

"Something Must Be Done for Them"

Establishing Minnesota's First Hospital for the Insane

William D. Erickson

Between 1850 and 1865 the population of Minnesota rose from about 6,000 non-Indian settlers to more than 250,000 of many nationalities, trades, and interests. Among them were men, women, and children with a wide variety of mental and emotional handicaps. Some had been brought to the new territory by their families, some arrived alone. The pioneer experience itself yielded many casualties. One early study, for example, showed that Norwegian immigrants to Minnesota suffered

from a variety of physical and emotional disorders more often and more severely than they had in their homeland. They became insane three times as frequently as in Norway.'

'Patricia C. Harpole and Mary D. Nagle, eds., *Minnesota Territorial Census, 1850* (St. Paul: Minnesota Historical Society [MHS], 1972), viii; Minnesota Secretary of State, *Annual Report, 1865*, 83; Ch. Gronvald, "The Effects of the Immigration on the Norwegian Immigrants," in State Board of Health, *Sixth Annual Report* (1878), 29-31.

This article is based on the author's longer work, *This Great Charity: Minnesota's First Mental Hospital at St. Peter, Minn., 1866-1991*.

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Minnesota Hospital for Insane, its outbuildings and grounds in St. Peter, about 1910

In this new land there were no means for their care beyond friends and families. Most disturbed persons stayed in their own homes. The well-to-do might hire private attendants or send the afflicted family member back East to a private asylum. The less affluent gathered friends and relatives to sit with the stricken one. Those who became acutely violent were tied up or locked in secluded rooms until they calmed. Chronically violent men and women were often confined with shackles. It is no wonder that an early report concluded, "The history of all our states shows that the first great charity demanding legislative action is the proper accommodation for the safety and medical treatment of the insane."²

The mentally ill became a matter of concern if they were paupers or dangerous to the public. But in the fluid situation of massive immigration into unbroken territory, there were neither the organization, funds, nor inclination to invest large amounts in new facilities for the poor and helpless. In 1849 the first territorial legislature had provided for the guardianship of insane persons—at least for those with property to protect and money to pay the guardians.³

Once a county was organized, a variety of arrangements were made for the care of paupers, including the pauper insane. As late as 1884, only twenty-four counties in Minnesota, less than one-third, actually maintained poorhouses. In most instances, poormasters were hired or contracts were put up for bid, the responsibility being awarded to the individual who proposed to carry out the task for the least amount of money. Nicollet County's first poormaster, for instance, was Almon C. Door, who contracted for an annual salary

of \$500. His successor, Josiah Horner, struck a better deal, getting \$300 per year to care for Napoleon Brisbo, "a lunatic and pauper," and \$144 per year for any additional paupers he took in.⁴

Almshouses and poor farms mingled mentally defective and "lunatic" persons who were quiet and cooperative with other clients. Local jails provided emergency confinement for new cases, for individuals who had become disruptive, or for those who were beyond the control of their guardians. Until 1901 county sheriffs had the authority to jail anyone turned over to them for any reason by a lawful authority. Inmates who calmed were returned to their previous placement. If they did not, these unfortunates might stay in jail for months or years. County jails still served as holding places for acute cases of insanity for decades after a state hospital opened in 1866. In an 1884 report, the state board of corrections and charities described the continuing mistreatment of the insane in Minnesota's county jails.⁵

The failure of counties to provide adequately for their indigent insane had been the crux of Dorothea Lynde Dix's national campaign for the establishment of state-run facilities. A single county rarely had either the number of insane or the assets to provide more than a jail cell, a locked room, or chains. After seeing the insane inmates of the East Cambridge, Massachusetts, jail in 1841, Dix launched a determined effort to shift responsibility for the care of the insane into the hands of state and federal government. After successful confrontations with the legislatures of Massachusetts, Rhode Island, and New Jersey, she journeyed westward, eventually reaching every state east of the

²List of patients, with diagnoses and dates of admission and discharge, attached to p. 21 of Minnesota Hospital for Insane casebook 1, St. Peter Regional Treatment Center Archives, St. Peter, hereafter cited as patient list, St. Peter Archives; Minnesota Hospital for Insane, *First Annual Report, 1867*, [3].

³Minnesota Territory, *Acts, Joint Resolutions and Memorials Passed by the First Legislative Assembly . . . 1849*, 72-74.

⁴State Board of Corrections and Charities, *First Biennial Report* (1884), 30, 175; *Saint Peter Tribune*, Mar. 31, 1866; William G. Gresham, *History of Nicollet and LeSueur Counties, Minnesota* (Indianapolis: B. F. Bowen, 1916), 1:91-92.

Lunatic referred to mental instability, with symptoms that waxed and waned like the phases of the moon. *Insane* always implied loss of control requiring confinement. One could be a lunatic without being insane.

⁵Corrections and Charities, *First Biennial Report*, 72-73, 135-236. Minnesota, *General Laws, 1858*, 270, formally authorized the common practice of housing insane persons in jails; it was banned, "except in case of absolute necessity," by *General Laws, 1901*, 475. The confinement of children in county jails was permitted until 1895; *General Laws, 1895*, 347.

Douglas County jail, Alexandria, 1876: a small, dark lockup in a pastoral setting.



Rockies with a ringing demand for new and better state hospitals."

In 1848 Dix first appealed to Congress for federal funding of state facilities for the insane. She reported seeing "more than nine thousand idiots, epileptics, and insane in these United States, destitute of appropriate care and protection . . . bound with galling chains, bowed beneath fetters and heavy iron balls, attached to drag-chains, lacerated with ropes, scourged with rods, and terrified beneath storms of profane execrations and cruel blows; now subject to jibes, and scorn, and torturing tricks—now abandoned to the most loathsome necessities or subject to the vilest and most outrageous violations."

After considerable debate, delay, and reapplication, both houses of Congress passed a bill in 1854 authorizing the sale of public lands to fund the building of hospitals for the insane, but President Franklin Pierce vetoed it. There was no dispute that the insane needed better care than they were receiving at the hands of county poormasters. States-rights advocates insisted, however, that this act exceeded the authority of the federal government. President Pierce feared that the law would shift responsibility for all welfare payments away from state and local authorities and into the lap of Congress. With his veto, responsibility for the insane settled firmly and for the next century on the individual states.⁵

BY THE TIME Minnesota began to grapple with the problem of the pauper insane, it was clear that primary responsibility would rest with the state rather than individual counties. Also clear was the probable form and function of the institution that should be built. While Dorothea Dix's campaign had dramatically stimulated a shift to state responsibility, years of pressure and testimony by doctors finally led people to view care as a medical—not charitable—endeavor. French law formalized that shift in 1838. Three years later New York passed the first American act requiring medical testimony at the time of commitment to a state facility. It also required medical leadership of that institution.⁶

The Association of Medical Superintendents of American Institutions for the Insane (AMSII) was founded in Utica, New York, in 1844 by thirteen physicians, eight of them superintendents of public institutions for the insane, the others of private facilities. This group quickly became the sole source of advice on the construction, management, and probable success of hospitals and asylums. Historians Gerald Grob and David Rothman have attributed the growth of the state-hospital movement to the instability and lack of permanent leadership of state governments at the time, to the prevalence of inaccurate information about men-



Dorothea Lynde Dix

tal illness, and to AMSII's vigorous self-promotion. State legislators were inexperienced and vulnerable to poor advice, which they got in great quantities on a wide range of topics. AMSII offered the promise of dramatic cure rates for previously incurable mental disorders—if hospitals were provided.¹⁰

Once state asylums were available, the pauper insane and those without families often ended up in them. In contrast to the small, well-run, successful private asylums that served as models for effective treatment, state facilities routinely suffered from the inabil-

⁵On Dix, see Albert Deutsch, *The Mentally Ill in America; A History of Their Care and Treatment From Colonial Times* (New York: Columbia University Press, 1949), 159–85.

⁶U.S. Senate, *Memorial of D. L. Dix . . . June 27, 1848*, 30th Cong., 1st sess., Misc. Doc. 150 (Serial 511), 7.

⁷Deutsch, *Mentally Ill in America*, 178.

⁸For a detailed history of the Utica, N.Y., asylum that served as a national model of design and administration, see Ellen Dwyer, *Homes for the Mad: Life Inside Two Nineteenth-Century Asylums* (New Brunswick, N.J.: Rutgers University Press, 1987).

¹⁰Gerald Grob, *Mental Institutions in America: Social Policy to 1875* (New York: Free Press, 1972), 115–30; David J. Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (New York: Little, Brown, 1990), 130–54. AMSII eventually became the American Psychiatric Association.

ity to screen admissions or control their numbers. They also struggled with chronic staffing problems and the vagaries of legislatures with many other demands for their funds. Nonetheless, state-run hospitals—or asylums, as they were more frequently called—initially cared for the insane in a manner far more humane and satisfactory than could most counties, especially in frontier areas. State after state in the Midwest and South made major financial commitments to large mental hospitals, constructed usually within a decade of achieving statehood or soon after the first population boom. Despite medical advice, medical names, and medical superintendents, these undertakings were charitable, not medical, enterprises. The Minnesota dialogue about establishing a state hospital consistently referred to it as “this great charity.”¹¹

IN 1862 Minnesota authorities began to look for a place to send the increasing number of insane persons who were gradually filling county poor farms and jails, especially in and around St. Paul. The legislature at first resisted the idea of building an asylum, arguing that the number of cases was small and could be handled more economically by paying for care at an established institution in an older state. Such interstate arrangements were common in this era, as was significant underestimation of the prevalence of mental illness. In addition, it was difficult to predict the rate of population growth and thus the likely increase in need. Medical professionals believed that the frequency of insanity in new areas was less than half that of the older, New England states. In 1864 R. J. Patterson, superintendent of the Iowa asylum, cited a ratio of 1 insane individual for every 1,300 persons nationwide, and 1 to 672 in New England.¹²

¹¹Grob, *Mental Institutions*, 373–95; Minnesota Hospital for Insane, *First Annual Report*, [3].

¹²Iowa Hospital for the Insane, *Second Biennial Report . . . 1863*, 25–26; R. J. Patterson to Stephen Miller, Dec. 10, 1864, Southern Minnesota Historical Archives (SMHA), Mankato State University, Mankato.

¹³Patient list, St. Peter Archives. The Minnesota hospital took in patients from Dakota Territory from 1873 to 1877; see Herbert S. Schell, *History of South Dakota* (Lincoln: University of Nebraska Press, 1961), 200, and A. LaBerge, “History of the Yankton State Hospital, 1878–1973” (M.A. thesis, University of South Dakota, 1974).

¹⁴Patterson to Ramsey, Sept. 20, 1862, SMHA; Minnesota Hospital, *First Annual Report*, [3]–4; Minnesota, *General Laws*, 1863, 41–42.

¹⁵Patient list, St. Peter Archives; official letters and communications of the Secretary of State, Book 1, Notice of April 12, 1863, p. 44, copy, SMHA; Minnesota, *General Laws*, 1863, 45.

¹⁶Ranney to Marshall, Mar. 27, 1866, SMHA.

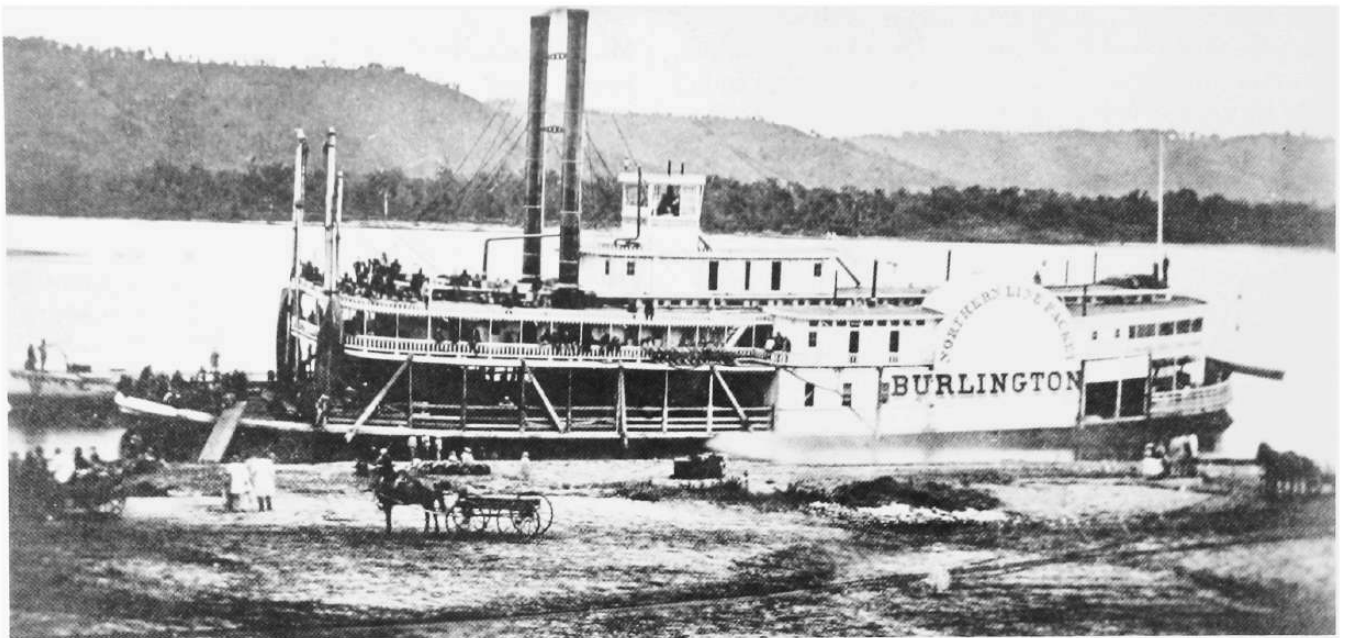
Iowa authorities had made the same mistake of underestimation. They at first placed patients in hospitals in Missouri, but local demands forced out the Iowa residents. In 1861 Iowa officials opened a hospital in Mt. Pleasant. This facility, in turn, took in a total of fifty-five patients from Minnesota, until the need for space forced their return in 1866 and the construction of the Minnesota State Hospital for Insane.¹³

In 1862, however, Superintendent Patterson told a legislative commission headed by Minnesota Governor Alexander Ramsey that Mt. Pleasant could accommodate a small number of Minnesotans. Ramsey agreed to send patients there at a per capita cost of \$4.75 a week. A front-page notice in the *St. Paul Daily Press* on October 19, 1862, instructed counties, towns, and individuals who wished to have someone admitted to the Iowa hospital to write to the Minnesota secretary of state, giving the details of the case. In March of 1863 the legislature passed a bill authorizing the governor to transport patients to Iowa and to pay up to two thousand dollars for the care of no more than twenty-five Minnesota residents.¹⁴

When the secretary of state accumulated a group of requests, he instructed those responsible to bring their charges to St. Paul or to a river point on the way to Iowa, along with a year's supply of clothing. The journey by steamboat took three to five days. By the time the legislature authorized the relationship with the Iowa hospital, ten patients had already been sent, including six who arrived overland from St. Paul on December 6, 1862. Another group was gathered in April of the following year, intending to sail on a Northern Line steamship on April 20. They embarked on April 22, with the patients in the charge of the Ramsey County sheriff. The assistant secretary of state accompanied them as far as Wabasha, where the last patient was taken aboard. They arrived at Mt. Pleasant on April 27, 1863.¹⁵

In March of 1866 the new Iowa superintendent, Dr. Ranney, notified Minnesota's new governor, William R. Marshall, that all Minnesota residents must be removed as soon as the coming fall. The capacity at Mt. Pleasant was 300 patients, and the census was 280, with all male beds filled. Iowa would accept no more patients “excepting recent acute cases.”¹⁶

Governor Marshall thus began to search elsewhere. He contacted the National Hospital for the Insane in Washington, D.C., inquiring if patients whose insanity was linked to their military service might be admitted. This request was declined on grounds that the illnesses were not adequately service connected: “The Act of Congress of March 3, 1855 confers [the privilege of admission] upon the insane of the army and navy and upon the indigent insane of the District of Columbia. . . . When the cause of insanity originated



Northern Line steamship Burlington at the St. Paul levee, about 1865

Governor William R. Marshall



in disease contracted during service in the army, but the insanity did not develop itself until after discharge from the service, it is held that such patients are not entitled to admission." R. J. Patterson, by then medical superintendent of the insane department of the Cook County hospital in Chicago, refused to recommend that institution. He did, however, offer to move to Minnesota and assume the care of all female insane patients "under a private contract."¹⁷

Eventually, St. Vincent's Institution for the Insane in St. Louis agreed to accept patients from Minnesota. This private hospital was run by the sisters of St. Vincent DePaul, an order devoted to the care of the insane. The cost was to be six dollars per week. Seven patients were sent there, the last four eventually returning to Minnesota on September 7, 1869.¹⁸

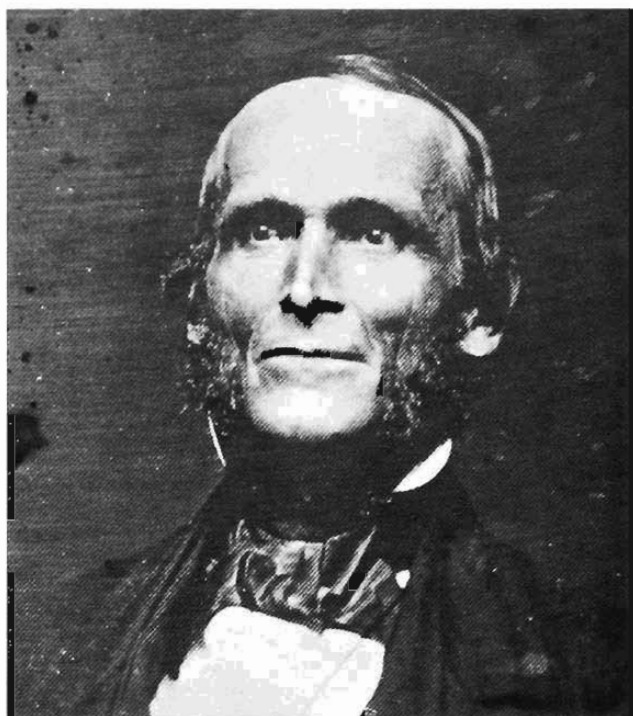
IN JANUARY 1864 Dr. Patterson, then superintendent at Mt. Pleasant, had written to St. Paul doctor Saul Willey, inquiring what Minnesota intended to do about founding a hospital of its own. Willey passed the letter on to Governor Marshall, who had made the establishment of charitable facilities a priority of his administration. The governor wrote Patterson, asking for infor-

¹⁷Downfeud to Marshall, Mar. 19, 1866, and Patterson to Miller, Nov. 26, 1866, both SMHA.

¹⁸Minnesota Hospital, *First Annual Report*, 4, and *Third Annual Report*, 1869, 22.



Henry A. Swift



Orrin Densmore

mation regarding the ideal location, design, and cost of an insane hospital for Minnesota.¹⁹

Patterson replied in great detail. His recommendations were carried out practically to the letter, essentially replicating the Iowa hospital down to the exterior design. His comments about expenses proved surprisingly accurate. He quoted the cost of the Iowa building at \$359,606.72 and estimated the cost of several other recently built facilities in Pennsylvania, the District of Columbia, and Cincinnati at between \$352,000 and \$450,000. (The Minnesota building was eventually completed for \$511,462.) While Patterson's letter appears to have been quite spontaneous, his recommendations were nearly verbatim transcriptions of AMSAII position papers on the topic.²⁰

At the urging of Governor Marshall, the 1866 legislature passed a bill ordering the establishment of a hospital for the insane in Minnesota, to be under the control of a board of trustees and directed by a physician. A committee would choose the site from those proposed by interested communities, each of which had to provide at least twenty acres. A temporary facility would

be used until the permanent building could be constructed. Marshall initially appointed as trustees three physicians, S. D. Flagg, Solomon Blood, and Luke Miller; Rochester banker and state senator John V. Daniels; former governor Henry A. Swift of St. Peter; Red Wing businessman Orrin Densmore; and Hastings merchant-banker John L. Thorne. These men decided at their first meeting, April 5, 1866, that the temporary and permanent sites should be in the same community. They then postponed selection of the temporary location until they heard the decision of the permanent site-selection committee.²¹

A number of communities responded to the search committee. Nininger, a rapidly dying town in Dakota County, lobbied long and hard for its site, a wooden building thirty-six by forty feet. Trustee Densmore suggested that a newly constructed but unoccupied University of Minnesota building in St. Anthony be used. Regent John S. Pillsbury vehemently opposed this proposal. While the building in question was not yet in use, Pillsbury argued that the original intent should be honored, rather than turn a center of higher learning into the state's insane asylum. St. Paul offered a set of three buildings, and a building on a private farm was also offered. Wabasha put forth land; Mankato tendered the required twenty acres and a hotel at South Bend that could be used for a temporary site. The energetic Densmore also proposed using land in his home town of Red Wing and a hotel in nearby Wacouta. The

¹⁹Patterson to Willey, Jan. 7, 1864, SMHA.

²⁰Patterson to Miller, Dec. 10, 1864, including a photograph of the Iowa hospital, SMHA; State Auditor, *Annual Report for 1877*, 107. The AMSAII position is reported in *Minnesota Hospital, First Annual Report*, 33-35.

²¹Minnesota, *General Laws, 1866*, 10-21; Minnesota Hospital, *First Annual Report*, 4-5.

St. Peter town council extended a generally worded pledge for the required land on April 5.²²

By late May it seemed to Daniels, president of the board of trustees, that Red Wing was the most likely permanent site, with the Wacouta hotel serving as a temporary facility. Dr. Patterson, who was serving as a consultant to the site-selection committee, also favored the Wacouta arrangement. Dr. William Lincoln of Wabasha, apparently an acquaintance of the governor but an outspoken critic of the legislature, sought the post of superintendent. Daniels's feeling on this was, "We shall see."²³

On May 10 the St. Peter group made a formal offer of the 210.9-acre Dorrington farm and an empty hotel, the Ewing House. For some reason, the selection committee made no public comment on this offer until the end of June. The governor, however, received an undated, unsigned, penciled memo that began, "I am in favor of St. Peter Because" and listed the advantages of that site. On July 1 the committee filed its report naming St. Peter. Soon thereafter the trustees published an announcement, which was dated June 30, in the *St. Paul Daily Press*.²⁴

At that point the land had been promised but not actually purchased. Former trustee Henry Swift (he had resigned before the first meeting in April) wrote from St. Peter on July 5, "We will deliver a good and sufficient deed of the tract selected at an early day—as soon as we can collect the money and communicate with the owner, Mr. Dorrington, now in Pittsburg [sic], Penna." The deed was finally delivered on September 12.²⁵

The committee's reasons for selecting St. Peter included the large, attractive site with a good view of the river valley and protection by the bluffs to the west, and the "living stream of water that by its own elevation could be carried to the upper stories of the hospital." There were springs and a lake, as well, and a quarry less than half a mile away. The site had good surface drainage and "an abundant and cheap supply of wood . . . in the Big Woods." Also, Minnesota authorities had agreed to locate public institutions throughout the state, and St. Paul, Faribault, and Winona each already had one.²⁶

The committee acknowledged that some felt that St. Peter was too far west. But settlement was proceeding westward at an increasing rate. Besides that, two railroad lines were already being built in the direction of St. Peter: the Minnesota Valley line and the Winona and St. Peter.

In their announcement, the committeemen made one ill-fated speculation, unsupported by the beliefs of the time and quite inadequate as a prediction. They reflected accurately that the best experts agreed on a maximum capacity of 250 patients for a hospital like

the one that was to be built. They then suggested that the proposed St. Peter facility would be adequate until the state reached a population of approximately 750,000, at least twenty years in the future. They anticipated building a new hospital somewhere in northern Minnesota at that date. Disregarding Dr. Patterson's 1864 estimate, their calculation implied a ratio of one insane person for every three thousand people, one-third the number predicted for newly developed territories and one-sixth that reported in older states. In planning to meet a demand based on these figures, they made preparations that were inadequate by two-thirds.

THE DORRINGTON FARM cost the St. Peter group seven thousand dollars, or thirty-three dollars an acre. Undeveloped government land around St. Peter was being sold in 1866 at four to seven dollars an acre, depending on the amount of usable timber present. Private sales, however, were often at a higher rate. Eighty acres of Dorrington's land were tilled, but there is no mention in subsequent reports by the trustees or the building committee of any structures. A new barn was needed immediately. Without substantial buildings on the property, the price was unusual.²⁷

The impetus for raising this large sum of money remains a mystery. There is no mention of the undertaking in the newspapers of the time, beyond a brief note that the money had been raised. No comment about the process appears in any surviving correspon-

²²Dakota County authorities to Marshall, May 17, Densmore to Marshall, Mar. 28, Pillsbury to Marshall, Mar. 31, C. Leonard to Marshall, April 9, and H. Swift to Marshall, April 5—all 1866, SMHA; K. T. Friend [?], St. Paul city clerk, to Marshall, April 11, thirteen signatories [Mankato] to Marshall, May 12, and B. Allen, Wabasha mayor, to Marshall, May 18—all 1866, MHS.

²³Daniels to S. Flagg, May 22, 1866, SMHA; Patterson to Marshall, May 10, 1866, MHS; Lincoln to Marshall, Mar. 12, 1866, SMHA.

²⁴Marshall to H. Swift, June 30, 1866, MHS; "I am in favor of St. Peter," not in Marshall's handwriting, and *St. Paul Daily Press*, undated clipping, both in Governor's Records, Minnesota State Archives, MHS; Minnesota Hospital, *First Annual Report*, 5.

²⁵Swift to Marshall, July 5, Sept. 12, 1866, Governor's Records, MHS; Minnesota Hospital, *First Annual Report*, 5.

²⁶Here and two paragraphs below, see *St. Paul Daily Press*, undated clipping, Governor's Records, MHS. In 1867 the new hospital's first superintendent, Samuel Shantz, cautioned trustees, "We as yet show but one [insane person] in three thousand. Let us not flatter ourselves, however, that our healthful climate, our youth and activity, &c., is going to exempt us from insanity. We have not yet had time to accumulate"; Minnesota Hospital, *First Annual Report*, 30–31.

²⁷Minnesota Hospital, *First Annual Report*, 5. Land values are based on contemporary newspaper announcements and N. Ollson, *A Pioneer in Northwest America* (Minneapolis: University of Minnesota Press, 1950).



Hardware, feed, and other essential businesses lining Minnesota Avenue, one of St. Peter's major thoroughfares, still unpaved in 1868

dence. Local merchants and the St. Peter Company, which had founded the town and still had a substantial financial interest, were most likely the driving force. They stood to benefit from the influx of state funds for the building, staffing, and running of the hospital. The author of all letters between the town and Governor Marshall during the site selection was former trustee Henry Swift, an early member of the St. Peter Company. In addition to his tenure as state senator and governor through the mid-1860s, he became register of the U.S. land office at St. Peter in 1865.²⁸

The subscription of money and the donation of land was described as a noble moral gesture on the part of the town, but the most plausible motive was future profit. In the spring of 1866 St. Peter had no paved streets, and money-raising for a new school building moved slowly. The county already supported a poor-master, who met the local need for care of the handicapped. Seven thousand dollars would purchase more than a thousand acres of unbroken land or support two dozen families for a year.²⁹

²⁸Warren Upham and Rose B. Dunlap, comps., *Minnesota Biographies*, Collections of the Minnesota Historical Society, vol. 14 (St. Paul: MHS, 1912), 764.

²⁹*St. Paul Daily Press*, undated clipping, Governor's Records, MHS.

³⁰State Auditor, *Annual Report for 1871*, 37, and *Annual Report for 1877*, 107.

The St. Peter group was well aware of the potential for income, as Dr. Patterson had provided information on the building cost of comparable hospitals. The town could anticipate the influx of several hundred thousand dollars—at least a fifty-fold return on the money donated—in the next few years. All building materials would be purchased locally, and local carpenters and stonemasons would be hired. Once completed, the hospital would be an enduring source of jobs, a significant market for area merchants, and the regular recipient of state funds for the care of the insane. Nevertheless, the willingness to strike a bargain of this size—and the fact that townsfolk could raise such a sum quietly in only three months—are measures of the energy and the focus of the times. For services to the insane, St. Peter, with 1 percent of the state's population, received \$214,540 in the next five years, 9 percent of the state's total cash expenditures—plus the additional \$511,000 in building costs.³⁰

ONCE ST. PETER was selected, the board of trustees set about rehabilitating the abandoned, dilapidated Ewing House as a temporary hospital. The three-story stone building, constructed in 1855, had served as a hotel for only a few years. By 1862 it had been abandoned but was pressed into service as an infirmary during the Dakota War and, later, as a convalescent home for wounded Civil War veterans. It had an attached

two-story wooden ell and an outdoor privy with a ten-foot-deep well nearby. The well silted up frequently and had to be dug out regularly in order to keep the water flowing. No one seemed concerned about having the main source of water immediately adjacent to the privy, although the water table in St. Peter was quite high and people routinely contracted enteric-borne diseases from contaminated wells.³¹

The trustees quickly purchased the Ewing House for \$2,500 and engaged local workmen to refurbish it. They plastered and papered the walls and replaced and painted the woodwork. The workers installed two furnaces and water closets run by rainwater that was stored in the attic. They secured cast-iron grids over the windows. There was no sewer system until 1906, so the waste from the water closets evidently emptied out into the street. Earthenware chamber pots served for night use, when patients were locked in their rooms.³²

The first floor was to be devoted to dayrooms and living space for staff, including the superintendent, matron, and steward. Chambers for quiet, cooperative patients were on the second floor, and single rooms for confinement of the violent or most disturbed were one floor above. One of these third-floor spaces was originally equipped as a "dark room," to be used for seclusion. Doctors believed that violent individuals could be frightened back into control by being left in the dark.³³

As a physician and secretary of the board of trustees, S. D. Flagg was responsible for managing the admission and discharge of insane patients until the temporary facility could be completed. He was besieged by letters from relatives, by commitment orders that could

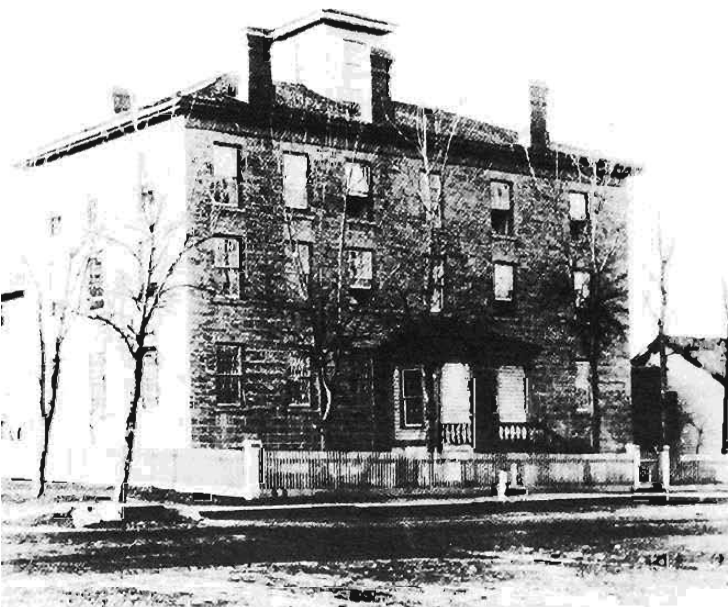
not be honored, and by discharged, supposedly cured patients that the Iowa hospital sent to his doorstep.³⁴

In March of 1866, when Superintendent Ranney at Mt. Pleasant had reported that all Minnesota inmates must be returned by fall, he also asked Governor Marshall if "a few of the most quiet, harmless and probably incurable patients cannot be removed to some suitably regulated alms house." In response, the board of trustees informed Marshall that they were unfamiliar with Ranney and did not know the names of the Minnesota patients at Mt. Pleasant. Thus, they recommended that Ranney use his own judgment in choosing whom to send.³⁵

Soon after, seven patients arrived back in Minnesota. On May 30, Flagg wrote an indignant letter to John Daniels, president of the board, protesting that seven "cured" (his emphasis) patients had been delivered to him unexpectedly. An accompanying letter from Ranney asserted that they were well—or at least stable enough to be returned—and indicated that the Iowa facility could accept two new patients in exchange. Flagg immediately returned one of the seven, a chronically demented young black man known only as Christopher, and sent two to St. Vincent's hospital in St. Louis. "Friends" gathered up the rest, except Anders Monsun. Monsun was a thirty-one-year-old Norwegian immigrant who was believed to have been driven mad by too much reading of the Bible. He had spent two years in Mt. Pleasant. Flagg requested that Daniels "make some arrangement for the reception of Anders Monsun at Red Wing [the riverboat landing]. He is demented, incurable and has been sent up here and is in the jail temporarily."

Flagg's letters grew increasingly impatient as 1866 drew to a close. James Chambers, for instance, had been a considerable annoyance, insistently writing letter after letter to Governor Marshall and to Dr. Flagg.

The Ewing House, as the temporary asylum



³¹Gresham, *History of Nicollet and LeSueur Counties*, 1:196.

³²Minnesota Hospital, daily expenses book, 1866–69, SMHA; Gresham, *History of Nicollet and LeSueur Counties*, 1:206.

³³Minnesota Hospital, Visiting Committee Report, Mar. 15, 1867, SMHA.

³⁴Ranney to Flagg, May 28, 1866, SMHA.

³⁵Here and below, see Ranney to Marshall, Mar. 27, Flagg to Daniels, May 30, and Ranney to Flagg, May 28—all 1866, SMHA. A second attempt to return Christopher to Minnesota also failed. He was on the roster of patients who left Mt. Pleasant on Dec. 24, 1866, but he never arrived at St. Peter. There is no reference to his fate in any correspondence. The hospital's first annual report indicates (p. 22) that nineteen patients arrived, but the case records show only eighteen, with no evidence of Christopher. Undesirable patients who were too confused to give an account of themselves were sometimes simply released in a strange town.

In April he proclaimed, "I would like to get my brother into an asylum of an old state for they have better doctors." By May Chambers was losing patience: "Sir—when will the patients we spoke of be able to start for Iowa. I am in hopes it will not be long, he is very troublesome. If those other two patients are troublesome it will require two men to take them. If you will furnish me with a good strong man I will attend to it for the state. A good man can be got in St. Paul & ex policeman that understood his business would be a good hand." Finally, Chambers forced immediate action by invoking the new commitment law, passed in St. Paul only six weeks before. His brother arrived at Mt. Pleasant a week later. The governor had warned Flagg that Chambers was "an estimable man." Because of his insistence, his brother was allowed to stay in Iowa after the Minnesota hospital opened and the other patients were transferred back. Tired and frustrated by his experience, Dr. Flagg no doubt welcomed the chance to resign from the board of trustees to make room for residents of St. Peter.³⁶

THE SEARCH for a medical superintendent and other professional staff led Minnesota authorities to the State Lunatic Asylum at Utica, New York. The source of this referral is unknown but was probably R. J. Patterson. The Utica superintendent, Dr. John Gray, would only hire assistant physicians who had prior experience treating insanity. Because of this policy and the resulting quality of the staff, Utica had sent several of its assistant physicians west to become superintendents of new hospitals.³⁷

One of the staff, Dr. Samuel E. Shantz, had previously served in the insane asylum in Toronto, Canada. Thirty-one and unmarried, he agreed to move west to run the Minnesota hospital. Educated partly at Harvard and partly in Toronto, he received his first training in the care of the insane under Dr. Joseph Workman, longtime superintendent of the asylum in Toronto. Shantz had served as a surgeon in the Civil War before going to Utica.³⁸

³⁶Chambers to Marshall, April 3, May 9, 1866, both SMHA; Minnesota Hospital, *First Annual Report*, 7. The statute establishing the hospital also included provisions for involuntary commitment of patients; Minnesota, *General Laws*, 1866, 16. Records at SMHA and the St. Peter Archives suggest that Chambers's brother was the first patient committed for insanity in Minnesota.

³⁷Dwyer, *Homes for the Mad*, 67, 70.

³⁸A. Kilbourne, "Minnesota in the Development of the Care of the Insane," *American Journal of Psychiatry* 84 (1929): 1077–1083.

³⁹Composite photograph of AMSAI members, about 1890, with dates of each member's superintendency, St. Peter Archives.



Samuel E. Shantz

The number of physicians in the field of mental illness was small, and the new Minnesota superintendent was unusual in having already worked in two facilities, in both cases under a well-known leader. Shantz was thirty-second in seniority among members of the Association of Medical Superintendents of American Institutions for the Insane. He was thus among the earliest active psychiatrists in the United States and Canada. By 1875 only seventy-five men in America were or had been superintendents.³⁹

His only surviving portrait shows Shantz as a slender, bearded man with a high forehead. His warmth and concern for patients repeatedly showed in letters to the board of trustees, in local newspaper comments, and in his case notes. He had been popular at Utica; when he left, the staff presented him with a large set of encyclopedias. His script is distinctive: a firm hand, always carefully formed with the same broad nib. His comments about patients were clear, well phrased, thoughtful, and always correctly spelled. The only notes that appear unsympathetic or judgmental to the modern reader are those describing masturbation, which he referred to as "*vicious habit*" or "*vic. hab.*" (his emphasis). He had patients restrained to prevent such "self-abuse" and sometimes blistered the penises of

those who persisted. A man of his times, Shantz undoubtedly held with the current theory that masturbation was a major cause of insanity, and he simply believed he was doing his best to help such patients recover. Blistering was believed to draw off the excitement in the blood that caused the behavior. The back of an agitated patient's neck was also blistered to draw irritation from the brain.¹⁰

Shantz recruited Mary L. Pexton from the attendant staff at Utica to be the matron of the new hospital. Several Minnesota residents had applied for the position earlier in the year, but the trustees obviously preferred to leave the choice to the superintendent. Pexton was a young widow who must have made a good impression at Utica. She was paid ten dollars a month when hired in August of 1865, but she received two raises of one dollar a month in the ensuing year, a hitherto unheard-of practice.¹¹

Originally, Shantz had been hired as both the superintendent and steward. In February 1867 George W. Dryer assumed the steward's duties, which were those of chief financial officer. Surviving St. Peter records do not specify that Dryer came from Utica, nor do existing records at Utica mention him, but the long-time steward there was named Horatio Dryer. The identical last name, the statement by both Shantz and the board of trustees that Dryer had "much experience in hospital administration," and his appointment so soon after Shantz's arrival in Minnesota suggest that he may well have been related to Horatio Dryer—and that the entire "management team" was recruited from Utica.¹²

There was, in fact, conflict over Dryer's appointment. The trustees chose him at a meeting which the Reverend A. H. Kerr, the only board member at that time from St. Peter, did not attend. Kerr protested to Flagg, the board's secretary, that the other trustees had no right to take such action in his absence: "Would you be so kind as to inform me why this was done—There must be some special reason for this action." There appears to have been a competing candidate for the stewardship, Albert Knight of St. Peter. Knight was actively involved with the St. Peter Company, apparently owned land immediately adjacent to the Dorrington farm, and was later the town's mayor. With an influential St. Peter native as steward, the merchants would have had a loyal person in control of the hospital's purse strings. Dryer, if he were an Easterner who knew Shantz better than he knew the local merchants, would be more difficult to influence.¹³

THE MINNESOTA Hospital for Insane, the forty-second such public facility in the United States, opened the doors of its temporary quarters to a raging blizzard

on December 6, 1866. Patients began to arrive six days later. Eighteen chronic incurables were returned from Iowa on December 28, having been on the road since Christmas Eve. Others arrived from the St. Paul jail. One man had been confined there for three years. A woman transferred after ten months in the same jail "was perfectly covered with lice."¹⁴

Additional staff hired that winter included two cooks, one washerwoman, one fireman, two female attendants, two male attendants, one supervisor, a nightwatch, and a chambermaid. The trustees' report of their inspection three months after the hospital opened gave a picture of a well-conducted group in cheerful surroundings. There were already twenty-one male patients, twenty-eight women, and two children. Only one patient was restrained. The well had silted up, though, and the water closets did not work for lack of water.¹⁵

By the spring of 1867 all beds were full. A race to stay ahead of overcrowding and to provide new hospital space began, a race that would last a hundred years. The 1867 legislature had provided forty thousand dollars as an initial payment for construction of the permanent hospital, but the trustees found it necessary to spend part of the money to build additional temporary quarters.¹⁶

The permanent hospital building, with an anticipated maximum capacity of three hundred patients, was begun in the summer of 1868 and was completed in 1876. Following the earlier advice of R. J. Patterson and the strong recommendations of the Association of Medical Superintendents of American Institutions for the Insane, the trustees chose a hospital design known as the "Kirkbride linear." First proposed in 1838 by

¹⁰See Minnesota Hospital, casebook 1, St. Peter Archives. On blistering, see Norman Dain, *Concepts of Insanity in the United States, 1789-1865* (New Brunswick, N.J.: Rutgers University Press, 1964), 91-92.

¹¹Personnel records, Historical Archives of the Mohawk Valley Psychiatric Center, Utica, N.Y.; Minnesota Hospital, *First Annual Report*, 37.

¹²On Horatio Dryer, see *Managers of the State Lunatic Asylum, Thirteenth Annual Report* (Utica, N.Y., 1858) and *Forty-fourth Annual Report* (1886), Historical Archives of the Mohawk Valley Psychiatric Center; on George Dryer, see Minnesota Hospital, *First Annual Report*, 6.

¹³Kerr to Flagg, Feb. 8, 1867, SMHA; Gresham, *History of Nicollet and LeSueur Counties*, 1:192, 205; map in Amelia and Florence Turner, *Lower Oshawa* (St. Peter Tribune Publishing, 1930).

¹⁴Grob, *Mental Institutions*, 374-94; patient list, St. Peter Archives; Minnesota Hospital, *First Annual Report*, 22; bill for cost of the journey from Iowa, submitted to board of trustees, Jan. 11, 1867, SMHA.

¹⁵Minnesota Hospital, Visiting Committee Report, Mar. 15, 1867, SMHA.

¹⁶Minnesota Hospital, *First Annual Report*, 6-7.



Linear layout of the St. Peter hospital, 1880, also showing fire damage. Winona photographers Elmer & Tenney sold this as a stereograph, probably as a souvenir of the disaster.

Dr. Thomas Kirkbride of the Pennsylvania Hospital for Insane in Philadelphia, it was adopted by one builder after another, public and private. Most also utilized the services of architect Samuel Sloan of Philadelphia, who provided the blueprints for the Minnesota hospital. Kirkbride's design specified a sequence of semidetached elements that included only a single row of rooms and a corridor on each floor, thus facilitating good cross-drafts, believed to have great beneficial effect. The design had the more practical advantage of being modular, so that patients could be moved into sections as they were completed. The center section was routinely left until last. It housed the offices and residences of the superintendent, and its completion did nothing to increase the patient capacity. It also tended

to be the most ornately decorated and thus the most expensive element. At St. Peter, patients moved into the first completed wing on February 7, 1870, and into the final wing in the fall of 1875.⁴⁷

The temporary hospital buildings continued in use until the end of January 1885. They were always crowded and, because of this, difficult to keep clean. By 1873 the census had risen from the well-ordered group of 49 patients, 2 children, and 6 live-in staff that the visiting committee had observed six years earlier to 132 patients and 26 resident staff. According to state health department officials, who began regular inspections in 1873, "The temporary hospital for the insane is a disgrace to the State. . . . No where else, except in the crowded tenement houses of our great cities are the same number of people crowded into so limited space. . . . Of the 158 in the temporary hospital, 132 are sick and crazy, too, presenting every form of mania, from raving delirium to paralytic idiocy." In its later years, only the most regressed patients, who were a disturbance to others, were kept there.⁴⁸

The permanent hospital, on the other hand, met with approval in the same report. The food was excel-

⁴⁷Gresham, *History of Nicollet and LeSueur Counties*, 1:208; Thomas S. Kirkbride, *On the Construction of Hospitals for the Insane* (Philadelphia, 1838); Minnesota Hospital, *First Annual Report*, 8-9, and *Fourth Annual Report*, 1870, 26.

⁴⁸Here and below, see State Board of Health, *First Annual Report*, 1873, 91-93, and *Fifth Annual Report*, 1876, 73-75. See also the hospital's annual reports from the late 1870s on.

lent and the surroundings bright, well furnished, and scrupulously clean. The new building quickly became nearly as crowded as the temporary buildings had been, however, with eighty patients sleeping on the floor. The main sanitary problem was still the water closets, which worked poorly and had to be watched constantly to prevent clogging and stench.

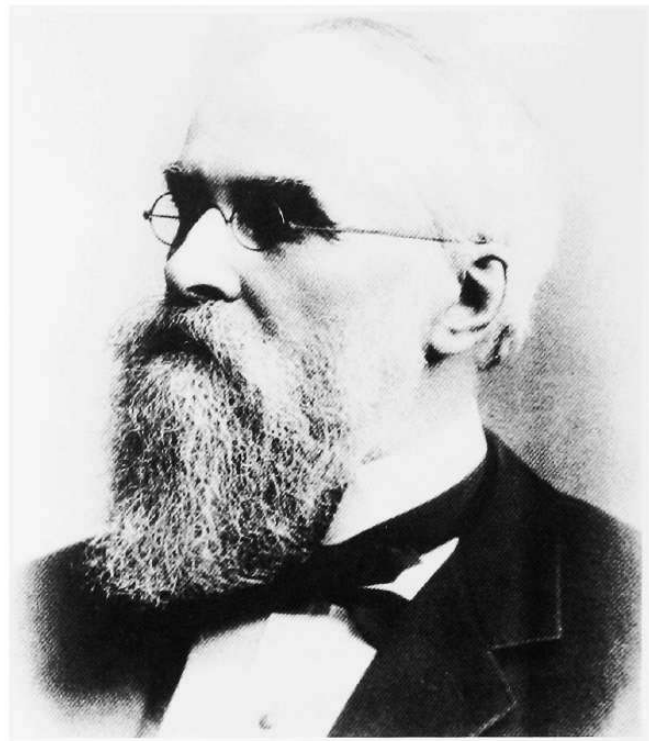
From the opening of the hospital until 1907, attendants were required to live on the ward with their charges. In 1884 they were paid ten to twenty-five dollars per month—the state paid prison guards forty-five dollars a month—and were allowed only every other Sunday off duty. The turnover rate was always high in facilities like this, and concern over the attendants' drinking and possible abuse of patients was always present. Records of the early years indicate that a number of inmates were simply "discharged as patient, hired as staff," sometimes on the same ward.⁵⁰

Samuel Shantz died in 1868 of typhoid fever, possibly contracted from a patient. He usually left the admission of new patients to his assistant, Dr. Jacob E. Bowers, but on June 28, 1868, the superintendent himself examined a twenty-eight-year-old Norwegian woman who had just been admitted. She had arrived on the train from Milwaukee after a six-week ocean crossing. She was not insane but simply delirious from typhoid fever. She died on July 23 and he died of the same disease, after a lingering illness, on August 20.⁵⁰

Shantz was succeeded by Dr. Cyrus K. Bartlett, a general practitioner with eight years of experience in the asylum for the chronically insane in Northampton, Massachusetts. There he worked under the direction of Dr. Pliny Earle, a skeptic about the treatability of insanity and a stern and vocal critic of AMSAI's promises of cure. Bartlett clearly absorbed Earle's skepticism. His notes in patient records occur rarely, are always perfunctory, and often indicate that "there is nothing to be done." Dr. Bowers, a new medical graduate at the time of his arrival in 1868, was the only assistant physician until 1877, by which time the hospital had an average daily census of 564 patients and had hired a second assistant.⁵¹

On November 15, 1880, a catastrophic fire destroyed much of the north wing of the St. Peter hospital, and many patients died. Bartlett's tenure was marked by repeated allegations of abuse of patients and misappropriation of funds. Repeated legislative investigations tended to end inconclusively with idealistic recommendations that were not often implemented. The embittered superintendent resigned in 1892.⁵²

BY 1890 the need to house increasing numbers of chronic, untreatable, and incurable patients had swelled the population of the hospital to three times its



Cyrus K. Bartlett

planned maximum capacity. This overcrowding persisted despite the addition of hospitals at Rochester and Fergus Falls in 1877 and 1890. During its first decade, the St. Peter institution was the only hospital of any kind in southern Minnesota. Many patients were admitted because of physical, as well as mental, illnesses. Roughly 30 percent were discharged within a year. The

⁵⁰Corrections and Charities, *First Biennial Report*, 1884, 23. For a description of this situation in a similar institution, see Dwyer, *Homes for the Mad*, 163–85.

⁵¹*American Journal of Insanity* 25 (1868): 272–73; Minnesota Hospital, *Second Annual Report*, 10.

⁵²Grob, *Mental Institutions*, 182, 184; Minnesota Hospital, *Second Annual Report*, [6], 10, and *Eleventh Annual Report*, 1877, [2], 12. Bowers left St. Peter in 1878 to head the temporary second Minnesota hospital for the insane, established at Rochester "to relieve the overflow from . . . St. Peter"; Minnesota Hospital, *Twelfth Annual Report*, 1878, 9; Senate Special Committee, *Report . . . to Investigate the Minnesota Hospital for Insane* (1879), [3], bound in with the hospital's annual reports.

⁵³Minnesota Hospital, *First Biennial Report*, 1880, 58; Corrections and Charities, *Fourth Biennial Report*, 1890, 250–56; Minnesota, *Journal of the Senate*, 1878, 96; Senate Special Committee, *Report . . . to Investigate Minnesota Hospital*, 1–22; Don A. Martindale and Edith Martindale, *Social Psychiatry in Minnesota: Coping with Mental Illness, Alcoholism, and Drug Dependence* (St. Paul: Windflower Publishing, 1972), 6–9; Minnesota Hospitals for Insane, *Seventh Biennial Report*, 1892, 12.

rest stayed on indefinitely, gradually withdrawing into the private world of their chronic, untreatable mental illnesses.⁵³

Within a few years of its opening, it was evident to all that the major task at St. Peter was custody of chronic patients, not active treatment and cure. Large state hospitals nationwide continued to bear this burden for the next century. The reasons for such prolonged neglect of a constantly growing national problem are complex. Historian Rothman, among others, argues that the desire to "put away" social undesirables—and the efficiency of doing so in insane asylums, poorhouses, and prisons—precluded any shift to more desirable forms of treatment.⁵⁴

The financial commitment to state hospitals—initially more than 10 percent of Minnesota's entire state budget—and the number of incurable patients made change difficult. Existing hospitals would still have to be supported while some new plan was being established. Scarce funds went to the care of acute, "curable" cases, leaving large numbers of chronic "incurables" with very little. Two world wars and a national depression drew money and attention away from the problems of institutionalized patients for half a century. Furthermore, until the first effective antipsychotic medications were introduced in 1954, the majority of patients in state hospitals were, in fact, untreatable and incurable. They did not recover from their illnesses no matter how well attended and could not regain their independence no matter how much money might have been spent.⁵⁵

⁵³Author's case-by-case analysis, in his possession.

⁵⁴Rothman, *Discovery of the Asylum*, 265–95.

⁵⁵State Auditor, *Annual Report for 1871*, 37, and *Annual Report for 1877*, 107. For a study comparing the treatment of schizophrenia with and without antipsychotic medication, see Philip R. May, *Treatment of Schizophrenia: A Comparative Study of Five Treatment Methods* (New York: Science House, 1968).

⁵⁶Kilbourne, "Minnesota in the Development of the Care of the Insane," 1077–1083. In contrast, see T. Powell, "A Sketch of Psychiatry in the Southern States," *Alienist and Neurologist* 7 (1886).

⁵⁷Patient census and figures, Medical Records Department, St. Peter Regional Treatment Center.



Corner of a second-floor dormitory, Women's Department, about 1910

Minnesota authorities were more responsive to the needs of the institutionalized mentally ill than were those in many other states, but state hospitals were always crowded. The population of Minnesota's state hospitals continued to grow until the early 1960s, when the advent of the first truly effective medications and the availability of federal funds made deinstitutionalization possible.⁵⁶

The first Minnesota Hospital for Insane is still active, now known as the St. Peter Regional Treatment Center. The average daily census today is 550, one-fourth the number thirty years ago. In its 126 years of service, the hospital has provided asylum and, more recently, active treatment to more than fifty thousand mentally ill Minnesotans.⁵⁷

The photographs on p. 50, 51, and 54 are the author's; all others are from the MHS collections.



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