658$ ; 47%), married ( $n=195/658$ ; 30%), and single categories ( $n=113/658$ ; 17%) for the 1900-1978 time frame. These categories remain the same for 1944-1978, where widowed women predominate ( $n=307/652$ ; 48%), followed by married ( $n=190/642$ ; 30%) and single women ( $n=105/642$ ; 16%).

### U of M

A total of 160 patients were sent to the U of M for use as cadavers following their death: 150 males (94%) and 10 (6%) females between 1900 and 1978 at a ratio of 15:1 (see Table 6.3). Single males ( $n=122/160$ ; 76%) appear in higher frequencies than any other category for civil status. Patients with unknown disposal of remains and unknown civil status do not represent a significant portion of males ( $n=16/160$ ; 10%) or females ( $n=15/160$ ; 9%). If we look at the time frame from 1944-1978, more males ( $n=15/24$ ; 63%) than females ( $n=9/24$ ; 37%) were sent to the U of M, but the ratio is not as extreme at ~2:1 (see Tables 6.4, 6.6, and 6.8).

**Table 6.3** Aggregate data for civil status for the total HSH deceased population, examining disposal of remains and civil status. The population in this table represents a complete listing of all males and females from 1900-1978.

Population Sample	Single	Married	Separated	Widowed	Divorced	Unknown	Total
HSHC	602	133	10	100	34	18	897
Private	888	923	27	615	102	9	2564
U of M	123	8	1	14	4	10	160
Unknown	16	8	0	4	3	0	31
Total	1629	1072	38	733	143	37	3652

**Table 6.4** Aggregate data for civil status for the total HSH deceased population, examining disposal of remains and civil status. The population in this table represents a complete listing of all males and females from 1944-1978.

Population Sample	Single	Married	Separated	Widowed	Divorced	Unknown	Total
HSHC	27	8	3	37	9	3	87
Private	240	540	21	479	64	6	1350
U of M	13	1	0	6	2	2	24
Unknown	13	8	0	4	1	0	26
HSH - Total	293	557	24	526	76	11	1487

**Table 6.5** Aggregate data for civil status for males in the HSH deceased population, examining disposal of remains, civil status, and gender. The population in this study represents a complete listing of all males from 1900-1978.

Population Sample	Single	Married	Separated	Widowed	Divorced	Unknown	Total
HSHC	596	127	10	77	33	18	861
Private	775	728	23	306	70	4	1906
U of M	120	6	1	11	3	9	150
Unknown	11	5	0	0	0	0	16
HSH - Total	1502	866	34	394	106	31	2933



**Table 6.6** Aggregate data for civil status for males in the HSH deceased population, examining disposal of remains, civil status, and gender. The population in this study represents a complete listing of all males from 1944-1978.

Population Sample	Single	Married	Separated	Widowed	Divorced	Unknown	Total
HSHC	22	4	3	15	8	3	55
Private	135	350	17	172	33	1	708
U of M	70	0	0	3	1	1	15
Unknown	9	5	0	0	0	0	14
HSH - Total	176	359	20	190	42	5	792

**Table 6.7** Aggregate data for civil status for females in the HSH deceased population, examining disposal of remains, civil status, and gender. The population in this study represents a complete listing of all females from 1900-1978.

Population Sample	Single	Married	Separated	Widowed	Divorced	Unknown	Total
HSHC	6	6	0	23	1	0	36
Private	113	195	4	309	32	5	658
U of M	3	2	0	3	1	1	10
Unknown	5	3	0	4	3	0	15
Total	127	206	4	339	37	6	719

**Table 6.8** Aggregate data for civil status for females in the HSH deceased population, examining disposal of remains, civil status, and gender. The population in this study represents a complete listing of all females from 1944-1978.

Population Sample	Single	Married	Separated	Widowed	Divorced	Unknown	Total
HSHC	5	4	0	22	1	0	32
Private	105	190	4	307	31	5	642
U of M	3	1	0	3	1	1	9
Unknown	4	3	0	4	1	0	12
Total	117	198	4	336	34	6	695

## **6.2 Discussion: Civil Status**

Social capital can be broadly defined as having a strong sense of belonging, which is strengthened by friend and family networks, community involvement, and participation in social groups (Pinillos-Franco-Kawachi 2018). There are gendered dimensions to social capital, which can help to explain disparities in health. The amount of social capital and the resources individuals have access to during times of stress and insecurity influence mental health outcomes (Pinillos-Franco and Kawachi 2018). Moreover, there is a strong association between social capital and power. According to Pinillos-Franco and Kawachi (2018), women are “... at increased risk of poor health compared to men because of the unequal distribution of power and resources – i.e. the social determinants of health – within the household and society at large. Thus women are more likely to experience gender-based discrimination, domestic violence, sexual abuse and poverty compared to men” (31).

Social capital can be measured in the HSH deceased population by examining the relationship between civil status and the disposal of human remains. When individuals have higher social capital, their bodies retain value in death, which in American society is expressed by private burial. In theory, individuals with higher value at HSH should be retrieved for private burial, while those with low social capital would either be buried in the asylum cemetery or sent to the U of M for dissection. If social capital is ranked from highest to lowest and classified in order as married, widowed, separated, divorced and unknown, I would expect to see a higher frequency of low status disposal as social capital decreases, and vice versa. Demographic analysis of the HSH population through both of the previously defined time periods (1900-1978 and 1944-1978) does in fact support this theory.

Several patterns emerge in an examination of civil status. People with unknown civil status exhibit the highest risk of low status disposal of their corpse than any other grouping. This is reflected in the 1900-1978 sample, where 76% of the unknown civil status cohort were either buried in the HSHC or sent to the U of M. In the smaller 1944-1978 sample, the number drops to 45%, but still represents the highest frequency of low status disposal in any category. This could be explained by considering protective factors; higher social status groups maintain stronger relationships and social bonds while being institutionalized. The presence of risk and protective factors impacts the experience of institutionalization, morbidity and mortality, and disposal of the body. According to the U.S. Department of Health and Human Services (2001), “Promotion and prevention [of mental illness] hinge on the identification of modifiable risk and protective factors, i.e., characteristics or conditions that, if present, increase or diminish, respectively, the likelihood that people will develop mental health problems or disorders” (12). Another potential explanation is that patients with unknown civil status were unable to communicate their identity or connections during the admissions process.

Not only is social capital associated with increased risk of institutionalization, it also illustrates gendered disparities in the treatment of deceased patients. Second to those of unknown civil status, single patients in the 1900-1978 sample exhibited the highest risk for low status disposal (45%), with single males presenting a 48% rate and single females a 7% rate (see Table 6.9). In the 1944-1978 group, single and divorced patients exhibit the lowest social capital, where 14% of individuals in each category were buried in the HSHC or sent to the U of M (see Table 6.10). A focus on gender illustrates that following unknown civil status, single males make up 52% of low status disposals, while widowed women make up 7% (see Tables 6.12 and 6.14).

The married population exhibits the highest social capital, where 86% of individuals in the 1900-1978 group were retrieved for private burial. In the 1944 to 1978 sample, 97% of individuals were retrieved for private burial. This shift could also be due to the reduced stigma associated with mental illness. Low status disposal (HSHC and U of M) results for married individuals had a prevalence rate of 13% in the large sample, with 15% of married males having low status burials and only 4% of married females (see Tables 6.9, 6.11, and 6.13). In the smaller sample, the total low status burial rate of married individuals was only 2%, with 1% of married males and 3% of married females falling into the category.

The following tables reflect the consolidated data for total deceased population, male deceased population, and female deceased population for the large sample (1900-1978) and the small sample (1944-1978). The risk of low status disposal was calculated by dividing the total known individuals in civil status categories for both the HSHC and U of M by the total number of deceased individuals.

**Table 6.9** Aggregate data for civil status for the total HSH deceased population, examining disposal of remains and civil status. The population in this table represents a complete listing of all males and females from 1900-1978.

Population Sample	Single	Married	Separated	Widowed	Divorced	Unknown	Total
HSHC	602	133	10	100	34	18	897
U of M	123	8	1	14	4	10	160
HSH - Total	1629	1072	38	733	143	37	3652
Frequency	45%	13%	29%	16%	27%	76%	29%

**Table 6.10** Aggregate data for civil status for the total HSH deceased population, examining disposal of remains and civil status. The population in this table represents a complete listing of all males and females from 1944-1978.

Population Sample	Single	Married	Separated	Widowed	Divorced	Unknown	Total
HSHC	27	8	3	37	9	3	87
U of M	13	1	0	6	2	2	24
HSH - Total	293	557	24	526	76	11	1487
Frequency	14%	2%	13%	8%	14%	45%	7%

**Table 6.11** Aggregate data for civil status for males in the HSH deceased population, examining disposal of remains, civil status, and gender. The population in this study represents a complete listing of all males from 1900-1978.

Population Sample	Single	Married	Separated	Widowed	Divorced	Unknown	Total
HSHC	596	127	10	77	33	18	861
U of M	120	6	1	11	3	9	150
HSH - Total	1502	866	34	394	106	31	2933
Frequency	48%	15%	32%	22%	34%	87%	34%

**Table 6.12** Aggregate data for civil status for males in the HSH deceased population, examining disposal of remains, civil status, and gender. The population in this study represents a complete listing of all males from 1944-1978.

Population Sample	Single	Married	Separated	Widowed	Divorced	Unknown	Total
HSHC	22	4	3	15	8	3	55
U of M	70	0	0	3	1	1	15
HSH - Total	176	359	20	190	42	5	792
Frequency	52%	1%	15%	9%	21%	80%	9%

**Table 6.13** Aggregate data for civil status for females in the HSH deceased population, examining disposal of remains, civil status, and gender. The population in this study represents a complete listing of all females from 1900-1978.

Population Sample	Single	Married	Separated	Widowed	Divorced	Unknown	Total
HSHC	6	6	0	23	1	0	36
U of M	3	2	0	3	1	1	10
HSH - Total	127	206	4	339	37	6	719
Frequency	7%	4%	0%	8%	5%	17%	6%

**Table 6.14** Aggregate data for civil status for females in the HSH deceased population, examining disposal of remains, civil status, and gender. The population in this study represents a complete listing of all females from 1944-1978.

Population Sample	Single	Married	Separated	Widowed	Divorced	Unknown	Total
HSHC	5	4	0	22	1	0	32
U of M	3	1	0	3	1	1	9
HSH - Total	117	198	4	336	34	6	695
Frequency	7%	3%	0%	7%	6%	17%	6%

### **6.3 Data Analysis: Immigrant Status**

#### Total Deceased HSH Population

Data for the total deceased population at HSH from 1900-1978 suggests that there were more U.S. born patients ( $n=2095/3652$ ; 57%) than foreign born people ( $n=1474/3652$ ; 40%), represented by a ratio of 1.4:1 (see Table 6.15). Individuals with unknown nativity only account for 3% ( $n=83$ ). Males outnumber females in each category for nativity: U.S. males ( $n=1559/2095$ ; 74%)/ U.S. females ( $n=536/2095$ ; 36%) / ratio 3:1, foreign born males ( $n=1308/1474$ ; 89%) / foreign born females ( $n=166/1474$ ; 11%) / ratio 8:1, unknown males ( $n=66/83$ ; 75%) / unknown females ( $n=17/83$ ; 25%) / ratio 4:1 (see Tables 6.15, 6.17, and 6.19). The 1944-1978 sample demonstrates a similar distribution for each category.

## HSHC

A gendered perspective indicates that there are more males ( $n=861/897$ ; 96%) than females ( $n=36/897$ ; 4%) in each category for the 1900-1978 cemetery population: U.S. males ( $n=330/897$ ; 37%)/ U.S. females ( $n=20/897$ ; 2%) / ratio 17:1, foreign born males ( $n=503/897$ ; 56%) / foreign born females ( $n=158/897$ ; 2%) / ratio 34:1, unknown males ( $n=28/897$ ; 3%) / unknown females ( $n=1/897$ ; 0.1%) (see Tables 6.17 and 6.19). Foreign born males are represented in the highest numbers ( $n=503$ ) and account for 56% of the total cemetery population ( $n=897$ ) compared to U.S. born males at 37% ( $n=330$ ). In the 1944-1978 sample, there are still more males to females, but these categories shift and more U.S. citizens ( $n=53/87$ ; 61%) were buried in the cemetery than foreign born ( $n=33/97$ ; 38%) (see Table 6.16).

## U of M

For patients sent to the U of M from 1900-1978, men ( $n=150/160$ ; 94%) outnumber women ( $n=10/160$ ; 6%) at a ratio of 15:1 (see Tables 6.17 and 6.19). Foreign born males ( $n=94/160$ ) represent the highest frequency at 59% when compared to the total number of patients sent to the U of M, and at 63% out of just the male patients ( $n=94/150$ ) sent to U of M. Unknown burials ( $n=31/3652$ ; 0.8%) do not account for a significant percentage of the total deceased population. These trends shift for patients in the 1944-1978 sample, where U.S. patients are sent to the U of M at a higher frequency than foreign born for both males ( $n=9/14$ ; 64%) and females ( $n=5/9$ ; 56%) (see Tables 6.18 and 6.20).

## Private Burial

From 1900-1978, U.S. private burials account for the highest prevalence of disposal between both males ( $n=1906/2564$ ; 74%) and females ( $n=658/2564$ ; 26%), with U.S. born

patients making up the greatest number of individuals for males ( $n=1176$ ; 62%) and females ( $n=497$ ; 75%) within each gendered private burial category. These trends are consistent in the 1944-1978 sample, data that corresponds with policies that reduced immigration.

**Table 6.15** Aggregate data for immigrant status for the total HSH deceased population. The population in this study represents a complete listing of all males and females from 1900-1978.

Population Sample	US	Foreign Born	Unknown	Total
HSHC	350	518	29	897
Private	1673	856	35	2564
U of M	50	97	13	160
Unknown	22	3	6	31
Total	2095	1474	83	3652

**Table 6.16** Aggregate data for immigrant status for the total HSH deceased population. The population in this study represents a complete listing of all males and females from 1944-1978.

Population Sample	US	Foreign Born	Unknown	Total
HSHC	53	33	1	87
Private	994	335	21	1350
U of M	14	8	2	24
Unknown	20	3	3	26
Total	1081	379	27	1487

**Table 6.17** Aggregate data for immigrant status for males in the HSH deceased population. The population in this study represents a complete listing of all males from 1900-1978.

Population Sample	US	Foreign Born	Unknown	Total
HSHC	330	503	28	861
Private	1176	709	21	1906
U of M	44	94	12	150
Unknown	9	2	5	16
Total	1559	1308	66	2933



**Table 6.18** Aggregate data for immigrant status for males in the HSH deceased population. The population in this study represents a complete listing of all males from 1944-1978.

Population Sample	US	Foreign Born	Unknown	Total
HSHC	33	21	1	55
Private	508	192	8	708
U of M	9	5	1	15
Unknown	9	2	3	14
Total	559	220	13	792

**Table 6.19** Aggregate data about immigrant status for females in the HSH deceased population. The population in this study represents a complete listing of all females that were from 1900-1978.

Population Sample	US	Foreign Born	Unknown	Total
HSHC	20	15	1	36
Private	497	147	14	658
U of M	6	3	1	10
Unknown	13	1	1	15
Total	536	166	17	719

**Table 6.20** Aggregate data about immigrant status for females in the HSH deceased population. The population in this study represents a complete listing of all females that were from 1944-1978.

Population Sample	US	Foreign Born	Unknown	Total
HSHC	20	12	0	32
Private	486	143	13	642
U of M	5	3	1	9
Unknown	11	1	0	12
Total	552	159	14	695

### **6.3 Discussion: Immigrant Status**

According to Harris and Ernst (1999), “Both race and gender have come to be seen as based on a number of similar principles: the locking of particular groups of people into fixed and quasi-transhistorical identities, for example, which enable some to lay claim to positions of power and to the right to self-determination, while excluding others. As well as race and gender here, too, other concepts such as class, nation, and nationalism are vitally implicated” (9). Magennis and Lacy’s (2014) examination of the Colorado Insane Asylum demonstrates that foreign born patients outnumbered U.S. born at two to three times greater ratios, with certain groups, such as the Irish, demonstrating rates significantly higher than all others (p. 251). The overrepresentation of immigrants that was present in the Colorado Asylum was not evident in the 1910 census data for institutions in Minnesota, where 671 U.S. born patients were admitted to asylums compared to 681 foreign born, an almost 1:1 ratio (Harris 1910). Within these categories, males (U.S.=405; 60%, Foreign=449; 66%) were more prevalent than females (U.S.=266; 40%, Foreign=232; 34%).

At the turn of the 20<sup>th</sup> century, immigrant status in the U.S. was accompanied by structural and social discrimination, as well as the inequitable distribution of resources, most often resulting in steep grades of inequality. American constructions of foreign identity characterized immigrants as inferior, promoting stereotypes that often had deleterious effects on health. The lack of family and community networks placed immigrants at increased risk of mental illness during times of stress. The Department of Health and Human Services (2001) argues that “... the support of other people is key to helping people cope with adversity... families and friends are the first sources to which people say they will turn to if they develop mental illness” (14). Without these protective factors in place, immigrants at HSH were at an

increased risk of institutionalization, dying at the asylum, and experiencing low status disposal of the body at death. According to Magennis and Lacy (2014), many immigrants ended up in institutions because of "... poverty, dislocation to new surroundings, and absence of supporting family networks" (254). An old HSHC report cites that "Those who are presently being buried in this cemetery either have indigent families or have lost contact with their relatives during a prolonged period of hospitalization" (see Appendix E).

Data from the HSH study reveals that there were more U.S. born patients at the institution than foreign born for both the 1900-1978 and 1944-1978 population samples. If disposal of the body after death is an indicator of status and social capital, as I argue it is, then foreign born males were at a disadvantage. Foreign born males (1900-1978) make up 56% of the HSHC cohort and 59% of the U of M cohort. However, data from the 1944-1978 cohort suggests that more U.S. born males experienced low status disposal than foreign born males. This distortion may be due to changes in immigration policy that limited the entrance of foreign-born peoples into the United States, illustrating how race based concepts became powerful drivers that transformed cultural ideologies and codified them into public policy. For example, the Homestead Act of 1862 opened up vast amounts of land to native and foreign born individuals for a miniscule fee, but concerns about the fitness of immigrants eventually led to rules prohibiting the quantity and types of immigrants that were accepted (National Park Service 2000; Magennis and Lacy 2014). On the other hand, the inclusion of women into the HSH after 1944 may potentially explain the shift in prevalence.

Private burials at HSH account for the highest frequencies in each category (1900-1978=2564/3652; 73%, 1944-1978=1350/1487; 91%), but U.S. born patients exhibited elevated numbers suggesting greater amounts of social and economic capital (1900-1978=1673/2095;

80%, 1944-1978=994/1081; 92%). Native born individuals had access to a number of protective mechanisms, such as friends and family networks, community ties, policy and legislation that favors U.S. born citizens, and familiarity with their environment. These elements gave them a social, psychological, and economic advantage over immigrants, giving U.S. citizens power in their cultural identity. Strong undercurrents promoting American nationalism emerged during the late 19<sup>th</sup> century, influencing immigration policy and forming the foundations of Social Darwinism and Eugenics. Both of these movements emphasized a heredity component to social, psychological, and biological traits, although the Eugenics movement sought to cull the population of deviants through forced sterilization, deportation, and genocide. These concepts reified the conflation of nationality and status, and formed an enduring foundation for both scientific and institutionalized racism in the U.S.

#### **6.4 Data Analysis: Occupational Status**

##### **Total HSH Deceased Population**

From 1900-1978 ( $n=3652$ ), there were 1362 laborers (37%), the highest number out of the occupational categories in the HSH sample (see Table 6.121). Farmers ( $n=557/3652$ ; 15%) and skilled laborers ( $n=534/3652$ ; 15%) exhibited the second and third highest representation, followed by domestic ( $n=423/3652$ ; 12%) which is highly gendered and eschewed towards females. I grouped farmers, laborers and skilled laborers together to create a larger working class category ( $n=2453/3652$ ; 67%), and grouped clerical, white collar, and sales together to create a middle/upper class category ( $n=426/3652$ ; 12%). Comparison between groups demonstrates that there were far more working class patients at HSH than middle/upper class patients, a ratio of almost 6:1. Individuals in the student ( $n=19/3652$ ; 0.5%) and other category ( $n=13/3652$ ; 0.3%)

account for a small portion of the 1900-1978 HSH population. Individuals were placed in the other category because they didn't fit into any of the generalized categories.

An examination of the 1944-1978 sample illustrates a different scenario, where the highest number of patients in the deceased HSH sample fell into the domestic category ( $n=408/1487$ ; 27%) (see Table 6.22). This shift is directly related to the admission of females into the HSH. The second highest representation of patients were laborers ( $n=354/1487$ ; 24%) and skilled laborers ( $n=218/1487$ ; 15%). When grouped together, working class patients ( $n=645/1487$ ; 43%) account for the highest number of individuals, followed by domestic ( $n=408/1487$ ; 27%) and middle/upper class ( $n=252/1487$ ; 17%).

### Private Burial

Private burials ( $n=2564$ ; 70%) make up the largest portion of the entire HSH deceased population ( $n=3652$ ) from 1900-1978. Males ( $n=1906$ ; 74%) outnumbered females ( $n=658$ ; 26%) by a ratio of 3:1 (see Tables 6.23 and 6.25). For males with private burials ( $n=1906$ ), there are more working class patients ( $n=1188$ ; 62%) than white collar patients ( $n=265$ ; 14%), while domestic females ( $n=385$ ; 56%) dominate female private burial categories ( $n=658$ ). Few women were sent to the U of M as cadavers ( $n=10$ ; %), most of the patients in this cohort were men ( $n=150$ ). Working class men ( $n=129$ ; 81%) account for the greatest portion of the U of M total cohort ( $n=160$ ), and few white middle/upper class men ( $n=5$ ; 3%) were present. Individuals in the unknown burial category made up the smallest cohort ( $n=31$ ).

The highest prevalence for burial type in the 1948-1978 sample was also private burial at 91% ( $n=1350/1487$ ), with more males ( $n=708/1350$ ; 52%) than females ( $n=642/1350$ ; 48%) (see Table 6.22). An analysis of only males demonstrates that there were more working class patients

( $n=488/69\%$ ) than white collar patients ( $n=130/708$ ; 18%) (see Table 6.24). Domestic females ( $n=378/59\%$ ) exhibit the highest frequency, followed by middle/upper class ( $n=116/642$ ; 18%) and working class ( $n=96/642$ ; 15%) for just females (see Table 6.26).

### HSHC and U of M

In the 1900-1978 grouping, there is a connection between occupational status and burial type, where more working class patients were buried in the HSHC or sent to the U of M ( $n=883/3652$ ; 24%) than middle/upper class ( $n=42/3652$ ; 1%). Within the HSHC cohort, working class patients ( $n=752/897$ ; 84%) are present in higher frequencies than middle/upper class patients ( $n=37/897$ , 4%) at a ratio of 20:1 (see Table 6.21). In an examination of males in the HSHC, working class males ( $n=747/861$ ; 87%) outnumber middle/ upper class males ( $n=37/861$ ; 4%) at a ratio of 20:1 (see Table 6.23). Females in the domestic category ( $n=27/36$ ; 75%) have the highest number of individuals than any other category of females in the HSHC cemetery (see Table 6.25).

Working class patients ( $n=49/111$ ; 78%) make up the largest category of patients buried at HSHC or sent to the U of M in the 1944-1978 sample, while middle/upper class patients ( $n=4/111$ ; 4%) accounted for only a small percentage (see Table 6.22). 38% of the HSHC group is composed of working class males ( $n=42/111$ ). In an examination of only males in the HSHC, the unknown category ( $n=23/55$ ; 42%) has the greatest number of patients followed by laborers ( $n=21/55$ ; 38%). Laborers ( $n=9/15$ ; 60%) have the highest prevalence of males sent to the U of M. In an examination of females, domestic females ( $n=23/32$ ; 72%) are most prevalent in the HSHC, while in the U of M cohort, there are more laborers ( $n=5/9$ ; 56%).

**Table 6.21** Aggregate data on occupational status for the total HSH deceased population. The population in this study represents a complete listing of all males and females from 1900-1978.

Population Sample	Farmer	Laborer	Skilled Laborer	Clerical	Sales	White Collar	Domestic	Student	Other	Unknown	Total
HSHC	132	495	125	13	11	13	27	2	5	74	897
Private	410	765	383	143	71	168	386	14	8	216	2564
U of M	15	93	23	2	0	3	5	1	0	18	160
Unknown	0	9	3	1	0	1	5	2	0	10	31
Total	557	1362	534	159	82	185	423	19	13	318	3652

**Table 6.22** Aggregate data on occupational status for the total HSH deceased population. The population in this study represents a complete listing of all males and females from 1944-1978.

Population Sample	Farmer	Laborer	Skilled Laborer	Clerical	Sales	White Collar	Domestic	Student	Other	Unknown	Total
HSHC	3	24	8	0	1	1	23	1	0	26	87
Private	68	311	205	93	44	109	378	3	5	134	1350
U of M	2	10	2	0	0	2	4	0	0	4	24
Unknown	0	9	3	1	0	1	3	2	0	7	26
Total	73	354	218	94	45	113	408	6	5	171	1487

**Table 6.23** Aggregate data on occupational status for males in the HSH deceased population. The population in this study represents a complete listing of all males from 1900-1978.

Population Sample	Farmer	Laborer	Skilled Laborer	Clerical	Sales	White Collar	Domestic	Student	Other	Unknown	Totals
HSHC	132	492	123	13	11	13	0	1	5	71	861
Private	410	694	354	92	60	113	1	13	6	163	1906
U of M	15	92	22	2	0	3	0	1	0	15	150
Unknown	0	4	3	0	0	1	0	1	0	7	16
Total	557	1282	502	107	71	130	1	16	11	256	2933

**Table 6.24** Aggregate data on occupational status for males in the HSH deceased population. The population in this study represents a complete listing of all males from 1944-1978.

Population Sample	Farmer	Laborer	Skilled Laborer	Clerical	Sales	White Collar	Domestic	Student	Other	Unknown	Total
HSHC	3	21	6	0	1	1	0	0	0	23	55
Private	68	244	176	42	33	55	0	2	3	85	708
U of M	2	9	1	0	0	2	0	0	0	1	15
Unknown	0	4	3	0	0	1	0	1	0	5	14
Total	73	278	186	42	34	59	0	3	3	114	792

**Table 6.25** Aggregate data on occupational status for females in the HSH deceased population. The population in this study represents a complete listing of all females that were from 1900-1978.

Population Sample	Farmer	Laborer	Skilled Laborer	Clerical	Sales	White Collar	Domestic	Student	Other	Unknown	Total
HSHC	0	3	2	0	0	0	27	1	0	3	36
Private	0	71	29	51	11	55	385	1	2	53	658
U of M	0	1	1	0	0	0	5	0	0	3	10
Unknown	0	5	0	1	0	0	5	1	0	3	15
Total	0	80	32	52	11	55	422	3	2	62	719

**Table 6.26** Aggregate data on occupational status for females in the HSH deceased population. The population in this study represents a complete listing of all females that were from 1944-1978.

Population Sample	Farmer	Laborer	Skilled Laborer	Clerical	Sales	White Collar	Domestic	Student	Other	Unknown	Total
HSHC	0	3	2	0	0	0	23	1	0	3	32
Private	0	67	29	51	11	54	378	1	2	49	642
U of M	0	1	1	0	0	0	4	0	0	3	9
Unknown	0	5	0	1	0	0	3	1	0	2	12
Total	0	76	32	52	11	54	408	3	2	57	695



## **6.4 Discussion: Occupational Status**

In order to understand the persistence of poverty as a major risk factor and contributor to mental illness and institutionalization, we must look at the complex interaction between patients at the HSH and the social forces that work against them, one of these being economic status. While information about income is not available for patients at the HSH, other factors can elucidate earnings potential, and can therefore contribute to a discussion about status and risk. Occupation is an indicator of earnings potential and status; it has implications for development of mental illness, increased risk of institutionalization, and disposal of the body after death.

Kaplan et. al. (1996) argue that income inequality is directly associated with morbidity and mortality. An examination of the total deceased HSH sample from 1900-1978 demonstrates that working class patients are 26% more likely to experience low status disposal of the body than middle/upper class patients. Working class males are 23% more likely than middle/upper class males to be sent to the U of M for dissection or burial at the HSHC, and working class females are 6% more likely to experience low status disposal of the body than middle/upper class females. These patterns suggest a close association between occupation and social capital, where working class individuals have lower social capital which is expressed by disposal to the HSHC or U of M. In addition, the evidence suggests that women had more social capital than men. The 1944-1978 HSH sample demonstrates similar trends, although the gap is not as pronounced: working class patients in the total deceased HSH population are 6% more likely to have a low status burial, followed by working class men at 8% and women at 6%.

Patients in the middle/upper class occupational category demonstrate the highest social capital and status, expressed by private burial. In the 1900-1978 total HSH sample, middle/upper

class patients were 26% more likely to be retrieved for private burial at death, with middle/upper class men at 24% and women at 10%. The distribution of patients in the 1944-1978 sample correlates with the 1900-1978 sample, but with smaller margins.

### **6.5 Discussion: Race**

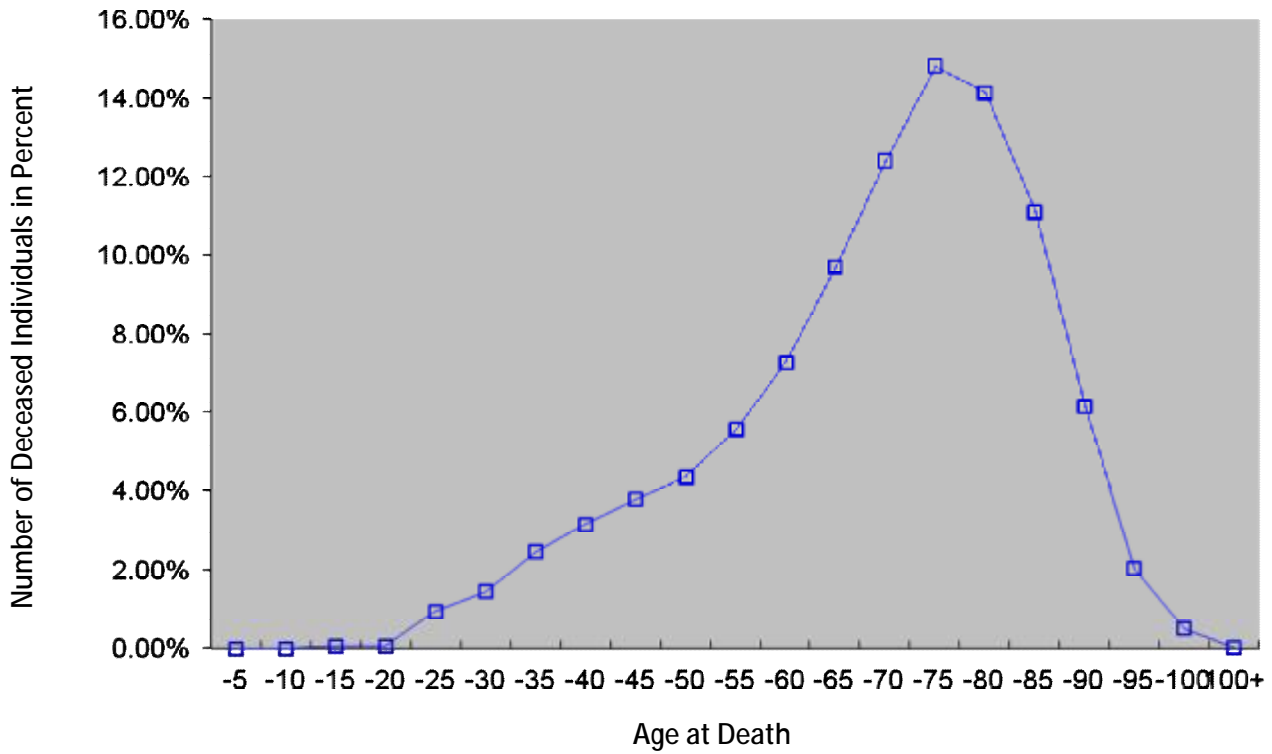
Scholars often discuss white privilege in conversations about race and social inequality, and while I cannot make any definitive statements about race due to inconsistent record keeping, there are trends that manifest in the HSH population. Racial categories, specifically distinctions between 'white' and 'black' patients, were recorded in the admissions logs, obituary logs, and patient indices. African American patients were labeled as 'colored' in the record books, and this indicator or race was usually placed in parentheses after the patients name and underlined in a red or green pen or pencil so that it stood out. There were only 10 African American patients (7 male, 3 female) out of 3652, 0.2%. Although this sample is very small, I do believe it represents overall trends at HSH.

During the 19<sup>th</sup> century and early 20<sup>th</sup> century, African Americans lived predominantly in the south U.S., in which many states in that region had separate asylums for black and white individuals. Seven of the patients in the HSH sample are from southern states, with one from the east and one from the Midwest; none of the patients were from Minnesota. Seventy percent of the African American patients (n=7/10) were buried in the HSHC or sent to the U of M as cadavers, while only 30% (n=3/10) of them were retrieved for private burial. Eighty percent of African Americans were working class (n=8/10), with the other being 10% domestic (n=1/10) and 10% unknown (n=1/10). Data about African Americans suggests that they had the lowest social capital of any group or cohort in the HSH deceased population.

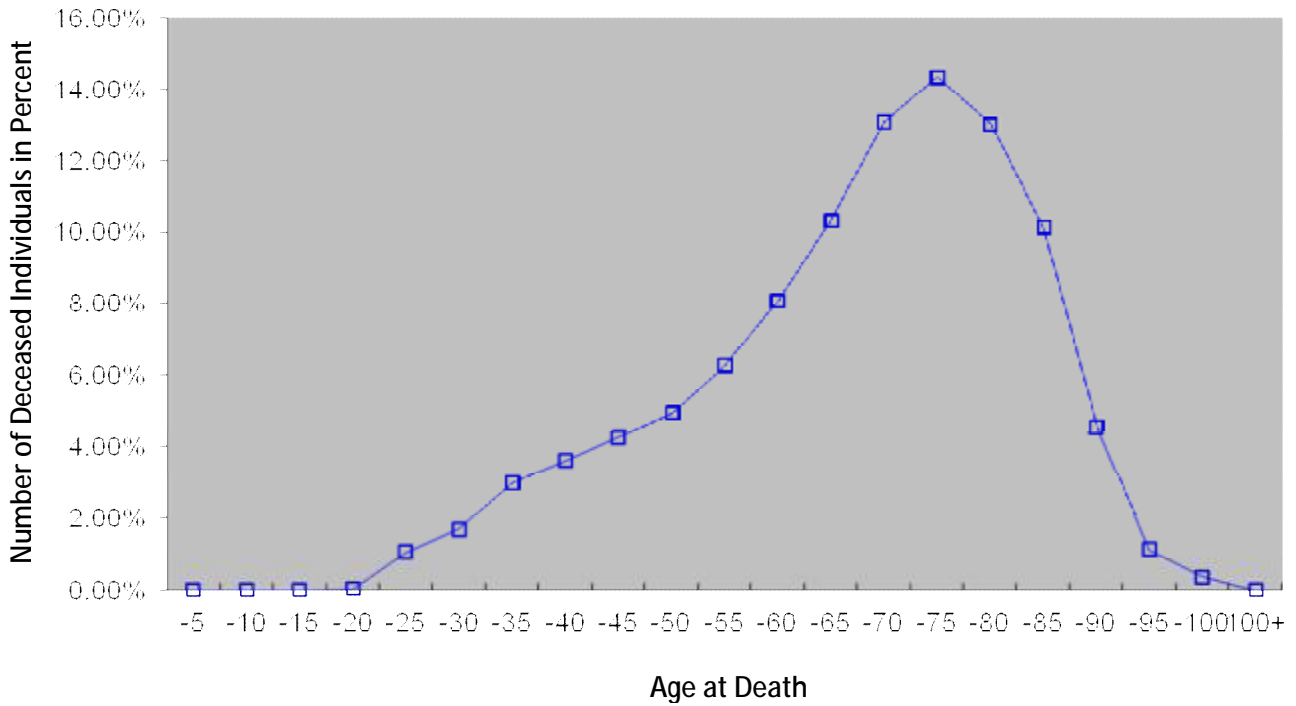
According to Harris and Ernst (1999), “The linking of race [ethnicity and class] with disease categories... suggests not only that racial preconceptions can inform and deform medical observations and practices, but it also constitutes evidence that medical theories are vitally implicated in the construction of ideas of race” (13). The placement of individuals in state institutions, diagnoses and treatments for disease, and treatment of the body after death are reflections of medicalized discourses that were established to impose meaning and order in an environment that both controlled and confined deviants. These discourses are characteristic of the cultural value assigned to subordinate populations, which often have had the effect of rendering them invisible in society, the landscape, and history.

## **6.6 Data Analysis and Discussion: Age**

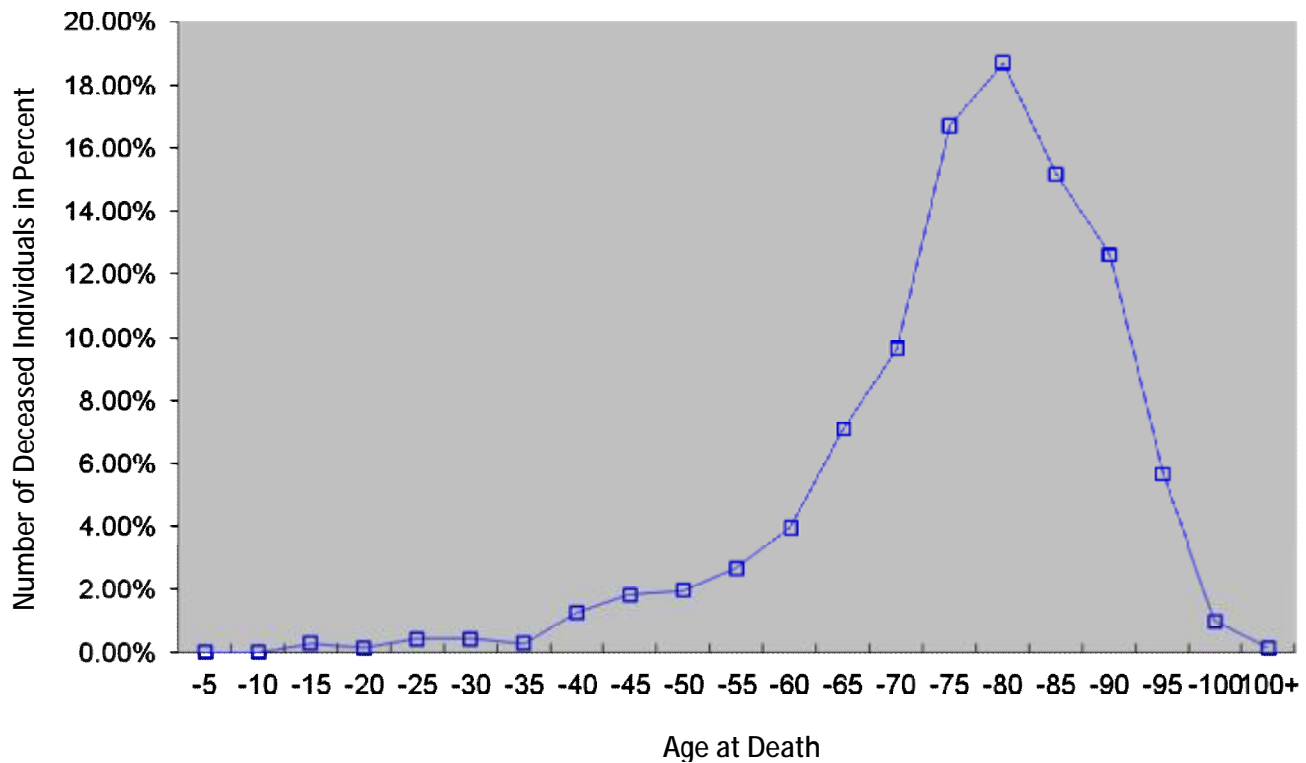
Data were analyzed for the total deceased HSH population and three additional cohorts: HSHC, U of M, and private burials. Analysis was confined to the total HSH deceased population from 1900-1978. Age was documented for 98% ( $n=3579/3652$ ) of the total deceased HSH population. Ninety-eight percent of the total number of HSH males ( $n=2873/2933$ ) were represented, as were 99% of females ( $n=706/719$ ). Results from life table analysis demonstrate that the greatest number of deaths in the HSH deceased population occur in the 70-74.9 age group ( $n=530/3652$ ; 15%), followed by 75-79.9 ( $n=506/3652$ ; 14%), 65-69.9 ( $n=444/3652$ ; 12%), and 80-84.9 ( $n=398/3652$ ; 11%) (see Fig. 6.1).



**Figure 6.1 Hastings State Hospital Mortality Curve**



**Figure 6.2 Hastings State Hospital Mortality Curve for Males**

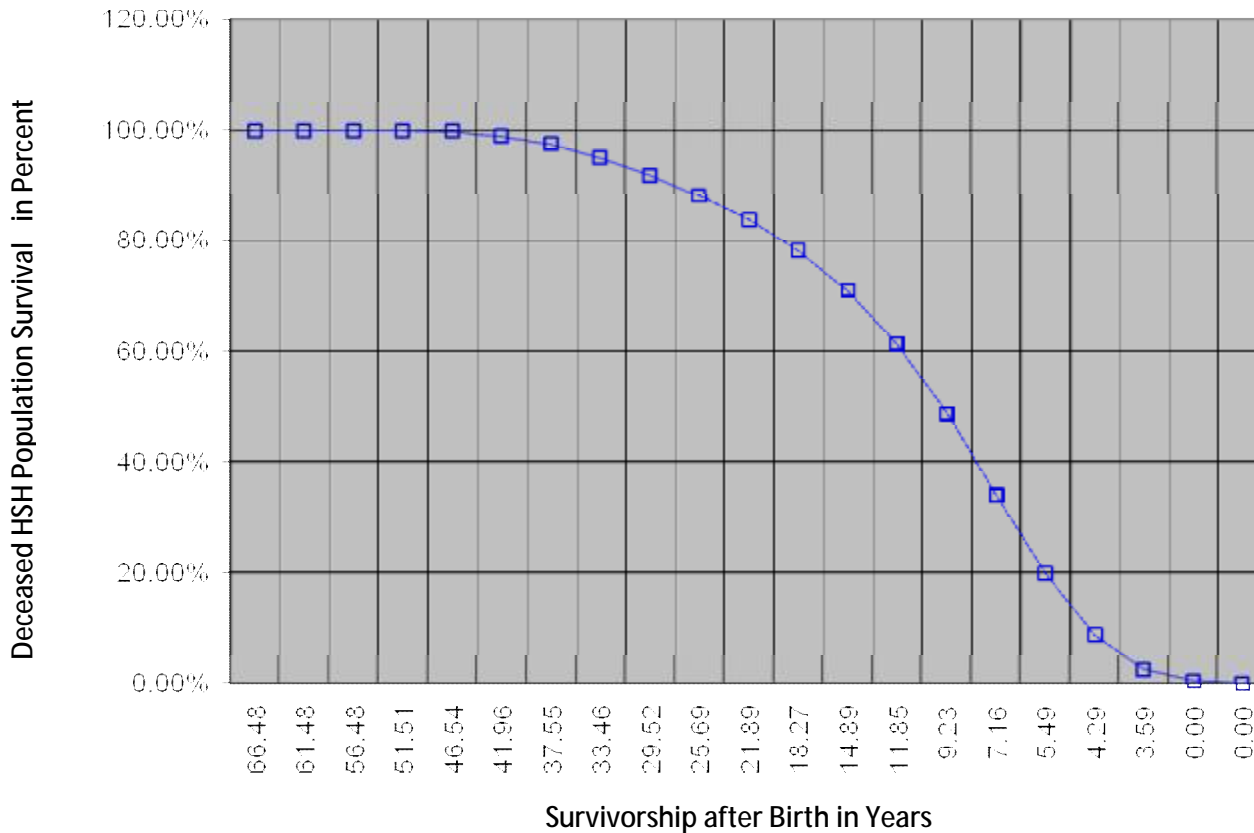


**Figure 6.3** Hastings State Hospital Mortality Curve for Females

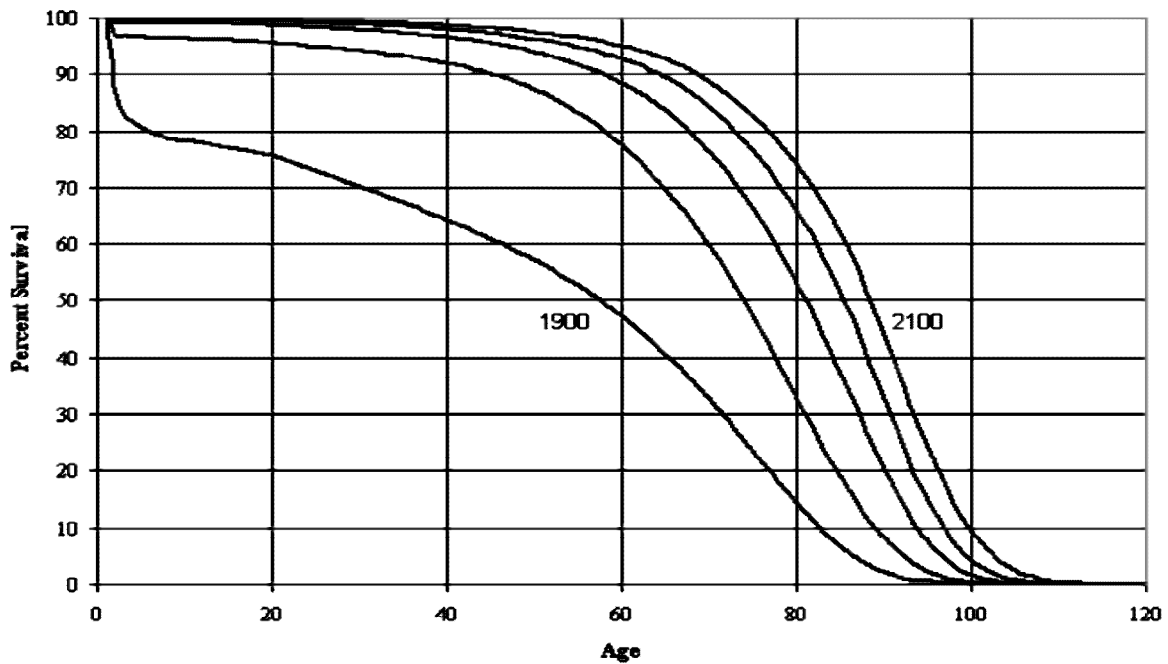
An examination of mortality curves for males and females exhibits a shift in age at death, where more females live to an older age than males (see Figs. 1.2 and 1.3). Women in the 75-79.9 year age category represent the highest percent of females at HSH (n=132; 19%), with the 70-74.9 age category second (n=118; 17%), then 80-84.9 (n=107; 15%), and 85-89.9 (n=89; 13%). The top four categories for males are: 70-74.9 (n=412; 14%), 65-69.9 (n=376; 13%), 75-79.9 (n=374; 13%), and 60-64.9 (n=297; 10%). Life expectancy for females is approximately 10 years longer than for men, which is demonstrated by a range of 70-89.9 years for females in the top four age categories, and 60-79.9 for men.

The survivorship curve for the total deceased HSH population illustrates a Type 1 survivorship curve, which is typical for humans and demonstrates age specific probability where survivorship declines as the population ages (LaFever, 2012; Weon and Je, 2012) (see Fig. 1.4).

According to the Encyclopedia Britannica, “Species such as humans and other large mammals, which have fewer numbers of offspring but invest much time and energy in caring for their young (*K*-selected species), usually have a Type I survivorship curve. This relatively flat curve reflects low juvenile mortality, with most individuals living to old age.” The HSH survivorship curve closely matches the survivorship curves for 1950 by Bell and Miller (2005) for the Social Security Administration, a study that was conducted specifically to examine the mortality of aging populations in America (see Fig. 1.3).

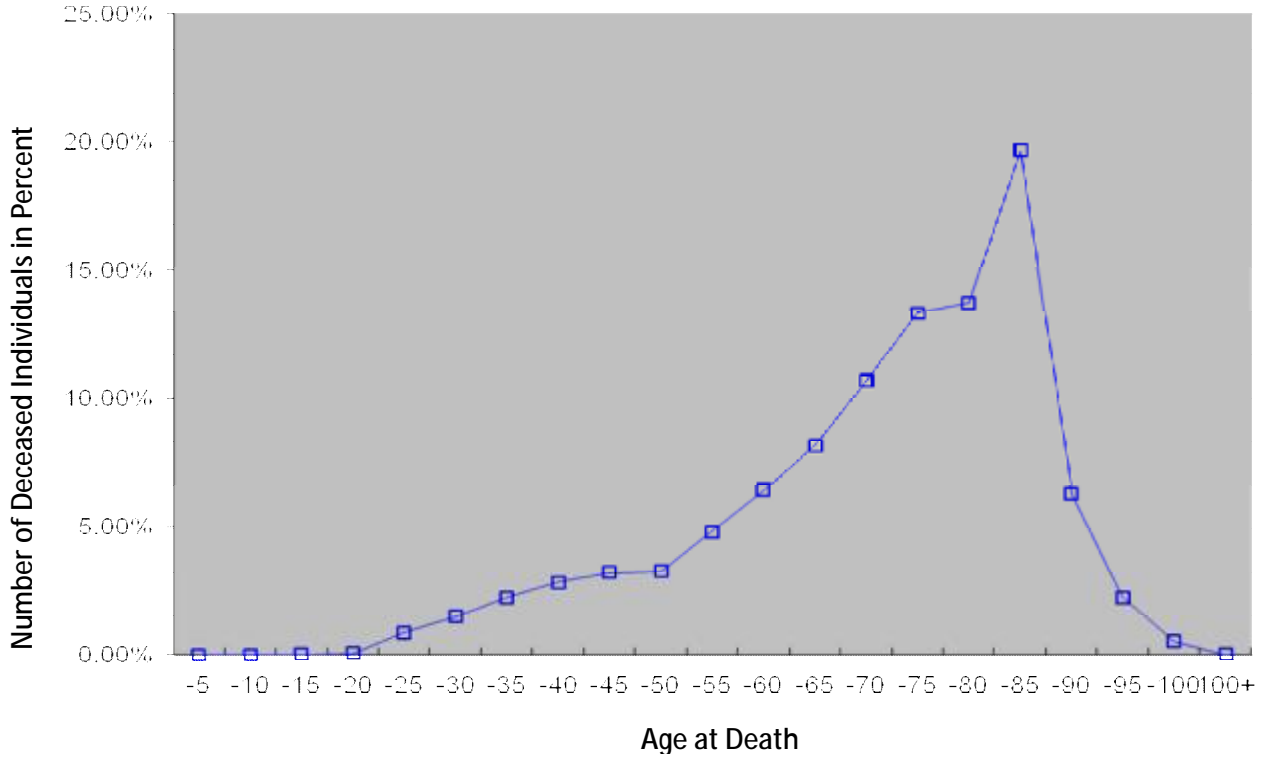


**Figure 6.4** Hastings State Hospital Survivorship Curve

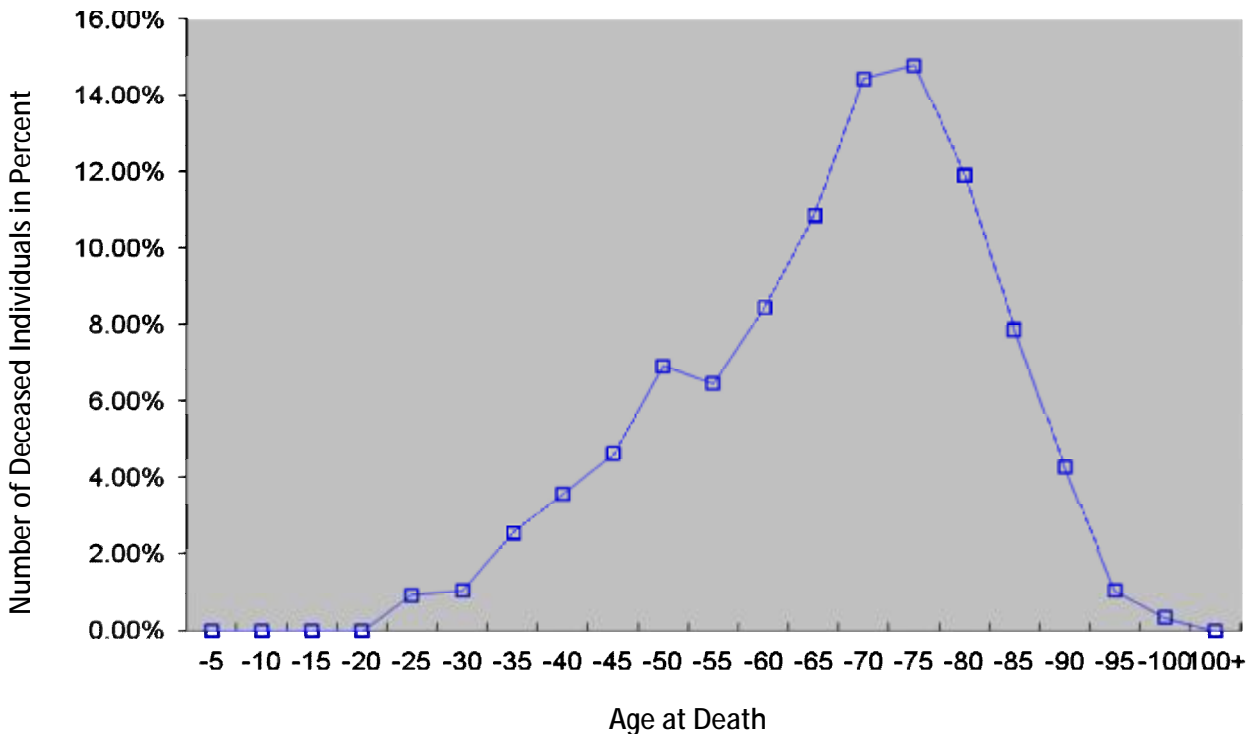


**Figure 6.5 —Survival Function for SSA Population**  
for Selected Calendar Years (1900, 1950, 2000, 2050, 2100)  
(Based on Period Tables). Table taken from Bell and Miller 2005, 16.

Mortality curves for the HSHC, U of M, and private burials look strikingly different, reflecting differential mortality patterns (see Figs. 6.6- 6.8). Individuals in the private burial cohort tended to live longer than patients in the HSHC or U of M cohort, expressed by a smoother rising slope that peaks at ~85 yrs. More private burial patients were in the 80-84.9 year age category than any other (n=541/2751; 20%), compared to U of M at 70-74.9 (n=30/159; 19%) and HSHC at 70-74.9 (n=128/866; 15%). I would expect patients in the private burial category to have greater social capital characterized by stronger friend and family networks, and access to better care and nutrition in the institution. The U of M and HSHC cohorts are similar, which I expected; the cohorts reflect a patient population composed of more working class and indigent patients.

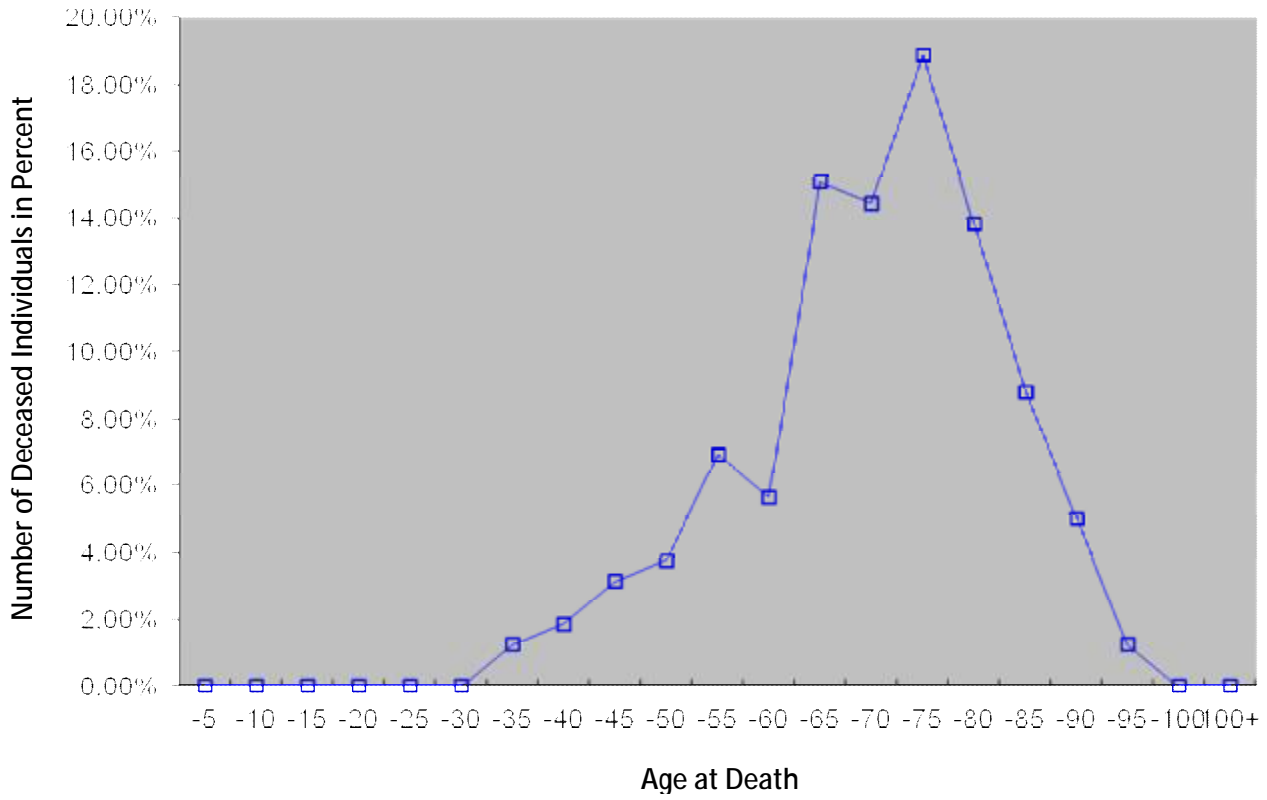


**Figure 6.6 Private Burials Mortality Curve**



**Figure 6.7 HSHC Mortality Curve**





**Figure 6.8 U of M Mortality Curve**

## CH 7: Conclusion

Mental illness is a global public health problem, affecting about 350 million individuals (Yu 2018). According to Madsen et. al. (2017), “People with mental illness have an elevated risk of dying prematurely from both unnatural causes, and their average life span is found to be 15-20 years shorter than that of the general population” (1). The deceased Hastings State Hospital population has provided a rich source of material for the study of status, risk, and power in institutions. The findings presented here contribute to our understanding about the social epidemiology of mental illness and institutionalization in Minnesota. Quantitative methods were used to examine how status, gender, and social capital impact the distribution of patients in each burial category. I focused on how identity and power exacerbate social inequality. Social capital was measured through disposal of the body; higher capital is expressed by private burial, whereas lower capital is associated with burial at the HSHC or transport to the U of M for cadaver studies. Different variables were incorporated to explore the intersectionality of status, risk, and power, such as gender, civil status, immigrant status, occupational status, nationality, and age.

The evidence presented in this research supports the argument that social and economic inequalities are central to understanding the risk of admission, dying in the institution, and treatment of the body after death occurs. Evidence from data analysis suggests that males were more likely to die in the institution than females, even when the time frames were adjusted to reduce gender bias. Civil status results demonstrate that second only to individuals with unknown civil status, single and divorced patients exhibit the lowest social capital, while married

patients exhibit the highest. A gendered perspective suggests that single men make up 52% of low status disposals. When the data analysis was complicated with the addition of immigrant status as a cofactor, it was apparent that foreign born males were at a significant disadvantage.

Income analysis through occupational status demonstrates that working class patients were more likely to experience low status disposal of the body than are the middle/upper class patients. Although I did not conduct an in-depth analysis of race due to incomplete record keeping at HSH, the available data suggest that African Americans are ranked among patients with the lowest social capital. Data analysis that explores the mortality and survivorship of the HSH reveals an aging population, where most patients probably had chronic or terminal conditions. The evidence from this study demonstrates that the following factors characterize patients with the highest risk and lowest social capital: male, foreign born, single, working class, and African American.

This research was multidimensional and incorporated theoretical perspectives from different disciplines, especially anthropology and sociology. The risk factors identified in this study correlate with contemporary research about mental illness, morbidity, and mortality, underscoring the relevance of examining the past to inform the present. Although this thesis addressed specific variables out of necessity, future research could and should include other factors to provide an even more in-depth evaluation. For example, future studies could generate a discussion about diagnosis at entry, cause of death, suicide and escape rates, treatment for disorders, and autopsy. I collected data for all of these topics, but limited my analysis to the variables discussed in this research for a more focused discussion. In addition, by expanding this research to include a sample of the total HSH population, specifically individuals that were discharged, it could provide a more comprehensive understanding about institutionalization in

Minnesota. Comparative studies between the HSH and other institutions could facilitate the development of policies to minimize the social and structural inequalities that contribute to mental illness.

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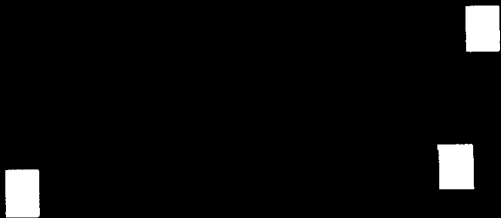
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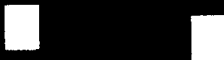
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## Appendix A

# MINNESOTA'S STATE HOSPITALS



- mental retardation
- mental illness
- chemical dependency



# MINNESOTA'S STATE HOSPITALS

## **Presented by:**

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**January 31, 1985**

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FERGUS FALLS

BRAINERD

MOOSE LAKE

CAMBRIDGE

WILLMAR

ANOKA

ST. PETER

FARIBAULT

# **DEFINITIONS**

## ***Deinstitutionalization***

(1) preventing admission of people to public residential facilities by finding and developing alternative community residential facilities; (2) returning to community residential facilities all public residential facility residents/patients who have been prepared through programs of habilitation and training to function in appropriate local settings; and (3) establishing and maintaining responsive residential environments which protect human and civil rights and which contribute to expeditious return of the individual to normal community living whenever possible.

## ***Patients***

people with chemical dependency or people with mental illness receiving services from state hospitals.

## ***Residents***

people with mental retardation living in state hospitals.

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**BACKGROUND OF THIS REPORT**

In 1984, the Minnesota Legislature established an “interagency board to be known as the institutional care and economic impact planning board” and directed the board to conduct a comprehensive study to provide information on topics to include, but not be limited to the following:

1. Projected displacement of state hospital employees because of deinstitutionalization by number, location, and job classification;
2. The extent to which displacement can be mitigated through attrition, retirement, retraining, and transfer;
3. The development of cooperative arrangements between the state and local units of government in the carrying out of these goals;
4. The necessary changes in the biennial budget to effect any fiscal and policy recommendations of the plan;
5. The necessary interagency agreements among and between appropriate departments and agencies as needed to effect recommendations contained in the plan; and
6. The energy efficiency of all state hospital buildings.

The Legislature also directed the interagency board to develop a plan for protecting the general interests of employees and communities affected by the reduction of state hospital population and specifying methods for assuring minimal impact on the economic life of communities affected by the changes.

These actions by the Legislature were based on a recognition that “closure and consolidation of state hospitals have negative economic effects upon public employees and communities.” The Legislature stated, “It is the policy of the state that deinstitutionalization policies shall be carried out in a manner that ensures fair and equitable arrangements to protect the interests of employees and communities affected.”

A series of recent actions preceded this decision and set the context:

- In 1980, the *Welsch vs. Noot Consent Decree* called for the placement of hundreds of mentally retarded residents in community-based facilities.
- In 1982, the Rochester State Hospital was closed as part of an effort to reduce state spending because of an economic recession.

- In December 1983, the Title XIX (Medicaid) home and community based waiver application was prepared which called for further reduction in the mental retardation population of state hospitals.

**HISTORY OF THE STATE HOSPITAL SYSTEM**

The care and treatment of Minnesotans with mental illness, mental retardation and chemical dependency has been an ongoing policy issue. The first institutions were developed as places to put people who were seen as “defective” or “insane.” The intent was to isolate people and protect society from them. There were hopes that such actions would also result in treatment and cure. The number of hospitals and the number of Minnesotans placed in them continued to grow. By 1960, the State of Minnesota operated 11 state hospitals. On any given day, there were approximately 16,000 people who were residents and patients in those hospitals.

The development and evolution of the state hospital system have resulted in a complex organization involving many interest groups. Parallel developments in social policy and court decisions had a major impact on patients and residents and those with a direct interest in the future of the hospitals. The result has been:

- Local communities have become economically dependent on hospital operations.
- Employees of state hospitals organized to improve their working conditions and protect job security.
- Taxpayers expressed growing concern with government spending as costs of long term care increased rapidly.
- Statutes and court decisions called for patients and residents to be supported in the least restrictive environment.
- The community system of services has not been completely developed.

The current state of affairs—a large but much reduced state hospital system and the interaction of differing and sometimes competing interests—has resulted from 120 years of changes in philosophy, treatment approaches, and public policy.

**1900** State Asylums for the Insane opened at Anoka and Hastings.

**1861** Institute for the Education of the Deaf and Dumb established in Faribault.

**1907** State Tuberculosis Sanatorium opened at Walker.

Minnesota State Institution for the Education of the Deaf & Dumb, and the Blind, Faribault ca 1870



Minnesota Historical Society

**1863** School for the Deaf established in Faribault.

**1911** The Asylum for the Dangerously Insane opened on the St. Peter State Hospital Campus (50 patients). Later, the name was changed to Minnesota Security Hospital.

"First Minnesota Insane Hospital," St. Peter ca 1868

**1864** School program established in Faribault as the Institute for the Deaf, Dumb and Blind; 1902—name changed to Minnesota School for the Blind; 1940—Name changed to Braille and Sight Saving School.



Minnesota Historical Society

**1866** Minnesota Hospital for the Insane established at St. Peter. Opened in December, 1867 for 50 mentally ill patients. State training school called House of Refuge established in St. Paul for boys and girls.

**1879** Hospital for the Insane opened at Rochester (68 mentally ill patients transferred from St. Peter).

**1911** Gillette State Hospital for Crippled Children opened in St. Paul.

**1912** Willmar Hospital Farm for Inebriates opened.

**1881** Legislature directed that the School for Idiots and Imbeciles be connected with the Institute for Deaf, Dumb and Blind. In 1887, the school was made a department of the Minnesota Institute for Defectives (largest state

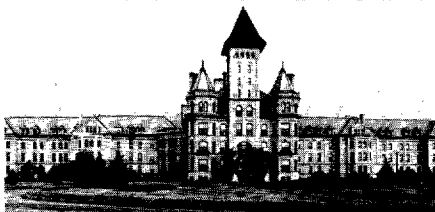
**1917** Mentally ill patients admitted to Willmar State Hospital.

institution). Present name is Faribault State Hospital.

**1925** Cambridge School and Hospital for Mentally Deficient and Epileptics opened.

**1885** State School for Dependent Children established at Owatonna.

Fergus Falls State Hospital ca 1913



St. Paul Dispatch-Pioneer Press

**1890** Fergus Falls Hospital for the Insane opened. (Eighty patients transferred from St. Peter.)

**1938** Moose Lake State Hospital for the Insane opened.

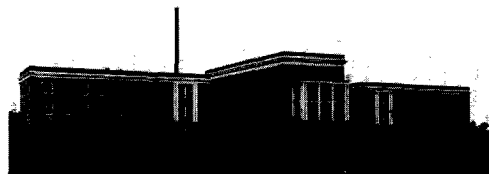
**1950** Sandstone State Hospital for the Insane established. (It was converted into a federal prison 1959.)

**1971** Rochester State Hospital designated as the surgical center for the Department of Public Welfare, and the only other remaining surgery unit in the state hospital system at Anoka closed.

**1955** Lake Owasso Annex (to Cambridge State Hospital) established for mentally retarded children.

**1972** Minnesota Residential Treatment Center for children at Anoka State Hospital closed.

Minnesota Colony for Epileptics, Cambridge ca 1925



Minnesota Historical Society

**1973** Responsibility for Gillette Children's Hospital removed from the State Department of Public Welfare and transferred to the Gillette Hospital Authority.

**1958** Brainerd School and Hospital for mentally retarded people opened.

Right to treatment in state hospitals established by state law.

**1961** State geriatric facilities opened at Ah-Gwah-Ching and Oak Terrace, former tuberculosis facilities.

Mental retardation program opened at Willmar State Hospital.

**1963** State residential treatment center for emotionally disturbed children opened at Lino Lakes.

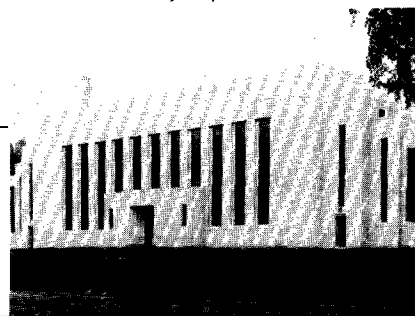
**1975** Sex offender treatment program established at Minnesota Security Hospital.

St. Peter State Security Hospital ca 1940

**1968** Unit for mentally retarded people established at St. Peter State Hospital.

**1969** Mentally retarded residents from Faribault State Hospital transferred to a newly established unit at Rochester State Hospital.  
Mental retardation unit opened at Moose Lake State Hospital.

**1976** Lake Owasso Children's Home transferred from Cambridge State Hospital to Ramsey County.  
Glen Lake Sanatorium no longer provided services for tuberculosis.



Minnesota Historical Society

**1970** Unit for chemically dependent people established at St. Peter State Hospital. Owatonna State School closed. Students not returned to the community were transferred to Brainerd State Hospital.

**1977** The Minnesota School for the Deaf and the Braille and Sight Saving School, on the Faribault State Hospital campus, transferred to the Department of Education.

Minnesota Learning Center established at Brainerd State Hospital.  
Minnesota Residential Treatment Center for emotionally disturbed children was transferred to Anoka State Hospital from Lino Lakes.

**1978** Hastings State Hospital closed.  
Legislature approved the construction of a new 165-bed security hospital on the St. Peter campus.

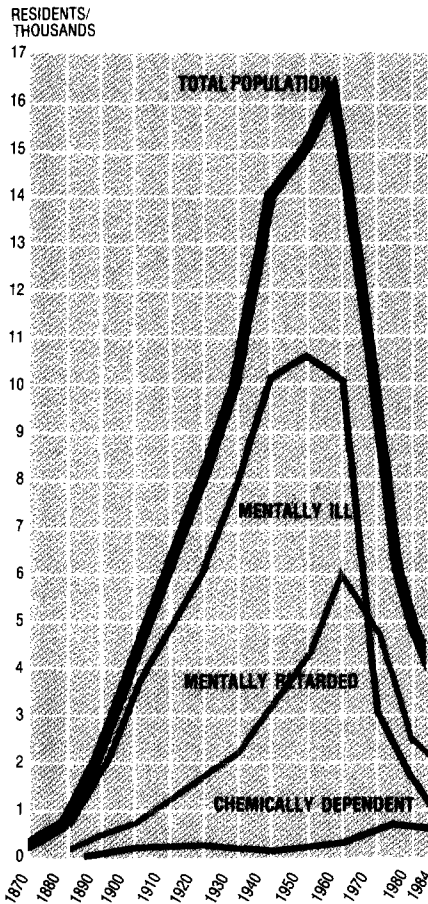
**1971** Establishment of programs for mentally ill and chemically dependent people at Brainerd State Hospital. Tuberculosis unit at Anoka closed.

**1982** Rochester State Hospital closed.



**FIGURE 1**

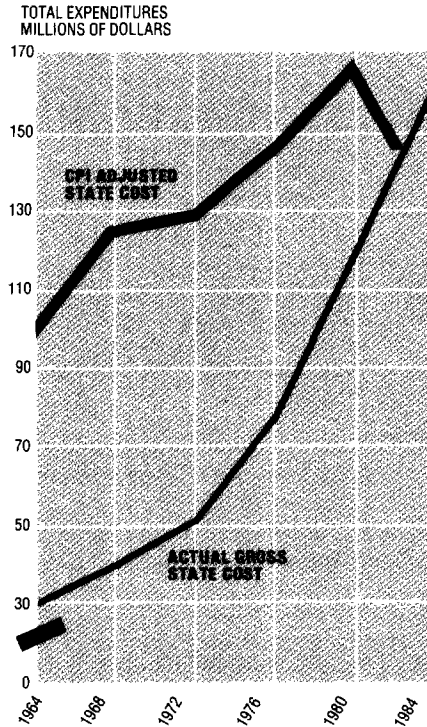
Changes in Mentally Ill, Mentally Retarded and Chemically Dependent State Hospital Populations, 1870-1984



SOURCE: Department of Human Services "Resident Population of State Institutions at End of Fiscal Years"

**FIGURE 2**

Gross State Cost for Minnesota State Hospitals 1965 through 1984 in Actual and CPI Adjusted Dollars (October 1983)



SOURCE: Department of Human Services

The Minnesota state hospital system can be put in historical perspective by summaries of 1) facility, organization and service development; 2) number of people served and 3) gross state cost of the state hospital system.

State institutions have had a dynamic history. Facilities have opened, closed, and reorganized. The types of programs offered as well as the geographic area served by each state hospital have also changed. Increasingly, hospitals have become multipurpose facilities, serving persons with acute and/or chronic mental illness, mental retardation, and chemical dependency. Minnesota currently operates eight state hospitals located in Anoka, Brainerd, Cambridge, Faribault, Fergus Falls, Moose Lake, St. Peter and Willmar.

The number of people with mental illness and mental retardation served by state hospitals grew rapidly and continuously until about 1960. (Figure 1) Recent patient/resident population trends indicate that:

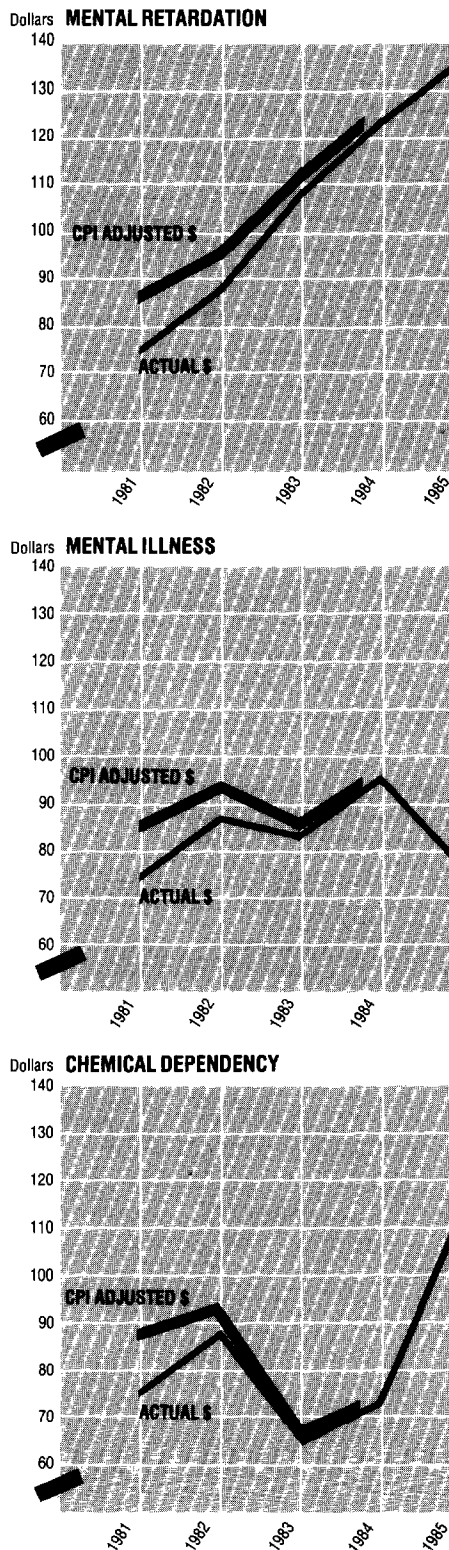
- Total state hospital population has dropped from 16,355 in 1960 to 4,006 in 1984, a decline of 75 percent.
- Patients with mental illness dropped from 10,093 in 1960 to 1,230 in 1984, a decline of 88 percent. Development of new drugs since 1950 has enabled many mentally ill people to return to their communities. In addition, greater attention has been paid to patients' rights and services in the community have developed.
- Residents with mental retardation dropped from 6,008 in 1960 to 2,182 in 1984, a decline of 64 percent. Reduction in the number of residents with mental retardation was required by the Welsch vs. Levine Consent Decree and facilitated by the availability of community-based facilities. Full implementation of the Consent Decree would further reduce the number of residents with mental retardation to 1,850 by 1987.
- The average daily population of patients with chemical dependency rose from 254 in 1960 to 594 in 1984, an increase of 134 percent. The average daily population with chemical dependency reached a peak in 1980 with 637 people. The increase in this group of patients is associated with heightened social and legal concern for alcohol and drug abuse and dependency.

Gross state cost combines all financial resources used by the state hospital system including operating expenditure, indirect expense, bond interest and depreciation. Offsetting cash receipts are not deducted from the gross cost. Annual gross state costs of the state hospital system are depicted for Fiscal Years 1965 through 1984 in Figure 2. Comparisons of actual gross costs from year to year are not valid because of the effects of inflation. The "constant" dollar trend line in Figure 2 shows actual gross costs adjusted to October 1983 values using the Consumer Price Index. Actual gross state costs increased from \$29,492,000 in Fiscal Year 1965 to \$159,045,000 in Fiscal Year 1984; with an average annual increase of 9.4 percent. With inflation taken into account, the state gross cost of the state hospital system grew at an average annual rate of 2.8 percent and increased about one and a half times during the period 1965 through 1984.

As population changes, unit costs become a second important measure in analyzing cost trends. Per diem rates are widely used cost measures in state hospital operations. They are calculated by dividing total program cost by the estimated daily population served multiplied by the number of days in the year. Separate per diem rates are currently calculated for service to persons with mental illness, mental retardation and chemical dependency to account for differences in care and treatment and to take advantage of federal reimbursement. Per diem rates for Fiscal Year 1984 were mental illness \$95.80, mental retardation \$123.25 and chemical dependency \$72.80. Actual per diem and adjusted per diem rates using the Consumer Price Index for Fiscal Years 1980-1984 are also presented in Figure 3. Per diem rates for Fiscal Year 1985 are mental illness \$108.60, mental retardation \$135.85 and chemical dependency \$77.05.

**FIGURE 3**

*Minnesota State Hospital Per Diem Costs 1981 through 1985 in Actual and CPI Adjusted Dollars (October 1983)*



SOURCE: Department of Human Services

# Minnesota's State Hospital System Today

## PATIENTS AND RESIDENTS IN STATE HOSPITALS

Minnesota's state hospitals exist to serve people with mental illness, mental retardation, and chemical dependency. While there are many factors which will influence the future of state hospitals, a very important factor must be the individuals for whom they exist. The issue to be addressed is—what is the general nature of the state hospital population which must be taken into account in planning for the future of the hospitals?

There are many ways of counting the number of people served by state hospitals, including the following:

1. a "census" gives the number of people who are patients or residents in the hospital on a particular day.
2. the "total patients/residents" count includes all people served during a year or other period of time.
3. the "average daily population" takes into account changes in population over a year, and provides a measure of operational size for comparison purposes.

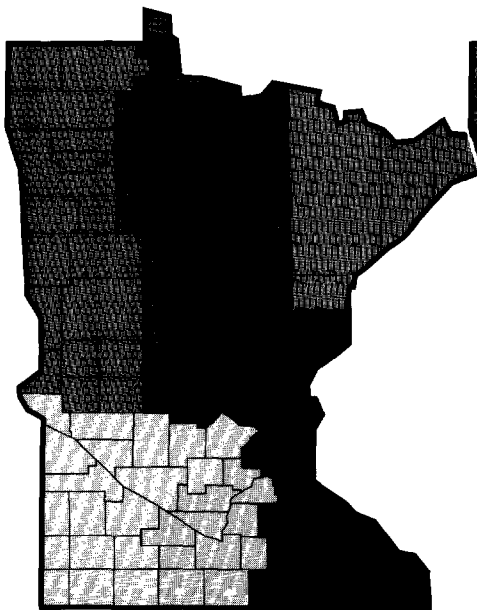
The average daily population of all state hospitals during Fiscal Year 1984 was made up of 1,230 mentally ill (30.7 percent), 2,182 mentally retarded (54.5 percent) and 594 chemically dependent (14.8 percent) people.

Table 1 (see Appendix) indicates the number and percent of persons with mental illness, mental retardation and chemical dependency in each state hospital and the entire system during Fiscal Year 1984.

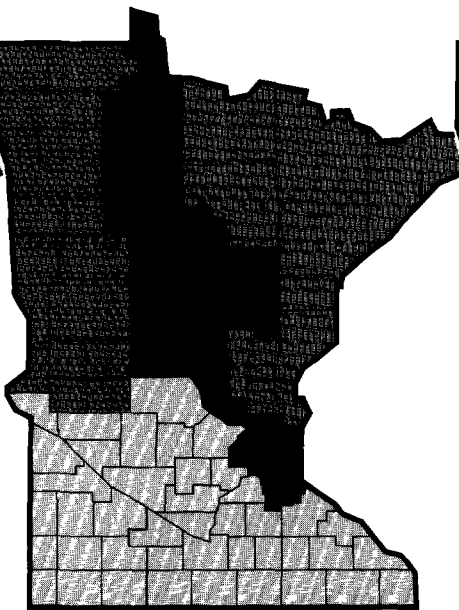
### State Hospital Service Areas

All eight state hospitals do not provide the same services. Cambridge and Faribault State Hospitals serve only persons with mental retardation; Anoka serves only persons with mental illness and/or chemical dependency. The catchment areas differ for each condition by state hospital and are designated groups of counties. Figure 5 indicates the mental illness catchment areas. The mental retardation catchment areas are presented in Figure 4 and catchment areas for people with chemical dependency in Figure 6.

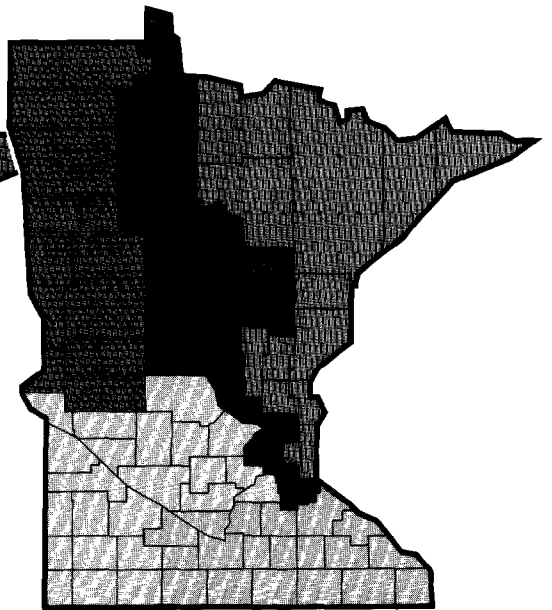
**FIGURE 4**  
State Hospital Receiving Districts  
Mentally Retarded



**FIGURE 5**  
State Hospital Receiving Districts  
Mentally Ill



**FIGURE 6**  
State Hospital Receiving Districts  
Chemically Dependent



KEY:	Anoka	Fergus Falls
	Brainerd	Moose Lake
	Cambridge	St. Peter
	Faribault	Willmar

## **Characteristics of Patients and Residents**

People with mental illness, mental retardation and chemical dependency are unique as individuals—each person has a unique set of strengths and needs, some of which are affected by the disability with which the person lives. As groups of people with specific disabilities, they require different kinds of services, treatment and/or care. Planning for the future of state hospitals and the individuals they serve requires an understanding of the special characteristics and needs of the patients and residents.

### **Patients with Mental Illness**

Available information about persons with mental illness in state hospitals as of September 1984 was limited to patients classified in terms of five “levels” based on the severity of illness. (Table 2, Appendix)

- Level I patients comprise 9 percent of all patients with mental illness in state hospitals. “Level I” refers to the most severe mental illness. Symptoms include high risk of suicide, assaultive/threatening behavior toward others, and psychotic behaviors such as seeing or hearing things others do not. Persons classified in Level I are confused and disoriented, can be dangerous in the community, and may have a history of chemical dependency or abuse. In September 1984, 91 individuals were classified as Level I. At that time, all state hospitals with mental illness programs served some Level I patients. The largest number in any specific hospital was 38 at Anoka.
- Level II patients made up 27 percent of the state hospital population with mental illness. Persons classified as Level II have serious mental illness, but their behaviors are somewhat less severe. Symptomatic behaviors in this classification include disruption, requires protection from exploitation by others, suicidal tendencies, physical problems, chemical dependency and abuse, and psychotic episodes. In September 1984, 256 patients of state hospitals were classified as Level II. Anoka State Hospital served the highest number (80) of any single hospital.
- Level III patients accounted for 39 percent of the total state hospital population with mental illness. Symptomatic behaviors for Level III classification include deficient self-care skills, social isolation, lack of initiative for activities, difficulty in self control, needs monitoring for medical problems, and episodic substance abuse. In September 1984, 386 individuals were classified Level III in the state hospitals. The largest number in a single hospital was 143 in Willmar State Hospital.
- Level IV patients comprised 13 percent of the total. Behaviors indicating Level IV include limited ability to engage in the following—participate in groups, assume much self care, participate in work programs and use leisure time reasonably well. These individuals need a period of stabilization prior to discharge. In September 1984, 124 individuals were classified as Level IV, with the largest single hospital population being 33 at Willmar State Hospital.
- Level V is the lowest classification which requires hospitalization. It involves the least severe behaviors, such as confusion, disorientation, inability for self-care or daily living activities, may be assaultive, memory loss, and vulnerable to exploitation. In September 1984, 122 individuals were included in this classification within the state hospitals. The largest number in a single hospital was 42 at Moose Lake State Hospital.

### Residents with Mental Retardation

State hospital residents with mental retardation have disabilities of varying severity. Many have multiple handicaps. In 1982, each resident was evaluated in terms of thirteen skill or trait areas listed in Table 3 (see Appendix). Programs are offered to residents based on their level of functioning in each area.

The numbers of residents rated at the various levels of functioning for each skill/trait area are reported in Table 3. The extreme levels ("highest" and "lowest") are reported and ratings between the extremes are combined as "other." These ratings indicate evaluations of current skill levels, not potential levels. In terms of these skill/trait areas, the 2,495 state hospital residents with mental retardation can be described in the following ways:

- **Orientation:** 27 percent are fully oriented to the world around them, while 23 percent are totally disoriented.
- **Self Preservation:** 43 percent were evaluated as mentally and/or physically unable to self preserve, while only 5 percent were judged to be independently able to self preserve.
- **Speech:** 31 percent are currently unable to speak, but 18 percent have normal speech.
- **Toileting:** 39 percent are independent in terms of toileting, while 22 percent are incontinent (bowel and bladder).
- **Behavior:** while 17 percent are evaluated as having no behavior problems, 43 percent have severe behavior problems.
- **Vision:** 61 percent have normal vision. About 7 percent are blind.
- **Hearing:** 84 percent have normal hearing. About 3 percent are deaf.
- **Walking:** 70 percent walk independently, while about 21 percent are currently unable to walk.
- **Bathing:** 45 percent require others to bathe them completely, but 8.5 percent bathe independently.
- **Bed Mobility:** About 12 percent must be turned and positioned in their beds, while 80 percent are independent in this area.
- **Eating:** 32 percent eat independently, while 13 percent are fed completely by others.
- **Grooming:** 46 percent currently require assistance in all areas of grooming, while 10 percent groom themselves.
- **Dressing:** 32 percent require complete assistance, but just over 16 percent can dress independently.

More up to date information about mentally retarded residents was recently collected and is being analyzed. Detailed reports will be issued in 1985.

### Patients with Chemical Dependency

The amount of time individuals with chemical dependency spend in state hospitals is relatively short compared to persons with mental illness or mental retardation. While the average daily population of state hospital patients with chemical dependency was 594 during Fiscal Year 1984, a total of 5,327 such individuals were treated during the year.

General characteristics of patients with chemical dependency include the following: (See Table 4, Appendix)

- Most (54.8 percent) were diagnosed as being dependent on alcohol. Alcohol abuse involved 14.6 percent, while alcohol and drug dependency (13.6 percent), and alcohol and drug abuse (8.9 percent) accounted for fewer patients.
- The vast majority are males (85 percent).
- The vast majority are Caucasian (87 percent).
- Most are young adults 30 years of age or younger (55 percent), while 40 percent are between 31 and 60 years of age.
- Most (48 percent) have never been married and another 34 percent were divorced, separated or widowed.
- The vast majority (87 percent) have a high school education or less.
- The overwhelming majority (95 percent) were "informally" admitted but there was some court involvement prior to admission.
- Many (49 percent) had been arrested or convicted within the previous 6 months.
- 42 percent of 4,713 individuals left the program without completing it.
- Most are indigent based on the fact that 77.7 percent paid no or reduced fees (the state assumed the cost) and 8.8 percent had their fees covered by the counties.

## **COMMUNITY OPINIONS**

A significant part of the study of the state hospital system was the development of a public process which provided Minnesotans with an opportunity to express ideas and concerns regarding the future of state hospitals and the delivery of services to persons with mental illness, mental retardation and chemical dependency. This public process involved three major elements:

- the convening of 9 town meetings, one in each area of the state served by a state hospital, and one in the Metro area;
- soliciting letters from the public and interested parties who would express their views; and
- receiving calls during a "toll-free call-in day."

In total, over 5,000 people attended and registered at the nine town meetings.

Over 80 separate organizations were represented and 362 individuals made presentations.

On October 16, 1984, 202 people called the toll-free number and made their views known. As of November 15, 1984, 178 letters and resolutions were received regarding state hospitals. After November 16, 1984, another 252 letters were received stating positive views about community services.

Transcripts of the town meetings, call-in messages and all letters were reviewed to identify information, concerns and points of view on specific issues. A speaker's presentation or a letter might contain more than one statement on issues. A total of 1,201 statements were identified in the views and sorted into 8 general categories. Table 5 (see Appendix) summarizes the type of statements made during the public process.

The contents of statements are summarized in the following themes or "messages."



*Brainerd Daily Dispatch*

### ***Concerns About Patients and Residents***

- The special needs of residents and patients should be the primary concern in planning the future of state hospitals.
- Persons most “difficult to place” because of severe behavioral, physical, medical, communication or multiple handicap problems are served by state hospitals.
- Persons who cannot afford private hospital and psychiatric care are served by state hospitals.
- Residents and patients need quality care and a base of support—state hospitals are the only home they have, they should not be made “homeless” nor “shuffled about.”
- The improvement of residents and patients has been documented. Individuals described the progress they have made. Some families prefer state hospital placement.
- The fact that state hospitals are geographically dispersed makes it easier for families to visit. Closure is viewed as forcing families to travel longer distances.
- During the call-in day, several callers cited incidents and criticized both state hospitals and community services because of inadequate or inappropriate treatment.
- Family members requested greater involvement and respect from staff.

### ***Views on Community Programs***

- Individuals have moved out of institutions and into the community. They have improved.
- Community programs (community mental health centers, case management and community support programs) need more financial support.
- Community placement will occur, but it must be orderly.
- Community-based services are client-centered and provide integration.
- Residents have a right to live in the community. The state hospital is not the least restrictive environment.
- The state should phase out of operating any program. The state should use a “request for proposal” approach. The state cannot provide services and at the same time monitor itself.
- We need a state policy on deinstitutionalization.
- Do not stop community-based facility development because of employees and economic impact issues.
- Community services are not available in all parts of the state. There is a specific lack of resources for people with mental illness.
- Some community services experience high staff turnover. Staff aren’t well trained. Community services are underfunded. Community programs do not provide a full range of therapy and health care services. Class action suits may be necessary to address inappropriate placements in the community.
- Community-based facilities do not accept all types of people.
- Community programs do not provide the same level of care as state hospitals.
- There is abuse in the community programs and overmedication in some.
- Community facilities are not prepared for the clients who are ready to leave state hospitals.
- County case management is understaffed.
- Some state hospital programs are smaller than larger group homes.



### ***Quality of State Hospital Staff and Care***

- State hospital staff and the care provided were described as caring, helpful, dedicated, the best, concerned, enthusiastic, skilled, loving, superior care, excellent care, warm, professional, and nationally recognized.
- Staff care about residents and patients, and provide a surrogate family relationship 24 hours per day.
- Staff are concerned about quality of care, continuity of care, standards, and a multi-disciplinary approach.
- State hospital staff salaries are justified because the residents/patients are the most difficult to serve. The salary levels in the community are low by comparison.
- Staff turnover rates are lower in state hospitals compared to community services.
- Staffing levels need to be increased in the mental illness units.

### ***Suggestions for Improvement***

- Change the policy and practice of community providers to a “zero-reject” approach to reduce the “revolving door” syndrome.
- Open the four buildings at Anoka State Hospital to handle demand of people with mental illness on the waiting list.
- Add more services to the state hospital such as halfway houses. Improve and expand state hospitals, do not close or reduce.
- Improve the security at state hospitals; improve the therapy and programs provided.
- Change the Commitment Act to let more people be admitted.
- Improve public education and attitudes about people with mental illness, chemical dependency and mental retardation.
- Resolve the conflict between state hospitals and the community. The Legislature needs to give direction and support. Counties have limited funds.
- More volunteers and visitors are needed.
- Use state hospitals as correctional facilities, veterans’ homes, elderly programs, and for dual diagnosis clients.
- Change state laws and make staff pensions portable (to other agencies).

- Any closure should be phased in over two to three years, not abrupt like Rochester.
- Create more outreach from state hospitals to provide services in the community, including training and therapy services.
- After-care needs to be improved.
- More emphasis must be placed on quality of care, dignity of residents and patients, monitoring of medications, consolidation of rules, and more surprise visits. State hospitals and community services must be improved.
- The state must operate with one set of rules. Currently state hospitals and community programs operate with two sets of rules. State operated services are not a good idea. Keep three state hospitals open—one each in North, Central and South.
- Develop pilot projects to try the Rhode Island approach of the State operating community services.
- Begin chemical dependency services for elderly persons who live alone.
- Begin a “Courage Center” operation at one of the state hospitals.
- Do not build any new state buildings until use of existing state hospital buildings has been considered.
- Move Faribault State Hospital residents who are deaf/blind to the State School.
- Open mental illness units at Faribault and Cambridge State Hospitals.
- More monitoring is needed to avoid patients bringing chemicals onto state hospital grounds.
- Cleanliness of buildings needs improvement.

### **Community Economic Impact on Hospital Closure**

- The effect will be an economic chain reaction characterized by direct loss of hospital jobs, indirect loss of jobs because of slowed industrial growth, lowered gross community income, reduced retail sales, closed stores, fewer families, underutilized schools, increased taxes, higher utility costs, depressed housing market and rising unemployment.
- Several attempts to estimate the magnitude of the economic impact were presented.
- The economic impact of any future closing would be greater than that experienced by Hastings and Rochester hospitals because most of the remaining state hospitals are located in smaller, primarily rural communities.
- Decisions about two shopping mall developments have been delayed because of the uncertainty about the continued operations of state hospitals.
- Family members who come to visit individuals represent another source of retail trade.
- Volunteer time and donations should be included in calculations of economic impact.
- The economic gains from preventing deaths because of chemical dependency treatment cannot be calculated.
- Preference for economic development grants should be given to communities in case of closure.
- Public school districts working cooperatively with state hospitals said that closure would affect state aid, number of teachers and the tax base.

### **Interagency Relations**

- Judges supported the continued operation of state hospitals because of the time involved in commitment proceedings. Judges believe closures would increase the time and costs involved.
- County sheriffs supported evaluation and treatment services provided by state hospitals. Sheriffs believe that closure would mean longer trips and extra costs for such services.

- Several county social services directors and county commissioners supported the state hospital system because it provides a necessary service.
- Local nursing homes cannot accommodate state hospital patients in the event of closure.
- Clergy described working relationships with state hospitals in terms of family issues—violence, incest and alcoholism.

### **Unique Programs Offered by State Hospitals**

- The Brainerd State Hospital chemical dependency program for Native Americans serves four northern Minnesota reservations and has a higher success rate compared to traditional programs.
- The Security Hospital at St. Peter was described as a newly constructed facility that provides service state-wide.
- The Minnesota Learning Center at Brainerd State Hospital is nationally recognized.
- The Adolescent Unit at Willmar State Hospital was praised as a unique program.
- Fergus Falls State Hospital has several unique chemical dependency programs—women to women counseling, adolescent care and the 2x4 program.
- The nurses at every state hospital were described as having extensive experience in providing quality care.
- Specially controlled settings are required to serve dual diagnosis clients and those who are extremely difficult.
- Camp Confidence was described as a unique service which serves both the state hospital and community programs.
- Foster grandparents described the personal relationships they have developed with residents.

### **Other**

- Closure means “banning people,” “economic catastrophe,” “human catastrophe,” “terrorizing patients,” and “uprooting people.”
- Several groups are held hostage by the indecision over state hospitals—residents and patients, staff, and communities.



Brainerd Daily Dispatch

- The League of Women Voters studied Anoka State Hospital in 1981 and concluded that the hospital was a benefit to the community.
- Frequent studies of state hospitals lower the morale of staff. Demoralization is at an all-time high.
- There is no justification for closure. Why are we assuming deinstitutionalization is a good thing?
- The Commitment Act needs revision according to relatives and judges.
- State hospitals are better and cheaper.
- The state will always assume responsibility for some residents and patients. The state has a moral responsibility.
- The communities extended a welcome to state hospitals when they were originally built and now the state wants to pull back on its commitment.
- Other town meetings should be scheduled to hear community concerns.
- Change is inevitable and so is closure.
- The adverse effects of the Rochester State Hospital closure included stress on families, divorce, unemployment, patients on the streets, three patient suicides, and higher use of hospital emergency rooms.
- Stop making the state hospitals the scapegoat.
- Closure does not save money.
- The advocacy system abuses parents' wishes.
- There are too many adversarial relationships among the state, counties, providers and state hospitals.

In translating all of these comments and opinions into state level policy-making the following limitations of the testimonial data should be kept in mind:

1. All town meetings were held at or near state hospitals and therefore might be expected to attract individuals and receive statements which support continued operation of state hospitals with a minimum of change.

2. There was no requirement that individuals making statements identify themselves. Based on information about people who did identify themselves, the largest group making statements tended to represent local government and community agencies: city and county officials, service providers, sheriffs, judges, clergy and school officials (27.6 percent). The second largest group of people making statements was state hospital employees (23.5 percent) followed by family and relatives (11.6 percent). Representation of business and groups was 11.1 percent, patients and residents 8.8 percent and advocates 2.5 percent.
3. Statements were not necessarily specific in terms of which group of people (mental illness, mental retardation, or chemical dependency) was of concern to the speaker. Statements about the needs of people in the hospital system, therefore, are not treated separately.

Based on the statements made during the public process, there is widespread support for the state hospitals, their role and function, and their impact on the communities in which they are located.

There are decidedly different views on the quality of care, treatment, and support provided to residents or patients in both the state hospitals and the community. There is no support for "dumping" people into the community without support.

The opinions expressed in the public process underscore the fact that whatever options are implemented in the future they must provide the following:

- support for people who are the "most difficult to place"
- affordable and accessible services
- services that respond to the special needs of each individual
- quality care and continuity
- good access to families and the opportunity for families to be involved
- a range of services in each area
- coordination, followup and monitoring
- staff who are competent and caring from several disciplines.

There is little doubt that any change in the state hospital system will have direct consequences on communities.

## STATE HOSPITAL EMPLOYEES

State hospitals are a labor intensive industry. Over 5,900 people are employed in the state hospitals. Some have devoted a significant part of their working lives to service in state hospitals. Many are dedicated to the work they do and the lives of the individuals to whom they provide service.

For planning purposes in terms of protecting the interests of employees and determining ways of mitigating the impact of displacement during change, two issues are of paramount interest:

1. The characteristics of the workforce—numbers, retirement eligibility, length of service, separations, and profession insofar as it relates to the likelihood of obtaining employment elsewhere. This information was assembled from the files of the Department of Employee Relations, as authorized by statute; and
2. Career preferences and contingency plans of the workforce. An on-site questionnaire was completed by state hospital employees on a voluntary basis. During July and August 1984, 66 percent of the employees completed the questionnaire.

### Workforce Characteristics

Following are the general characteristics of the state hospital workforce. (See Table 6, Appendix)

■ **Representation:** State hospital employees are assigned to 12 of the state's 16 bargaining units created by the Public Employment Labor Relations Act of 1971. The numbers in parentheses after job classifications in column 1 indicate bargaining unit. The employees are represented by six unions or employee associations—the American Federation of State, County, Municipal Employees; Middle Management Association; Minnesota Association of Professional Employees; Association of Institutional Dentists; Minnesota Nurses Association; and State Residential Schools, Education Association.

■ **Job Classification:** The distribution of employees by job classification is indicated in Figure 7.

■ **Sex:** State-wide, 63 percent (3,735) of the state hospital employees are female.

■ **Age:** One-half (50.1 percent or 2,908) of the employees are under the age of 35. Just over 40 percent (42.9 percent or 2,489) are between 36 and 59 years of age, while 7 percent (411 individuals) are over 60 years of age.

■ **Retirement:** About 6 percent (369 employees) were eligible for immediate retirement under the Rule of 85 at the time of data collection. An additional 12.5 percent (742) will be eligible for retirement within the next 5 years.

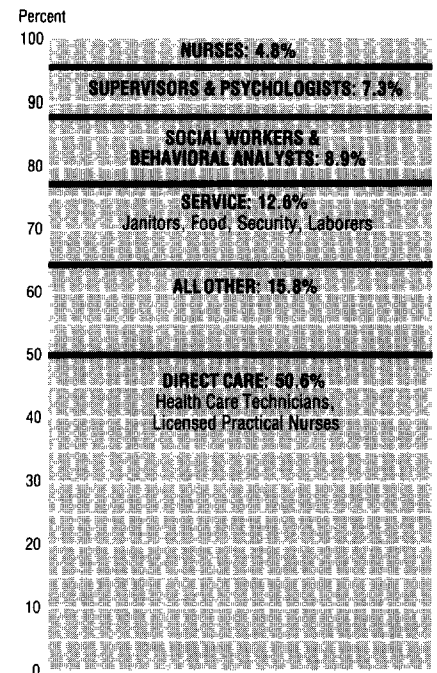
■ **Separation:** 820 employees separated from the state hospital during fiscal year 1984.

■ **Staff-to-resident Ratios:** The state-wide ratio is 1.48 employees for every patient or resident. This is based on 1984 average daily population information. For detailed planning purposes, this ratio must be analyzed further by job classification, hospital sub-population, and severity of condition of residents/patients.

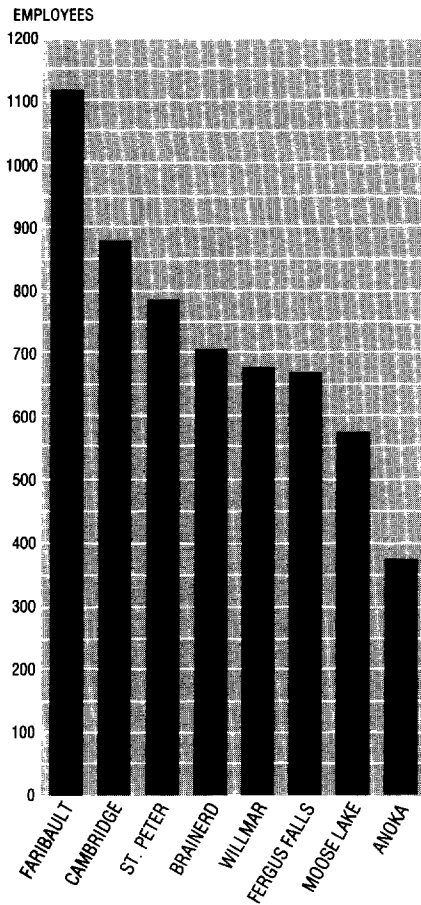
■ **Wages:** The state-wide average hourly wage for employees ranged from \$8.10 (for service workers) to \$22.70 (for managers). The largest group of workers (health care technicians and licensed practical nurses) averaged \$8.53 per hour.

**FIGURE 7**

*Distribution of State Hospital Employees by Job Classifications*



**FIGURE 8**  
State Hospitals by Staff Size (Employees)



■ **Staff Variation Among Hospitals:** There is little variation from one state hospital to another in terms of workforce characteristics except for staff size. Figure 8 rank orders the state hospitals by staff size. The range of variation on other characteristics is as follows:

Sex/Percent Females:

Low—61.1 percent (Brainerd)  
High—69.3 percent (Cambridge)

Age/Under 35:

Low—37.8 percent (Anoka)  
High—63.2 percent (Faribault)

Retirement/Within 5 Years:

Low—7.9 percent (Cambridge)  
High—17.8 percent (St. Peter)

Average Length of Service:

Low—6.2 years (Anoka)  
High—10.5 years (Fergus Falls)

Separations:

Low—63 (Anoka)  
High—210 (Faribault)

(Sex, age, and separations refer to all employees while retirement and length of service refer to full time employees).

■ **Employee Separation Benefits:** The collective bargaining agreements provide for severance pay and health benefits in the event of involuntary termination other than dismissal for cause. Federal and state laws require payment of unemployment insurance. These benefits have a monetary value that could become a cost to the state. Regular employees are eligible for severance pay at a rate of 40 percent up to 900 hours and a rate of 25 percent for the hours above 900 of unused sick leave at their last hourly wage. Total cost of severance pay by state hospital is presented in column 2 Table 7 (see Appendix).

State employees with three or more years of service receive six months of health insurance benefits paid by the state upon involuntary termination except in cases of dismissal for cause. Cost of health insurance varies by employee depending on coverage. The system-wide average is \$923 per employee for six months and the estimated total value of this benefit for each state hospital is reported in column 3 of Table 7. Unemployment benefits are paid to employees meeting specified eligibility requirements. Maximum benefits are \$198 per week for 26 weeks.

## STATE HOSPITAL COSTS

The amount and use of financial resources for state hospitals can be analyzed in terms of operating expenditure by the hospitals, gross and net cost to state government, and unit costs. Cost is the amount of money or "money's worth" that is exchanged for services and property. Unit costs were discussed in Part I. Operating expenditure is an accounting term used for the cost of goods and services to carry on state hospital programs during a specified period of time, e.g., a fiscal year.

### Operating Expenditure

Minnesota state hospital operating expenditures during Fiscal Year 1984 are presented in Table 8 (see Appendix). Expenditure reported by hospital indicates the relative size of hospital operations; reporting by object of expenditure indicates the use of financial resources. Total expenditures by hospital and by object were divided by the number of patients/residents in average daily population in all programs to give a per capita operating expenditure.

Total operating expenditure ranged from \$11,875,263 at Anoka State Hospital to a high of \$29,115,435 at Faribault State Hospital with a total operating expenditure of \$149,498,251 for the entire system during Fiscal Year 1984. Staff salaries, which include employee benefits, represented the largest object classification at \$128,433,135 or 85.9 percent of total operating expenditure. The second largest object classification for all hospitals was fuel at \$3,973,204 (2.7 percent) followed by food at \$3,576,272 (2.4 percent). While per capita operating expenditure by hospital is of interest, it is not a valid measure of comparative efficiency because of differences in composition of patient/resident population, staff seniority and other factors among the eight hospitals. Both total and per capita operating expenditure for Anoka State Hospital are somewhat overstated because \$357,210 for 11 positions with systemwide and central office responsibility are included.

While separate reimbursement rates are applied to services for mental illness, mental retardation and chemical dependency, the \$37,317 per capita indicates the statewide average hospital operating cost of care for one patient/resident for one year.

### Gross and Net State Cost

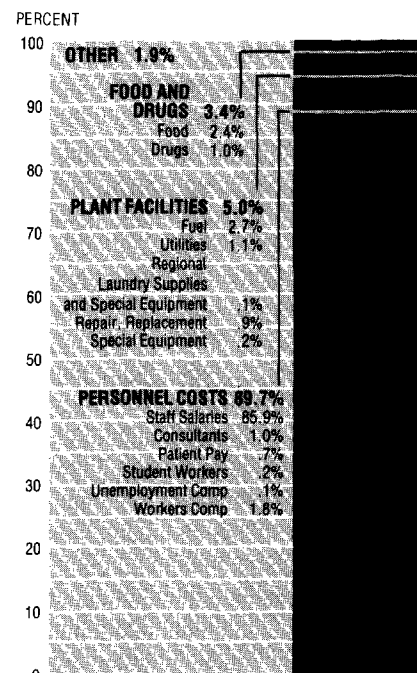
The gross state cost aggregates all financial resources used by the state hospital system: operating expenditure, indirect expense, bond interest and depreciation added together. Indirect expense includes expenditures for Department of Human Services operations associated with or prorated to state hospital operations including Fiscal Management, Reimbursement, Personnel, Information Systems and Mental Health Bureau. It also includes prorated expenditures for Departments of Administration, Employee Relations, Finance, Attorney General and other state agencies that provide services to the state hospital system. Bond interest is the cost of money borrowed to finance construction and improvement of plant facilities. Depreciation expense recognizes an amortized amount of capital expenditure for land, buildings and equipment. The depreciation expense is not placed in a reserve account, but it does recognize state capital costs and is an allowable item for federal reimbursement.

Table 9 (see Appendix) presents a breakdown of actual gross state cost for Fiscal Year 1984 and estimates for the next three fiscal years. The operating expenditure of \$147,755,064 is less than the total in Table 8 because: 1) offsetting receipts for regional laundry services, state hospital miscellaneous cash receipts and central office salaries paid on hospital line items have been deducted and 2) it reflects account balances as of August 1, one month after the end of the fiscal year, but before closing entries on or about September 1.

Actual indirect costs for Fiscal Year 1984 totaled \$3,970,098. Addition of \$2,284,951 for bond interest and \$5,035,366 for depreciation brought the gross state cost to \$159,045,479. Dividing the total gross cost by the 4,006 average daily population gives a per capita gross cost of \$39,702. In other words, \$2,385 or 6 percent of the state gross cost per patient/resident is made up of indirect, bond interest and depreciation expense.

FIGURE 9

State Hospital Operating Expenditures  
Fiscal Year 1984



The Reimbursement Section of the Department of Human Services recovers state hospital costs from many sources through calculation of per diem rates and billing procedures. During Fiscal Year 1984, reimbursements totaled \$120,594,420 from all sources. The largest source was the federal share of Medical Assistance, \$52,656,694 or 43.7 percent of all reimbursements. The second largest source was the state's own share of Medical Assistance at \$46,825,724 or 38.8 percent followed by county payments for hold orders, poor relief and detoxification charges for \$6,362,510 or 5.3 percent of the total. Counties also pay a share of Medical Assistance that amounted to \$5,202,858 for state hospitals during Fiscal Year 1984.

The Legislature appropriates the gross state cost of the state hospital system. State hospital reimbursements are deposited into the State General Fund and designated as dedicated revenue for Medical Assistance, thereby reducing that appropriation. The presence of substantial reimbursement collection is the basis for computing net costs. Had eligible persons been treated in other settings, the state's share of Medical Assistance would clearly have been a "cost" to the state with no chance of cost recovery through the reimbursement process. In the case of treatment in state hospitals, reimbursement from the state's share of Medical Assistance functions more like an inter-agency transfer; state government helps individuals, but in doing so moves money from one account to another. From the state government's viewpoint, state hospital reimbursements from other than state sources are revenue receipts and, therefore, the gross state cost of state hospitals minus reimbursements from non-state sources yields a net cost. Following this procedure, the net state government cost for the state hospital system in Fiscal Year 1984 was \$85,276,783. If the net cost were divided by the 4,006 average daily population, the net state cost per capita becomes \$21,287, slightly more than half (53.6 percent) of the gross state per capita cost.

## ***ECONOMIC IMPACT***

A large industry, like a state hospital, contributes significantly to a community's economy. The smaller the community and less diverse its commercial or industrial base, the greater the impact. Determining a valid "bottom line" amount of economic impact by a particular state hospital is difficult because many factors are involved, some factors interact and there are many "unknowns." A detailed economic impact study was underway, but not completed at the time this report was prepared. This section highlights state hospital employment opportunity, payroll and local purchasing.

### ***State Hospital Employment Opportunity***

Jobs are a key factor in the vitality of a community's economy. Table 6 (see Appendix) indicated that the state hospitals provided 5,919 jobs (including part-time) distributed across eight communities. The number of full-time jobs by community ranged from 1,093 in Faribault to 378 in Anoka. Clearly, state hospitals are major employers. One way to assess the impact of these jobs is to determine what proportion they are of all jobs available in geographic areas surrounding each state hospital. "Community" was defined as the area in which state hospital employees live. Areas of employee residence were determined by aggregating postal zip codes into three zones. The primary zone was defined as that geographic area which included the zip codes of 50 percent of employees residing closest to the hospital. Primary and secondary combined zones were larger areas that included zip codes of 75 percent of employees living closest to the hospital. The regional impact areas are the largest of the three zones and include zip codes for 90 percent of a state hospital's employees. Geographic boundaries of these three zones are presented graphically in Figure 10.

The first three rows in Table 10 (see Appendix) indicate the percent state hospital jobs are of the total number of jobs in geographic areas surrounding each state hospital. When data for primary and secondary zones are identical, it means that the zip code area is not enlarged when the percent of employees is increased from 50 to 75 percent.

Data for the primary zones indicate that the greatest economic impact was in the immediate area of Moose Lake where 18.8 percent of the workforce was employed by the state hospital. Second and third ranked primary zone impacts were at Faribault and St. Peter where hospital employees represented 9 percent and 8 percent of the workforce respectively.

The U.S. Census Bureau has identified the total number of health or social services jobs in the state hospital regional areas. The percent of state hospital jobs of that total number was then calculated. The higher the percent, the lower the likelihood of finding another health or social services job. Fergus Falls (44 percent), Brainerd (37 percent) and Moose Lake (30 percent) are the areas in which finding another health or social services job would be most difficult.

Those areas in which state hospital jobs represent the largest proportion of total employment, Moose Lake, Faribault, Brainerd and Fergus Falls, also tended to have the highest county unemployment rates during July 1984. Highest unemployment rates were in Carlton County at 10.1 percent (Moose Lake State Hospital), followed by Crow Wing at 8 percent (Brainerd State Hospital), Otter Tail at 7.9 percent (Fergus Falls State Hospital) and Rice County at 7.1 percent (Faribault State Hospital).

### State Hospital Payrolls

Salaries of state hospital employees may be the most significant factor in community economic impact. Table 8 (see Appendix) indicated that \$128,433,135 or 85.9 percent of total operating expenditure are for personnel costs. The amount ranged from \$9,809,295 at Anoka State Hospital to \$24,993,232 at Faribault. Patient pay totaling \$1,089,570 and student worker pay of \$340,120 could be added to staff personnel costs. Personnel operating expenditures overstate the direct community economic impact because it includes employee benefit costs, state and federal income tax, social security and other deductions that are not local transactions.

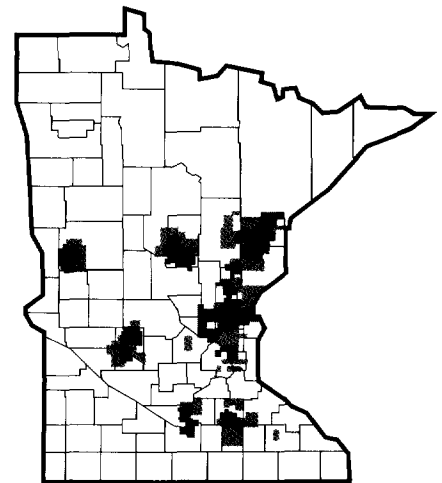
The amount of impact state hospital payrolls have on the local economy is difficult to estimate. While it is relatively easy to determine where the employees reside, it is more difficult to know where they spend their income. Persons working at Fergus Falls State Hospital and living in Fergus Falls are very likely to spend most of their money in or around Fergus Falls. Workers at Anoka State Hospital are very likely to shop in St. Paul, Minneapolis and suburban shopping centers outside the immediate Anoka area. The economic impact of salaries spent in the local community can be expected to "multiply" about one and one-half to two times in succeeding transactions.

The Department of Employee Relations and Demographer's Office provided information on state hospital payroll as a percent of total area income. Rows 5, 7 and 8 of Table 10 (see Appendix) provides this information for the three zip code based zones surrounding each state hospital.

In the primary zone, Moose Lake State Hospital's payroll represented 28.8 percent of total area income. Second highest was St. Peter State Hospital's payroll at 16.9 percent followed by Faribault State Hospital's at 12.5 percent.

**FIGURE 10**

*Economic Impact Area for Minnesota State Hospitals*



**KEY:**

- Primary Zone
- Secondary Zone
- Remainder of Impact Area



### ***Local Purchasing***

State hospital purchases of supplies appear to have a relatively minor impact on local community economies. The economic impact is reduced because most purchasing is accomplished through state offices in St. Paul. One of the issues in assessing the impact of hospital purchasing is whether or not fuel and electricity should be included. Money expended for electricity and gas from companies like Northern States Power and coal from Burlington Northern probably have little local economic impact, but a high local impact is possible when municipal power plants are involved. Purchasing information excluding fuel and electricity is reported in Table 10 (see Appendix).

Hospital purchases were analyzed to determine the amount and percent of total purchases that were made from local city and county businesses during Fiscal Year 1983. The largest amount of local city purchases ranged from \$230,384 or 18.7 percent of all purchases by Willmar State Hospital to \$14,526 or 1.8 percent by Anoka State Hospital. The amount at Willmar State Hospital was relatively high compared to the second-place amount of \$167,156 or 14.4 percent of total purchases at Fergus Falls State Hospital. Similar amounts and percents are reported for the counties in which the state hospitals are located. While amounts and percents of total local purchases increased as the area of impact was extended to the entire county, the major portion of impact for each state hospital tended to occur in the immediate city.

The magnitude of local state hospital purchases depends on what percentage those purchases are of total retail sales. In this context the largest economic impact occurred in St. Peter where \$96,194 in transaction constituted 1.25 percent of total retail sales reported by the Minnesota Department of Revenue. Moose Lake followed with \$72,905 in sales or 1.2 percent of total retail sales. Lowest impact of local purchasing occurred at Cambridge with \$27,056 in transactions representing .11 percent of retail sales.

If fuel and electricity are included, the percent of purchases made locally, amount of transactions and percent of retail sales all increase.

## **STATE HOSPITAL BUILDINGS AND ENERGY USE**

Hospitals vary considerably in terms of the age of buildings, number of buildings, amount of land, and condition of buildings. Table 11 (see Appendix) summarizes information collected during a 1982 inventory of Minnesota state hospital plant facilities.

### ***Anoka State Hospital***

Anoka State Hospital has 22 main buildings on a 243 acre site. Total area of main buildings is 454,455 square feet and it has a licensed bed capacity of 347. Of the main buildings on which rating data are available, 9 are rated poor or poor to fair (4 are vacant and 2 are identified for demolition), 6 fair, 3 fair to good or good, and one, the chemical dependency unit built in 1980, is rated excellent. Seven of the buildings contain licensed beds and all are accessible to persons with handicaps. Anoka State Hospital is located in a high density suburban area. Ninety-five percent of its property is zoned single family residential and 5 percent is zoned multiple dwelling. Mixed zoning of property surrounding the hospital includes multiple dwelling, commercial and industrial.

### ***Brainerd State Hospital***

Brainerd State Hospital has 14 main buildings on a 198 acre site. The total area of main buildings is 698,178 square feet and its licensed bed capacity is 531. All buildings were constructed between 1958 and 1967. Thirteen of the buildings are rated good to excellent and one is rated poor to good. Eleven of the main buildings are residential facilities. The site is zoned "public" giving it the same classification as parks, hospitals, churches, colleges, etc. Surrounding area is zoned agricultural, rural residential, green space and some commercial.



*Brainerd Daily Dispatch*



### **Cambridge State Hospital**

Cambridge State Hospital has 26 main buildings on 245 acres. The majority of buildings were constructed between 1925 and 1937, but larger buildings constructed since 1953 account for over half of the 669,908 square feet of floor area. Of the main buildings, 18 (82 percent) were rated fair, fair to good or good, one was rated poor and 3 were rated excellent. Licensed bed capacity is 556 and 11 buildings are used as residential facilities; all meet life safety codes but 6 do not meet handicapped access requirements. The state hospital is zoned professional/medical. Zoning of surrounding area includes professional/medical, single family residential, multiple dwellings, flood plain and shore land.

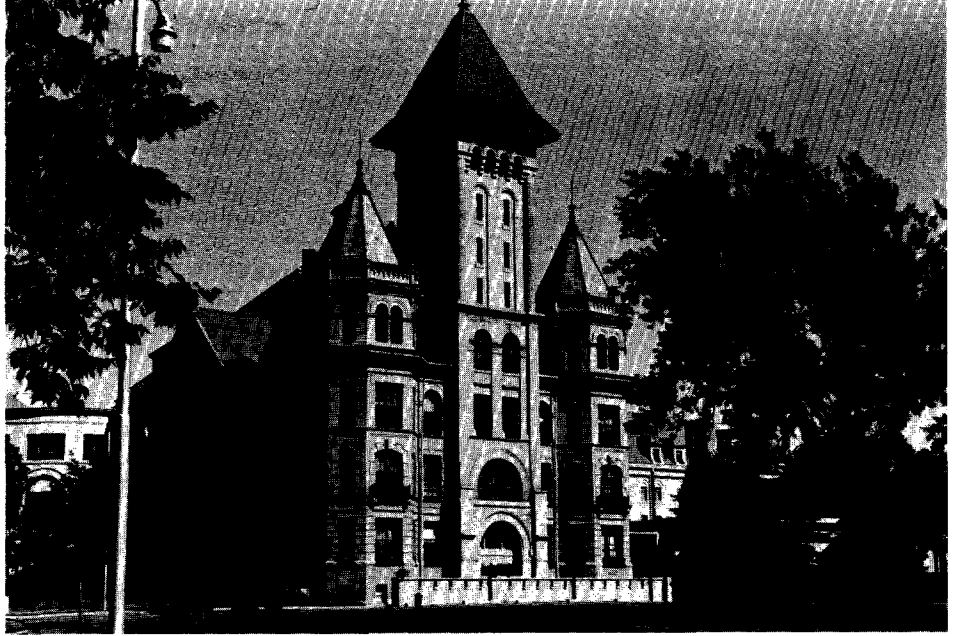
### **Faribault State Hospital**

Faribault State Hospital has 52 main buildings on a 760 acre site; 593 acres are leased out. The oldest building is the power plant constructed in 1896; about half of the buildings were constructed between 1900 and 1937 and the remaining half between 1947 and 1964. Total floor area of the main buildings is 939,104 square feet and licensed bed capacity is 845. Of the 40 buildings for which ratings were available, 21 were rated fair to good or good, 14 were rated poor or fair to poor, and 5 were rated good to excellent. Fifteen buildings are used as residential facilities; all meet life safety codes but 3 do not meet handicapped access requirements. The state hospital is zoned high density residential. Surrounding property is zoned residential, agricultural and industrial.



### **Fergus Falls State Hospital**

Fergus Falls State Hospital has 40 main buildings on a 320.25 acre site; 164 acres of the site are leased out for farming. Total area of the main buildings is 867,010 square feet and licensed bed capacity is 561. Twenty-four of the main buildings were constructed between 1890 and 1923, 4 during the early 1930s and 12 between 1950 and 1964. Of the 27 buildings for which rating information was available, 10 were rated poor, fair to poor, or fair. Eleven buildings were rated fair to good or good and 5 were rated good to excellent or excellent. Eleven buildings are used as residential facilities. All residential buildings will meet life safety codes by March 1985; 10 are not in full compliance with handicapped access requirements. The hospital is zoned residential/agricultural and surrounding property is zoned multiple family residential, business district and industrial.

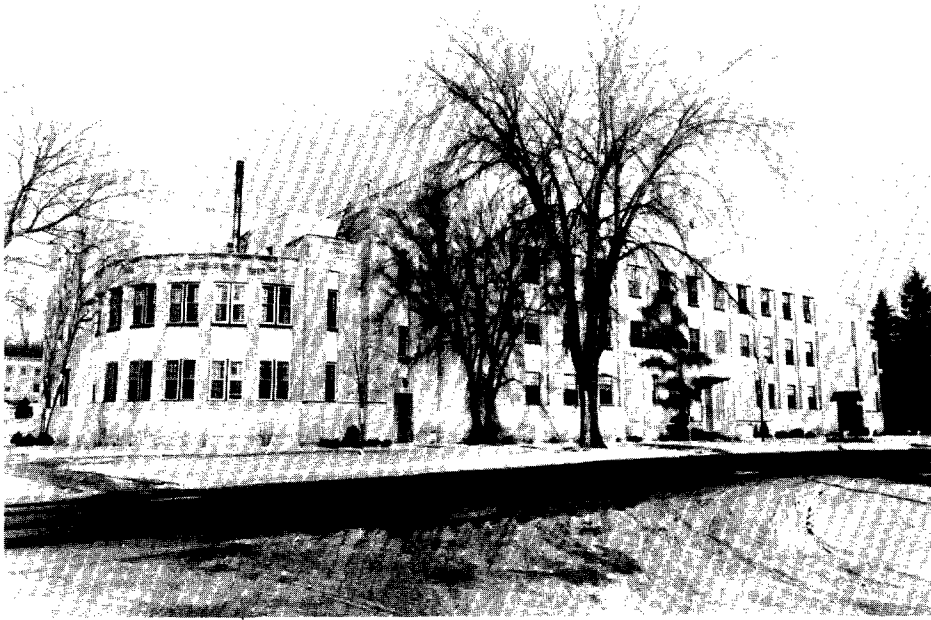


### **Moose Lake State Hospital**

Moose Lake State Hospital has 23 main buildings on a 175 acre site. Main building area totals 518,815 square feet and licensed bed capacity is 645. Thirteen of the buildings were constructed in 1938 and the remaining 10 between 1949 and 1964. Of the 21 buildings with ratings, 7 were rated good to excellent or excellent and 14 were rated fair to good or good. Ten buildings are used as residential facilities; all meet life safety codes and nine meet handicapped access requirements. The hospital is zoned governmental/open. Surrounding property is zoned park, multiple dwelling and light industrial.

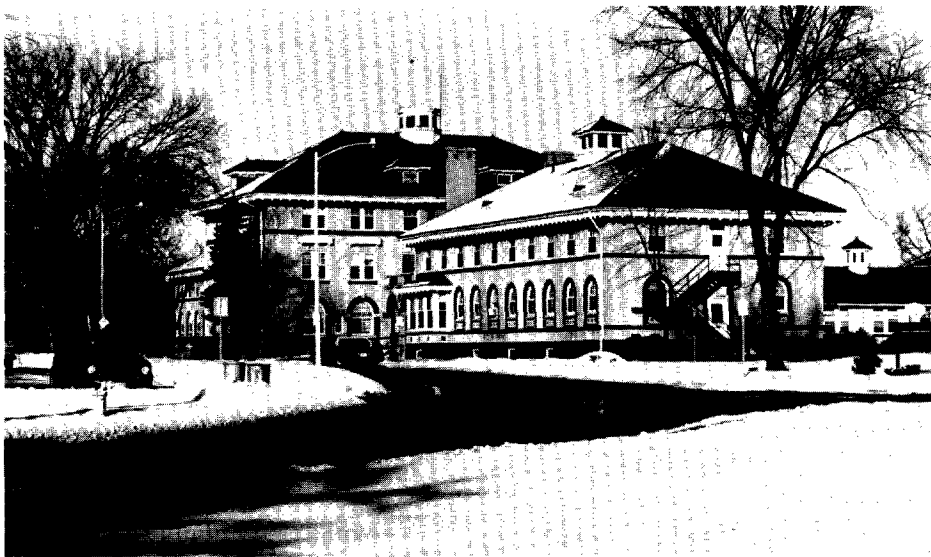


Moose Lake Star-Gazette



### ***St. Peter State Hospital***

St. Peter State Hospital has 35 main buildings on a 743.6 acre site of which 220 acres are leased out. A major renovation and replacement program during the past 20 years has transformed the first state hospital into one of the newest. Total area of main buildings is 857,404 square feet and its licensed bed capacity is 674 including the security hospital. Rating information indicates that 19 of the main buildings are fair to good, good, good to excellent or excellent, 4 are rated fair and 2 rated fair to poor. Eight buildings are used as residential facilities; all meet life safety codes and 6 meet handicapped access requirements. One of the main buildings is the Minnesota Security Hospital, started in 1981 and completed in 1982. It is a modern 117,072 square foot building with a licensed bed capacity of 236 and the only complete security building at any of the state hospital sites. The state hospital and surrounding property are zoned residential multiple dwelling.



Michael Smith, Willmar

### ***Willmar State Hospital***

Willmar State Hospital has 39 main buildings on a 158 acre site. Total area of main buildings is 562,151 square feet and licensed bed capacity is 644. Twenty-five of the buildings were constructed between 1912 and 1933; the remaining 14 were built between 1948 and 1979. Available rating data indicate the 18 buildings are in fair to good, good, good to excellent or excellent condition; 5 buildings were rated fair. Fifteen buildings are used as residential facilities; all will meet life safety code requirements when fire exits under construction are completed and 6 are in full compliance with handicapped access requirements. The state hospital is zoned governmental and institutional district with surrounding property zoned residential and agricultural.

### **State Hospital Energy Use**

Many of the issues related to physical plant have implications for the future in terms of disposition of properties and possible consolidation. The same is true of energy costs. Energy consumption in buildings is affected by such factors as original construction features, efficiency of heating plant, severity of weather, and type of heating fuel used. Conversion from one fuel to another, installation of more efficient heating plants, replacing old windows and adding insulation are major capital expenditures in physical plants of state hospitals. Investment in major energy-saving modifications can be justified by estimated savings or "pay-back" over a period of time. Price of energy is a function of supply as well as state hospital location and access to energy suppliers.

Meaningful comparison of energy use at the eight state hospitals is difficult. Total usage and total energy cost data are informative, but do not take important variables such as size of plant, type of construction, price of energy and climate differences into account. Energy use and expenditure data per patient/resident are somewhat more useful because energy is essential to achieving the state hospital's purpose of serving people. However, the usefulness of per patient/resident energy use and expenditure data are limited by the fact that within a defined operating size, total energy expenditure is a fixed cost.

The adjusted total energy cost for all state hospitals was \$4,440,820 in 1983. Lowest energy consumption per square foot was .145 million BTU's and per patient was 164 million BTU's, both at Moose Lake. The smaller number of buildings and their relatively recent construction would contribute toward lower energy use. At the same time, Moose Lake State Hospital's cost of energy, \$.967 per square foot, ranks fifth and its \$1,057 per person cost ranks third lowest among the eight state hospitals. On the other hand, Fergus Falls has the lowest energy cost per square foot of \$.479 and the second lowest cost per person of \$746. Even with the lowest cost, Fergus Falls State Hospital had the highest energy consumption per patient/resident and the second highest use per square foot. (See Table 12, Appendix)

### **Alternative Use**

There has been considerable experience across the United States concerning the conversion and disposal of state hospital properties. In discussion with other states, the following trends are evident:

- Generally speaking, state agencies report that they do not save money by using former state hospitals for other government uses rather than renting or building other facilities. This is due in large part to the condition and age of the buildings, energy costs, and renovation costs.
- Of the 31 institutions reported closed nationwide, none has been purchased by private industry. One has been converted to geriatric apartments, and one has been purchased by a religious organization.
- Over half of the former state hospitals in the nation have been converted to other types of institutions (correctional or veterans). Sixteen of them continue to be maintained by the state.
- Like Minnesota, all states surveyed (except California) have laws which give priority to state, county and local agencies before the property is offered to the general public.

In Minnesota, state hospital properties have been leased or sold for other uses. The following observations can be made based on the experience over the last decade:

- Most surplus buildings have been leased to other state, county and local agencies as well as to school districts. The annual rent charged to these agencies is minimal and may not cover the maintenance and/or energy expenses associated with the properties.
- Former staff homes have been sold at several locations.
- The closure of Hastings State Hospital was quickly followed by its conversion to a Veterans' Home.
- The Rochester State Hospital closure was different. The site was marketed for two years. The county purchased Rochester State Hospital for \$1.00, but was unable to utilize all the buildings on the campus. Eventually, the federal government bought it for use as a prison.

State hospital lands and buildings have been appraised by local assessors. In 1980, estimated market values range from \$7.5 million (Faribault) to \$37.3 million (Brainerd). As experience elsewhere has demonstrated, however, the estimated market value of the property may be less than actual market value.

### **Final Note**

Dramatic change has taken place in Minnesota during the last two decades in terms of reducing the numbers of people served by state hospitals. There is increasing awareness that the system continues to change and that the changes directly affect the lives of patients, residents, employees and communities. The system has reached a point where decisions are required regarding the types and levels of services offered for people with mental illness, mental retardation and chemical dependency. The seven studies summarized in this report will assist the 1985 Legislature in the decision-making process.



# ***Appendix***

## ***Tables 1-12***



**TABLE 1**

*Average Daily Population by Type of Condition  
Served in Minnesota State Hospitals During Fiscal Year 1984*

	ANOKA		BRAINERD		CAMBRIDGE		FARIBAULT		FERGUS FALLS		MOOSE LAKE		ST. PETER		WILLMAR		TOTAL	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Mental Illness and others	237	75.0	65	14.4	0	0	0	0	99	21.1	169 <sup>a</sup>	38.9	365 <sup>b</sup>	62.0	295 <sup>c</sup>	53.4	1,230	30.7
Mental Retardation	0	0.0	325	72.2	483	100	712	100	231	49.3	107	24.6	170	28.9	154	27.9	2,182	54.5
Chemical Dependency	79	25.0	60	13.3	0	0	0	0	139	29.6	159	36.5	54	9.1	103	18.7	594	14.8
Total	316	7.9	450	11.2	483	12.1	712	17.8	469	11.7	435	10.9	589	14.7	552	13.7	4,006	100

<sup>a</sup>Includes 107 in Geriatrics Unit

<sup>b</sup>Includes 210 in Security Hospital

<sup>c</sup>Includes 42 in Adolescent Treatment Unit

SOURCE: Department of Human Services 1985-87 Budget Request

**TABLE 2**

*Selected Characteristics of Persons with Mental Illness  
Served by Minnesota State Hospitals During September 1984*

	ANOKA		BRAINERD		FERGUS FALLS		MOOSE LAKE		ST. PETER		WILLMAR		TOTAL	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
<b>NUMBER</b>	235	100	64	100	98	100	169	100	155	100	258	100	979	100
<b>LEVEL I</b> Suicidal, self-injurious, assaultive, psychotic, etc.	38	16	10	16	3	2	15	9	13	8	12	5	91	9
<b>LEVEL II</b> Disruptive, suicidal tendencies, chemical abuse, psychotic episodes, etc.	80	34	25	39	17	18	54	32	35	23	45	17	256	27
<b>LEVEL III</b> Requires daily supervision, lacks social skills, lacks self-control, etc.	80	34	20	31	21	21	39	23	83	54	143	55	386	39
<b>LEVEL IV</b> Limited ability to participate, some self-care, can work, needs stabilization, etc.	31	13	8	12	17	18	19	11	16	10	33	13	124	13
<b>LEVEL V</b> Confused, disoriented, requires supervision, withdrawn, etc.	6	3	1	2	40	41	42	25	8	5	25	10	122	12

SOURCE: Department of Human Services Survey of Mentally Ill People.





**TABLE 5**

Summary of Town Meeting Statements

	Town Meetings									TOTAL	PERCENT
	ANOKA 9/6/84	BRAINERD 9/24/84	CAMBRIDGE 8/22/84	FARIBAULT 8/29/84	FERGUS FALLS <sup>a</sup> 9/25/84	METRO 10/9/84	MOOSE LAKE 10/4/84	ST. PETER 9/17/84	WILLMAR 9/13/84		
<b>ISSUES PRESENTED</b>											
Residents/patients	19	30	17	18	53	25	13	21	19	215	22.9
Community and individual economic impact	1	10	14	5	7	6	8	9	17	77	8.2
Quality of staff and care	14	19	9	19	34	8	15	12	27	157	16.7
Unique programs	3	8	0	0	11	1	3	4	9	39	4.1
Interagency relations	0	14	4	4	21	5	8	5	17	78	8.3
Suggestions for improvement	16	2	11	16	26	13	5	2	8	99	10.5
Acknowledgment/support of community programs	1	2	1	0	7	10	3	3	7	34	3.6
Shortcomings of community programs	4	17	11	16	40	14	10	11	17	140	14.9
Other	10	5	9	13	24	8	7	9	16	101	10.8
Total	68	107	76	91	223	90	72	76	137	940	100
<b>REGISTERED ATTENDANCE</b>	260	1500+	425	750	300	105	605	550	350	4,845	—
<b>ORGANIZATIONS REPRESENTED</b>	20	85	36	59	29	33	68	40	52	422	—
<b>COUNTIES OF RESIDENCE REPRESENTED</b>	N.A.	9	13	21	11	4	N.A.	14	19	—	—
<b>SPEAKER IDENTIFICATIONS</b>											
Volunteers/citizens	5	2	3	5	6	0	2	5	4	32	8.8
Business/civic	3	12	4	4	1	0	3	6	7	40	11.1
Employees	7	12	12	7	24	2	5	12	4	85	23.5
Counties, cities, providers, clergy, sheriffs, judges, schools	2	24	5	6	14	7	13	9	20	100	27.6
Relatives/family	2	4	1	8	5	9	2	5	6	42	11.6
Residents/patients (inc. letters read into record)	15	3	0	0	12	0	0	1	1	32	8.8
Advocates	1	0	0	0	1	5	1	1	0	9	2.5
Legislators	2	3	3	2	1	0	3	4	4	22	6.1
Total	37	60	28	32	64	23	29	43	46	362	100

<sup>a</sup>The Fergus Falls Town Meeting was preceded by 8 separate local meetings.

SOURCE: Tabulation by staff.



**TABLE 7**

*Estimated Potential Cost of Severance and Health Benefits  
for Minnesota State Hospitals as of August 1, 1984*

	<b>ANOKA</b>	<b>BRAINERD</b>	<b>CAMBRIDGE</b>	<b>FARIBAULT</b>	<b>FERGUS FALLS</b>	<b>MOOSE LAKE</b>	<b>ST. PETER</b>	<b>WILLMAR</b>	<b>TOTAL</b>
<b>SEVERANCE</b>	\$412,800	\$ 777,100	\$ 614,400	\$1,204,200	\$ 908,600	\$ 614,600	\$1,036,300	\$ 944,400	\$ 6,512,400
<b>HEALTH</b>	289,375	543,881	601,336	812,072	511,384	436,516	562,673	516,301	4,273,538
<b>TOTAL</b>	\$702,175	\$1,320,981	\$1,215,736	\$2,016,272	\$1,419,984	\$1,051,116	\$1,598,973	\$1,460,701	\$10,785,938

**SOURCE:** Minnesota Department of Employee Relations, August 1, 1984.



**TABLE 9**

Gross and Net State Cost of State Hospitals  
Fiscal Years 1984 Through 1987

	FISCAL YEAR 1984 (Actual)	FISCAL YEAR 1985 (Estimated)	FISCAL YEAR 1986 (Estimated)	FISCAL YEAR 1987 (Estimated)
<b>Hospital Operating Expenditure<sup>a</sup></b>	\$147,755,064	\$154,662,055	\$159,952,300 <sup>k</sup>	\$160,385,100 <sup>k</sup>
<b>Hospital Indirect Expense</b>				
Central Office Support and Reimbursement <sup>b</sup>	2,395,743	1,737,538	—	—
Statewide Support <sup>c</sup>	1,444,517	1,435,484	—	—
Other <sup>d</sup>	129,838 <sup>i</sup>	2,710,725	—	—
Total Indirect	\$ 3,970,098	\$ 5,883,747	\$ 6,119,097 <sup>j</sup>	\$6,363,860 <sup>j</sup>
<b>Bond Interest<sup>e</sup></b>	2,284,951	2,078,545	1,891,476 <sup>m</sup>	1,721,243 <sup>m</sup>
<b>Depreciation<sup>f</sup></b>	5,035,366	4,566,573	4,141,882 <sup>n</sup>	3,756,687 <sup>n</sup>
<b>Gross State Cost</b>	159,045,479	167,190,920	172,104,755	172,226,890
<b>Reimbursements</b>				
Medicare <sup>g</sup>	1,847,435	—	—	—
Insurance <sup>h</sup>	2,024,030	—	—	—
Medical Assistance				
Federal	52,656,694	—	—	—
State	46,825,724	44,144,460 <sup>o</sup>	42,974,580 <sup>o</sup>	40,434,350 <sup>o</sup>
County	5,202,858	—	—	—
County <sup>l</sup>	6,362,510	—	—	—
Patients/families	5,675,169	—	—	—
<b>Total Reimbursement</b>	120,594,420	121,532,800	122,071,400	119,623,000
<b>Net State Government Cost<sup>i</sup></b>	\$ 85,276,783	\$ 89,802,580	\$ 93,007,935	\$ 93,038,240

<sup>a</sup>Includes salaries, employee benefits, food, fuel, drugs, supplies and all other current operating expense. FY 1984 net Reimbursement Section figure is less than total in Table 8 because 1) \$414,281 Regional Laundry receipts, \$417,422 miscellaneous cash receipts and \$394,430 central office salaries are excluded and 2) Reimbursement Section data are obtained from State Accounting as of August 1 while the Financial Management section data are as of September 1 when books are closed.

<sup>b</sup>Includes state hospital share of Department of Human Services costs for Institution Fiscal Management, Personnel, Information Systems, Mental Health Bureau and Reimbursement sections.

<sup>c</sup>Includes proration of costs for statewide Departments of Administration, Finance, Employee Relations, Legislative Auditor, Treasurer, Attorney General and others.

<sup>d</sup>In prorations of Regional Laundry, Client Protection, Commissioner's Office, etc., actual amount for FY 1984 lower because offsetting receipts and other adjustments.

<sup>e</sup>Portion of interest on state bonded debt chargeable to construction and improvements at state hospitals.

<sup>f</sup>Recognizes prorated portion of long-term plant construction and remodeling costs.

<sup>g</sup>Includes Part A Inpatient Hospital Services, Part B Physicians Services and Ancillary Services.

<sup>h</sup>Includes all private health insurance carriers.

<sup>i</sup>Includes hold orders, poor relief and detoxification charges at Fergus Falls State Hospital.

<sup>j</sup>Gross State Cost minus Total Reimbursement excluding state share of Medical Assistance.

<sup>k</sup>Same level funding department requests. Not included in these amounts are 1) a projected reduction of 644 MR staff positions to be accomplished by 6/30/87 2) projected increase of 125 MI staff.

<sup>l</sup>Assumes a 4 percent increase over prior year.

<sup>m</sup>Assumes a 9 percent decrease based on the change from FY 1984 to FY 1985.

<sup>n</sup>Assumes a 9.3 percent decrease based on the change from FY 1984 to FY 1985.

<sup>o</sup>Based on 44.73 percent state share.

**SOURCE:** Financial Management and Reimbursement Section, Department of Human Services.



**TABLE 10***Selected Indicators of State Hospital Economic Impact*

	<b>ANOKA</b> (Anoka)	<b>BRAINERD</b> (Crow Wing)	<b>CAMBRIDGE</b> (Isanti)	<b>FARIBAULT</b> (Rice)	<b>FERGUS FALLS</b> (Otter Tail)	<b>MOOSE LAKE</b> (Carlton)	<b>ST. PETER</b> (Nicollet)	<b>WILLMAR</b> (Kandiyohi)
<b>Hospital Employment as Percent of Total Employment<sup>a</sup></b>								
Primary Zone <sup>b</sup>	.5	5.5	6.2	9.4	6.9	18.8	8.2	4.0
Primary and Secondary Zone <sup>c</sup>	.2	5.5	3.5	9.4	6.9	5.0 <sup>g</sup>	2.1	4.5
Regional Impact Area <sup>d</sup>	.1	4.8	1.5	1.6	4.2	2.3	2.2	3.9
<b>State Hospital Jobs as Percent of Health Service Jobs in Entire Impact Area<sup>e</sup></b>								
	1.0	37.0	16.0	8.0	44.0	30.0	26.0	26.0
<b>July 1984 Unemployment Rate in County Hospital (Percent)</b>								
	5.0	8.0	6.8	7.1	7.9	10.1	4.7	5.3
<b>Hospital Payroll as Percent of Total Area Income<sup>a</sup></b>								
Primary Zone <sup>b</sup>	.5	7.6	7.7	12.5	10.5	28.8	16.9	5.7
Primary and Secondary Zone <sup>c</sup>	.2	7.6	4.4	12.5	10.5	6.0	3.4	6.4
Regional Impact Area <sup>d</sup>	.1	6.7	1.7	1.9	10.1	5.2	3.5	5.9
<b>Impact of Hospital Purchases (Excluding Fuel and Utilities)</b>								
<b>City</b>								
Percent of Total Purchases	1.8	13.7	2.6	9.5	14.4	8.4	7.7	18.7
Amount	\$14,526	\$139,777	\$27,056	\$152,397	\$167,156	\$ 72,905	\$ 96,194	\$230,384
Percent of Total Retail Sales <sup>f</sup>	.18	.27	.11	.19	.30	1.2	1.25	.24
<b>County</b>								
Percent of Total Purchases	4.0	14.8	4.6	13.9	14.7	12.7	9.9	18.7
Amount	\$32,964	\$151,683	\$47,709	\$222,859	\$172,218	\$110,027	\$123,318	\$230,942
Percent of Total Retail Sales <sup>f</sup>	.09	.20	.45	.17	.15	.56	.66	.17

<sup>a</sup>Data provided by Minnesota Department of Employee Relations.<sup>b</sup>Area consisting of zip code zones for 50 percent of personnel on state hospital payroll.<sup>c</sup>Area consisting of zip code zones for 75 percent of personnel on state hospital payroll.<sup>d</sup>Area consisting of zip code zones for 90 percent of personnel on state hospital payroll.<sup>e</sup>Based on number of health and social service jobs counted in the 1980 U.S. Census.<sup>f</sup>Retail sales data provided by Minnesota Department of Revenue.<sup>g</sup>Moose Lake's secondary economic impact is being recalculated to exclude Cloquet.

**TABLE 11***Descriptive Summary of Minnesota State Hospital Plant Facilities*

	<b>ANOKA</b>	<b>BRAINERD</b>	<b>CAMBRIDGE</b>	<b>FARIBAULT</b>	<b>FERGUS FALLS</b>	<b>MOOSE LAKE</b>	<b>ST. PETER</b>	<b>WILLMAR</b>	<b>TOTAL</b>
<b>Dates of Construction and Additions</b>	1905-1921 1930-1935 1950-1964 1980	1958-1964	1925-1935 1946-1961 1971 1981	1900-1937 1947-1966 1974	1890-1923 1930-1932 1950-1964	1938 1948-1954 1960 1964	1866 1919-1927 1937 1949-1954 1960-1974 1981	1912-1935 1948-1970	
<b>Site Size (Acres)</b>	243.5	198	245	760 593 acres leased out	320.25 164 acres leased as farmland	175	743.6 220 acres leased out	158	2,843.5
<b>Number of Buildings</b>									
Total Main Bldgs. <sup>b</sup>	22	14	26	52	40	23	35	39	250
Number unoccupied or in storage	14	3	22	15	14	12	20	13	113
Area of Main Buildings in Sq. Ft. <sup>c</sup>	454,455	698,178	669,908	939,104	867,010	518,815	857,404	562,151	5,567,025
<b>Percent Area Vacant or in Storage<sup>d</sup></b>	26	7	10	10	15	7	15	8	12.25
<b>General Condition of Buildings<sup>e</sup></b>	poor to excellent average to fair, needs much repair	good to excellent	fair to good	old buildings: fair to good; new buildings: good to excellent	fair to good: exterior repairs needed	good	excellent: major remodeling completed	good to excellent	
<b>Resident Capacity 1984 Average Daily Population</b>	316	450	483	712	469	435	589	552	4,006
<b>Licensed Bed Capacity</b>	347	531	556	845	561	645	674	644	4,988

<sup>a</sup>Includes Minnesota Security Hospital.<sup>b</sup>In addition to main buildings, there are small service structures such as storage sheds, garages, band-stands, backstops, etc. called "MC's."<sup>c</sup>Area includes storage "MC's."<sup>d</sup>Square footage for partially vacated and partial storage buildings not available; actual areas and percents could be higher.<sup>e</sup>Ratings:**Good to Excellent:** Interior and exterior are in relatively good condition, relatively new or recently repaired or replaced. Needs little or no repairs.**Fair to Good or Good:** Between good to excellent and fair. Requires little or no repair.**Fair:** Currently meets code and is in operating order. May need some upgrading.**Fair to Poor or Poor:** In need of extensive repairs or replacements. May not meet code.**SOURCE:** Minnesota State Planning Agency, *Minnesota State Hospital Facilities and Alternative Use Report, 1985.*

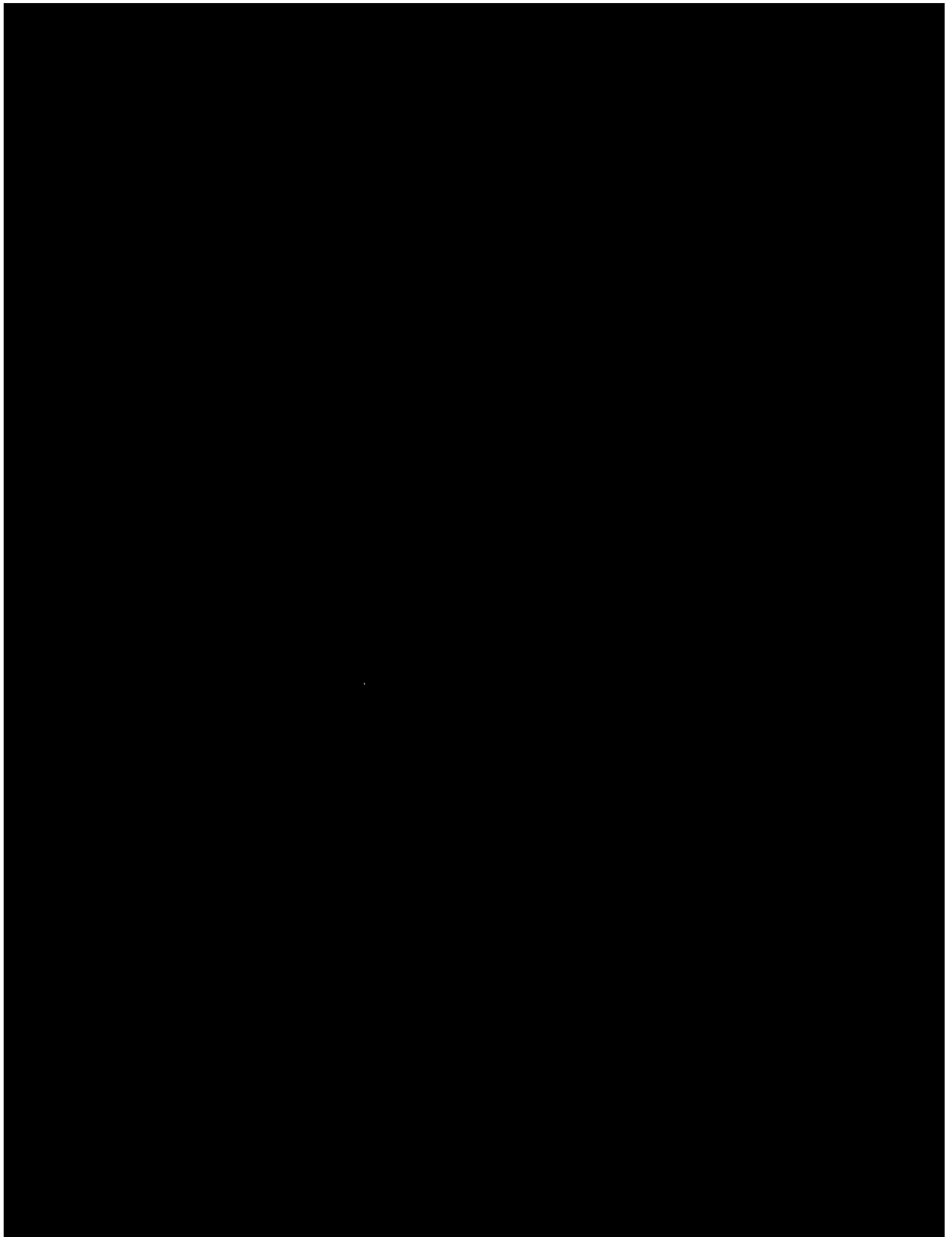
## TABLE 12

Adjusted Fuel Use and Energy Cost  
in Minnesota State Hospitals, Fiscal Year 1983

	ANOKA	BRAINERD*	CAMBRIDGE*	FARIBAULT*	FERGUS FALLS	MOOSE LAKE	ST. PETER*	WILLMAR*	TOTAL/ AVERAGE
<b>FUEL USE</b>									
Source	Natural Gas	Natural Gas	Coal/Natural Gas	Natural Gas	Coal	Natural Gas	Natural Gas	Natural Gas	—
Total Energy Used (Million BTU)	76,468	105,101	148,200	195,884	173,454	72,408	126,520	88,889	986,924
Energy Per Square Foot (Million BTU)	.207	.159	.232	.238	.228	.145	.174	.175	(average) .195
Energy Per Resident (Million BTU)	257	227	306	273	363	164	229	163	(average) 248
<b>ENERGY COST</b>									
Total Energy Cost	\$397,676	\$658,165	\$521,165	\$958,050	\$364,460	\$481,681	\$654,635	\$404,988	\$4,440,820
Energy Cost Per Square Foot	\$1.078	\$ .9974	\$ .8156	\$1.1863	\$ .479	\$ .967	\$ .9062	\$ .7962	(average) \$.9032
Energy Cost Per Resident	\$1,185	\$1,378	\$1,083	\$1,365	\$ 746	\$1,057	\$1,126	\$ 742	(average) \$1,085

\*Figures are adjusted to factor out the extraordinary cost of the regional laundry facilities. In addition, use and cost for Faribault were adjusted to reflect some short-term technical difficulties in the provision of steam to the Braille School.

**SOURCE:** Minnesota State Planning Agency. *Minnesota State Hospital Energy Use and Costs*, 1985.



## **Appendix B**

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

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

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

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

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

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

## INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The majority of patients receive no routine physical examinations.

Restraints are substituted for treatment measures.

Food and food service are unsuited for mental patients.

Clothing is grossly inadequate.

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



## TREATMENT AND STAFF

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

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

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

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

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

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

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

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

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

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

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

#### LACK OF ACTIVITIES IMPEDE RECOVERIES

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

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

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

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

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

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

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

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

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

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

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

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

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

#### HOUSING

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

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

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

#### CLOTHING

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

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

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

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

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

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

#### SANITATION AND PERSONAL HYGIENE

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

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

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

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

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

#### FOOD

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

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

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

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

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

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

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

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

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

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

#### RESTRAINTS AND SECLUSIONS

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

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

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

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

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

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

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

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

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

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

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

In one hospital, the following was found:

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

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

#### SOCIAL WORK AND RETARDED RELEASES

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



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

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

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

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

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

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

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

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

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

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

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

#### ANALYSIS OF PERSONNEL PROBLEMS

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

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

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

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

Attendants: Training and Pay for More Than Menial Service

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

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

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

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

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

5. Social Therapists; Need for a New Classification.

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

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

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

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

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

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

PHYSICIANS - DECEMBER 1947 APA

Standards: One Physician for Every 150 Patients

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

\* Fellows and residents listed as full time.

\*\* Fractions show part-time doctors.

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

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

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

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

Note: Supervisory grades excluded.

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

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

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

1 Ward duties consist mainly of housekeeping activities.

2 Not day of visit.



I and II

Basic \$ 90 - \$145  
 Adjusted Cost-of-Living \$130 - \$187

Minnesota Prison Attendant-Guard I and II

Basic \$135 - \$190  
 Adjusted Cost-of-Living \$177 - \$238

Veterans Administration . \$163 - \$218

COMPARATIVE SALARIES - PHYSICIANS AND NURSES

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

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

TOTAL NURSING PERSONNEL - DECEMBER 1947  
NURSES AND ATTENDANTS

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

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

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

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

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

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

## Appendix C

When the Hastings State Asylum was established in April, 1900, (which later became the Hastings State Hospital) the property included a large farm of about 500 acres lying south of the institution's buildings. A cemetery was established at the extreme southeast corner of the property where patients were buried who had died without known relatives. The first burial was made in July, 1901, and the last burial was made in December, 1964. A total of 901 graves were used, laid out in 25 rows. Although the ends of each row are marked, there are no headstones, except for one headstone which is flush with the ground.

When the Hastings State Hospital was closed on May 1, 1978, the Hastings property was transferred to the Commissioner of Veterans Affairs ~~who~~ <sup>to</sup> establish a veterans' home at Hastings. The responsibility for the former Hastings State Hospital cemetery was transferred to the Commissioner of Veterans Affairs on May 1.

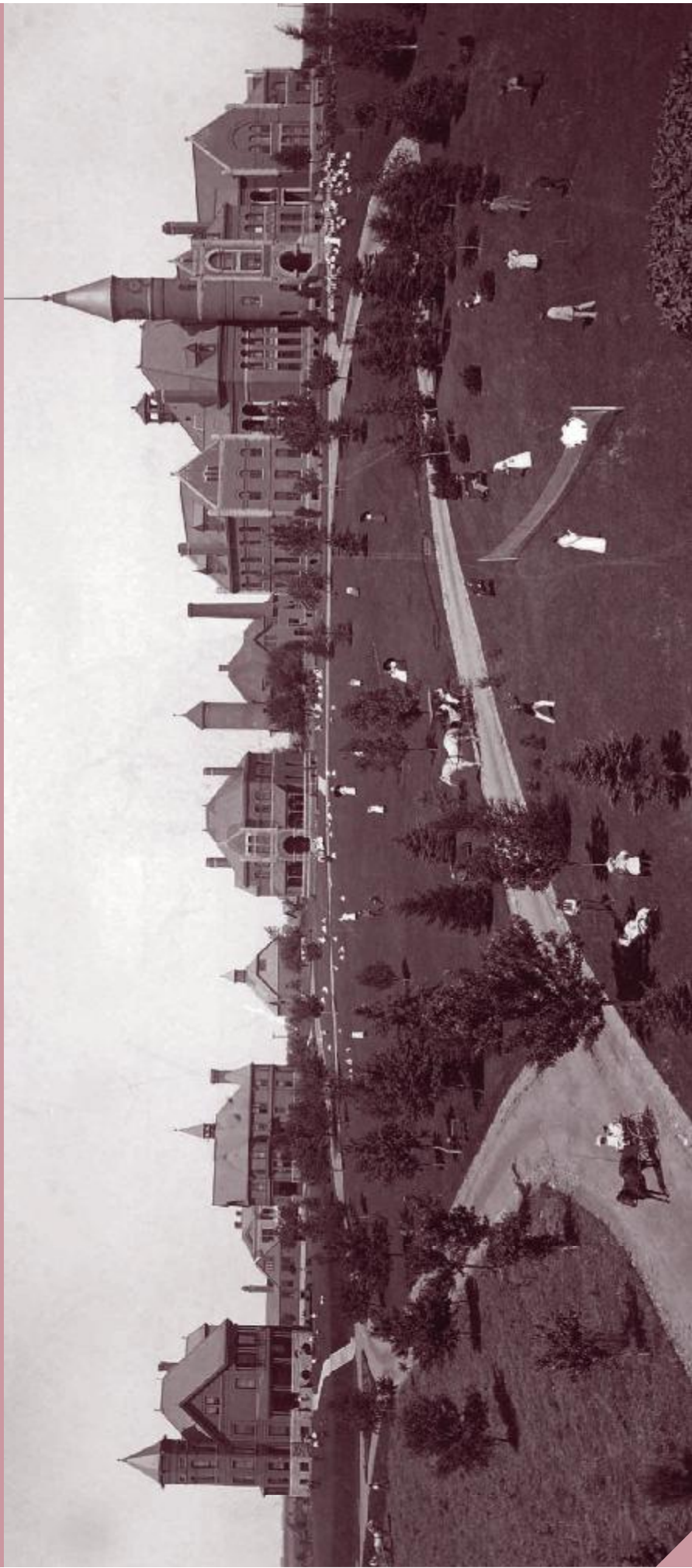
## **Appendix D**



Minnesota Department of **Human Services**

State Operated Services (SOS) consists of an array of campus and community-based programs serving people with mental illness, developmental disabilities, chemical dependency and traumatic brain injury.

# The evolution of STATE OPERATED SERVICES



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## St. Peter Asylum for the Insane

**1866, March 2** – The MN Legislature passed an act for the establishment and location of a hospital for the insane in Minnesota.

**1866, July** – A farm containing 210 acres was purchased by the citizens of St. Peter, at \$7,000, and conveyed to the state in fee simple for the use of the hospital. The St. Peter Tribune reported that we are now fully authorized to announce, that both the permanent and temporary locations for the Insane Asylum have been positively settled at St. Peter.

**1866** – The Ewing House property was purchased by the state to be used as a temporary Asylum for the Insane.

**1866, October** – Dr. Samuel Shantz elected medical superintendent and Physician (from Utica, NY). He entered upon his duties November 1, 1866.

**1866, December 6** – Temporary Hospital opened and declared ready for the reception of patients. December 28<sup>th</sup> patients who had been sent to the Iowa hospital were returned to Minnesota and admitted to the Temporary Hospital.

**1867, February** – Trustees unanimously adapted for our state institution on the linear plan, consisting of a centre building with sections and return wings. The proposal from architect Samuel Sloan of Philadelphia was accepted. Work began July 22, 1867.



**1868, August 20** – Dr. Samuel Shantz died of typhoid fever.

**1868, November 6** – Dr. Cyrus K Bartlett of Northampton, Mass. Lunatic Asylum was unanimously elected to the position of superintendent.

**1873, January 29** – South wing of the permanent hospital so far completed and furnished as to admit partial occupancy, and 53 female patients were removed from their crowded quarters in the temporary asylum much to their comfort and that

of the officers and attendants; others followed as fast as rooms were provided until the number was nearly one hundred in the new apartments.

**1874, June** – Miss Dorothea Lynde Dix, reformer, who effected great improvements in conditions of criminals, paupers and insane in Europe and US visited St. Peter. She was superintendent of women hospital nurses during the Civil War.

**1875** – A Gas House, 38x30 feet and 13 feet high above the water table with a tinned roof, was constructed. Contained necessary apparatus for

manufacturing gas for lighting purposes. Built of stone, lined with brick with dead air space.

**1875** – Gaslight in place of candles and moveable lamps filled with inflammable oil, one of the most important improvements.

**1880, November 15** – North wing burns. Rebuilding began April 1881.

**1885, January 1** – Temporary Hospital vacated.

**1888** – A tunnel has been constructed between the south detached ward and the main building for the transportation of food from the main kitchen.

**1889** – Training school for nurses established.

**1890, March** – Elizabeth C. Mallison, first woman assistant at the state hospital for the insane at St. Peter was employed.

**1892, June 31** – A telephone system of thirteen stations has been put in giving quick and convenient communication with all the halls of the main building, detached wards, stable, carpenter and engineer shops, the steward's office and the telegraph office in the city during the biennial period ending on the above date.

**1892** – Dr. Bartlett resigned. Farm increased to 810 acres.

**1893, May** – Elizabeth C. Mallison, first woman assistant physician employed at the state hospital for the insane at St. Peter terminated to accept the position of first assistant in the women's department of the Western Pennsylvania Hospital for the Insane at a salary of \$1,200 per year.

**1893** – Hospital designated as St. Peter State hospital rather than first Minnesota State Hospital for the Insane.

**1904** – Shack built for new Tuberculosis ward.

**1907** – \$40,000 appropriated by MN Legislature for construction of a Nurses Home.

**1908** – Cottage for tuberculosis insane built.

**1911** – Detention Hospital built.

**1911** – Asylum for the Dangerously Insane added to.

**1919** – Dormitory #1 (building 30) and Dormitory #2 (building 31) built.

**1920** – Nurses annex built (married couples home).

**1922** – From the opening of the institution to the year 1900, 52% of all admissions were foreign born. The number of admissions of foreign born is lessening, the percentage this year being about 36. This is probably a result of the lessening number of foreign born coming to this state.

**1926** – New industrial department for men opened in one of the small cottages formerly used for isolation.

**1927** – Malaria treatments in parietic cases started.

**1937** – The Professional Student Nurses Program (Affiliate Program in Psychiatric Nursing) established at St. Peter.

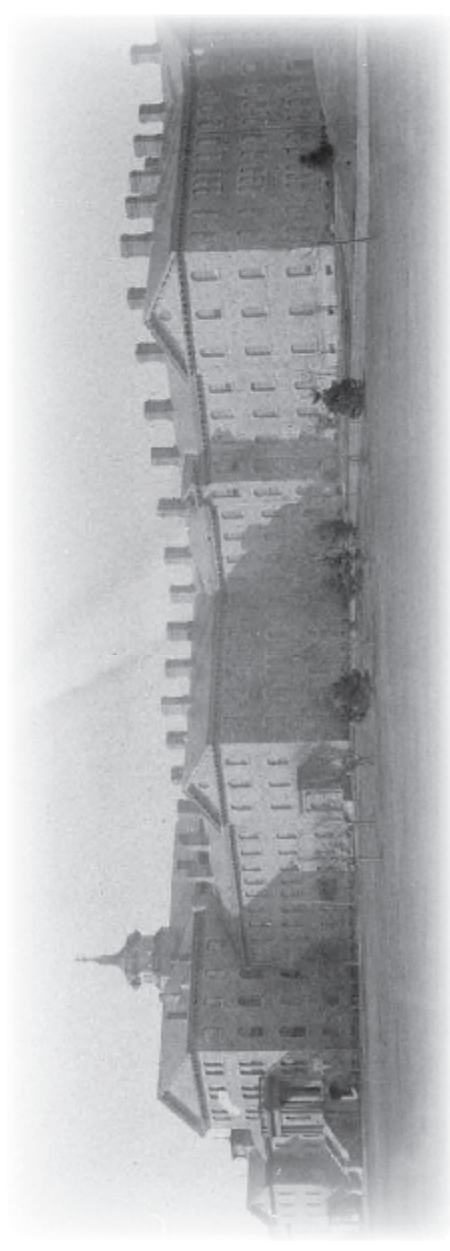
**1937, December** – Detention Hospital (supplanted by the Psychiatric Hospital) converted to a residence for women and renamed Liberty Hall.

**1937** – A Mind Restored, the story of Jim Curran, by Elsa Krauch, was published. Recollections of a patient at St. Peter State Hospital in the early 1930's. Names of places and people are disguised but recognizable by St. Peter employees.

**1944** – Nursing school discontinued.

**1954** – The Alcoholics Anonymous chapter at the St. Peter State Hospital was founded at the request of Dr. Grimes, superintendent.

**1962, May** – Open house at Continuous Treatment Building #1 (Shantz Hall).



**1962** – Cottage 10 is converted from a ward to Recreational Therapy Center.

**1964, April 30** – New nurses home dedicated and named Johnson Nurses Home in honor of Miss Mary O. Johnson, Director of Nurses 1926-1956.

**1964, May 9** – The old pump house (building at the spring), probably one of the oldest buildings on the hospital campus was wrecked by hospital maintenance crew.

**1965** – Phelps Hall converted to Occupational Therapy Center.

**1965** – Continuous treatment building #2 (Pexton Hall) opened and occupied.

**1966** – Bartlett Hall (continuous treatment building #3) opened and occupied.

**1966** – St. Peter State Hospital celebrated its centennial. Museum opened.

**1966** – Psychopathic Hospital converted to Administration Building.

**1967** – St. Peter State Hospital held a reception for the first patient to graduate from college while in the hospital. The young man had also completed his high school work while at the hospital and then continued on to a Bachelor of Arts degree. The hospital believes this is a first for any of the state hospitals.

**1967** – MN Legislature directed that transfers be made to relieve overcrowding at the hospitals for the mentally retarded and to use vacant space in institutions serving persons with mental illness.

**1968** – First large unit opened was Minnesota Valley Social Adaptation Center. Planning and staff recruitment started.

**1968, January** – Charles Turnbull appointed Program Director.

**1968, August 19** – St. Peter received the first mentally retarded residents from Faribault State Hospital.

**1970** – Work began on the rehab therapies building (Tomlinson Hall).

**1970, August 17** – St. Peter State Hospital opened a new treatment program for alcoholics and non-narcotic drug addicts. The program originally housed in Shantz Hall with a capacity of 46 beds. Presently the Chemical Dependency Unit has its own building, Johnson Hall.

**1973** – Patient advocate appointed.

**1985** – Governor Perpich officially changed the names of the State Hospitals to Regional Treatment Centers.

**1988** – Dr. William Erickson accepts position as medical director.

**1997** – Last three patients with developmental disabilities discharged.

**2003** – The MN Legislature authorizes further community-based development for persons with Mental Illness.

**2007, May** – Community Preparation Services opened in Green Acres.



### ***Rochester Asylum for the Insane***

- 1874** – MN Legislature taxed all liquor dealers \$10 to raise funds to establish State Inebriate Asylum, Asylum Board purchased 160 acre farm near Rochester and began building in 1877.
- 1876** – Created by act of MN Legislature as Asylum for Inebriates.
- 1878** – MN Legislature repealed tax levying act and by enactment designated partially completed inebriate asylum as Second Hospital for the Insane.
- 1879** – Opened. 68 patients transferred from St. Peter. Dr. Jacob E. Bowers elected Superintendent and began duties.
- 1880** – Wing for women built (100 women transferred from St. Peter following its fire).
- 1897** – Inebriate department abolished.
- 1900** – 1,207 patients.
- 1937** – Name designated as Rochester State Hospital.
- 1969** – Mental Retardation Programs established.
- 1971** – The facility was designated as a surgical center.
- 1975** – Chemical Dependency Treatment programs were established.
- 1982** – The facility is closed
- Presently** – The main building of this mental hospital built on the Kirkbride plan is long gone.



## School for Imbeciles

**1879** – MN Legislature authorized the Board of Directors of the MN Institution for the Deaf and Dumb to establish an Experimental School for Imbeciles.

**1881-1899** – The MN Legislature appropriated \$25,000 for construction of Center Unit to house the new “Department for the Training of Imbeciles and the Custody of Idiots. Dr. Henry Knight and son Dr. George Knight became the first two superintendents. The Columbian Exposition in Chicago acknowledges Faribault for “work accomplished by pupils both in what they learn from books and in varied industries, illustrating the beneficial provision of the state for its feeble-minded.” Skinner Hall opened for girls and women amid claims that “no superior building for this purpose exists in the country.”

**1900-1934** – A 40-bed Hospital opened in the building later known as Oaks. The first burial of a resident took place in the new cemetery south of the main campus. The name of the Institution was changed by adding “Minnesota School for the Feeble-Minded.” An additional 500 acres purchased to establish a Farm Colony in Walcott Township. A new barn and silos were built south of the campus in Peaceful Valley. An Accredited School for Nurses affiliated with Minneapolis City Hospital opened. Population rose to 2000.

**1935-1959** – A new 205-bed Hospital was built as a WPA project. The “Association of Friends of the Mentally Retarded” was organized, later known as the “Minnesota Association for Retarded Citizens.” The name of the institution was changed to the Minnesota School and Colony. Population reached a high of 3355.

**1960-1979** – The name of the institution was changed to Faribault State Hospital. The practice of lodging employees on campus ended. All farming operations ceased. The Faribault Area Training and Education Center becomes the Public Education Model for Minnesota.



Cedric Adams Gift Center opens. 100 year Gala celebration held in 1979, thousands attend. Population declined to 901.

**1980-1989** – State Operated Services begins operating homes and vocational programs in community settings. The MN Legislature authorizes the turnover of the institution to Corrections for a new Prison. Institution name changed to Faribault Regional Center.

**1990-1998** – Southern Cities Health Clinic to serve persons otherwise not served opens in Faribault. Health Services Building dedicated as the Nickerson Memorial Care Center. 40 State Operated Group Homes, 3 Crisis Homes and 5 Vocational Training sites opened.

**1998** – The last individual left the institution.



### **State School for Dependent Children**

**1885** – The State Public School was established by the MN Legislature as a public institution for dependent and neglected children between the ages of 3 and 14. The School was created as a state-of-the-art institution. Management of the school was vested in a three-member board. Its goals were to educate the students under its jurisdiction, to find adoptive families for them,

and to enable the students to be self-supporting upon discharge. Essentially, the school functioned as the state's public orphanage and adoption agency. Children who were not adopted or placed out were discharged when they became self-supporting, reached the age of majority (usually 18 for girls and 21 for boys), or when their parents were able again to care for them.

**1917** – Children were committed to the facility by the Juvenile Court, if the county had a separate Juvenile Court. Management of the facility changed to the State Board of Control.

**1936** – The school ceased the practice of “indentured placement” (frequently termed placing out), whereby children were placed in homes (often farms) on contract to do work or to learn a trade in exchange for a payment to the state.

**1939** – Management of the school changed and was under the Division of Public Institutions, Department of Social Security.

**1945** – State public welfare officials believed that early foster or adoptive placement was preferable to institutionalization and admissions to the school ceased. In the twentieth century, the resident population of the school fluctuated between 200 and 400. Between 1886 and 1945, there were 10,635 children who passed through the doors of the School.

**1970** – The State Public School was officially abolished and all its lands, buildings, property, and funds were transferred to the newly established Owatonna State School, which provided academic and vocational training for the mentally retarded. The Owatonna State School closed, the remaining individuals and staff moved to the Faribault State Hospital.

**1974** – After standing empty for four years, the city of Owatonna purchased the property to house its city administrative offices and other related city facilities.



## ***Fergus Falls Asylum for the Insane***

**1885** — MN Legislature commissioned a third state asylum for the mentally ill to be built and located in Fergus Falls.

**1887** — MN Legislature formally ordered construction to begin. The new facility was designed by Warren B. Dunnell, a prominent architect from Minneapolis, who incorporated Dr. Thomas S. Kirkbride's standard for asylum construction.

**1890** — The first patients were transferred from St. Peter to the newly completed West Detached Section.

**1891** — Farming was a core rehabilitative activity for patients, as well as providing food for the facility. Its first crops, milk, beef, veal and pork were valued at \$4,133.35.

**1894** — A Training School for Nurses opened on campus.

**1897** — Construction was completed on the Administrative Building.

**1899** — The East Detached Section was completed.

**1906** — Construction of the eight-story Romanesque Tower marked the completion of the facility.

**1937** — Patient census reached an all-time high of 2,078.

**1941** — The Training School for Nurses graduated its last class.

**1990** — FFRTC celebrated its Centennial.

**1993** — The first Adult Foster Care Home for people with developmental disabilities opened in Fergus, as these services transitioned to the community.

**1996** — The first Adult Mental Health Initiative projects began, involving multi-county groups, consumers, community providers and regional treatment centers across the state.

**2000** — On June 30, Developmental Disability Services became totally community based.

**2003** — The MN Legislature authorizes further community-based service development for individuals with mental illness.



**1965** — Fergus Falls State Hospital (FFSH) was first accredited by Joint Commission on Accreditation of Hospitals.

**1968** — The MN Legislature made the decision to cease farming operations.

**1969** — FFSH became one of the first multi-purpose treatment campuses, serving those with developmental disabilities, chemical dependency as well as psychiatric illnesses.

**1979** — Alcohol and drug abuse treatment programs were established.

**1985** — By executive order of Governor Perpich, the names of all State Hospitals were changed to Regional Treatment Centers, to reflect the broad spectrum of professional treatment services provided by the facility to the 17-county catchment area in northwestern and west central Minnesota.



## Minnesota State Hospital for Crippled and Deformed Children

**1897, April 23** – The MN Legislature gave the University of Minnesota the authority to establish a “Minnesota Institute for Crippled and Indigent Children.” A ward was set aside at City and



County Hospital in St. Paul the state providing braces and surgical appliances at minimal cost. The regents named Dr. Gillette chief surgeon and Dr. Gillette’s medical school colleagues agreed to donate their services. The number of patients Dr. Gillette served outgrew the space at City and County Hospital and the need for a separate institution was apparent. Citizens of St. Paul, the Business League and the Commercial Club of St. Paul donated 23 acres in Phalen Park and its new facilities opened in 1911.

**1921, March 21** – Dr. Gillette died at the age of 57. He had been responsible for the treatment of 4,171 children. More than 80 percent were cured or discharged as improved and able to



live independently. In 1925, in memory of Dr. Gillette, the hospital was renamed the Gillette State Hospital for Crippled Children.

**1971** – Renamed Gillette Children’s Hospital.

**1973** – Gillette Children’s Hospital was transferred to the Gillette Hospital Authority, a public nonprofit organization under the executive branch of the state of Minnesota. Staff were provided the option of remaining in state civil service.



## *Anoka Asylum for the Insane*

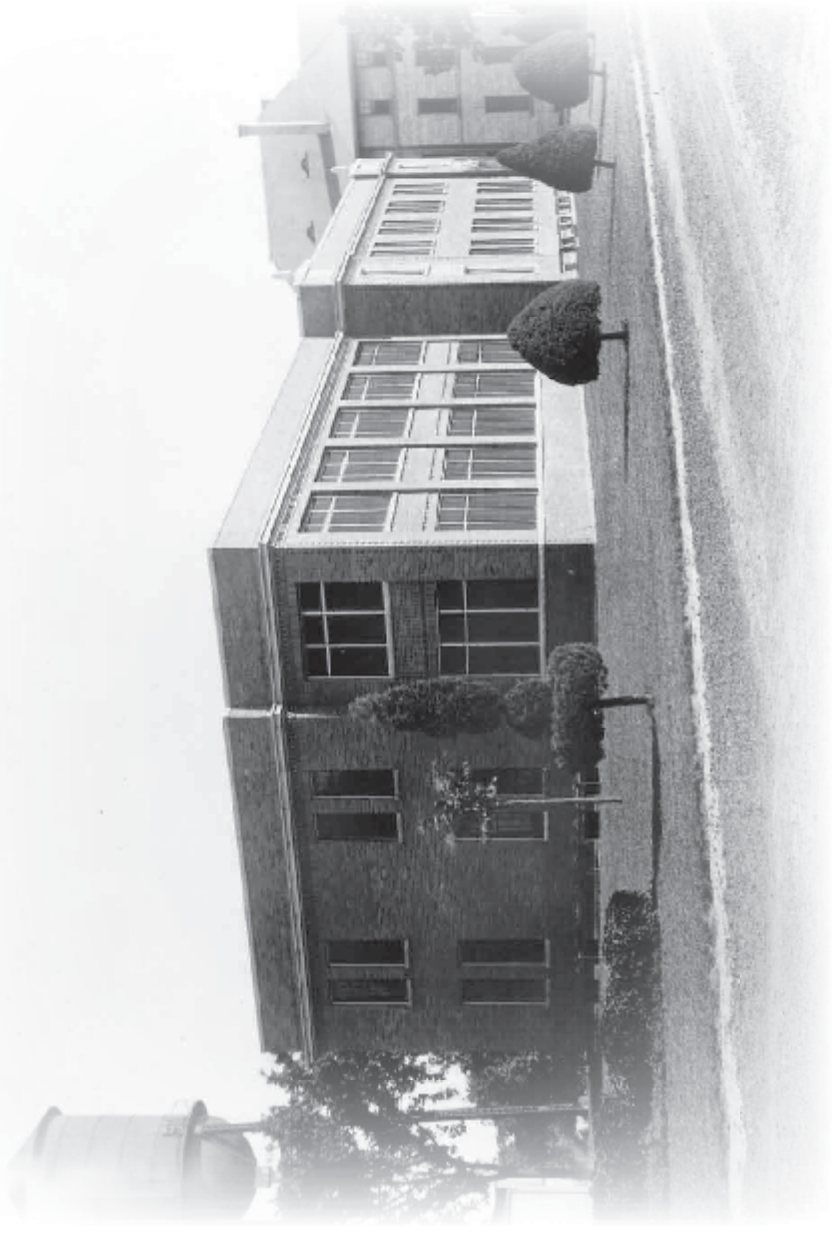
**1899** – MN Legislature established Anoka Asylum for Insane.

**1900** – Facility opened. 113 patients transferred from St. Peter State Hospital.

**1900** – Farmstead consisted of two barns, granaries, machine sheds and outbuildings. It eventually built up to approximately 100 head of Holstein cattle, (well known at the State Fairs as a prize dairy herd), 6 teams of horses, 200 hogs, 1000 chickens and 200 turkeys. Vegetables were canned there, homemade jellies and jams preserved and butter and ice cream made.

**1904, August 29** – Cottage 1 (Women's Cottage) opened and women were admitted. It was planned that Anoka would care for women patients with just enough men on the grounds to milk cows, shovel snow, etc. This resulted in a disproportionately large number of women (approximately 1,000 as compared to 400 men). To care for the approximately 100 women in each cottage, there was an average of 1.8 employees per shift.

**1908-1915** – Cottages 2 through 10 were completed and occupied. The buildings were placed in a circle to follow the “Cottage Plan” or the “Home Idea”, where it was felt the separate buildings would allow a closer relationship between the attendants and the patients. There would be useful employment for the patients either on the farmstead or assisting with housekeeping tasks in the cottage. Patients who were sent here or placed



here were considered to be long-term residents. It was understood that they would live and work here for the rest of their lives.

**1919** – Law made this Anoka State Asylum.

**1920** – Influenza epidemic; decrease of 176 patients during this period; many died of influenza.

**1925** – Occupational therapy was introduced and a teacher of “industrial work” for women patients was hired.

**1935** – First full-time woman psychiatrist, Dr. Gladys Trummald, was hired.

**1937** – Name changed to Anoka State Hospital.

**1940** – Fully approved by the American Hospital Association.

**1946** — Electroshock machine purchased and first utilized.

**1947** — Anoka State Hospital became one of the first hospitals in the Union to be approved for funding by the MN Legislature to provide a Tuberculosis Center to serve the Minnesota State mental hospitals.

**1950** — Construction began to build a Receiving Building to accommodate sixty patients for careful study, diagnosis and treatment. Renamed the Miller Building after Superintendent Dr. Edmund Miller.

**1950-1969** — The Anoka State Hospital became the Tuberculosis (TB) Center for mentally ill in the state and was located in the Burns Building. Prisoners from Stillwater were also sent here for TB treatments and were housed in Cottage 8.

**1955** — Tranquilizers were first used to treat patients.

**1961** — First state hospital in Minnesota to be accredited.

**1965** — Cottage 6 and 7 joined to form the Adult Psychiatric Center (APC); later renamed the Vail Building after Dr. David J. Vail.

**1966** — Farming operations ceased.

**1970** — Chemical Dependency treatment program opened.



**1971** — General surgery program closed.

**1980** — Cronin Building completed and occupied by the Chemical Dependency Treatment Program on the grounds of the former Burns Building.

**1985** — Name change to the Anoka-Metro Regional Treatment Center.

**1995, November 8** — Groundbreaking ceremony for new facility. Excavation delayed to March 11, 1997.

**1999, April 28** — Patients scheduled to move from old facility to new facility.

**2000** — Centennial celebration.

## ***Hastings Asylum for the Insane***

**1899** – MN Legislature established Hastings Asylum for Insane.

**1900** – Facility opened. 112 patients transferred from Rochester State Hospital.

**1919** – Law made this Hastings State Asylum.

**1937** – Name changed to Hastings State Hospital.

**1968** – Alcohol and drug abuse program was established.

**1969** – Mental Retardation programs were established.

**1976** – Mental Retardation unit closed.

**1978** – The State Hospital closed. Facility transferred to Veterans Affairs.



## Minnesota State Sanatorium for Consumptives

**1901** – The MN Legislature authorized Governor Samuel R. Van Sant to appoint a commission to locate and establish a State Sanatorium for Consumptives. The commission recommended a 700 acre site overlooking Shingobee Bay on the south shore of Leech Lake near Walker, Minnesota.

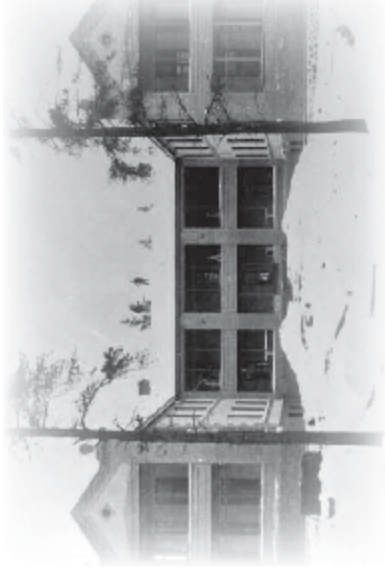
**1903** – A bill was approved by the MN Legislature authorizing the purchase of land and construction of the facility. The buildings of the Minnesota State Sanatorium for Consumptives were designed by Clarence H. Johnston Sr. in the nationalistic colonial revival style of architecture.

**1907, December 28** – The Minnesota State Sanatorium for Consumptives officially opened with the admission of two male patients.

**1914** – The Recreation Hall was built to provide a place for entertainment for the patients, who were isolated from family and friends.

**1922** – Construction of the first two infirmaries began as a response to isolate the more severe cases of tuberculosis from those who were less severe.

**1922** – The United States Government legally changed the name of the post office from “State Sanatorium” to “Ah-gwah-ching,” meaning “out of doors” in Ojibwa. Congress approved funding for a building to be constructed to be available for the care and treatment of Minnesota Indians and the Indian Building was constructed.



**1924** – A new Power House was built and began providing the facility with heat and light. The smoke stack rose 150 feet above the building foundation.

**1928** – The Hall Pavilion building was constructed to house ambulatory patients.

**1936** – The main building constructed in 1907 was remodeled under the WPA (Works Progress Administration or Works Project Administration) program initiated by President Franklin D. Roosevelt. Wooden porches were enclosed and fireproofed and terrazzo floors replaced all wooden floors.

**1937-1940** – Ah-gwah-ching was decorated with WPA paintings and other art objects.

**1960** – With the development of community nursing homes many of the persons who once would have received care at the Ah-gwah-ching Nursing Home were admitted to community nursing homes.

**1962, January 1** – After treating nearly 14,000 patients over 50 years through the isolation of infected individuals, early diagnosis and admission, tuberculin testing, improved care and surgical techniques, mass x-ray examinations, and antibiotic therapy, the Minnesota State Sanatorium for Consumptives/Ah-gwah-ching closed. The facility was immediately converted to a state nursing home for geriatric patients and was renamed the Ah-gwah-ching Nursing Home. Under its new mission, in the 1970's the nursing home served a high of 462 geriatric patients with a wide variety of physical and mental illnesses.

**1983** – The Lakeside Treatment Center was opened on the Ah-gwah-ching campus as a 40-bed Rule 35 chemical dependency treatment center for chronic chemically dependent patients.

**2003** – The mission of Ah-gwah-ching was refined.

**2006, January 1** – Temporary location of the State Operated Forensics Nursing Facility until a new facility is completed in St. Peter in the summer of 2008.



### **State Hospital Farm for Inebriates**

**1907** – Willmar Hospital Farm for Inebriates was established by the MN Legislature as Minnesota's second state hospital for alcoholics.

**1909** – The land was purchased from the Tallman family.

**1912** – Opened December 26 with two major buildings on a 500-acre farm site. Financed through a state tax of 2% on all liquor license fees.

**1917** – Due to Prohibition and the decline of the chemical dependency population, services were expanded to include custodial care for the chronically insane.

**1919** – Name changed to Willmar State Asylum.

**1935** – Cottages 4 and 10 treated active tuberculosis patients through the early 1950s.

**1937** – Name changed to Willmar State Hospital.

**1951** – Willmar became an intensive receiving hospital rather than a custodial hospital. This marked the transition to modern treatment.

**1973** – Glacial Ridge Training Center was established as a residential service program to provide services to the developmentally disabled.

**1985** – By executive order of Governor Perpich, the name was changed to Willmar Regional Treatment Center.

**1996** – In April, Developmental Disability Services became totally community-based.

**2003** – The MN Legislature adopts a plan to develop additional community-based services for individuals with mental illness.

**2006** – The sale of the Willmar Regional Treatment Center campus was finalized on January 16. 37 buildings were purchased by Nova-Tech Engineering and Epitopix. Seven buildings were purchased by Kandiyohi County to be leased back to the State of Minnesota for State Operated Services programs.

**2007** – Site selected for construction of the new Community Behavioral Health Hospital in Willmar.



**1953** – Pastoral clinical training program started for future chaplains and resident pastors.

**1954** – The “Minnesota Model” of chemical dependency treatment is born under the direction of Dr. Nelson Bradley and Dan Anderson.

**1956** – Medications began to play a significant role in psychiatric treatment. Thorazine is introduced.

**1957** – Release of film “The Human Side” which was filmed at Willmar State Hospital depicting the role of volunteers and the integration of patients into the community. This film was given the Silver Award from the American Psychiatric Association.

**1963** – Accredited by Joint Commission on Accreditation of Hospitals.

**1965** – Began Adolescent Program for boys and girls 12 to 17 years of age. 50-bed capacity.

**1969** – Farm auction held. Farm activities closed out in June.



## ***Asylum for the Dangerously Insane***

**1906** – Recommendation made by the Minnesota State board of Control for the building of a facility to house the “dangerously and criminally insane” at the site of the Hospital for the Insane at St. Peter. It was called the “Asylum for the Dangerously Insane.”

**1909** – Construction began.

**1910** – Facility opened.

**1930** – Psychosurgery, electroconvulsive therapy, and insulin coma therapy were introduced as methods for treatment.

**1954** – The custodial period ended with the introduction of Thorazine the first effective medication for the treatment of mental illness.

**1957** – The MN Legislature allowed the residents to choose the current name of the Minnesota Security Hospital (MSH).

**1963** – The MN Legislature allowed the facility its own administrative and medical management, separate from the St. Peter State Hospital.

**1970** – The Intensive Treatment Program for Sexual Aggressives (ITPSA) was established. The ITPSA served men who had committed sexual crimes and were deemed appropriate for treatment rather than going to prison to serve their correctional sentence.

**1982** – MSH moved to a new state-of-the-art building on the upper campus of the treatment



center. The new building contained seven units with 164 beds and was considered to be the finest structure of its kind serving patients that were mentally ill and dangerous.

**1980-1990** – The courts in Minnesota began to more actively apply the Psychopathic Personality law from 1939 and as a result the number of men committed for treatment related to sexual crimes began to grow quickly. The ITPSA program was ended and the new Minnesota Sex Offender Program began to take shape.

**1996** – A 50-bed addition to the MSH building was completed.

**1998** – The Forensic Transition Program was developed as a non-secure program for patients committed as mentally ill and dangerous who had successfully completed treatment at the MSH and who had gained approval from the Special Review Board to move from MSH to a less restrictive setting.



### ***State School and Hospital for Feeble-Minded and Epileptics***

**1919** – MN Legislature authorized the State Board of Control to select from the public lands of the state sites for a colony for feeble-minded and a colony for epileptics.

**1923** – Law was amended to purchase a site for a colony for epileptics. Land was secured in Cambridge. Construction on Cottage One began.

**1925** – Cottage One completed April 1925. On June 1, 1925, the first 5 residents transferred from Faribault State Hospital for the Feeble Minded. Others arrived in small groups later. Main clientele: then untreatable victims of epilepsy.

**1949** – Name changed from Minnesota Colony for Epileptics to the Cambridge State School and Hospital. State's solution for the care of patients was to continue to build more institutions.

### ***State School and Hospital for Mentally Deficient and Epileptics***

**1960** – Efforts were made by the Department of Public Welfare and hospital staff to “humanize” the living conditions of the residents. They also adapted an aggressive placement policy and tried to place as many residents as possible into suitable community facilities.

**1961** – Peak population: 2008.

**1967** – MN Legislature changes name to Cambridge State Hospital (CSH).



**1968** – After a successful pilot camping program, Camp New Hope, Inc., a non-profit corporation, is organized at CSH to “acquire, provide, and maintain therapeutic experiences in group living for handicapped persons, primarily those at Cambridge State Hospital.” They purchased a 40-acre campsite on Glacier Lake, north of McGregor, MN. The corporation was created and funded entirely by donations.

**1972** – MN Legislature requires mandatory schooling for children who are mentally retarded and trainable. Classes are conducted by school district 911 starting in August.

**1972** – Population near 935. Lawsuit filed against CSH and 5 other State Hospitals and the Administrator of each. The suit was filed by the parents of 6 individuals (2 from Cambridge) who felt that the physical conditions, care, treatment, and training did not meet constitutional standards. This was a “Class Action” Suit, meaning that any orders issued by the court would benefit all residents in all Minnesota State Hospitals. CSH becomes more program-oriented, trying to involve each resident on campus with six hours of programming per day, five days a week.

**1973** – CSH becomes more program-oriented, instead of medically oriented, attempting to involve every resident on the campus in six hours of programming per day, five days a week. When possible, this was done outside of the resident's immediate living area.

**1974** – 97 percent of residents were involved, compared to about 50 percent or less in years past. Higher functioning residents have been discharged into the community as much as possible, so the severity of the disabilities of the residents has increased dramatically as the population decreases.

**1975** – 658 residents. 90% severely and profoundly retarded, 85% have little to no speech, and about 50% have multiple handicaps (physical handicaps besides mental retardation.) Staff to resident ratios have changed due to the great amount of care each resident needs to reach their highest potential.

**1980-1990** – Continued downsizing and placement of clients into community-based programs.

**1999, June** – Last client from the Cambridge Regional Center is placed in community. Facility is officially closed.



## **Moose Lake State Hospital**

**1935** – MN Legislature enacted law authorizing appointment of commission to select land in northeast Minnesota for Fourth State Hospital for Insane.

**1935** – Special Session confirmed location of Institution at Moose Lake.

**1938** – Facility opened on May 2.

**1949** – Use of restraints discontinued. Patients are to be treated humanely and therapeutically rather than threatened with restraint.

**1950** – Moose Lake State Hospital receives an award from the American Psychiatric Association for their achievement in eliminating restraints.

**1952** – Efforts began at MLSH to coordinate and promote the use of volunteerism.

**1954** – The onset and use of Thorazine.

**1955** – Peak census of 1290 patients with at least one third being age 65 years old or older.

**1957** – Formal one-year training course for psychiatric aide trainees replaces two and half week training program started in 1950 for all employees.

**1958** – The Minnesota Department of Public Welfare won an award from the American Psychiatric Association for their efforts to involve the community.

**1959** – 40% of the patients are on psychotherapeutic medications.

**1959** – A Chemical Dependency Program was established.

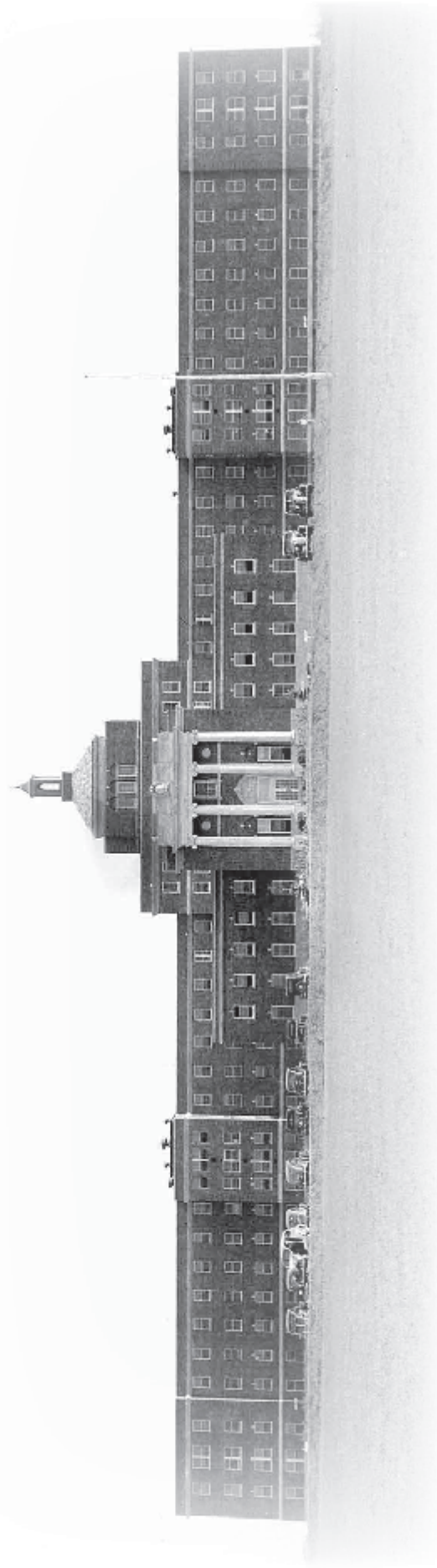
**1966** – MLSH successfully completes their first JCAHO survey and were accredited for three years.

**1969** – Mental Retardation and Developmental Disabilities programs were established.

**1973** – The first Patient/Resident Advocate is appointed at MLSH.

**1993** – The MN Legislature approves a plan to convert the hospital into a State Correctional Facility.

**1995** – The hospital is closed and transferred to the Minnesota Department of Corrections. Chemical Dependency, Developmental Disability, and Mental Health programs are moved into the community.





## ***Sandstone State Hospital***

**1950** — The State leases the site of Sandstone Federal Correctional Institution (since 1939) and converts the site to Sandstone State Hospital.

**1959** — The facility was reclaimed as a Federal prison, due to fluctuations in prison populations. 428 residents were returned to the State Hospitals in their own receiving districts. 107 employees were transferred to other State Hospitals or joined the Prison Staff.



## **Lake Owasso Annex**

**1955** – Lake Owasso Annex was established for children with mental retardation was established.

**1976** – The facility was closed and transferred to Ramsey County. Employees were either transferred to other state facilities or to the county.



## **Brainerd State School and Hospital**

- 1958** – The facility opens.
- 1967** – Name changes to Brainerd State Hospital.
- 1969** – Camp Confidence (Northern Therapeutic Camp) opens.
- 1969** – Hubert and Muriel Humphrey speak at Open House.
- 1970** – 20 medical bed and 1,322 beds for patients with developmental disabilities licensed.
- 1970** – Minnesota Learning Center (MLC) opens (patients from Owatonna).
- 1972** – Deaf Blind program opens.
- 1974** – Four Winds Lodge (chemical dependency) opens.
- 1981** – Pope John Paul II sent a photo/special message for the patients and staff at BSH.



**1985** – Name changes to Brainerd Regional Human Services Center.

**1998** – BRHSC Hosts 40<sup>th</sup> birthday.

**1999** – New Dawn Board and Lodge licensed (women with chemical dependencies).

**2000** – Outpatient Gambling Addiction Services begin.

**2003** – The MN Legislature adopts a plan to develop additional community-based services for individuals with mental illness.

## **Oak Terrace Nursing Home**

**1961** – The State began leasing the Glen Lake Sanatorium that had been a county tuberculosis sanatorium facility at Oak Terrace, MN from Hennepin County. The Oak Terrace Nursing Home was created in part of the facility. 274 geriatric residents from other State Hospitals were transferred to Oak Terrace. 287 Hennepin County Employees at Glen Lake were transferred into state service. The Minnesota Children's Treatment Center also opened. It closed in 1963.

**1976** – The facility stopped providing inpatient tuberculosis treatment services.

**1991** – The Nursing Home is closed and the remaining property is transferred back to Hennepin County and subsequently demolished.

**1993** – The entire Glen Lake complex was demolished. It had served over 17,000 people in its 75 years.



## **Minnesota Extended Treatment Options (METO)**

**1991** – Cambridge Task Force recommends the Commissioner of Minnesota Department of Human Services (DHS) develop a long-term residential program for individuals with high risk behaviors.

**1995** – Legislation directs DHS to “develop a specialized service model at the Cambridge campus to serve citizens of Minnesota who have a developmental disability and exhibit severe behaviors which present a risk to public safety. This service will have the capacity to serve between 40 and 100 individuals.”

**1996** – Bonding of 3.4 million dollars for the construction of new residential units at Cambridge to serve 36 clients and remodeling of existing buildings for day program and recreation activities.

**1997** – METO was established on the former Cambridge Regional Treatment Center campus to provide specialized services for persons with Developmental Disabilities who present a public safety risk.

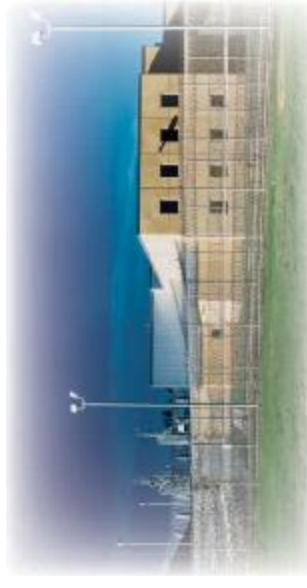
**1998** – Bonding of 1.5 million dollars for the construction of 12 additional residential beds.



**1999** – Opening of new residential units (initial 36 beds authorized in 1996 bonding) and completion of remodeling of existing buildings for day program and recreation activities.

## **Minnesota Sexual Psychopathic Personality Treatment Center**

**1993** – The MN Legislature authorizes construction of the Minnesota Sexual Psychopathic Personality Treatment Center (MSPPTC).



**1995** – The MSPPTC is opened and begins providing treatment to individuals committed as psychopathic personalities.

**1999** – The MN Legislature authorizes a 50-bed expansion of the facility.

**2000** – Completes 50-bed expansion.

**2003** – The name of the MSPPTC is changed to the Minnesota Sex Offender Program (MSOP) at Moose Lake.

**2007** – MSOP presently operates facilities at St. Peter and Moose Lake and at the Minnesota Correctional Facility in Moose Lake.

## **Community Support Services**

**1993** – The MN Legislature created seven Community Support Services (CSS) Teams across the state. While all CSS Teams originally were housed on former RTC campuses, today's CSS Teams provide decentralized clinical consultation and technical assistance in all 87 Minnesota counties. As in 1993, today CSS assists clinically complex individuals remain in their communities and builds support networks. Services promote supports that are person-centered and that develop paid and non-paid caregiver skills. A primary emphasis for all services is to assist those who know the individual best. CSS may fill a direct service gap temporarily while elements of a successful life plan are developed, however training and mentoring others remains the focus of Community Support Services. CSS continues to evolve to build community capacity to service clinically complex individuals.

**2003** – Synergy was developed to build support networks for individuals with serious and persistent mental illness.

**2005** – Forensic CSS was developed to serve individuals that have been committed as mentally ill and dangerous on provisional discharge living in the community.

## **Minnesota Security Hospital**

See page 14.

# SOS TODAY (ADULT MENTAL HEALTH)

## **Community Behavioral Health Hospitals (CBHH)**

**1987** – The MN Legislature enacted the Adult Mental Health Act which set the stage for system changes for increased consumer choice and expanded marketplace for mental health services.

**2003** – The MN Legislature adopts a plan to expand community-based alternatives for persons with mental illness. Eleven public/private partnerships were formed and collaborated over a period of several years to build adult mental health treatment capacity in smaller settings, closer to individuals' communities, homes, and natural supports of family and friends. Regions reviewed locations of available psychiatric inpatient mental health services and population centers to ensure adequate capacity and access.

**2005** – CBHHs were designed as part of a new array of services. Regional Planning groups asked State Operated Services to operate hospitals. Provide acute psychiatric hospitalization

for assessment, stabilization and treatment. Maximum 16 bed capacity with an expected average length of stay less than 30 days.

**2006** – CBHHs opened in Alexandria, St. Peter, Rochester, Annandale, Wadena, and Fergus Falls.

**2007** – CBHHs opened in Baxter, Cold Spring, and Bemidji.

**2008** – Tenth CBHH will open in Willmar.

**2005** – A community dental clinic was opened in Fergus Falls.

**2006** – A dental office operated in conjunction with Central Lakes Community College was opened in Brainerd. A clinic continues to be operated on the former Willmar campus.

## **Eveleth Behavioral Health Services**

**1995** – Eveleth Behavioral Health Hospital, a community based state operated sixteen bed psychiatric hospital, opened after the closure of Moose Lake Regional Treatment Center. This acute care facility was the first community-based, sixteen-bed psychiatric hospital founded by the State of Minnesota. The successful implementation of treatment programs and services at Eveleth Behavioral Health Hospital proved the state's hypothesis that quality health care could be delivered in smaller, community-based facilities. Eveleth Behavioral Health Hospital was also the first community-based, sixteen-bed psychiatric hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).



## **Clinics**

**1991** – Health Source Clinic in Cambridge and Southern Cities Clinic in Faribault were opened as part of the closure agreement of their respective Regional Treatment Centers. The Clinics originally provided a full range of services including Psychiatric, Dental, Occupational Therapy, Physical Therapy, Speech Therapy and General Physician services. The intent was that over time these services would be replaced by the private sector. This has happened except for Dental Services statewide and Psychiatric services out of Faribault.



## **Bridge House**

**1995** – Bridge House opened in Duluth following the closure of Moose Lake Regional Treatment Center earlier that summer. Bridge House had 12 beds designated for Seriously and Persistently Mentally Ill adults. Bridge House served many of the same clients who had stayed at Moose Lake Regional Treatment Center, but also served many new clients. From its inception, Bridge House has tried to help provide services which are not already available in the community to mentally ill clients. To that goal, Bridge House has worked closely with the counties served to meet changing needs.



## **South Central Crisis Center**

**2003** – Regional Planning Groups established to develop community-based services. The South Central Ten Regional Planning Group in collaboration with area consumers and mental health service providers, identified need for sub acute crisis stabilization services. The South Central Ten Regional Planning Group appointed a sub-committee to design a crisis stabilization program which would serve the consumers residing in the ten counties.

**2004** – Program components, location and staffing needs were identified and proposal submitted to the South Central Ten Community-Based Initiative and State Operated Services. The

South Central Ten Community-Based Initiative requested that State Operated Services operate the crisis stabilization program. A Memorandum of Understanding for South Central Community-Based Initiatives and State Operated Services was established to detail the scope of the Crisis Center, define the roles and responsibilities of the parties and discuss procedures for timely project reviews.

**2005** – South Central Crisis Center opened in Mankato, Minnesota.

## **Anoka-Metro Regional Treatment Center**

See page 9.

# SOS TODAY (SPECIAL POPULATIONS)

## Community Addiction Recovery Enterprise

**1872** – Dr. Charles N. Hewitt was appointed Executive Secretary of the newly created State Board of Health launching Minnesota's movement toward institutional treatment for alcoholism.

**1873** – After considerable study of asylums serving the inebriate population, Dr. Hewitt and his allies convinced the MN Legislature to pass "An Act to Establish a Fund for the Foundation and Maintenance of an Asylum for the Inebriates."

**1907** – The MN Legislature passed an act authorizing establishment of a State Hospital Farm for Inebriates.

**1909** – The Board of Control purchased 482 acres from the D.N. Tallman family for the location of the new State Hospital Farm for Inebriates located in Willmar.

**1912** – The first patients were admitted to the State Hospital Farm for Inebriates in Willmar. Patients are still being served at that site.

**1950** – Dr. Nelson Bradley and Dan Anderson developed a holistic approach to treatment of alcoholism, known as "The Minnesota Model" treating the whole person—body, mind and spirit—which shortened lengths of stay to just 60 days.

**1959** – Treatment services were established at Moose Lake.

**1970** – Treatment services were established at Fergus Falls.

**1971** – Treatment services were established at Anoka, Brainerd and St. Peter.

**1974** – The Counselor Training Program was established at Fergus Falls, which continued until 1996.

**1975** – Treatment services were established in Rochester and Brainerd opened their Four Winds program for Native Americans.

**1977** – Fergus Falls established its Youth Treatment Program, which ended in 1992.

**1982** – Treatment services at Rochester closed.

**1983** – The Drug and Alcohol Abuse Normative Evaluation System (DAANES) was initiated.

**1984** – St. Peter began their dual diagnosis (mental illness/chemical dependency) program.

**1986** – The Consolidated Chemical Dependency Treatment Fund (CCDTF) was established into one fund administered by counties and Indian reservations.

**1988** – Treatment programs began operations under a competitive model with the implementation of the CCDTF.

**1994** – Due to the closure of Moose Lake State Hospital, Liberalis, a specialized women's treatment program, moved off campus, leasing the third floor of the Community Memorial Hospital

in Cloquet. The men's program was moved to Cambridge. A dual diagnosis (mental illness/chemical dependency) outpatient program was established at Willmar.

**1996** – Fergus Falls established a treatment program focusing on adolescents, ages 12-18 years of age.

**2000** – Brainerd established a treatment program for adolescents.

**2003** – The Willmar dual diagnosis program becomes an enterprise, residential program.

**2005** – The MN Legislature established the Minnesota Methamphetamine Resource Center in Willmar to support evidence-based practice research statewide and to create training for addiction counselors specializing in the treatment of methamphetamine abuse.

**2007** – St. Peter opened a new 36-bed facility. This was the first State Operated Services facility built specifically for individuals with chemical dependency since Willmar in 1912. The Otter Tail County Board approved construction of a new 60-bed facility at Fergus Falls.





## Minnesota State Operated Community Services (MSOCS)

**1986** – The first state operated group homes were opened.

**1987** – State Operated Community Services (SOCS) began as a pilot project to move developmentally disabled individuals into the community.

**1997** – Governor Arne H. Carlson established an Executive Order creating Eastern Minnesota State Operated Community Services (EMSOCS) to manage community-based homes, intermediate care facilities and day training and habilitation programs for Minnesotans with developmental disabilities formally managed by Faribault Regional Center and the Cambridge Regional Human Services Center.

**2002** – Minnesota State Operation Community Services (MSOCS) was created as a result of a merger between state operated programs managed by five separate regions throughout the state.



## Minnesota Neurorehabilitation Services (MNS)

**1994** – Established MNH on the Brainerd Regional Human Services Campus to provide inpatient services for adults with TBI (traumatic brain injury) or ABI (Acquired brain Injury) who were not being served adequately.



## Child & Adolescent Behavioral Health Services (CABHS)

**2002** – CABHS was established, combining existing programs and resources from the Brainerd and Willmar Regional Treatment Centers (RTICs). Minnesota Intensive Therapeutic Homes (MITH) are developed to provide a unique alternative to institutional placement for children with severe emotional disturbance. Foster families receive rigorous support from CABHS mental health professionals. Community support staff members maintain daily contact with the provider and facilitate support group meetings for foster parents each week. They are available for crisis support for the child/adolescent and the foster parent 24 hours a day/7 days a week.

**2005** – CABHS received JCAHO Accreditation.





Minnesota Department of **Human Services**

**STATE OPERATED SERVICES**

PO Box 64979

St. Paul, MN 55164-0979

This information is available in other forms to people with disabilities by contacting us at (651) 431-3676 (voice). TTY/TDD users can call the Minnesota Relay at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.

## Appendix E

HASTINGS STATE HOSPITAL

HASTINGS, MINNESOTA

- Cemetery Legend.

April 26, 1900 to December 28, 1964

(Last burial)

On April 26, 1900 the first patients, a group of 100 transferred from the Rochester State Hospital, were admitted to "Asylum Number Two For The Insane at Hastings, Minnesota" (original title given by State legislature; Asylum Number One For The Insane was located at Anoka, Minnesota and opened on March 14, 1900; present title given by State legislature on March 25, 1937). These patients and their baggage were brought to Hastings by special train which deposited them near the present site of the King Midas Mill, and they walked across a field of a privately owned farm to their new "home". (The 18th Street bridge, giving private and direct access to the City of Hastings, was not completed until February 13, 1903).

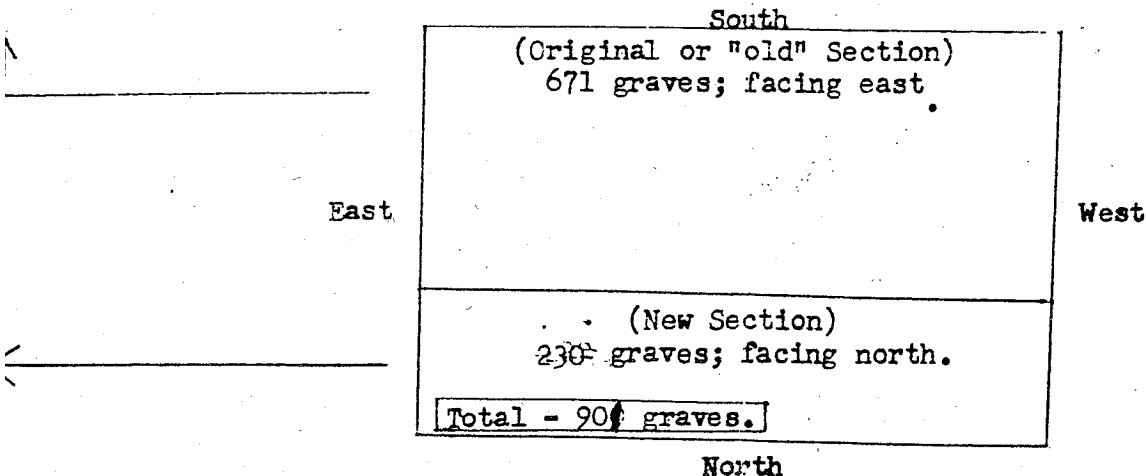
The Hastings State Hospital Cemetery, located at the southeast corner of the hospital property, now has two "sections"; the original or "old section" and the "new section" adjoining on the north side. It is interesting to note that, due to earlier burial customs, the graves in the "old section" face to the east as these souls await the day of resurrection; this section contains 671 graves. The "new section", opened on October 7, 1944, with the graves facing to the north, contains 230 graves - a total of 901 graves as of December 28, 1964. i.e., the last burial.

The first burial in this cemetery took place on July 16, 1901 - he was medical file #13 of the original 100 first admissions; aged 45, of tuberculosis, at Hastings 9 months. (Medical file #1 was buried in this cemetery on March 12, 1925; a male, aged 67, of chronic Brights Disease, at Hastings 24 years and 11 months).

As progress has been made in the treatment of mental and emotional disorders, and the Hastings State Hospital has changed from a "custodial asylum" to a "treatment center" with shorter periods of hospitalization and continuance of close family ties, the number of burials in this cemetery has gradually decreased to about 4 a year. It should be noted that there were no burials in this cemetery during 1963. Those who are presently being buried in this cemetery either have indigent families or have lost contact with their relatives during a prolonged period of hospitalization.

\*\*\*\*\*

(Hastings State Hospital Cemetery)



## **Appendix F**



Leo Grieben, M.D.  
Medical Director

HASTINGS STATE HOSPITAL  
HASTINGS, MINNESOTA

John R. Malban  
Administrator

Rev. Joseph J. Quinlan  
Resident Chaplain

September 1, 1967

Dick A. Dobrick  
Business Manager

\*\*\*\*\*

Cemetery Review:

First Burial - July 16, 1901  
Last Burial - December 28, 1964  
Total Burials - 901

\*\*\*\*\*

Contents of Review:

I - Copy of Cemetery Plot; 2 Sheets; completed in April 1967.  
Surveyor: Harry S. Johnson, Associates, Inc.

Sheet #1 indicates (a) Grave Row Number;

- |     |
|-----|
| 33  |
| III |

 (b) Individual Grave Number in Grave Row;
- (c) Medical File Number of Patient Burial.

Sheet #2 indicates (a) Grave Row Number;

- |      |
|------|
| 33   |
| 2103 |

 (b) Individual Grave Number in Grave Row;
- (c) Distance of Grave from Row Marker at top of Grave Row.

II - Alphabetical Listing of Patients Interred.  
(Includes Medical File Number, Grave Row Number and Individual Grave Number in Grave Row.  
After verifying on above Sheet #1, use Sheet #2 for location of Patient Grave. )

III - Listing according to Sequence of Medical File Numbers.  
(Also contains Grave Row and Individual Grave Number.)

~~IV - Listing according to Sequence of Interments.  
(Also contains Medical File, Grave Row and Grave Numbers.)~~

IV - Fiscal Year Summary of Patient Deaths and Interment or Removal.

\*\*\*\*\*

In Original (South) Section:

1901-1944 = 671 Graves.  
16 Grave Rows; Numbered West to East.  
Indiv. Graves Numbered North to South.  
Graves face to East.

In Addition (North) Section:

1944-1964 = 230 Graves.  
9 Grave Rows; Numbered South to North.  
Indiv. Graves Numbered West to East.  
Graves face to North.

## Appendix G

I) Original or "Old Cemetery".

- a) Rows of Graves numbered from West to East; 16 Rows.
- b) Individual Graves numbered from North to South; #1 to #66.
- c) Bodies buried facing West to East.

Row #1:

- Grave #6 - Remove marker #1280 (this number also in R#1, G#11); #1280 not buried at HSH.  
Install marker #2322 (make new marker).
  - Grave #7 - Remove marker #2985; not buried at HSH.  
Install marker #2285 (make new marker).
  - Grave #8 - Install marker #1841 (grave not marked now).
  - Grave #11 - Remove marker #1280; not buried at HSH.  
Install marker #280
  - Grave #13 - Install #2301; grave not marked now.
  - Grave #16 - Empty grave; not marked now.
  - Grave #17 - Remove #827; not buried at HSH.  
Install #828.
  - Grave #19 - Empty grave.
  - Grave #20 - Empty grave.
  - Grave #22 - Empty Grave.
  - Grave #27 - Install #826; grave not marked now.
  - Grave #29 - Empty grave.
  - Grave #32 - Empty grave.
  - Grave #36 - Empty grave.
  - Grave #40 - Empty grave.
  - Grave #43 - Empty grave.
  - Grave #47 - Empty grave.
  - Grave #49 - Empty Grave.
  - Grave #53 - Install #47; grave not marked now.
  - Grave #54 - Remove #659; not buried at HSH.  
Install #3017.
  - Grave #62 - Remove #1913; not buried at HSH.  
Install #2122
  - Grave #63 - Remove #2036; not buried at HSH.  
Install #2202
  - Grave #64 - Remove #2097; not buried at HSH.  
Install #2307
- (Rest of graves in Row #1 correct)



"Old Cemetery"

Row #2:

- Grave #7 - Empty grave.
- G. #11 - Empty grave.
- G. #12 - Remove #331; not buried at HSH.  
Install #330
- G. #16 - Remove #1263; not buried at HSH.  
Install #1265
- G. #18 - Empty grave.
- G. #20 - Empty Grave.
- G. #26 - Empty grave.
- G. #27 - Empty grave.
- G. #32 - Empty grave.
- G. #33 - Empty grave.
- G. #36 - Empty grave.
- G. #42 - Remove #285; not buried at HSH.  
Install #997.
- G. #43 - Install #16; grave not marked now.
- G. #47 - Empty grave.
- G. #56 - Install #986; Grave not marked now.
- G. #57 - Empty grave.
- G. #69 - Empty grave. End of Row #2; rest O.K.

\*\*\*\*\*

Row #3:

- G. #1 - Remove #3029; not buried at HSH.  
Install #3069
- G. #7 - Install #2511; Grave not marked now.
- G. #11 - Remove #879; Duplicate of R.3;G.13.  
Install #826
- G. #14 - Empty grave.
- G. #20 - Remove #1420; not buried at HSH.  
Install #1424
- G. #22 - Install #741; grave not marked now.
- G. #26 through #33 - Empty graves (Old shed location)

Row #3:(continued)

- G. #35 - Remove #1055; not buried at HSH.  
Install #1058
- G. #43 - Install #139; grave not marked now.
- G. #46 - Empty grave.
- G. #48. - Empty grave.
- G. #51 - Remove #1184; not buried at HSH  
Empty grave.
- G. #60 - Remove #8; duplicate of R.1;G.68.  
Install #423
- G. #68 & #69 - Empty graves. End of Row #3.

\*\*\*\*\*

Row #4:

- G. #\* - Empty grave.
- G. #7 - Correct #1784; check to see if correct
- G. #9 - Empty grave.
- G. #14 - Empty grave.
- G. #16 - Remove #1695; not buried at HSH.  
Empty grave.
- G. #19 - Install 1784; not marked now.
- G. #21 - Install #2635; not marked now.
- G. #25 through #33 - Empty graves (former shed
- G. #36 - Remove #1662; not buried at HSH.  
~~Install #~~ Empty grave.

- G. #68 & #69 - Empty graves. End of Row #4.

\*\*\*\*\*

Row #5:

- G. #1 - Remove #1725; duplicate of R.5;G.5.  
Install #1100
- G. #10 - Empty grave.
- G. #16 - Remove #1065; duplicate of R.5;G.34.  
Install #1064
- G. #17 - Empty grave.
- G.#19,#20 & #21 - Empty graves.
- G. #22 - Install #2565; not marked now.

("Old Cemetery"; continued)

Row #5:

- G. #23 - Remove #2037; not buried at HSH.  
Install #3037.
- G. #24 - Empty grave.
- G. #27 - Empty grave.
- G. #37 - Remove #2395; not buried at HSH.  
Install #2375
- G. #43 - Remove #302; not buried at HSH  
Install #1577
- G. #46 - Remove #3211; not buried at HSH.  
Install #1422
- G. #54 - Install #3037; grave not marked now.
- G. #55 - Install 1443; grave not marked now.
- G. #56 - Install #3039; grave not marked now.
- G. #58 through #69 - empty graves. End of Row #5.  
\*\*\*\*\*

Row #6:

- G. #1 through #5 - Empty graves.
- G. #10 through #21 - empty graves.
- G. #28 - Remove #1742; not buried at HSH.  
Install #1422.
- G. #50 through #69 - Empty graves. End of Row #6.  
\*\*\*\*\*

Row #7:

- G. #11 - Remove #2461; not buried at HSH  
Install #2481
- G. #13 - Install #3454; grave not marked now.
- G. #15 - Install #1054; grave not marked now.
- G. #17 - Remove #142; not buried at HSH.  
Install #3228
- G. #22, #23, #24 & #25 - Empty graves.
- G. #29 - Correct to #1081.
- G. #30 & #31 - Empty graves.
- G. #49 through #69. End of Row #7.  
\*\*\*\*\*

Row #8:

- G. #3 - Correct #2130; check for correcti
- G. #8 through #17 - Empty graves.
- G. #22, #23 ~~#1724~~ - Empty graves.
- G. #24 - Remove #1655; not buried at HSH.  
Empty grave.
- G. #28 - Remove #309; not buried at HSH.  
Empty grave.
- G. #49 through #69 - Empty graves. End Row  
\*\*\*\*\*

Row #9:

- G. #1 - Remove #100.  
Install #1100.
- G. #3 - Install #2408; grave not marked now
- G. #5 - Remove #3455; not buried at HSH.  
Empty grave.
- G. #7 - #2130; not buried at HSH; Remove mar  
Install #2139. 8
- G. #8 - Remove #1442; duplicate of R. #, G. 4  
Install #1078
- G. #10 - Remove #2790; Duplicate of R. #, G. 1  
Install #253
- G. #11 - Remove #2653; duplicate of R., G. 1
- G. #18 - Remove #1940; not buried at HSH.  
Empty grave.

- G. #23 - Empty grave.

- G. #25 - Empty grave.

- G. #49 through #69 - Empty graves. End Row.  
\*\*\*\*\*

Row #10:

- G. #23 - Empty grave.
- G. #32 - Remove #237; not buried at HSH.  
Empty grave.
- G. #43 - Check for Correct #1374; Install.  
Remove #1405.
- G. #45 - Empty grave.
- G. #48 through #60 - Empty graves. End Row

("Old Cemetery"; continued)

Row #11:

- G. #5 - Install #962; grave not marked now.
- G. #11 - Empty grave.
- G. #22 - Empty grave.
- G. #26 - Install #1152; grave not marked now.
- G. #26 - Install #2694; grave not marked now.
- G. #47 - Empty grave.
- G. #49 through #60 - Empty graves. End Row.#11.  
\*\*\*\*\*

Row #12:

- G. #3 - Remove #3555; Dan Sheehy, still Pt HSH.  
Empty grave.
- G. #18 & #19 - Empty graves.
- G. #26 - Empty grave.
- G. #46 & #47 - Empty graves.
- G. #50 through #60 - Empty graves. End Row #12.  
\*\*\*\*\*

Row #13:

- G. #11 - Remove #314; not buried at HSH.  
Install #2347.
- G. #13 - Empty grave.
- G. #21, #22, #23 & #24 - Empty graves.
- G. #29 - Empty Grave.
- G. #30 - Remove #699; not buried at HSH.  
Install #625.
- G. #33 - Empty grave.
- G. #36 - Empty grave.
- G. #40 & #41 - Empty graves.
- G. #43 through #60 - Empty graves. End Row #13.  
\*\*\*\*\*

Row #14:

- G. #1 through #6 - Empty graves.
- G. #8 - Empty grave. Remove #274; not buried HSH.

Row #14: (continued)

- G. #13 - Remove #2737; not buried at HSH.  
Install #273.
- G. #20 - Remove #2251; not buried at HSH.  
Install #2241.
- G. #26 - Remove #266; not buried at HSH.  
Install #289.
- ~~G. #27 - Remove #2766; not buried at HSH.  
Install #2771~~
- G. #29 - Remove #342; not buried at HSH.  
Install #100.
- G. #35 - Remove #292; not buried at HSH.  
Empty grave.
- G. #37 - Remove #336; not buried at HSH.  
Install #335.
- G. #42 through #60 - Empty graves. End Row  
\*\*\*\*\*

Row #15:

- G. #1 & #2 - Empty graves.
- G. #5 - Empty grave.
- G. #6 - Remove #287; not buried at HSH.  
Empty grave.
- G. #7 - Empty grave.
- G. #8 - Remove #367; not buried at HSH.
- G. #16, #17 & #18 - Empty graves
- G. #21 - Remove #311; not buried at HSH.  
Empty grave.
- G. #23 - Empty grave.
- G. #35 - Remove #271; not buried at HSH.  
Empty grave.
- G. #36 - Empty grave.
- G. #42 through #60 - Empty graves. End Row  
\*\*\*\*\*

Row #16:

- G. #1, #2, #3, #5, #6, #8, #9, #11, #12, #13, #14 &  
#16 through #60 - Empty graves. End R
- G. #4, #7, #10 & #15 occupied in this Row.  
END OF "OLD CEMETERY"  
\*\*\*\*\*

"New Cemetery": Rows of Graves numbered from South to North; 12 Rows.

- b) Individual Graves numbered from East to West ; #1 to #28.
- c) Bodies buried facing South to North.

Row #1:

Grave #9 - Remove #3282; not buried at HSH.  
Empty grave. (body to U of M)

~~###/###/###~~ Rest of Row #1 = Correct.  
\*\*\*\*\*

Row #2:

G. #2 - Remove #3955; body disinterred.  
Empty grave.

G. #4 - Empty grave.

G. #20 - Empty grave

G. #28 - Remove #1513; Pt on P.D. & Living.  
Empty Grave. (Prime Berad)

Row #3:

G. #11 - Remove #2908; body to U of M.  
Empty grave.

G. #19 - Empty Grave,  
\*\*\*\*\*

Row #4:

G. #3 - Empty grave.

G. #27 - Remove #5237; Pt Allen Stasel on P.D.  
Empty grave.  
\*\*\*\*\*

Row #5:

G. #9 - Empty grave.

G. #18 - Empty grave.  
\*\*\*\*\*

Row #6:

G. #18 - Install #5089; grave not marked now.

G. #20 - Empty grave.

G. #24 - Empty grave.  
\*\*\*\*\*

Row #7:

G. #2 - Install #1315; not marked now.

G. #13 - Install #2553; not marked now.

G. #19 - Install #3821; not marked now.

G. #21 - Install #5328; not marked now.

G. #24 - Remove #2144; Pt still living HSH.

G. #26 - Install #735; not marked now.  
\*\*\*\*\*

Row #8:

G. #3 - Install #5327; not marked now.

G. #8 - Install #5560; nor marked now.

G. #10 - Install #5611; not marked now.  
\*\*\*\*\*

Row #9:

G. #1 & #2 - Empty graves.

G. #3 - Install #6947; not marked now.

G. #4 - Install #4064; not marked now.

G. #5 - Install #3011; not marked now.

G. #7 - Install #3839; not marked now.

G. #8 - Install #3862; not marked now.

G. #9 - Install #821; not marked now.

G. #17 - Remove #7693; shipped out for burial

G. #22 - Install #7529; (or is G.#23 right Gr

G.#23 - Empty grave (or is this #7529)

G. #27 - Empty grave.  
\*\*\*\*\*

No Graves in Rows #10, #11, #12 yet.  
\*\*\*\*\*