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REPORTS AND MEMORANDA FOR DAVID J. VAIL, M.D.

FROM DR. RUSSELL BARTON, M.B., M.R.C.P., D.P.M.

August 14 to September 2, 1967

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67-RMD-RUB

I N T R O D U C T I O N

I was employed by the Department of Public Welfare as a Consultant Psychiatrist, from August 14th to September 2nd, 1967, to consult with the Director of the Medical Services Division and his staff on implementation of the program for improving humane practices and living conditions in the institutions for the mentally ill and mentally retarded under the jurisdiction of the Medical Services Division, especially those having to do with the mentally retarded. Such consultation included but was not limited to the reevaluation of ward ratings and checking research instruments used in the ward evaluation study; conferences with the Medical Services Division staff, the Humane Practices Committee, and other groups; and participation in meetings with hospital and institutional personnel, in particular those working in mental retardation facilities, such meetings were aimed at further reducing problems in those facilities, especially problems related to living conditions on wards and other dwelling units. Such consultation included general advice to the Medical Services Division Director and his staff on methods of improving the overall programs, including but not limited to institutional programs.

During this period I have visited various institutions, attended meetings of committees, given talks and discussed with many people the plans and problems of care of the mentally ill and retarded in the State of Minnesota.

I have welcomed the privilege to work with the staff of the Medical Services of the Department of Public Welfare and have pleasure in presenting some account of my work.

Russell Barton.

Russell Barton, M.B., M.R.C.P., D.P.M.
Consultant Psychiatrist

TO: David J. Vail, M.D.
Medical Director

DATE: August 26, 1967

FROM: Dr. Russell Barton
Visiting Consultant Psychiatrist

SUBJECT: Confidential Report on Visit to Cambridge State Hospital 8/22/67

Mr. Lucero and Dr. Russell Barton visited Cambridge State Hospital on Tuesday, August 22, 1967. Their objectives were:

1. For Dr. Barton to make independent ratings of a sample of Ward Living Conditions to test consistency of rating made by Dr. Vail and Joe Lucero in April, 1967.

2. To compare 1967 ratings with ratings made in May, 1965. The principal instrument in rating being the Ward Rating Scale developed by Vail, Barton, and Lucero in 1965. This consists of a questionnaire which is filled in by ward staff. From the completed questionnaires the wards are rated and then a sample of wards visited to check reliability of answers.

3. To discuss the implications at the changed rating in ward living conditions with Dr. Gailitis and Miss Anderson, Director of Nurses, and to formulate the nature and content of an afternoon meeting with senior hospital staff which they thought would be most helpful in furthering the aims of the institution and Central Office.

We were received with cordiality and kindness at Cambridge State Hospital and every help and facility was given to us.

Cottages #2,3,5,9,11,12, Independent Living and day activity centers were inspected and the rating scale found to be consistent and reliable.

Considerable improvement has occurred but the immeasurable improvement which strikes a visitor after two years' absence is the great increase and extension of morale and sense of commitment of members of hospital staff, especially psychiatric technicians. This was the outstanding impression of change. This sincerity and dedication has been matched by improvements in Ward Living Conditions and by patients' performance. To quote one example: The reorganization of eating arrangements so that more disturbed and regressed patients eat first and sit at places next to the wall has enabled an increased number of patients to be trained to feed themselves and to carry their own trays from self-service counter to their tables. This achievement should not be underrated.

Other impressive schemes were the foster grandparents program and the college students activities. The introduction of a six monthly program assessment appears to be successful in getting staff to consider and take stock of their MR services. In the afternoon, we met with departmental heads; program leaders; medical staff; nurses and psychiatric technicians.

The purpose of the meeting: to enable staff to scrutinize their practices, to examine their objectives, and to discuss ways and means of

achieving them.

The afternoon discussion group was rather too large to allow usual group techniques.

PROCEDURES AND DISCUSSION

Scores taken from the 1965 and 1967 Ward Rating Scales, with graphs to show raw scores and gradient of change were distributed and the significance of these changes was discussed.

The importance of alignment of goals for all members of staff was emphasized and the reasons for improvement of morale and patient achievement examined.

The meeting was somewhat dominated by Mr. Charles Turnbull who acted as spokesman, thus preventing other members of the group from contributing as much as they might, reducing their role from participant to onlooker.

Nevertheless the discussion was satisfactory. Opportunity was taken to congratulate the staff on their achievement.

CONCLUSIONS

The sharing of charisma with ward technicians, recognition of their responsibility to patients and judicious delegation of authority has resulted in great improvements. This has been given added fillip by the Federal foster grandparents and college student programs.

OBSERVATIONS

Continuing education of staff with workshops and so forth remains essential. Especially required is a working knowledge of the purpose and function of groups (Executive, Advisory, Therapeutic, Educational). The nature of participation, communication and simple discussions on the lines of "Games People Play" by Eric Berne.

Scrutiny of functions and efficiency of the various programs should be made at, say, six month intervals. This could well follow the six month program assessment made by the cottages.

Now that the programs are underway, examination of 'discontinuity' of personnel may be useful. The lines of authority and sources of advice may have become obfuscated. Psychiatric technicians did not always seem to know to whom they should take their problems. Problems did not always seem to be dealt with expeditiously -- according to several workers.

It seems probable that some of the hostility and dissension noted at times results from the threat to the sense of responsibility of department heads by the authority of the program leaders and the programs themselves.

It seems important that the requests for supplies, staffing, population changes, recommended in the six month program assessments are manifestly seen to be noticed by the appropriate authorities -- maintenance staff, business manager, Central Office, and so forth. Maybe the comparatively minor recommendations could be implemented without great

cost or delay. Arrangements of requests under priorities such as "Urgencies", "Necessities", and "Niceties" by the staff could be helpful to the executive in deciding priorities.

The need for all staff to define and accept the objectives of the service for mentally retarded patients persists. Perhaps it would make a useful, albeit implicit, theme for further workshops. Medical records appear to need scrutiny and simplification.

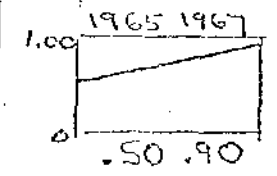
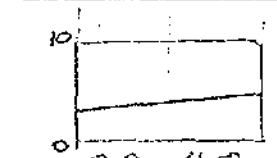
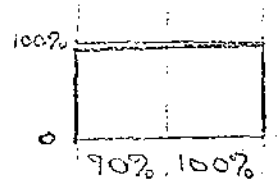
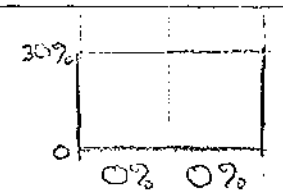
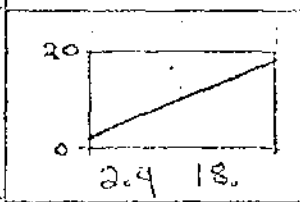
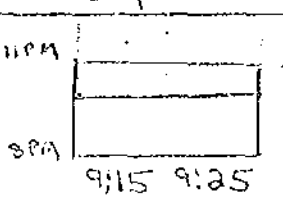
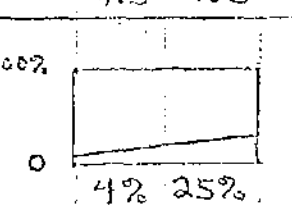
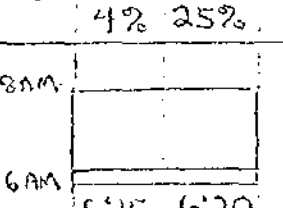
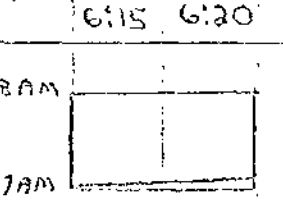
In spite of the above observations, we came away with a feeling that a good job is being done. So much is happening at Cambridge, it might be useful for groups of staff from other MR institutions to visit.

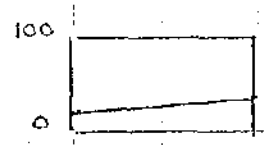
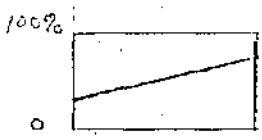
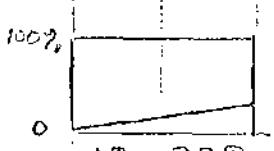
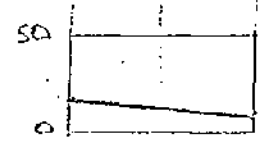
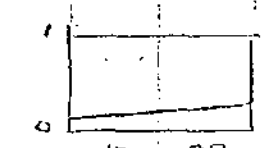
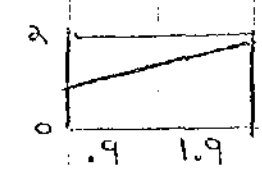
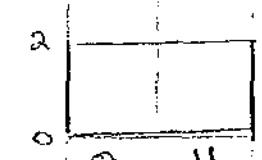
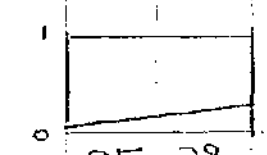
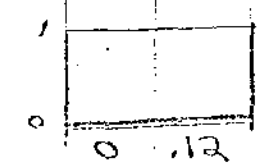
Appendix I: Details of changes in Ward Living Conditions at Cambridge State Hospital, 1965-1967.

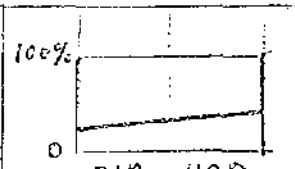
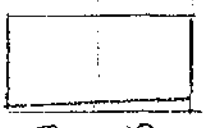
Appendix II: List of suggested improvements made by staff.

CAMBRIDGE

— 17 —

NUMBER OF DORMS LOCKED ALL DAY. 10A	
NUMBER OF PATIENTS IN SECLUSION PAST MONTH. 11F	
PERCENT OF PATIENTS ALLOWED A NAP. 12	
PERCENT OF PATIENTS ALLOWED TO WATCH TV AFTER 10:00PM 15	
NUMBER OF PLANTS ON WARD. 17AB	
WHEN IS BEDTIME? 20	
PERCENT OF PATIENTS ALLOWED UP AFTER BEDTIME. 21	
WHAT TIME ARE PATIENTS UP IN THE MORNING? 22	
WHAT TIME IS BREAKFAST? 23A	

NUMBER OF PICTURES. 24AB	
PERCENT OF PATIENTS WITH PLACE FOR POSSESSIONS. 27A	
PERCENT OF PATIENTS WITH LOCK. 27B	
NUMBER OF WINDOWS WITHOUT CURTAINS. 28	
NUMBER OF SNACK ROOMS 29	
NUMBER OF IRONS. 31	
NUMBER OF WASHERS AND DRYERS. 32	
NUMBER OF POP MACHINES 37	
NUMBER OF WATER COOLERS. 38	

PERCENT OF PATIENTS WITH ACCESS TO TOILETRIES. 42	
NUMBER OF FULL LENGTH MIRRORS. 44	

CHANGES IN WARD LIVING CONDITIONS 1965-1967

APPENDIX II. LIST OF SUGGESTIONS FOR IMPROVEMENTS MADE BY WARD STAFF IN ANSWER TO QUESTION #47 IN APRIL, 1967.

QUESTION 47: WHAT THINGS WOULD YOU LIKE TO SEE IMPROVED ON YOUR WARD?
(Listed in the Order of Frequency)

More staff, technicians, linen workers
More electrical outlets in day rooms, bathrooms, wards, recreation rooms, and barber shop
More privacy in dorms and bathrooms
More outdoor and indoor recreational equipment in buildings
More toilets to speed up toilet training program
Toilet seats
More play equipment for children's wards; balls, plastic toys
New curtains or drapes
More and better furnishings for wards and day rooms (chairs, rockers, sofas)
Fewer residents
Better facilities for handling soiled laundry and garbage
Removal of security screens
Better storage for residents' clothes and for private belongings
Washer and dryer
Valances on the windows
Air conditioning
Partitions in toilets
More ward activity
More aides
More volunteers
Open doors to outside controlled areas
New reading lamps
Cooking facilities for patients to prepare snacks
Better facilities for receiving food in cottages and for keeping it warm
Ramp so residents have easier access to play yard
More time to conduct group sessions
New plastering and a paint job
Picnic tables and benches in yards and on the mall
Dixie cups for drinking
Paper towels in bathrooms
More and better clothes closets, closer to sleeping area
Better lighting in clothes rooms
Cabinets for storage of toys and games on wards
Divide day rooms into several areas for smaller groups of patients and for different types of patients
Paper towel cabinets in dorms
Portable library, puzzles, pictures
New medicine cabinet
Beauty parlor
A flush hopper for washing out soiled clothing
Built-in bookcases
More help for remotivation program
Cupboards for storing dishes
Night aide relief
More small quiet rooms where residents can go to be alone
Upper-half-opening doors to day rooms for better supervision when staff is short
Screen enclosures to stairs to dorms allowing for more open wards
Better side rooms
Sick room facilities

Cambridge (Cont.)

Screen door to front hall for better ventilation
Windows in halls adjoining day rooms
Curtains for all rooms on children's and North and East wards
Clock on south side of Cottage 5
Outside lines to hang clothes on
Subscriptions to daily papers and current magazines
A yard with grass and no sand burrs
Outside entrance from South Ward porch to play yard so patients can go in and out at will
Exhaust fan for North Ward
New Hi-lo hospital beds

TO: David J. Vail, M.D.
Medical Director

FROM: Dr. Russell Barton
Visiting Consultant Psychiatrist

SUBJECT: Confidential Report on Visit to Faribault State Hospital 8/24/67

Mr. Lucero and Dr. Russell Barton visited Faribault State Hospital on Thursday, August 24, 1967. Their objectives were:

1. For Dr. Barton to make independent ratings of a sample of ward living conditions to test consistency of ratings made by Dr. Vail and Joe Lucero in April, 1967.

2. To compare 1967 ratings with those made in 1965, the principal instrument for ward rating being the ward rating scale developed by Vail, Barton, and Lucero in 1965. This consists of a questionnaire which is filled in by ward staff. From the completed questionnaire, the wards are rated and then a sample of wards visited to check reliability of answers.

3. To discuss the implications of the changes noted in Ward Living Conditions with principal officers: Dr. Engberg (Medical Director), Mrs. Audrey Lethebridge (Director of Nursing), and Mr. Dean Nelson (Chief of Social Service) and Mrs. Alvira Hiltz (Chief of Nursing Programs); and to formulate the nature and content of an afternoon meeting with selected hospital staff which they consider would be most helpful in furthering the aims of the institution and Central Office.

Cottages: Ivy North; Holly; Oaks; Poppy North; Poppy South; Dakota North; East Birch; West Birch; Spruce; Linden East and Linden West were inspected and the rating scale found to be consistent and reliable.

Considerable improvement in the care of patients has occurred over the last two years. Ward living conditions have improved and staff seem more generally conscious of their goals and their own personal contributions. The improvement is not uniform and one or two areas will probably not improve until more resources in the way of staff are made available -- and the number of severely and profoundly retarded patients in any building reduced.

It was pointed out to us that removing patients with mild and moderate retardation will not basically assist Faribault service. Patients who can dress and feed themselves do not command too much time -- indeed by having certain ward or hospital tasks assigned they may assist staffing problems "Patient Paeonage". Some patients doing a useful job in cafeteria are being paid only one dollar a month.

The suggestion that removal of a number of profoundly retarded patients would give staff elbow room and breathing space to intensify their programs is worth noting.

The system of reviewing medical records to decide whether admission

was necessary, whether investigation and treatment was adequate and whether discharge was too soon or too late seems a most useful exercise. This type of scrutiny of professional care and concern coming from within the hospital could well serve as a model for other institutions.

Scrutiny of admissions with increased emphasis on need for community care has resulted in only the more difficult, destructive or demanding patients coming into hospital. This, in turn, may increase the stigma of admission to Faribault which exists in the mind of the general public.

With the programs at present being energized and the results being obtained, it is difficult to understand the goals of the commissioners for accreditation. Presumably more stress has been paid to standards of building, medical records, overcrowding, and general medical and nursing care than on the standards of care and service directed at making the most, utmost, of the limited abilities of mentally retarded patients.

The suggestion that new patients be admitted directly to the cottage on which they would subsequently live seems worth pursuing. This enables the patient and his family to relate to one set of staff and reduces the confusion caused by moving from admission hospital ward to a cottage after rapport has been established with relatives and friends have been made by the patient.

The learning experiment (picnic and circus) for August 26 appeared to have been well organized and communications adequate.

The Foster Grandparents scheme and college student activities seem to be well integrated and providing invaluable assistance to patients. Continuing instruction and encouragement to foster grandparents by staff seems desirable.

The cardex system in some wards with a card giving details of each patient and objectives of good nursing care was most impressive. It orientates nursing staff, new to a ward, right away and gives them essential cues for action. It would be worth introducing in other hospitals and schools.

In the afternoon we met with departmental heads, program leaders, medical staff, nurses and psychiatric technicians and maintenance engineer -- about 30 people were present.

The purpose of the afternoon meeting: to enable staff to scrutinize their practices, to examine their objectives and discuss ways and means of achieving them.

PROCEDURES AND DISCUSSION

Scores taken from the 1965 and 1967 ward rating scales, with graphs to show raw scores and gradient of change were distributed and the significance of these changes was discussed.

The importance of alignment of goals of program leaders, psychiatric technicians and other staff was discussed and examples of non-alignment of goals given.

The reasons behind the improvement of Faribault's services to M.R. patients was discussed and the nature of commitment, responsibility and morale discussed.

The meeting was too large to allow usual group techniques, but Dr. Engberg acted as a permissive chairman and useful comments were made. An interesting discussion between psychiatric technicians, the housekeeper and maintenance engineers occurred, enabling each to appreciate the problems (and prejudices) of the others.

CONCLUSIONS

Faribault State Hospital is carrying a heavy load and disappointment occurred with failure to obtain accreditation when everyone appreciates the service is good in spite of overcrowding, staff shortage and some poor buildings.

OBSERVATIONS

There is a great deal of anxiety that with the removal of the most rewarding M.R. patients the staff will be left with a surfeit of chronic, regressed, demanding and difficult patients who will not respond to treatment programs sufficiently to motivate staff to sustain their efforts.

Continuing education of staff is necessary and perhaps further clarification of the roles of program leaders, nurses, psychiatric technicians, and so forth, would help. "Discontinuity" of Personnel is worth scrutinizing. The lines of authority and sources of advice may have become abfuscated. Psychiatric technicians did not always seem to know to whom they should take their problems. Problems did not always seem to be dealt with expeditiously -- according to several workers.

It seems probable that some of the hostility and dissension noted at times results from the threat to the sense of responsibility of department heads by the authority of the program leaders and the programs themselves. It seems important that the requests for supplies, staffing, population changes, recommended in the six month program assessments are manifestly seen to be noticed by the appropriate authorities -- maintenance staff, business manager, Central Office, and so forth. Maybe the comparatively minor recommendations could be implemented without great cost or delay. Arrangements of requests under priorities such as "Urgencies", "Necessities", and "Niceties" by the staff could be helpful to the executive in deciding priorities.

The need for all staff to define and accept the objectives of the service for mentally retarded patients persists. Perhaps it would make a useful, albeit implicit, theme for further workshops.

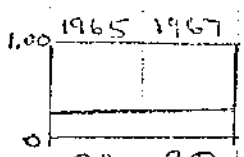
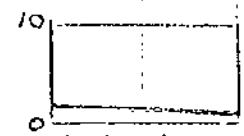
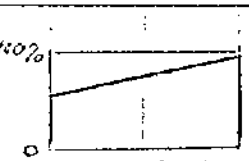
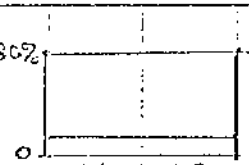
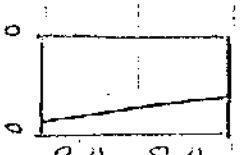
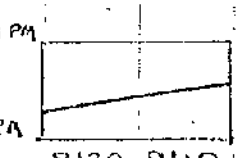
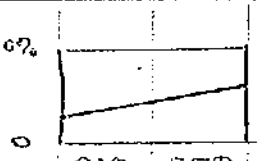
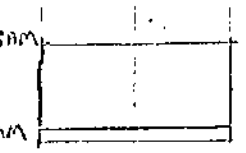
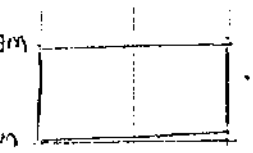
Medical records appear to need scrutiny and simplification.

In spite of the above observations we came away with a lasting impression that a lot of programs and first class work is being done at Faribault.

Appendix I: Details of changes in Ward Living Conditions at Faribault State Hospital, 1965-1967.

Appendix II: List of suggested improvements made by staff.

FARIBAULT
—33—

NUMBER OF DORMS LOCKED ALL DAY. 10A	
NUMBER OF PATIENTS IN SECLUSION PAST MONTH. 11F	
PERCENT OF PATIENTS ALLOWED A NAP. 12	
PERCENT OF PATIENTS ALLOWED TO WATCH TV AFTER 10:00PM 15	
NUMBER OF PLANTS ON WARD. 17AB	
WHEN IS BEDTIME? 20	
PERCENT OF PATIENTS ALLOWED UP AFTER BEDTIME. 21	
WHAT TIME ARE PATIENTS UP IN THE MORNING? 22	
WHAT TIME IS BREAKFAST? 23A	

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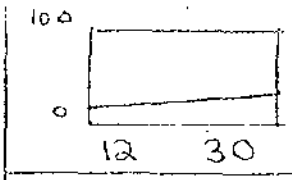
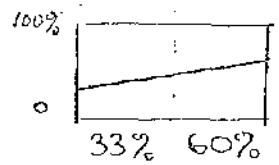
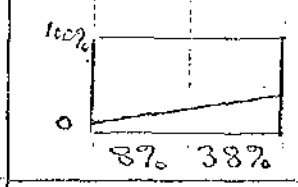
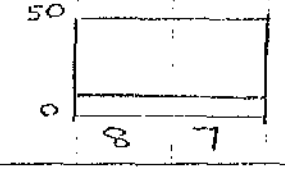
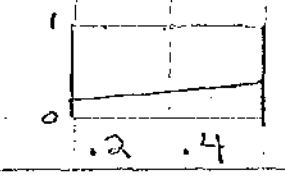
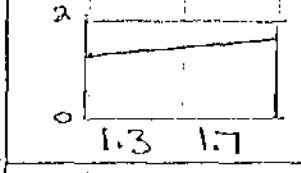
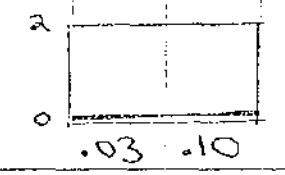
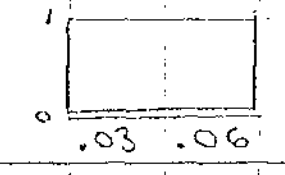
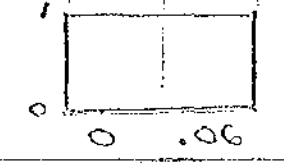
NUMBER OF PICTURES. 24AB	
PERCENT OF PATIENTS WITH PLACE FOR POSSESSIONS. 27A	
PERCENT OF PATIENTS WITH LOCK. 27B	
NUMBER OF WINDOWS WITHOUT CURTAINS. 28	
NUMBER OF SNACK ROOMS 29	
NUMBER OF IRONS. 31	
NUMBER OF WASHERS AND DRYERS. 32	
NUMBER OF POP MACHINES 37	
NUMBER OF WATER COOLERS. 38	

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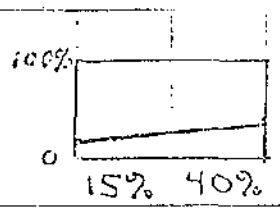
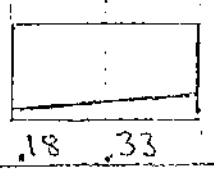
PERCENT OF PATIENTS WITH ACCESS TO TOILETRIES.	42	
NUMBER OF FULL LENGTH MIRRORS.	44	

CHANGES IN WARD LIVING CONDITIONS 1965-1967

APPENDIX II. LIST OF SUGGESTIONS FOR IMPROVEMENTS MADE BY WARD STAFF IN ANSWER TO QUESTION #47 IN APRIL, 1967.

QUESTION 47: WHAT THINGS WOULD YOU LIKE TO SEE IMPROVED ON YOUR WARD?
(Listed in the Order of Frequency)

More technicians
More toilets
Fans for toilet rooms, sleeping rooms, day rooms
Drapes and curtains
Fewer patients
More showers
More curtains for showers
Water coolers
Full length mirrors
Partitions with doors between toilets
Wardrobes in dormitories (to provide 'personal territory')
Rumpus rooms with equipment
New beds and mattresses
New furniture: davenports, chairs, tables
Appliances: washers, dryers, vacuum cleaners, refrigerators, clocks, scrubbers
Better lighting
Electrical outlets in bathrooms for shaving and better shaving facilities
Re-painting walls in color (I think white or off-white walls are more elegant. Color can be provided by curtains, carpets, furniture, and flowers.) Comment by Dr. Russell Barton inserted.
More tubs and better bathing facilities
Bed-stands and lockers
Wash bowls off wards and day rooms
TV in bedfast dorms
Replacements for broken TV sets
More custodial help
Empty rooms off dorms for sick patients on short-term basis
Stoves and cooking facilities for group therapy
More supplies for patient care
Newer equipment
New building
Better exits
Better ventilation
Better, more modern and lighter wheelchairs
Better salaries
New files located near wards
Humidifiers
Lunch room in building
Stereo for therapy
Seat covers for stools
Larger clothing room and more individually-marked clothing
Coffee tables in coffee room
Pop machine
Telephone on wards
Tile on bathroom walls
Pictures and planters
Lounges with carpeting
Dressing tables on wards with mirrors and drawers
Treatment office on ward for giving medications
Protective screens on windows to prevent window breakage

TO: David J. Vail, M.D.
Medical Director

FROM: Dr. Russell Barton
Visiting Consultant Psychiatrist

SUBJECT: Confidential Report on Visit to Brainerd State Hospital 8/23/67

Mr. Lucero and Dr. Russell Barton visited Brainerd State Hospital on Wednesday, August 23, 1967. Their objectives were:

1. For Dr. Barton to make independent ratings of a sample of ward living conditions to test consistency of ratings made by Dr. Vail and Joe Lucero in April, 1967.

2. To compare 1967 ratings with those made in 1965, the principal instrument for ward rating being the ward rating scale developed by Vail, Barton, and Lucero in 1965. This consists of a questionnaire which is filled in by ward staff. From the completed questionnaire, the wards are rated and then a sample of wards visited to check reliability of answers.

3. To discuss the implications of the changes noted in Ward Living Conditions with principal officers: Mr. Peterson (Administrator), Mrs. Eckstrom (Director of Nursing), Father Tyson (Chaplain), Mr. Russ Burton (Maintenance Engineer), Dr. David Willenson (Psychologist) and Mrs. Alvira Hiltz (Chief, Nursing Programs); and to formulate the nature and content of an afternoon meeting with selected hospital staff which they consider would be most helpful in furthering the aims of the institution and Central Office.

We were received with cordiality and kindness at Brainerd State Hospital, and every help and facility was given us.

Buildings #5,6,7,8,19 (Cafeteria) were inspected and the rating scale found to be consistent and reliable. Improvement has occurred both in ward living conditions and in some groups of patients. Unfortunately, we were not able to see the operant conditioning program in action, since our tour of the wards began at 10:45 A.M. and the programs were suspended for lunch. The large amount of solicitous importuning encountered "Do you know my name" or "Look (admire what I've got)" suggests the programs still fall short of individual care directed at improving social adaptation.

A particularly ingenious incentive was the itemized chart of patient behavior, publicly displayed in Ward #10. Bedmaking, Good Grooming, Behavior, and Meals were the headings across the top and stars awarded to each patient according to performance. A further notable achievement was the arrangement of tables in the cafeteria (Building 19) so that, as patients improve in their eating habits, they move to better tables. Incentive to move to tables with more prestige is provided by enthusiasm of staff.

The Foster Grandparents scheme and college students activities were witnessed in action. Discussions with foster grandparents and students reveal the obvious that success and satisfaction or failure and frustration

are functions of the personality of individual foster grandparent or student. The initial orientation course is appreciated. Maybe brief refresher periods and inclusion in one or two pertinent, purposive discussions by program leaders would be worth considering.

In the afternoon, we met with heads of departments, program leaders, nurses, psychiatric technicians, and Mr. Peterson (Administrator). The purpose of the meeting: To enable staff to scrutinize their practices, to examine their objectives and discuss ways and means of achieving them.

The meeting was dominated by Mr. Peterson who acted as spokesman. Presumably he felt a personal responsibility to prevent silences but in acting as spokesman reduced the role of others present to passive onlookers rather than active participants. However, there was general agreement with most of the points made.

The afternoon discussion group was rather too large to allow usual group techniques.

PROCEDURES AND DISCUSSION

Scores from the 1965 and 1967 ward rating scales with graphs to show raw scores and gradient of changes were distributed and the significance of these changes was discussed. The importance of alignment of goals for all members of staff was emphasized.

It was generally felt that improvements at Brainerd had been achieved by:

1. The introduction of programs.
2. Increase of number of staff.
3. Staff were getting incentive and reward from feedback from improvements in patients' behavior.
4. The reorganization of social workers.
5. The decentralization of medical records.
6. Weekly meetings of a "cabinet of supportive services" to discuss patient care.
7. Increasing exercise of ingenuity and effort to overcome obstacles by psychiatric technicians.

In discussing Patient-Staff ratio it became apparent that the general feeling was that the reduction of number of patients per ward was preferred to increasing numbers of staff -- but both reduction of patients and increase of staff were deemed necessary.

Opportunity was taken to congratulate staff on their achievement.

CONCLUSIONS

Improvements indicated on the scales were confirmed by this visit.

OBSERVATIONS

The contribution (success or failure) of the Operant Conditioning program requires further evaluation.

Unconscious obstructions to programs need identifying, wherever possible, and correcting, e.g., Foster Grandparent Program may be obstructed by poor matching of patient and grandparent -- e.g., assigning a frail arthritic foster grandparent to an overactive child.

The level of psychiatric and medical skill with the present consultant or call system may present problems from time to time.

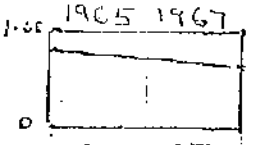
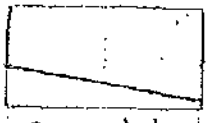
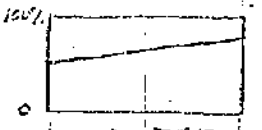
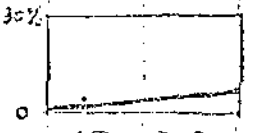
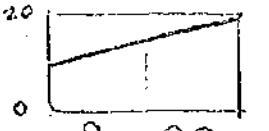
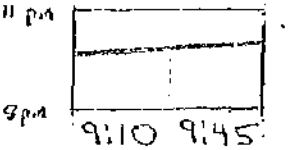
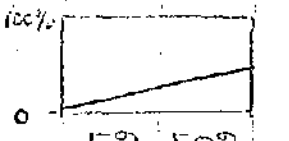
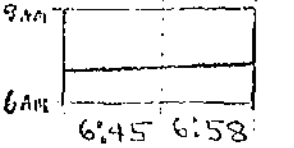
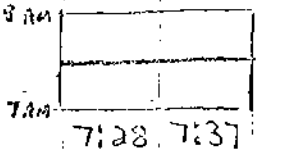
One gets the impression at times of an uneasy equilibrium between senior staff. Psychiatric technicians and nursing staff impressed us with their dedication and devotion.

More planned activities so that each child has as full a program of interests and occupations as possible seem desirable.

Appendix I: Details of changes in Ward Living Conditions at Brainerd State Hospital, 1965-1967.

Appendix II: List of suggested improvements made by staff.

BRAINERD
— 15 —

NUMBER OF DORMS LOCKED ALL DAY. 10A	 .80 .67
NUMBER OF PATIENTS IN SECLUSION PAST MONTH. 11F	 3.8 1.1
PERCENT OF PATIENTS ALLOWED A NAP. 12	 50% 78%
PERCENT OF PATIENTS ALLOWED TO WATCH TV AFTER 10:00PM 15	 1% 7%
NUMBER OF PLANTS ON WARD. 17AB	 9. 20.
WHEN IS BEDTIME? 20	 9:10 9:45
PERCENT OF PATIENTS ALLOWED UP AFTER BEDTIME. 21	 5% 50%
WHAT TIME ARE PATIENTS UP IN THE MORNING? 22	 6:45 6:58
WHAT TIME IS BREAKFAST? 23A	 7:28 7:37

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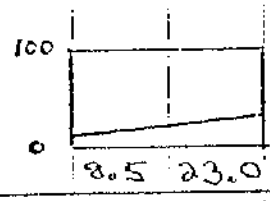
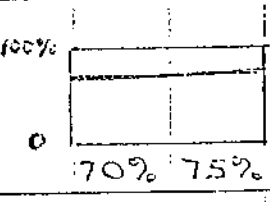
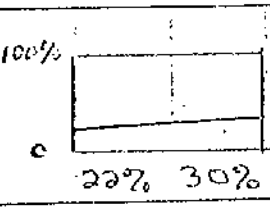
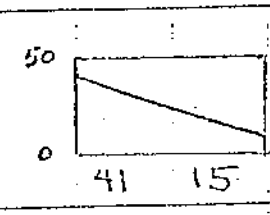
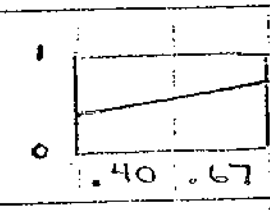
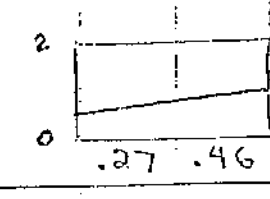
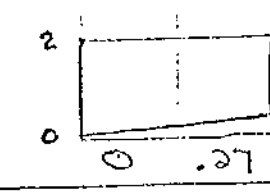
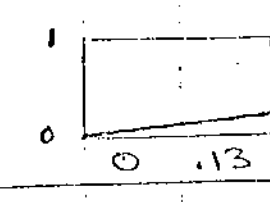
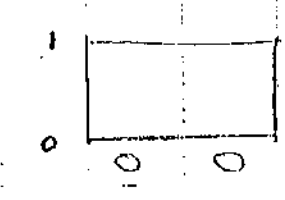
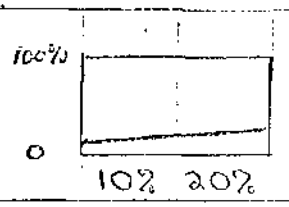
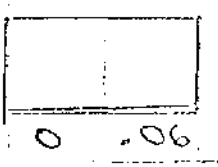
NUMBER OF PICTURES. 24AB	
PERCENT OF PATIENTS WITH PLACE FOR POSSESSIONS. 27A	
PERCENT OF PATIENTS WITH LOCK. 27B	
NUMBER OF WINDOWS WITHOUT CURTAINS. 28	
NUMBER OF SNACK ROOMS 29	
NUMBER OF IRONS. 31	
NUMBER OF WASHERS AND DRYERS. 32	
NUMBER OF POP MACHINES 37	
NUMBER OF WATER COOLERS. 38	

PERCENT OF PATIENTS WITH ACCESS TO TOILETRIES. 42	
NUMBER OF FULL LENGTH MIRRORS. 44	

CHANGES IN WARD LIVING CONDITIONS 1965-1967

APPENDIX II. LIST OF SUGGESTIONS FOR IMPROVEMENTS MADE BY WARD STAFF IN ANSWER TO QUESTION #47 IN APRIL, 1967.

QUESTION 47: WHAT THINGS WOULD YOU LIKE TO SEE IMPROVED ON YOUR WARD?
(Listed in the Order of Frequency)

More staff to train patients in table manners, personal grooming, bed making, housekeeping in bed area, social graces, personal hygiene, less tension and aggression
More soft furniture: benches, sofas, chairs
Fewer patients per ward
Cabinets and shelving for storage space for storage of clothing
Volunteers to activate patients
Lawn swings, slides, picnic tables and chairs
Furniture to fit the type of residents using it
Clothing marked with residents' names and in proper sizes
More supplies for general care of patients
More remotivation equipment
Minimum two technicians on each ward for first and second shifts
More recreational items in building
Need of a constant source of toys
Smaller units for small group therapy
Place near dining area for washing hands before meals
Recreation time indoors and outdoors
Curtains and drapes
Hassocks for geriatric wards
More basic clothing: underwear, socks, trousers, shirts
Games, phonograph records, chairs, tables, TV for basement
Non-disciplinary places for privacy
Seats on toilets
Custodial clothing-room lady
Shopping tours, fishing trips, picnics, etc.
Three full-length mirrors for good grooming classes
Fenced area for boys to play in
Building re-designed for youngsters

TO: David J. Vail, M.D.
Medical Director

FROM: Dr. Russell Barton
Visiting Consultant Psychiatrist

SUBJECT: Confidential Report on Visit to Willmar State Hospital 8/18/67

Mr. Lucero and Dr. Barton visited Willmar State Hospital on Friday, August 18, 1967, to check the rating scales and present the changes in Ward Living Conditions that have occurred from 1965-1967 to the staff.

The meeting with senior staff enabled useful discussions to be held. I had the impression that staff were still discouraged by the recent resignation of one or two key people. It is probably too early to judge rights and wrongs and assess the actions of personnel in this situation.

Various cottages were visited and the scales found to be reliable.

A meeting of the hospital Humane Practices Committee involved some confusion about the role of the committee -- was the committee executive or advisory?

Discussion of the advisory nature of the committee and the need to arrange suggestions for improvements into priorities, such as:

1. Urgent requirements
2. Necessities
3. Niceties

and the need to keep communications short and to ensure they reach the correct destination was stressed.

The alcoholic program was discussed. It seemed that counsellors would be grateful for more assistance from psychiatric and other professional services. One wondered if they were always as acutely aware of their patients' problems as they claimed to be (having been alcoholic previously). Strengthening of the "cabinet of supportive services" does seem desirable. The possibility of wider use of aversion therapy, hypnotism, antabuse, psychotherapy, and behavior therapy could well be explored.

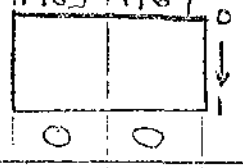
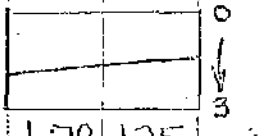
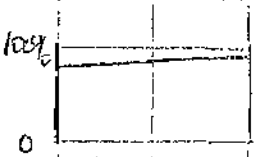
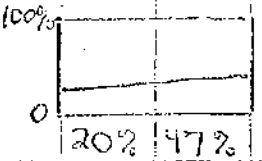
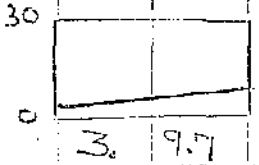
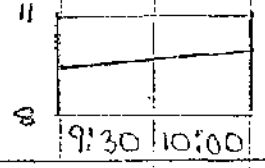
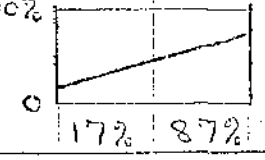
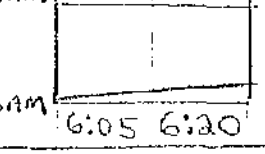
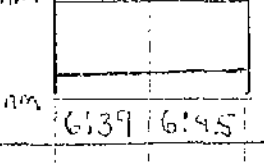
Willmar State Hospital has improved considerably in the last two years.

Opportunity was taken to congratulate the staff on their achievement.

Appendix I: Details of changes in Ward Living Conditions at Willmar State Hospital, 1965-1967.

Appendix II: List of suggested improvements made by staff.

WILLMAR
— 16 —

NUMBER OF DORMS LOCKED ALL DAY. 10A	
NUMBER OF PATIENTS IN SECLUSION PAST MONTH. 11F	
PERCENT OF PATIENTS ALLOWED A NAP. 12	
PERCENT OF PATIENTS ALLOWED TO WATCH TV AFTER 10:00PM. 15	
NUMBER OF PLANTS ON WARD. 17AB	
WHEN IS BEDTIME? 20	
PERCENT OF PATIENTS ALLOWED UP AFTER BEDTIME. 21	
WHAT TIME ARE PATIENTS UP IN THE MORNING? 22	
WHAT TIME IS BREAKFAST. 23A	

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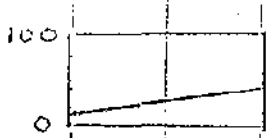
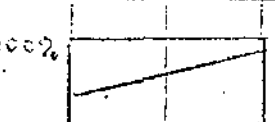
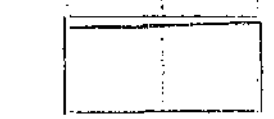
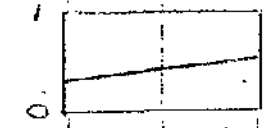
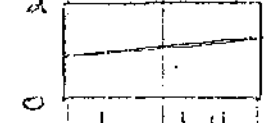
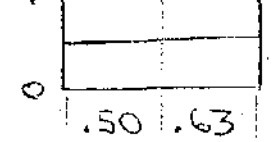
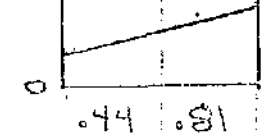
NUMBER OF PICTURES. 24AB	 11 45
PERCENT OF PATIENTS WITH PLACE FOR POSSESSIONS. 27A	 55% 94%
PERCENT OF PATIENTS WITH LOCK. 27B	 0% 2%
NUMBER OF WINDOWS WITHOUT CURTAINS. 28	 10.4 4.3
NUMBER OF SNACK ROOMS 29	 .19 .56
NUMBER OF IRONS. 31	 1. 1.4
NUMBER OF WASHERS AND DRYERS. 32	 0 .13
NUMBER OF POP MACHINES. 37	 .50 .63
NUMBER OF WATER COOLERS. 38	 .44 .81

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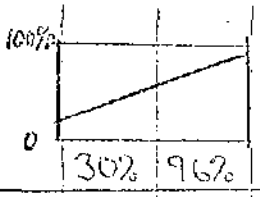
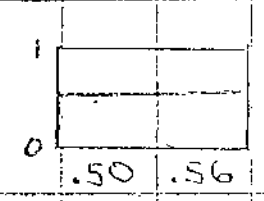
PERCENT OF PATIENTS WITH ACCESS TO TOILETRIES, 42	
NUMBER OF FULL LENGTH MIRRORS, 44	

CHANGES IN WARD LIVING CONDITIONS 1965 - 1967

APPENDIX II. LIST OF SUGGESTIONS FOR IMPROVEMENTS MADE BY WARD STAFF IN ANSWER TO QUESTION #47 IN APRIL, 1967.

QUESTION 47: WHAT THINGS WOULD YOU LIKE TO SEE IMPROVED ON YOUR WARD?
(Listed in the Order of Frequency)

More comfortable furniture, especially chairs
More bath tubs and showers
Washers and dryers
Larger closets
Better lighting
Coffee room with facilities: toaster, coffee pot, stove
New beds and mattresses
Canteen open at night
Air-conditioning
Stove for patients to prepare snacks
Refrigerator
TV
Bedspreads
More privacy in bathrooms
More privacy in sleeping quarters: two only to a room
Improved tunnels
"Less starch and grease at cafeteria" (quote from a patient)
Swimming pool
Sewing machine
Locked cabinets for personal things
Re-painting all rooms in color
Pictures
Fans
Places for suitcases
Larger office
Larger detention room
Wooden floors removed
Seats on toilets
Serving and cooking facilities improved on unit
Daily newspapers
Current magazines
Recreation facilities
Better heating system
Improved toilet facilities for training of patients
Improved wash rooms
Locked bedside cabinets
Pop machine
Paid janitors and grounds-keepers
Water cooler
More electrical outlets
Recreation for weekends and holidays

Public Welfare

Mr. R. Joseph Lucero September 1, 1967

Russell Barton, M.B., M.R.C.P., D.P.M.

Comments on Rating Scale for Mentally Retarded Services

The proposed scale asking 91 questions and requesting 50 explanations would probably take a psychiatric technician the best part of a day to fill in.

It appears somewhat jejune to me, dealing with physical things to the detriment or exclusion of:

(1) Education. To what extent does each patient have the opportunity to learn (on or off the ward)? What proportion are deemed ineducable (I do not believe any mentally retarded patient is completely ineducable). How does the patient make contact with and become involved in the educational process?

These questions should embrace such activities as occupational therapy, recreational therapy, rehabilitation, operant conditioning, habit training and so forth.

--But only 10 questions should be allowed. Can you cast a net with 10 questions sufficiently large to include a reliable sample of educational activities, yet with sufficiently small mesh not to allow important practical information to slip through.

On the whole I am not in favor of sub-questions; they suggest lack of ingenuity.

(2) Medical and Psychiatric Care. How often is the patient examined by an M.D.? Can we be sure the psychiatric technicians and others appreciate the symptoms and signs of physical or mental illness to seek help for the patient? To what extent do non-medical staff pursue personal goals which prevents them seeking medical or psychiatric advice for an individual patient or counsel for themselves? Who decides whether tranquilizers, thymoleptics, hypnotics should be prescribed or stopped? Who brings patients forward for treatment or discontinuation or change of treatment? 10 single questions only allowed.

(3) Social Care. How many patients have friends? Are patients involved in the care program for their child? Who comforts patients who have fallen and hurt themselves or been assaulted by other patients? Who controls bullying and tyranny from other patients? Who matches patients with foster grandparents, college students, volunteers, and so forth? What social life occurs outside the institutions? 10 questions only allowed.

(4) Work. I hesitate to include this under education or rehabilitation -- it seems to become formalized and professionalized so quickly. What work does the patient do? Can they do work? What facilities for placement in jobs inside and outside the hospital exist? Are they used? How many patients work outside the hospital for proper wages but live in? 10 questions only allowed.

(5) Ward Living Conditions. Problem here is to reduce the 91 questions to 10 germane ones. One would be, How many patients have personal territory -- a place of their own with clothes closet or wardrobe, chest of drawers and mirror by bed, which is not shared by any more than two other patients? This may be in a ward or side room. 10 questions only allowed.

Hope you find these suggestions pertinent and helpful. I would extend the therapeutic process by asking the heads of departments at each institution for the mentally retarded to help us formulate the questionnaire by (donating) (not submitting) questions they think relevant to the contribution their department is or should be making.

TO: R. Joseph Lucero
Research Coordinator

FROM: Dr. Russell Barton
Visiting Consultant Psychiatrist

SUBJECT: Suggestions for organization of hospital visits

1. Visits should be arranged so that if visitors from Central Office should be late due to weather, car breakdown, etc., a group of hospital staff will not be kept waiting assembled. Perhaps the first meeting could be with the Administrator or Medical Director.

   If staff are assembled, it is so easy for righteous indignation to set in, for them to assume that Central Office visitors are callous or indifferent and prepared to squander the devotion and time of people who "really do the job". In all organizations, tensions exist between Central Office and front lines.

2. Senior staff of an organization should never be bypassed in meetings with Central Office staff or visitors. If their non-participation is essential, this should be explained, preferably by letter beforehand.

   As a general rule, it would be wiser to meet with senior staff of the institution first and explain fully the purposes of the meeting and the objectives.

   It would probably be wiser to make reports to the institutions rather than to Central Office. (Otherwise accusations of a gestapo, etc., could be nourished.)

3. Visits to different hospitals should not be made on consecutive days. A day is required to collect and collate information, and a succession of visits acts with retrospective inhibition on the institution seen earlier.

GENERAL CONCLUSIONS

Considerable improvement has occurred in the services for mentally retarded patients as presented by ward rating scales and confirmed by visits to various institutions.

The possibility of conflict between program leaders and department heads causing more disruption in certain cases than leading to improved services is worth examining.

Scrutiny of the needs for psychiatric diagnostic services to patients in institutions and in the community continues to be necessary. The identification of psychiatric disturbance and formulation of plans for cure, comfort or maximizing residual ability seems a more positive approach than denial of illness. It seems to me that one of the most urgent needs is recruitment of more capable, industrious, stable psychiatrists.

The division of responsibility for mental care between comprehensive community mental health centers and state institutions may result in quarrels rather than cooperation. The receiving area could become a battlefield; the sociopath or chronic schizophrenic becoming a missile in an administrative battle as to which agency is responsible for providing care. A possible solution is joint appointments between state institutions and community mental health centers so that one psychiatrist, social worker or welfare officer continues responsibility whether the patient is in an institution or mental health center. This would also economize on staff. If the institution personnel have to hand over to community center personnel a great deal of professional time will be consumed in meetings and handover. Better use of staff time could possibly be affected by joint appointments.

The need for the educational programs introduced to continue has been supported by my discussions. Staff are grateful for the opportunity to attend these events.

My visit has been enjoyable; I am most grateful to those who have worked with me in such a pleasant and friendly manner. I am most impressed by the improvements I have seen on my second visit and am aware of the terrific amount of planning, devotion and hard work that has gone to bring about this achievement.

Russell Barton

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Consulting Psychiatrist