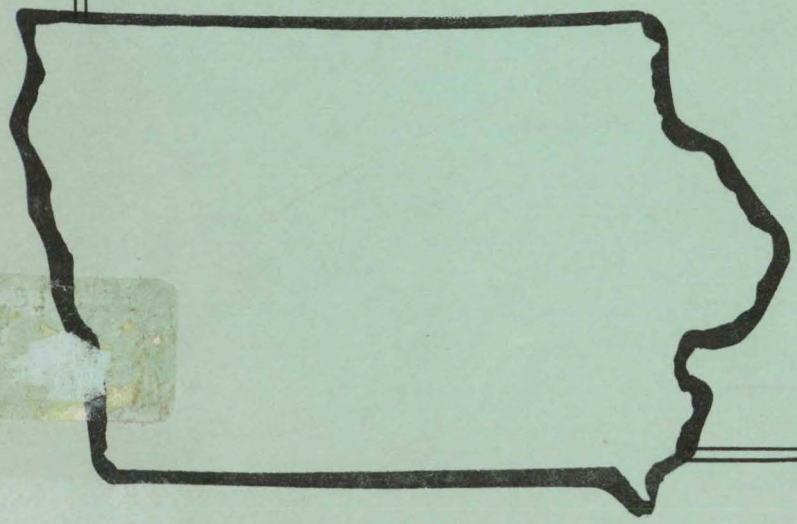
Board of Control

MENTAL HEALTH DIVISION



Biennial Report

1958

BOARD OF CONTROL
OF STATE INSTITUTIONS
DES MOINES, IOWA

3/4/80

PRELIMINARY BIENNIAL REPORT

DEPARTMENT OF MENTAL HEALTH

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HERSCHEL C. LOVELESS, GOVERNOR

Robert C. Lappen, Chairman George W. Callenius John R. Hansen
Mrs. Esther Wright, Secretary
BOARD OF CONTROL OF STATE INSTITUTIONS

James O. Cromwell, M.D.
DIRECTOR OF MENTAL INSTITUTIONS

Biennial Period: July 1, 1956 - June 30, 1958

PRELIMINARY BIENNIAL REPORT

FOR THE YEAR ENDING JUNE 30, 1958

BOARD OF CONTROL OF STATE INSTITUTIONS

DIVISION OF MENTAL HEALTH

STATE OF IOWA

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Grace M. Sawyer, M. D.,	Woodward State Hospital and School
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State of Iowa

BOARD OF CONTROL OF STATE INSTITUTIONS

Department of Mental Health
State Office Bldg.
Des Moines

March 9, 1959

Board of Control of State Institutions
State Office Building
Des Moines, Iowa

Gentlemen:

I am pleased to transmit to you a preliminary biennial report on the Department of Mental Health for the fiscal year ending June 30, 1958.

Respectfully submitted,

James O. Cromwell M.D.

James O. Cromwell, M.D.
Director of Mental Institutions

MENTAL ILLNESS IN IOWA TODAY

The Problems and Objectives of Our Program

As Director of Mental Institutions in Iowa's Board of Control of State Institutions I must assume a role comparable to the master of ceremonies in a T.V. production, and present to you the mentally ill and the mentally retarded of Iowa, with the numerous and complex problems involved in their care.

True, my program, if rated by Pulse or Trendex, would fall far short of an "A" rating for popularity. But my motive is not entertainment. And it is human to avoid the emotionally disturbing, the distressing, and that which may seem to be reproachful. Only when it directly concerns us do we "tune in" with attention.

Yet it is my responsibility to present my revue, and that of the citizen to listen, ponder, and act. For the "stars" are people you know and for whom society is responsible. Perhaps your neighbor across the street, the child who lived next door, your cousin's husband - or even your own brother! But it doesn't happen to the "other fellow" alone. It could be you!

Certainly, every Iowan, public official and private citizen alike, shares the responsibility with those of us entrusted with the administration of a program for the care of our mentally and emotionally ill, and the mentally retarded.

Who Are The Mentally Ill?

First of all, they are people. Just like you and me.

From the tiny infant brought to Woodward or Glenwood, the teenager, the middle aged, to the grandfather who remembers only a long-gone yesterday and wanders off down the street in search of dear ones now dead, yet somewhere nearby to him.

Nor is there discrimination as to age, sex, creed, color, social or financial status. All are represented in the mystery of mental disturbance in a world that condones only the "normal".

Today, in Iowa, more than twelve thousand patients are in residential care in mental health institutes, schools and hospitals for the mentally retarded, nursing homes, private hospitals, and county homes. In our communities are thousands more - those developing symptoms of mental illness for the first time, convalescing patients recovering from mental illness, and many chronically ill. There is also a legion of unrecognized cases of mental and emotional disturbances.

From among all of these we expect approximately three thousand to enter our state mental institutions each year. Others will seek treatment in the community mental health clinic. An unknown number, estimated to be seven thousand, will seek help from psychiatrists in private practice and far more will be seen by the general medical practitioner.

Especially must I plead the cause of the seriously mentally ill and mentally retarded person needing hospitalization or specialized treatment, but unable to obtain private care as it now exists, and who is partially or fully dependent upon public facilities for help. It is estimated by the National Association of Mental Health that 80 percent of those developing serious mental illness must turn to such public facilities if they are to receive any help at all, due to the small number or complete lack of private facilities available to them today.

Must Have A Guide

We who are charged with the responsibility of caring for Iowa's mentally ill and mentally retarded must have as a guiding principle a specific philosophy and a clear-cut policy. Further, we might well emulate the example of the wise traveller who frequently consults a reliable road map to prevent taking the wrong course and to insure safe arrival at a specific destination at a predetermined time.

Our map should indicate: 1. Where we have been; 2. Where we are today; 3. Where we should go; 4. How we plan to get there; and 5. Designate at least an approximate time for arrival.

Even then, with a guiding principle, and a planned course, the success of our journey and safe arrival depends upon the dedicated, united efforts of the private citizen, the public official, the administrator, the legislator, and the professional specialist in all disciplines. For this reason, and for the sake of my dependent charges, I present a road map showing our problems together with a plan, a program, and an objective.

Four Major Problems

The first major problem is the care and treatment of 12,500 patients in residential care in Iowa today as follows:

a. State Mental Health Institutions: 8,151. These patients require continuing examination, evaluation, treatment, and nursing care. They require feeding, clothing and shelter. Real effort is required to make life worthwhile for them while in our hospitals, and to rehabilitate them for return to the community.

b. County Homes: 2,400. These patients are entitled to psychiatric re-evaluation and treatment at least once a year.

It is the duty of the state to provide all or some of the services these two groups of people need.

c. Private Nursing Homes: 2,000, or more. These patients are not the financial responsibility of the state - except that a considerable number of them receive financial assistance from Social Welfare. Existing statutes do place responsibilities on several departments for inspection of private facilities to see that health, fire and sanitary regulations are followed.

The second major problem is the admission of an expected seven to eight thousand patients during the next two years. The hospitals will be required to examine, evaluate, admit if necessary, treat, care for, rehabilitate, discharge and return to the community this influx of patients. Some of them may be handled by our out-patient departments. More will be admitted for residential care and treatment. Some will report as out-patients for a time, but later will be admitted as in-patients.

This is the chief concern of the State Division of Mental Health: Providing adequately for the care and treatment of: (a) 8,000 residential patients at any one time; (b) Caring for from 6,000 to 7,000 new or returned patients each biennium.

The third major problem confronting us is the shortage of professional personnel trained to work in the mental health field.

The ideal is to bring about conditions where physicians, psychiatrists, and the auxiliary professions who work with physicians, especially psychologists, social workers, nurses and special educators engage in private practice and take care of the problem in the community where it exists. The state hospitals would then function only in a limited fashion - very much as the University Hospital functions now. Their chief role would be training of professional mental health workers, and conceivably, they would eventually be considered a part of the educational system. When that time comes their role as service institutions must have been almost entirely supplanted by professional people working in every major community in the state, adequately supported by psychiatric wards in the community hospitals, small private psychiatric hospitals, nursing homes, boarding homes and specialized class rooms which accept mentally ill and mentally retarded people.

At the present time, the state must provide professional services for the patients in our state hospitals. The types and number or professional personnel required properly to staff large state hospitals has been carefully established. We must do this in such a way that we shall be able to meet the demands made of our state hospitals for service - and simultaneously contribute effectively to the training of professional personnel. Only in this way can the shortage of such personnel be met. It is likewise the most economical way of providing the services required.

The fourth major problem is to define and provide the right sort of physical plant in which to operate. With the picture changing so fast we probably should not contemplate building any new major buildings at this time. Rather, our existing facilities should be repaired and modernized. Only a few might need to be replaced. Emphasis should be placed on doing the thing which contributes most to strengthening the services: Strengthening the personnel structure through getting sufficient numbers, and securing a complement of adequately trained people to serve as a nucleus upon which to train others.

All other problems arise from the first four: Personnel now employed is far short of the number required to provide the service that acceptable hospital practice requires. Roughly, we employ seven-tenths of the number needed.

While the people we do employ as attendants are among the finest in the world - our fellow citizens - they are not given the opportunity to learn how best to perform the duties of an attendant according to the latest methods. This is because we have been unable to establish adequate in-service training programs. Further, the turnover of newly employed attendants remains over 40% per year. Actually, it requires more than two years adequately to train an attendant. Our wards are always staffed with a majority of willing, fine, dedicated people who have not had the opportunity to learn enough about their work simply because we have been unable to establish adequate training programs for them.

The professional people we employ have been especially short in number, and we have been compelled to ask many of them to assume responsibilities for which they were inadequately trained. With a grave shortage of professionally trained people available, the difficulty of securing our fair share of those available, and the necessity for assigning them to work other than their own specialty, has created a difficult situation.

The theory of administration is that excessively high turnover rates indicates a low wage scale, poor indoctrination and in-service training, which results in low job-satisfaction. Therefore, we must implement better in-service training and pay our attendants salaries commensurate with those paid by private industry. Until we do stop the turnover in personnel we cannot implement a program of proper treatment and care!

Maintenance Level Inadequate

Our maintenance level is obviously inadequate. A visit to some of our wards reveals unpainted walls, floors needing repairs, plaster off the walls, broken furniture in use, steam and water leaks. In short, far too much evidence of "neglect". This is due both to a shortage of maintenance personnel and funds for supplies.

The total number of persons employed to maintain our plants and our capital investment is roughly two-thirds of the number needed to do an acceptable job. The funds we expend for upkeep, charged to Repairs, Replacements, and Alterations, and Capital Equipment, is roughly one-third of the money needed to keep the plant in good repair. It is roughly one-half of the amount spent by University Hospitals to do a similar job, but not one-third the amount industry would consider essential to protect capital invested.

At today's price level, it would cost $88,000,000 to replace the plants of our six mental hospitals, yet we expend under $800,000 annually for maintenance. Further, from a time viewpoint, it would require 110 years to replace our existing plants!

Our immediate problem, therefore, is how to elevate the maintenance level in order to restore and maintain the usefulness of our existing structures. While we do need some new construction, should we not place our primary emphasis on renovation and repair?

Planning a Program

The establishment of a specific philosophy and a clear-cut policy requires collective study, discussion and planning. Participating in such action have been the Governor's Professional Advisory Committee on Mental Health, the Citizens' Advisory Committee, the superintendents and business managers of the six mental institutions, as well as the Director of Mental Institutions and the Board of Control.

This group has sought the advice and counsel of many citizens and those with specialized knowledge in the fields of: Juvenile delinquency, alcoholism, mental retardation, penology and criminology, social welfare, et cetera. Contributing their time, knowledge, and experience have been physicians and psychiatrists, psychologists, attorneys, welfare workers, judges, legislators, state officials, and many others.

As a result, we have evolved a "Mental Health Program for Iowa" - which we believe to be practical, attainable, and desirable in advancing the state toward the goal of properly caring for our mentally ill and mentally retarded. In condensed version we propose:

The Objectives of the Iowa Mental Health Program

The State of Iowa traditionally has assumed two principal roles concerned with the mental health of its citizens:

1. The education and training of professional mental health personnel in our schools and colleges;

2. The care of the mentally ill persons who are financially unable to afford private care and treatment, in our state mental institutions.

Cognizant of these traditional roles, it is the objective of the Board of Control:

1. To improve the quality of the existing state institutions for the mentally ill to the point where they fully meet the requirements of the various professional organizations which recommend standards for such mental institutions - with the intent of administering better service to the patients who enter these institutions, and to better implement and further the objectives of education, training and research.

2. To expand and strengthen the liaison with all schools of higher education in the state, especially with the University of Iowa Medical School and the Psychopathic Hospital in the education and training of mental health personnel, so that the number trained each year will be adequate to meet the demands of the people of Iowa for mental health services for its citizens, and to carry forward a sound research program.

3. To encourage a sufficient number of psychiatrists, backed up by the necessary auxiliary personnel who have received their training in our approved training center or in approved training centers of other states, to enter into the private practice of psychiatry in communities throughout the state. To encourage these private practitioners to provide professional services and treatment for the mentally ill within each community, with the end in view of eventually reducing the services available to patients at tax expense, aiming then to provide only for that minimum of mental health service needed to insure facilities for the continuance of our education and training program so that an adequate supply of well trained private practitioners and auxiliary professional personnel is perpetually insured.

Collectively, we studied hospital administration standards, and early in 1957 we prepared tables of organization to be used by all administratively responsible persons as a guide for future budget planning and present spending. This series of charts appears under the section entitled "Charts" in this publication.

The "Modern Hospital"

The mental health institutions in Iowa are established by statutes to provide care and treatment for the mentally ill and the mentally retarded. To to this in the most efficient manner is our administrative objective.

Concensus of professional opinion is that the most efficient was to provide proper care and treatment is to transform our mental institutions into "Modern Hospitals".

The concept "Modern Hospital" is not personal. It is defined by a number of professional organizations in terms of recommended standards of staffing, organization and operation. The organizations which help define this concept by their recommended standards are:

The Joint Commission on Accreditation of Hospitals
The Council on Hospitals and Education of the American Medical Ass'n.

American Hospital Association
The American Psychiatric Association
The National League of Nursing
U. S. Public Health Service
Similar State Associations, to some extent.

Those administratively responsible should continuously strive to meet the recommended standards of these organizations and thus transform their hospitals into a "Modern Hospital".

When we have finally succeeded in fully transforming our six state mental institutions into "Modern Hospitals", and when we have fully established the close liaison with the communities which this implies, we shall probably need not more than 7,000 hospital beds: 1,000 beds in each of our mental health institutes, and 1,500 in each of our two schools and hospitals for the mentally retarded. Therefore, our concept of the "Modern Hospital" as to size should be 1,000 beds.

WHY WE STIGMATIZE MENTAL ILLNESS

Yes, we are still ashamed of mental illness and the mentally ill!

And we are afraid! Of the illness and of the patient!

This is perfectly logical when we review the history of man from primitive ages to the present. But it is hoped that enlightenment as to the cause will help eliminate the stigma which retards progress today.

Primitive man thought only in terms of "magic". Natural phenomena as the consequence of natural law was beyond his understanding. Trees were moved by "spirits". Storms, lightning, thunder, stones rolling down hills, babbling brooks, illness and death -- all were explained in terms of magic. Today, we pride ourselves upon logical thinking. Yet in the field of health, and particularly mental health, many of us are governed by thought patterns stemming entirely from "magic thinking", or a misconception of natural law and science. Consider, for example, the common belief that wearing asafedtida around one's neck wards off the flu.

The Influence of Religion

Even religion has influenced our concept of health and disease. Man's first religion was "spirit" worship. Like "magic thinking", he endowed the spirits with unlimited powers and thus explained natural phenomena in terms comprehensible to him.

Today, most of us believe in an all-powerful Supreme Being, and view all creation as aspects of this Being's manifestation. Yet we have only vaguely formed ideas of the nature of this relationship. Historically, and even today, some ideas about mental illness can be directly attributed to our religious concepts rather than to our knowledge of science.

In Biblical and even early colonial times, people believed that mental illness was due to being "possessed by spirits". These spirits were classified as "good and evil". Illness was due to "evil spirits". Evil spirits were agents of the devil - also an evil spirit. Therefore, disease was the work of the devil. The only effective treatment, obviously, was to drive out the feared "spirit" possessing the person.

And they did try literally to "drive the devil out" by whipping, abusing, starving, and confining the mentally ill. In conformity with the "possession theory, medical men during colonial times actually invented machines to stretch, deform and torture patients, so intent were they upon driving out the feared evil spirits.

Believe in Witches

Despite our pride of intellect today, popular thinking still is tainted with ideas of "possession" - the belief that mental illness stems from evil thinking and represents just punishment. And we are still afraid of the mentally ill. Expression is given to this fear by driving the mentally ill out of the community, barring them from jobs, declaring them legally incompetent when they may be quite competent. Although we know that treatment of the mentally ill should be governed by logical consideration of what is for their benefit, still, the layman, psychiatrist, and other professionals, react to emotionally charged preconceptions.

Belief in witches was another mass delusion of colonial times. Historians tell us that large numbers of people believed that the mentally ill were witches who had sold their souls to the devil. Historical evidence of the belief in witches is provided by the Salem, Massachusetts, witchcraft menace in 1692, in which 250 people were arrested and tried for witchcraft. Of this number, fifty were condemned, nineteen were executed, two died in prison, and one died of torture. This type of evidence, accepted as "proof" of the truth of their guilt, reveals the prevalence of belief in "possession" and in primitive "magic thinking." It reveals the fervent conviction that witches should be punished by death for their collaboration with the devil.

Little consideration was given the mentally and physically ill, the criminal offender, and the economically dependent as long as the colonies were sparsely settled. However, they became a danger or a nuisance as the community grew. Prime consideration was then given to the safety or convenience of the community and to the elimination of the nuisance with little concern for the needs or welfare of the unfortunates concerned.

If the family of a mentally ill person was prosperous, a small house was built beside the residence to shelter him like an animal. Because it was believed that a mentally ill person was incapable of normal human feelings, it was assumed that he did not suffer from hunger, cold, heat, pain, or mistreatment. Consequently, his "house" was a small, unheated shelter, with a mat of straw on the floor. This was changed occasionally and food was slid under the door. History records that many families confined their mentally ill relatives under such primitive conditions for years. Locked in a cage, fed like an animal, and rejected!

The poor fared even worse! The community would at times provide from the village treasury a shelter of confinement, and a small amount for food. However, from 1736 on, the "workhouse" grew in popularity. The mentally ill were herded together in a common lock-up with custodians authorized to keep order by lashing and other forms of punishment.

Auctioned to Slavery

The mentally ill and other dependent people of all types were also auctioned off to the lowest bidder who agreed to keep them for a small stipend from the community treasury, and was permitted to work them for his own private ends under threat of lash or chain. Human slavery did not begin in America's Southland by any means! It existed in the northern colonies almost from the beginning!

Establishment of some of our present day institutions such as hospitals, poor houses, jails, and mental hospitals are the aftermath of practices developed in the work houses. Group assignment of the physically ill, mentally ill, dependent poor, and criminals took place there as the desirability of separation became evident.

The Pennsylvania General was the first general hospital to be founded in America providing treatment for the mentally ill. Both mentally and physically ill patients were accepted. Petition for its establishment in 1750 as presented to the Provincial Assembly was in the handwriting of Benjamin Franklin. The assembly passed an Act on May 6, 1751, "to encourage the establishing of a hospital for the relief of the sick poor of this Province, and for the reception and cure of lunatics."

A Treatment Summary

Thus we may summarize the treatment meted out to the mentally ill in the century just preceding the American Revolution as characterized by hopeless confusion. It was based upon lack of understanding of the nature of disease, and consequently absence of attempting cures. Even physicians shed little light on the subject. The people in general believed in "spirit" possession, witchcraft, and a world inhabited by evil spirits ever ready to dispossess a person of his body. The only treatment was an attempt at driving out the evil spirits. Diagnosis and the basis for separating dependent persons into types were vaguely and crudely conceived.

The attitude of society toward dependent persons is reflected in a quotation from a Connecticut statute first enacted in 1727: "for the establishment of all rogues, vagabonds and idle persons going about the town or countryside begging, or persons feigning themselves to have knowledge in physiognomy, palmistry or pretending that they can tell fortunes or discover where lost stolen goods may be found; common pipers, fiddlers, runaways, common drunkards, common night-walkers, pilferers, wanton and lascivious persons, common railers and brawlers, as also persons under distraction and unfit to go at large, whose friends do not take care of their safe confinement."

On occasion, mentally ill persons were hanged as "witches," imprisoned, tortured, or otherwise persecuted as agents of the devil. They were regarded as sub-human beings, incapable of human feelings or emotions, and were chained in specially devised kennels like wild animals, and thrown in prison and jail like criminals. Too, they were incarcerated in primitive camps called "work houses", and made to slave like able bodied paupers. They were allowed to wander about stark naked, driven from place to place, subjected to whippings. Deported from the community, due to harsh and inhumane settlement laws, they were prevented from becoming the legal responsibility of any community. Even the prosperous provided little more for their mentally ill relatives than society granted the mentally ill poor.

"Moral Treatment" Spreads

In medical circles, the humanitarian philosophy of treatment of the mentally ill became widely known as the "moral treatment" during the century following the American Revolution. This philosophy spread among doctors throughout the world.

Benjamin Rush, an American physician, and a co-signer of the Declaration of Independence, made several advances in medical treatment, beginning in 1783. The first American physician to classify the mentally ill into diagnostic groups, he wrote the first treatise on treatment of the mentally ill. With Benjamin Franklin and a number of others, Rush helped pioneer many reforms in America: They reformed the first prison; abolished the death sentence in Pennsylvania for all crimes except murder; instigated better treatment of imprisoned debtors; advocated a public school system; and helped found the first free dispensary in America, the Philadelphia Hospital for the Poor. Through Rush's efforts and professional acumen, the Philadelphia General Hospital became a model and leader among hospitals, a position it holds today.

Progress Further Delayed

The new philosophy of "Moral Treatment" did result in the establishment of hospitals, better jails and better provisions for the poor, but the seeds were sown in thin soil and during the last fifty years of the century following the American Revolution conditions generally regressed. Few states extablished hospitals admitting the mentally ill, and fewer had special hospitals for them. Most states operated on only the over-the-hill-to-the-poor-house philosophy.

The common lot of all dependent persons in the states comprising the Union remained the same as in colonial days. Mentally ill persons were not segregated and treated but were grouped with all other "paupers" and disposed of in one of four methods:

1. Given some financial help and remained with relatives or kept segregated by them in their homes;
2. Auctioned off to the lowest bidder, and the bidder permitted to employ them as his personal slaves;
3. Cared for on contract at a fixed price;
4. Sent to a public poor house or jail.

The guiding principle was to rid the community of public charges at the lowest possible immediate cost. No consideration was given to long-term costs.

Wile the most significant of all social reforms stemming from the life and work of Dorothy Linde Dix had already begun, it was not to bear fruit for some time. So, we find the lot of the mentally ill in the quarter century preceding the Civil War almost the same as in the quarter century before the American Revolution.

The Crusade of Dorothy Dix

One lone woman literally unlocked the door of America's dungeon housing the mentally ill, and let the sunlight of humanitarianism in!

Dorothy Linde Dix, nearing forty, and a highly respected, efficient teacher in an exclusive private school in Boston, became a living bomb that shattered the ignorance and complacency of professional and layman alike. It all began one cold winter day in 1841 when a shy theological student sought her advice in teaching a Sunday School class for women confined in the last Cambridge jail. She would teach it!

Expecting fo find women confortably confined for specific violations of law, but soon to be released, she was horrified to discover half-clad, shivering, hungry, mentally ill women jammed into filthy quarters with evidence of brutality and neglect on their bodies. Her demands for heat met with the contemptuous reply that the insane are oblivious to cold. Demands for constructive action from the jailor and the mayor netting nothing, she approached the governor from whom she received consideration.

From that day to the end of her long life, her zeal in behalf of the mentally ill took her into jails, almshouses, cages, caverns, wherever they were segregated. She took her findings to the Massachusetts General Assembly - where the voice of womankind had not heretofore been heard--and as a result appropriations were forthcoming for the construction of asylums for the mentally ill.

Influences Iowa Institutions

Scoffing at the idea that one person can do nothing, she visited England and other European countries, made the same discoveries and informed the civil authorities of the conditions she found. No shy spoken school teacher, she raised her cry in words and tones that echoed from state to state, from almshouse to parlor and legislative halls.

Some thirty asylums were constructed as a direct result of her efforts, and the light of knowledge thrown into the dark places of ignorance. Although she did visit Illinois, it is not known that she visited Iowa, but the asylums built in this state were influenced by the life and efforts of this magnificent lone female crusader.

Dorothy Linde Dix thought of her asylums as hospitals where treatment would be carried on by men of science, yet she, also, went along with the idea of these institutions being located in quiet, country towns well removed from the centers of population. Doubtless this was due to her lack of a clear concept of staffing requirements, or of what the maintenance of a true hospital for treatment must be. Nor was she alone in this viewpoint. Even the medical profession lacked the modern concept of a hospital as a treatment and training center.

Living to be eighty, Dorothy Dix spent her declining years working in one of the asylums she helped bring into existence. There, too, much to her dismay, she found conditions of neglect and abuse due to the lack of trained personnel and a medical viewpoint. However, she did unlock the doors of the dungeons, and it still remains for us to throw the full sunlight of knowledge, understanding, and scientific treatment into the remaining dark corners.

The Challenge of Tomorrow

Great strides have been made in Iowa, as elsewhere, in medical understanding and public opinion regarding what should be done for the mentally ill. We first moved away from the asylum philosophy, inferring a quiet rest home surrounded by kndly caretakers, to a custodial hospital standard. In the 1930's, one state after another struck the word "asylum" from their code books and substituted "mental hospital".

Iowa's Fifth General Assembly provided for an "Insane Asylum," and the 1860 Code named it the "State Hospital for the Insane". However, a change in name does not assure an altered viewpoint or program, although it may indicate

public expectation. Iowa's institutions remained custodial homes for most patients, although an increasing number were brought under medical treatment.

In 1946 the four mental institutions in Iowa were designated "Mental Health Institutes" instead of hospitals for the insane, thereby indicating the trend toward treatment and training centers. In most states the "institutes" are closely aligned with the higher education system, especially the medical education program. Only recently has such coordination been effected in Iowa.

Increasing numbers of Iowa's citizens are today manifesting their interest in and assuming their responsibility for the instigation of educational and clinical programs, and providing facilities for the prevention and treatment of emotional and mental illness. As the zeal that embued America's lone woman crusader revolutionized the concept of mental illness and the lot of the mentally ill, so will the same sparks, motivating the average citizen, move America forward toward acceptance of mental illness as but "another ill the flesh is heir to". In the light of knowledge, fear and stigma will disappear as scientific diagnosis and treatment is promptly and adequately applied.

Then, and only then, will America have forever closed its dungeons, and the crusade of Dorothy Dix reached fruition.

I O W A M E N T A L H E A L T H I N S T I T U T E S

Summary of Accomplishments, Problems, and Needs

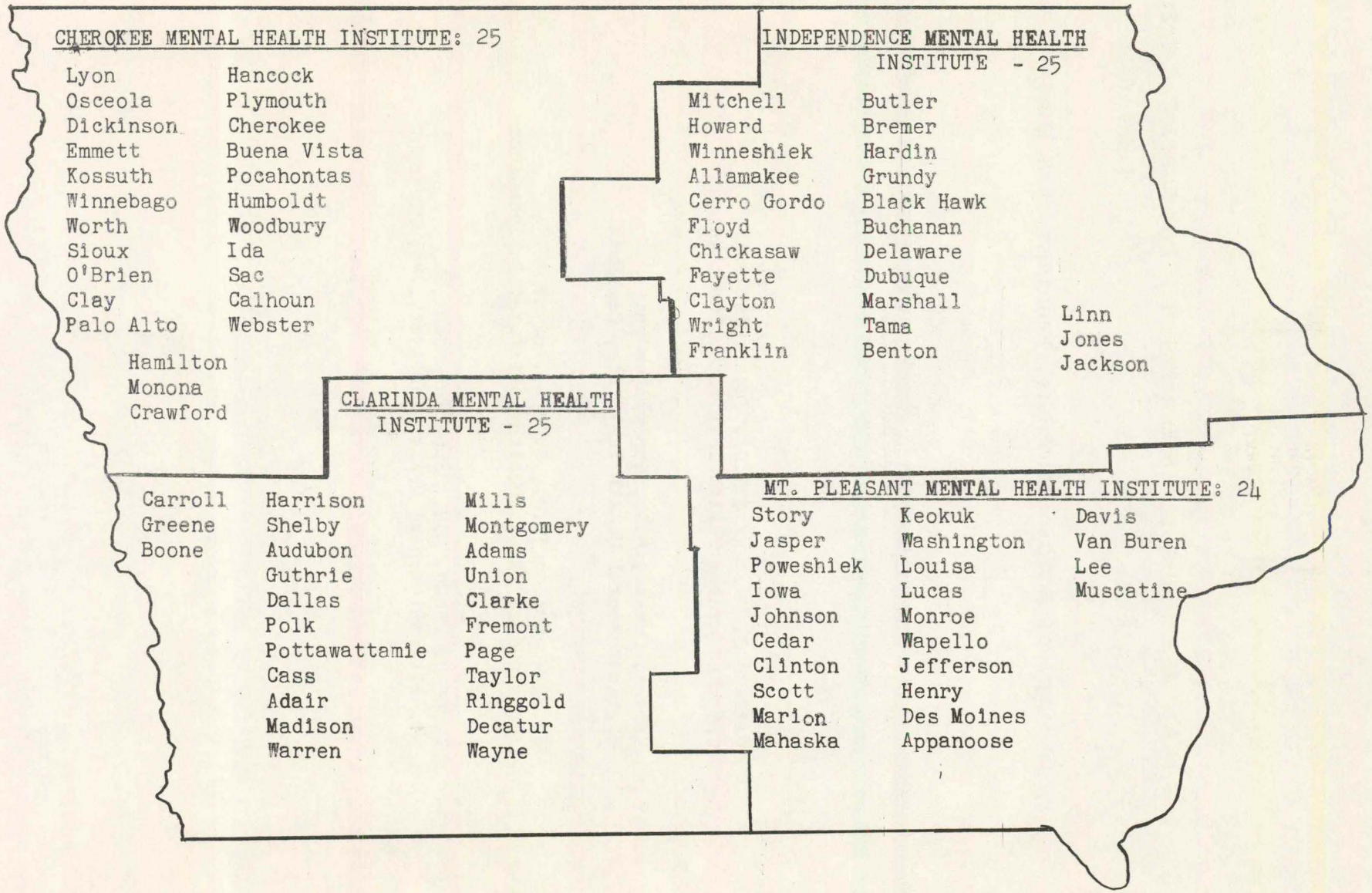
Willard C. Brinegar, M.D., Superintendent
Cherokee Mental Health Institute, Cherokee

Karl A. Catlin, M.D., Superintendent
Clarinda Mental Health Institute, Clarinda

Selig M. Korson, M.D., Superintendent
Independence Mental Health Institute, Independence

Wayne B. Brown, M.D., Superintendent
Mt. Pleasant Mental Health Institute, Mt. Pleasant

COUNTIES SERVED BY IOWA MENTAL HEALTH INSTITUTES



1902 - CHEROKEE MENTAL HEALTH INSTITUTE - 1902

The Cherokee Mental Health institute was opened as an institution for the mentally ill and inebriates on August 18, 1902.

In 1958 - with a rated capacity of 1200, the average daily population in residence was 1225. A total of 453 full time and 12 part time employees were on the payroll at June 20, 1958. Seventeen physicians and 15 registered nurses, as well as 17 other professional personnel were employed. A ratio of 1 physician to 72 patients and 1 registered nurse to 82 patients.

Costs: For the fiscal year ending June 30, 1958, total expenditures were $1,798,023.26. The average daily cost per patient was $4.90. Total expenditures were divided as follows:

Salaries	$ 1,170,667.47
Support and Maintenance	553,222.85
Repairs, Replacements and Alterations	44,003.45
Equipment	30,129.49
Total	$ 1,798,023.26

By: WILLARD C. BRINEGAR, M.D.

Major progress has been made at this hospital during the last biennium. Near the close of the biennium we were approved for a three-year residency training program in psychiatry by the Council on Medical Education of the American Medical Association, The American College of Surgeons, and the American Board of Psychiatry and Neurology. The hospital is now able to provide a three-year residency training program for psychiatrists which, after additional experience and an examination will enable physicians taking the residency to become fully certified specialists in psychiatry. This is one of only twenty-eight state hospitals in the nation so approved, most of the others being intimately related both administratively and geographically to university medical schools. This will do much to relieve the critical shortage of psychiatrists from which this state has suffered for so long. This program was made possible by the decision of the Budget and Financial Control Committee to allocate a major portion of the appropriation for professional salaries made to them by the last General Assembly, to the Mental Health Institute at Cherokee for the specific purpose of setting up such a training program. The necessary personnel to set up this program cost substantially more than the money allocated by this committee, so the difference, was drawn from our regular salary appropriation. For this reason we are weaker than the other Mental Health Institutes in Iowa in personnel in many other departments. For instance, we have no occupational therapists or recreational therapists, and we have a somewhat smaller number of employees and lower salaries in several other departments than the other comparable institutions. We believe that the benefits to the state derived from this training program warrant this

deficiency, but hope that the next legislature will take this into account and provide more money so that we can staff these important ancillary services more properly.

AFFILIATES WITH UNIVERSITIES

Affiliations have been established with the medical schools of the State University of Iowa and the University of Nebraska. In addition to receiving lectures by telephone circuit from both medical schools, our residents spend some months at the Psychopathic Hospital in Iowa City and in the Neurology Department of the University Hospitals at Iowa City. There are other aspects of the affiliations which are very valuable but are too complicated to describe in detail here.

To be approved for the three-year residency training program, a mental hospital must meet certain standards. This includes employment of enough certified psychiatrists. It is also necessary that there be a definite curriculum in post-graduate medicine emphasizing psychiatry and that a faculty exist which consists not only of psychiatrists, but specialists in other fields of medicine related to psychiatry. The teaching staff must also provide psychologists, psychiatric social workers and other professional people.

In the beginning of the biennium we had only three licensed physicians on our staff and only one physician who was certified as a specialist in psychiatry. Now we have eleven licensed physicians and five certified specialists in psychiatry. In addition, we have a certified specialist in internal medicine who will join our staff soon. There has also been some improvement in our nursing and social service departments but these are still far from adequate. If they could be increased along with the ancillary services mentioned previously, we could get many more patients out of the hospital. We have done a fairly good job in getting them out in the last biennium. In spite of a steadily increasing admission rate, 1148 patients were in residence at the end of the biennium as compared with 1231 in the beginning. Actually, the situation is better than these figures show, since we are temporarily housing twenty-four chronic state patients from Mt. Pleasant, who will return to Mt. Pleasant when the present building program is completed.

PATIENTS ARE CLASSIFIED

In accordance with the well established fact that an intensive treatment program is essential to solve the problem of the ever increasing rate of admission and the attendant over-crowding, this hospital has increased its efforts considerably in this area during the past biennium. The patient population in this hospital can be divided into three main categories:

1. The acutely ill, recently admitted patient
2. The chronically ill, long-term patient
3. The elderly, or geriatric patient

In order to increase the rate of discharge, each category requires special consideration. To be effective in the first category, the admission and intensive treatment service has been reorganized into a single unit for male and female patients respectively. Each is under the supervision of a certified psychiatrist who is assisted by three residents in various gradations of professional development.

THE NEW PATIENT

The newly admitted patient receives complete but rapid initial evaluation. The treatment plan is immediately begun and carried out and active plans for return to the community are initiated early. It is our belief that this program has greatly reduced the hospital stay of our patients.

THE CHRONIC PATIENT

To a large extent, patients in the second category have accumulated over the years because of the lack of therapeutic possibilities. Since many of these patients require retraining as well as medical treatment, the active rehabilitation and recreational program has been started, despite the woeful lack of trained personnel. Concomitantly, the principles of the "therapeutic community" are being applied, thus giving our patients greater freedom, making the period of hospitalization more agreeable and inculcating in them a sense of personal and social responsibility. That this program is effective is reflected in the number of discharges of patients who were formerly considered to be incapable of leaving the hospital.

THE GERIATRIC PATIENT

In regard to the geriatric patient, the medical and the activities programs have been increased, and, in addition, the program of county home and nursing home placement has been emphasized so that it has been possible to place patients outside of the hospital environment. It is our earnest belief that the continuation of the program will gradually reduce the patient population and serve the public more effectively and will eventually lead to greater economy despite the fact that at this point it is necessary to increase the staff and all personnel in every department in order effectively to carry out our intention.

NEED CHILDREN'S PROGRAM

We have still not yet established a children's service, due to shortage of funds. There is a great demand for more facilities to care for disturbed children, and we are hopeful that the legislature will provide funds for this at Cherokee in the next biennium, as they did for Independence in the last.

The stepped-up medical program has required the expenditure of most of our very limited equipment funds for medical equipment. For this reason we have not been replacing rugs, furniture and other equipment as fast as they wear out, so the need for such articles is greater than it has been in past years.

URGENT NEED OF EMPLOYEE HOUSING

The recruiting of physicians and of professional personnel has been greatly simplified by the fact that we no longer need to clear these people through the personnel department. This previously led to time-consuming delays which frequently resulted in our losing potential professional employees. In addition, our salary schedule is now competitive with other states, which was not true prior to the present biennium. The major factor retarding us in such recruitment, other than shortage of funds for salaries, is the lack of employee housing. We have found it necessary to turn down many good physicians because we are not able to provide quarters for their families, and have had to concentrate on hiring single people or married couples without children. Several

new houses should be constructed which are large enough to hold families with more than one child. We also have an inadequate number of rooms for employees other than professionals, and wish to renew our repeated requests for an employees' building which will bring our housing up to the standards already provided by the other Mental Health Institutes in Iowa.

As has been pointed out in previous biennial reports, we are in need of a new intensive treatment building to relieve over-crowding and replace the building now used for such purposes, which was built in 1908. We have had no new buildings for patients here since 1932. In spite of the reduction in patients mentioned above, we still have as many as 60 patients residing on wards designed to accommodate 28 people.

We also wish to again call your attention to the fact that we have no paved roads on our campus. This year the road is in even worse shape than usual because we did not feel that we could spare the funds to have it oiled, as we did the last few years.

We also still need the auxilliary heating and ward remodeling which has been mentioned in previous reports, for our fifty-four year old main building. The fire marshall has repeatedly called our attention in detail to the fire hazards which exist. We are in agreement with their recommendations for correction of these hazards but can do nothing for lack of funds. To completely conform to their recommendations would cost somewhere in the neighborhood of one-half million dollars. We hope that the 58th General Assembly will provide funds to take care of at least part of the more urgent fire hazards.

1888 - CLARINDA MENTAL HEALTH INSTITUTE - 1888

The Clarinda Mental Health Institute admitted 222 male patients transferred from Independence, Mount Pleasant, and Mercy Hospital in 1888.

In 1958 - with a rated capacity of 1300, the average daily population in residence was 1328. A total of 456 full time and 15 part time employees were on the payroll at June 30, 1958. Ten physicians and 10 registered nurses, as well as 20 other professional personnel, were employed. A ratio of 1 physician to 133 patients, and 1 registered nurse to 133 patients.

Costs: For the fiscal year ending June 30, 1958, total expenditures were $1,673,723.52. The average daily cost per patient was $3.53. Total expenditures were divided as follows:

Salaries	$ 1,111,737.46
Support and Maintenance	502,748.70
Repairs, Replacements and Alterations	39,305.43
Equipment	19,931.93
Total	$ 1,673,723.52

By: KARL A CATLIN, M.D.

Clarinda's allotment of $46,700 from the special fund appropriated by the Legislature for employing additional professional personnel coupled with a new personnel policy established by the Board of Control, has made it possible to achieve definite progress toward our goal of developing an adequate mental hospital at Clarinda.

Much credit is due Dr. J. O. Cromwell for the inspiration and guidance he has given in helping develop realistic personnel policies and in working toward a proper balance between the various departments within the hospital. The gains that have been and still are being made under such progressive policies may be ensured by making the necessary changes in the Code of Iowa to enable the Board of Control to continue making its own personnel policies; by increasing funds for salaries to reduce turnover, particularly in the nursing service and to permit continued progress toward acquiring the staff needed to operate an adequate modern mental hospital.

NEW CONSTRUCTION

A new two-story store building, connected to the main corridor, located between the chapel and the cold storage building, came into use during this biennium. This makes it possible to centralize our more important supplies and to keep inventory more efficiently. The building replaced some 30 improvised storage rooms in the basement. Remodeling projects provided a

modern, convenient clinical laboratory at the old location. Also, six additional offices with a dictating room for each group of three were provided from former apartments for employees on the second floor corridor of the main building. Many items of modern analytical equipment were added to the laboratory and a central dictating system was installed to serve strategic offices in the main building. With this system, the recording is made in the stenographic pool by remote telephone connection.

Modernization of the X-Ray equipment was completed. Important additional equipment was added and replacements made in surgery. The electroencephalograph laboratory began operation. An overhead glass milk transfer system was installed in the dairy. A number of additions and replacements were made in the chapel, including the installation of a church-model electronic organ, air conditioning, and a wide-screen movie projection system. This makes the chapel available for year-round activities.

PUBLIC RELATIONS PROGRAM STRENGTHENED

Public relations continue to improve. Various staff members have been available and in demand for public speaking engagements. The volunteer program has grown considerably and there has been a remarkable growth in excursions outside the hospital for patients. Private cars owned by volunteers and employees have been made available for taking patients to activities in town.

Unfortunately, staffing difficulties have led to an instability in the out-patient service, but the local medical profession and other referring agencies have been most patient and understanding in view of our efforts to correct the situation.

The development of closer relations with the Psychopathic Hospital at Iowa City and the Nebraska Psychiatric Institute has provided us with regular lectures by outstanding authorities in pyschiatry and related fields, transmitted to our staff by two-way telephonic communication and reproduced by loud speaker. Both institutions have provided some service from consultants and this promises to develp into a larger program. Plans have been completed for a five-year package plan for psychiatric residents involving Iowa Psychopathic and Clarinda as well as the other five mental institutions in Iowa.

Local groups have taken an active interest in our staffing problem and have assisted in a number of ways in bringing new staff members to the institution. The Clarinda Chamber of Commerce has supplied literature, located housing, and performed many individual services. The Industrial Planning Board has succeeded in attracting a housing project of from twenty to fifty new houses, a part of which project is to meet our particular needs, and the Clarinda Welcome Wagon has supplied literature to prospects and assisted new arrivals in Clarinda in a number of ways. The local realtors have been especially cooperative in helping new residents find proper housing.

The Clarinda Mental Health Institute became a part of the City of Clarinda in January 1958, and the hospital and city share jointly financed sewage and water works.

PROFESSIONAL PERSONNEL ADDED

New personnel policies made it possible to add Dr. Edwin O. Niver

to the staff as Director of Research and Education in December 1957, and Dr H. Randolph Unsworth, Director of Admission Service in June 1958. Dr. Niver is certified by the American Board in Psychiatry. Dr. Unsworth has had more than twenty years experience teaching neurology and psychiatry in a southern medical school. Both have proved to be valuable menbers of the staff. Dr. Niver has carried on treatment programs on various wards, making it possible to change continued treatment closed wards to open wards. He is also working toward standardizing drug treatment methods and carries on various teaching activities.

SOCIAL SERVICE WORK MULTIPLIED

With many chronic patients becoming available for placement due to treatment methods, the activities of social service has multiplied roughly threefold. Follow-up care of patients leaving the hospital on continued drug medication requires involved social service work. The department has developed exellent working relationships in this area with private physicians, social agencies and county welfare agents. This increased activity has over-burdened the department to the point where great expansion in personnel is urgently needed to meet their assignment.

NEW PSHCYOLOGISTS EMPLOYED

In the fall of 1956 one psychologist left to enter medical school. another left to accept a position elsewhere in Jamuary 1957. This left the department with only Dr. Albert C. Voth, the department head, for about one year. Two psychologists with master's degrees, Mr. Errion and Mr. Erwin, joined the staff in January 1958, and early in March 1958, Mr. Huckins, holding a master's degree and five years' hospital experience was employed. Dr. Voth has continued to carry on a remarkably good program of therapy for alcoholics in addition to his other work. Activities of the department include: group and individual psychotherapy, diagnostic testing, mental examinations, out-patient service, assistance in orientation of new employees, and presentations for visiting groups and students.

HAVE MEDICAL CLINICS

A medical clinic meeting has been held twice weekly during most of the biennium, operated by eight medical doctors in private practice in Clarinda. This has proved very useful in early case finding of medical and surgical conditions in our patient population, and has helped to improve the management of our tuberculosis service. In addition, this has led to holding joint staff meeting of the Municipal Hospital Staff and the Clarinda Mental Health Institute staff. The meetings are held at the Municipal Hosiptal some of the time. A consultant pathologist from Omaha is employed on a part-time basis. He makes regular calls and supervises the work of Mr. Max Beemblossom who is in charge of the laboratory. Mr. Beemblossom has been largely responsible for develping our laboratory into one of the best in the area.

NEW SUPERINTENDENT OF NURSING

With a new department head as of September 1, 1957, the administration of the service has been combined in a central office to help standardize procedures and make more efficient use of employees. Special efforts have been directed toward avoidance of duplication and the reduction of paper work. Such streamlining has given the attendant staff more time with patients and has helped to make possible the beginning of a remotivation program in the spring of 1958.

Experience so far indicates that this project helps to shift the thinking of personnel toward patient rehabilitation, improve inter-personal relationships on the ward, and bring about a more therapeutic atmosphere. Recruiting registered nurses, particularly those with advanced degrees, has so far not been very successful. Turnover in the attendant group continues to defeat the results of our in-service training program, since the complete training of an adequate attendant requires two years. It is hoped that the salaries of this group can be raised to the place where it becomes an attractive career. This will make possible the develpment of a stable, competent foundation for the various treatment methods. The ward attendant spends more time with the patient than does anyone else. His competence, devotion and skill can make our program a success. Conversely, his deficiency will ruin our efforts.

NEED EXPANSION IN OCCUPATIONAL THERAPY

Due to some increase in personnel, it has been possible to increase recreational activities under the direction of Fred Humphrey, now employed on a full-time basis. Occupational therapy needs more space and personnel, both to provide better service to patients and to provide better in-service training. This would prove especially valuable in lending assistance to the attendant group involved in the remotivation program.

The volunteer groups continue to give more and more time to the patients of the institution, and are rendering a valuable service that would otherwise be impossible.

HAVE PASTORAL PSYCHIATRY

Chaplain Herbert H. Stahnke found it possible to accept full-time service. He has developed an inclusive, well-rounded department that is a credit to the hospital. Of particular interest is the training and rehabilitation efforts he has initiated for stenographers and secretaries. In consultation with other staff members concerned, he selects patients for training as stenographers and secretaries, works with two at a time in his office, and has been obtaining a most encouraging response from patients concerned.

THE MATRON'S OFFICE

Attempts have been made to supply patients with more attractive clothing to wear at recreational and other activities and definite progress is being made. The plan is hampered to an extent by the extra load this places on the laundry, particularly in the case of the wash clothing for men. The lack of cleaning facilities practically rules out the use of most types of dress clothing.

THE HOSPITAL PHARMACY

James Montgomery, owner of the Hawley Drug Company and past president of the Clarinda Chamber of Commerce, has reorganized the pharmacy to meet the increased demand for drugs. He has proved himself a great friend to the institution. The use of drug therapy has grown at a rapid rate, now reaching a high percentage of patients. In addition, this increases the work load on the nursing service, to say nothing of the more complicated operation of the pharmacy.

TO SUMMARIZE

A continued rise in the admission rate reflects greater acceptance of the hospital by the area it serves. We now admit over 1,000 patients per year and I believe the rate will continue to go up to 1,200 - 1,500 per year before the needs of the area are adequately met. Our out-patient service falls far short of meeting the existing demands, to say nothing of real needs as yet unexplored. Every professional department remains much under-staffed, but knowledge and skill for their proper development is already employed within the state, prepared to move toward the goal of a modern hospital that offers adequate services to meet the needs of the community. Better staffing can bring adequate treatment to all, instead of a fraction of our patients. At the same time it will make possible adequate in-service training in all the areas where it is needed, thereby allowing the institution to be come equipped to fit into a statewide program of treatment and education meeting the standards set as a goal.

1873 - INDEPENDENCE MENTAL HEALTH INSTITUTE - 1873

The Independence Mental Health Institute was the second mental hospital in the state for the care and treatment of mentally ill and inebriates. The first patient was admitted May 1, 1873.

In 1958 - with a rated capacity of 1100, the average daily population in residence was 1103. A total of 484 full time and 15 part time employees were on the payroll at June 30, 1958. Fourteen physicians, 15 registered nurses and 46 other professional personnel were employed. A nursing affiliate bringing 60 student nurses into the hospital for training. A ratio of 1 physician to 72 patients, and 1 registered nurse to 73 patients.

Costs: For the fiscal year ending June 30, 1958, total expenditures were $1,995,201.12. The average daily cost per patient was $5.02. Total expenditures were divided as follows:

Salaries	$ 1,360,075.31
Support and Maintenance	548,369.07
Repairs, Replacements and Alterations	56,288.74
Equipment	30,468.00
Total	$ 1,995,201.12

By: SELIG M. KORSON, M.D.

No major change in administrative policy was inaugurated during the biennium. Dr. Selig M. Korson succeeded Dr. James O. Cromwell as superintendent at the close of the period, when Dr. Cromwell became Director of Mental Institutions in the Board of Control. During the second year of the biennium, Dr. Cromwell continued as superintendent of the Independence Mental Health Institute in addition to assuming the responsibility of Director in the Central Office at Des Moines.

MORE PROFESSIONAL PERSONNEL

The revised pay scale for professional personnel which was instituted July 1, 1957, has attracted more qualified personnel to service on our professional staff. On July 1, 1957 we had only one board certified psychiatrist, and one board eligible psychiatrist. Only one psychologist held a Ph. D. degree, while no social worker held a master's degree. At the close of the fiscal year ending June 30, 1958, the staff included two board certified and three board eligible psychiatrists, in addition to three Ph. D. degree psychologists, and three master's degree social service workers.

DECREASE IN EMPLOYEE TURNOVER RATE:

In addition to attracting more qualified professional personnel in the higher grades, there has been a decrease in the employee turnover rate. The rate from July 1, 1956 to June 30, 1957 was 248 employees, or 53.07 percent of 467 employees. In the period between July 1, 1957 to June 30, 1958 there was a marked reduction in turnover: a total of 192 employees, or 37.87 percent of our total of 507 employees. This represents an over-all reduction of 27.64 percent in turnover. One significant factor in bringing about this decrease was the raising of our starting salary from $120 to $140 per month. Of the 248 employees terminating employment in the year ending June 30, 1957, 224 were psychiatric aides in the $120 per month salary range, or 90.79 percent of the total aides. In contrast to this, 126 aides or 51.67 percent terminated employment at June 30, 1958. This represents a reduction of 43.09 percent in the turnover of aides.

THE THERAPEUTIC PROGRAM

Great strides were made toward rounding out a therapeutic program in the various ancillary services.

A vocational rehabilitation and recreational therapy department was established.

A music therapy department was organized and is functioning at a high level.

A chaplaincy department was established, with pastoral counseling training facilities. We now have a protestant and a catholic chaplain on full-time duty.

An out-patient program has been established with a complete psychiatric team consisting of psychiatrist, two social workers, and one psychologist. A total of 380 patients were examined and treated in this division.

The occupational therapy program has increased its scope with five full-time occupational therapy aides. A total of 2,491 patients received 48,250 hours of therapy during the period.

A volunteer coordination department was organized in November 1956. A number of organizations in the surrounding communities are regular contributors of time and effort, and have served to boost the morale of the patients. This great work continues unabated. In addition, numerous groups of people from surrounding communities have toured the hospital and have been able to gain some first hand insight into the problems and accomplishments of a large mental hospital.

MOVEMENT OF POPULATION INCREASES

An increase in both admission and discharge rates are shown during the period. For the fiscal year ending June 30, 1957, we have 976 admissions and 551 discharges, with a daily average resident population of 1114. For the fiscal year ending June 30, 1958, there were 1,035 admissions and 771 discharges, with an average daily resident population of 1104. Our out-patient service has been greatly expanded with 175 patients examined and treated in 1956-1957, as compared with 223 patients in 1957-1958.

THE CHILDREN'S PROGRAM

The physical facilities for the children's program are make-shift. Two wards housing children are in the Main Building and the remainder of the children are in an antiquated building in great need of repair, called Hilltop. A modern new building will greatly facilitate the treatment of this age group.

The children's unit was activated July 1, 1957. During the six-month period ending December 31, 1957, 42 new cases were admitted and 38 cases were discharged. A total of 89 cases were in residence at the close of this period with 4 on convalescent leave. In March, 1958, there were 107 under the age of 21 in residence. The age limit for treatment in the children's unit is defined by the Board of Control as 16. At this time, doors were closed to further admissions until such time as the staff could re-evaluate the cases, re-assort, and discharge such cases as were not proper cases for treatment.

At the close of the biennium, with a total of 90 children in residence, 50 of these under age 16 were treated and cared for in the Children's unit. There were a total of 27 discharges during the six-month period ending June 30, 1958. The program staff consisted of the psychiatric team of one psychiatrist, one social worker, one psychologist; and five full-time teacher therapists, one half-time teacher therapist, and three recreational therapists.

THE PHYSICAL PLANT

The physical plant leaves much to be desired: Our storeroom is very old and inadequate for our needs. It has an all-wood interior which is not fire- resistant. We have numerous other locations in which we must store supplies since the building is too small to take care of the need. It has a small area converted to cold storage, but we cannot handle frozen foods, so we are compelled to use the locker plants in Independence and Jesup. The estimated cost for a new store room and cold storage unit is $150,000.

BUILDING RENOVATION

Our Main Building is especially in need of repairs. Heating is uneven with some areas too warm and some too cold. This is partially due to old windows that are not weather-proofed, and partially to lack of heating zone control. Plumbing is inadequate and wiring overloaded. Some roofs leak badly and must be replaced. Some floors are in very poor condition. This is true of other buildings also. Estimated cost for renovation and repair is $250,000.

LAUNDRY ADDITION

The laundry building is inadequate to take care of our needs with overcrowding of equipment. We have no storage space for supplies nor linen sorting facilities. Estimated cost for laundry addition is $100,000.

NEED STAFF HOUSES

We should have five houses with three bedrooms in each for our doctors and other professional employees. If we are to attract and hold these people we must provide them with acceptable housing facilities. At present we do not have this, and the city of Independence is always short of housing facilities. Estimated cost for erecting five such staff houses is $100,000.

PAVING FOR ROADS

Our beautifully landscaped and maintained grounds are a source of pride, but our unsurfaced roads set up a black smoke-screen every time a vehicle passes over the cinders. This is not only annoying and a health hazard, but creates a very unfavorable public impression. We need approximately $75,000 to pave the roads on the campus.

1861 - MT. PLEASANT MENTAL HEALTH INSTITUTE - 1861

The oldest mental institution in Iowa and the second oldest hospital of its kind to be constructed west of the Mississippi River. The first patient was admitted February 27, 1861. In 1902 the institution began to admit inebriate patients.

In 1958 - with a rated capacity of 1200, the average daily population in residence was 1197. A total of 450 full time and five part-time employees were on the payroll at June 30, 1958. Eight physicians, 11 registered nurses, and 13 other professional personnel were employed. A ratio of one physician to 140 patients, and one registered nurse to 109 patients.

Costs: For the fiscal year ending June 30, 1958, total expenditures were $1,665,386.48. The average daily cost per patient was $3.92. Total expenditures were divided as follows:

Salaries	$ 1,095,123.29
Support and Maintenance	491,652.29
Repairs, Replacements and Alterations	50,853.35
Equipment	27,757.55
Total	$ 1,665,386.48

By: WAYNE B. BROWN, M.D.

Nearing the end of a century of operation, much of the physical plant at Mt. Pleasant Mental Health Institute has become obsolete and inadequate. Some buildings are not only in bad repair and urgently in need of attention, but present serious fire hazards with wax-soaked wooden floors and other wooden parts. They are below minimum sanitary standards. Fireproof structures should replace these as soon as possible.

A replacement project is now under way in the women's section of the hospital. During this biennium, nine women's wards have been razed and construction begun to replace them. When completed, we shall have accommodations for about 250 patients in a modern fireproof hospital structure.

PRESENT FIRE HAZARD

The state fire marshal has repeatedly criticized several buildings because of great fire hazards. Modernization and repairs are needed on many of these. Specifically, the roof over the boiler room is in a deteriorated state and needs replacement. The Oaks Farm, located about three and one-half miles from the institution, is without adequate water supply. For years we have had to haul much water this distance in order to supply the livestock there. Another well is urgently needed on this farm.

OTHER URGENT NEEDS

A water softening plant is needed to soften water as it comes from the wells. The dairy is located some distance from the main institution and has only a two-inch water line. This provides an inadequate water supply under normal conditions, and leaves the dairy almost without fire protection. It should be replaced with a six-inch line.

Much of the dairy plant is fifty years old and needs modernization, and other dairy facilities are outmoded and inadequate. We are in especial need of a milking station and a new milk processing plant, along with a bulk tank and homogenizer. A hay keeper and shed for young cattle is also needed. A farrowing house at the Oaks Farm frequently has been requested and is still needed.

Automatic controls are needed on our boilers in the power plant for more adequate and efficient operation, and a street lighting system has been needed for years. Cinder surfaced roads should be replaced with paving.

EMPLOYEE HOUSING PROBLEM

While the current trend is to encourage employees to reside in the city of Mt. Pleasant rather than at the institution, this can be accomplished only to a certain extent. The city itself has had a housing shortage over a long period and in many instances no housing is available for our employees. This presents an employment handicap since most professional people who are so urgently needed in our treatment program, will not consider employment here because of unsuitable living quarters. A superintendent's residence should be constructed as well as additional residences to house key professional personnel.

PERSONNEL PROBLEMS

Personnel continues to be one of our major problems, with a high turnover rate. Alghough certain salaries have been increased during the biennium, the employees are still on salary scales below private enterprise. Most of our employees are rated on a base salary plus maintenance basis. However, maintenance has a monetary valuation of only $36.00 per month. This is insufficient to maintain an employee outside the institution. As a result of this allowance, their total salary is too low. It is felt that a realistic salary without maintenance allowance would greatly help solve the problem. Also, those who do live on the grounds should be charged a fair price for maintenance if they are paid a realistic salary.

DRASTIC ECONOMY MEASURES TAKEN

Mt. Pleasant found itself in financial difficulties at the beginning of the biennial period. For various reasons, the institute received the lowest salary appropriation and the lowest total appropriation of any of the four mental institutions. At the beginning of the period our monthly payroll was larger than the monthly appropriation for the two-year period. Consequently, we were compelled to take drastic action by laying off some employees and not filling vacancies when they occurred. The Occupational Therapy Department, a very important activity in the care of the mentally ill, was closed.

Accordingly,we built up a reserve in the salary account so that we were able to give some employees their periodic increases as provided by the personnel department. Also, we were able to meet the general salary increase for attendants from $120 to $140 per month.

However, this financial situation made it impossible to undertake procedures and treatments that would otherwise have been possible. It is to be hoped that in the coming appropriation a more equitable distribution will be made between the four institutes.

Our most urgent personnel need is for an adequate professional staff. Here, too, we were unable to fill vacancies as they occurred. Later some additional funds became available for professional salaries and we were able to increase our registered nursing staff from three to ten, and to add social workers and some other professional people.

PROVIDE DRUG TREATMENT

We have attempted to provide out-patients with the best medical and psychiatric care that our facilities would permit. Electrotherapy has been used for many years with good results in some cases. It is still used to some extent. The tranquilizing drugs have been helpful in managing patients and have brought good results in a large number of cases. As a result of chemotherapy, we have reduced the use of electrocoma therapy. But the drug therapy has not solved the treatment problem. We believe that our treatment has been reasonably effective, as evidenced by the number of patients leaving the hospital during the period as recovered or improved. A large number of patients might recover sufficiently to return to their homes if we were equipped to administer the modern treatments proving effective. We also use music, recreation and psycho therapies.

MOVEMENT OF PATIENT POPULATION

A total of 1,312 patients were resident in the hospital at the beginning of the biennial period, with 1,218 patients admitted from all sources during the biennium. Returning home on convalescent leave, discharges, transfers to other institutions, and deaths totalled 1,356. Of this number, 100 female patients were transferred to other hospitals in December 1956 when the walls on the wards in which they were housed began to settle and the building was condemned for occupancy. At the end of the biennium, 1,174 patients were in residence, or 138 less than at the beginning.

SUMMARY OF ACCOMPLISHMENTS, PROBLEMS AND SPECIAL NEEDS

of

IOWA MENTAL HEALTH INSTITUTIONS

The following summarization of the accomplishments, problems, special needs, and plans for the future of the Iowa Mental Health Institutions was given in reply to a special questionnaire issued by the Director of Mental Institutions. Replies to the three questions posed serve to highlight subjects covered in their biennial reports published in this brochure.

The questions:

1. List in order of their importance at least five accomplishments or improvements in your institution during the biennium.
2. List in order of their importance the five major problems confronting you and state briefly what you plan, or at least hope, to be able to do about each during the next two years.
3. You received a sum of money from the Budget and Financial Control Committee over and above your regular appropriation. What evidence is there that your institution did a better job than you would have been able to do without the money?

The replies:

CHEROKEE MENTAL HEALTH INSTITUTE

Question 1: Accomplishments.

a. The establishment and approval of a three-year residency training program in psychiatry. This, of course, helps our recruiting of competent physicians to train and should eventually help the whole state system to obtain and retain the services of well trained psychiatrists.

b. Employment of a reasonable adequate staff of phsycians, including five certified psychiatrists.

c. Marked improvement in the rehabilitation program in spite of inadequate personnel. We have been able to do this because of a change in attitude of a great many of our employees, not only on the wards, but in the hospital industries and elsewhere. This change has been due largely to a program of re-education conducted by the people recruited under items 1 and 2 above.

d. Greatly improved patient care, both psychiatric and general medical.

e. Reduction of the number of patients in residence, in spite of an increased admission rate. This has been accomplished by a more rapid turnover, which, in turn, is due to the increased amount and quality of medical care, and the change in attitude of other personnel mentioned above. These factors have also resulted in a considerable increase in the number of patients who are admitted voluntarily, most of whom stay a relatively short time and receive intensive treatment.

Question 2: Major problems.

a. Shortage of ancillary professional and semi-professional personnel. This is particularly true in social service and the various rehabilitation services.

b. Lack of a children's service.

c. Very inadequate equipment funds, which results in a lack of much needed medical equipment, as well as our inability to replace worn out rugs, furniture, farm machinery and other equipment items.

d. Continuing shortage of housing for personnel, especially professional personnel, which has interfered with our recruitment program. Much of the housing we do have is inadequate from many points of view and is so undesirable that often people we are trying to recruit lose interest when they see the quarters we are trying to assign to them. Many of our personnel, including the superintendent, live in quarters which have been condemned as unsafe by the fire marshal's inspection.

e. Continued over-crowding of patients. Although this has, of course, improved somewhat with our decrease in number of patients, we are still housing up to sixty patients on wards which were built for only twenty-eight. Many of our buildings are old andobsolete, the latest quarters for patients having been built in 1932. Again, many of these have been condemned by the fire marshal as fire hazards, and very considerable funds are needed to make them safe, and even more to remodel them for modern treatment facilities. We particularly need a new research and treatment building.

Question 3: Use of special professional funds.

Cherokee received the largest share of money allocated by the Budget and Financial Control Committee. All of the improvements mentioned under Question 1 were financed primarily from these funds. The establishment of the residency training program was totally dependent upon these funds, which were allocated by the Interim Committee for this specific purpose. However, all of the other factors are related or dependent upon the personnel who were recruited for teaching purposes, and on the residents and regular staff members whose efficiency as psychiatrists has been greatly improved by the teaching program.

These new people are largely responsible for the changes in attitude on the part of non-professional employees mentioned above. It should be emphasized that, since nearly all of the improvements mentioned were a direct result of the extra money allocated by the Interim Committee, these programs will automatically collapse unless new appropriations, either regular or again through the Interim Committee, are sufficient to continue and expand this program. We have recently received a federal grant to pay for a small part of the residencey training program. This subsidy would not, of course, have been granted had we not set up the

program by the use of the Interim Committee funds. The grant is small at present, amounting to only $12,000 a year. However, I have reason to believe that this can be considerably expanded at a later date provided we keep up our standards, and that we can eventually have a federal subsidy paying the salaries of a number of our residents as well as part of the salaries of our teaching staff. We may obtain some other subsidies to cover training programs in psychiatry for general practitioners, ministers, and other appropriate persons residing in the twenty-five counties which we serve. This cannot be guaranteed, but it is my intention to apply for grants covering all of these matters.

CLARINDA MENTAL HEALTH INSTITUTE

Question 1: Accomplishments.

a. The addition of two well-qualified certified psychiatrists and two other psychiatrists, trained but not certified, has enormously strengthened the administrative branch. It has provided great stimulation to the medical staff, and has improved the overall quality of the medical care, although we remain short of service chiefs and other senior positions. A marked improvement in in-service training for medical staff - a healthier and more satisfying professional atmosphere has developed.

b. The establishment of a department of research and training under a certified psychiatrist has helped to coordinate teaching activities, improve morale and lead to better use of treatment methods. We hope it will lead to new developments.

c. Nursing and care has been elevated to a full-fledged department under the direction and leadership of registered nurses. This has resulted in an atmosphere of spontaneity and imagination in the work of the attendants. Nurse and attendant, alike, have been able to achieve a greater self respect under this leadership.

d. With the employment of a full-time recreational director, and with additional employees in the department of special services, marked expansion has been possible, filling a need greatly increased by the improvement in patients brought about by the use of drugs. At the same time, the department of special service has helped induce greater community activity and participation in this program.

e. Particularly in the medical and nursing services, the great need for expansion in the in-service training programs are being more adequately met. Courses for attendants have been lengthened, expanded, and new courses developed. Professional education and stimulation for medical staff members has been stepped up. The development of a residency training program is in the planning stage. Use of conferences for administration of professional activities has been broadened in departmental and inter-departmental areas.

Question 2: Major problems.

a. The shortage of professional staff, most severe in social service, nursing and psychology service, but also in the medical service, becomes an emergency in view of the greatly increased patient turnover rate. More adequate funds for salaries, and continuation of competitive pay scales is basic to the solution, but other factors such as personnel policies and professional gratification are worthy of thought and consideration. The solution to this number-one problem has a direct bearing on other problems, such as adequate supervision of junior staff members in in-service training.

b. Efforts to delegate and decentralize authority and to encourage various departments to reach a higher level of self-government have met with serious resistance, and have revealed an apparent lack of initiative and imagination. This can be met by re-education, using conference methods and, in some instances, may be necessary.

c. While relations between the institutions and community are in most respects favorable, we believe joint efforts in a number of areas are needed. Increased joint use of recreational, educational, and professional facilities should be encouraged by fostering public speaking engagements by our staff, participation in conferences, workshops and joint recreational programs. The rebuilt activities building is designed and worked out with such uses in mind.

d. We need stronger, better trained leadership in our personnel department and are in the process of hiring such an individual. Consistent local personnel policies might well be worked out in a joint effort by representatives of the various institutions.

e. Further expansion of in-service training in every department is needed and will be necessary if we are to offer adequate treatment. We must create a stable organization and meet the needs that exist. An energetic, well-trained, skillful psychiatrist has been employed as clinical director. He will arrive on or before July 1, 1959, and should be able to contribute much to the solution of this and other problems. We must also employ two nurse educators, at least two well qualified social workers capable of teaching, and additional well qualified psychologists.

QUESTION 3: Use of special professional funds.

This money has been used to attract two certified psychiatrists, as well as a third psychiatrist, trained and capable but not certified. The three have been assigned as follows:

1. Director of Research and Training.
2. Assistant Superintendant.
3. Acting Director of Out-Patient Services.

These three have played a most important role in the improvement of administrative practices, have succeeded in bringing us a stimulating and progressive professional atmosphere, and are greatly improving our service to the patients. An atmosphere of little hope and almost insurmountable obstacles has changed to one of optimism. Encouraging initiative and arousing enthusiasm, they have brought hope for the future in an operation of achievement that would otherwise have been long delayed.

The transfer of our chief of psychology to this payroll made expansion of the department possible by adding junior members on the regular payroll.

INDEPENDENCE MENTAL HEALTH INSTITUTE

Question 1: Accomplishments.

a. Improvement in salary scale resulting in the recruitment of more qualified personnel on the professional level.

b. Overall improvement in the therapeutic program with establishment of ancillary services: Vocational rehabilitation, music therapy, occupational therapy, volunteer coordination department, chaplaincy department.

c. Establishment of an out-patient department.

d. Reduction of turnover of employees in general, and psychiatric aides in particular, due to salary increases.

e. Establishment of a children's program.

Question 2: Major problems.

a. Increasing the therapeutic potential of the hospital by: Recruitment of more qualified personnel, expansion of in-service training in all departments, both professional and administrative, organization and implementation of a three-year residency program in psychiatry, and expansion of out-patient facilities.

b. Maintenance of physical plant in at least a minimal state of repair. This is dependent, of course, upon sufficient funds; and, also, upgrading of salary qualifications to attract more qualified personnel.

c. Promoting good public relations: Staff members speaking before civic groups on mental health problems; better press relations with the appointment of a news coordinator to keep the press informed; community adult education courses on aspects of mental health; cultural exchange by the community and hospital staff such as the International Club with sixty members and the music appreciation lectures by Dr. Chambers. Also seminars or workshops on the problems of school teachers; expanding volunteer program; closer liaison between doctors in private practice and mental health institute staff members through the county medical society; and expanding pastoral counselling to include courses beamed at the clergy in the community.

d. Lack of sufficient and adequate housing for medical personnel to be added to the staff. The American Medical Association will require that we have at least eight residents in training, if we are to be approved. At present we have no facilities for housing such a group of doctors and their families. We need at least five additional three-bedroom ranch type houses. This has been requested in capital askings. The estimated cost:$100,000.

e. Problems of vocational rehabilitation: Expand facilities and strive toward eventual establishment of a rahabilitation center on the campus. Close liaison with the State Vocational and Rehabilitation Department, and eventually securing federal aid toward building a center, if possible.

Question 3: Use of special professional funds.

Appropriation from Interim and Finance Committee. As I understant it, after discussing the matter with my business manager, in November 1957 a supplementary appropriation was received. This sum was $13,700. This enabled the superintendent to employ a qualified psychiatrist, and of course, resulted in much better care for the patients.

MT. PLEASANT MENTAL HEALTH INSTITUTE

Question 1: Accomplishments during the biennium.

a. For the first time the services of a certified psychiatrist became available to the patients.

b. Nursing service was improved by virtue of increased numbers of registered nurses.

c. Number of patients in the hospital reduced by 38, when consideration is given to transfers.

c. Nine old wards presenting great fire hazards and not meeting the standards, were demolished and new construction started to replace these beds.

e. Minimum wage scale raised from $120 to $140 per month, with limited salary funds.

Question 2: Major problems.

a. Lack of adequate professional personnel. I hope to convert all possible increases in salary appropriations to employing professional personnel.

b. Lack of adequate out-patient services. I hope to establish and develop an adequate out-patient service.

c. Lack of adjunctive therapies. I hope to re-establish occupational therapy and add other adjuntive therapies to the extent permitted by funds.

d. Lack of adequate salary funds to maintain a balanced professional staff. Substantial increases in salary have been requested, and, if forthcoming, will be used largely for professional personnel.

e. Lack of adequate modern physical facilities for the housing of patients. Funds have already been requested to eliminate serious fire hazards and unsanitary physical facilities which are not up to minimum standard. If forthcoming, I hope to see an additional eight wards razed and replaced with a new structure.

Question 3: Use of special professional funds.

a. Our registered nursing staff was increased to eighteen, more than we have ever had before. This greatly improves our nursing service and the care

received by the patients in this hospital.

b. The social service staff was increased from three to seven. This, too, greatly increased the service to the patients and permitted planning for return to the community, and for referral to vocational rehabilitation programs. It enabled steps to be taken for returning patients to county care and nursing homes.

c. Better psychological services was made possible by an increase in personnel in the psychology department.

d. Group therapy was started for the benefit of the patients due to the availability of therapists.

e. The services of two certified psychiatrists have been obtained. One is now working and the other will arrive soon. I believe the addition of a clinical director and other qualified professional personnel is evidence that the therapeutic program has definitely been strengthened.

SCHOOLS FOR THE MENTALLY RETARDED

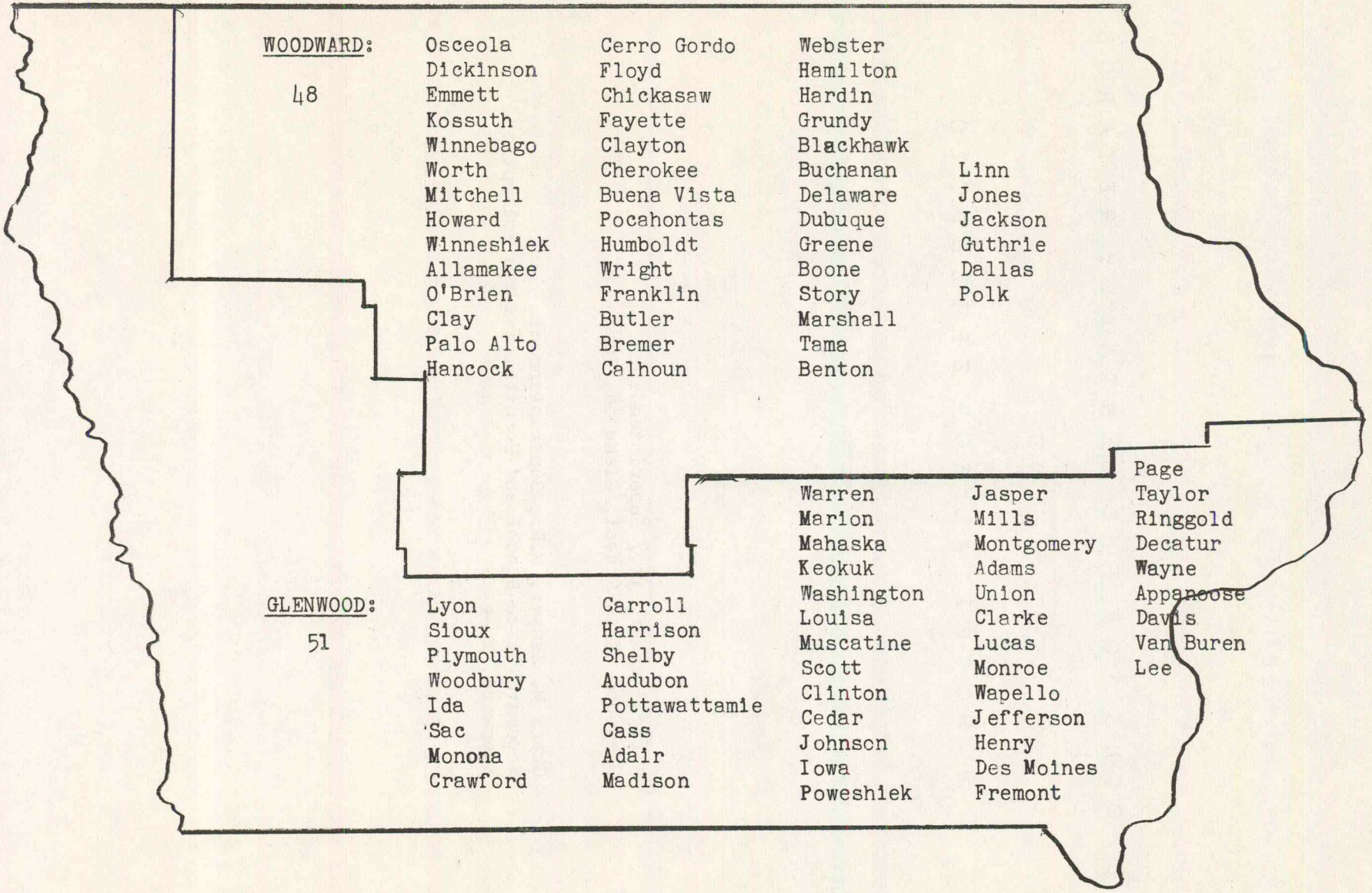
AND

HOSPITAL FOR EPILEPTIC

Alfred Sasser, Jr., Superintendent
Glenwood State School, Glenwood, Iowa

Grace M. Sawyer, M.D., Superintendent
Woodward State School and Hospital for the Epileptic
Woodward, Iowa

DISTRICTS SERVED BY SCHOOLS FOR THE RETARDED AND HOSPITAL FOR EPILEPTICS



WOODWARD: 48

Osceola, Dickinson, Emmett, Kossuth, Winnebago, Worth, Mitchell, Howard, Winneshiek, Allamakee, O'Brien, Clay, Palo Alto, Hancock

Cerro Gordo, Floyd, Chickasaw, Fayette, Clayton, Cherokee, Buena Vista, Pocahontas, Humboldt, Wright, Franklin, Butler, Bremer, Calhoun

Webster, Hamilton, Hardin, Grundy, Blackhawk, Buchanan, Delaware, Dubuque, Greene, Boone, Story, Marshall, Tama, Benton

Linn, Jones, Jackson, Guthrie, Dallas, Polk

GLENWOOD: 51

Lyon, Sioux, Plymouth, Woodbury, Ida, Sac, Monona, Crawford

Carroll, Harrison, Shelby, Audubon, Pottawattamie, Cass, Adair, Madison

Warren, Marion, Mahaska, Keokuk, Washington, Louisa, Muscatine, Scott, Clinton, Cedar, Johnson, Iowa, Poweshiek

Jasper, Mills, Montgomery, Adams, Union, Clarke, Lucas, Monroe, Wapello, Jefferson, Henry, Des Moines, Fremont

Page, Taylor, Ringgold, Decatur, Wayne, Appanoose, Davis, Van Buren, Lee

1876 - GLENWOOD STATE SCHOOL - 1876

The Glenwood State School is located on the original site of the Western Branch of the Iowa Soldier's Orphans Home, which institution opened in 1866 and operated until 1874, when the children were transferred to the Iowa Soldier's Orphans Home at Davenport. The first patients were admitted to the institution then known as the Asylum for Feeble Minded Children in 1876. The administration building erected in 1884 burned, and the present building was completed in 1896.

In 1958 - with a rated capacity of 1790, the average daily population in residence was 1710. A total of 484 full time and 3 part time employees were on the payroll at June 30, 1958. Two part time physicians, six registered nurses and 17 other professional personnel were employed. a ratio of 1 employee to 35 residents.

Costs: For the fiscal year ending June 30, 1958, total expenditures were $1,711 $1,711,195.05. The average daily cost per patient was $2.80. Total expenditures were divided as follows:

Salaries	$ 1,108,707.66
Support and Maintenance	520,272.81
Repairs, Replacements and Alterations	51,903.00
Equipment	30,311.58
Total	$ 1,711,195.05

By: ALFRED SASSER, JR.

"The Patient" is the star in Glenwood's new philosophy of performance.

Helping the individual with mental, physical, emotional or society disability to attain his fullest potential is the prime motive of the Glenwood program. Primary consideration is given to: 1. Equipping the individual to live a life that is as nearly normal as possible in the community; 2. Equipping the individual who cannot reach the capacity of normal living in society to live more fully within the environs of the institution.

Great strides have been made toward this goal in the short time the new program has been in operation. A great challenge lies ahead. As every story must have a problem and a solution, we shall first present our problem as it existed at the beginning of our new approach. Secondly we shall trace our achievements toward the solution, and point out our goal.

THE NEW PHILOSOPHY

The Glenwood State School, the seventh oldest institution for the mentally retarded in the nation, is the largest public mental institution in Iowa. Along with some one-hundred institutions of its kind in the country, it

has long struggled with a multiplicity of functional problems, the greatest of which is negative custodialism. In fact, this is the prime problem, with other functional perplexities by-products of this state of mind. That the mentally retarded cannot be helped but must remain dredges of our society is today an outmoded and obsolete philosophy, with which Glenwood does not concur. We defintely believe that the mentally retarded can be helped! And our program is designed to render that service!

CRITICAL PERSONNEL SHORTAGES

The custodialism so prevalent in institutions for the mentally retarded in the past has created a paucity of professionally trained personnel, with the concomitant lack of therapeutic and programming services. Several examples from our first population survey are:

Several hundred patients who had had no psychological examinational, and hundreds more with inadequate old evaluations; over a thousand patients with speech and hearing problems; thirty-two blind patients who had never had programming of any kind; more than two-hundred convulsive cases; over two-hundred cerebral palsied and orthopedic cases. There were no physicians trained in mental retardation, psychiatry and other pertinent specialities. There were no trained psychiatric social workers, special education teachers, nor clinical psychologists. In the therapies we had no recreational, physical, speech nor occupational specialists. There was no trained chaplaincy, personnel officer, psychiatric nurse, business manager, psychiatric aide, electroencephalography service, and only a very limited dental service. We had no trained vocational rehabilitation therapist, or nursery education specialists.

STAFFING PROGRESS MADE

Considerable progress has been made in ameliorating some of the basic professional personnel needs of the institution. We now have:

1. The first trained and qualified director of psychiatric nursing.
2. The first trained director of clinical psychology.
3. The first trained director of special education.
4. The first director of psychiatric social work.
5. The first trained director of recreation.
6. The first trained speech pathologist.
7. The first trained electroencephalography technician.
8. The first trained vocational rehabilitation counselor.
9. The first trained and qualified business administrator.
10. A medical and psychiatric staff, as well as medical consultants.

PROBLEMS STILL EXIST

Although this is an exceptionally good beginning for so short a period of time, it is extremely important not to be misled insofar as adequacy is concerned. It is true that we now have a basic key professional staff, but these must be supplemented by trained workers in the respective professional areas if we are adequately to render proper service to our 1800 to 1900 resident patients.

We are much below the American Psychiatric Association standard insofar as the non-professional attendant personnel staff is concerned with a ratio of one attendant to every ten patients, whereas the standard is one to four patients.

Our extremely low salaries accounts for shortages in trained psychiatric aides or attendants. If we are to render the best possible service to our population, it is imperative that we get into the salary brackets of the competitive labor market.

PLANT INADEQUACIES AND HAZARDS

The overall age of our buildings creates an excesssive, continuous and costly maintenance problem. Not only has age taken its toll in depreciation, but functionally the buildings do not lend themselves to rehabilitation programs.

Electric re-wiring in the older buildings is essential due to the increased use of appliances and power equipment. According to a recent survey made by the American Psychiatric Association, no patient-occupied building can meet their standards in toilet and lavoratory facilities.

Buildings are in need of tuck pointing, frame repair, roof repair, plumbing, terrazo floors to replace old wooden ones not only for sanitary but fire control reasons. Structural changes are made necessary for ward and dormitory improvement. Our repair, replacement and alteration appropriation of $45,000 a year is sufficient only to meet basic needs. Emergencies such as the current D.H. Kitchen condition, the continued reconditioning of Mogridge Hall and other large repair projects, will have to be met by special appropriation, as have some of our major repairs in the past.

Another important factor is the extreme fire hazard existing. Some of our buildings present serious dangers in this respect.

DIETARY STANDARD TOO LOW

It is an accepted fact that dietary requirements for mentally retarded children are higher than for adults, and mental develpment correlated with physical deficiency occurs during maturation. A caustive factor of mental retardation is, in some instances, dietary deficiency.

Although our present support appropriation is comparable to that of other state institutions, we feel it is still too low to give adequate care in some departments and to maintain our present standards in others. Our population is composed of many young and growing children who are "hard on clothes", destructive of furniture and their physical home. We need a nutritious diet for active, growing children as compared with the more inactive adult. And, correspondingly so, our older patients have the same youthful characteristics toward personal and state property.

At present our cost per meal is .1782 cents and this is a small increase over the daily average of .1516 for the fiscal year just past. We would like to increase our diet by .10 cents per meal, which would be a step in progress toward dietary standards set forth by the American Psychiatric Association and the American Dietary Association.

CAPITAL IMPROVEMENT GOALS

Before discussing Glenwood's problems in this area, attention should be directed toward another highly important goal. We should be planning for a third

institution to be erected in the geographical area of the State University of Iowa. It would be a mistake to continue to add to Glenwood and Woodward, since they cannot now take proper care of their residents. Far better to get caught up, so to speak, than to continue to enlarge. Once an institution passes 1,000 population, the individual and his individuality become lost in the masses.

As to Glenwood and its needs, we should inaugurate a ten-year building program to replace the old and inadequate functional building we have. Small, home-like cottages are preferable to buildings housing 500 patients. This reflects rehabilitational rather than custodial planning. We need several such cottages as a large number of our population could be rehabilitated, given the proper facilities and training.

A number of other urgent capital improvement needs have been noted in the institution's budget requests presented to the 58th Iowa General Assembly.

INNOVATIONS AND IMPROVEMENTS

Many program innovations and improvements recently have transpired and certainly are reflective of the institution's conversional efforts toward a rehabilitation center:

1. Considerable organizational and administrative effort has been put into effect, thus bringing about better practices and procedures in the institution's affairs of operation.
2. All patients now undergo a pre-planned standard pre-admission procedure so as to determine eligibility for admission.
3. An intensive in-service training program has been instituted.
4. Develpment of better inter-agency and inter-institutional relationships.
5. A recreation therapy program was put into operation.
6. A vocational rehabilitation program has been begun and patients for the first time in 81 years are leaving the institution for job training with the State Vocational Rehabilitation Agency.
7. An outstanding special education program under a trained director has been put into operation. The comparison of 250 children attending school prior to the present attendance of 700 is noteworthy.
8. A Parent's Association group has been formed with the first institute in the history of the institution held in September 1957 and attended by over 500 parents.
9. Discharges and job placements have been increased.
10. An electroencephalography has been purchased.
11. Affiliation with Nebraska Psychiatric Institute, especially our becoming a participant in the weekly telecommunication broadcasts.
12. Expanded special services, highlighted by our Forgotten Patient program. With over 800 completely forgotten patients, a public appeal for sponsors was made and the response was overwhelming. Today, we have almost 3,000 sponsors for these forgotten people
13. On May 18, 1958, twenty-four patients betweeen the ages of eleven and nineteen, with an average I.Q. of forty-eight to fifty, went to Disneyland, Los Angeles, California. This is the first tour of its kind in the country. The project was sponsored by the Junior Chamber of Commerce of the state at a cost of $5,000. This will be an annual project.
14. Girl Scouts, Boy Scouts, 4-H Clubs have been instituted.
15. Extensive efforts have been made to improve environmental conditions throughout the entire institution.

16. Considerable effort has been made toward team effort and committee work on problem areas.

ENTHUSIASM ABOUNDS

The enthusiasm of the staff seems to permeate every corner of the institution. An easy permissive, relaxed relationship between personnel and patients is a very wholesome thing in all operations of the institution. The team comprises both professional and lay personnel, and gives a balance to our operations. Staff meetings and case conferences are held on a weekly basis. With an increasingly positive approach to mental illness on the part of the public, we at Glenwood feel that we are contributing a part toward such an awakened and positive attitude toward mental retardation. This is particularly evidenced by the communications from organizations, agencies and institutions throughout the state and nation expressing interest in our efforts.

It is, furthermore, recognized that with the inception and development of this program, many fine results have ensued. However, one would lack cognizance of reality if he did not know that all which has been accomplished serves to open new vistas toward better patient-centered programming. Glenwood's efforts stand out as a challenge to itself, as well as to others in the field. Ours is a story of all desciplines playing an active part, because we believe in a whole-person approach, rather than a discipline segmentation. And our star is - The Patient!

1917 - WOODWARD STATE HOSPITAL AND SCHOOL - 1917

The Woodward State Hospital for Epileptics and School for Feeble Minded, now known as the Woodward State Hospital and School, admitted its first patients in 1917.

In 1958 - with a rated capacity of 1700, the average daily population in residence was 1573. A total of 532 full time and 10 part time employees were on the payroll at June 30, 1958. Five part time physicians and 11 registered nurses, as well as 15 other professional personnel, were employed. A ratio of one employee to three residents.

Costs: For the fiscal year ending June 30, 1958, total expenditures were $1,758,511.88. The average daily cost per patient was $2.88. Total expenditures were divided as follows:

Salaries	$ 1,194,124.60
Support and Maintenance	491,765.88
Repairs, Replacements and Alterations	42,852.53
Equipment	29,768.87
Total	$ 1,758,511.88

By: GRACE M. SAWYER, M.D.

Linden Courts, a new structure providing four units for children, was completed and opened during this biennium. With room for 288 patients, we were able to accommodate most of those on our waiting list, as well as many new urgent cases. The Board of Control established the policy of admitting no patients under the age of six years except those diagnosed as urgent medical and nursing care cases.

The basement of the building provides completely equipped facilities for a canteen, a pre-school room, recreation room, physical therapy department, vocational rehabilitation training center, and crafts classes.

SUPPLEMENT STAFF

The additional facilities and therapies made it necessary to supplement our staff and we were able to secure: A clinical director, a social service director, a social service supervisor, a director of clinical psychology with two assistants, one a graduate student and the other a graduate psychologist, a registered physical therapist, a neurology consultant, a chiropodist, and an optometrist.

REMODEL AND REDECORATE

Pine Hurst and Oak Hall were completely redecorated in a variety of pleasing colors. A new ramp was built at Pine Hurst. The rooms on the old side of the employees homes were redecorated, and a cement floor was laid on the porch of the old side of the employees home.

A gas line was laid from the supply depot to the residences to the east and conversion units in the old coal furnaces were installed. Six new steel coal hoppers were installed on the boilers at the power plant and several sections of pipe on the hot water lines were replaced. Repairs to the cement walks and steps over the entire length of the grounds sidewalks was completed. A new shirt unit was added to the laundry equipment, which does the work of several patients and turns out an excellent finished product.

FARM EQUIPMENT PURCHASED

A new tractor for the farm and one for the dairy with a manure loading attachment were purchased.

The calf barn ceiling was insulated, and new stanchions, mangers, and ventilating fans were installed.

One of the root cellars was refrigerated, making it possible to keep vegetables and fruits in better condition.

Much grading and oiling was done on the new roads and around the new buildings, as well as filling, grading and landscaping new lawns.

PLAN TO REMODEL FURTHER

The old kitchens and dining rooms are to be remodeled in the near future into usable ward and recreation space. Other necessary improvements are a dish-washing machine and stainless steel tables at the Birches dining room.

The return of patients to community living continues, but the progress is slow. This is largely due to the fact that placements in the institution are cases not suitable for community living. We are not able to keep pace with applications for admission, consequently, a new waiting list is accumulating and is reaching sizeable proportions. What is the answer? More buildings?

My appreciation is extended to the members of the Board of Control and to the Director of Mental Institutions for the support and counsel which has made our progress possible.

SUMMARY OF ACCOMPLISHMENTS, PROBLEMS AND SPECIAL NEEDS

of

IOWA SCHOOLS FOR THE MENTALLY RETARDED AND
HOSPITAL FOR EPILEPTICS

GLENWOOD STATE SCHOOL

Question 1: Accomplishments.

a. Acquisition of trained professional staff.

b. Complete change of mental health dynamics from a negative, custodial concept to that of hopeful rehabilitative attitudes.

c. Establishment of needed professional services.

d. Public education and awareness of Glenwood State School and the mentally retarded as a whole.

e. Substantial increase in volunteer and total state "community" participational services to the institution.

Question 2: Major Problems.

a. Severe lack of funds for: Professional personnel, non-professional personnel, salary adjustments, merit increases.

b. Severe lack of funds for: Diet operation, clothing, equipment, utilities operation.

c. Severe lack of funds for capital improvements: Great need for patient building replacement, specifically D. H. Kitchen, Mogridge Hall. Critical need to create new buildings and concomitant services: Hospital, rehabilitation center.

d. Severe overcrowding, plus a long waiting list.

e. Severe need for funds to catch up with pressing maintenance and repair needs so that we can operatively reach the point of functionally "preventive maintenance".

Question 3: Use of Special Professional Funds.

We have, through this "grant in aid", been able to secure professional personnel of the type which the institution has not previously had. Their re-

spective services have given to our patients a therapeutic significance which they previously did not have.

a. Hundreds of patients had not previously been evaluated either psychiatrically nor psychologically; this was made possible by the addition of a professional staff.

b. Special education personnel was employed to establish such a department. Previously the educational program was administered on a "watered down" public school basis.

c. Psychiatric nursing care was established, to form the basis for teaching attendants how to understand the patient with his particular type of handicap, and how best to help him.

d. Medical consultant services were implemented including: pediatrics, psychiatry and neurology.

e. With well over a thousand patients with speech and hearing defects, trained professional personnel are essential if the patients are to have a rehabilitative chance.

The institution has been able to render better patient service on a therapeutic basis than in the past. However, I should be remiss if I did not point out and emphasize the fact that what we have accomplished is but a scratch on the surface of the total needs. We have been able to help a number of patients very substantially in their rehabilitative processes, and even to aid some patients in leaving the institution. However, we have a large residual group with rehabilitative potential that might be reached with additional professional personnel and services.

WOODWARD STATE HOSPITAL AND SCHOOL

Question 1: Accomplishments.

a. Physical Plant Expansion: Opening of Linden Courts with room for 288 additional patients. Opening of: A new central cafeteria for ambulatory patients with a new modern kitchen; a new modern kitchen; a new and much larger canteen; a pre-school class area; recreation unit; physical therapy department area; vocational rehabilitation section and a new arts and crafts department area.

b. Personnel Expansion: Addition of a clinical director, a social service director, a social service supervisor, a chief director of psychology, two new professionals in the pyschology department, addition of a new registered physical therapist, a new registered nurse anesthetist, consultant neurologist, consultant chiropodist, and a consultant optometrist.

c. Equipment Expansion: Acquired new electrocardiograph equipment; a new Heidbrink anesthesia machine so that we can give all modern anesthesias with all gases, including cyclopropane; acquired the services of Palm Splint and Brace Company in Des Moines, so that under medical prescription, all braces and appli-

ances may be fitted and kept properly serviced. Obtained complete and well stocked equipment for pyshical therapy procedures.

d. Medical Investigations and Research: The practice of performing autopsies was resumed. For forty years none had been done. To date, sixteen autopsies have been performed. This practice will add to our medical knowledge of mental retardation. In conjunction with Dr. Eugene Petry, pediatric resident under Dr. John Gustafson of Blank Memorial Hospital Cardiac Station, an investigation of types of cardiac lesions in mongoloid children has been started. Projects on temporal bone biopsy material was started with interest shown by the Department of Otolaryngology at the State University of Iowa. A project on the utilization of new drugs in the retardate was begun.

e. Educational Advances in the Problem of Retardation: A re-fortified program for orientation of the senior medical students, who come from the state university to get an overall picture of our institution and its program was instigated.

A program using clinical case conferences, motion pictures, guest speakers, et cetera, was started on Friday afternoons, geared to both attendant and professional levels. Many talks were given by various department heads in Iowa Association for Retarded Children groups, parent groups, nursing groups, service club groups, and others.

f. Professional Patient Care Instigated: A total of 222 patients were presented before diagnostic staff clinic between June 1, 1958 and December 31, 1958. Thirty girls were placed in work training situations under supervision, representing fourteen Iowa counties and one each in Nebraska and Arizona. Twenty-eight boys were placed under work training situation with supervision, representing approximately 11 counties in Iowa, and one in Kansas City, Missouri. A planning program was reactivated. Attendant in-training service was begun under the auspices of psychological services. A vocational rehabilitation training program was started to orient patients toward communal living and job placement. A total of 137 appointments were kept at the State University of Iowa departments of University Hospitals for specialty care in 1958.

Question 2; Major Problems.

The major general problems confronting the institution might well be summarized as special needs for: More money, adequate numbers of professional personnel, and capital improvements and equipment.

Specifically, since we are required to function in the following areas, numerous specialized equipment and personnel needs arise. We are asked by the courts, social welfare departments, physicians, parents, and society in general to perform the following services:

a. Hospital for epileptics.
b. Hospital for severely mentally retarded.
c. Hospital for severely mentally and phsyically handicapped.
d. School for school-aged mentally retarded children.
e. School for school-aged mentally normal but epileptic children.
f. Rehabilitation center for the retarded beyond school age.
g. Rehabilitation for emotionally tranquilized children who are functioning for the time at a psychologically retarded level.
h. Rehabilitation center for delinguent youths who are function-

ing for the time at a psychologically retarded level.

i. Rehabilitation center for defective delinquent youths for whom we have no maximum security area.

j. Rehabilitation center for criminally delinquent youths for whose care we have no adequate personnel.

A. To cope with these demands, we greatly need physical plant expansion.

1. A new administration building to house an adequate staff, and provide a conference room, library, reception and waiting room, ladies lounge, and file and storage room.
2. Enlarged laundry facilities and replacement of old equipment.
3. Additional school rooms and auditorium.
4. Cottage type buildings with class rooms for a geared vocational training and rehabilitation center program.
5. A new pediatric hospital with infirmary area.

B. We would also require personnel expansion to cope with the multiple problem, as follows:

1. Additional personnel for hospital areas: doctors, nurses, et cetera.
2. Additional personnel for school area: teachers, speech therapists, special educators, et cetera.
3. Additional personnel for rehabilitation center to give vocational training to those who can be made self-supporting.
4. Personnel to staff our own sheltered workshop area.

C. Equipment Expansion needed:

1. New X-Ray machine.
2. Electroencephalograph machine.
3. Oxygen tents and medical equipment needed for general pediatric hospital.
4. Reduplicating machines, office bookkeeping machines modernized.

D. Retardation Center:

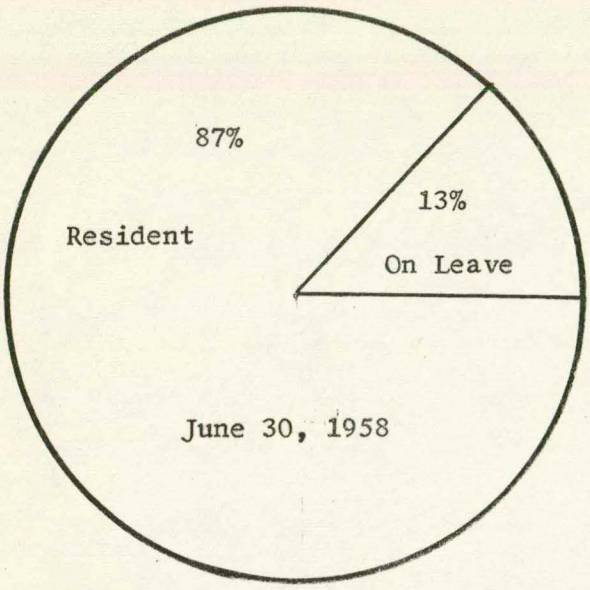
1. A need exists for establishing a retardation center in Iowa.
2. Funds and personnel for research in medical, educational, psychological, and social service aspects of the problem.
*3. Revitalized utilization of integrated resources of: Department of Public Health, Department of Public Instruction, and Department of Social Welfare to solve these problems.

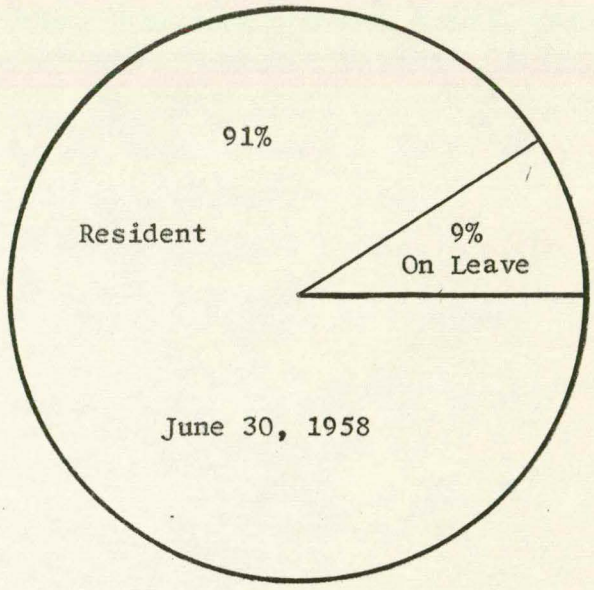
Question 3: Use of Special Professional Funds.

No additional funds were granted this institution by the Interim Committee.

* See Iowa State Medical Society Journal for special article on this subject.

MENTAL RETARDATION





GLENWOOD STATE SCHOOL		WOODWARD STATE HOSPITAL & SCHOOL	
Resident Population	1574	Resident Population	1766
Population on Leave	246	Population on Leave	170
Population on Books	1820	Population on Books	1936
Average Daily Resident Pop.	1710	Average Daily Resident Pop.	1779

Total Resident Population	3340
Population on Leave	416
Population on Books	3756

MENTAL RETARDATION: Refers to that group of conditions characterized by:

1. Slow rate of maturation
2. Reduced learning capacity
3. Inadequate social adjustment

Present singly or in combination, associated with a degree of intellectual functioning which is below the average range, and is present from birth or early age.

Mental retardation is an inclusive term, incorporating all that has been meant in the past by such similar terms as mental deficiency, feeble mindedness, etc.

MENTAL RETARDATION LEVEL

Severe Retardation - I. Q. 0-25
Moderate Retardation - I. Q. 25-50
Mild Retardation - I. Q. 50-75

REPORT OF SPECIAL CONSULTANTS

Chief Consulting Dietitian

Chief Consulting Psychologist

Chief Consulting Engineer

FOOD SERVICE PROGRAM

By: BEATA L. REAGER
Chief Consulting Dietitian

The food service program encompasses three fields: 1. Physical plant; 2. Dietaries; 3. Personnel.

1. Physical Plant

The building program in the dietary departments at the six mental institutions has been extensive and very satisfactory. Credit for the improvement and progress that has been made should go to Ralph Arnold, architect for the Board of Control, and to his able assistants. My part in this program has been minor compared to the time and effort expended by them.

Listed are the major improvements made at each institution. In addition to the major items, many minor improvements have been made in the way of purchases of new equipment, redecorating, et cetera:

A. Cherokee: Voldeng Cottage - new serving room and automatic dishwashing equipment installed in order to serve approximately 80 bed patients; central kitchen completely remodeled and re-equipped; dishwashing room for patients' cafeteria completely renovated with installation of new automatic dishwashing machine, garbage disposal units and stainless steel tables; employees cafeteria remodeled and enlarged and new equipment installed, including dishwashing equipment; staff dining room built in connection with the employees' cafeteria; in the hospital building, remodeling and installation of all new kitchen equipment and automatic dishwashing machines; Kinne Cottage for the tuberculous, purchase of all new kitchen equipment and installation of proper diswashing equipment in the serving rooms; bake shop completely re-equipped with automatic bakery equipment; staff kitchen, Donohow kitchen and Wade kitchen - new heavy duty ranges, roast ovens, steamers and steam kettles.

b. Clarinda: Northview - remodeled, new equipment in kitchen, automatic dishwashing machine installed, built in a walk-in-reach-in cooler; converted an old dining room into a semi-cafeteria for elderly women: Southview - remodeled and purchased new equipment for kitchen, installed an automatic dishwashing machine, built in a walk-in-reach-in cooler; Hope hall - completely remodeled the kitchen, installed all new equipment and an automatic dishwashing machine, built a walk-in-reach-in cooler, dining rooms - renovated and new furniture and equipment installed; deep freeze unit, converted old cold storage unit into four deep freeze units for the freezing of surplus fruits, vegetables and meats; canteen -- planned, furnished and equipped a new patients' canteen; employees' cafeteria - enlarged the employees' dining room to include a cafeteria counter; staff dining room - an addition built onto the employees' dining room to accommodate the staff; canning factory - remodeled an old building and equiped it for a canning plant; Sunset tuberculosis unit - remodeled serving area and installed suitable dishwashing equipment; Main Building - re-equipped all ward dining rooms in the main building; garbage disposal units - installed for use of all buildings.

C. Glenwood: Employees' Cottage - Built and equipped a new kitchen, walk-in cooler and cafeteria for employees, replacing three old dilapidated dining rooms; school building - equipped a large dining room, dishwashing room, and serving room in the new school building; Canning plant; Lacey hall - built a walk-in cooler in connection with the kitchen; canteen - installed and equipped a new canteen for patients and employees.

D. Independence: Main Building - replaced a very old and unsanitary kitchen and three employees' old dining rooms with a new central kitchen, large cafeteria for patients, cafeteria for employees, dishwashing facilities for both cafeterias, and walk-in coolers; new patients' building - entire new food service department which included a central kitchen, diet kitchen, eight serving dining rooms, patients' cafeteria, automatic dishwashing equipment on all wards and walk-in coolers; Infirmary Building - remodeled and equipped the three serving rooms; Grove Hall - remodeled and purchased all new equipment for the kitchen and dining room, including automatic dishwashers, garbage disposal units and walk-in coolers; bake shop - remodeled the bake shop and purchased a large revolving bake oven.

E. Mt. Pleasant: New patients building - entire new food service department, which includes one large central kitchen, walk-in coolers, garbage disposal units, cafeteria and dining room for employees, eight ward serving and dining rooms, each equipped with automatic dishwashing equipment; Infirmary Building - equipped a new serving room and automatic dishwashing facilities, replaced many old cement sinks used for dishwashing with either dishwashing machines or stainless steel sinks suitable for dishwashing; patients' dishwashing room - purchased new automatic dishwashing machine, stainless steel dishwashing tables, stainless steel pot drying cabinets and installed a new dish conveyor from the congregate cafeteria to the dishwashing room, installed large garbage disposal units in the buildings.

F. Woodward: Employee's Building - built and equipped a new kitchen and two cafeterias in the employees' building and by so doing did away with employees eating in all the nine kitchens in the individual buildings; Linden Courts - entire new dietary department which included a large central kitchen, walk-in coolers, dishwashing machines in patients' dining room, eight ward dining and serving rooms; Oak Hall - remodeled and purchased all new equipment for the kitchen, installed a small cafeteria for the patients, installed new automatic dishwashing equipment, walk-in cooler, and dumbwaiter to second floor dining room; Larches - remodeled kitchen, purchased new equipment, built a walk-in cooler, refurnished dining room and installed automatic dishwashing machine; Birches - installed a new cafeteria counter in patients dining room and a new automatic dishwashing machine; Cold Storage - four large deep freeze units for storage of surplus commodities was installed.

G. Projects now under construction:

Clarinda: Remodeling and equipping bake shop with automatic equipment and installing a large rotating bake oven.

Glenwood: Remodeling and equipping the kitchen and dining rooms in the D. H. Building.

Mt. Pleasant: Remodeling and enlarging the employees' kitchen.

Woodward: Remodeling the vacated kitchens of Maple Lodge, Elmcrest and Pinehurst into new dining rooms for patients.

2. Dietaries:

A diet that is nutritionally adequate contains the essential nutrients to meet individual needs. Many different combinations of foods will provide an adequate diet. In analyzing the dietaries for all the institutions under the supervision of the Board of Control, I have used the recommendations set forth by the National Research Council, Department of Agriculture Division of Human Nutrition.

Following is the food classification. The amount of food needed in each group for each institution is based on the age, occupation and sex of the individual patient:

1. Leafy, green and yellow vegetables; 2. Citrous fruits and tomatoes; 3. Potatoes, sweet potatoes; 4. All other vegetables and fruits not included in the above items; 5. Milk, poultry, fish; 7. Eggs; 8. Dry beans, peas, nuts; 9. Flour, cereals, baked goods; 10. Fats and oils; 11. Sugar, syrups, preserves.

In analyzing the dietaries of ten years ago, they fell into what is known as the "Low Cost Food Plan", that is, they were very high in Groups 3-8-9-10-11, but were very low in Groups 1-2-4-6-7. During the summer months, when the gardens were in production, groups 1 and 4 would increase to the amounts needed for an adequate diet.

In some instances, milk was down to .3 of a pound per person per day. The minimum amount recommended is 1 pound per person per day. Over a period of ten years the following results have been attained:

Group 1 - Leafy, green and yellow vegetables: Taking 100 percent as the minimum requirement, this group has increased considerably. In some instances where it was as low as 5 percent, it has now risen to 105 percent, the mean being about 8- percent. This means that the institutions still need to purchase more of the leafy green and yellow vegetables, especially during the winter months.

Group 2 - Citrous fruits and tomatoes has increased to the point where several of the institutions have exceeded the minimum requirements. The rest are within 10 percent of the amount required.

Group 4 - All other vegetables and fruits, practically all institutions have reached the required goal, and in summer when gardens are productive they far exceed the required amount.

Group 5 - Milk and milk products, all institutions have far exceeded the minimum requirements of 1 pound per person per day. This is very commendable.

Groups 6 and 7 - Meats, poultry, fish and eggs. The "Protein Groups" have reached the 100 percent requirement at practically all of the institutions.

3. Personnel:

The most difficult problem in the dietary department is personnel. The number of patient-helpers has decreased during the past ten years. Those who are assigned to this department stay for only a very short period. Some of them work only intermittantly as they participate in institutional activities. The amount of actual help to the department is practically nil.

The number of employees is so limted that when some are ill or on vacation or have days off, it is necessary for the dietitian or food supervisor to step in and do the cooking or serving in the dining rooms or the cafeteria.

Very short training programs of three-day duration have been offered at Iowa State College for cooks and food supervisors. Plans are under way this year to give a four-week course. It is hoped that those attending this course will be able, in turn to train employees and patients in their respective institutional departments.

Our dietary departments are badly in need of in-training programs, especially for the new employees.

4. Conclusion:

Listed in order of importance are the things I consider the most vital needs of our institutions in the dietary department:

1. Trained dietitians and food supervisors.
2. Increased numbers of employees.
3. Increased budget so that adequate amounts of fresh fruits and vegetables may be served throughout the year.
4. Food service units and dining rooms, especially those on the wards that have not already been renovated and modernized, should be renovated and modernized immediately.

THE PSYCHOLOGICAL PROGRAM

By: LOWELL W. SCHENKE
Director of Psychological Services

The greatest advance in the development of our psychological program during the past two years has been made with respect to the increased number of psychologists with proper training and experiential background who have been added to the staff at the various institutions. A brief comparison will serve to give a proper understanding of this improved condition.

As of July 1, 1956 there was a total of 16 clinical psychologists employed in the various institutions, only four of whom were at the Doctor of Philosophy level of training, and the remaining twelve at the Master of Arts level. In comparison, at the present time we have a total of 31 employees, 15 of whom hold Ph. D. degrees, and 16 master's degrees.

This comparison shows quite clearly the trend toward employing more psychologists at the higher and more desirable levels of academic training. Whereas in July of 1956 only four of the psychologists were at the Ph. D. level, at the present time 15 of these individuals are so qualified.

This improved situation has been made possible through the establishment of a realistic job classification and corresponding salary schedule. A brief comparison here may also be of interest. In July 1956 there existed only six different classification levels within any one of which a psychologist might be employed. The highest salary it was possible to offer a qualified applicant was $6,200 per year. The revised classification and salary schedule makes it possible to employ psychologists within nine different and separate classification levels. Also, the spreading of the salary range has made it possible to employ psychologists with varying levels of training and experience and to pay them a realistic salary commensurate with their academic and experiential background. The highest beginning salary which it is presently possible to offer is $12,000 per year. Only persons of exceptional proven ability are, however, able to qualify for this salary.

In summary, the revised classification and salary schedule has made it possible to secure the services of a strong staff of highly qualified psychologists. Their function and duties have been enlarged, and they are increasingly providing a more varied type of service within the institutions. Many more improvements are needed. We need, for example, many more psychologists in order to provide an optimum degree of service. We need, also, to place increased emphasis upon research development and to develop a suitable training program. These represent only a few of the areas to which we need to direct our efforts, and it is my opinion that within the next two years we shall be able to effect considerable improvement.

ENGINEERING SERVICES

By: WILLIAM A ROBINSON
Chief Consulting Engineer

In order properly to operate the facilities at each of the mental health institutions, various problems and needs exist. As the consulting engineer I shall point out some of the situations needing particular consideration.

1. Power Plant: Each institution has at least one turbine and switchboard, and some have two turbines. Glenwood, Woodward, Clarinda, and Mt. Pleasant still have some old reciprocating engines. From a monetary viewpoint the old engines are not too valuable, but as generators for standby emergency service they are quite valuable. Today it would cost approximately $85,000 to replace the turbines. Some institutions are growing, electrically speaking, to a point where it will become necessary to run two units together in parallel. The turbines have an R.P.M. of 3600 to 4950, depending on the type of machine. The direct connected machine is slower than the geared type, but much more expensive. Obviously, the faster a machine runs, the faster a bearing becomes heated up and burns out. Furthermore, parallel operation requires constant attention to regulate the two producing units, whether it is two turbines, one turbine and one high line, or one turbine and one engine. When running in parallel, an operator should be in front of his board as much and as often as time permits.

Some institutions have lime-soda hot process softening plants for boiler water make-up. These demand care of operation as well as periodic cleaning and inspection, which also requires time from an operator.

Cleaning is an essential activity to prevent too much dirt from accumulating in the generators and switchboards. Formerly, this work was done by patients, but in recent years, due to the progressive type of treatment, few patients are available. I believe the time is coming under the new intensive treatment policy when we shall have no patients available at all. They will be discharged as soon as they recover sufficiently to be of service to us.

The engine room is dependent upon the boiler room for steam, so we must have a fireman. Some of our plants have new boilers with automatic combustion controls, but most do not. The addition of combustion controls in all our plants would save considerable money. A pneumatic ash handling system will cost from thirty to fifty thousand dollars installed, and a coal handling system of track unloader hoppers to elevated silos with spout discharges into the boiler rooms would be about seventy-five to one-hundred-twenty-five thousand dollars. This is the simplest and least expensive. In lieu of these mechanical devices we must substitute paid employees for coal and ash handling.

In making a survey of other utility plants in our area pertaining to wages, I find that this will be very expensive. Attached, you will find an hourly pay schedule used by the power company in areas adjacent to our own institutions. In order to employ experienced help we must compete with this wage scale. It will be seen that the fireman, ash handler, and coal handler will average more than $400 per month. Our average scale for the same work is about half that amount.

We feel that it is essential that we start a training program of our own so that we may train our own employees. This method is being used in our prisons and we might employ men paroled from there who have no record of violence or sex offences.

In summarizing the numbers necessary to operate a power plant, 12 men are a minimum. One man working 52 weeks a year, 40 hours per week, can cover 8,260 hours, but allowing time off for vacation, sick leave, and legal holidays, he will be off duty about 328 hours work time per year, so 5 x 1652 = 8260 hours. In other words it will take five firemen, five operators plus one boiler room foreman and one helper. This would cover an institution's shifts in the power-house and take care of normal maintenance. The boiler room helper, in most cases, could help part time with shop work, and it would be ideal if he were also a machinist.

2. Sewage Plant: Sewage plants need at least two operators as they have routine jobs that should be done daily, and if an operator is working a forty-hour week he can be there only five days. Most of these operations cover large areas and should be very well policed, not only keeping the place neat and attractive, but as a strict sanitary measure. These operators should be trained to run routine tests for acidity of the primary clarifier, B.O.D. of effluent of final clarifier, chlorine residual, etc. Many of the men have taken short courses that have been offered from time to time from Iowa City or Ames and have first, second or third grade operators certificates. This has been of real help to the institutions, and the Department of Health is deserving of our wholehearted thanks for making these schools available. I sincerely hope that in the future more of these schools become available in more fields such as water plants, boiler room operation, etc. I have been advised that this is now under consideration, and I strongly urge you to take advantage of any of these made available.

3. Water Works: Some of the institutions have purification water plants, some have cold process softening plants. These plants are essential to public health and I strongly advise you to employ operators who are completely familiar with these operations and are made fully aware of their responsibility to all of the people in the institutions. One eight-hour run of unsatisfactory water could be very detrimental to the health of all the people in an institution. Woodward, of course, supplies the town of Woodward with water, and an even greater number of people would be affected, were the water not pure.

All of the employees in the sewage and water plants should be innoculated for typhoid and booster shots should follow at proper intervals. The number of people involved in these operations vary from two to four, depending upon type and location. Some are merely pumping operations and demand less maintenance and less personnel.

4. General Maintenance: Getting into more general maintenance, I feel this is more an institution problem and policy to be determined by the Board of Control. If services are to be maintained at high levels, more employees are needed. Money alone is not the thing in life that attracts dedicated people. Comfortable and convenient living is just as essential to keep them on the job and keep them happy. Following is a suggested set-up for consideration. Additions to or subtractions from this standard must be an institutional matter to be determined by geographical location of buildings, age and state of repair of the structures, anticipated future projects, present projects, and the quality of service.

Chief Engineer: needs a staff of one assistant engineer, 1 boiler room foreman, 5 fireman, 5 operators, and 1 machinist,for a total of 14.

Steamfitters: 1 master steamfitter and 2 helpers.

Plumbers: 1 master plumber and 2 helpers.

Electricians: 1 master electrician and 2 helpers.

Welders: 1 welder.

Sewage and water plant operators: 2 sewage plant operators, 3 water plant operators, 5 laborers.

In lieu of no patient help, add 13 laborers for coal and ash handling.

Grounds and Buildings: 1 Superintendent of grounds and buildings, or 1 superintendent of maintenance; 1 master carpenter with 4 helpers; 1 master painter with 5 helpers; 1 master mason with 2 helpers.

The total staff would be 48.

Following is a suggested wage scale which I feel would permit us to employ competent help, but would still be considerably under industrial competition. The only reason we can hire employees for less than industry is our advantage of operation on a 12-month basis without shut downs for inventory, strikes, et cetera.

These salaries are on the basis of one flat deal. The men draw their check like anyone working in private industry and live down town. Due to the difference in maintenance at the various institutions, I think this schedule advisable.

Position	Scale	
Chief Engineer	$ 600.....	$ 675
Assistant Engineer	500.....	575
Boiler Room Foreman	415.....	475
Operators	340.....	405
Machinist	340.....	405
Fireman	280.....	340
Master Steam Fitter	340.....	405
Helpers	280.....	340
Master Plumber	340.....	405
Helpers	280.....	340
Master Electrician	340.....	405
Helpers	280.....	340
Master Carpenter	340.....	405
Helpers	280.....	340
Master Painter	340.....	405
Helpers	280.....	340
Master Mason	340.....	405
Helpers	280.....	340
Laborers	235.....	275

After careful survey, the following work should be done during new biennium. I should like to stress the fact that my comments and advices are presented as a consultant only.

Mt. Pleasant: Repair projects: replace hot process softener reactionery tank, re-design present hot well and replace pump, install ash handling equipment, replace boiler room roof, re-point and seal maintenance and engine room, rewire existing main building general kitchen, remodel bakery and install new equipment, replace guttering and down-spouts on wards 10 to 17 east, replaster east wards 10 through 17 east, remodel milk processing room and milking set-up at dairy, build hog farrowing house at Oaks, build oil storage shed at power plant, build fire engine house, overhaul pumps, valves, motors, fittings, and filters at pumping station.

Cherokee: Install hot process softener, finish dairy barn, addition to laundry, remodel and paint wards as needed, replace return main in basement, supplement present heating, remodel dishwashing equipment.

Clarinda: Install new turbine, remove one old engine, install new switchboard, repair fire damage in main building, rebuild line to Willowdale, water line to South View and Sunset, remodel gutter work, re-roof Sunset Cottage, install boiler at dairy barn, install pressure regulator on water supply.

Independence: Remodel heating system in Hilltop, remodel heating system in basement of main building, install thermostat valves where necessary, tear down part of old greenhouse, remodel transformer banks, detergent both wells, paint boiler room, shop, pump room, and engine room, and remodel and paint wards.

Glenwood: Finish hospital conversion job, lay cable to new hospital, set new transformers, start to rewire buildings, change heating system in dairy barn, change heating system in houses, enlarge piping in tunnel to use exhaust steam.

Woodward: Remodel abandoned kitchen to dormitories at Pinehurst, Elmcrest and Maple Lodge, renew hot water line tunnel, well-pumping station, repair Maple Lodge roof, repair windows at Meadows, renew sidewalks, hot feed water heaters, ash conveyors, rewire old buildings, gas line to farm, dairy and new garage.

C O S T S

IT TAKES MONEY TO SAVE MONEY -- AND HUMAN LIVES

THE BUDGET REQUEST

Guide Lines Established

Iowa's prime policy is to build a staff adequate in training and numbers to administer a modern treatment program that is available to all patients.

In order that such a staff may function effectively, consideration must be given to the condition of the physical plant. While it does not imply an extensive building program, it does stress the need for renovation and modernization of existing facilities.

Consequently, a survey of the most serious hazards and defects existing in the six mental institutions was made. As a result of this survey, and consequent consideration given to action for correction, we established "guide lines" to direct our budget requests for the 1959-1961 period, as follows:

1. Place primary emphasis on building an adequate staff - not on the construction of more buildings.

2. Define an adequate staff by the standards recommended by the national associations in the respective areas of operation.

3. Limit our request for repairs, replacements, alterations and equipment to those funds needed to begin the renovation and modernization of existing structures. The only new major construction request was determined to be the continuation of replacement of the condemned buildings at Mt. Pleasant.

Details of the budget askings are given in Table No: 8.

The survey revealed serious hazards and defects existing in all six mental institutions. The following positive action was suggested to correct and renovate the physical plants:

1. Eliminate fire hazards. Fireproof all curtains and stage equipment. Carry out all recommendations of the fire marshal. Some of these will require long-range planning and considerable capital expenditure.

2. Eliminate safety hazards. Tools, machinery, and equipment should be bought, installed, and used with safety provisions and precautions in mind.

3. Install emergency lighting equipment - especially in surgery, but also in the emergency room, stair wells, and on the wards.

4. Re-wire many old buildings. Provide adequate lighting and power outlets.

5. Install new plumbing in many old buildings. Meet humane and sanitary standards by providing:

   a. At least one electrically cooled water fountain on each ward.

   b. Establish and equip a ward laundry room on each ward.

   c. Install modern automatic equipment where needed in institutional laundry.

   d. Install additional toilets to allow at least one toilet for each eight patients on the ward.

   e. Install additional lavoratories to allow at least one for each six patients on the ward.

   f. Install additional tubs or showers to allow at least one tub or shower for each fifteen patients on the ward.

   g. Make at least one tub available on each ward.

   h. Provide at least one lavoratory in each toilet room.

6. Provide at least 40 square feet of floor space for each patient in the day room.

7. Provide at least 70 square feet of floor space for each bed in a dormitory.

8. Build additional, adequate storage space for institutions lacking such provisions.

9. Build additional modern cold storage plants at each institution. Roughly, 300 square yards of cold storage space is needed, or 900 cubic yards. Install at each institution a sharp freeze unit.

10. Re-build sanitary, modern floors in many old wards.

11. Repair and paint walls, ceiling and woodwork in many old wards.

12. Provide ward furnishings sufficient to meet recommended standards. Each ward should have:

    a. At least one comfortable chair for each patient on the ward in the day rooms.

    b. At least one table for each 20 patients in a day room.

    c. Recreation equipment such as card tables, ping pong or pool tables should be available on each ward, if not actually a part of ward furniture.

d. A locker for each patient.

e. A bedside table with drawers, a cabinet, and space to hang a few items of clothing should be beside each bed.

f. Sufficient lamps to provide lighting adequate for reading without eyestrain, should be available in the day room.

g. Bedside chairs should be provided for each bed.

13. Review carefully plans for new construction for patients.

14. Review carefully plans for new construction for employees.

C O S T S

It Costs Money to Save Money - and Human Lives

There IS something we can do about mental illness despite the fact that we know neither the exact cause nor the specific cure in all cases.

Early diagnosis and prompt treatment are known to offer the greatest hope for recovery. But treatment is costly! Therefore, a decision has to be made by the taxpayer and his legislator as to which of the two courses of action are most proper and practical.

1. To treat the patient promptly and adequately at the onset of illness, knowing that the period of hospitalization will be much shorter even though more costly, and the hope for recovery proportionately greater or,

2. Hold costs to a minimum, with the resultant probability that the period of hospitalization will be much longer, and the recovery rate reduced, thus entailing as much or greater expense in the long run.

To help arrive at a decision we are supplying the following information in narrative and graphic form.

Gradually, a "modern mental hospital concept" is being developed in Iowa. It will consider prevention, treatment, follow-up care, and research. We believe all this can be done on the basis of the commercial world's truism: "It takes money to make money", - but, paraphrasing, "It costs money to save money - and human lives."

Let us compare Iowa's support of its mentally ill and mentally retarded with other states. There are numerous ways of looking at statistics. While very few people are "simply fascinated" with statistical studies, we can learn some pertinent and interesting things about our own state program by comparing it with that of other states.

Appropriations for state mental health programs have been increasing year after year. The usual way of looking at maintenance appropriations is to compare costs per patient per day. The following table gives such costs in public hospitals for the period 1947-1958.

Cost Per Patient Per Day - Public Hospitals for Mental Disease

	Vets Admin.	U. S. High	U. S. Average	U. S. Low	Iowa
1958	10.76	5.75	4.07	2.11	4.06
1957	10.31	5.46	3.61	1.86	3.60
1956		4.97	3.24	1.70	3.11
1955	8.99	4.71	3.03	1.54	3.07
1954		4.16	2.84	1.34	2.47
1953		5.13	2.70	1.03	2.31
1952		4.91	2.56	1.12	2.14
1951	7.22	4.13	2.27	0.99	1.93
1950		3.53	2.11	0.96	1.78
1949		3.11	1.97	0.88	1.54
1948		2.49	1.80	0.84	1.35
1947		2.38	1.50	0.66	1.12

It has been claimed that "per diem" costs are a poor index of a hospital's inner operations; that some other facts make our position more understandable.

1. IOWA HOSPITALIZES FAR FEWER MENTALLY ILL THAN THE AVERAGE STATE

Iowa has 4,850 patients resident in her four Mental Health Institutes. This is a hospitalization rate of 179, assuming the present population to be 2,700,000. The average hospitalization rate is 325 per 100,000. If Iowa hospitalized 325 for every 100,000 in its population, there would be 8,775 patients in our Mental Health Institutes instead of 4,850.

2. IOWA PLACES MORE MENTALLY RETARDED PERSONS IN HER TWO HOSPITALS AND SCHOOLS THAN THE AVERAGE STATE.

In the United States there are some 90 persons per 100,000 in state schools for mentally retarded. The rate for Iowa, with 3,605, is 133 per 100,000 population.

3. IN THE U. S. THE AVERAGE PER CAPITA EXPENDITURE FOR THE MENTALLY RETARDED IN STATE SCHOOLS: Is about the same as the per capita expenditure for mentally ill persons, about $4.00 per day in 1958.

In Iowa, the daily per patient expenditure for 1958 is as follows:

Independence Mental Health Institute	$ 5.02
Cherokee Mental Health Institute	4.09
Mt. Pleasant Mental Health Institute	3.92
Clarinda Mental Health Institute	3.53
Glenwood State School	2.80
Woodward State School	2.88

ANOTHER COMPARISON

BUT - Suppose Iowa placed its six mental institutions:

1. An average amount of money for
2. An average number of persons for the population.

WHAT SUM OF MONEY WOULD THIS AMOUNT TO?

8,775 Mentally Ill (Average rate 325 x 27 hundred thousand)
2,430 Mentally retarded (Average rate 90 x 27 hundred thousand)
11,205 Mentally ill and mentally retarded persons in our six mental institutions

TO REPEAT - If Iowa kept an average number of persons, according to her population, in her six state mental institutions - the number would be 11,205, whereas we actually have 8,455.

At an average per diem of $4.00 per day in 1958 for an average number of 11,205 patients, the cost to the state would be:

$ 16,359,300.00

In other words, if Iowa had expended only an average amount of state tax money for its mental institutions in 1958, we would have expended $ 16,359,300.

Average amount	$ 16,359,300.00
Actually expended	10,602,041.00
Less than average	$ 5,757,259.00

PER DIEM INCREASES: Since 1947 the average per diem for state mental hospitals has risen an average of over 9 per cent each year over the preceding year. Iowa, to have provided an average amount of money for the past three years would have had to provide:

Year	Average Amount		Actually Expended
1956	$12,719,355	(11,205 x $ 3.11 x 365)	$ 9,037,872
1957	14,764,368	(11,205 x $ 3.61 x 365)	10,082,502
1958	16,359,300	(11,205 x $ 4.00 x 365)	10,602,041

Since the population of Iowa remains about constant at 2,700,000, since the rate of hopitalization will remain about constant (at 325 per 100,000 general population), and since the national average per diem expended for state hospitals has increased about 9 per cent per year over each previous year for the past 10 years, we can predict that to provide an average total amount of money for its state hospitals in 1959 and 1960, Iowa would need to provide:

In 1959	11,205 x $ 4.36 x 365 : $ 17,831,637
In 1960	11,205 x $ 4.75 x 365 : $ 19,426,668

ANOTHER WAY OF LOOKING AT STATISTICS -- "DOLLAR PER CITIZEN":

Is the cost per citizen general population. In other words, how much do our state hospitals for mental illness and mental deficiency cost each man, woman and child in Iowa:

In the United States, as an average, the states expended or will expend the following "dollars per citizen" for state hospitals and schools.

	Year	Amount
	1943	$ 1.35
	1944	1.41
	1945	1.59
	1946	2.10
	1947	2.15
	1948	2.49
	1949	2.51
	1950	2.90
	1951	3.23
	1952	3.49
	1953	3.72
	1954	3.97
	1955	4.33
	1956	4.72
	1957	5.47
	1958	6.08
Estimated	1959	6.62
Estimated	1960	7.19

Applying the estimated national average to Iowa:

In 1956 the total for 2,700,000 citizens @ $ 4.71 each - $ 12,717,000
In 1957 the total for 2,700,000 citizens @ $ 5.47 each - 14,769,000
In 1958 the total for 2,700,000 citizens @ $ 6.06 each - 16,362,000
In 1959 the total for 2,700,000 citizens @ $ 6.62 each - 17,874,000
In 1960 the total for 2,700,000 citizens @ $ 7.19 each - 19,413,000

WHAT ABOUT THE EXTREMES:

The above comparisons are to the national averages - but what about the extremes?

For years New York has led the nation in providing hospital beds and money.

The Council of State Governments, in a report for 1956, entitled "Thirteen Indices", presents a table showing the amount of money that would be spent by each person in a state per year if each contributed equally to the support of the state hospitals. The figures given are:

NEW YORK - the highest -	$ 8.42
NATIONAL AVERAGE -	3.74
TENNESSEE - the lowest	1.35

If, to these figures, we add the amounts spent by the same groups for mentally retarded, the following figures are obtained:

NEW YORK	$ 10.44
NATIONAL AVERAGE	4.72
TENNESSEE	1.52

Now let us see what Iowa would have done in 1956 if she provided the same support as New York, the national average, or Tennessee.

NEW YORK $ 10.44 x 2,700,000	- $ 28,180,000
NATIONAL AVERAGE $ 4.72 x 2,700,000	- 12,744,000
TENNESSEE $ 1.51 x 2,700,000	- 4,104,000
IOWA in 1956 EXPENDED	- 9,037,872

TABLE NO: 1

COMPARING THE COST PER DAY TO THE COST PER "STAY"

The total funds actually expended by each institution for the year ending June 30, of year shown is as follows:

	1954	1955	1956	1957	1958
Cherokee	$ 1,308,447	$1,559,626	$1,566,559	$ 1,715,632	$ 1,798,023
Clarinda	1,192,267	1,540,211	1,365,224	1,586,539	1,673,723
Independence	1,336,868	1,532,202	1,557,220	1,742,813	1,752,584
Mt. Pleasant	1,278,071	1,442,881	1,545,286	1,672,041	1,665,386
Total M.H.I.	5,115,653	6,074,920	6,034,289	6,717,025	6,889,716
Glenwood	1,220,478	1,510,896	1,588,939	1,718,244	1,711,195
Woodward	1,247,097	1,446,121	1,414,648	1,647,233	1,758,512
Total Schools	2,467,575	2,957,017	3,003,587	3,365,477	3,469,707
Total Inst. and Schools	7,583,228	9,031,937	9,037,876	10,082,502	10,359,423

TABLE NO: 2

AVERAGE POPULATION & TOTAL ADMISSION

The average population and total admission for the year ending June 30, for the year shown:

	Av. Pop.	Tot. Adm.	Av. Pop.	Tot. Adm.	Av. Pop.	Tot. Adm.	Av. Pop.	Tot. Adm.	Av. Pop.	Tot. Adm.
Cherokee	1358	579	1338	619	1269	615	1247	566	1221	565
Clarinda	1326	595	1325	642	1285	695	1307	643	1317	720
Independence	1342	821	1217	755	1166	876	1115	977	1104	1036
Mt. Pleasant	1356	475	1355	453	1338	500	1243	459	1181	530
Total M.H.I.	5382	2470	5235	2469	5058	2686	4912	2645	4823	2851
Glenwood & Woodward	3303	259	3475	234	3510	244	3438	200	3284	314
Total Inst. and Schools	8685	2729	8710	2703	8568	2930	8350	2845	8107	3165

If we divide the average population for one year by the total admissions during that period the result is the "average stay". Thus in 1958 there were 4,823 patients "on the average" in the four mental health institutes and 2,851 total admissions. 4,823 divided by 2,851 equals 1.69 year "average stay". That is, the average patient stayed one year, 8 months and 11 and 8/10 days.

TABLE NO: 3

The following table shows the average stay for each institution based on data ending June 30th for the periods shown:

	1954	1955	1956	1957	1958	Total 1958 U.S. Hospitals
Cherokee	2.34	2.16	2.06	2.20	2.16	
Clarinda	2.23	2.06	1.85	2.03	1.83	
Independence	1.63	1.61	1.33	1.14	1.06	
Mt. Pleasant	2.85	2.99	2.68	2.71	2.23	
Total M. H. I.	2.19	2.12	1.96	1.86	1.69	2.65 Years
Glenwood & Woodward	12.75	14.85	14.38	17.20	10.46	10.93 Years

By dividing the total funds expended in a year by the average number of patients in the hospital we get the cost per year. By multiplying cost per year by average stay in years we get the average cost of stay in hospital.

The following table gives the average cost per stay in the hospital for period based on costs per year for period shown:

TABLE NO: 4

	1954	1955	1956	1957	1958	Total 1958 U. S. Hospitals
Cherokee	$ 2,254.44	$ 2,517.78	$ 2,543.03	$ 3,026.78	$ 3,180.73	
Clarinda	2,005.08	2,394.58	1,965.49	2,464.17	2,324.10	
Independence	1,623.76	2,026.97	1,776.24	1,781.89	1,682.74	
Mt. Pleasant	2,686.21	3,183.90	5,356.00	3,645.39	3,144.63	
Total M. H. I.	2,072.06	2,460.13	2,242.85	2,543.89	2,414.18	3,396.60
Glenwood & Woodward	9,524.00	12,636.00	12,305.00	16,910.00	11,051.00	$16,077.48

TABLE NO: 5 TOTAL FUNDS EXPENDED BY EACH INSTITUTION BY YEAR

YEAR	1952	1953	1954	1955	1956	1957	1958
CHEROKEE	1,165,562	1,230,294	1,308,349	1,559,627	1,566,559	1,715,632	1,798,023
CLARINDA	1,152,469	1,148,240	1,192,267	1,540,211	1,365,224	1,586,539	1,673,723
INDEPENDENCE	1,232,156	1,294,747	1,336,868	1,532,202	1,557,220	1,742,814	1,995,201
MT. PLEASANT	1,079,167	1,188,539	1,278,071	1,442,880	1,545,286	1,672,041	1,665,386
GLENWOOD	1,013,901	1,064,118	1,220,478	1,510,896	1,588,938	1,718,244	1,711,195
WOODWARD	1,072,938	1,093,666	1,247,098	1,446,121	1,414,646	1,647,233	1,758,512

TABLE NO: 6 PERCENT OF TOTAL EXPENDITURES FOR WAGES AND SALARIES

YEAR	1952	1953	1954	1955	1956	1957	1958
CHEROKEE	52.78	49.56	58.91	56.48	64.65	63.80	65.10
CLARINDA	42.49	55.16	63.63	56.52	67.17	62.16	66.42
INDEPENDENCE	52.71	52.49	60.50	54.62	62.65	63.18	63.76
MT. PLEASANT	52.10	46.63	57.45	60.01	66.02	65.65	65.58
GLENWOOD	52.09	49.88	57.82	57.80	67.45	68.04	68.48
WOODWARD	56.03	57.42	63.89	63.73	70.21	67.33	70.83

A hospital which fully meets accepted standards expends from 75% to 80% of funds in wages and salaries.

TABLE NO: 7 TOTAL SALES AND COLLECTIONS BY INSTITUTION

YEAR	1952	1953	1954	1955	1956	1957	1958
CHEROKEE	38,727	48,317	101,872	54,516	79,629	94,995	118,774
CLARINDA	60,642	43,568	62,088	42,159	49,215	50,890	51,595
INDEPENDENCE	71,502	103,622	100,090	100,518	133,721	105,067	206,138
MT. PLEASANT	32,803	60,622	65,292	50,764	55,678	73,079	63,692
GLENWOOD	38,297	24,452	64,548	41,828	46,777	39,879	43,827
WOODWARD	26,726	24,014	58,735	47,732	39,879	46,777	52,850

TABLE NO: 8 BOARD OF CONTROL OF STATE INSTITUTIONS

DIVISION OF MENTAL HEALTH

	Present Situation June 30, 1958				Priority "A"			
1. Range Distribution	Children	Glenwood Woodward	Mental H. In.	Total	Children	Glenwood Woodward	Mental H. In.	Total
I.	39	640	987	1666	4	48	198	250
II.	11	159	411	581	50	211	327	588
III.	15	102	167	284	142	1036	1089	2267
IV.	6	42	95	143	52	99	328	479
V.	8	19	72	99	24	92	252	368
VI.	1	5	26	32	32	46	92	170
VII.	5	8	26	39	12	30	108	150
VIII.	1	9	15	25	20	17	60	97
IX.	2	4	19	25	8	16	40	64
X.	0	3	7	10	4	7	40	51
XI.	0	1	9	0	0	3	72	75
XII.	0	2	2	4	0	20	32	52
XIII.	1	0	5	6	0	2	28	30
XIV.	0	1	6	7	4	3	24	31
XV.	0	1	8	9	4	8	32	44
2. TOTAL	89	996	1855	2940	356	1638	2722	4716

	Cherokee, Clarinda, Independence, Mt. Pl.:		
3.	*Salaries	$ 5,179,680	$11,322,562
4.	Support & Maintenance	1,867,695	2,732,080
5.	R.R. & A.	180,000	347,000
6.	Equipment	120,000	282,400
7.	TOTAL	$ 7,347,375	$14,684,042
	Glenwood & Woodward:		
8.	*Salaries	$ 2,571,432	$ 5,785,683
9.	Support & Maintenance	956,045	1,643,127
10.	R. R. & A.	90,000	219,387
11.	Equipment	60,000	248,375
12.	TOTAL	$ 3,677,477	$ 7,896,572
	Total Six Mental Institutions:		
13.	*Salaries	$ 7,751,112	$17,108,245
14.	Support & Maintenance	2,823,740	4,375,207
15.	R. R. & A.	270,000	566,387
16.	Equipment	180,000	530,775
17.	** GRAND TOTAL	$10,754,452	$22,580,614
18.	Children's Program	270,400 (Indep. Salaries) only	
	Salaries, Support, RRA & Equip.		440,672
		$11,024,852	$23,021,286
	Cherokee	--	$ 451,113
		$11,024,852	$23,472,399
	Clarinda	--	436,321
		$11,024,852	$23,908,720

* Salaries: Includes FICA, IPERS, and Maintenance

** Total: Includes Children's Program

Priority "B" 85% Adequate		Priority "C" 70% Adequate	
No. Emp.	Amount	No. Emp.	Amount
3706		3052	
	$ 9,624,178		$ 7,925,793
	2,322,268		1,912,456
	294,950		242,900
	240,040		197,680
	$12,481,436		$10,278,829
	$ 4,917,830		$ 4,049,978
	1,396,658		1,150,189
	186,479		153,570
	211,120		173,863
	$ 6,712,087		$ 5,527,600
	$14,542,008		$11,975,771
	3,718,926		3,062,645
	481,429		396,470
	451,160		371,543
	$19,193,523		$15,806,429
	440,672		440,672
	$19,634,195		$16,247,101
	451,113		451,113
	$20,085,308		$16,698,214
	436,321		436,321
	$20,521,629		$17,134,535

COST PER PATIENT INCREASES AS POPULATION DECREASES

The accompanying graph shows that in 1946, when the per capita expenditure per patient per day rose from 85 cents to $ 1.26 in 1948, the resident population began to drop. This trend of increased cost and decreased resident population has continued. In 1958, the resident population dropped to the all-time low of 4,850 during the period 1926-1958, while the per capita per day rose to $ 4.14.

At the end of 1957, Iowa was in 18th place in the nation in per patient maintenance expenditures in all public hospitals for the care of the mentally ill. Ranking among the four high states were:

Kansas	Michigan
Connecticut	Nebraska

The high turnover of new patients is largely due to prompt, modern treatment. Shorter periods of hospitalization at higher cost is therefore a specific economy. First, because it costs less to keep a patient under intensive treatment at higher cost for a shorter period of time than to keep the same patient over a longer period at a lower per diem cost; second, because shorter periods of hospitalization result in a lower rate of loss in earnings of the recovered patient.

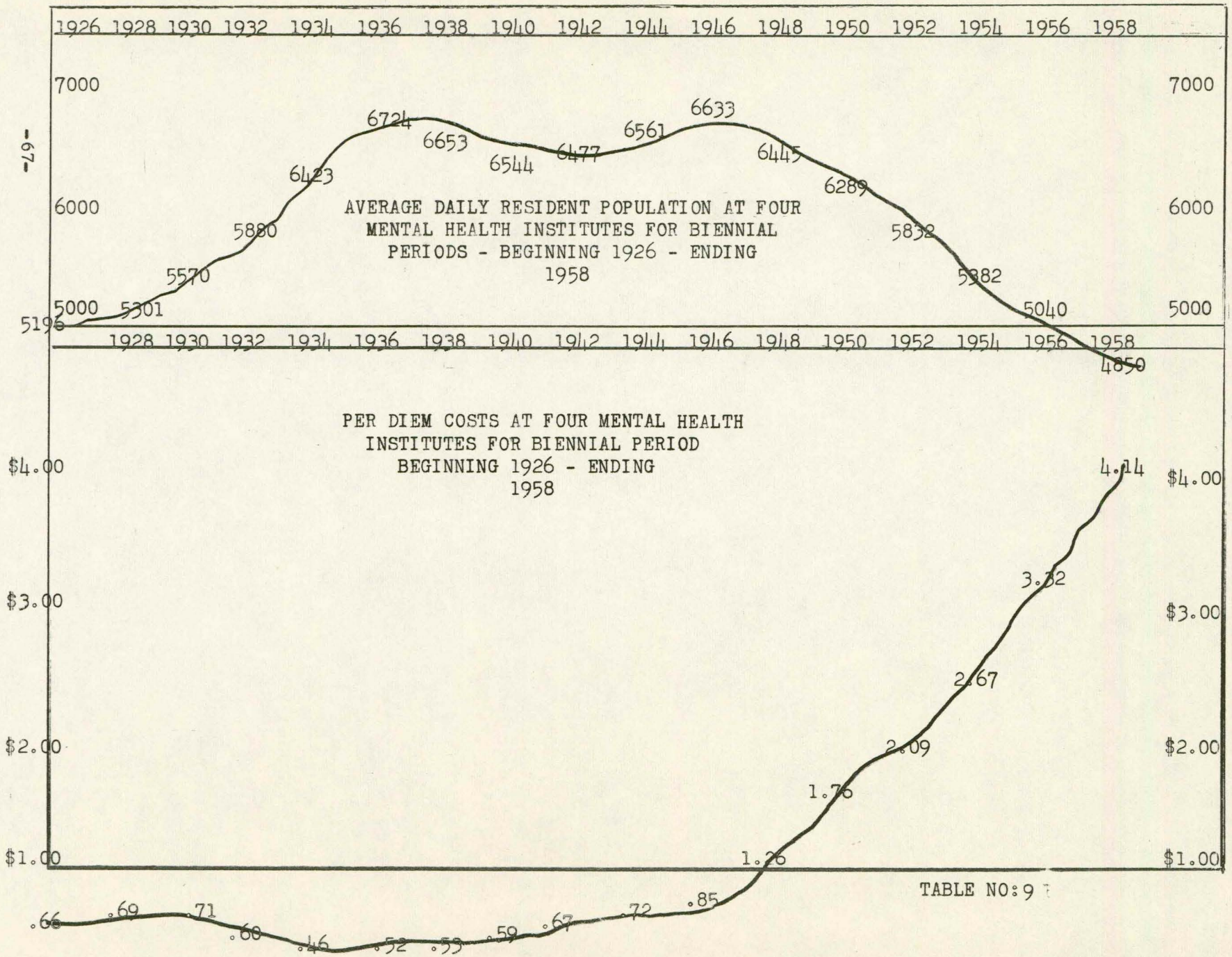

1926 1928 1930 1932 1934 1936 1938 1940 1942 1944 1946 1948 1950 1952 1954 1956 1958
7000
6000
5000
5196
5301
5570
5880
6423
6724
6653
6544
6477
6561
6633
6445
6289
5832
5382
5040
4850
AVERAGE DAILY RESIDENT POPULATION AT FOUR MENTAL HEALTH INSTITUTES FOR BIENNIAL PERIODS - BEGINNING 1926 - ENDING 1958
PER DIEM COSTS AT FOUR MENTAL HEALTH INSTITUTES FOR BIENNIAL PERIOD BEGINNING 1926 - ENDING 1958
$4.00
$3.00
$2.00
$1.00
.66
.69
.71
.60
.46
.52
.53
.59
.67
.72
.85
1.26
1.76
2.09
2.67
3.32
4.14

TABLE NO: 9

PROBLEMS OF PERSONNEL

Over-all personnel shortages in general and particularly lack of trained personnel to assume positions of great responsibility, is the most critical problem in each of the six mental institutions.

The over-crowding, deficiencies of the physical plant, lack of adequate supplies, and even dietary deficiencies, are all relatively unimportant compared to the lack of personnel to provide proper treatment.

An analysis of the personnel problem is reflected in the succeeding tables:

Tables 10 to 14 inclusive record the situation in our six mental institutions, and reveal the proper standards for purposes of comparison.

Tables 16 to 19 inclusive were developed to serve as a guide to our operation, and are based on accepted standards. The proper personnel distribution for a 1,000-bed hospital is as follows:

Admission and intensive treatment service	300 beds
Continued treatment service	300 beds
Geriatric service	300 beds
Medical and surgical service	100 beds

Collectively, they are a guide to planning hospital personnel requirements, assigning personnel, the salaries we should expect to pay, and the budget required. Also, they establish a budget plan as a guide for expending available funds for the best results.

TABLE NO: 10 TABLE OF RATIOS: Number of Employees to Number of Patients

	PHYSICIANS-PSYCHIATRISTS								PSYCHOLOGISTS							
	Adequate Bal.					Staff Req'mt			Adequate Bal.					Staff Req'mt.		
	CH	CL	IN	MP	TOT	GL	WO	TOT	CH	CL	IN	MP	TOT	GL	WO	TOT
	59	59	59	59	59	88	88	88	59	59	59	59	59	88	88	88
Jan.	Actual Ratio Year Shown								Actual Ratio Year Shown							
1949	547	314	284	218	307	455	554	498	1641	1571	0000	0000	3225	0000	1664	3484
1950	299	250	271	198	211	902	542	686	1607	1505	1625	0000	2042	1825	815	1143
1951	146	183	212	206	183	375	326	350	0000	732	745	1143	1172	0000	815	753
1952	145	234	212	206	193	436	268	435	725	1408	745	1418	965	1872	805	1160
1953	139	164	242	206	180	377	418	395	696	1312	727	709	796	1886	836	1186
1954	150	189	196	169	173	475	274	354	679	656	671	271	489	950	821	885
1955	111	189	173	150	149	460	329	386	669	441	304	338	402	920	817	868
1956	90	160	106	167	123	359	412	383	423	642	583	1338	632	1797	825	1149
1957	113	145	101	113	117	355	412	380	249	435	371	1243	409	888	825	856
1958	93	146	92	197	120	188	423	261	610	658	221	1181	482	424	1694	678
Nov. 1958	75	127	82	188	104	426	614	506	283	318	214	564	306	284	460	354
Jan.	59															

	SOCIAL WORKERS								THERAPISTS & OTHER PROF.							
	Adequate Bal.					Staff Req'mt.			Adequate Bal.					Staff Req'mt.		
	CH	CL	IN	MP	TOT	GL	WO	TOT	CH	CL	IN	MP	TOT	GL	WO	TOT
	59	59	59	59	59	88	88	88	22	22	22	22	22	33	33	33
Jan.	Actual Ratio Year Shown								Actual Ratio Year Shown							
1949	547	1571	1709	764	921	910	832	871	102	314	427	101	161	130	79	99
1950	535	501	541	347	471	601	813	686	160	150	203	69	127	112	77	92
1951	487	732	497	000	732	938	1631	1169	146	183	106	65	108	98	54	72
1952	362	1408	497	1441	643	936	805	870	181	201	106	102	134	93	41	59
1953	464	1312	363	1418	619	943	836	889	198	145	63	88	101	72	54	62
1954	452	442	268	1356	448	950	547	708	169	165	58	61	88	65	50	57
1955	334	656	304	451	402	920	545	695	167	147	58	75	93	50	56	52
1956	211	428	291	446	316	599	550	574	211	214	72	121	129	42	47	44
1957	311	261	223	414	288	888	550	685	155	186	65	95	109	43	44	43
1958	305	263	78	590	192	849	564	678	203	109	32	168	81	60	37	46
Nov. 1958	126	212	76	225	135	852	307	443	70	85	29	225	63	47	46	46
Jan.	59															

$\left(\frac{\text{number of patients}}{\text{number of employees}}\right)$

This table shows the ratio : , expressed as number of patients for one employee, by type of employee - e. i. number of patients for one medical doctor, number for one psychologist, number for one social worker, etc.

TABLE NO: 10 TABLE OF RATIOS: Number of Employees to Number of Patients

	TOTAL PROFESSIONAL Adequate Bal. Staff Req'mt.								REGISTERED NURSES Adequate Bal. Staff Req'mt.							
	CH	CL	IN	MP	TOT	GL	WO	TOT	CH	CL	IN	MP	TOT	GL	WO	TOT
Jan.	10.4	10.4	10.4	10.4	10.4	15.6	15.6	15.6	9.8	9.8	9.8	9.8	9.8	14.7	14.7	14.7
1949	71	130	155	63	92	91	61	74	182	000	1709	764	537	1820	208	387
50	66	75	90	45	65	82	58	68	160	752	406	347	306	1805	325	571
51	63	73	57	48	59	72	43	54	133	732	212	721	266	312	544	389
52	60	93	57	62	66	74	33	47	132	1408	249	480	275	624	536	580
53	63	69	41	54	54	55	43	48	174	328	145	709	232	471	334	395
54	61	66	36	38	46	51	37	43	150	331	122	678	207	475	234	322
55	51	63	33	40	45	41	42	41	167	220	135	677	209	460	204	290
56	43	67	35	58	48	35	37	36	115	321	89	446	163	256	206	230
57	44	54	31	44	42	35	36	36	113	218	65	177	119	355	206	263
58	48	47	17	73	36	39	32	39	111	188	78	147	120	283	282	282
Nov. 58	25	36	15	62	28	35	34	35	70	255	66	63	83	243	153	186
Jan. 59																

	ATTENDANTS Adequate Bal. Staff Req'mt.								TOTAL NURSING & CARE Adequate Bal. Staff Req'mt.							
	CH	CL	IN	MP	TOT	GL	WO	TOT	CH	CL	IN	MP	TOT	GL	WO	TOT
Jan.	4.5	4.5	4.5	4.5	4.5	6.8	6.8	6.8	3.1	3.1	3.1	3.1	3.1	4.7	4.7	4.7
1949	10	10	14	16	12	14	16	14	9	10	14	15	12	13	15	14
50	9	9	10	15	10	14	16	14	9	9	10	14	10	13	15	14
51	9	8	9	10	9	16	15	15	9	9	9	10	9	13	15	13
52	9	8	9	10	9	16	15	15	8	8	9	10	9	14	15	14
53	9	7	9	10	8	15	16	15	9	7	8	10	8	14	15	14
54	9	7	8	7	7	12	13	12	8	7	8	7	7	12	12	12
55	6	6	6	6	6	10	10	10	6	6	6	6	6	11	10	10
56	5	6	5	5	5	8	10	8	6	6	5	5	5	10	10	10
57	5	5	5	4	4	7	9	8	5	5	5	4	5	10	9	10
58	5	6	5	5	5	8	9	8	5	5	5	4	5	8	9	9
Nov. 58	5	5	5	4	4	7	7	7	5	5	5	4	5	8	7	8
Jan. 59																

	ADM. MTNC. FARM & OTHERS Adequate Bal. Staff Req'mt.							
	4.3	4.3	4.3	4.3	4.3	6.4	6.4	6.4
Jan.	Actual Ratio Year Shown							
1949	13	12	17	13	13	13	12	12
50	11	12	16	8	11	10	11	11
51	10	13	12	11	11	13	13	13
52	11	11	12	11	11	13	12	13
53	10	10	10	11	10	14	12	13
54	10	10	9	9	9	12	11	11
55	9	9	8	9	8	11	9	10
56	7	9	15	9	7	10	9	10
57	8	9	6	7	7	10	9	10
58	9	9	6	8	7	8	8	8
Nov. 58	6	8	5	7	6	9	8	9

TABLE NO: 11 EMPLOYEE DISTRIBUTION

	ADMINISTRATION						
	Adequate Staff Req'mt.						
	CH	CL	IN	MP	GL	WO	ST
	60	60	60	60	60	60	360
	Persons Period Shown						
Dec. 58	29	24	33	25	35	31	177
July 58	29	25	38	23	31	28	174
Jan. 58	30	23	36	22	27	29	167
Jan. 57	29	25	29	22	21	29	155
Jan. 56	29	23	28	22	21	28	151
Jan. 55	23	23	29	20	21	29	145

	DIETARY						
	Adequate Staff Req'mt.						
	CH	CL	IN	MP	GL	WO	ST
	53	53	53	53	53	53	318
	Persons Period Shown						
Dec. 58	43	43	42	38	48	54	268
July 58	40	43	42	38	47	53	263
Jan. 58	42	42	46	37	49	51	267
Jan. 57	42	49	45	40	43	44	263
Jan. 56	40	41	45	38	44	41	249
Jan. 55	37	41	39	37	44	39	237

	HOUSEKEEPING						
	Adequate Staff Req'mt.						
	CH	CL	IN	MP	GL	WO	ST
	20	20	20	20	20	20	120
	Persons Period Shown						
Dec. 58	12	9	14	10	8	15	68
July 58	13	9	18	7	8	15	70
Jan. 58	15	9	18	7	8	15	72
Jan. 57	13	9	16	11	16	12	77
Jan. 56	13	9	17	11	17	12	79
Jan. 55	13	10	13	11	15	11	73

	LAUNDRY						
	Adequate Staff Req'mt.						
	CH	CL	IN	MP	GL	WO	ST
	16	16	16	16	16	16	96
	Persons Period Shown						
Dec. 58	12	14	13	11	14	17	81
July 58	11	14	14	11	13	17	80
Jan. 58	11	14	15	10	14	14	78
Jan. 57	11	13	15	12	13	13	77
Jan. 56	11	13	15	12	12	12	75
Jan. 55	12	13	14	12	9	9	69

	SPECIAL SERVICE						
	Adequate Staff Req'mt.						
	CH	CL	IN	MP	GL	WO	ST
	5	5	5	5	5	5	30
	Persons Period Shown						
Dec. 58	6	7	6	6	21	10	56
July 58	6	8	4	6	22	11	57
Jan. 58	6	6	4	6	23	11	56
Jan. 57	6	6	7	6	18	11	54
Jan. 56	6	6	7	7	18	10	54
Jan. 55	5	5	8	6	19	9	52

	PLANT OPERATION						
	Adequate Staff Req'mt.						
	CH	CL	IN	MP	GL	WO	ST
	19	19	19	19	19	19	114
	Persons Period Shown						
Dec. 58	17	11	17	16	14	20	95
July 58	17	11	17	16	14	20	95
Jan. 58	17	11	17	16	18	19	98
Jan. 57	18	12	18	16	14	19	97
Jan. 56	17	10	18	16	14	19	94
Jan. 55	12	12	14	14	14	14	80

The internal distribution of the administrative, maintenance, farm, laundry, etc. personnel is of considerable concern to those interested in the business like operation of a hospital. While each hospital is different, and the actual distribution of employees shoudl be different, in general at least 233 employees are required to adequately staff their departments in each of our six mental institutions. The proper distribution of their 233 employees, and the actual distribution of the employees of each hospital at the dates shown (as near as this can be determined from an examination of the payroll) is given in this table.

TABLE NO: 11 EMPLOYEE DISTRIBUTION

	MAINT. & REPAIR Adequate Staff Requirement							GARAGE Adequate Staff Requirement						
	CH	CL	IN	MP	GL	WO	ST	CH	CL	IN	MP	GL	WO	ST
	28	28	28	28	28	28	168	5	5	5	5	5	5	30
	Persons Period Shown							Persons Period Shown						
Dec. 58	22	16	19	21	24	19	121	3	1	5	3	3	6	21
July 58	22	15	22	21	23	20	123	3	1	5	3	3	6	21
Jan. 58	23	16	25	21	19	18	122	3	1	5	3	3	7	22
Jan. 57	22	18	24	22	21	16	123	3	1	4	3	3	5	19
Jan. 56	23	17	23	22	21	15	121	3	1	4	3	3	5	19
Jan. 55	20	18	20	20	22	20	120	3	1	3	3	3	6	19

	FARM, GARDEN, DAIRY & GREENHOUSE Adequate Staff Requirement							MISCELLENOUS Adequate Staff Requirement						
	CH	CL	IN	MP	GL	WO	ST	CH	CL	IN	MP	GL	WO	ST
	21	21	21	21	21	21	126	6	6	6	6	6	6	36
	Persons Period Shown							Persons Period Shown						
Dec. 58	23	20	18	19	18	19	117	5	5	8	6	7	4	35
July 58	23	21	20	18	18	19	119	5	4	7	6	7	4	33
Jan. 58	23	19	23	18	18	20	121	5	4	6	6	3	3	27
Jan. 57	22	20	21	20	21	20	124	5	4	7	6	2	2	26
Jan. 56	23	20	20	19	21	20	123	5	3	7	6	2	2	25
Jan. 55	22	21	20	20	21	22	126	5	3	5	6	2	3	24

TABLE NO: 12 EMPLOYEE DISTRIBUTION BY TYPE OF EMPLOYEE FOR 10-YEAR PERIOD 1949 - 1959

	PSYCHIATRIST Adequate Staff Req'mt.							PSYCHOLOGISTS Adequate Staff Req'mt.							SOCIAL WORKERS Adequate Staff Req'mt.						
	CH	CL	IN	MP	GL	WO	ST	CH	CL	IN	MP	GL	WO	ST	CH	CL	IN	MP	GL	WO	ST
	17	17	17	17	17	17	102	17	17	17	17	17	17	102	17	17	17	17	17	17	102
Jan.	Actual Pers. Yr. Shown							Actual Pers. Yr. Shown							Actual Pers. Yr. Shown						
1949	3	5	6	7	4	3	28	1	1	0	0	0	1	3	3	1	1	2	2	2	11
50	10	6	6	7	2	3	34	1	1	1	0	1	2	6	3	3	3	4	3	2	18
51	10	8	7	7	5	5	42	0	2	2	1	0	2	7	3	2	3	0	2	1	11
52	10	6	7	7	2	6	38	2	1	2	1	1	2	9	4	1	3	1	2	2	13
53	10	8	6	7	5	4	40	2	1	2	2	1	2	10	3	1	4	1	2	2	13
54	9	7	7	8	4	6	41	2	2	2	5	2	2	15	3	3	5	1	2	3	17
55	12	7	7	9	4	5	44	2	3	4	4	2	2	17	4	2	4	3	2	3	18
56	14	8	11	8	5	4	50	3	2	2	1	1	2	11	6	3	4	3	3	3	22
57	11	9	11	11	5	4	51	5	3	3	1	2	2	16	4	5	5	3	2	3	22
58	13	9	12	6	9	4	53	2	2	5	1	4	1	15	4	5	14	2	2	3	30
Nov. 58	15	10	13	6	4	3	51	4	4	5	2	6	4	25	9	6	14	5	2	6	42
Jan. 59																					

	THERAPISTS & OTHER PROF. Adequate Staff Req'mt							TOTAL PROF. PERSONNEL Adequate Staff Req'mt.							REGISTERED NURSES Adequate Staff Req'mt.						
	CH	CL	IN	MP	GL	WO	ST	CH	CL	IN	MP	GL	WO	ST	CH	CL	IN	MP	GL	WO	ST
	45	45	45	45	45	45	270	96	96	96	96	96	96	576	102	102	102	102	102	102	612
Jan.	Actual Pers. Yr. Shown							Actual Pers. Yr. Shown							Actual Pers. Yr. Shown						
1949	16	5	4	15	14	21	75	23	12	11	24	20	27	117	9	0	1	2	1	8	21
50	10	10	8	20	16	21	85	24	20	18	31	22	28	143	10	2	4	4	1	5	26
51	10	8	14	22	19	30	103	23	20	26	30	26	38	163	11	2	7	2	6	3	31
52	8	7	14	14	20	39	102	24	15	26	23	25	49	162	11	1	6	3	3	3	27
53	7	9	23	16	26	31	112	22	19	35	26	34	39	175	8	4	10	2	4	5	33
54	8	8	23	22	29	33	123	22	20	37	36	37	44	196	9	4	11	2	4	7	37
55	8	9	21	18	37	29	122	26	21	36	34	46	39	202	8	6	9	2	4	8	37
56	6	6	16	11	42	35	116	29	19	33	23	51	44	199	11	4	13	3	7	8	46
57	8	7	17	13	41	37	123	28	24	36	28	50	46	212	11	6	17	7	5	8	54
58	6	12	34	7	28	45	132	25	28	65	16	43	53	230	11	7	14	8	6	6	52
Nov. 58	16	15	36	5	36	40	148	44	35	66	18	48	53	264	16	5	16	18	7	12	74
Jan. 59																					

This table gives the number of employees by type of employee for each institution and for all institutions over a ten year period. For purposes of comparison, the number of employees required for a balanced adequate staff is also shown.

TABLE NO: 12 EMPLOYEE DISTRIBUTION BY TYPE OF EMPLOYEE FOR 10-YEAR PERIOD 1949 to 1959

	ATTENDANTS Adequate Staff Req'mt.							TOTAL NURSING & CARE Adequate Staff Req'mt.							ADM. MTNC. FARM & OTHERS Adequate Staff Req'mt.						
	CH	CL	IN	MP	GL	WO	ST	CH	CL	IN	MP	GL	WO	ST	CH	CL	IN	MP	GL	WO	ST
	220	220	220	220	220	220	1320	322	322	322	322	322	322	1932	233	233	233	233	233	233	1398
Jan.	Actual Pers. Yr. Shown							Actual Pers. Yr. Shown							Actual Pers. Yr. Shown						
1949	163	156	121	96	133	102	771	172	156	122	98	134	110	792	130	122	98	114	141	132	737
50	177	162	161	92	133	101	826	187	164	165	96	134	106	852	140	124	100	171	168	142	845
51	153	168	163	148	111	109	852	164	170	170	150	117	112	883	147	105	127	128	144	123	774
52	159	170	160	140	117	105	851	170	171	166	143	120	108	878	127	128	123	136	135	132	781
53	153	177	161	144	125	103	863	161	181	171	146	129	108	896	133	136	144	122	132	136	803
54	158	188	165	195	149	127	982	167	192	176	197	153	134	1019	135	135	146	156	152	150	874
55	208	223	188	221	184	157	1181	216	229	197	223	188	165	1218	146	143	154	154	169	168	934
56	216	226	210	249	237	165	1303	227	230	223	252	244	173	1349	165	139	175	156	166	168	969
57	231	238	221	299	251	178	1418	242	244	240	306	256	186	1474	156	138	186	185	165	174	1004
58	228	235	215	256	202	180	1316	239	242	229	264	208	186	1368	132	140	189	144	199	196	1000
Nov. 58	213	252	210	267	238	257	1437	229	257	226	282	245	269	1508	171	156	181	156	191	205	1060
Jan. 59																					

	STATE TOTAL AS % OF IDEAL Adequate Staff Requirement									
	MD	PSY	SW	T&O	TOT	RN	ATT	N&C	ADM	TOT
Jan. 1949										
50										
51										
52										
53										
54										
55										
56	42	11	22	43	55	8	99	70	70	64
57	45	16	22	46	37	9	107	76	69	67
58	46	15	30	49	40	8	100	71	72	66
Nov. 58	45	25	42	55	46	12	109	78	76	73
Jan. 59										

TABLE NO: 13 - STUDY OF TURNOVER RATE AMONG EMPLOYEES

Termination per 100 positions for six months period.

ATTENDANTS:	Average % of Turnover	CH	CL	* IN	MP	GL	WO
Jan. 1956 - June 1956	30.7	28.8	17.4	50.4	31.4	26.0	30.0
July 1956 - Dec. 1956	25.0	20.9	16.3	47.4	29.8	15.0	20.4
Jan. 1957 - June 1957	21.2	16.5	17.9	28.7	25.8	17.0	21.4
July 1957 - Dec. 1957	21.9	14.7	19.3	27.9	25.7	34.0	10.0
Jan. 1958 - June 1958	19.8	19.3	17.4	21.2	21.6	23.0	16.4
July 1958 - Dec. 1958	18.9	14.8	18.6	23.5	13.3	29.0	14.4
PROFESSIONAL:							
Jan. 1956 - June 1956	9.3	10.7	17.0	3.9	6.5	6.0	11.7
July 1956 - Dec. 1956	18.3	12.5	15.4	19.2	20.7	11.0	31.0
Jan. 1957 - June 1957	9.3	12.5	9.1	17.0	7.1	0	10.3
July 1957 - Dec. 1957	23.3	18.6	20.0	8.9	38.2	17.0	37.3
Jan. 1958 - June 1958	14.5	10.0	11.6	13.8	17.0	16.0	18.3
July 1958 - Dec. 1958	22.7	16.6	17.2	33.3	16.9	23.0	29.1
OTHER DEPARTMENTS:							
Jan. 1956 - June 1956	14.6	18.9	20.4	12.6	10.5	12.0	13.4
July 1956 - Dec. 1956	17.8	22.3	16.3	18.3	19.8	17.0	13.3
Jan. 1957 - June 1957	18.1	17.9	21.5	14.2	20.0	23.0	11.7
July 1957 - Dec. 1957	19.2	30.6	16.2	18.7	23.4	14.0	12.2
Jan. 1858 - June 1958	11.1	16.6	13.0	10.6	4.7	11.0	10.8
July 1958 - Dec. 1958	14.1	15.1	1.9	12.6	8.4	15.0	14.5

* Nurses are included in Professional Department.

TABLE NO: 14

PROFESSIONAL PERSONNEL EMPLOYED

For a ten-year period, prior to 1947, the number of qualified personnel changed very little. Since 1957 there has been some increase shown in the following table.

	PSYCHIATRISTS						PSYCHOLOGISTS			
	Board Cert. by Exam.		Licensed Experienced		Other Psychi. Physicians		With Ph. D Degree		With Masters	
	57	59	57	59	57	59	57	59	57	59
Cherokee	1	5	1	3	9	9	0	1	4	2
Clarinda	0	2	1	3	8	7	1	1	1	3
Independence	2	4	2	4	7	6	2	3	1	2
Mt. Pleasant	0	2	1	1	5	6	1	3	0	0
Glenwood	0	0	0	0	3	4	0	1	1	2
Woodward	0	1	1	2	3	1	0	0	1	2

	Other		SOCIAL WORKERS With Masters		Other		OTHER PROFESSIONAL Fully Quali- by Training		Others	
	57	59	57	59	57	59	57	59	57	59
Cherokee	1	1	0	2	4	7	0	2	28	42
Clarinda	1	0	1	1	4	5	2	7	5	10
Independence	0	0	0	4	5	9	6	18	31	22
Mt. Pleasant	0	0	1	1	2	6	0	4	13	3
Glenwood	1	1	0	0	2	2	26	23	17	23
Woodward	0	2	1	2	2	4	18	22	19	18

TABLE NO: 15

TABLE OF ORGANIZATION

Table of Organization for Budget Planning

Position		III	IV	V	VI	VII	VIII	IX	X	XI	XII	XIII	XIV	XV
Psychiatrists	17									5		2	5	5
Clinical Psychologists	17					5			2	5	5			
Psych. Soc. Ser. Wkrs.	17					5		2	5	5				
Special Therapists	45	17	7	6	5	4	3	2	1					
Registered Nurses	102		40	33	9	9	6	3	2					
Attendants	220	202	9	9										
Administration	60	54	2		1	1	1							2
Dietary	53	38	3	3	3	3	2	1						
Housekeeping	20	17	1	1										
Laundry	16	13	1	1										
Special Services	5	5												
Plant Operation	19	12	4	2										
Maintencance & Repair	28	20	4	2	1	1								
Garage	5	5												
Greenhouse, Farm, Garden & Dairy	21	16	3	1										
Miscellaneous	6	5		1										
TOTAL	651	404	74	59	22	28	12	8	10	15	5	2	5	7

TABLE NO: 16

TABLE OF ORGANIZATION

Monetary Values of Pay Ranges

Pay Range No.	Base Range Cash Plus Mntce. or Cash Plus Fam. Mntce.	Cash Range In Lieu of Individual Mainten'ce	Cash Range In Lieu of Family Mainten'ce	FICA and Base Range	IPERS ADDED TO: Cash in Lieu of Self Mainten'ce	IPERS ADDED TO: Cash in Lieu of Family Mainten'ce
III	$ 2,520.00	$ 3,120.00	$ 4,320.00	$ 2,664.90	$ 3,299.00	$ 4,554.50
IV	3,060.00	3,660.00	4,860.00	3,235.95	3,870.00	5,094.50
V	3,720.00	4,320.00	5,520.00	3,933.90	4,555.00	5,754.50
VI	4,500.00	5,100.00	6,300.00	4,734.50	5,334.50	6,534.50
VII	5,340.00	5,940.00	7,140.00	5,574.50	5,174.50	7,374.50
VIII	6,450.00	7,050.00	8,250.00	6,684.50	7,284.50	8,484.50
IX	7,650.00	8,250.00	9,450.00	7,884.50	8,484.50	9,684.50
X	8,850.00	9,450.00	10,650.00	9,084.50	9,684.50	10,884.50
XI	10,050.00	10,650.00	11,850.00	10,284.50	10,884.50	12,084.50
XII	11,250.00	11,850.00	13,050.00	11,484.50	12,084.50	13,284.50
XIII	12,900.00	13,500.00	14,700.00	13,134.50	13,734.50	14,934.50
XIV	16,050.00	16,650.00	17,850.00	16,284.50	16,884.50	18,084.50
XV	$ 19,650.00	$ 20,250.00	$ 21,650.00	$ 19,884.50	$ 20,484.50	$21,884.50

TABLE NO: 17 COST OF STAFFING PATTERN

Based on 651 Employees as 100% - $2,803,620

NO.		CLASSIFICATION	UNIT RATE	TOTAL	GROUP TOTAL	PERCENTAGE
17:	5	Psychiatrist	$ 11,850.00	$ 59,250.00		
	2	Psychiatrist	14,700.00	29,400.00		
	5	Psychiatrist	17,850.00	89,250.00		
	5	Psychiatrist	21,450.00	107,250.00	$ 285,150.00	10.7
17:	5	Cl. Psychol.	5,940.00	29,700.00		
	2	Cl. Psychol.	9,450.00	18,900.00		
	5	Cl. Psychol.	10,650.00	53,250.00		
	5	Cl. Psychol.	11,850.00	59,250.00	161,100.00	5.75
17:	5	Soc. Service	5,940.00	29,700.00		
	2	Soc. Service	8,250.00	16,500.00		
	5	Soc. Service	9,450.00	47,250.00		
	5	Soc. Service	10,650.00	53,250.00	146,700.00	5.23
45:	17	Special Ther.	3,120.00	53,040.00		
	7	Special Ther.	3,660.00	25,620.00		
	6	Special Ther.	4,320.00	25,920.00		
	5	Special Ther.	5,100.00	25,500.00		
	4	Special Ther.	5,940.00	23,760.00		
	3	Special Ther.	7,050.00	21,150.00		
	2	Special Ther.	8,250.00	16,500.00		
	1	Special Ther.	9,450.00	9,450.00	200,940.00	7.18
102:	40	Reg. Nurses	3,660.00	146,400.00		
	33	Reg. Nurses	4,320.00	142,560.00		
	9	Reg. Nurses	5,100.00	45,900.00		
	9	Reg. Nurses	5,940.00	53,460.00		
	6	Reg. Nurses	7,050.00	42,300.00		
	3	Reg. Nurses	8,250.00	25,750.00		
	2	Reg. Nurses	9,400.00	18,900.00	475,270.00	16.92
220:	202	Attendants	3,120.00	630,240.00		
	9	Attendants	3,660.00	32,940.00		
	9	Attendants	4,320.00	38,880.00	702,060.00	25.04
50:	54	Administration	3,120.00	168,480.00		
	2	Administration	3,660.00	7,320.00		
	1	Administration	5,940.00	5,940.00		
	1	Administration	7,050.00	7,050.00		
	2	Administration	$ 21,450.00	$ 42,900.00	$ 231,690.00	8.26

TABLE NO: 17 COST OF STAFFING PATTERN

Based on 651 Employees as 100%--$2,803,620

NO.		CLASSIFICATION	UNIT RATE	TOTAL	GROUP TOTAL	PERCENTAGE
58:	38	Dietary	$ 3,120.00	$118,560.00		
	3	Dietary	3,660.00	10,980.00		
	3	Dietary	4,320.00	12,960.00		
	3	Dietary	5,100.00	15,300.00		
	3	Dietary	5,940.00	17,820.00		
	2	Dietary	7,050.00	14,100.00		
	1	Dietary	8,250.00	8,250.00	$ 197,970.00	7.06
20:	17	Housekeeping	3,120.00	53,040.00		
	1	Housekeeping	3,660.00	3,660.00		
	1	Housekeeping	4,320.00	4,320.00		
	1	Houskeeping	5,100.00	5,100.00	66,120.00	2.39
16:	13	Laundry	3,120.00	40,560.00		
	1	Laundry	3,660.00	3,660.00		
	1	Laundry	4,320.00	4,320.00		
	1	Laundry	5,100.00	5,100.00	53,640.00	1.91
5:	5	Special Services	3,120.00	15,600.00	15,600.00	.56
19:	12	Plant Operation	3,120.00	37,440.00		
	4	Plant Operation	3,660.00	14,640.00		
	2	Plant Operation	4,320.00	8,640.00		
	1	Plant Operation	5,100.00	5,100.00	65,820.00	2.35
28:	20	Maintenance & Rep.	3,120.00	62,400.00		
	4	Maintenance & Rep.	3,660.00	14,640.00		
	2	Maintenance & Rep.	4,320.00	8,640.00		
	1	Maintenance & Rep.	5,100.00	5,100.00		
	1	Maintenance & Rep.	5,940.00	5,940.00	96,720.00	3.45
5:	5	Garage	3,120.00	15,600.00	15,600.00	.56
21:	16	Farm, Garden, Dairy	3,120.00	49,920.00		
	3	Greenhouse	3,660.00	10,980.00		
	1	Farm, Garden, Dairy	4,320.00	4,320.00		
	1	Farm, Garden, Dairy	5,100.00	5,100.00	70,320.00	2.48
6:	5	Miscellaneous	3,120.00	15,600.00		
	1	Miscellaneous	4,320.00	$ 4,320.00	19,920.00	.71
TOTAL	651			$ 2,813,620.00		100.%

TABLE NO: 18 SUMMARY OF FINANCIAL DATA

NO.	CLASSIFICATION	UNIT	TOTAL	PERCENTAGES Actual	Assigned
17	Psychiatrists	$ 16,773.53	$ 285,150	10.17	10
17	Clinical Psychologists	9,476.47	161,100	5.75	6
17	Social Workers	8,629.41	146,700	5.23	5
45	Special Therapists	4,465.33	200,940	7.18	7
102	Registered Nurses	4,649.21	474,270	16.92	17
220	Attendants	3,191.18	702,060	25.04	25
233	Admin. & Maintenance	3,576.82	833,400	29.73	30
651	TOTAL PERSONNEL (Av)	$ 4,306.64	$2,803,620	100%	

BREAKDOWN OF ADMINISTRATION-MAINTENANCE-REPAIR-ETC.

60	Administrative	$ 3,861.50	$ 231.690	8.26	25
53	Dietary	3,735.28	197,970	7.06	22
20	Housekeeping	3,306.00	66,120	2.39	9
16	Laundry	3,342.50	53,640	1.91	6
5	Special Services	3,120.00	15,600	.56	2
19	Plant Operation	3,467.89	65,890	2.35	9
28	Maintencance & Repair	3,454.29	96,720	3.45	12
5	Garage	3,120.00	16,600	.56	2
21	Farm, Garden, Dairy, Gr. H.	3,348.57	70,320	2.48	9
6	Miscellaneous	3,320.00	19,920	.71	4

BALANCE ASSIGNMENT OF PERSONNEL TO SERVICES 1000-BED HOSPITAL

CLASSIFICATION	Admission Inten. Tr. 300-Beds	Continued Treat. Ser. 300-Beds	Geriatric Service 300-Beds	Medical Surgical 100-Beds	Extra-Mural or Out- Pat. 500 Cases Year
1. Psychiatric-Phy.	9	2	2	2	2
2. Clinical Psych.	9	4	2	1	1
3. Social Service	9	2	2	1	3
4. Therapists - Other	27	8	8	1	1
5. Registered Nurses	60	7	15	20	0
6. Attendants	75	50	75	20	0
7. Admin. & Maint.	69	69	69	23	3
TOTAL SER. PERSONNEL	258	142	173	68	10

OPERATIONAL COST BY SERVICE

PERSONNEL	Average Salary	Admission Inten. Tr.	Continued Treat. Ser.	Geriatric Service	Medical Surgical	Extra-Mural or Out-Pat.
Psych.	$ 16,773.53	$ 150,962	$ 33,547	$ 33,547	$ 16,774	$ 50,321
Cl. Psych.	9,476.47	85,288	37,906	18,953	9,476	9,476
Social S.	8,639.41	78,528	17,259	17,259	8,629	25,888
Other T.	4,465.33	120,564	35,723	35,723	4,465	13,396
Reg. Nur.	4,649.21	278,953	32,544	69,738	92,984	
Attend.	3,191.00	239,338	159,559	239,338	63,824	
Adm. - Mt.	3,576.82	246,801	246,801	246,801	82,267	10,730
Salaries:		1,200,434	563,339	661,359	278,419	109,811
Add Support & R.R.A		203,265	203,265	203,265	67,755	5,000
Cost per Year		1,403,699	766,604	864,624	346,174	114,811
Cost per Pt. per Day		$ 12.83	$ 7.01	$ 7.91	$ 9.50	Cost per Tr. $8.53

TABLE NO 18 SUMMARY OF FINANCIAL DATA

APPLICATION

1. Budget Request:	For Salaries and Wages - Basic	$ 2,803,620.00
	Add for IPERS and FICA	161,208.00
	Total Request for S. & W.	$ 2,964,828.00
	For Support	531,000.00
	For Repairs, Replacements & Alter.	90,000.00
	For Capital Equipment	60,000.00
	Annual Budget Request to implement program	$ 3,645,828.00

2. Present Operation:		If present payroll is $90,000 per mo.	If present payroll is $113,000 per mo.
Allot to Psychiatrists	10% or	$ 9,000. per mo.	$ 11,300 per mo.
Allot to Psychologists	6% or	5,400. per mo.	6,780 per mo.
Allot to Social Workers	5% or	4,500. per mo.	5,650 per mo.
Allot Special Therapy	7% or	6,300. per mo.	7,910 per mo.
Allot Reg. Nurses	17% or	15,200. per mo.	19,210 per mo.
Allot Attendants	25% or	22,500. per mo.	27,825 per mo.
Allot to Nurses & Attendants	42% or	27,800. per mo.	47,035 per mo.
Allot to Admin. - Mt. & Repair	30% or	27,000. per mo.	33,900 per mo.

OF THIS 30 PER CENT, ALLOT:

25% - Administration	$ 6,750. per mo.	$ 8,475 per mo.
22% - Dietary	5,940. per mo.	7,458 per mo.
9% - Housekeeping	2,430. per mo.	3,051 per mo.
6% - Laundry	1,620. per mo.	2,034 per mo.
2% - Special Services	540. per mo.	678 per mo.
9% - Plant Operation	2,430. per mo.	3,051 per mo.
12% - Maintenance & Repair	3,240. per mo.	4,068 per mo.
2% - Garage	540. per mo.	678 per mo.
9% - Farm, Garden, Dairy & Greenhouse	2,430. per mo.	3,051 per mo.
4% - Miscellaneous	1,080. per mo.	1,356 per mo.

TABLE NO: 19

PERSONNEL REQUIREMENTS FOR STAFFING

A STANDARD 1000-BED HOSPITAL

Standards have been set after careful study by the following organizations: The Joint Commission on Accreditation of Hospitals, The Council on Hospitals and Education of the American Medical Association, The American Hospital Association, The American Psychiatric Association, The National League of Nursing, The U. S. Public Health Service, and similar state associations to some extent.

	Reception-Intensive Treatment Service			Contd. Serv.				
CLASSIFICATION	100-Bed Admi. & Screening Ser.	100-Bed Intens. Treat. Ser.	100-Bed Short Conval. Service	300-Bed Lg. Term Conval. Service	300-Bed Geriatric Service	100-Bed Med. Surg. Service	Extra-Mural & OP Serv.	Total for 1000-Bed Hospital
Psychiatrists	3	3	3	2	2	2	2	17
Clinical Psychologist	3	3	3	2	2	1	3	17
Psychiatric Social Worker	3	3	3	2	2	1	3	17
Other Special Therapists	6	15	6	8	8	1	1	45
Registered Nurses	15	30	15	7	15	20	0	102
Attendants	25	25	25	50	75	20	0	220
Administrative-Maintenance	23	23	23	69	69	23	3	233
TOTAL	78	102	78	140	173	68	12	651

THE AGED IN IOWA MENTAL HEALTH INSTITUTES

OUR POPULATION IS AGING

One of the major problems facing Iowa's Mental Hospitals is the increasing number of persons aged 65 or older in the state population, combined with a lack of suitable facilities for older persons who can no longer be cared for at home.

While the national population as a whole is increasing, the number aged 65 and older is increasing at a faster rate. In 1900 only one in every 26 persons was 65 years of age or older. By 1930 about one in every 16 persons, and by 1950 one person in every 11 was in this older age group. It is estimated that today one in every nine persons is 65 years of age or older.

At present, 189.8 per 100,000 of the total population of the state is resident in Iowa's Mental Health Institutes. This includes all age groups. However, 32% of the total hospital population falls in the 65 years of age and older group. This is almost one-third of the total population in the mental health institutes. As the total population in the state increases, and the percentage of aged in the population likewise increases, the aged population in the mental institutions will increase sharply unless other provisions are made for the care of these patients.

BOTH ADMISSIONS AND DISCHARGES ARE INCREASING

A total of 574 patients aged 65 or over were admitted to the Iowa Mental Health Institutes during the period. A total of 354 patients in this age group were discharged and 354 died, or a total of 708 patients were separated from the books of the institutions. This resulted in a decrease of 134 patients or 7% in this group on the books of the Iowa Mental Health institutes at the end of the period.

About one-third of the patients entering our mental hospitals are voluntary admissions, while two-thirds are committed. Voluntary admission is the preferred procedure with the exception of a few cases requiring coercion.

The following tabulation indicates that 50% of the total number of patients entering the mental institutions were first admissions, or those cases who had never before been treated in a hospital for mental diseases. Fifty-percent were readmissions, or those patients who had previously been treated in institutions for mental diseases. However, in the 65 years of age and older group, 73% or 421 were first admissions, while 27% or 153 were readmissions.

Of the total patients entering the institutions, 77% are under 65 years and 23% are 65 years of age and older.

TABLE NO: 20 MOVEMENT OF PATIENT POPULATION AGED 65 YEARS AND OVER IN IOWA'S MENTAL HEALTH INSTITUTES

Bar 1: On Books Beginning of Period.

Bar 2: Admissions During Period

Bar 3: Separations During Period.

Bar 4: On Books Close of Period

Period: 6/30/56 - 7/1/57

Patients 65 years of age and over comprise 32% of entire patient case load of 4,935 at end of period

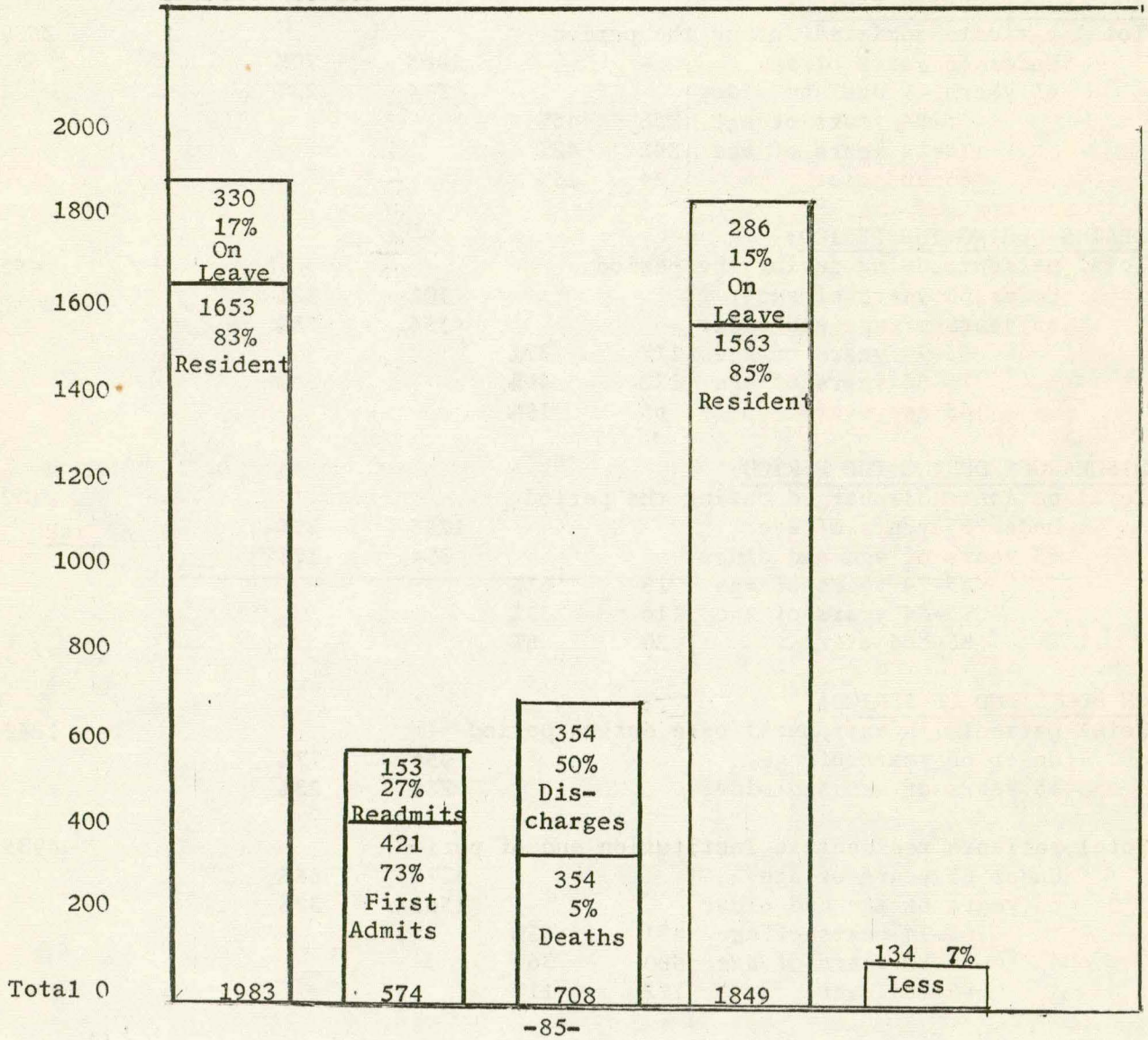


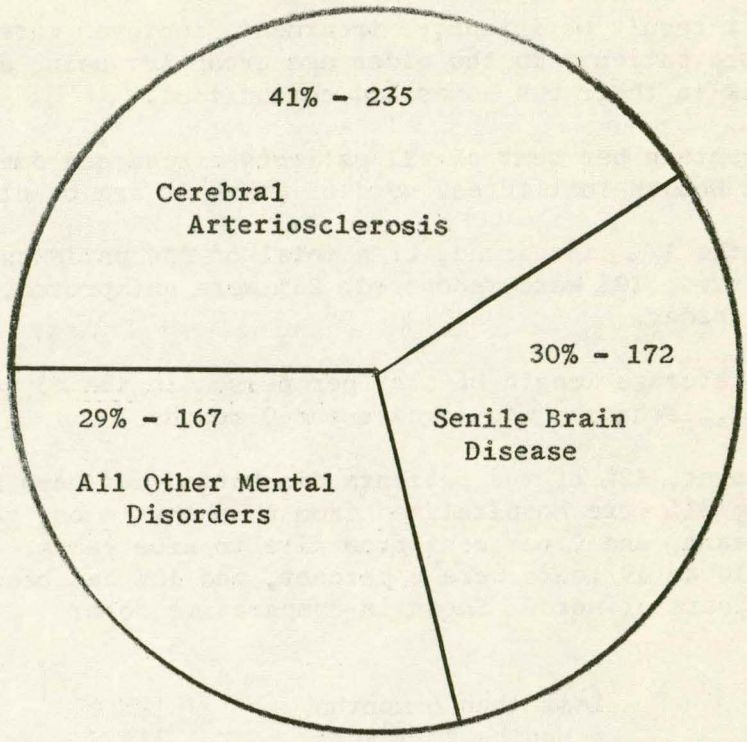
TABLE: 21 MOVEMENT OF PATIENT POPULATION IN IOWA'S MENTAL HEALTH INSTITUTES

Divided by Patients Aged 65 and Over and Under 65
Period: July 1, 1956 - June 30, 1957

PATIENTS ON BOOKS:				
Total patients resident in Mental Health Institutes 7/1/56				4982
Under 65 year of age			3329	67%
65 years of age and older			1653	33%
Total patients on leave of absence but not formally discharged				1218
Under 65 years of age			888	73%
65 years of age and older			330	27%
Total patients on books of Institutions				6200
Under 65 year of age			4217	68%
65 years of age and older			1983	32%
ADMISSIONS DURING PERIOD:				
Total patients admitted during the period				2539
Under 65 years of age			1965	77%
65 years of age and older			574	23%
65-74 years of age	258	45%		
75-84 years of age	242	42%		
85 and over	74	13%		
DEATHS DURING THE PERIOD:				
Total patients dying during the period				455
Under 65 years of age			101	22%
65 years of age and older			354	78%
65-74 years of age	117	33%		
75-84 years of age	172	49%		
85 and over	65	18%		
DISCHARGES DURING THE PERIOD:				
Total patients discharged during the period				2107
Under 65 years of age			1753	83%
65 years of age and older			354	17%
65-74 years of age	218	61%		
75-84 years of age	116	33%		
85 and over	20	6%		
ON BOOKS END OF PERIOD:				
Total patients in extramural care during period				1242
Under 65 years of age			956	77%
65 years of age and older			286	23%
Total patients resident in Institution end of period				4935
Under 65 years of age			3372	68%
65 years of age and older			1563	32%
65-74 years of age	831	53%		
75-84 years of age	560	36%		
85 and over	172	11%		

TABLE NO: 22 PRINCIPAL MENTAL DISORDERS OF ALL PATIENTS AGED 65 YEARS AND OLDER ENTERING IOWA'S MENTAL HEALTH INSTITUTES DURING THE PERIOD

July 1, 1956 - June 30, 1957



GLOSSARY

Cerebral Arteriosclerosis: A condition of loss of elasticity and thickening of the coats of the arteries with inflammatory changes, degenerative or productive. Cerebral arteriosclerosis - arteries of the brain. Here are classified chronic, progressive mental disturbances occurring in connection with cerebral arteriosclerosis.

Senile Brain Disease: This category is designed for the classification of organic brain symptoms occurring with senile brain disease, classified as mild, moderate, or severe. These cases vary from mild symptoms with self-centering of interest, difficulty in assimilating new experiences, and "childish" emotionality up to and including those so severely affected by senile brain disease as to require institutional care.

All Other Mental Disorders: Here are included all other mental disturbances than the two major classifications above.

IMPROVED CARE AND INTENSIVE TREATMENT RESULTS IN INCREASED NUMBER OF DISCHARGES

As a result of intensive treatment, improved care, and periodic examination, more patients in the older age group are being discharged, and more are going back to their own homes and communities.

Seventeen per cent of all patients discharged during the period from Iowa's Mental Health Institutes, were 65 years of age or older.

Of the 17% discharged, or a total of 354 patients aged 65 or over, 50% were improved, 19% were recovered, 25% were unimproved, and 6% were without mental disorder.

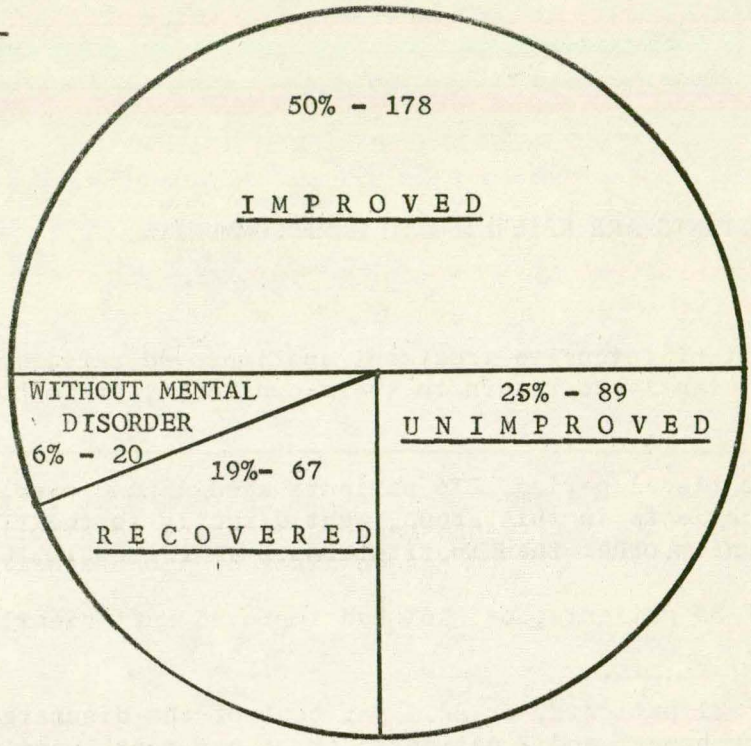
The average length of stay per person in the 65 years of age and older group at discharge, was 4 years and 9 months.

However, 12% of the patients discharged had been hospitalized less than 6 months; 31% were hospitalized from 6 months to one year; 32% from two to four years, and 9 per cent from five to nine years. Under long term care of from 10 to 19 years were 6 percent, and 10% had been in the institutions for 20 years or more. Shown in comparative form:

Less than 6 months	12%
6 Months to 1 year	31%
From 2 to 4 years	32%
From 5 to 9 years	9%
From 10 to 19 years	6%
20 Years or more	10%

CONDITION OF PATIENTS 65 YEARS OF AGE AND OVER AT DISCHARGE

TABLE NO: 23



Of a total of 2107 patients discharged during the fiscal period, 354 or 17% were 65 years of age or older. The average length of stay per person was 4 years and 9 months for the 65 and over age group.

All patients discharged:	2107	
Patients 65 years of age and older	354	17%
Patients under 65 years of age	1753	83%

Condition of Patients 65 Years of Age and Over at Discharge:

Recovered:		
Patients 65 years of age and older	67	10%
Patients under 65 years of age	604	90%
Improved:		
Patients 65 years of age and older	178	25%
Patients under 65 years of age	521	75%
Unimproved:		
Patients 65 years of age and older	89	23%
Patients under 65 years of age	305	77%
Without Mental Disorder: (Alcoholic and Other)		
Patients 65 years of age and older	20	6%
Patients under 65 years of age	323	94%

MORE PATIENTS ARE RETURNING TO HOME COMMUNITY

As a result of intensive treatment and improved care, more patients are recovering sufficiently to return to their own homes, or to homes in the community.

During the fiscal period, 216 patients aged 65 and over, or 61% of the 354 discharged patients in this group, went directly to their homes or care in the community other than institutions.

A total of 55 patients, or 16% had improved sufficiently to be cared for in county homes.

A total of 81 patients, or 22.4 per cent of the discharges in this group went to nursing homes, and 2 patients, or .6 per cent, went to the Veterans Administration.

The average length of stay per patient in the group aged 65 and over was:

4 Years and 9 Months

The average length of stay per patient in the group under age 65 was:

2 Years and 7 Months

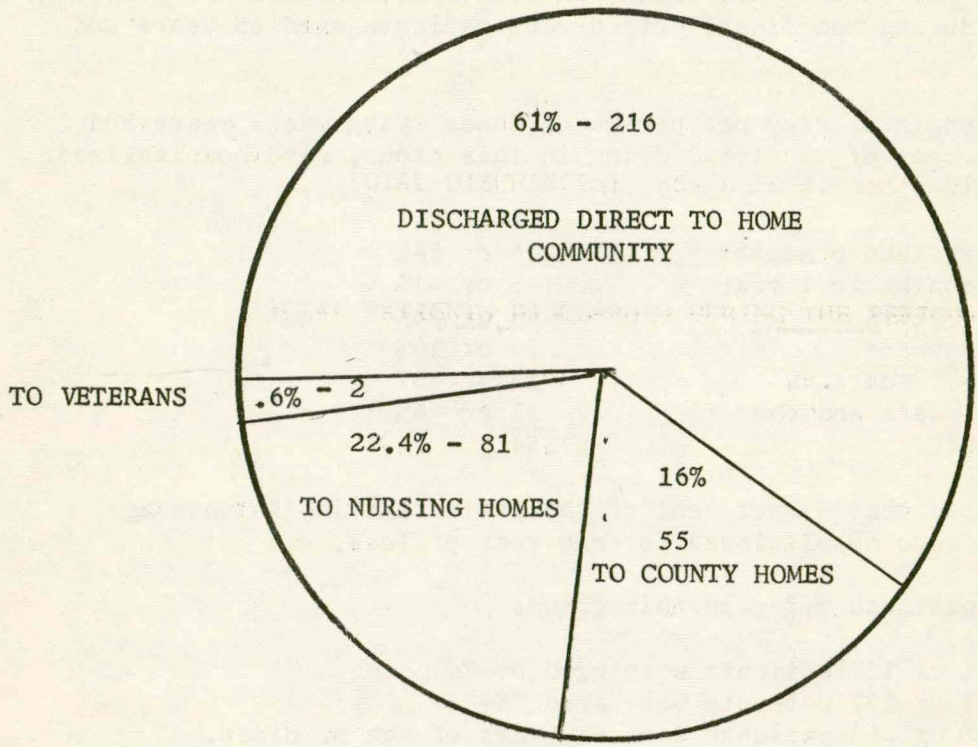
Most of the patients in the older age groups die within the first year or so after admission, but among the younger patients, those who are not released by the end of the first year stay on in the hospital with less and less likelihood of release.

The patients in the older age groups, for the most part, have grown old in the institution. With early, intensive treatment, this trend should be prevented, particularly in the schizophrenic group. Early treatment - early recovery, is the trend in the schizophrenic group, the largest group in the institutions.

TABLE NO: 24

DESTINATION OF MENTAL PATIENTS AGED 65 AND OVER DISCHARGED FROM IOWA MENTAL HEALTH INSTITUTES

During the Fiscal Period: 7/1/56 - 6/30/57



TOTAL DISCHARGES: 354 AGED 65 and OVER

TOTAL PATIENTS DISCHARGED DURING THE PERIOD: 2,107

Patients under 65 years of age:	1,753	83%
Patients 65 years of age and up:	354	17%

MORE PATIENTS IN THE 65 YEARS OF AGE AND OVER GROUP DIE IN MENTAL HEALTH INSTITUTES

Seventy-eight per cent of all deaths in Iowa Mental Health Institutes and in extramural care during the fiscal period were patients aged 65 years and over.

The average length of stay per person of those dying was 3 years and 8 months. Fourteen per cent of the total dying in this group, were hospitalized less than six months.

Less than 6 months	46 or 14%
6 months to 1 year	146 or 41%
2-4 years	93 or 26%
5-9 years	36 or 10%
10-19 years	12 or 3%
20 years and over	21 or 6%
TOTAL	354

It will be noted that 55 per cent of the patients dying in this age group, or 192 patients, were hospitalized for one year or less.

Of the total patients dying in this group:

33% or 117 patients were aged 65-74
49% or 172 patients were aged 75-84
18% or 65 patients were 85 years of age or older.

Of the patients hospitalized 1 year or less:

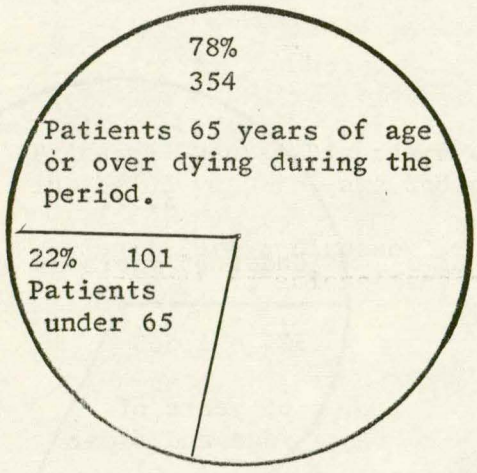
59 were in the 65-74 age group
93 were in the 75-84 age group
40 were in the 80 and over age group
192 TOTAL

TABLE NO: 25

MENTAL DISORDER OF PATIENTS AGED 65 AND OVER DYING IN MENTAL HEALTH INSTITUTES OR IN EXTRAMURAL CARE DURING FISCAL PERIOD: 7/1/56-6/30/57

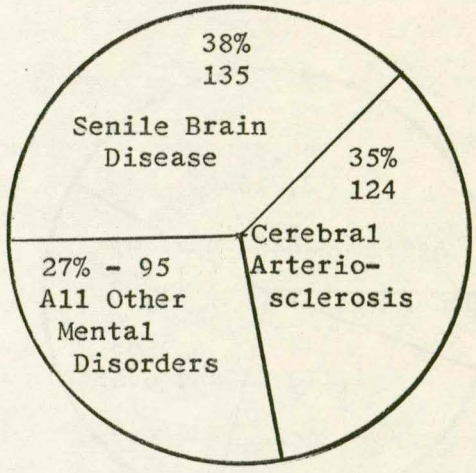
Seventy-three per cent of patients dying in Iowa's Mental Health Institutes or in extramural care not yet officially discharged were in the senile brain disease or cerebral arteriosclerosis groups. Twenty-seven per cent died of all other mental disorders.

Principal Mental Disorders of patients dying in the 65 years of age and older group	354	
Senile Brain Disease	135	38%
Cerebral Arteriosclerosis	124	35%
All other Mental Disorders	95	27%
Total all deaths during the period	455	
Patients 65 years of age and older	354	78%
Patients under 65 years of age	101	22%
Average length of hospitalization per person 65 years of age or over	3 years 8 mo.	



AGE OF PATIENTS DYING

Total: 455



MENTAL DISORDERS OF PATIENTS DYING

Total: 354

TABLE NO: 26 PATIENTS RESIDENT IN MENTAL HEALTH INSTITUTES
AT END OF FISCAL PERIOD: 7/1/57

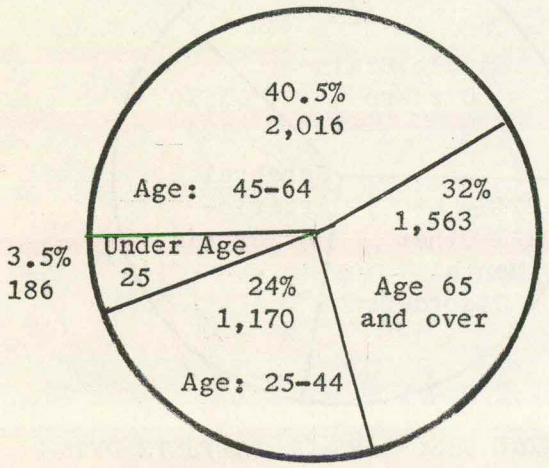
All Patients resident in institutions at end of period:
189.8 per 100,000 population.

All Age Groups

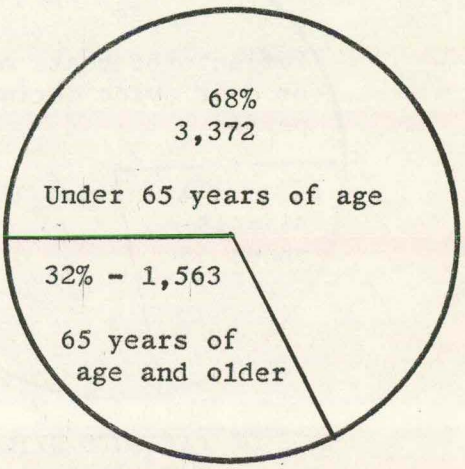
Under 15 years of age	30
15-24 years of age	156
25-34 years of age	404
35-44 years of age	766
45-54 years of age	1,051
55-64 years of age	965
65-74 years of age	831
75-84 years of age	560
85 years of age and over	172
TOTAL	4,935

Total patients under 25 years of age	186	3.5%
Total patients 25-44 years of age	1,170	24.0%
Total patients 45-64 years of age	2,016	40.5%
Total patients 65 years of age and over	1,563	32.0%
Total patients under 65 years of age	3,372	68%
Total patients 65 years of age and over	1,563	32%

PERCENTAGE OF PATIENTS IN VARIOUS AGE GROUPS END PERIOD



AGE OF PATIENTS IN RESIDENCE
Total: 4,935



AGE OF PATIENTS IN RESIDENCE
Total: 4,935

PRINCIPAL MENTAL DISORDERS OF PATIENTS RESIDENT IN IOWA
MENTAL HEALTH INSTITUTES AT END OF PERIOD
7/1/57

TABLE NO: 27

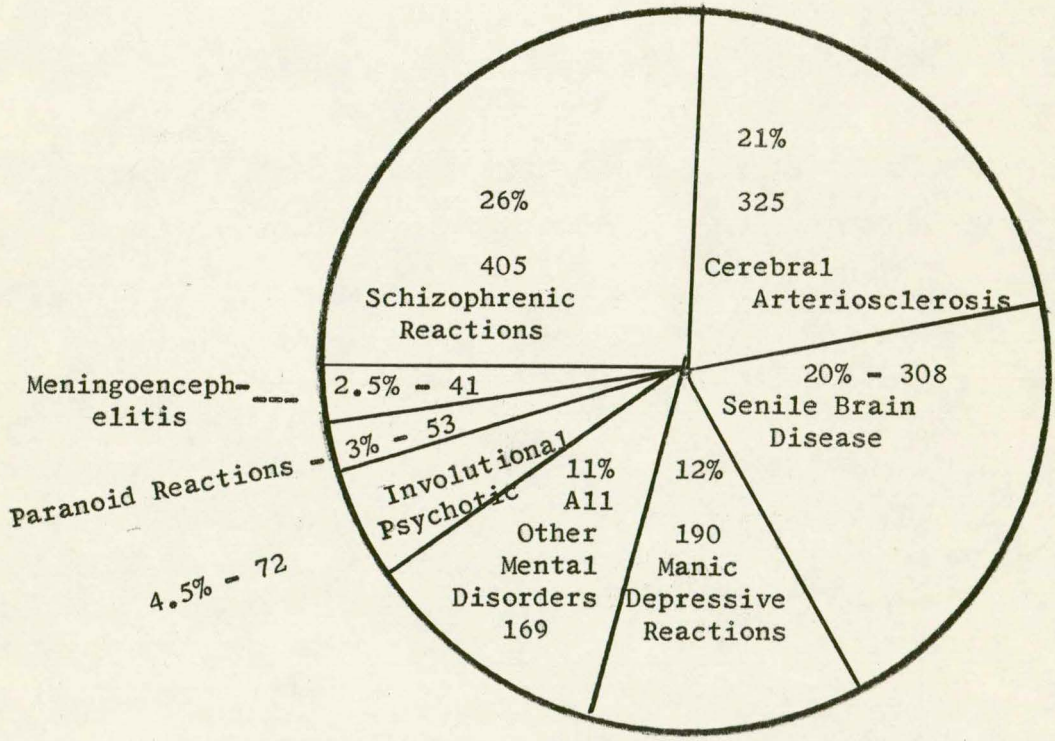
65 YEARS OF AGE AND OLDER

At the end of the fiscal period, about 189.8 persons per 100,000 population in Iowa were resident in State Mental Health Institutes.

Thirty-two per cent of the total resident population comprise the 65 years of age and over group. It is anticipated that the population in this group will increase in the mental institutions as it increases in the general population.

Of the schizophrenic reactions in the 65 years of age group, it is reasonable to assume that most of these patients have grown old in the state hospital. Today's prompt, intensive treatment should greatly reduce this group as long-term care residents in the future.

PRINCIPAL MENTAL DISORDERS OF PATIENTS IN RESIDENCE
IN IOWA MENTAL HEALTH INSTITUTES - 7/1/57



TOTAL - 1563

THE ALCOHOLIC AND ALCOHOLISM IN IOWA

TABLE NO: 28

MOVEMENT OF INEBRIATE POPULATION IN IOWA MENTAL HEALTH INSTITUTES
Period: 1953-1957

DESCRIPTION	Total Patients Five-Year Period					Average Over Five-Year Period				
	All Patients	Psychotics		Inebriates		All Patients	Psychotic		Inebriates	
	No.	No.	%	No.	%	Av. No.	No.	%	No.	%
1. On Books Beginning Pd.	33,127	30,959	93	2168	7	6626	6192	93	434	7
2. Admissions During Pd.	12,808	10,633	83	2175	17	2562	2127	83	435	17
3. Discharged During Pd.	10,082	7,760	77	2322	23	2016	1552	77	464	23
4. Deaths During Period	2,833	2,766	98	67	2	567	554	98	13	2
5. Out-Transf. During Pd.*	738	738	100	0	0	148	148	100	0	0
6. On Books End Period	32,282	30,328	94	1954	6	6456	6065	94	391	6
7. Decreased Population	845-	631	75	214	25	170	127	75	43	25
	2.55%	2.03%		9.87%		2.56%				

* Out-Transfers limited to movement between like state institutions only.

Averages: On an average, 6 percent of the book population are inebriates. About 3 percent of the total resident population are inebriates.

Admissions: During the five year period, 17% of admissions were inebriates. In 1953, 19% were inebriates and in 1957, 16% were inebriates. This variance is due to the fact that this study is based on clinical diagnosis and different institutions classify their inebriates on different clinical patterns. For example, in 1957 Independence diagnosed a great many of its inebriates as primary psychoneurotics. For the purpose of this study, only acute brain syndrome with alcoholism, chronic brain syndrome with alcoholism, and alcoholic addiction were considered. In 1958 a special study will be made of inebriates, using as a base all patients with alcoholic problems, irrespective of legal commitment or clinical diagnosis.

Discharges: Of the total number discharged during the five-year period, 23% were inebriates.

Deaths: Of the total number of deaths during the five-year period, only 2% were inebriates.

On Books: Seven percent of the book population at the beginning of the period were inebriates, and six percent at the close of the period were inebriates.

Residents: Over the five-year period, about 3 percent of the resident population each year were inebriates. A study by institution is available in this office for this period.

THE ALCOHOLIC AND ALCOHOLISM IN IOWA

Iowa has a serious alcoholism problem that is statewide.

This conclusion was reached by Harold A. Mulford, Ph. D. and Carl E. Waisanen, Ph. D., Faculty members of the State University of Iowa, as a result of a research study made by them in 1956. Iowa has 44,000 alcoholics, including the "problem drinker", according to their survey.

As chairman of the Governor's Committee for Research on Alcoholism, Dr. Paul E. Huston, Director of Psychopathic Hospital at the State University of Iowa, summarizes the conclusions of the two research specialists as follows:

1. There is a serious alcoholism problem in the state.

2. The problem is statewide.

3. The problem is complex: It involves medical, psychic, social, moral, and economic factors.

4. The economic costs are measured in millions of dollars. The social cost cannot be measured in money.

5. The problem will grow worse with time if not solved.

6. The problem deserves prompt and adequate attention.

7. The alcoholic problem can be most effectively met if approached as a public health problem and attacked with a comprehensive state program of education, treatment and research, in cooperation with local communities.

8. An intelligently operated alcoholism program, used for humanitarian consideration, would mean financial savings for the people of Iowa.

Dr. Huston made recommendations in a special report entitled, "Governor's Study of Alcoholism - 1956", edited by Dr. H. A. Mulford, research association in the Department of Sociology and Anthropology, State University of Iowa, and his associate, Dr. Carl E. Waisanen. Among the recommendations:

"It is recommended that the General Assembly of Iowa enact legislation which gives a policy-making body the necessary authority and funds to develop a broad program of education, research, and treatment". These suggestions are further expanded in the report.

APPROACHING THE PROBLEM:

Various viewpoints are taken in regard to coping with the problem. Our present statutes set the alcoholic apart from other mentally ill persons

through providing separate statutes governing admission to state institutions. The statutes require that separate accommodations be maintained for them. Legislation which would define still more distinctly the state's responsibility for alcoholics was prepared two years ago, but did not become law.

To consider some of the views taken:

1. Some would provide a program for the alcoholic which is entirely divorced from the mental institution.

2. Some would provide separate rehabilitation clinics and farms for the alcoholic, but would retain the present program in the mental institutions.

3. Some believe alcoholism is but one aspect of mental illness, and therefore no separate and distinct institutions for their care should be established. That what is needed is to exploit the possibilities of our existing institutions, and staff them adequately to do the entire job. We do have large state farms, but the treatment and rehabilitation personnel needed to make them therapeutic and rehabilitative farms are not provided. We have large numbers of patients seeking care and treatment for alcoholism under present conditions. The number would increase tremendously if we really provided modern treatment in our existing facilities.

SUGGESTED SOLUTION:

I believe that the report of the Governor's Committee for Research on Alcoholism should be taken seriously, and I also believe that:

1. All that is essential to implement research and basic scientific studies is that funds be made available for that purpose to our medical school and to certain other departments of the State University of Iowa and other institutions of higher education, as well as to the state mental institutions.

2. Alcoholism is an aspect of mental health - and mental health is an aspect of public health. Our entire code relating to mental health is in need of being re-written. However, without any significant change in statutes, the Board of Control can implement a modern treatment program for alcoholism, if given the required funds. The requested appropriation would hasten the establishment of an adequate residential treatment program. An additional sum of from $25,000 to $200,000 at each mental health institute would staff a full or part time out-patient department. This unit would assist, consult, and work with physicians in private practice in private hospitals or in the community mental health clinics. This would be the most simple and economical manner in which to implement treatment.

3. Education is a powerful defense against alcoholism It is best implemented in the schools of higher learning by developing and teaching a research program in the university, beginning in the school of medicine, then extending to other scientifice disciplines in both the university and all state schools. A body of scientific information will then be produced and passed on to all teachers of elementary schools as well as the higher grades. At present, education is best implemented in the field by the development of treatment centers. Personnel of these centers will serve as teachers and leaders of groups interested in solving the problem of alcoholism. In time, people will demand an educational program in the public schools, and the teacher will be prepared to teach the required courses.

CHILDREN IN IOWA MENTAL HEALTH INSTITUTES

CHILDREN IN IOWA MENTAL HEALTH INSTITUTES

We have always admitted an occasional child to each mental health institute, but the number requesting admission is steadily increasing. In the report to the governor submitted two years ago, one of the areas covered was the urgent need for children's services. At the time of the report it was concluded that our four mental health institutes should provide 400 beds for children and that a 100 bed research and teaching unit should be established at Iowa City to meet the needs for such services in Iowa with a population of 2,700,000.

A children's ward was established at Independence about seven years ago. Two years ago, for the first time, a special budget request for salaries for this children's unit was presented to the Legislature, and $276,000 a year was appropriated. This unit has been quite successful. However, it does not begin to meet the demand since Independence has been compelled to discontinue further admission while its resident case load is at capacity level.

At the close of the biennium, with a total of 90 children in residence, 50 of those under the age of 16 were under treatment in the children's unit. The remaining 30 were on other wards. The program staff consisted of the psychiatric team of one psychiatrist, one social worker and one psychologist. In addition the unit was staffed by five full-time teacher therapists, one half-time teacher therapist, and three recreational therapists.

TABLE NO: 29

CHILDREN IN IOWA MENTAL HEALTH INSTITUTES

Period: 1953 - 1957

Age Group: 19 and under.

INSTITUTION	1953	1954	1955	1956	1957	1958
I. ON BOOKS AT BEGINNING OF PERIOD:						
1. In Residence:						
a. Cherokee	1	6	13	16	12	17
b. Clarinda	4	4	10	20	15	13
c. Independence	13	26	22	26	39	56
d. Mt. Pleasant	14	9	4	17	15	15
Total in Residence:	32	45	49	79	81	101
2. In Extramural Care:						
a. Cherokee	0	0	4	7	14	11
b. Clarinda	0	5	6	7	22	31
c. Independence	0	8	15	14	14	22
d. Mt. Pleasant	0	3	7	0	0	2
Total in Extramural Care:	0	16	32	28	50	66
3. Total on Books:						
a. Cherokee	1	6	17	23	26	28
b. Clarinda	4	9	16	27	37	44
c. Independence	13	34	37	40	53	78
d. Mt. Pleasant	14	12	11	17	15	17
Total on Books:	32	61	81	107	131	167
II. ADMISSIONS DURING THE PERIOD:						
a. Cherokee	14	19	20	17	18	-
b. Clarinda	6	16	22	21	19	-
c. Independence	44	33	34	51	67	83
d. Mt. Pleasant	14	9	17	12	17	-
Total Admissions:	78	77	93	101	121	-
III. DISCHARGES DURING PERIOD:						
a. Cherokee	9	8	14	14	16	-
b. Clarinda	1	9	11	10	12	-
c. Independence	23	30	31	38	42	56
d. Mt. Pleasant	16	9	11	14	15	-
Total Discharges:	49	56	67	76	85	56

IV.	DEATHS DURING PERIOD:						
	a. Cherokee	0	0	0	0	0	0
	b. Clarinda	0	0	0	1	0	0
	c. Independence	0	0	0	0	0	0
	d. Mt. Pleasant	0	1	0	0	0	0
	Total Deaths:	0	1	0	1	0	0
V.	RESIDENT END OF PERIOD:						
	a. Cherokee	6	13	16	12	17	-
	b. Clarinda	4	10	20	15	13	-
	c. Independence	26	22	26	39	56	58
	d. Mt. Pleasant	9	4	17	15	15	-
	Total Resident:	45	49	79	81	101	58
VI.	EXTRAMURAL CARE END PERIOD:						
	a. Cherokee	0	4	7	14	11	-
	b. Clarinda	5	6	7	22	31	-
	c. Independence	8	15	14	14	22	47
	d. Mt. Pleasant	3	7	0	0	2	-
	Total Extramural Care	16	32	28	50	66	-
VII.	ON BOOKS END OF PERIOD:						
	a. Cherokee	6	17	23	26	28	-
	b. Clarinda	9	16	27	37	44	-
	c. Independence	34	37	40	53	78	105
	d. Mt. Pleasant	12	11	17	15	17	-
	TOTAL END OF PERIOD:	61	81	107	131	167	-

Note: Computations for the period ending 1958 were unavailable at time of preparation of this table, with the exception of Independence. However, they would be comparable to 1957 since no change in accommodations for children occurred.

MENTALLY ILL PATIENTS IN COUNTY HOMES

MENTALLY ILL PATIENTS RESIDENT IN COUNTY HOMES

Classified by District and County
June 30, 1958

TABLE NO: 30

DISTRICT NO. 1 CHEROKEE		DISTRICT NO. 2 CLARINDA		DISTRICT NO. 3 MT. PLEASANT		DISTRICT NO. 4 INDEPENDENCE	
Buena Vista	12	Adams	5	Appanoose	19	Allamakee	25
Calhoun	12	Audubon	3	Cedar	19	Benton	30
Cerro Gordo	86	Boone	41	Clinton	59	Black Hawk	30
Cherokee	3	Carroll	9	Davis	13	Bremer	22
Clay	15	Cass	5	Des Moines	104	Buchanan	30
Crawford	12	Clarke	0	Henry	12	Butler	6
Dickinson	10	Dallas	28	Iowa	17	Chickasaw	9
Emmet	10	Decatur	20	Jasper	64	Clayton	55
Hamilton	22	Fremont	6	Jefferson	21	Delaware	20
Hancock	0	Greene	4	Johnson	20	Dubuque	16
Kossuth	20	Guthrie	10	Keokuk	15	Fayette	68
O'Brien	35	Montgomery	11	Lee	75	Floyd	25
Plymouth	23	Page	13	Louisa	7	Hardin	15
Pocahontas	11	Polk	218	Lucas	36	Howard	11
Sac	0	Pottawattamie	17	Mahaska	50	Jackson	21
Sioux	22	Shelby	2	Marion	22	Jones	23
Webster	37	Taylor	15	Monroe	27	Linn	75
Winnebago	13	Union	20	Muscatine	25	Marshall	45
Woodbury	32	Warren	0	Poweshiek	11	Mitchell	16
		Wayne	11	Scott	22	Tama	13
				Van Buren	17	Winneshiek	52
				Wapello	47		
				Washington	31		
Total	375		438		800		707

TOTAL ALL PATIENTS IN
COUNTY HOMES

District No. 1	375
District No. 2	438
District No. 3	800
District No. 4	707
Total	2320

NOTE: Includes patients transferred from Mental Health Institutes and patients admitted directly by the County as mental patients.

A few counties have contracts with nursing home operators and maintain no county home care for mental patients.

THE CRIMINAL INSANE

THE CRIMINAL INSANE

Dr. J. Stomel assumed charge of the Division for the Criminal Insane at the Men's Reformatory in July 1958, beginning a two-day per week schedule.

On January 1, 1959 a full-time program was begun under the direction of Dr. Stomel. A treatment facility with an attendant in-service training program is being developed.

MOVEMENT OF PATIENT POPULATION IN THE DIVISION
FOR CRIMINAL INSANE AT MEN'S REFORMATORY

Biennial Periods Ending 1950 - 1958

	7-1-56 to 6-30-58	7-1-54 to 6-30-56	7-1-52 to 6-30-54	7-1-50 to 6-30-52	7-1-48 to 6-30-50
1. ON BOOKS BEGINNING OF PERIOD:					
a. In residence	67	70	75	70	114
2. ADMISSIONS:					
a. First admissions	11	4	5	28	20
b. Re-admissions	3	1	1	0	0
c. In-Transfers	16	23	18	2	3
TOTAL ADMISSIONS:	30	28	24	30	23
3. TOTAL PATIENTS:	97	98	99	100	137
4. SEPARATIONS:					
a. Discharges	3	13	9	7	16
b. Deaths	5	6	14	3	4
c. Out-Transfers	22	12	6	15	47
TOTAL SEPARATIONS:	30	31	29	25	67
5. RESIDENT END OF PERIOD:	72	67	70	75	70
6. AVERAGE DAILY RESIDENT POPULATION:	72	69	73	73	72
7. RATED CAPACITY:	140	140	140	140	140

DETAIL ON MOVEMENT OF POPULATION

1. IN INSTITUTION BEGINNING OF PERIOD:	67	70	75	70	114
2. ADMISSIONS:					
a. Transferred from Ft. Madison	24	23	18	25	12
b. Other and Court Orders	6	5	6	5	11
TOTAL ADMISSIONS:	30	28	24	30	23
3. SEPARATIONS:					
a. Transferred to Ft. Madison	12	12	2	5	24
b. Transferred to Cherokee	0	1	0	0	5
c. Transferred to Clarinda	1	1	2	0	2
d. Transferred to Independence	9	3	0	2	13
e. Transferred to Mt. Pleasant	0	1	0	1	0
f. Trsferred to Anamosa Population	0	0	0	5	3
g. Transferred to Knoxville	0	0	2	2	0
h. Court Order Discharge	0	0	0	2	2
i. Discharged	3	7	9	5	14
j. Deaths	15	6	14	3	4
TOTAL SEPARATIONS:	30	31	29	25	67

OUT-PATIENT SERVICES

TABLE NO: 32

OUT-PATIENTS SEEN IN IOWA MENTAL HEALTH INSTITUTES
Period: July 1, 1956 - June 30, 1957

	EXPLANATION	TOTAL	CHEROKEE	CLARINDA	INDEPENDENCE	MT. PLEASANT
1.	Carried Over From Prior Period:	62	0	58	4	0
2.	Admitted During Period.....	464	147	87	172	58*
3.	Total Patients Seen.....	526	147	145	176	58
4.	Total Interviews.....	3235	1799	--	1436	--
5.	Total Hours.....	2752	1652	1100	--	--
6.	Cases Terminated.....	275	--	115	160	--
7.	Cases Carried Over.....	46	--	30	16	--

* Of the total patients seen, 47 were prisoners from Ft. Madison.

The above figures are incomplete. During the next year, a standard statistical system will enable us to present statistics on a uniform basis.

OUT-PATIENT SERVICES

An active, adequate out-patient department is becoming increasingly important in the modern well-rounded mental health program. Significant in at least three phases, such services offer:

a. Diagnostic evaluation, referral, and/or treatment of out-patients not requiring institutional care.

b. Pre-admission evaluation.

c. Post-release follow-up care, and periodic check-up services.

In the past, the out-patient services in Iowa's mental health institutions have long provided some such service, and have at times examined patients without subsequently admitting them. However, the conviction has developed rather slowly that it would be better for some patients, and more economical generally, to provide treatment on an out-patient basis for some patients, rather than admit them for residential care.

Certainly, all patients can be discharged sooner if the hospital is able to offer continued treatment on an out-patient basis. This is particularly true since the adoption of modern drug therapies. While all institutions accept this philosophy, only now is it beginning actually to influence our operation.

Again, such a service requires personnel. Theoretically, it is wise to assign regular personnel to an out-patient schedule. However, with an overload of work in the residential treatment and care program, it is obvious that the instigation of a full-time out-patient service is practically impossible without augmentation of the staff.

LEGISLATIVE RECOMMENDATIONS

LEGISLATIVE RECOMMENDATIONS

The Board of Control will endeavor to have certain statutes amended, or sticken by the 1958 General Assemble. The purpose of each measure is self-explanatory.

In considering statutory changes, we agreed that:

a. Legislature should be sought to enable the Board of Control to accept and use research grants, and federal funds available for rehabilitation.

b. To set up a division of Mental Health and empower the director to administer such division under policies established by the Board of Control.

c. The ten or eleven chapters of the Code governing admission of patients should be re-coded, except for a few simple changes in language. However, such changes should not be made until careful research has been done, and the opinions of all interested persons sought. Therefore, the 1958 General Assembly should not be requested to change the legislation, but should be requested to set up a plan for a careful study of the existing laws and the needed changes. (The actual suggestions were submitted to Legislative Research Bureau and bills prepared.)

Legislation for implementing these changes:

1. An Act relating to the appointment, removal and responsibility of executive officers of institutions under the jurisdiction of the Board of Control.

2. An Act to provide for a Director of Mental Health and to specify his duties.

3. An Act to authorize the Board of Control to secure and pay consultants.

4. An Act to authorize the Board of Control to transfer employees from any institution under its jurisdiction to any other such institution at state expense.

5. An Act relating to the custody, pending appeal, of persons found by the commission of hospitalization to be mentally ill.

6. An Act to permit the transfer of inmates of the training school for boys to the Men's Reformatory.

7. An Act relating to voluntary mental illness patients and to the creation of a voluntary mental illness patient fund.

8. An Act to permit the transfer of patients from institutions under the jurisdiction of the Director of Mental Health to the Men's Reformatory.

9. An Act to authorize the Board of Control to accept and use gifts, grants, devises or bequests of real or personal property.

10. An Act relating to payment due the state from counties for mentally ill patients.

11. An Act to exempt employees of the Board of Control or in institutions under the Board of Control from the jurisdiction of the division of personnel.

12. An Act to repeal separate billing of clothing accounts from Woodward and Glenwood as it entails a considerable amount of bookkeeping in the counties and institutions.

13. An Act to make living accommodations optional in the institutions, and to provide cash in lieu of living accommodations.

14. An Act to strike certain objectionable terms from the several chapters of the Code relating to mental illness and to substitute modern terminology thereto.

ADMISSION AND SEPARATION PROCEDURES

TABLE NO: 33

A STUDY OF ADMISSIONS TO IOWA MENTAL HEALTH INSTITUTES

Comparison of Voluntary and Committed Entry

Period: July 1, 1957 - June 30, 1958

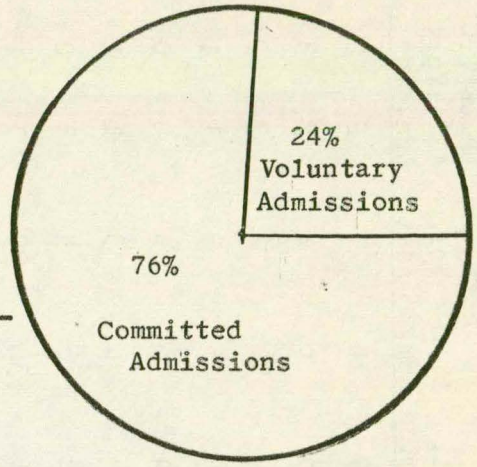
MONTH	TOTAL		CHEROKEE		CLARINDA		INDEPENDENCE		MT. PLEASANT	
	All Admits	Vol. Admits	All Admits	Vol. Admits	All Admits	Vol Admits	All Admits	Vol. Admits	All Admits	Vol. Admits
July 1957	217	56	43	14	40	6	94	32	40	4
August 1957	201	41	48	11	42	6	64	19	47	5
September 1957	212	49	40	8	43	10	78	23	51	8
October 1957	230	63	43	7	45	10	101	44	41	2
November 1957	226	52	60	13	54	6	68	29	44	4
December 1957	207	52	45	6	46	12	76	30	40	4
January 1958	252	53	34	10	63	10	113	33	42	0
February 1958	233	58	46	10	65	15	88	31	34	2
March 1958	264	61	43	7	*81	14	96	29	44	11
April 1958	289	74	61	14	*86	18	98	37	44	5
May 1958	224	57	55	12	58	17	75	22	36	6
June 1958	246	59	46	10	52	8	84	30	64	11
TOTAL	2801	675	564	122	675	132	1035	359	527	62
Percentage Voluntary Entry	24%		22%		20%		35%		12%	

* Increase in admissions at Clarinda was due to entry of patients from County Homes re-admitted to the institute for re-evaluation.

HOW A PATIENT MAY ENTER OUR
MENTAL HEALTH INSTITUTES

Four types of admission to a Mental Health Institute are available in Iowa

1. Voluntary Admission
2. Admission on Physician's Certificate
3. Commitment by Commission of Hospitalization
4. Court Commitment



MENTAL HEALTH INSTITUTE ADMISSIONS
During Fiscal Period Ending June 30, 1958

HOW A PATIENT MAY LEAVE THE MENTAL HEALTH INSTITUTE

1. By direct discharge to the community.

2. By discharge to other types of care:

   a. County Home.
   b. Nursing home.
   c. Veteran's Administration.
   d. Another state of legal settlement.
   e. To an institution other than mental.

3. By death.

4. By departure on provisional discharge (convalescent leave). These patients are retained on the institution's books until finally discharged.

5. On temporary visit. These patients remain on the institution's books, and have a specific date to return.

6. On unauthorized absence. These patients remain on the institution's books until or unless discharged from unauthorized absence.

7. Patients on provisional discharge, temporary visit, or unauthorized absence may be permanently separated from the institution's books by:

   a. Discharge to the community from leave of absence.
   b. Discharge to other facility for care.
   c. Death while on leave.

8. Patients may also be released from the institution on various types of legal action.

TABLE NO: 34

A STUDY OF ADMISSIONS TO IOWA SCHOOLS FOR MENTALLY RETARDED AND HOSPITAL FOR EPILEPTICS

Period: July 1, 1957 - June 30, 1958

Comparison of Voluntary and Committed Entries

MONTH	TOTAL		GLENWOOD RETARDED		WOODWARD TOTAL		WOODWARD RETARDED		WOODWARD EPILEPTIC	
	All Adm.	Vol. Adm.	All Adm.	Vol. Adm.	All Adm.	Vol. Adm.	All Adm.	Vol. Adm.	All Adm.	Vol. Adm.
July 1957	29	23	5	5	12	9	10	7	2	2
August 1957	27	17	9	7	9	5	6	2	3	3
September 1957	17	10	3	2	7	4	4	2	3	2
October 1957	21	14	9	6	6	4	5	3	1	1
November 1957	14	10	2	2	6	4	6	4	0	0
December 1957	13	9	3	1	5	4	4	3	1	1
January 1958	18	11	4	3	7	4	6	4	1	0
February 1958	75	67	5	5	**35	31	34	30	1	1
March 1958	227	184	3	2	**112	91	105	86	7	5
April 1958	37	28	9	8	14	10	14	10	0	0
May 1958	31	29	1	1	15	14	13	13	2	1
June 1958	49	33	11	7	19	13	18	13	1	0
TOTAL	558	435	64	49	247	193	225	177	22	16
Percentage Voluntary Entry	78%		77%		78%		79%		73%	

** Increase in admissions due to opening of new building.

HOW A PATIENT MAY ENTER OUR SCHOOLS

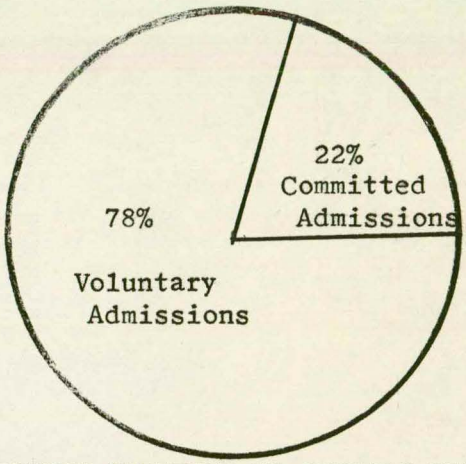
FOR MENTALLY RETARDED AND

HOSPITAL FOR EPILEPTICS

Two types of admission to a school for the mentally retarded and hospital for epileptics are available:

1. Voluntary admission upon application to the superintendent.

2. Court commitment.



PATIENTS ADMITTED TO SCHOOLS FOR RETARDED AND EPILEPTIC

Fiscal Period Ending June 30, 1958

HOW A PATIENT MAY LEAVE A SCHOOL FOR THE

MENTALLY RETARDED OR HOSPITAL FOR EPILEPTICS

Two types of separation are available:

1. Discharge to home, family care, or community.

2. Death.

Leaves of Absence:

1. A patient may depart on provisional discharge (convalescent leave);

2. A patient may depart on temporary visit with specific date due to return to the institution;

3. A patient may depart on unauthorized absence.

Discharges from leave of absence: A patient may be discharged while on leave of absence or on unauthorized absence to:

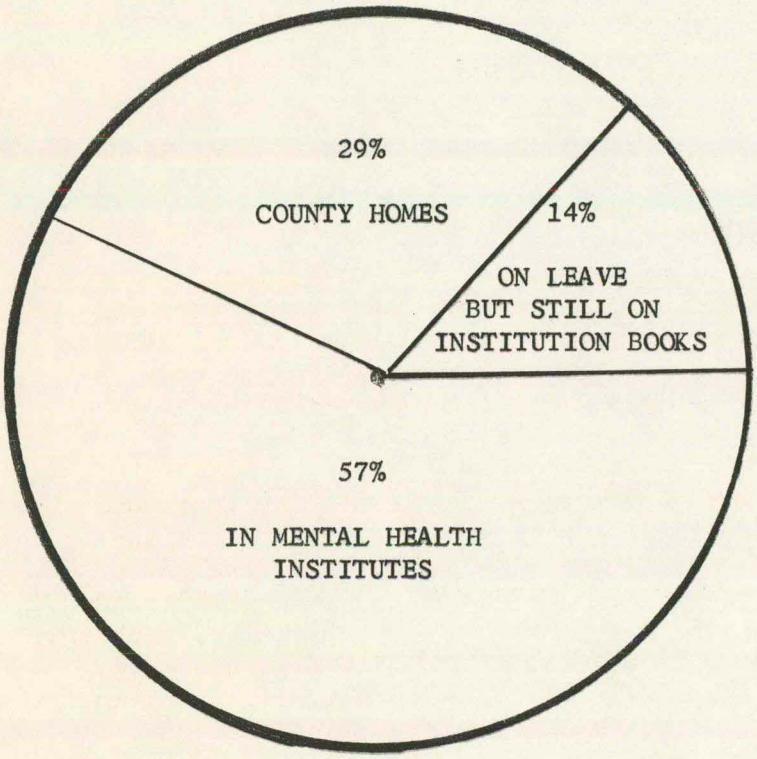
a. His home, family care, the community, or a county home.
b. To other facility.

MOVEMENT OF PATIENT POPULATION

TABLE NO: 35

MENTALLY ILL PATIENTS UNDER BOARD OF CONTROL JURISDICTION

at June 30, 1958



A total of 8270 patients were in institutional care or on provisional discharge (convalescent leave), on temporary visit, or unauthorized absence at the close of the fiscal year - June 30, 1958.

In residence in Mental Health Institutes	4720
In residence in County Homes	2400
On Convalescent Leave, Temporary Visit, or Escape	1150
TOTAL	8270

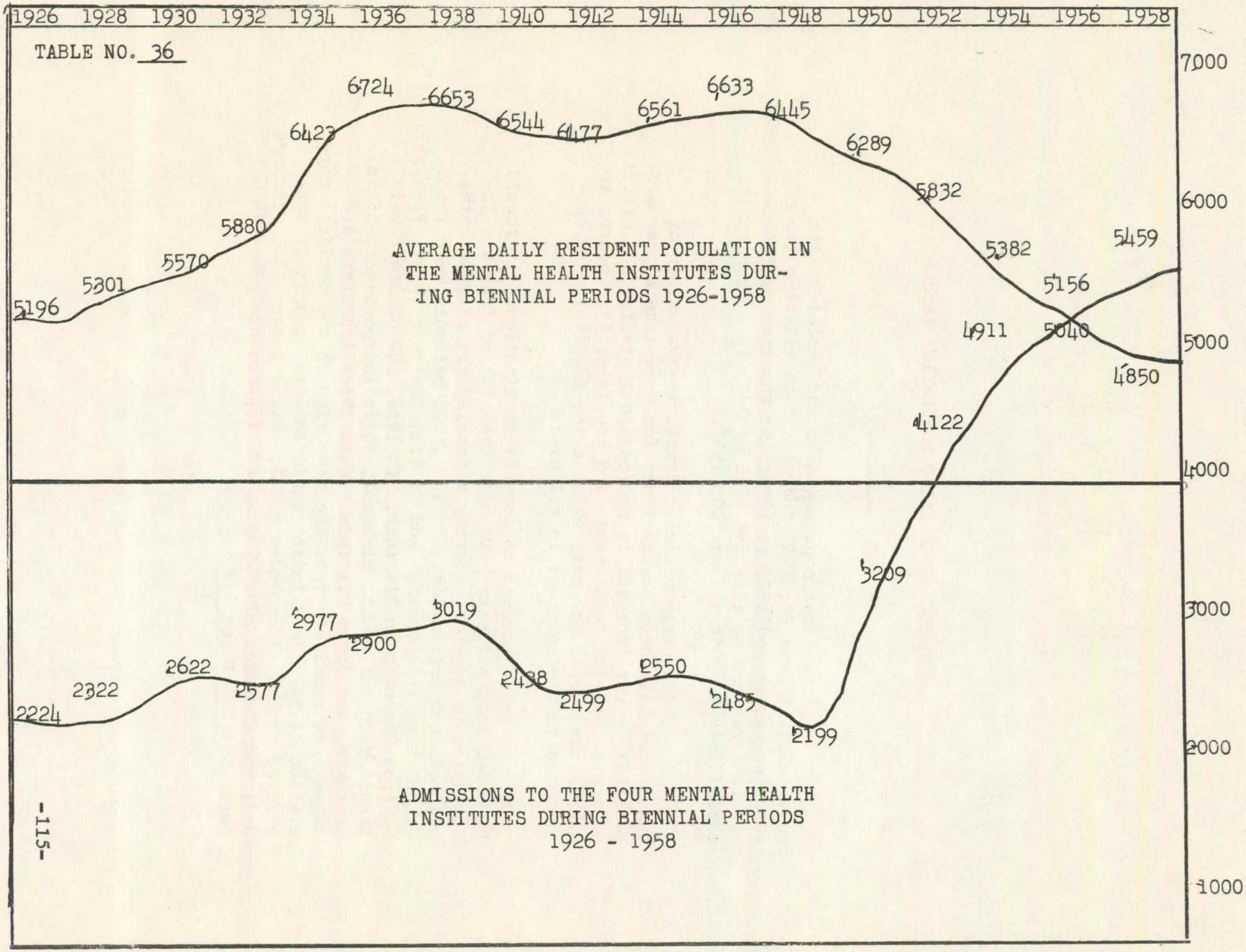
MOVEMENT OF PATIENT POPULATION TRENDS

The resident population in our Mental Health Institutes at June 30, 1958 dropped to an all-time low of 4850 for the period 1926 to 1958. At the same time, admissions reached an all-time high of 5459 for the biennial period July 1, 1956 to June 30, 1958.

Use of tranquilizing drugs, re-evaluation of cases that have been hospitalized for more than a year made possible by our increase in professional staffs, and efforts of social service departments and county welfare boards to make arrangements for care outside the hospital have contributed to the increase in releases.

In an attempt to compare institutions, it should be noted that patients have been transferred from one institution to another, thereby affecting the release rates and resident population: In 1951, 112 patients were transferred from Independence and 76 from Cherokee to Mt. Pleasant; 60 from Cherokee to Clarinda. In 1957, 100 patients were transferred out of Mt. Pleasant, 40 to Independence, 25 to Cherokee, and 35 to Clarinda. When these transfers are taken into consideration, the reduction in the resident population of each institution would be more accurately considered to be: Independence 533; Mt. Pleasant 436; Clarinda 349; and Cherokee 309. The actual figures are given in Table No. 39 Page: 119

TABLE NO. 36



AVERAGE DAILY RESIDENT POPULATION IN THE MENTAL HEALTH INSTITUTES DURING BIENNIAL PERIODS 1926-1958

ADMISSIONS TO THE FOUR MENTAL HEALTH INSTITUTES DURING BIENNIAL PERIODS 1926 - 1958

ADMISSION AND RESIDENT POPULATION TRENDS

Table 36 indicates the trends in resident population and admission rates. In 1926, with a resident population of 5196, admissions totaled 2224. In 1958, with 5459 admissions, or more than twice that in 1926, the resident population fell to an all-time low of 4850.

This indication of faster turnover of population, increase in number of patients treated, and a lower population resident in the institutions is evidence of effective treatment programs.

It is anticipated that our admission rates will increase sharply as active treatment becomes available, and as patients are seen early in their illness as a result of education of the public in respect to mental illness. This increase in admissions should be accompanied by a steady decrease in resident population.

TABLE:NO: 37

MOVEMENT OF PATIENT POPULATION IN IOWA
MENTAL HEALTH INSTITUTIONS
During the Ten-Year-Period: 1949-1958

	1949	1950	1951	1952	1953	1954	1955	1956	1957	1958
Av. Dly Population:										
All Institutions	9934	9559	9367	9277	9135	8925	8710	8505	8337	8216
Institutes Only	6450	6128	5860	5795	5577	5382	5235	5058	4912	4823
Schools Only	3484	3431	3507	3482	3558	3543	3475	3447	3425	3393
Cherokee	1641	1607	1463	1451	1392	1358	1338	1269	1247	1221
Clarinda	1571	1505	1464	1408	1312	1326	1325	1285	1307	1317
Independence	1709	1625	1490	1495	1455	1342	1217	1166	1115	1104
Mt. Pleasant	1529	1391	1443	1441	1418	1356	1355	1338	1243	1181
Glenwood	1820	1805	1876	1872	1886	1900	1840	1797	1776	1699
Woodward	1664	1626	1631	1610	1672	1643	1635	1650	1649	1694
Admissions:										
All Institutions	1769	2139	2577	2839	2758	2729	2703	2930	2845	3165
Institutes Only	1474	1705	2168	2442	2441	2470	2469	2686	2645	2851
Schools Only	295	434	409	397	317	259	234	244	200	314
Cherokee	346	414	470	563	546	579	619	615	566	565
Clarinda	444	388	496	573	568	595	642	695	643	720
Independence	330	558	543	863	903	821	755	876	977	1036
Mt. Pleasant	354	345	659	443	424	475	453	500	459	530
Glenwood	125	293	144	149	144	108	113	139	107	65
Woodward	170	141	265	248	173	151	121	105	93	249
*Separations:										
All Institutions	1932	2322	2260	2869	3131	3030	3021	3146	2875	3378
Institutes Only	1543	1954	1770	2495	2880	2663	2736	2894	2668	3154
Schools Only	389	368	490	374	251	367	285	252	207	224
Cherokee	384	546	471	564	627	596	654	662	590	637
Clarinda	442	375	450	619	761	487	683	765	549	862
Independence	380	495	411	808	1019	1012	973	941	1012	1126
Mt. Pleasant	337	538	438	504	473	568	426	526	517	529
Glenwood	217	239	151	156	115	137	139	167	125	136
Woodward	172	129	339	218	136	230	146	85	82	88

* Includes Deaths, Discharges and Out-Transfers

A STUDY OF DEATHS IN MENTAL HEALTH INSTITUTES
AND SCHOOLS FOR THE RETARDED DURING THE PERIOD

TABLE NO: 38

1949 - 1958

	1949	1950	1951	1952	1953	1954	1955	1956	1957	1958
Deaths:										
All Institutions	672	781	719	746	686	693	599	761	534	653
Institutes Only	561	630	624	612	585	603	522	668	455	545
Schools Only	111	151	95	134	101	90	77	93	79	108
Cherokee	148	144	122	118	132	123	115	142	94	100
Clarinda	148	201	164	155	168	187	179	251	155	201
Independence	135	129	166	160	149	134	125	126	122	125
Mt. Pleasant	130	156	172	179	136	159	103	149	84	119
Glenwood	39	84	35	48	48	36	32	55	44	45
Woodward	72	67	60	86	53	53	45	38	35	63
Percentage of Sep. Due to Death:										
All Institutions	34.8	33.6	31.8	26.0	21.9	22.9	19.8	24.2	18.6	19.3
Institutes Only	36.4	32.2	35.3	24.5	20.3	22.6	19.1	23.1	17.1	17.3
Schools Only	28.5	41.0	19.4	35.8	40.2	24.5	27.0	36.9	38.2	48.2
Cherokee	38.5	26.4	25.9	20.9	21.1	20.6	17.6	21.5	15.9	15.7
Clarinda	33.5	53.6	36.4	25.0	22.1	38.4	26.2	32.8	28.2	23.3
Independence	35.5	26.1	40.4	19.8	14.6	13.2	12.8	13.4	12.1	11.1
Mt. Pleasant	38.6	29.0	39.3	35.5	28.8	28.0	24.2	28.3	16.2	22.5
Glenwood	18.0	35.1	23.2	30.8	41.7	26.3	23.0	32.9	35.2	33.1
Woodward	41.9	51.9	17.7	39.4	39.0	23.5	30.8	44.7	42.7	71.6

TABLE NO: 39 MOVEMENT OF PATIENT POPULATION IN IOWA MENTAL HEALTH INSTITUTES
Period: July 1, 1957 - June 30, 1958

ITEM	GRAND TOTAL			CHEROKEE			CLARINDA			INDEPENDENCE			MT. PLEASANT		
	All	Male	Fe.	All	Male	Fe	All	Male	Fe	All	Male	Fe.	All	Male	Fe.
ON BOOKS 7/1/57.....															
Resident.....4935	2383	2552		1259	593	666	1329	573	756	1117	565	552	1230	652	578
On Leave or Absent W.O.L..1242	560	682		230	129	101	428	165	263	321	144	177	263	122	141
TOTAL ON BOOKS:.....6177	2943	3234		1489	722	767	1757	738	1019	1438	709	729	1493	774	719
ADMITTED DURING YEAR:															
First Admissions.....1356	851	505		334	201	133	241	150	91	516	329	187	265	171	94
Readmissions.....1474	758	716		227	109	118	476	233	243	514	274	240	257	142	115
In-Transfers from M.H.I... 21	9	12		4	1	3	3	1	2	6	4	2	8	3	5
TOTAL ADMISSIONS.....2851	1618	1233		565	311	254	720	384	336	1036	607	429	530	316	214
TOTAL ON BOOKS 6/30/58.....9028	4561	4467		2054	1033	1021	2477	1122	1355	2474	1316	1158	2023	1090	933
SEPARATIONS DURING PERIOD:															
Discharges from Hospital..1765	1034	731		363	188	175	392	223	169	771	456	315	239	167	72
Discharges from Leave..... 823	387	436		167	86	81	261	111	150	225	114	111	170	76	94
TOTAL DISCHARGES:.....2588	1421	1167		530	274	256	653	334	319	996	570	426	409	243	166
OUT-TRANSFERS TO M.H.I..... 21	9	12		7	3	4	8	3	5	5	2	3	1	1	0
DEATHS:															
Deaths in Hospital..... 512	292	220		95	53	42	191	101	90	116	71	45	110	67	43
Deaths on Leave of Absence. 33	17	16		5	3	2	10	4	6	9	3	6	9	7	2
TOTAL DEATHS..... 545	309	236		100	56	44	201	105	96	125	74	51	119	74	45
GRAND TOTAL SEPARATIONS....3154	1739	1415		637	333	304	862	442	420	1126	646	480	529	318	211
PATIENTS ON BOOKS END PD:															
Resident in Hospital.....4722	2284	2438		1162	551	611	1281	574	707	1105	566	539	1174	593	581
On Leave or Absent W.O.L..1152	538	614		255	149	106	334	106	228	243	104	139	320	179	141
TOTAL ON BOOKS END PERIOD: 5874	2822	3052		1417	700	717	1615	680	935	1348	670	678	1494	772	722
AVERAGE DAILY RES. POP:..	4853				1225			1328			1103			1197	

Definitions: First Admission: Patient admitted to the institution who has not previously been hospitalized in an institution for the treatment of mental illness anywhere.

Readmission: Patient who has previously been admitted to any institution for the treatment of mental illness anywhere and has been officially discharged.

Transfer: This term is limited to mean transfer of patients between Iowa Mental Health Institutes only. Patients going to county homes, nursing homes, or other care are classified as discharges when they leave; readmissions upon return.

TABLE NO: 40 MOVEMENT OF PATIENT POPULATION IN IOWA MENTAL HEALTH INSTITUTES
Period: July 1, 1956 - June 30, 1957

ITEM	GRAND TOTAL			CHEROKEE			CLARINDA			INDEPENDENCE			MT. PLEASANT		
	All	Male	Fe.	All	Male	Fe.	All	Male	Fe.	All	Male	Fe.	All	Male	Fe.
ON BOOKS 7/1/56:															
Resident	4982	2352	2630	1254	603	651	1287	573	714	1130	537	593	1311	639	672
On Leave or Absent W.O.L.	1218	558	660	259	138	121	376	165	211	343	138	205	240	117	123
TOTAL ON BOOKS 7/1/56	6200	2910	3290	1513	741	772	1663	738	925	1473	675	798	1551	756	795
ADMITTED DURING PERIOD:															
First Admissions	1266	768	498	315	203	112	232	126	106	492	295	197	227	144	83
Readmissions	1273	670	603	225	118	107	374	169	205	443	266	177	231	117	114
In Transfers from M.H.I.	106	2	104	26	1	25	37	1	36	42	0	42	1	0	1
TOTAL ADMISSIONS	2645	1440	1205	566	322	244	643	296	347	977	561	416	459	261	198
TOTAL ON BOOKS:	8845	4350	4495	2079	1063	1016	2306	1034	1272	2450	1236	1214	2010	1017	993
SEPARATIONS DURING PERIOD:															
DISCHARGES:															
From Hospital	1240	729	511	271	161	110	250	144	106	555	325	230	164	99	65
From Leave	867	427	440	220	124	96	143	73	70	335	132	203	169	98	71
TOTAL DISCHARGES:	2107	1156	951	491	285	206	393	217	176	890	457	433	333	197	136
TOTAL OUT TRANSFERS TO M.H.I.	106	2	104	5	1	4	1	1	0	0	0	0	100	0	100
DEATHS:															
Deaths in Hospital	418	226	192	91	54	37	146	71	75	102	58	44	79	43	36
Deaths While on Leave	37	23	14	3	1	2	9	7	2	20	12	8	5	3	2
TOTAL DEATHS:	455	249	206	94	55	39	155	78	77	122	70	52	84	46	38
GRAND TOTAL SEPARATIONS:	2668	1407	1261	590	341	249	549	296	253	1012	527	485	517	243	274
ON BOOKS END OF PERIOD:															
Resident in Hospital	4935	2383	2552	1259	593	666	1329	573	756	1117	565	552	1230	652	578
On Conv. Leave	1160	516	644	220	123	97	411	159	252	270	116	154	259	118	141
On Temporary Visit	54	23	31	6	2	4	8	1	7	40	20	20	0	0	0
Otherwise Absent	28	21	7	4	4	0	9	5	4	11	8	3	4	4	0
TOTAL ON BOOKS AT 6/30/57	6177	2943	3234	1489	722	767	1757	738	1019	1438	709	729	1493	774	719
AVERAGE DAILY RES. POP:		4912			1247			1307			1115			1243	

Definitions:

First Admission: Patient admitted to the institution who has not previously been hospitalized in an institution for the treatment of mentall illness anywhere.

Readmission: Patient who has previously been admitted to an institution for the treatment of mental illness anywhere and has been officially discharged.

Transfers: Between Mental Health Institutes only.

TABLE NO: 41

MOVEMENT OF PATIENT POPULATION IN SCHOOLS FOR THE RETARDED AND HOSPITAL FOR EPILEPTICS - Period: 7/1/57-6/30/58

ITEM	RETARDED & EPIL. GRAND TOTAL			RETARDED TOTAL		GLENWOOD RETARDED		WOODWARD TOTAL		WOODWARD RETARDED		WOODWARD EPIL.	
	Total	Male	Fe.	Male	Fe	Male	Fe.	Male	Fe.	Male	Fe.	Male	Fe.
PATIENTS ON BOOKS 7/1/57:													
Resident in Institution	3404	1853	1551	1649	1333	959	744	894	807	690	589	204	218
On Leave of Absence	262	114	148	103	134	78	110	36	38	25	24	11	14
TOTAL ON BOOKS BEGINNING OF PERIOD:	3666	1967	1699	1752	1467	1037	854	930	845	715	613	215	232
ADMISSIONS DURING PERIOD:													
First Admissions	274	157	117	148	112	23	25	134	92	125	87	9	5
Readmissions	38	22	16	21	12	10	7	12	9	11	5	1	4
In-Transfers	2	1	1	1	1	0	0	1	1	1	1	0	0
TOTAL ADMISSIONS:	314	180	134	170	125	33	32	147	102	137	93	10	9
TOTAL ON BOOKS THIS PERIOD:	3980	2147	1833	1922	1592	1070	886	1077	947	852	706	225	241
SEPARATIONS DURING PERIOD:													
DISCHARGES:													
From Institution	33	16	17	15	14	10	7	6	10	5	7	1	3
From Leave of Absence	81	40	41	37	40	34	38	6	3	3	2	3	1
TOTAL DISCHARGES:	114	56	58	52	54	44	45	12	13	8	9	4	4
DEATHS:													
In Institution	107	55	52	46	43	24	20	31	32	22	23	9	9
While on Leave of Absence	1	0	1	0	1	0	1	0	0	0	0	0	0
TOTAL DEATHS:	108	55	53	46	44	24	21	31	32	22	23	9	9
TOTAL OUT-TRANSFERS:	2	1	1	1	1	1	1	0	0	0	0	0	0
GRAND TOTAL SEPARATIONS	224	112	112	99	99	69	67	43	45	30	32	13	13
ON BOOKS END OF PERIOD: 6/30/58													
In residence in institutions	3340	1825	1515	1631	1314	875	699	950	816	756	615	194	201
On Leave of Absence	416	210	206	192	179	126	120	84	86	66	59	18	27
TOTAL ON BOOKS END OF PERIOD:	3756	2035	1721	1823	1493	1001	819	1034	902	822	674	212	228

Definitions:

First Admissions: A patient admitted to the institution who has not previously been hospitalized anywhere in any institution for the treatment and care of the retarded or epileptic.

Readmission: A patient admitted to the institution who has previously been hospitalized somewhere in an institution for the treatment and care of the retarded or epileptic.

Transfers: Between Iowa Schools and Hospitals for the Retarded and Epileptic only.

TABLE NO: 42 MOVEMENT OF PATIENT POPULATION IN SCHOOLS FOR THE RETARDED AND HOSPITAL FOR EPILEPTICS - Period: 7/1/56-6/30/57

ITEM	GRAND TOTAL RETARDED & EPIL.			TOTAL RETARDED		GLENWOOD RETARDED		WOODWARD TOTAL		WOODWARD RETARDED		WOODWARD EPILEPTIC	
	Total	Male	Fe.	Male	Fe.	Male	Fe.	Male	Fe.	Male	Fe.	Male	Fe.
PATIENTS ON BOOKS 7/1/56:													
Resident in Institution	3458	1879	1579	1661	1359	991	793	888	786	670	566	218	220
On Leave of Absence	215	81	134	69	117	47	78	34	56	22	39	12	17
TOTAL ON BOOKS BEGINNING OF PERIOD:	3673	1960	1713	1730	1476	1038	871	922	842	692	605	230	237
ADMISSIONS DURING THE PERIOD:													
First Admissions	180	97	83	89	75	54	42	43	41	35	33	8	8
Readmissions	20	14	6	13	5	7	4	7	2	6	1	1	1
In-Transfers	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL ADMISSIONS:	200	111	89	102	80	61	46	50	43	41	34	9	9
TOTAL ON THE BOOKS THIS PERIOD:	3873	2071	1802	1832	1556	1099	917	972	885	733	639	239	246
SEPARATIONS DURING PERIOD:													
DISCHARGES:													
From Institution	31	17	14	12	12	9	6	8	8	3	6	5	2
From Leave of Absence	97	51	46	42	39	36	30	15	16	6	9	9	7
TOTAL DISCHARGES:	128	68	60	54	51	45	36	23	24	9	15	14	9
DEATHS DURING PERIOD:													
In Institution	78	36	42	26	38	17	27	19	15	9	11	10	4
While on Leave of Absence	1	0	1	0	0	0	0	0	1	0	0	0	1
TOTAL DEATHS:	79	36	43	26	38	17	27	19	16	9	11	10	5
OUT TRANSFERS:	0	0	0	0	0	0	0	0	0	0	0	0	0
GRAND TOTAL SEPARATIONS:	207	104	103	80	89	62	63	42	40	18	26	24	14
ON BOOKS END OF PERIOD: 6/30/57													
Resident in Institution	3404	1853	1551	1649	1333	959	744	894	807	690	589	204	218
On Leave of Absent or Absent W.O.L.	262	114	148	103	134	78	110	36	38	25	24	11	14
TOTAL ON BOOKS END OF PERIOD:	3666	1967	1699	1752	1467	1037	854	930	845	715	613	215	232

Definitions:

First Admissions: A patient admitted to the institution who has not previously been hospitalized anywhere in any institution for the treatment and care of the retarded or epileptic.

Readmission: A patient admitted to the institution who has previously been hospitalized somewhere in an institution for the treatment and care of the retarded or epileptic.

Transfer: Between Iowa Schools and Hospitals for the Retarded and Epileptic only.

MOST NEW PATIENTS DO NOT STAY LONG

The best chances of release come in the first six to 11 months after admission. Those patients who remain continuously hospitalized for several years become part of the large group of long term care patients who make up one of our hospitals' major problems. As with releases, relatively few deaths occur after the first year. Many of the patients admitted are very old and some are in poor physical condition as well, so that about one in every seven patients admitted die within the first three months after admission.

Younger patients have a better chance of release than older patients.

In a special cohort study, it was found that within six months after admission, more than half of the first admissions under age 45 had been released. Almost half of those aged 45-54 and more than one-third of those aged 55-56 had also been released within this period of time. Very few patients over 65 had been released within six months, although more of those aged 65-74 were released than was true of the oldest patients.

By the end of two years following admission, the proportion released ranged from over 80 percent of those admitted when under 25 years of age down to less than seven percent of those aged 85 or over.

Most of the patients in the older groups die within the first year or so after admission, but among the younger patients, those who are not released by the end of the first year stay on in the hospital with less and less likelihood of release.

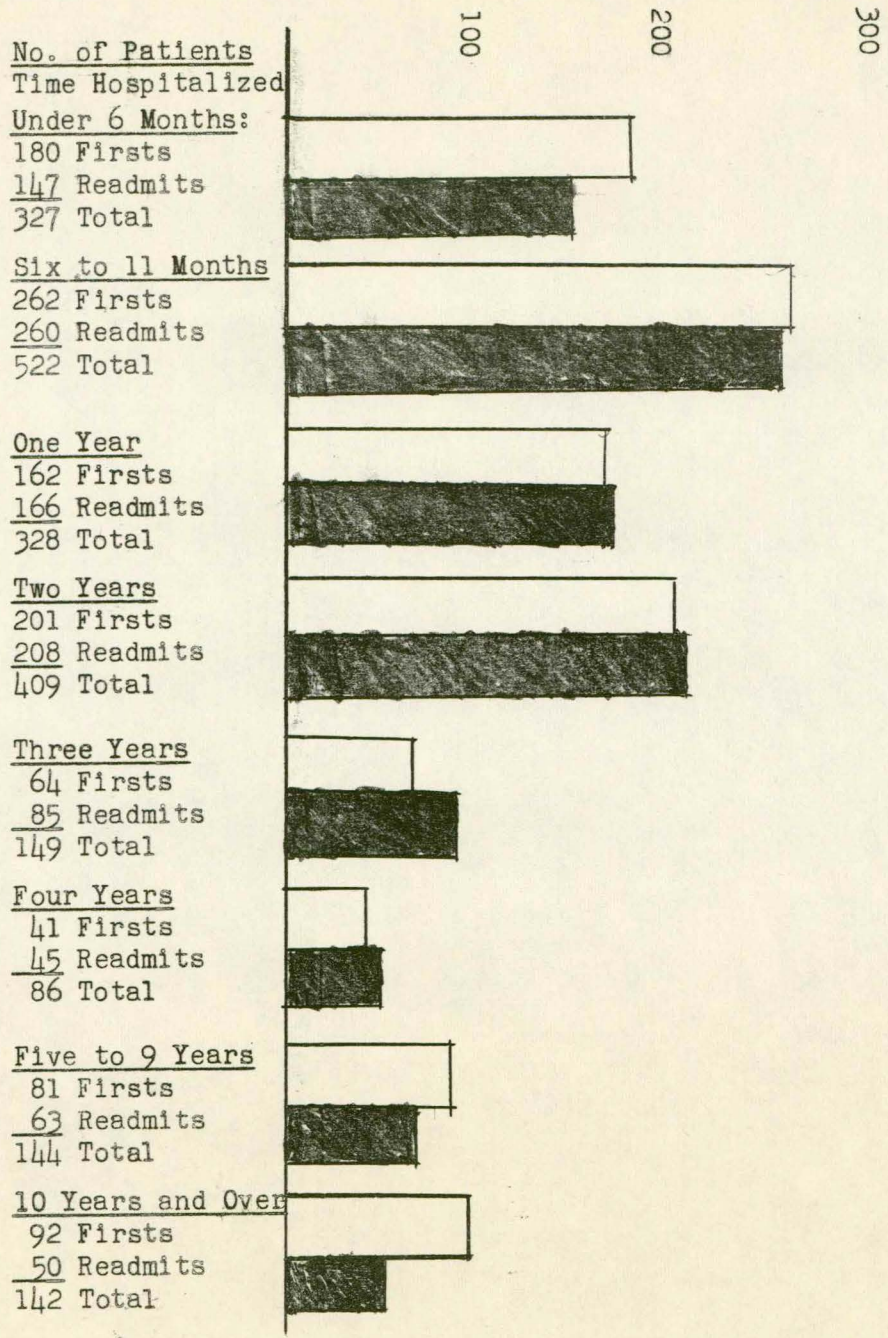


TABLE NO:43

PATIENTS ENTERING THE HOSPITAL AS FIRST AND READMISSIONS DISCHARGED DURING THE FISCAL PERIOD, CLASSIFIED BY TYPE OF ADMISSION AND NET PERIOD OF HOSPITALIZATION.

Period: 7/1/56 - 6/30/57

Shaded Bar: Readmissions

Unshaded Bar: First Admissions