Tom Anderson
Anoka State Hospital Oral History Project
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Neal: Good morning.

Tom: Good morning.

Neal: I am Neal Holtan. I am here with Tom Anderson as part of the Anoka County Historical Society's Oral History Project concerning Anoka State Hospital. Thank you for coming in.

Tom: My pleasure.

Neal: Could you tell us a little bit about yourself, where you grew up and…

Tom: Well, I grew up on a small dairy farm outside of Elk River, left there when I was about 18 and actually moved to Anoka in the Anoka area, and have lived in that area ever since.

Neal: And, how about school?

Tom: I graduated from St. Cloud State University. I have a degree in criminal justice studies. I did some graduate work there in site, but never finished my Master's. I got sidetracked with building a house and living and that sort of thing. And, then got further sidetracked with the police department starting the security on up at the hospital and getting involved in law enforcement accreditation as well as emergency management. And, so I never returned to grad school.

Neal: And, could you talk about your career? Where did you work?

Tom: Well, I started with the City of Anoka Police Department in 1970. I was a dispatcher, and in those days that agency had its own communications. It is not as grand as what it might sound. I think there were three, four lines that came into the station, one radio frequency, but we did dispatch all of our own calls and handle all of our own communications. I left to go back to school and relatively shortly started with the City of Ramsey Police Department when they started a police department. In fact, in the earliest time I was a, I believe it was a deputy constable for about ten days before the city became a city. And, worked primarily patrol, but some investigation out there, and then came back to Anoka in 1986. I worked patrol for about five or six months and then was promoted and assigned to build the State Hospital security unit, resulting from a contract with the state and the city.

Neal: Any particular highlights from all those years that come to mind?

Tom: Oh, I think there is all kinds of odd stories. It was not too long after I started with the hospital unit that a patient was discovered having two World War II hand grenades in his possession, which caused a bit of a stir. We could not see from the way they were packaged in his belongings whether it was a live hand grenade or inert. And, nobody really had an urge to pick them up and shake them. So, we had to have the bomb squad come out and take them away, and in fact, even the bomb squad initially could not tell if they were inert or not. But, eventually took them

away and the excitement died down. We went on about our business. Both of them were inert as it turned out.

Neal: And, how did the relationship between the hospital and the police department develop?

Tom: It developed over a long period of time. In the '70s particularly, there were some very difficult situations that were involving hospital patients. One or two in the early '70s had left the grounds and set a lumber yard, the lumber company, set that on fire. In, I believe, 1976, in the winter, a patient left the grounds without authorization, what they call AWOL, and pushed his way into the home of a widow woman that lived nearby and killed her. And, subsequent to that, there was a real hue and cry from the citizenry for the hospital to be closed. There had been a long history of patients leaving grounds and just wandering into shops downtown, wandering into homes unannounced. There was one that I can remember getting a call that a patient had just on a nice summer afternoon just wandered into the house, took a beer out of the refrigerator, sat down on the couch next to the family and started watching television, which was little disconcerting. Although, they seemed to take it in stride pretty well. But, it was a common occurrence. We had patients involved in all kinds of activities, shoplifting and disorderly conduct and checking into local motels, and of course not necessarily have appropriate funds.

And, it was not just a one-way street. The patients were also victimized by members of the community. They would be, the female patients would be sexually abused when they went off grounds. They would be lured off grounds with liquor and dope and so on, so that there was a real kind of a mutual victimization or a bilateral, if you will, victimization.

Neal: And, your unit, was that formed to try to address some of these problems?

Tom: Well, after the homicide, the result was that the state agreed to have security on the hospital grounds. And, they contracted with a private security organization, and at first that went quite well. But, as things go with large government, they go with the low bid, and the situation deteriorated to the point that the patients were being discharged from the chemical dependency unit and hired as security officers and going back onto the hospital as security officers. And, it was not functioning and really not doing what needed to be done. So, Chief Revring [PH] collaborated with the CEO of the hospital at that time, a man by the name of Jonathan Balk [PH], and put together a contract. And, I was tasked with putting that into operation. It was staffed by law enforcement students. They were non-sworn folks. They were all in uniform but non-sworn, and they were part-time employees. They worked about 30 hours a week each, and they would work on that unit while they went to college and through skills as a real adjunct to their law enforcement training.

Neal: And, what kind of strategies were used?

Tom: The first thing is to establish just a baseline safe environment, so that the staff can treat the patients and the patients can safely receive care. The patients very often victimized one another. There just was not a sense of generalized safety. So, the first thing is just to try to maintain that. You need to remember that the institution is really nothing more than society in general, but in microcosm and in a very concentrated form. The behaviors that you see on the hospital are simply

extreme behaviors that you might see in the community, just with greater frequency. So, establish a safe environment, establish some accountability for the patients in terms of criminal actions. It had gotten to the point that a patient would leave the grounds, commit a crime and simply be brought back. The prosecuting attorneys did not want to deal with them, the courts did not want to see them, because so many of them were simply not competent to be prosecuted.

What we found as we worked through this, is that about 60 or 65% of the patients were competent to be held responsible for their actions. The agreement that we made as an agency, as a police department with the courts is that I would go through and do kind of an informal Rule 20 with each of these folks that were going to be charged. And, simply by sitting down with their psychiatrist and getting an opinion, is this person right now mentally competent. And, those that were, were plugged into the system of criminal justice and they were held responsible as anybody else would. We tried to make it as normal a mirror of society as we could.

Neal: Did you spend full time on that type of work?

Tom: Initially, I did. The first year or two years, I was officed in the State Hospital and that was my primary responsibility. As time passed, I was promoted again and given additional responsibility, so that I was back and forth between the station and the hospital. But, that was always my primary responsibility.

Neal: I think you mentioned the year that this happened, when did the unit start?

Tom: The unit started toward the latter part of July in 1986.

Neal: Going back to the unfortunate event of the woman who was murdered, how did the community react specifically to that? I mean, what happened?

Tom: Well, the lady was named Mary Goldbraith [PH]. She had been a city employee, had retired from the city, so was fairly well-known in the community. And, the reaction was harsh, vocal and in addition to vocal, there was really a press for political action to prevent it. It was taking the position that the city, the citizens were just tired of the antics of the patients and they laid the blame at the doorstep of the hospital, and pressed at that time for closure.

Neal: And, were there groups organized?

Tom: Yes, and I do remember if they took a name, but there was a fair organization that went on at that time. I was not with the City of Anoka, I was next door with Ramsey, and so more of a spectator so you get a little broader view of it. But, yes, they were organized and pressed both state government and city government.

Neal: And, how do you see that having been resolved?

Tom: Well, the resolution was that, among other things, but the primary was that security would be applied at the hospital, that there would be uniformed security on the hospital with an eye toward

keeping the patients on the hospital, reducing the number of AWOL patients, which was absent without leave, them walking off and going into town.

Neal: How often did security at the hospital have to have reinforcements from your department?

Tom: Oh, anecdotally, at that time, probably once or twice a week.

Neal: What kind of events?

Tom: Patient violence, a patient that would be out of control and maybe armed themselves with some kind of a weapon, whether it be broken glass or a stick or piece of furniture, a part of a piece of furniture, that sort of thing.

Neal: And, how did the police officers view the hospital?

Tom: It was kind of a nuisance, frankly. The officers knew that these calls are difficult to manage. Once the physical part is settled, basically, you take the patient and gain physical control. There was always a certain discussion among staff, "Well, what are we going to do them? Well, take them to jail." Well, the jail is not where he belongs and back and forth. And, also for the youngsters that are not up there on a day-to-day basis, just the sights and the smells and the sounds can be unpleasant, especially in the older buildings.

Neal: Just maybe some overall questions, do you think that attitudes in Anoka reflect society in general in terms of attitudes toward mentally ill people?

Tom: Well, no, I think that there is a more focused attitude. I think that it has come a long way. Right now, the attitude, my perception is that for the city and the citizens, is much different than it was prior to the new building and prior to having law enforcement security up there. I think now there is more of a benign attitude that it is there, but it really is not an issue anymore. The issue was not so much focused on the mentally ill, but it was focused on behavior. So, once the behaviors were removed, then the focus of their attitude changes.

Neal: Do you think that your education and training equipped you to understand the hospital and how it was working? I mean, they chose you to do that job.

Tom: Yes, and I have always wondered what I did to deserve that. And, I think I will probably try not to do it again. No, certainly the education prepares you. Does it prepare you for that role? No. When I started, I had no idea what we were going to do. I had been given a framework of how this was supposed to run, but you need to establish relationships with the people at the hospital and beyond them, the people in the department of DHS. And, the bigger the government agency, I think it tends to be a little more clumsy and accountability tends to be blurred a little bit. One of the things that I had to get used to was a lot of decisions were made by committee, and I was not accustomed to that. I came from a paramilitary agency where the structure and the lines of authority of very clear, who was the deciding body and person and lines of responsibility were very clear. And, with the larger agencies and larger organizations, that tends to be a little bit blurred.

Neal: Who did you relate to on a day-to-day basis among the staff or administration?

Tom: Primarily administration, but also treatment staff and patients. I had contact with those, especially in the early days, every day. That contact became a little less as time passed, because I found that when I went on a unit, I was uniformed a little differently, I was armed, I was a different role. And, I found out that I could use that to have a calming effect and so I did not go out on the units as often so that that impact would be greater when there was trouble. And, then when I was not working, of course, the uniformed officers off the street came in and they all looked like me, they were dressed like me, and so that was a little more effective impact. But, I had responsibility to attend safety meetings, security meetings, and a number of other treatment oriented meetings. Because, we were an adjunct to treatment, we did not have anything to say about treatment, we did not apply treatment, but we were an adjunct there. We were trying to maintain an environment in which the patients and the staff were all safe.

Neal: What do you think your biggest challenge was when you started that unit?

Tom: The biggest challenge was perception. I can remember one of the advocates from the state level very loudly proclaiming to anyone that would listen that if you have the cops up there long enough they will kill a patient. And, the perception was, I think, on the part of staff that, "Oh, they're here now, they'll take care of all the rough stuff." And, that really was not the point. We would assist them. They would make the decisions when a physical confrontation was controlled, control immediately went back to the staff. They had to make decisions. They would ask security officers, "What do you think we should do with them?" And, that was one of the things that we trained those folks that, no, that is not a question you can answer. So, perception is so many times more important than reality, and I think that was a big issue in the early years especially.

Neal: As somewhat of an observer, did you ever see things that you thought were not right or done well?

Tom: Oh, sure.

Neal: And, how would you handle that?

Tom: I would not, because I was not a treatment person. There is all kinds of things that we look at. I was raised with a real personal responsibility base, you are responsible for your own actions. And, you would see both with staff and with patients from time-to-time that that was not really being held to them. And, so yeah, there are kinds of things in this life that I do not agree with, and about which I do nothing.

Neal: Did you have an office, or were you in a certain building?

Tom: Yes. I had an office in the administration building on the first floor, right by the front door. Had the department seal on the door and so on, and it was an office that we shared with the nursing

supervisors. Nursing supervisors ran the hospital after hours, and so there would be two shifts of them, afternoon and the night shift, and they also shared that office.

Neal: And, how about the tunnels, did you ever go down there or need to go down there?

Tom: Oh, yes. The tunnels are famed in song and story at the state hospital. They are haunted, you know. That was the rumor. And, aside from being useful for moving about underground, out of the weather and so on, they were also the focus of a great many pranks, of which I had nothing to do with personally. But, they are a scary looking place, they are dank and not particular clean, also quite low for anybody that is over six feet. But, we did, and one of the things that we did, we housed or put patients down there for, as a tornado shelter, in those entry ways. The sad thing is, tornadoes come in the hot weather, and those tunnels were horribly hot. They were not well-ventilated, so, yeah, we got down into the tunnels from time-to-time. We patrolled, the officers patrolled the tunnels to maintain some sort of decorum and so on down in the tunnels.

Neal: Do you think they are haunted?

Tom: Oh, that is a tough question. I am more of a, if I can see it, smell it, touch it sort of a person. But, I would not say that they are not haunted, and I do not know that I would say that they are. But, that is such a long history of interesting behavior and people were, died in the tunnels, either at their own hand or natural causes and so on. So, there is the basis for all kinds of wonderful stories.

Neal: So, have we forgotten to talk about? Any areas that come to mind?

Tom: No, not really. I think that just one thing to remind ourselves is that this was, we tend to think that the security was patient-caused. It was patient-behavior caused, but it was also, we were there to protect the patients, we were there to protect the staff, and we were there to protect the community. And, we maintained that balance, I think fairly well. There have been times over the years that staff has been prosecuted for abusing patients. Patients have been prosecuted for assaulting staff and so on. And, we tried to maintain that neutrality much as a law enforcement agency in the community maintains it. We try to run that so it was just about the same as inside and out.

Neal: Did the other state hospitals have similar units?

Tom: No, not that I know of. St. Peter, of course, does. St. Peter is, at the security hospital—there are two facilities in St. Peter. There is the regional treatment center and then there is the security hospital. And, the security hospital has its own rather robust security organization.

Neal: So, any other thoughts?

Tom: No, I do not think so.

Neal: Well, thank you for describing your work at Anoka State Hospital.

Tom: You are welcome.

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