Chapter 11

A Rural County in Sweden: Malmohus County

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A RURAL COUNTY IN SWEDEN: MALMOHUS COUNTY

Some General Facts

At the end of 1966, the population of Sweden was 7,800,000, with roughly 4,200,000 persons living in urban areas. During that year, 125,000 births were registered.

The country is organized into 25 counties and 3 county boroughs, the latter being the metropolitan areas around Sweden's major cities: Stockholm, Gothenberg, and Malmo. The counties vary in population between 58,000 to 424,000, with an average cf 250,000.

A county council, whose members are elected by the public every 4 years, is responsible for local government with respect to certain matters such as health services, children's homes, vocational training and rehabilitation. Such councils meet twice a year for sessions lasting 3 to 5 days during which budgets are approved and general policy guidelines laid down for the coming year's activities. Administrative and executive power is vested in the county council's board of administration.

The county councils have an unrestricted right to levy taxes. The rates are based on the same system used for municipal taxes, and the national average is between 5 percent and 7 percent of the taxpayer's net income.

The Organization of Health-Related Services in Sweden

Sweden has more hospital beds and days of hospitalization per capita than either the United States for England and Wales. It also has a lower mortality rate and longer average lifespan. It is unclear, however, whether or not the liberal access to medical and hospital care has reduced the extent of disease and invalidism among the Swedish population. Data on health-related expenditures in Sweden, and comparisons of patterns of such services between Sweden, the United States, and England and Wales are presented in Tables 1 and 2.

Health-related services in Sweden are today organized at three geopolitic levels: the county level, averaging between 200,000 and

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Peterson, O.L. , Burgess, A.M., Berfenstam, R., Smedby, B., Logan R.F., & Pearson, R.J. What is value for money in medical care? Experiences in England and Wales, Sweden and the United States, Lancer, 1967, 1, 771.

Table 1

Comparison of Sweden, U.S.A., and England and Wales on

Various Aspects of Medical Care

Country	Ambulatory service use	Hospital use	Expenditures	Death rates
U.S.A.	High	High	High	Highest
England & Wales	High	Low	Low	Average
Sweden	Low	High	Low	Lowest

Table 2

Growth of Combined Expenditures(including Investments) by the State, Public Health Insurance Funds, the Counties and County Boroughs Between 1959 and 1965

Types of Expenditures	Total Expenditures 1959	1965
	$436 million	$915 million
Health and medical care, total Per capita Breakdown:	58 million	120 million
General hospital care and maternity	41.2%	42.7%
Care of the chronically sick	5.3	5.8
Mentally ill	13.4	13.0
Mentally retarded	3.2	4.3
Epileptics	0.3	0.1
Public health nursing	1.7	1.4
Prenatal and child welfare	0.7	0.6
District midwifery .B.: The increase in	0.4	0.2

the expenditure for the care of the mentally retarded was relatively *highest.* In 2966, it amounted to 4.5% of all expenditures.

300,000 people; the regional level, covering roughly one million people; and the total or national level, which involves close to eight million pecple.

Planning, organization, administration, and financing of somatic hospitals in Sweden has been entrusted to the local authorities throughout the 200 years during which we have had hospitals in the modern sense of the word. An increasing trend in the planning of health and medical sick care in Sweden is a growing integration of all services under a single authority--the county councils. Over the years, the counties have been given or have assumed the responsibility for the tasks involved in the national health services decreed by Parliament. Among other things, this includes responsibility for mental hospitals and the care of the mentally retarded. This responsibility has grown to such an extent that today the operation of hospitals and other health service agencies accounts for 80-85 percent of the counties' total expenditures.

In accordance with a government decision, Sweden has been divided into seven multicounty geographical areas ("hospital regions") which are to function independently regarding inpatient care. Each regional hospital is to have specialty clinics to handle diseases the low prevalence of which does not warrant specialized facilities at the county level.

In many different branches of medicine, the following line of development can be traced in the struggle to balance between centralization and decentralization. Initially, specialized institutional care was at the total or national level, owing to the shortage of local facilities. It was thus isolated from the local level in the rehabilitation process. However, this situation gradually changed with an increase in the resources available at the local and county levels as smaller facilities in different specialities were established. It thus became no longer necessary to send persons to faraway hospitals or institutions.

An interesting aspect of this line of development is that with increased technical and medical resources at the county level, the need for specialization grows as a natural result of the efforts of certain progressive specialists. Regional units are thus created as an extension of the improved and continually more advanced local facilities.

At present, the first receiving agencies identify individuals who require more specialized forms of care at higher levels. The size of the facilities being established at the regional level is determined by prevalence, demongraphic factors, and the number of special problems that justify the services of a specialist.

The higher the level of care, the more restrictive the form of care will be and the more activity there will be in an around a resident's bed. In other words, it will become a matter of specialist care and thus proportionally more expensive. Or looked at from the opposite angle: the lower the level, the more the bed will, as it is for the rest of us, become a place to sleep, and day activities, as in boarding homes, will take place outside the facility. The staff's work will become more collective and efficient.

The chief motives for regional care are rational and economic ones. In addition, there is wider scope for further progress within a specialty through research and training. It must be emphasized that the decisive factor for any successful care program is a functional interrelationship between the various levels.

Planning and Organization of Services to the Mentally Retarded

Planning Considerations

Ever since 1954, Swedish legislation regarding services for the mentally retarded has been comprehensive. This means that with the exception of certain general provisions such as those contained in social security legislation, a single law enumerates all these services that must be provided for retardates. Most of these services are provided on the county level, while certain special ones are on the regional level, and practically nothing on the national level.

There are three basic requirements that must be fulfilled if the planning of the various services for the mentally retarded is to proceed smoothly and with an ethically well-balanced division of responsibilities. These are (1) a law and an expert agency which ensures that law is followed, (2) an implementing agency rooted in a democratic system, and (3) representation from the consumer of services.

The law should preferably cover all the various forms of special services required by the mentally retarded. The 1954 legislation regarding the mentally retarded has been mentioned above. The responsibility for the implementation of this legislation lies with the National Board of Education and the National Board of Health and Welfare. In these two Boards, there are roughly 15 officials representing the fields of medicine, pedagogy, psychology, social welfare, and jurisprudence with regard to the mentally retarded. Their supervisory duties are not so much in the form of inspection visits to the individual facilities, but rather advisory and consultative. An important part of the work carried on by such personnel involves the arranging of courses and conferences, and of educating politically appointed members of the counties's boards of services for the mentally retarded.

The plans drawn by the various county councils for the implementation of the law are approved by the central authorities, as are architect's drawings for the buildings, the number of places, the qualifications of the chief officials and administrators at the facilities, etc.

A more direct influence on planning is achieved when representatives for the two central Boards confer with the county boards of services. This gives the former wide scope for initiating and controlling the planning process. At the government (national) level, these two Boards, of course, will represent the opinions of the county boards in committee work, statistical studies, etc.

One-sided pressure from above is not always alone sufficient to activate the county councils. It is just as necessary to have some kind of pressure coming from below from those who represent the "consumers." They are the only ones who can provide detailed and shaded descriptions of all the services required by the mentally retarded. The trick or finesse is to give as little help as possible as early as possible, and not, as was done previously, nothing for a long time and then everything all at once. It may be important for parent associations and similar organizations to start day activities and counseling services themselves, but only turn them over as soon as possible to the county council. In order that they may be in a position to criti-size and influence the county council, it is in our opinion wrong, in principle, for parents' associations to run facilities themselves. In Sweden, the few homes in this category are for the short-term care of children.

The planning process for the services for the mentally retarded as carried out by a county council follows much the same lines as the planning of other health and medical care services. Naturally, there are occasionally differences of opinion between the board for services and the government agencies which approve actions and grant funds. In this aspect, however, the boards are greatly aided in that there is no other group in Sweden which has its social, pedagogic, and medical needs and rights written in the law so strongly and in such detail as the mentally retarded.

In planning residential services, a number of arguments bear upon the determination of the optimal size of facilities. In favor of small facilities are the following arguments:

1. Greater proximity to residents' own home towns and relatives is made possible. This is an important and often decisive factor in the rehabilitation of retarded persons. It allows more visits, better emotional ties with people and things outside the institution, and more frequent periods (hours, days, weeks or months) outside the institution. (See Fig. 1.)

2. It is easier to integrate the residences socially and geographically within the community. Larger residences require such large closed-off areas that they tend to be excluded instead of included in the community.

3. Both the retardate himself and the community regard the retarded as less odd a person, and his handicap as a less severe one, as a result of the wider social contacts made possible in 1 and 2 above.

Against the relatively small facilities are the following arguments:

1. A small number of retardates do not "warrant" certain technical facilities such as gyms, swimming pools, sheltered workshops, dental care.

2. A small number of residents do not provide an adequate base for differentiated care, specialist examinations, and the employment of staff specialists, whether on a full-time basis or as consultants.

3. The staff feel isolated and do not obtain the same opportunity for teamwork, further training, etc.

To us, in Sweden, the advantages of the small residences are so clear that it is generally accepted that everything must be done to enable the majority of the mentally retarded to be cared for in such residences. It is thus important that the mentally retarded receive residential care which involves a minimum of encroachment upon their freedom to develop, but which is still sufficiently effective. For this reason, residents must be screened so that the relatively small number who require a greater degree of specialized care and comprehensive facilities receive them, but, in such cases, at a higher level. A person or facility with the responsibility for caring for a retardate will, in a properly organized system, never lack the necessary assistance: there will always be a back-up facility, a next step to which the retardate can be referred and where care of a more specialized nature is available. Naturally, the highest level will then be without any form of back-up facilities. However, this level will have at its disposal the resources for a maximum effort; and furthermore, the number of retardates being screened to this level will be relatively *few in* number.

Services for the Retarded at the Regional Level

Principles. Whether they be for somatic or mental problems, the aim of regional care facilities is to provide efficiently organized services

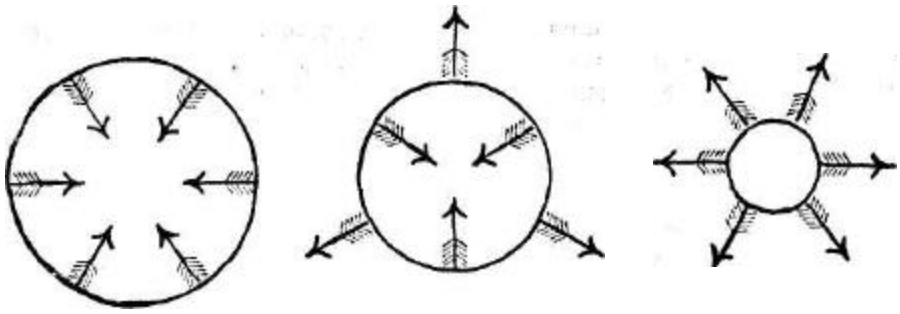


Figure 1: The Resident's Opportunities for Social Contacts in Large, Medium-Sized and Small Institutions

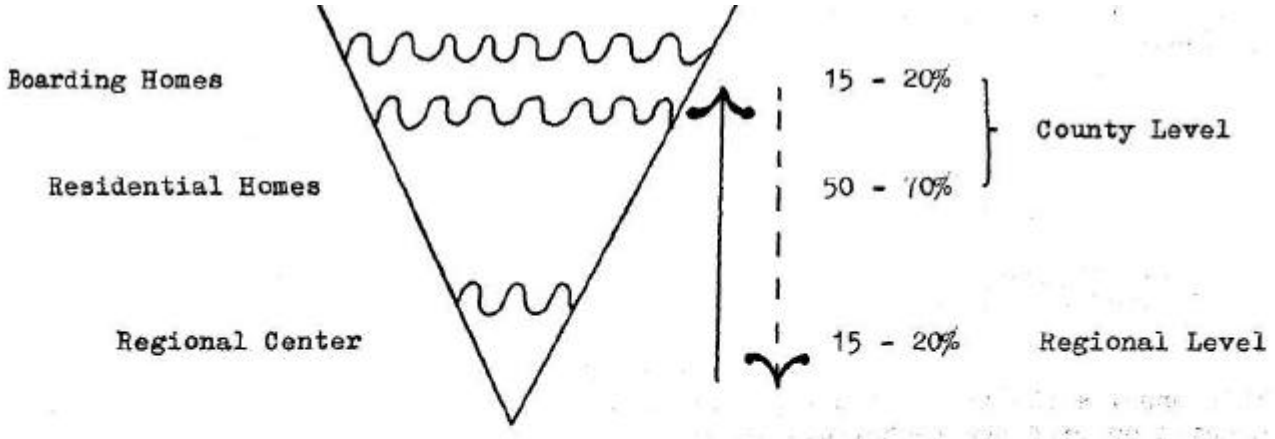


Figure 2: Breakdown of the mentally retarded adults who require residential care, indicating the direction of rehabilitation process.

using specially trained personnel and consultants. With the aid of special techniques and drugs, the mentally retarded can be brought to the state where they become receptive to activational and rehabilitation programs. Even low functioning retardates can in this way be induced to participate in meaningful activities to an extent once considered impossible. If regional care is to be progressive in diagnostic and therapeutic methods, it must be linked with a university and research center.

There are three basic requirements that must be fulfilled if a regional residential center for the mentally retarded is to function in a satisfactory way:

1. The center must fulfill a well-defined need by providing the special facilities for care, research, and training that cannot be made available at a lower level.

2. It must have good geographic and administrative ties to other specialized facilities and research activities.

3. It must be integrated administratively with the county levels. This enables the staff at a regional center to have the opportunity of keeping up with new techniques in diagnosis and therapy, and of passing this knowledge on to the lower care levels.

When planning a regional residential center for the mentally retarded, the following seven considerations are of importance:

1. The population base. The optimum seems to be roughly one million. This figure can be raised in densely populated areas and correspondingly reduced in more sparsely inhabited parts of the country.

2. Demographic factors and the available means of communications.

3. The number of persons requiring long-term and short-term care.

4. The optimum size of the regional unit, which seems to be 200-400 beds.

5. The location of the regional unit in relation to other facilities and to research and training centers.

6. Specialists require a certain number of patients and patient turnover in order to obtain sufficient practice and experience.

7. In metropolitan centers, with populations approaching a million or more, the various departments of the regional unit can be deployed and tacked on as special departments at different local-level institutions.

According to Engel , a number of different special branches for somatic care can be maintained at the regional level. Only four of ' these are mentioned here as a means of comparing the respective need for number of beds per 100,000 population: plastic surgery, 5.5 beds; thoracic surgery, 5.5; neurosurgery, 4.1; and radiotherapy-cancer clinics, 8. The following special disciplines also belong on the regional level: special audiological laboratories; phoniatric clinics; rehabilitation centers for the neurological disabled; facilities for psychotic children and juveniles; educational and care facilities for children suffering from cerebral palsy, and for other severely handicapped children who are not mentally retarded.

The following specialities will be represented at the regional but not the county level: internal medicine; orthopedic and physical therapy; neurophysiological diagnosis; genetic and chemical diagnosis; aptitude testing for vocational training; intensive social rehabilitative care; and clinical research.

Retarded individuals who might appropriately be serviced at the regional level include groups described below:

1. The severely disabled and multihandicapped who required considerable personal attention owing to their restless, impulsive, and sometimes destructive behavior. In the initial stage, special arrangements and facilities may be needed to protect such a person from himself. There may be feeding problems in the form of refusals to eat, habitual vomiting, or certain types of swallowing difficulties. Problems in self-control may mean that the resident cannot be looked after in the customary manner or take part in group activities.

2. Mentally retarded persons with severe physical handicaps who require a period of special diagnosis and intensive treatment must also be cared for in special residential facilities. At a regional unit, the particular technical resources for their care can be made available, and any aids that *might be required can be tried* out.

3. Retardates suffering from epilepsy may need care in a special facility, particularly if the use of drugs does not relieve them from numerous of severe attacks in which they may injure themselves

Tottie, M. , & Janson (eds.). Regional Hospital Planning. Nordiska Bokhandeln, 1967, Stockholm.

or others. They may also be strongly behaviorally affected by their epilepsy, and exhibit such peculiar behavior that their presence would have a detrimental effect on group associations in a smaller residential home.

4. Regional care will be needed for the small group of blind retardates who, after training at a special school, have mastered braille and can benefit from special technical facilities such as occupational therapy. In their case, an attempt would first be made to place them in a freer form of residential care. Regional care can often be made to have the character of a continued period of training.

5. Similarly, deaf retardates who can make themselves understood through sign language may be in need of common social contacts, as they might otherwise be completely isolated in a small institution.

6. Mental retardates with contagious tuberculosis must, of course, receive special care. Since this affects only a small group and requires special medical facilities, the best solution is to place them together at a regional hospital.

7. Mentally retarded persons with antisocial behavior, See further below.

Apart from the long-term care facilities for the groups listed above, a specialized center must also be able to provide short-term care for periods lasting a few months. This is intended as a service to various residences at the county level for those cases requiring special personnel and facilities during a case study or treatment phase. In many cases, this extends to children and youngsters, particularly when diagnosis is combined with a therapy program. In addition, there is a group, primarily made up of older children and young adults, who require careful psychological testing of their ability to absorb vocational training.

Under the heading of "acute care" at a regional center come both somatic and psychiatric cases such as jaundice, heart disease, aggravated epilepsy, postoperative care, increased anxiety or aggressiveness among the normally easily managed, etc.

For the adult mentally retarded, Engel[3] proposed that the desired number of residential beds per 100,000 inhabitants should be 30 on the regional level and 120 on the local level, boarding and foster homes excluded.

[3] Ibid.

As a comparison, I can mention that a new hospital plan for England and Wales dating from January 1962 calls for 130 hospital beds for the mentally retarded per 100,000 people by 1975. However, the plan did not include any differentiation regarding types or levels of residences.

It must, however, be emphasized in this context that estimates regarding the mentally retarded must be considered in relation to the size of various age groups and to demographic conditions. Regarding the breakdown by causes, it will be noted that there is a fairly high degree of concurrence in the frequency statistics for different countries with respect to the more severely afflicted mental retardates than is generally found among the less severely afflicted. And it is generally the former group that require care in regional centers.

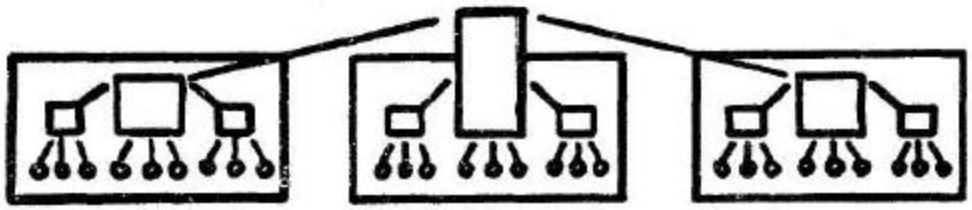
Residents in regional centers can, in principle, always be re returned to a local residential home. This also means that they will return to the proximity of their home communities. The flow of residents is thus reversible.

Figure 3 provides a schematic representation of organization of the ordinary hospital services on regional and county levels; the services for the mentally retarded are organized along the same lines.

The extent of the regional facilities is decided jointly by the member counties, but the facilities are owned and run by the county in which they are located. However, the entire responsibility for the clients still rests with the individual counties, both legally and financially.

Services for the Retarded With Antisocial Behavior. The number of retardates characterized as being antisocial is largely dependent upon how actively society helps the retardate at a preventive stage to either control his behavior or not let it lead to criminal acts. In all countries, the residential care of this group constitutes a very special problem, largely because the group includes a small number of persons who require other forms of care and confinement than the majority of retardates, e.g., those committing criminal and delinquent acts, sexual offenses, arson, etc.

In Sweden, there are as yet only four special facilities, ranging in size from 175 to 280 beds, intended for mental retardates whose behavior may be socially uncontrolled. One of these centers is for females. During recent years, the demand for such beds has dropped, and about 300 of the 900 being cared for in these institutions are actually no longer there for criminal reasons, but rather because of other mental complications, the most frequent being aggressiveness, which makes it difficult to care for them in ordinary



Regional Center serving several counties with about 1,000,000 people, as well as serving as the Central Hospital for its own county.

Central Hospital serving a county with about 250,000-300,000 people.

District Hospital serving a catchment area of about 60,000-90,000 people.

Health Centers and Nursing Homes for long-term care serving a catchment area of about 10,000-15,000 people.

Figure 3: A schematic representation of the regional organization for somatic care in Sweden. The services for the mentally retarded are along the same line.

residential homes. Of the other 600, some 100 are not classified as mentally retarded. Among the remaining 500, about half (of which only 15-20 are women) require special forms of care. They are referred to below as psychopathic mental retardates and constitute 3 per 100,000 population.

At our mental hospitals for those who are not mentally retarded, there are roughly 700 psychopaths of normal intelligence. They make up 10 per 100,000 of the population.

It is now being suggested that in a future reorganization, the approximately 250 mentally retarded psychopaths be cared for together with the other groups of psychopaths, and not at the regional facilities for the mentally retarded. The aim of this plan is to enable the other mental retardates with antisocial and delinquent but not psychopathic behavior, now being cared for in the four special facilities mentioned, to be moved to the regional centers, or to residential, homes within the various counties.

The motive for this course of action is the following. It is vital that any differentiation within the heterogeneous group of antisocial retardates is carried out with consideration to the special type of care that is desirable or necessary. At the same time, it is important that the units thus created do not cover population areas larger than a region, since the geographic distance to resident's home community and county is always an important, and sometimes decisive, factor in the social rehabilitation program. Like all other psychopaths, mentally retarded psychopaths require care facilities with relatively strict forms of custody in which there are locked quarters, special observation, and special procedures and attitudes in the personnel carrying out the rehabilitation program.

Mental retardates with antisocial and delinquent behavior who do not show any severe symptoms of criminality or psychopathy can, after detection, often be sent straight to the regional center for the mentally retarded. There they can be cared for together with the other residents or eventually placed in county residential homes. This procedure is particularly relevant for elderly persons in this group.

Two conclusions derived from programs for antisocial retardates may be mentioned here:

1. Preventive measures in the form of close supervision, provision of residential care and employment, and organized recreational activities yield greater results with the mentally retarded than with any other group in the danger zone for antisocial behavior.

2. While mentally retarded individuals may on occasion commit serious criminal acts, perhaps violent in nature, appropriate subsequent treatment may be quite mild in comparison to what is indicated for an intellectually normal person committing the same offense.

Services for the Retarded at the County Level

The current law lays down the county councils' total obligation to retardates who, because of their limited intellectual development, are in need of special services for their education, their social adjustment, or for other reasons. This is irrespective of whether the retardate is served in a county's own facilities or at the regional center. As a general rule, each county has a single agency, the Board for the Services for the Mentally Retarded, which implements the law as it affects the services for retarded children and adults.

Admission to a home or institution ordinarily requires the consent of the retardate's parents, guardian, etc., or, if the retardate is of age, he may give consent himself. Admission may take place without consent under special conditions prescribed by law.

Each county council must submit a plan for its services for the retarded for approval by the National Board of Health and Welfare and the National Board of Education. The plan must list the residential facilities required for its fulfillment. Residential facilities and schools owned and operated by private foundations or organizations must also be approved by the authorities. Such agencies may care for only those retardates directed to them by the Board for the Services for the Mentally Retarded. All services and care for the mentally retarded that are prescribed by law are provided free of charge unless the retarded person has a considerable income of his own.

Most of the retarded are served at the county level, as will be illustrated below with the example of Malmohus County.

The Services Provided by Malmohus County

Malmohus County is located at the southern tip of Sweden, across the strait from Denmark (see map, Figs. 4 and 5). Although it is one of the most populous counties, having 424,000 inhabitants and a population density of 239 persons per square mile (92/km2), it is nonetheless considered a rural area. Some 5,500 babies are born annually within the county, and more people move in than out. The County area also encircles the city of Malmo; however, since Malmo has its own organization for health services, medical care, etc., it is not included in the county administration or this description.

The County Council is responsible for all health services and medical care for the people living within its area, and it

Figure 4: Map Showing the Position of Malmo'hus County in Sweden.

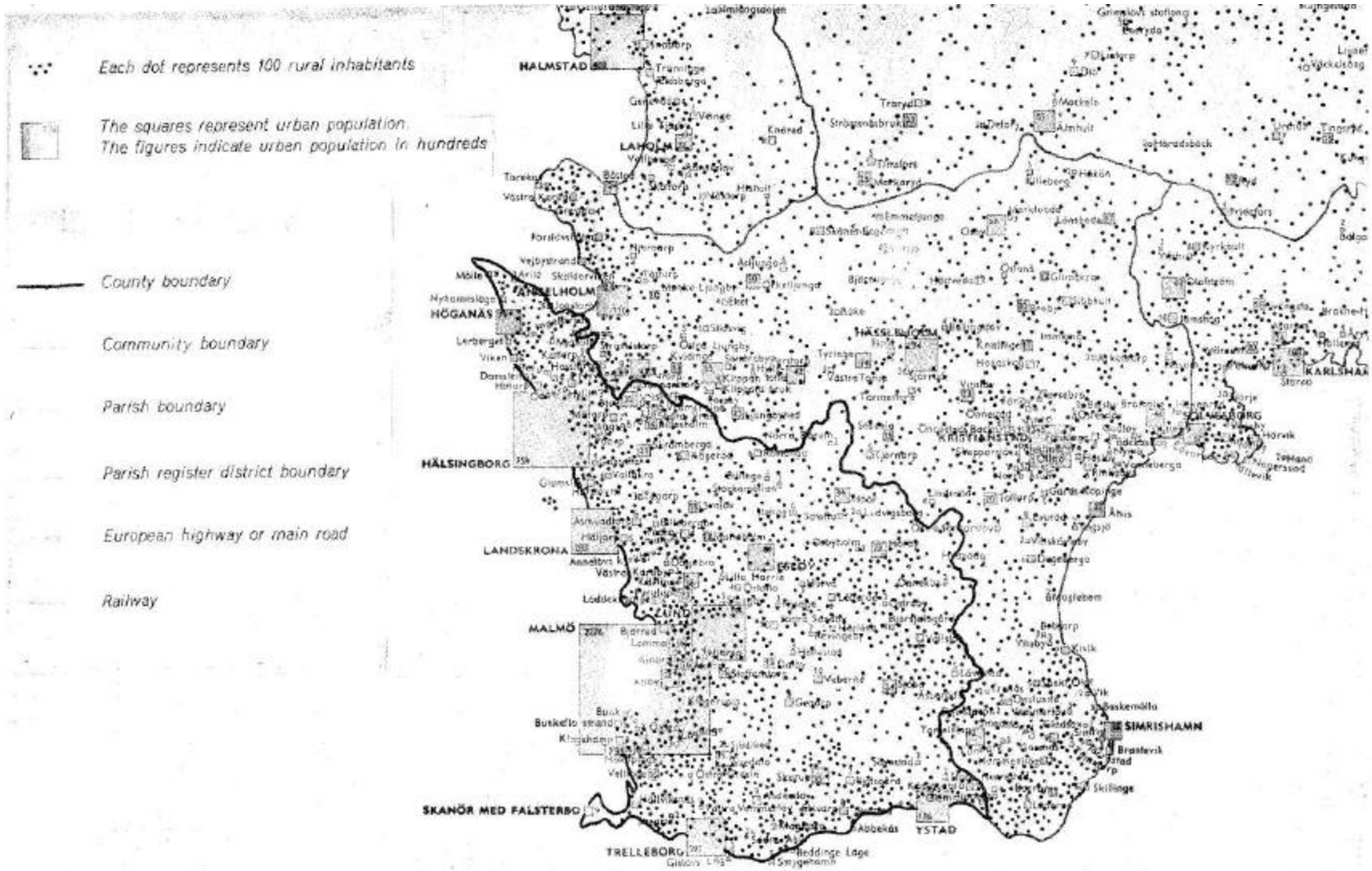


Figure 5: Malmöhus County

employs *8,270* people to this end. Of these, 574 (7 percent) are employed in the training, education and care of the mentally retarded, 111 in social services, and 166 in central administration, to mention only figures of interest here. These figures include only people on the permanent staff and not temporaries, etc.

The County Council's expenditure budget for 1968 amounts to $120 million, of which $16 million is earmarked for investments and $ 104 million for operating expenses. Seventy-seven percent of the total will be spent on general health and medical care. While 5.8 percent will be used for the education and care of the mentally retarded, compared to 2.2 percent in 1959. While County Council expenditures are now five times higher than they were in 1959, the outlay for the education and care of the mentally retarded has risen 7.5 times.

The County Council obtains 54 percent of its funds through direct taxes, currently being levied at a rate of 7.5 cents per $1.00 taxable income. State contributions and patients' fees account for roughly 45 percent, and 2 percent is derived from loans and foundations.

The County Council operates the following facilities within the pediatric and psychiatric specialists; 3 pediatric clinics with 26, 28, and 139 beds; 2 psychiatric clinics for children with 32 and 52 beds; 1 psychiatric clinic for adults with 93 beds , 2 mental hospitals for adults with a combined capacity of 2,700 beds, about 1,500 of which are occupied by patients from ether counties; and 7 mental homes with a total of 506 beds.

The medical diagnosis of the mentally retarded as well as the major part of case finding is chiefly in the hands of the pediatric and psychiatric clinics. There is thus no special diagnostic agency among the services for the mentally retarded. The motive for this is a conscious effort towards "normalization": the mentally retarded (or those suspected of being retarded) should enjoy the same resources and facilities as other members of society, up until the time at which they require special facilities. It is only then that they are directed to the County Council's organization for the mentally retarded.

It is natural that not all mentally retarded individuals are registered with the Boards of Services. The under-seven age group is probably fairly large, since all are not yet diagnosed as mentally retarded. To these must be added the mentally retarded children who receive a certain degree of therapy and guidance at pediatric and child psychiatric clinics, etc. A more active detection program is

Some of these beds are occupied by patients from other counties.

being planned: a pilot project is being carried on by the county in which all four-year-olds are given a complete physical and mental examination.

The County of Malmohus contains the regional center for four counties and Malmo City. This regional center is situated in Lund (population 50,000). In 1935, it was opened as Sweden's first special hospital for mental retardates on a national basis. Now serving as a regional center, it has some 700 beds for adults and 50 for children under 16. It will be rebuilt, with the exception of a children's unit which is only about seven years old. The new existing facilities will successively be torn down and replaced by now single story buildings. Eleven residents, divided into two groups, will be cared for in each living unit, grouped in complexes of three houses joined together.

Prior to its current reorganization as a regional center, a study was made of the requirements for the four counties and Malmo City--in all some 1.4 million people. The results are summarized in Table 3. The number of cases requiring long-term care at the regional center, in relation to the number of mentally retarded receiving care in the counties and the city of Malmo surveyed, was estimated at bewteen 13 percent and 21 percent, with a mean value of 16 percent.

The Mental Retardation Services Provided by Malmohus County

The Malmohus County Council has 98 members who are assembled for two sessions per year, lasting from 3 to 5 days each time. Under the Board of Administration, there are six subcommittees. One of these is called Committee for Educational and Social Services, which, in turn, has under it the Board for the Services for the Mentally Retarded.

The Board is made up of seven appointed directors and generally meets once a month. Its daily activities are handled by a central office with a staff of seven, including a "chief of care" and an assistant (both trained social workers), a psychiatric social worker, and an occupational therapist (both primarily occupied with retardates living in their own homes.) Attached to the central office staff are a school principal and a consultant child psychiatrist.

Figure 6 shows the age breakdown of the mentally retarded receiving services from the County Board in relation to 0.7 percent

0.7 percent of the population is estimated to be mentally retarded and in need of total or partial assistance. There is some controversy as to why this figure is smaller than comparable estimates in the United States. Better health services to mothers and young children, and lower rates of poverty and deprivation may partially account for the difference.

Table 3

A Survey of Specialized Regional Residential Needs for the Retarded of Region in Which Malmöhus County is Located

Types of Care	Age Groups			
	0-17 yrs.	18-23 yrs.	Over 23	Totals
Total Pop. in Age Group	355,000	133,000	889,000	1,375,000
Long-term Care				
Totals	73	76	317	466
Totals per 100,000 pop.	20	60	40	30*
Severely disabled difficult to manage on county level	36	44	199	279
Anti-social and delinquent	3	13	48	64
Severely physically handicapped	19	3	21	43
Epileptics	9	14	34	57
Blind	6	2	3	11
Deaf			3	3
Tuberculosis			9	9
Short-term Care	38	5	31	74
Acute Care	4	2	11	17

*Of these, 20 per 100,000 are in the severely disabled group.

of the age groups indicated. Figure 6 also comprises those who receive no more than state allowances, without being registered with the Board. There are 593 retardates over 16 in this category, of whom 11 percent live in mental hospitals or homes, and 8 percent in ordinary homes for the aged; 43 percent are being cared for by their parents or relatives; and 16 percent live in homes of their own.

In addition, Table 4 shows the number of mentally retarded children and adults receiving various forms of services the facilities shown in Table 5. A total of 2,100 mental retardates within the county receive some form of assistance from the community. They make up 0.5 percent of the population. About half of them receive residential care.

Mental retardation services in Malmohus County can be divided into residential and nonresidential services. However, some facilities render both types of service. I will now describe a few of the local service facilities in more detail.

Details About Nyhen?

This residential facility was opened in 1902 as a private establishment near the city of Halsingborg. In 1916, the home was taken over by two county councils and cared for 109 retardates. In 1923, a separate building was erected for the moderately retarded. This building was remodeled in 1965 for 26 profoundly retarded children. In 1925 another building was added for 66 profoundly and severely retarded males. At that time, this building was regarded as a model institution because of its spacious dayrooms, special isolation rooms, large wash and changing-rooms along the corridors, a special ventilation system, and many other features. In 1963, it was rebuilt to provide care facilities for 56 residents and, among other things, the entire attic was remodeled as a sheltered workshop.

Between 1959 and 1968, Nyhem has undergone a transformation typical of Swedish institutions. A substantial decrease in the . number of residents accompanied by an increase in the staff strength has resulted in considerably higher operating costs (see Table 6). However, an entirely positive result is that anxiety and aggressiveness 'have practically disappeared and the residents have become more active, happier and self-confident.

Apart from attendants and domestic staff, the staff at Nyheir, includes the following: 4 administrators and assistant administrators; 1 physical therapist; 2 qualified nurses; 2 kindergarten teachers; 1 handicrafts teacher; 7 occupational therapists and assistants; and 1 recreational supervisor. The attendants number 54, of which 56 percent have received the desired special training.

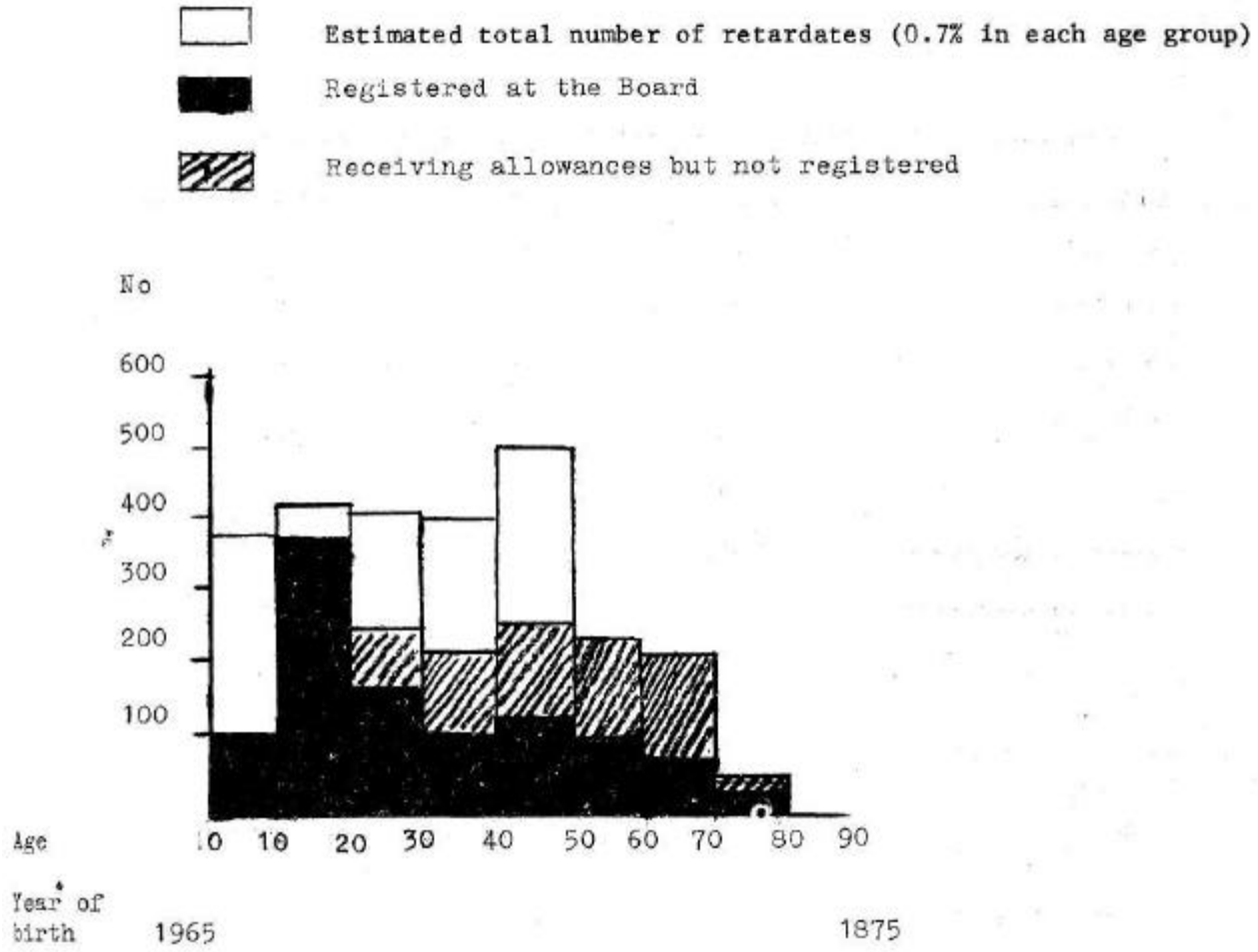


Figure 6: The Retarded of Malmöhus county by age categories.

Table 4

The Retarded in Malmöhus County and the Services They Receive

Categories	Children	Adults	Total
Boarders	278	810	1,088
Day pupils	150	41	191
Family care	1	55	56
Discharged probationally, etc.	50*	198**	248
Total	443	1,063	1,506
Percent of age group	0.55%	0.31%	0.36%
Receive allowances but not registered	—	593	—
Total		1,656	2,099
Percent of age group		0.48%	0.50%
Est. number of retardates in county			3,000 (0.7% of pop.)

*36 are day pupils

**41 attend day activities

N. B.: Children comprise the 0-16 age group

Table 5

Provisions Under the Board For the Services to the Mentally Retarded in Malmöhus County

Facilities	Residential Services		Non-Residential Services	
	Children	Adults	Children	Adults
Nyhem	26	115		20*
Möllevang School	139	36	37	3*
Georgshill		176		
Ronneholms slott		75		
Blinkarpshemmet		58		
Kullenbohemmet		25		
Osterhemmet		24		
Rabylundshemmet		23		
Furulundshemmet		22		
Klagerupshemmet		10		
Special class at Halsingborg			51	
Special class at Ystad			18	
Special class at Landskrona			8	
Vastervangen	71	48		
Day and activity home at Halsingborg			12*	2*
Day and activity-home at Lund			14*	5*
Day and activity home at Trelleborg			10*	11*
In regional centers	22	152		
At private facilities	20	46		
Foster or boarding homes			1	55
Discharged on probation, etc.			50	198
Totals	278	810	165	253
On waiting list for residential education:			11	
On waiting list for residential care:				22

*Included in the figures for those discharged on probation.

Table 6

Patterns of Change Between 1959 and 1968 in Resident, Staff and Cost Characteristics at Nyhem Residential Center

Categories	1959	1968
Residents	215	141
Staff	62	97
Residents/staff	3.46	1.45
Operating budget	$255,000	$864,000
Annual cost/resident	1,200	6,000
Daily cost/ resident	3.20	16.50

Since the center now more or less covers an entire block in a fairly central part of the city, the community has become the natural place for social training. There has thus been no need to create artificial situations within the facility. On the other hand, it is only in recent years that mental retardates living in their own homes in the city have come to the center for their daily activities, such as workshops. It is as if Nyhem has finally started to breathe.

Details About Georgeshill

Georgeshill is situated on the outskirts of Horby, a small community with roughly 4,000 inhabitants. The facility is designed for the care of 176 moderately and severely retarded adult men and women. The home was built in 1966 at a cost of approximately $2.25 million (about $13,000 per bed) and replaced an older institution which had been started in the 1920's and taken over by the County Council in 1958.

The new home is made up of six H-shaped pavilions, five being identical in layout, with 30 residents in each, and the sixth having a more hospitallike setup with 26 beds. Each residential pavilion is divided into two halves by the staff office, the toilet and bathroom units, and the kitchen. Each half is then further divided by the resident entrances into sections for seven or eight persons each. The four sections share a combined corridor-dayroom, and there is one dayroom and dining room for every two sections. There are bedrooms for one, two, or four residents, and each resident keeps his clothes in closets along the corridor. A separate building houses the administration offices, an assembly hall, and a sheltered workshop.

The 1968 operating budget at Georgeshill is $1,100,000; per resident, this amounts to.$6,150 per annum and $17,000 per diem. The staff, exclusive of consultants, consists of 95 persons, with a resident: staff ratio of 1.85.

Details About Vastervangen

Vastervangen is a newly built facility for the residential care of 71 severely and profoundly retarded children and young adults-It was constructed at a cost of $1.8 million ($16,000 per bed), and has a 1968 operating budget of $690,000. Cost per resident is $5,800 per annum, or $15.75 per diem. Vastervangen is situated in the small town of Eslov (population 15,000), and lies in a residential district consisting of one-family homes, and is bounded by streets on three sides. It is thus very much a part of the community. Its location in Eslov, however, is a departure from what is considered advisable by the authorities, as it should really be in a city where pediatric and child psychiatry clinics are available. Nonetheless, Eslov has been accepted partly because of its closeness to the University

Hospital at Lund (11 miles away), and partly because Lund is over-populated with institutions, a circumstance which has resulted in difficulties in recruiting personnel.

Various units within the facility are designed to serve different age groups. Each department has 11 or 12 beds. One building is used for personnel training, and its services are available to all the facilities for the mentally retarded within the county. Like-all residential facilities, Vastervangen is also utilized for day activities for children and adults living in the vicinity.

The staff, exclusive of consultants, consists of 75, with a resident: staff ratio of 1.58. Apart from attendants and domestic personnel, the staff includes 3 administrators and assistants, 1 physiotherapist, 1.5 trained nurses, 2 kindergarten teachers, 3 occupational therapists and assistants, 4 occupational supervisors, and 1 recreational supervisor.

Details About Mollevang School

As early as 1874, a committee was appointed by the County Council to draw up a proposal for the "care and educational establishments for idiot children." In 1878, Mollevang School was opened outside Lund and has ever since served as the county's boarding school for mentally retarded children. The school has, of course, been rebuilt and expanded several times, most recently in 1957, and a special home for 35 small children was added in 1956.

In the traditional manner, there had been special units for residents who after completing their training at the school, and after becoming adults, could not return to society. It was not until this year that the last group of such adults could be transferred to other facilities, finally making Mollevang School a home strictly for children. Mollevang School is almost the last residential school in the county to accomplish this. At present, the age of the children range from 5 to about 20, but 74 percent are between 9 and 16. Most of the children have IQs between 50 and 70.

The school serves 139 boarders and 37 children who live in their own homes but come to the school every day. Five of the bedrooms accommodate 506 pupils, while all the others have three beds.

The teaching staff at Mollevang School is made up of the following: 11 general school teachers; 3 handicraft instructors; 2 kindergarten teachers; 1 housekeeping teacher; 1 physical training instructor; and 1 gardener-instructor

During the past 10 years or so, great efforts have been devoted to eliminate the boarding school character of Mollevang School so that the children get as much contact with the community as possible. One way to accomplish this was to increase the children's contact with their families. At present, about 50 percent go home over the weekend, 19 percent go at least twice a month, and 8 percent once a month. Nineteen percent go home only for major vacations, and a mere 4 percent never go home. Also, the number of children attending the school on a day basis has increased greatly since 1959 (see Table 7). As can be seen, while the number of day pupils attending special schools has increased greatly, the number of boarders has dropped slightly.

Miscellaneous Service Provisions

There are now plans to expand day-school education, and for this purpose the county had been divided into six school districts. The populations in these districts range from 42,000 to 121,000. The number of places at special schools is based on a ratio of 70 per 100,000 population," corresponding roughly to 0.5 percent of children born in any one recent year. In Malmohus County, this amounts to 30 to 87 places per district. Some cf these children will still have to be boarders for social reasons because of poor travel communications with the school.

The expansion of day-school services will be accomplished by establishing special classes at ordinary schools--a form of class integration. Finally, a regional vocational school will shortly be opened in another county, and Malmchus County has contracted 11 places there.

There are at present 25 men, but no women, with antisocial behavior in the special facilities for the mentally retarded in Malmohus County. It is expected that in the future, about half of these will probably be confined at the national level together with other categories of psychopaths, who are not mentally retarded, while the remainder will be cared for at the regional center and at residential homes in the county.

Fifty-five adults (and one child) are placed in foster boarding homes. These individuals are mildly or moderately retarded persons for whom the Board has assumed full economical and guidance responsibility and who are boarded with families other than their own. About

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This ratio has been derived from available statistics and previous experience. No county ought to base calculations on a lower figure, while some are likely to use a higher one, up to 100 per 10C,OCO.

Table 7

Changes in Resident Data at Møllevang School Between 1959 and 1967

Year	Boarding Pupils	Day Pupils	Probationary Discharges	Placements Into Special Schools Outside the County	Totals
1959	144	15	38	5	197
1967	139	104	95	20	362
Differences	-5	+83	+57	+15	+165

57 percent are employed on farms. All received a basic $17 per month as pocket money and were also paid wages based on performance.

In addition, there are also 198 retardates above the age of 16 who have been probationally discharged from care. The majority live with their parents. About half of these 198 are mildly retarded young people who have completed vocational training in special schools and require some form of guidance during their first year of employment. The other half are moderately and even severaly retarded persons. They are entitled to free medical and dental care and generally some form of financial aid ranging from $20 to $80 per month, over and above their state pension of approximately $80 received by all retardates. Nearly half of them work in sheltered workshops or have similar employment. About one-fourth are visited regularly by an occupational therapist, while the remainder are incapable of or have access to organized activities.

Finally, there are 50 children under 16 who have been registered with the Board but reside in their own homes; 36 of them participate in day activities. These are severely or profoundly retarded children whose parents receive $60 per month from the state, as do all parents who care for a severely handicapped child at home. This benefit is also given to parents whose children attend special classes but live at home, in all 114 children in the county. (See Tables 4 and 5)

Conclusion

If we compare our situation today with that of the preceding generation, it is easy to get the feeling that all that now remains are a few minor details, some subtle features regarding the actual design of services for the mentally retarded. However, if we look to the future and compare today's objectives with the available resources--ideals with reality--the discrepancy sometimes seems paralyzing. The ultimate solution will probably be found in a sort of following-up process in which a feedback of the results at every stage leads to further innovations in methods and actions. Elaboration of regional services (as propounded by Engel) would be one such innovation.