

# CITIZENS LEAGUE REPORT

No. 38

**Recommendation:**  
**Appropriation for expanded psychiatric  
service at General Hospital**

**March 1955**

601 CITIZENS LEAGUE OF MINNEAPOLIS AND HENNEPIN COUNTY  
601 Syndicate Bldg. LI 0791

TO: Board of Directors  
FROM: Special Sub-Committee, Health, Hospitals and Welfare Committee  
DATE: March 1, 1955

APPROPRIATION FOR EXPANDED PSYCHIATRIC SERVICE AT GENERAL HOSPITAL

PROBLEM: Should General Hospital add a 20-bed unit for short-term psychiatric care and should the City Council appropriate an additional \$42,000 for staffing that service in 1955?

THE LEAGUE'S CONCERN: The Board of Public Welfare, which operates General Hospital, proposed to staff 20 additional beds in 1955 to give short-term treatment in the hospital's psychiatric service. Up until now the hospital has operated 32 beds, nearly all of them occupied by patients held for only diagnosis.

The City Council Ways and Means committee has withheld approval of the project under its policy of generally denying funds for any increased city services this year.

Because the League had established a committee in 1953 specifically to follow developments at General Hospital in the light of the League's 1953 recommendations, the League's responsible committee asked the Council committee to delay final action until further study was possible.

The League made it clear that it had no opinion whether the 20 beds should be added, but it wished to study the matter. This report and recommendation is the result of the Ways and Means Committee agreement to that study.

RECOMMENDATION: The City Council Ways and Means Committee should approve expansion of the psychiatric service at Minneapolis General Hospital to provide 20 beds for short-term treatment. Funds for this should be provided from within the level of appropriations for the Board of Public Welfare already approved by the committee.

DISCUSSION: While an appropriation for expanded service would be a wise use of public money, the League opposes deficit financing or further manipulation of current funds to support this service. Hence, the recommendation that the service be provided from within funds already allocated for the general purposes of health and welfare.

## INTRODUCTION

This report seeks to answer the question of whether 20 beds and staff for them should be added to the psychiatric service at Minneapolis General Hospital in 1955.

Such expansion has been requested by the Board of Public Welfare which operates the hospital. The City Council Ways and Means Committee withheld approval under its policy of refusing funds for additional personnel in any city services.

The Citizens League is interested in this situation because of its continuing study of Minneapolis General Hospital on which the first report was made in August, 1953. On Wednesday, February 9, the League appeared before the Ways and Means Committee to express its interest in the appropriation for the psychiatric service. Appearing for the League were, Charles Bellows, immediate past president, and first chairman of the Health, Hospitals and Welfare Committee, and Albert Richter, research director. They said the League had no opinion whether the appropriation should be made, but the League considered the matter important enough to justify special study. The Committee accepted the League's offer to study the matter and set March 3 for report.

The study was the responsibility of the Health, Hospitals and Welfare Committee, Gordon Mikkelson, chairman, and the chairman of the continuing study sub-committee on Minneapolis General Hospital, James Stephan. They and Mr. Bellows used the services of Al Richter, League research director; gathered information from the printed sources listed in the bibliography; and consulted the following persons: Dr. Thomas Lowry, chief of staff, Minneapolis General Hospital; Morris Hursh, commissioner, Minnesota Department of Public Welfare; Dr. Dale C. Cameron, director of medical services, Minnesota Department of Public Welfare; Dr. Richard Anderson, chief, psychiatric service, Minneapolis General Hospital; Kenneth Holmquist, superintendent, Minneapolis General Hospitals; Omar Schmidt, assistant executive director, Community Chest and Council of Hennepin County; Clare Gates, Director, Health and Medical Care Division, Community Welfare Council; Rev. Frederic Norstad, president, Citizens Mental Health Association of Minnesota; Mrs. Geri Joseph, Citizens Mental Health Association of Minnesota and Max R. Williamson, Citizens Mental Health Association of Minnesota.

The persons above contributed factual information and professional opinions but are not responsible for the presentation of that information here nor for the findings and recommendations drawn by the League committee.

## APPROACH TO THE STUDY

The study was narrowed to two questions: (1) Is addition of 20 beds desirable? (2) If so, should money be appropriated at this time in view of the restricted funds available to the city?

To answer No, 1, the group considered the value of a short-term treatment service to the public and to the institution. Then it asked if those benefits

were desirable. The conclusion was "yes".

To answer question 2, the group considered alternatives to city appropriation. Could funds be obtained from other than city sources? Could money be transferred from non-Welfare Board sources, and is this proper management of city finances? Could appropriation be delayed without loss of any of the essential benefits? The general answer was that approval for the necessary expenditure should be given now, but funds for the service should come from within the amounts already set up for the general field of city health and welfare services.

## SECTION I

### IS THE ADDITION OF 20 BEDS FOR SHORT-TERM TREATMENT DESIRABLE?

#### A. Value of early diagnosis and short-term treatment

There was universal agreement among professional persons that early diagnosis and treatment of mental illness is desirable for patients and the public paying the costs. They reported this situation, applied to public care patients: Mental illness, like other disease such as tuberculosis and cancer, may be cured if discovered and treated early. Undetected and untreated mental illness develops seriously enough to require long-term and expensive treatment. Treating mental illness early and near the residences of patients greatly increases the possibility of cure and reduces costs of treatment to the public.

Facilities such as proposed at Minneapolis General Hospital are the kind which can treat and cure large percentages of the patients who would be given attention in such a unit, thus returning to the community many persons who can support themselves rather than become a more or less permanent charge on the public.

#### B. Value of diagnostic and treatment facilities in local communities

1. Persons can be restored who might otherwise be lost.
2. Costs to the public are less than when only state facilities are available.
3. Community social service agencies benefit.

1. Professional literature and interviews impressed the committee that persons who volunteer for treatment have a better chance for recovery than those who resist and are committed, even though relatively short-term care is indicated for each. We were advised further that persons will volunteer for treatment in a local general hospital who refuse voluntary treatment in a state mental hospital. There are several reasons: (1) There still is stigma to mental hospitals as places for "crazy people" while general hospitals are identified as places for "sick people". (2) Treatment in a hospital close to home seems to assure a patient that he will continue contacts with friends and relatives while treatment away from home threatens him with separation.

(3) By accepting voluntary treatment in a state hospital, a patient risks being held by a legal commitment. State law provides that "The superintendent of such hospital or unit shall detain such person (voluntary patient) during the time of such treatment as though he had been committed... If such superintendent deems such release not to be for the best interest of such person, his family, or the public, he shall, within the same three days, file a petition for the commitment of such person to such hospital or institution in the probate court...."

2. Proximity of friends and relatives makes treatment easier and faster in local facilities. Case histories can be developed more rapidly than when sources are distant from the patient. Kin and associates can aid in hospital treatment easier when they are nearby residents. Because of crowding and pressures for service foreseeable in state receiving units for some time, treatment is more likely to be delayed there than in a local institution, thus decreasing the probability of cure or lengthening the treatment required for cure. The effect of each of these factors is to decrease the costs to the public in treating a patient in a local facility as compared with treating him in a state unit.

The committee found no economic measure of the difference in cost between short-term care facilities at Minneapolis General and the costs that would be incurred if short-term treatment at the hospital were not provided and longer-term care were required for those persons. The group was satisfied that the difference in public costs is significant on the basis of the professional opinions of city, state and non-public professional workers.

3. The Community Welfare Council, planning agency for the Community Chest and Council of Hennepin County, is summarizing the benefits to community social services of an expanded psychiatric service at General Hospital in a separate report of its own.

C. Other considerations

1. Important effect on integrated medical program at a general hospital.
2. Important effect on total teaching function of Minneapolis General Hospital.
3. Minneapolis' relatively low in psychiatric bed ratio.
4. 50 beds are overall minimum for psychiatric unit, 20 beds for treatment section.

1. The chief of staff at General Hospital has emphasized that improved psychiatric service at the hospital is of great value to the entire medical program. The psychiatric staff is available for consultation and help on mental problems of patients who are in the hospital for other primary illnesses. The chief of staff therefore says that a functioning psychiatric service with early treatment facilities is as much a part of a well-rounded general hospital as the service of medicine, surgery or the other long-recognized medical services.

The literature in the field we examined tends to support this statement.

2. The League's 1953 first report on General Hospital stressed the important role played by the hospital and its staff as a teaching hospital, which results in good care for patients in most services. To attain a comparable status in the field of psychiatry, General Hospital needs a treatment unit of 20 beds.

3. We have sought to determine to what extent public general hospitals in the United States provide psychiatric beds. St. Paul and nine cities of Minneapolis' size were queried, and all but Cincinnati responded. These are the results:

<u>Hospital</u>	<u>City</u>	<u>Ownership</u>	<u>Number of beds</u>	<u>Number of psych. beds</u>	<u>Number of psychiatric beds per 1,000 population</u>
1. Milwaukee County Hospital for Mental Diseases	Milwaukee	County	1,018	1,018	1.17
2. E. J. Meyer Memorial	Buffalo	County	1,011	149	.26
3. City Hospital for Mental Diseases	New Orleans	City-County	100	100	.18
4. Indianapolis General	Indianapolis	City	691	62	.14
5. Kansas City General	Kansas City, Missouri	City	537	82	.14
6. Ancker Hospital	St. Paul	City-County	850	40	.11
7. King County Hospital System	Seattle	County	700	42	.09
8. Denver General	Denver	City-County	422	34	.08
9. Martland Medical Center	Newark, N.J.	City	740	36	.08
10. Minneapolis General	Minneapolis	City	471	32	.06
(7) Minneapolis General (with proposed addition)			(491)	(52)	(.097)

The table shows that so far as quantity of service is concerned, measured by the ratio of beds to population, Minneapolis General is lowest of the 10 hospitals compared. The data do not indicate what type of service is provided, that is, whether it is diagnostic, early treatment or custodial. However, we understand from competent authority that the use of psychiatric beds is a flexible matter, depending on the immediate demand. Thus, 10 of 30 beds may now be used for diagnosis, whereas at some other time 20 or more beds may be used for this purpose.

On this basis it appears that public hospitals in other comparable cities provide more psychiatric service than Minneapolis General Hospital.

4. The United States Public Health Service sets 50 beds as the minimum number for an effective psychiatric unit combining diagnostic and treatment services. Dr. Cameron told the committee that at least 20 beds are required in an intensive treatment unit which is part of a complete service.

We do not recommend that the hospital have more than 52 psychiatric beds at this time, and do believe that before any increases are considered in the future, the entire question of state-local relations in the field of mental health, including finances, should be carefully explored.

D. What has the City been doing in psychiatric service?

1. Prior to 1954 -- diagnostic service only.
2. Since 1954 -- effort to provide limited amount of early treatment.

1. Until early last year mental health care at Minneapolis General Hospital was confined to observation and examination of persons for whom a petition for commitment had been filed with the court. The Hennepin County Court Commissioner referred all persons on petition to the hospital for examination. The City paid the cost. The psychiatric service had 32 beds.

During this period, the hospital superintendent states, the chief of service spent about five hours a week at the hospital. He examined patients to determine whether they should be recommended for commitment or discharge. No effort was made to provide short-term treatment which might restore patients and prevent long-term commitment. No physician was in attendance. There were no visiting consultants. Basically, the psychiatric unit was an emergency facility for confinement pending diagnosis to determine commitment status. The League in its 1953 report found that a community need was not being met in short-term psychiatric care.

In 1953, the last full year during which the psychiatric service was operated in this way, the average stay was 12.17 days.

2. In the past year or so the nature of the psychiatric service at General Hospital has changed greatly. The new chief of psychiatric service spends full time on the job. Many of the cases are still emergencies, but diagnosis has been supplemented with some short-term treatment. The length of stay increased to 15.74 days from 1954. The chief of psychiatry says that it would have been longer reflecting more treatment - except that he had to release patients to handle emergencies. The capacity was still 32 beds, with an occupancy ratio of 91%. Two beds - one for a man, one for a woman - were kept empty for emergencies.

The change in psychiatric service at General Hospital from a purely diagnostic unit to one which provides some short-term treatment is possible because (1) the new chief of psychiatric service gives more time to the service and (2) seven private psychiatrists have assisted on a consulting basis without fee. This additional professional service undoubtedly is now available because the hospital is doing more than mere diagnosis.

The additional staff requested for short-term treatment would permit consolidation of the start made in 1954, and expansion to a minimum size for effective operation.

E. Can the State provide the service through mental hospitals?

1. Mental hospitals are mostly for senile persons and persons with serious mental disturbances.

2. Mental hospitals are overcrowded, understaffed.
3. No program in sight at state level for type of short-term treatment facilities asked for Minneapolis General Hospital.

1. The state of Minnesota, through its Department of Public Welfare, offers a program for the care and treatment of the mentally ill of the entire state, including residents of Minneapolis. It has eight mental hospitals and four follow-up clinics. The clinics primarily provide continuing care for those discharged from state hospitals. The Minneapolis clinic is limited solely to follow-up.

Mental patients enter state hospitals in two ways. They are (1) committed by court order (by Court Commissioner in Hennepin County) upon petition of a reputable person and after the court finds need for care; (2) they voluntarily enter to receive the care available there.

Before making a commitment, the court determines that the patient really needs hospital care. Careful work at this point is important because a patient surrenders all civil rights when he is committed. The court has the patient examined by two physicians. This can be done either at the state hospital or at a local institution.

The mental hospitals have separate receiving units. They screen new admissions. One function of the receiving units is to give intensive short-term treatment (a maximum of about 90 days) to patients whose condition indicates a good possibility of successful response.

On the whole, however, the state hospitals are used mostly for senile persons and persons with serious mental disturbances.

2. The statistical report of the mental hospitals for the year ending June 30, 1954 indicates that the hospitals averaged over 97% full last year on the basis of designed capacity, and 119% of capacity according to the state Health Department standard. It also shows that the hospitals were clearly understaffed. The figures are summarized in appendix A attached.

3. The state commissioner of Public Welfare told a committee member (February 28) that "our state facilities are crowded, inadequate for short-term care in both space and personnel. There is no program in sight which would provide for the City of Minneapolis the kind of short-term treatment of psychiatric patients which is proposed in the 20-bed expansion of psychiatric service in Minneapolis General Hospital as I understand it."

F. Can the State provide the services through University Hospitals?

1. University Hospitals are primarily for teaching and research and serve the entire state.

The University of Minnesota Hospitals, though it is an instrumentality of the state government, is set up primarily for teaching and research. It accepts patients, including mental health patients, on referral from private physicians. The hospitals' psychiatric service of 63 beds is a receiving unit for diagnosis and intensive treatment of mental patients. The hospital serves the state as a whole, not just Minneapolis. The psychiatric service has a 20-day waiting list, (Jan. 1955).



## SECTION II

### SHOULD MONEY BE APPROPRIATED AT THIS TIME FOR AN ADDITIONAL 20 BEDS IN VIEW OF RESTRICTED CITY REVENUE?

#### A. Could funds be obtained from other than city sources?

The service is desirable, and it appears that the state government is not now providing it and will not be able to provide it in the foreseeable future. There is no legal obligation of the federal government in this field.

Counties are now required to pay up to \$10 per month for patients in state mental hospitals who have no other source of money (see Appendix B. for a detailed description of present allocation of financial responsibility). However, there is no authority for counties to pay for treatment in institutions other than the state mental hospitals at the present time. It may be desirable to seek legislation to authorize such payments.

We found no indication that funds could be made available as grants or loans from other government agencies. Private gifts were not considered as a possibility.

#### B. Could revenues within existing appropriations be transferred?

Yes. There are funds which could be taken from other city services, but this is the only source. All revenues in sight, by most optimistic revenue estimates, had been appropriated when the study of psychiatric service was undertaken.

#### C. Is this proper city financial management?

No. The committee rejected further transfers as a source of funds. It is not qualified to say that all other city functions are budgeted most effectively and that each dollar otherwise appropriated is a wise or economical use of public money. But it took note of the fact that to provide for Welfare Board financing without the expanded psychiatric service, the Ways and Means Committee has already strained good financial practice. For example, it has borrowed from bond redemption fund.

#### D. Could appropriation be delayed without loss of the essential benefits?

Some benefits would be lost. Delay in continuing to develop the psychiatric service is likely to lead to deterioration of the existing service by loss of personnel. Delays further aggravate those cases which now go without early short-term treatment. Each month lost costs money to the extent that it delays eventual recovery of patients or places them beyond reasonable hope of recovery.

## SECTION III

### CONCLUSION

These findings of the study group lead to the recommendation that the psychiatric service at Minneapolis General Hospital be expanded by 20 beds for short-term care as proposed by the Welfare Board, that the City Council approve the expansion of staff required, and that in the interest of financial responsibility and sound city financial management the funds for this service come from within the limits already appropriated for use of the Board of Public Welfare.

# APPENDIX A

## OCCUPANCY AND STAFFING IN STATE MENTAL HOSPITALS

June 30, 1954

1. <u>Occupancy</u>		Average pop. designed capacity		Average pop. over budget capacity		Health Dept. stand	Average pop. over H. D. Standard			
<u>1953-54 average population</u>	<u>Designed Capacity</u>	<u>No.</u>	<u>%</u>	<u>Budgeted capacity</u>	<u>No.</u>		<u>%</u>	<u>No.</u>	<u>%</u>	
Total 8 mental hospitals	11,362	11,688	-326	-2.8	11,565	-203	-1.8	9,546	x1,816	x19.0%

## 2. Staffing

Number of medical employees and number needed to meet American Psychiatric Association standard, July 1954. All 8 hospitals.

<u>Position</u>	<u>Number budgeted</u>	<u>A. P. A. standard</u>	<u>Shortage</u>
Physicians *	57.0	156.4	-99.4
Dentists	8.0	11.6	- 3.6
Dental hygienists	5.0	23.0	-18.0
Clinical psychologists	7.0	37.1	-30.1
Registered occupational therapists	14.0	57.9	-43.9
Other activity therapy workers	80.0	137.1	-57.1
Psychiatric social workers	11.0	82.5	-71.5
Nurses and aids	1,374.9 **	2,957.5	-1,582.6

\* Excludes superintendents, clinical directors and consultants.

\*\* Actual number.

SOURCE: Dittoed report from State Department of Public Welfare for period ending June 30, 1954.

## APPENDIX B

### ALLOCATION OF FINANCIAL RESPONSIBILITY FOR PATIENTS AT STATE MENTAL HOSPITALS

The order of responsibility for paying for patient care in a state mental hospital is: 1) the patient through his guardian, 2) spouse, 3) children, 4) parent, 5) the county of legal settlement, and 6) the state. Counties are not required to pay for voluntary admissions to mental hospitals.

The basic charge for state care is \$10 per month, paid by the responsible parties in the order listed. If a patient has no dependents and if he has sufficient resources, he is subject to the per capita cost for the previous fiscal year at the hospital where he is a patient. This system of charges set in the law results in two broad classes of patients for whose care payments are received - private pay patients and county charge patients. The private pay patients may be further subdivided into those who pay or upon whose behalf is paid \$10 per month or less and those who pay the per capita rate. The Legislative Research Committee in 1952 reported that little attempt is made to charge persons, who are subject to the per capita rate but not able to pay the full per capita, an amount between the per capita cost and \$10 per month.

An exception to the above applies to indigent patients committed prior to April 1947. The entire cost of their care is borne by the state.

The bulk of the payments are at the rate of \$10 per month. "One reason for the relatively low number of patients paying the per capita rate is the fact that under current interpretations of existing laws based upon legal definition of a dependent the Collections Unit considers a husband and wife to be dependent upon each other and not subject to per capita costs for that reason. For persons having a dependent the maximum legal liability for costs of care in a state mental hospital is \$10 per month regardless of ability to pay in excess of that amount." (LRC, Relative Responsibility for Costs of Care in State Institutions, Publication No. 44, May 1952)

A law was passed at the 1953 legislative session aiming to correct this situation, among other things, by placing responsibility on the county for collection of costs from relative and dependents (Chap. 732), but it was declared invalid by the attorney general. Newspaper accounts of the present session indicate action with a similar aim is being considered again.

The LRC reported that for the fiscal year ending June 30, 1951 the mental hospitals collected \$667,104.58, or 6.8% of the total operating expenditures of \$9,815,525.71. The general state taxpayer thus paid the bulk of the share of the cost of the mental hospitals.

The total operating cost of the mental hospitals in fiscal year 1953-54 was about \$12,500,00.

For the calendar year 1952 Hennepin County Welfare Board paid for patients with legal settlement in Hennepin County about \$101,000.

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