

COMMENTS
ON
MENTAL RETARDATION PROGRAMS
MINNESOTA

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CHAPTER I

BRAINERD STATE SCHOOL AND HOSPITAL

Brainerd has a population of about 1400.

Reading the report of the hospital improvement publication gives us an up-to-date picture of Brainerd State School and Hospital.

The well organized treatment plan and the hospitality I was met with gave me an opportunity in the short visit to get, I believe, an impression of the work and the main problems in this hospital. The treatment plan organized this 1400 hospital into four relatively autonomous units according to Programs 1 and 4, Programs 2 and 3, Program 5, and Program 6. Each unit carries out a different program and is situated in a different part of the campus. It seems to me that this organization utilizes the personnel available in the best manner; the buildings at Brainerd are of two main types. We have Buildings 5 and 22, two-floor buildings with 2-4 bedrooms. They contain 184 beds each. They are used for patients with Program 6. These buildings give rather good facilities and more privacy than in the usual buildings in the hospitals for the mentally retarded. Here too, the ward units are too big and the staffing too small. In the other buildings the ward units contain from 20-36 beds. Each building consists of three such units. In the dormitories with 30-36 beds in each ward semi-privacy is afforded by partitions which divide the beds in groups of six. Each ward unit has a separate day room which is too small, and three ward units together have a general purpose and a recreational room in the basement. The facilities in the ward units at Brainerd are better than in the other hospitals for the mentally retarded, but lack of staff makes it difficult to use these facilities. Lack of workshops also makes it impossible to activate many of the patients in the right manner. None of the buildings are well suited for children.

In Building 6 with 78, some more systematic activation program has been started by taking the children in smaller groups for training purposes, both at meals and in the general purpose room and in the recreational room in the basement. One of the ward units in this building has only 12 children which are most hyperactive children, and is possible for the ward personnel to work actively with these children somehow each day. 30 of the children in the building go to recreation, (summer program) 5-6 hours each day. About 20 go to school. By speaking to the psychiatric technician in charge of the building I got the impression that this situation and, work has had a very good influence on the behavior and development of the children. It is possible to make this building into a fairly good situation. Reducing the population in the two other ward units to 20 (or 24) would make it possible to make one section of the dormitory into "kindergartens" and training classes.

The same situation is present in Building 8.

This building has now 99 children, ages 4-16 years, the building is divided into three ward units, with 36, 34, and 28 children. Personnel in all 18 1/2 plus three hospital aides. (In the morning only five are working in the building, at night only two.)

In the summer 48 children are in the summer program, 9 go to school one hour each day, 2 are in physical therapy.

Most of the patients in this building are hyperactive, aggressive, tearing their clothes. The building has only one fenced area, 35 are out each time. The large basement play area is used for groups. Half of the children are bathed in the morning, the other half in the evening.

With the staff available in this building, the situation at present is almost impossible. I would suggest that the following program be tried. Reducing the population to 24 in each ward unit, in each dormitory make two training group rooms by closing the sections and adding a door. The population in each ward unit could then be broken down in three groups, and it would be possible to manage the children in these groups.

Necessary personnel in such a program: Each shift should have four personnel in each unit. This would need 12 personnel on each shift. Some of the personnel ought to be trained in occupation.

Needed personnel in all: To cover two shifts, 24, night personnel, 3.

To cover vacations, etc.: 9.

In all: 36 personnel (ratio 1:2),

The fenced play area is perhaps too big to make it possible to arrange group activities with the children of this category. I would suggest small fenced areas in one of the corners and then equip this for outside group activities. With personnel as cited above it would be possible to work with groups of children and it would in this manner be possible to make a real good pilot study of what is possible to do for this category of children.

Another interesting proposal is made by the Chief Psychologist, Dr. David Williamson, in the hospital improvement project, with 36 adult hospital residents, by planning an intensive training unit for them. After reading the training program, I would suggest that training occupational skills and work in suitable workshops, if possible, should be contained in the training program.

The school and rehabilitation, therapies building was completed in November, 1965. This building has excellent opportunities for covering an active and comprehensive training program, but the staffing is too small. There are now 21 legal positions. To give possibilities for using this facility in the rehabilitation building to the fullest extent would require twice as much personnel. I do not think that this will cover all the needs, especially for occupational and industrial workshops (O.T.). In the further planning of one of the other buildings, or perhaps part of it, by reducing the population, space should be made available for workshops.

The physical therapy. There are at Brainerd two physical therapists and then, three aides were in the physical therapy unit. The two physical therapists have developed an excellent treatment program, with some occupational training. But the unit is too small to cover the hospital's needs and ought to be extended. At least four physical therapists are needed if the most necessary needs in the hospital are to be covered. I would like to stress that both the school and the rehabilitation department, and the physical therapy department in this hospital, are doing excellent work, and should be given opportunity to extend so it may be possible to cover the hospital's needs in these trades and also for the motivating of the severely retarded, especially the children.

Conclusion

Brainerd has the best facilities of the state schools and hospitals but the population is too big. I would estimate that by making one building into work-shops and reducing the population in the several ward units, the adequate population would be about 1,000. Brainerd has no real good facilities for children and in planning further buildings in this institution the new buildings ought to be special buildings for children. I would recommend the building of a separate children's unit, a "Children's Institution" at Brainerd, for about 120 children, more as a village for children with small ward units. The program to be based on a philosophy of the children's hospital at Vangede, Copenhagen. The new children's unit would also need kindergartens and training classes that would not covered by the rehabilitations building. I would then suggest that one other building, with three ward units, would be remodeled as kindergarten and training classes for the groups.

The nursing staff ratio has to be increased.

There should be more training classes and workshops.

There should be more staff for occupations and schools.

The physical therapy department should be increased.

The specialist team, physician's psychologists, and social workers ought to be increased.

The hospital is in need of a psychiatrist (as medical director?) for programming and coordinating all the work in the hospital.

Chapter II

CAMBRIDGE STATE SCHOOL AND HOSPITAL

Population about 1600

The buildings at Cambridge consist of several old cottages built for epileptics: Cottages 1, 3, 5, 7, 2, 4, 6, 9, 12, 14, and an independent living unit in their administration building.

The new cottages, 8 and 11, and two big, large buildings, McBroom and Boswell.

The old buildings.

All these buildings are not very well suited for the purpose.

Example 1

Cottages 14 and 19. The situation is not so bad, but they, too, are too crowded. The real and big problem, as I see it, is in Cottages 6, 7 and 12.

In Cottage 6 some arrangements have been made and the situation has been much improved. To make a real use of this situation more staff is needed and the population ought to be reduced.

In Cottage 7 the problem is tremendous, as set forth in my memorandum of July 8, 1966. I do not think that the decisions made at the meeting of July 20, 1966, are enough to get an improved situation in cottage 7. I recommend the proposals of July 8, 1966.

In fact, none of these old buildings are suitable for children, and new facilities ought to be established for children (See Chapter VIII recommendations).

I would recommend that these old buildings be used for adults. Dividing the dormitories and reducing the population would make them suited for ambulatory adults (in this connection a study of the rebuilding program at Ebboridgard, near Copenhagen, is recommended).

Cottages 8 and 11

Cottage 11 is organized as a mental health treatment service. This unit is much better staffed and the population in the cottage is reduced. The unit has also an active program covering all the patients in the unit. The program here demonstrates that much can be done in a facility like Cottage 11 by reducing the population and by better staffing.

Cottage 8 has a population of 136, most trainable children, ages 6-23. The building is divided in five ward units. In the cottage there are two classrooms for the trainable. (But one of these also serves Cottage 6.) It is possible to get a fairly good situation in Cottage 8 by reducing the population as in Cottage 11 down to about 100, 20 in each ward unit. Twice as much personnel are needed and it ought to be organized into training classes or workshops for the total population. This can be done in a certain degree inside the cottage. If necessary the population has to be reduced to 80 to get enough space. (If and when Boswell or a part of it could be rebuilt into classrooms and workshops, these children should have the opportunity for training there several hours each day.)

Boswell and McBroom

These buildings are perhaps the buildings at Cambridge which are most difficult to make suitable.

As they are now functioning, they are far too overcrowded and understaffed. As their situation is today it is, in my opinion, impossible for the ward personnel to do more than the most necessary custodial care. There is almost no time for the stimulation and real personal contact. The physical therapy unit with only two physical therapists is also quite too small and is only able to give some of the children some few hours each week in training, and this is almost nothing.)

The population in these buildings must be radically reduced.

I would recommend that one of these buildings, or in the beginning a part of it, is remodeled to give space for a large physical therapy unit training classes and workshops. It seems to me that this can be done with reasonable expense.

Infirmery

This is a good building with very good facilities for several treatment purposes, including dental services.

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If Cambridge State School and Hospital should be remodeled and organized after those recommendations the population has to be reduced. It is impossible to estimate the exact number of patients that would be suitable at Cambridge then. I am quite sure

that there will not be adequate accommodations for more than 1,000 perhaps less than this number.

Building of more school facilities (including training classes), workshops, and physical therapy must be done according to the plumed population at Cambridge, especially workshops (O.T.) and physical therapy must be built so it is possible to reach every patient in the hospital.

Training classes and workshops should provide training and occupation to all patients who are capable of taking benefit from it. This will be at least 80%, perhaps 90% of the population, Training and work should cover 5-6 hours each day.

There ought also to be more opportunity for physical, training of most of the patients.

The specialists, physicians, psychologists and social workers, are also too few to be able to cover the work inside the hospital. In this area the hospital is very much in need of a psychiatrist (as medical director?), who can plan and coordinate the work of the several departments in the hospital.

CONCENTRATED PROJECT ON COTTAGE 7

Letter of June 27, 1966, from Department of Public Welfare, states: "I would like the problem concentrated on Cottage 7 for the purpose of determining what can be done jointly between three major departments on what appears to be one of the most difficult groups of patients to work with

Cottage 7; 70 hyperactive destructive "boys, divided in two large units, one with 40, and one with 30. There are 17 ward personnel in all. Several hours each day only one aide to 30 or 40 boys in the dayroom.

Discussion of the Problem: The population of Cottage 7 is one of the most difficult groups of patients to work with.

In setting up an ideal program for such a group, the following four points must be covered:

1. Their living facilities, that is, the cottage: Most ideal would be to have several small cottages connected together, each cottage with one or two small units for about 8 children in each.
2. Facilities for training and occupation, also in small groups.
3. Facilities for recreation,

The population in the cottages could then be broken down into small units, both in the several wards and in rooms for training and occupation (day activity centers). Then enough personnel must be available for the work in the ward units and for training, occupation, and recreation. To effect such a program would require a range of new facilities and new buildings. That will probably take several years.

The next question to discuss is the possibility of rebuilding the cottage. In my opinion the cottage, by rebuilding, would not be suitable for this category at all, but it could be rebuilt for other purposes, especially for adults. Rebuilding the cottage will also take a lot of time, perhaps a year or more.

The only thing that can be done now is to arrange some temporary changes in Cottage 7 and work out a temporary program.

This project should also be based on the thesis: working with small groups. That is, to make the ward units as small as possible and take out of the ward units population, several small groups for training, occupation, and recreation for several hours each day. This must be done in such a way that their population which is back in the dayroom in the ward units also makes such a group that is manageable.

Discussing the possibilities of available rooms in Cottage 7 in connection with such a program: It could be possible to make four ward units in the cottage without rebuilding, but it seems that this will be very difficult in that it will cost too much to be convenient in a temporary project.

Fortunately there are several rooms in Cottage 7 that can be used as day activity center and smaller group rooms: Three rooms with a kitchen on the first floor could be made into a good day activity center for about 12-15 children. The activity room in the basement could be used for eight or perhaps 10 children. Another room in the basement could be used for a group room.

It would be possible to arrange group situations for about 50-55 children in the cottage if one could work also with two groups taken care of by the recreation and/or education department.

Dormitories: It would be expensive to rebuild the dormitories to smaller units, so temporarily they must be used as they are, but reducing the population to 50-59 they will not be so crowded.

Dining Room: To try to make the feeding of the children to a training situation is almost impossible: if you cannot break the situation down into groups there; too. It would be possible to arrange some groupings in the dining room by setting up some walls (not to the ceiling) so that the dining room would be divided into about five groups.

It is also necessary to arrange the facilities for bathrooms

A more detailed program for the improvements in the building must be worked out. A more detailed program for furniture and other equipment for the day activity centers and such must also be worked out.

Staffing of the cottage:

Working with small groups as outlined above make it necessary to get more staff in the cottage: To several group activities there is needed 5-6 personnel (in the big activity room in the basement there could be 10 children if there were two attendants there), the groups playing outside could perhaps be arranged with the recreation department and volunteers

Personnel in the ward. units and dining room: Has to be discussed if 17 ward personnel: would be enough by reducing the population as mentioned and arrange group activities as mentioned above. It must be taken in account that at the several meals there must be at least one attendant to each group in the dining room. If it is possible to get these facilities and this situation in Cottage 7, programs for the activities in the several groups have to be worked out.

CHAPTER III

FARIBAULT STATE SCHOOL AND HOSPITAL

Faribault has a population of 2,700. The population has been reduced the last years from 3,131 in 1962 to about 2,700 today. The general impression also is that the hospital today is overcrowded, that many of the buildings are not suited for the mentally retarded, and especially not for mentally retarded children.

Handling such a big hospital unit must be a big problem. The unit system now in use, which divides the hospital in six separate units, seems to be the best way to handle this problem with the staff available. In this connection it is to be mentioned that the specialists concerning physicians, psychologists, and social workers, is too small.

My visit at Faribault lasted five days and it was a too short visit to get a real impression of the work there.

My general impression is that the hospitals are in lack of staff in all fields and increasing the staff immediately needed. This is the situation concerning both the specialist staff and the nursing staff. The medical director has requested more staff; I will as much as possible support this request. The number required by him is an absolute minimum

Most of my work at Faribault was to investigate the several buildings and get an impression of the overall work there, the staffing problems, the training and treatment program, occupation of the patients, etc.

The examples below will illustrate the almost impossible situation in some of the buildings.

1. Pine Building

The infirmary building for children (boys) age 4-10. Population - 106. The building has one dormitory and ten side rooms, one big day room. The unit has 25 bedfast patients, the rest ambulatory severely retarded. In my opinion it is impossible in such a building to create a stimulating environment for this category of children. The building is in fact, quite unsuitable and to rebuild it is really quite expensive. I would suggest that this building ought to be used as workshops.

2. Spruce

Quite like Pine. Used as infirmary building for girls age 3-22. Population - 90. Of these 60 are ambulatory. Conclusion the same as for Pine.

3. Cedar

Hyperactive girls age 8-20. Population - 80. The building is divided in two ward units, 40 in each. Big dormitories with eight side rooms. Recreation room in the basement. 10 go to school every day, 1 ½-2 hours; 3 in occupational therapy one-half hour each day. The psychiatric technicians give also some instructions. The building is too crowded and with personnel available it is impossible to stimulate and activate the children. The building could be divided in four ward units, with about 13-14 children in each. Doing this and getting twice as much personnel, the situation for the children would be much better.

4. Maple

Like Cedar. Hyperactive boys age 8-22. Population 92. None of them in school. The same conclusion as in Cedar.

5. Osage

Population 86; school boys, all in school from 9 to 11:30. The rest of the day play; some work in the ward unit. There are two ward units, 43 in each. Two big dormitories. The situation in this building is better than in Maple and Cedar, but the population ought to be reduced. The boys should have more opportunity for privacy and practical work.

6. History

Building for 114 adult men, some hyperactive. There are two dayrooms, four dormitories, eight side rooms. Many are working in the building, in the kitchen etc. But out of this no occupation. Most of them ought to be working in a workshop. The building is difficult to rebuild but some arrangements in the dormitories may be made. Reducing the population, one could use one of the dormitories as a dayroom.

7. Dakota

Population 104 patients, most of them profoundly and severely retarded, any hyperactive and destructive. The building is quite unsuitable and it seems not possible to rebuild it. It would perhaps be possible also to use the Dakota Building as workshops.

Several of the other buildings, such as, for example, Ivy and Sioux, are much better. But there also the population has to be reduced. To make recommendations regarding the several buildings at Faribault is very difficult after such a short visit, but my conclusion must be that Faribault has today no ward unit really suitable for mentally retarded children.

In this situation I would recommend that one try to start a project with the buildings Maple and Cedar. These buildings ought then to be divided as mentioned in four separate ward units, with about 12-14 children in each, and then grouping the children in training groups for several hours each day. Training them both in self-help skills, occupations, communication and social skills. If a real pilot project should be done, I think about twice as much personnel as now will be needed and an occupational therapist should also be connected with the project, and the program being laid in connection with the physicians, psychologist, and the school,

The hospital building is a very old, big building, but the program there seems to be very good. I was especially impressed by the research program in this hospital and also by the diagnostic work done there.

The school department carries 300 children. It seems to be a very good and systematic program, but with the staff available it is impossible for the school to cover the needs of the institution. Many trainable children have no training at all and some only for a few hours each week. I was very much impressed by what I heard about the work in the school and perhaps especially concerning the music therapy and the work with the deaf retarded. If it were possible for the school to get more staff and through this be able to take more responsibility for training of the children in the several ward units, it would be a great advantage for the institution. The hospital has now six occupational therapists. They do a very good job also with training self-help skills in the several ward units. The occupational department ought to have at least three or four times as much personnel. The need for occupational therapy, occupation and training is very great in an institution like Faribault. The occupational department should have the opportunity of working out a program for many more, both children and adults, and this program should cover several hours each day. If Pine and/or Spruce could be used for this purpose, the occupational department could get enough spruce for training classes and workshops.

Physical Medicine

Faribault has orthopedic and physical programs in cooperation with Rochester. This is much needed and I got the impression also it was a very good program. But Faribault does not have a registered physical therapist. Planning of a physical treatment unit is very much needed, especially for the many crippled children.

Nursing and ward care is much hampered by the big ward units and lack of staffing. The request from the Medical Director for more staff is quite realistic and I will, as strong as I can support this. If it is possible to increase the staff, one should also in the old buildings try to make training and occupational groups for as many patients as possible, by: decreasing the population. The training should not only be on self-help skills - but also through training occupational skills give especially children the opportunity of better development.

The training program for psychiatric technicians is going on with PROGRESS, but perhaps the training should also include more training in occupations (handicrafts).

The specialist team consisting of physicians, psychologists and social workers, is quite too small for this big institution, through the unit system it seems that they are utilized in the best manner. In all I was very impressed by what the specialist team, the nursing staff and the psychiatric technicians were able to do in the difficult situation in the several ward units. My impression was that the whole staff was very interested and motivated towards their work, but they ought to have better opportunities for doing the work they are trained for.

The research program in the institution was really impressive.

The hospital improvement program is highly recommended.

Conclusions

Faribault does not have adequate space for 2,700 mentally retarded. The population has to be reduced. I am not able to estimate what would be the right size of an institution like Faribault. That ought to be estimated in connection with the area Faribault has to cover in the future, and by a thorough investigation of the several buildings. As mentioned above, some of the buildings ought to be used as workshops, and an institution like Faribault has a very big need for such workshops.

Some of the buildings may be useful for children by dividing them, but I will recommend that new buildings for children should be planned, and in this connection it should be estimated, if this is convenient to do, on the campus of Faribault, or if it is better to get a new hospital for children in Ramsey County (see Chapter VIII for recommendations).

The nursing staff ratio has to be increased.

There should be more training classes and workshops.

There should be more staff for occupational therapy and school.

There should be a department established for physical therapy.

CHAPTER IV

LAKE OWASSO CHILDREN'S HOME

With 130 mentally retarded females, supervised from Cambridge State School and Hospital.

I get a very good impression of Lake Owasso Children's Home, and I feel it demonstrates the advantage of smaller institutions. It has a really home-like atmosphere in spite of the big dormitories in the two cottages. The living facilities for the 24 mentally retarded in the main building were very good. The institution has only one classroom and a canteen. My impression of the population at Lake Owasso is that most of the patients there could be able to work in workshops, perhaps most suitably occupied by handicrafts. Besides the plan of erecting a home economic unit, there ought to be arranged for several workshops.

The location of Lake Owasso Children's Home make it reasonable to consider if this institution perhaps ought to be reorganized as a vocational residential training unit for mentally retarded girls.

CHAPTER V

OWATONNA STATE SCHOOL

For educable mentally retarded children with behavior problems, age up to 21.

The living facilities at Owatonna are good. The buildings for the children with the most severe behavior problems seem suitable.

The school problems:

1. Child development program.
2. Teenage program.
3. Adult social achievement program seem very convenient.

When I was visiting Owatonna, almost all the children there were on vacation, so I could not get a personal impression of the population, though I get the impression that most of the children have severe behavior problems and that a closer cooperation with a child psychiatrist, if possible, would be very important with these severely disturbed children.

The program and the work at Owatonna gave me an impression of an active, really working institution. According to the program for vocational training, I would recommend the plan of taking one of the cottages for a training center. It ought to be possible to erect a real good vocational training industrial workshop. If there is any concern about utilizing the several recommendations at Owatonna, I think that a program of this kind would solve this.

It seems to me in a state like Minnesota that it is very convenient to have an institution like Owatonna to take care of, educate and treat the educable mentally disturbed children. If there is, in the future, any concern about utilizing the several accommodations, I think that if the program could be suitable also for more bright trainable mentally-retarded, there will be no concern about this.

CHAPTER VI

SMALL PRIVATELY- OWNED INSTITUTIONS RESIDENTIAL INSTITUTIONS

During my stay in Minnesota I visited several smaller privately-owned residential institutions; and I am now making some remarks in regard to these.

1. Roseau Children's Home

For 45 mentally retarded boys and girls with physical handicaps, ages birth-12 years.

The Roseau Children's Home is located in a new building. The building is very nice and seems to have adequate space for the children also for recreation and play. The owner and director, Marie M. Olson, and her husband, seem very interested in the work and have been able to create a good situation at a small home. There were in this home severely handicapped children, and a real active program for the children. The children got out of bed every day, they were clothed and sitting in chairs both inside in the play area and outside. There seems to be some group work and also some physical activity and treatment. I was especially impressed by the real personal contact which the ward personnel afforded to every child. The treatment in this home was suitable for the children and, it seems that their needs are met. The location far up in the north may make some difficulties regarding specialists, especially in orthopedics. I got the impression that this situation was covered in a real good manner by the local physicians.

This small institution seemed to cover a real need in the state of Minnesota, but located so far away, it shouldn't be expanded.

Also this home demonstrated some of the problems with the small facilities, for children. When the children are growing up after the age of 12, a real difficult situation arises.

By planning more regional services for the mentally retarded, this situation should be taken into account, and the need for a home for children between the ages of birth-12 years must be considered in relation to the other facility which is erected in connection with the buildings of a regional program. But the situation and the treatment in this home was so good that it seems to me that it also in this situation will be badly needed.

2. Lake Park-Wild Rice Children's Home, Fergus Falls

Residential care and schooling for ambulatory educable retarded children with social adjustment problem from 10-16 years of age. This school is owned by the Norwegian-Swedish Lutheran church. It was built in 1949 as an orphanage, and converted to mentally retarded in 1957. The house is a nice building but they are in lack of space, so that the house is perhaps too crowded, but they make it as homelike as possible, and the atmosphere in the school was real homelike.

The staffing was very good. The school has a director, a social worker, two teachers, and a care staff of 13, one custodian, one housekeeper, and two cooks. The program in the school was very active, and they were trying to meet the emotional needs of the children. The school was an open institution and the children had an opportunity for play with children in the neighborhood and some of them went to school in the public school in the city. They had at the school some horses and other animals, and a garden, and in the summer they trained in swimming, hiking, and the children seem to be very activated, trained and treated. The professional service was given from the local mental health center, which is very interested in the running of this school. The daily cost of the running of this school was estimated at about \$14. The church pays about half of this. There were plans for new buildings so that the school could take about 30-40, and they could get a diagnostic unit. Many of the children were from the metropolitan area and socially deprived. The children were leaving this school at about age 16. The school period was, in most cases, about 2 ½ years. The goal was to get them back to the community and to the home, but some of them could not do this and some of them go back to foster homes at the age of 16, or to state schools and hospitals. The Lake Park-Wild Rice Children's Home seems to be a very good, institution for the category of children who are there. As in the other private homes' facilities, there is a problem with the age groups the children leaving at the age 16. This should be taken into account by further planning for building facilities for the mentally retarded in Minnesota. The children at Lake Park-Wild Rice should perhaps be transferred, to vocational rehabilitation units at the Owatonna State School (?) if not able to get back to their home.

3. Champion Children's Home, Duluth

Residential care for mentally and physically handicapped children, between birth-12 years. In all 39 children 6 of these children in trainable classes in Duluth, 6 in the activities center, 3 children in rehabilitation center, where they get physical therapy, speech therapy and occupational therapy.

The Champion Children's Home is situated in an old building and the home was really overcrowded and they do not have enough space for the children. On the other side, the work in the home was very good, and it was a good and homelike atmosphere. The Champion Children's Home is in need of a building especially for bedroom. In all 15 of the children get education and training other places, but there ought to be some kindergarten and training classes also in the children's home. Very remarkable at this institution was a very close cooperation with St. Louis County Welfare Department, and the use also of this home as an observation unit. The St. Louis County Welfare Department has been able to erect a real good team for this home, in connection with the mental health center; a psychologist, a pediatrician, psychiatrist, social worker, teacher, and public health nurse. The St. Louis County Welfare Department has a real good program for this and a good program for utilizing foster homes and erecting day activity centers.

The St. Louis County Welfare Department have worked out a good program for observation and treatment of mentally retarded children, and it is a question to be discussed if the team at the St. Louis County Welfare Department should be the starting point if it is decided to erect a central institution for the region around Duluth. This region should then cover a population of 200,000. It seems also in Duluth there are good classes for the trainable in the public schools and day activity centers (the day activity center was closed at the time I visited, so I could not see it).

As mentioned, the development in the County Welfare Department for St. Louis County seems to have the readiness of erecting and starting a diagnostic evaluation and treatment center in Duluth. The possibility of this ought to be discussed in relation to the overall needs of the state of Minnesota.

4. Welcome Homes, St. Paul

Residential care for severely retarded socially deprived children from birth-10 years of age.

This home was real nice looking with small bedroom and a central dayroom for the children. According to the program I get the impression that everyone was out of bed regardless of how disabled they were, and all are clothed there were 17 staff, and the care seems to be very good. This home has the possibility of getting medical service from the city hospital in the neighborhood and also has the possibility of getting physical therapy there. It seems to be a daily activity and they also had an active parent group and group meetings with the parents. One of the things I mentioned during my visit was that the home ought to have a physical therapist directing the staff; of the home so that the physical therapy could be done with all of the children in the home, and the personnel could be more activated in this direction. There ought also to be a kindergarten in the home the possibility of getting this improvement in the home seems to be connected with economic problems relating to the economic problems in private residential homes in general. The same problems arise with the children when they are leaving, this home as by the children in the Roseau Children's Home.

5. Hammer School, Inc., Wayzata

This school now has 42 residents with 10 day pupils. Some of the children there leave at the age of about 20, but some of them are in long-term care and there is planning to build a new buildings for long-term care, The staffing is 22 in all, and of these five are teachers (the five teachers are paid by the institution, but the salary is lower than they can get in the public schools). Especially the dormitories in this institution were very good, homelike, equipped, and with small rooms. The dayrooms and classrooms were in older buildings, but seemed suited for the program there. I get the impression that the training and education in this school is very good. The training, with special attention to training self-help skills, and socialization skills, and also occupational skills by using more handicrafts. There was also much training in academic skills. In all the program in this school was very active and shows very well the advantages of a small unit and, a homelike atmosphere. The children I saw seem to be in the trainable group and seem to be very happy and well activated. This school is also a demonstration of what can be done by training the trainable children in a real good atmosphere and by an active teaching program.

6. Greenbrier Home, St. Paul

Boarding care for 112 adults needing personal and custodial care.

This was a very interesting institution, situation in the city. The training seems to

be good, with bedrooms for 2, 3 and 4 in each. Only the dayrooms seem to be too small. The institution has relation to the Ramsey County Welfare Department, which decides which patients should go into the Greenbrier Home. Most of the patients are from St. Paul, but there are also some from other counties. The population is both educable and trainable, but none with severe emotional disturbances and all are toilet trained. 20 of the population are working in private industry and are earning some money. (The director told me that: if they were earning money, they only get \$11 each month as pocket money, and this is not increased if their salary for work is increased. This seems very little motivating.) Some of the other mentally retarded get some training in handicrafts and such, done by volunteers. We discussed here how many of this population could be working in sheltered workshops especially arranged for mentally retarded. The director estimated that today perhaps 30 could be working in sheltered workshops. A facility like Outreach should be connected with sheltered workshops for the mentally retarded; best if this sheltered workshop is located out in the community. I think that very many of the population in this facility could be able to work or trained to be able to work there. A facility like Greenbrier should have also a training workshop in the institution and I would recommend that the possibility of this be discussed. In fact, I think it is an economic problem. The director of the institution said that there were many difficulties with the neighbors in the beginning, but now they have very little difficulty. Many of the patients go around in the neighborhood, using shops playgrounds, and such, without any difficulty. In all this institution was a very interesting place and should be taken into account by discussing plans for the mentally retarded in the metropolitan area.

7. Outreach Living Center

Residential institution situated in the city of Minneapolis, for about 100. Outreach is an independent living unit with some training opportunity and a sheltered training work-shop, Most of the mentally retarded here are in the educable group, and the Institution has worked out a real good recreation program for them. Most of the mentally retarded come from state institutions but also from institutions for the mentally ill. It seems to be the aim in this living center to train in self-help skills, social skills, and also in occupational skills, and the aim is to get the mentally retarded out in the community. The institution was in a reorganizing period, and it was difficult to get a real impression of the work here, but a plan like this is very interesting; by giving good and excellent support it would be possible to work this institution into real vocational training institution situated in the city. I would propose that the possibility of using Outreach in an overall plan for mentally retarded should be taken into account very seriously.

8. Foster Homes in Hennepin County

Organized and supervised by the County Welfare Department in Hennepin Country.

This is a very interesting project. As I understand, the foster homes have been instituted because of lack of space in the state hospitals, and most of them have children. I had the opportunity of visiting four of these places. Two of them were really very good, one with three children and one with ten. In the home with three children, small children, it was a real good foster home. In the other place there were seven boys and three girls, and of this eight went to school, six for educable and two for trainable. One was in Opportunity Workshop and two in out places outside in the city. One of the foster homes was for ten crippled children. This last home seems not to be good and the activity there with seems not to be suitable. I got the impression that most of the children were lying on their beds. It was only a short visit to these foster homes and I was only able to see a very few of them. I got the impression that it would be possible to utilize these foster homes in overall planning for children who are able to attend either school or day activity centers. In some of those foster homes I got the impression that if space were available

at the state institutions, the county welfare board would decide that the child should take this space. This seems to be related to the economic situation. The cost of care for a mentally retarded child between state and county should be the same regardless of placement, so that the decision of where the child should be placed could be taken without economic considerations.

CHAPTER VII

COMMUNITY-CERTIFIED FACILITIES FOR THE MENTALLY RETARDED

According to the program of observation clinics in each region, this is discussed is the chapter organization. What I would like in connection with discussing community-centered facility such as day activity centers and workshops is to stress that multi-disciplinary outpatient clinics are necessary links in a coordinated and well-supervised system of community-centered. The staffing of the specialist team in the central institution should then also be responsible for the work in the outpatient clinic. The fact that this team also is responsible for the early diagnostic and evaluation work and for the community-centered facilities may make the work situation more interesting and thereby facilitate the influx of such specialists in the work with the mentally retarded.

Day Activity Centers

I was able to see the Hennepin County Day Activity Center in work and saw some facility for day activity centers at Willmar and Rochester. The work with the day activity centers in Minnesota (total now 42 for children and adults) is, in my opinion, very interesting and impressive. I would like to stress the importance of the day activity centers which make it possible for the parents to have their children at home and. in on overall program for the mentally retarded the day activity center is an important link. As mentioned I had little opportunity to see the day activity centers at work, but I feel I got some impression of the work there. Most of the day activity centers are in a starting period and all of them I think need a working out of further programs, both for preschool children and for children of school age, and especially for mentally retarded. After school age, one has to take up the problem according to day activity centers and sheltered workshops. I will mention something more about this in discussing the sheltered workshops. According to day activity centers, I got the impression that training: self-help skills, communication skills, and socialization skills were very well worked out. Perhaps the training in occupational skills and utilizing this work also for academic training is not so well worked out. The work with the parents is also to be worked out, and this can best be done in connection with more central service units such as outpatient clinic for mentally retarded or local mental health center. .

The situation in Minnesota, according to the day activity centers, is different from what we have in Norway, The school system may initiate classes for trainable in their public schools and this has been done several places in Minnesota. I have no material to discuss the convenience of initiating classes for trainable in school age in the public schools, but when this is the program the responsibility for doing it should be clear. The law should then require the local school districts to do it. Having training classes for the mentally retarded in the public schools will require a very close cooperation between the services for the mentally retarded and the school authorities. The service for the mentally retarded will have the responsibility for the trainable in preschool age and also after-school age. This problem is closely related to the work with preschool children in day activity centers and. the work of initiating day activity centers or workshops for training the trainable in after-school age. Here also the question about training industrial workshops may be discussed.

Sheltered Workshops

I have visited Opportunity Workshop in Minneapolis with 115 sheltered workers and trainees. The workshop has a very suitable building and the program and the work was realistic and impressive, working with several contractors from the industries.

In a booklet from 1965 it is stated that the group which began in 1953 was composed of pupils whose maximum potential was for sheltered employment. The present group includes many who are being prepared for competitive employment. The average IQ is now 64. Range in IQ is 39-66. The booklet states that there has been a raising of the IQ range with retention of the lower level of it. My impression was also that most of the work was directed at the educable mentally retarded. This has now led to the fact of the opening of the day activity program for the adult mentally retarded who have been deemed not ready for vocational rehabilitation in a sheltered workshop. It seems to me that this proposal demonstrates the need of erecting workshops aiming to train trainable mentally retarded and also some of the severely retarded, and giving the mentally retarded either at home or in boarding homes, or institutions like Greenbrier, an opportunity for a work place regardless if the aim is limited.

I also visited workshops at Willmar (West Central Industries, Inc.) (The Lake Region Sheltered Workshop, Inc.) and Ability Building Center at Rochester. Especially at the last workshop the industrial contract work was real established and impressive. Most of the trainees and sheltered workers have been mentally ill, only a limited number mentally retarded, and then most of them at the educable level.

Also at these places I got the impression that the place of the trainable and severely retarded was not really decided upon.

SOME GENERAL REMARKS ABOUT WORK AND WORK TRAINING (Rehabilitation)

Community-centered day activity centers and sheltered workshops are closely related to the question of training facilities and workshops in the state hospital and other residential institutions.

I have received the impression that establishing some facilities has many difficulties according to economic problems and the legal relation. I am not enough acquainted with this situation in Minnesota, and therefore unable to discuss it. Instead of this I will discuss some of the general principles.

Rehabilitation of the mentally retarded starts in childhood. The education, training, and treatment he gets as a child is a decisive factor regarding what is possible to teach him as an adult. Meeting the needs of the mentally retarded child also in the hospital is therefore very important (see design of facilities for the mentally retarded). One of the decisive factors in relation is training and education.

As the situation is today many mentally retarded are under-functioning. In fact, vocational rehabilitation starts in the first years of the mentally retarded, and if he, as a young adult, will be able to join in a program for vocational rehabilitation depends not only (perhaps to a less degree) on IQ, but much more on his life experiences and the treatment and training he got as a child.

The training of the children's population in the hospital should be worked so that all children can benefit from it. The training for the more low-graded mentally retarded should be to train in (1) self-help skills, (2) communication, (3) socialization, and (4) occupational skills. And if they are also able to take it, academic skills.

The vocational rehabilitation {in its broadest meaning) with youngsters and adults can be done both in hospitals and in community-centered facilities. Training in Community-centered facilities (workshops and perhaps also hostels) has many advantages, If the training is done in the hospital the training must be "for life outside" and not "adjustment for life inside". In this connection it has to be mentioned that many subnormal require such a density of treatment and training in the hospital unit. Units for vocational rehabilitation aiming: at independent living inside the hospital should be units for themselves designed for training only, and with no obligation for custodial care.

It must also be kept in mind that training refers to a stage in the people's career, and that this term is misused if referring to a comparatively static state. Training should proceed as long as improvement in skill and competence can be reasonably expected. A time will come when a point has been reached and further training should then only aim at some minor special skills and motivating the person not to forget what he has learned and to maintain the way of life he has reached. It is at that point that the decision will have to be made whether the mentally retarded has a chance to survive, in the open community or whether it is to his interest to live and work in a more sheltered condition. The all-day workshop either inside or outside the hospital should therefore only be introduced after the training period has been finished.

What is the general aim of vocational rehabilitation?

Our optimal goal is clear: It is placement in a job in open industry and living an independent life. Discussing the new outlook that our aim will be services for the mentally retarded is to give them an existence which is as close to the normal life as possible, our aim is much broader. It is to train as many as possible of the hospital population to do some sort of meaningful work.

When a retarded person is prepared for employment and placed in a job the benefit is clear. Also from an economical point of view.

But the benefit of training the more severely retarded and giving him a chance of a meaningful life is also important, and in the long run both for the community and for the mentally retarded himself. The philosophy in the new outlook has not to be only the economic viewpoint. A program of occupational preparation and placement which encompasses all retarded will result in a greater number of personal rehabilitated into employment than a program which centers only on a selected group. In this connection it can be mentioned from several experiments conducted in England. This experiment states:

1. The initial ability of the moderately and severely retarded on industrial as on other tasks is exceedingly low.
2. The initial abilities have little relationship to the level achieved with training. The end level can be very good on simple performance tasks also in the severely retarded and this is related both to living skills and working skills. We can state: Low intelligence is only a complicating and not a real decisive factor.

In trying full vocational rehabilitation for the mentally retarded one must not exclude the necessity for assistance and support from time to time. It is therefore very important that the region has "a fixed point of referral" in an outpatient clinic, and enough staff to supervise the mentally retarded that is placed outside in the community. They should be given counseling, or taken in hospitals, hostels and other provisions in the same way as a mentally ill or a physically ill person might require frequent specialists' help. Our aim with vocational rehabilitation should therefore be;

1. Full employment and independent living.
2. Full employment and sheltered living in hostels.
3. Sheltered work and independent living.
4. Sheltered work, sheltered living in hostels.
5. Sheltered work in residential institutions or hospitals.

And it should be easy to switch our program from one end to the other of these points in both directions.

The real vocational rehabilitation in industrial training workshop should not start before the mentally retarded has reached an age of about 18 years. Before this age, there should be possibility for establishing some pre-training from the age of about 16, aiming more the self-help skills, the socialization skills, communication and academic skills, but also with some training in industrial work. The real vocational training should then start in a training workshop and after the observation end training there it should be decided if the person could go to a sheltered industrial workshop aiming at the production or if he is better off in a sheltered workshop aiming at only occupation, or if it is possible for the person to get out in open industry, perhaps also in independent living. There should therefore be, in a vocational training program, established several steps. Here I will only state that the rehabilitation work must be comprehensive. It must not refer to only one aspect, for example work, because the mentally retarded in the community are also social human beings and not simply working human beings. The training must be intensive and directive and apply those skills and knowledge which will help him to find his place in the outside world. In short, it should be trained "skills of living". In this connection I would like to mention a book from England. Gunzburg, Herbert C.: Social Rehabilitation of the Subnormal. Bailiore, Tiuidall & Cox, London, 1960. Gunzberg has also worked out a checklist according to the several skills. These are called Progress Assessment Charts and they have three stages. The first primary "P.A.C." is for children and PAC 1, followed by PAC 2 for youths and adults. They are available from:

In England, N.A, M.H., *39, Queen Anne Street, London W. 1.

* National Association for Mental Health

CHAPTER VIII

RECOMMENDATIONS

1. Organization

The services for the mentally retarded that are not under the Department of Education (special classes in the public schools for educable and. trainable) ought to be organized under one office in the Department of Social Welfare. If it seems convenient under the same office as the service for the mentally ill.

The organization should be based upon regional principle - each region covering a geographical area. One problem in this connection is how large a population base or area is required to enable a proper and efficient plan to be drawn up for the care of the mentally retarded. In Sweden it is stated that the population base of at least 200,000 would be required; but preferably not over half a million, since such a large area would be unmanageable - if we disregard the large metropolitan cities.

In Norway, too, the population base differs between 200,000 and 500,000. Denmark with a population of about 4 1/2 million is divided into eleven regions. Copenhagen, with about one million, is one region. The service in this region is divided into service for children and adults. Minnesota, with 3 1/2 million, should at least be divided into seven regions, such as the service for the mentally ill. The region for the mentally retarded should not be a subdivision of the service for the mentally ill, but have its independent organization, but work in close contact with the organization for the mentally ill in the same region. In the same way, the central institution for the mentally retarded should work in close contact with school authorities concerning the mentally retarded who get their education and training in the public schools.

The head of the organization in each region could be a medical superintendent (psychiatrist) as in Norway, or be led by a team consisting of an administrator, chief physician, chief social worker, and a chief teacher as in Denmark (according to the organization, the situation in Denmark is different in that the schools for the educable are a part of the service for the mentally retarded and not of the Department of Education). The head of the organizations or the team should be responsible for working out plans for all services in that region, both residential and community centered facilities, in near cooperation with a central office.

Each region should have a central residential institution or a central state school and hospital. This central institution should have several wards for observation, training, education and treatment for all ages and categories of mental retardation.

The specialist team consisting of physicians (psychiatrist, pediatrician, child psychiatrist if possible), psychologist, social worker, nurse and special teacher, should be connected with the institution. This team should have the responsibility for the planning and treatment in all facilities in the region, both residential, state institutions, private residential institution, and community centered facilities. The team should there-fore have the supervision of all facilities in the region and coordinates their work. The office in the central institution should also be in charge of the waiting list.

Each region should run an out-patient clinic covering the task of early diagnosis, evaluation, treatment, and counseling, and being a "fixed point of referral" for the region.

According to the plan for the mentally retarded, that the mental health centers scattered over the state also serve mental retardates, the out-patient clinic at the central

institution should work in close connection with these centers.

The mental health centers serve more as screening centers, and refer to the central institution the more specific problems concerning mental retardation. On behalf of their situation in close contact with the community they should also serve as counseling centers for the mentally retarded situated in the community but also in close contact with the central institution.

The central institution should also work in close contact with the facilities worked out by the several County Welfare Boards.

If regional planning is decided upon, as described above, perhaps the difficult situation, according to the specialists team (especially psychiatrists, child psychiatrists, psychologists) we may find it impossible almost to establish this organization the first years. I would then suggest that some of the mental health centers and child development centers, and also county welfare boards are now working in this direction, and that the regional organization in the beginning can be based on these existing organizations. I am especially thinking of Fergus Falls Mental Health Center and the County Welfare Board in Duluth {see report from these areas). In this connection I would like to mention the unique situation in Rochester with Rochester State Hospital now erecting a day activity center on the hospital ground, and its connection with the Mayo Clinic. Here it would be possible to organize a unit for observation, evaluation and also treatment for the most difficult cases, especially children. This unit could then also function as a research unit and a unit for post-graduate education of specialists, working in the field of mental retardation. These observations units will contain 50-100 beds for children, either situated on the campus of the state hospital or in another place in Rochester. The observation unit ought also to be run with an out-patient unit. If it were possible to erect such a unit in Rochester, it would have a tremendous influence in the direction of getting medical doctors, especially psychiatrists and child psychiatrists, interested in the work with mental retardation and I would also think that research work in this field would be highly stimulated. The unit should then serve the whole state of Minnesota, concerning more special cases. . .

The ratio of patient for state and county should be the same for all the several facilities, both state hospitals, private residential facilities, in the county, and community centered facilities (such as day activities centers, workshops, and half-way houses). In this way the choice of the most convenient treatment of the mentally retarded individual can be done without taking economic considerations. According problems of payment from the patients, I have no background to discuss.

2. The Several Facilities in the Region

A. Residential facilities.

The central institution (the state schools and hospitals).

Today Minnesota has three state schools and hospitals: Faribault with 2,700 beds; Cambridge with 1,600 beds and Brainerd with 1,400 beds. Especially Faribault and Cambridge have many old buildings and big ward units (up to 104). Many of these buildings are not suited for ward units for the mentally retarded. Brainerd has more modern units but none that are good for children. Especially there are in none of these institutions buildings that are suited for mentally retarded children and none, that by rebuilding, will be suited without very big expenses.

There is, therefore, absolutely needed a thorough remodeling of both Faribault and Cambridge, and at Brainerd plans should be worked out for now and modern buildings for children. In this connection it must also be underlined that all three institutions (and again, especially Faribault and Cambridge) are la lack of space for workshops if we will state that opportunity for work is a human need for most of the patients.

Possible plans for remodeling these institutions is closely related to the question, if the organization for the mentally retarded in Minnesota should be worked out on a regional principle, with at least 7 regions. This is highly recommended and it is, in my opinion, the only way to get a real comprehensive and coordinated organization. Also related to the question of the most convenient size of the institution, is the necessary breaking down in regions. In this connection I will cite from National Action to Combat Mental Retardation, Report to the President, 1962, page 143! "The Key Factor, of course, is the progressive, will being of the individual patient. When that, and other factors are taken into consideration, a reasonable conclusion is: (1) That in situations for the retarded should not exceed 1,000 beds, and those whose populations presently exceed this number should take steps as soon as possible to provide snail living units within the facility to provide individual care: and (2) that residential facilities now being planned, and those to be built in the future, should not exceed 700 beds in general, and for certain specific, purposes, any number under that might be well regarded as advantageous,"

Such a plan requires, therefore, the remodeling of Faribault and Cambridge, and to a certain degree also, Brainerd.

Then it would also be necessary to plan and build new institutions to cover the remaining areas. The place for a new institution ought to be a not too small city; with good general health service, including hospitals. The next step is to decide the most convenient size of each of the 7 central institutions according to the population area they have to cover. The size of a central institution depends on the whole program for facilities in the area, and the possibility of working out community centered facilities (day activity centers, workshops, halfway houses) and the use of smaller privately owned residential facilities for special purposes.

The possibilities for these will differ in the several areas. As a guideline, for areas with not too scattered population, we can use the estimate made in Denmark: in daytime activity centers for children and classes for trainable together accommodation per 1,000 population (children up to 20 years of age}. In sheltered workshops for adults, one per 1,000 population (in halfway houses then one accommodation per 2,000), and in residential institutions about two per 1,000 of the population. The ratio between accommodation in central institutions and smaller homes is more difficult to estimate and it depends also on the policy in each country as well as the situation in the different areas, As an estimate we can take 1.5 accommodation in central institution per 1,000 of population. The situation at Faribault, Cambridge, and Brainerd will be discussed in more detail, especially concerning the existing buildings and the use of these buildings in a new program. The time to work out such a program and get the new facilities will take many years, and in these years the existing hospitals will have to cover bigger districts and have a bigger population than when the program is fully worked out.

In remodeling and planning new wards, the plans should be based on the following principles;

1. Living Facilities

The ward units should not be too big. For children 8 to 12 beds. For adults, not to exceed 16 beds. There should be no big dormitories, only 1 to 3 bedrooms. Perhaps for crippled children and adults, 4 to 5 beds. Each unit should have a dayroom and a hobby room (the use of the hobby room according to the category of patients in the building). Each unit for children a separate dining room connected with a small kitchen necessary toilets, bathrooms and showers. 2-4 units may be connected together in the same building or connected to each other. Special arrangements are naturally necessary concerning special categories such as non-ambulatory and hyperactive, and destructive patients.

All three existing hospitals do not have almost any ward unit well suited for the development of mentally retarded children and it is an impressive task to erect new living facilities for residential children.

2. Enough facilities to cover training, education and work, each day 5 to 9 hours for almost every patient.

The opportunity for work training and work should be the right of every mentally retarded person. Each of the existing hospitals has a good program for the education of educable and the more bright trainable Children (especially the program at Faribault was in this report impressive), but no capacity for covering the training of most of the moderately and profoundly retarded children. In most of the ward units for children, only a small portion has the opportunity for training some few hours each week. In my opinion, the working out of a real comprehensive training program for children of these categories, besides the revision of building faculties for children in the hospital is the most important and pressing task of all. All the hospitals have an excellent (but quite too small) staff in these areas and given the facilities and possibilities, will be able to work out a program covering all aspects and reaching all children.

All hospitals have a program for patients working in the several services in the hospital units, and this work is also, to some degree, a training situation aiming at vocational rehabilitation and covering also the need of work (payment for the work). Patients working, in the ward units are, according to my opinion, in some degree working with tasks such as feeding children, that ought to be done by the ward personnel.

In contrast to this, none of the hospitals have a program for workshops covering the training and working needs of the adult patients. A big category of adult patients has, therefore, no opportunity for training and work. Building up of training workshops, occupational workshops, and industrial workshops in the hospital is, therefore, also an impressive task. The program of work should at least cover 80% or perhaps 90% of the adult population in the hospital.

None of the existing hospitals has today space to cover these aspects and in remodeling one should consider the possibility of using some of the older buildings as workshops and kindergarten and training classes. This may, in many cases, especially at Faribault and Cambridge, be convenient.

3. Facilities for Recreation.

The facilities and program for recreation are well worked out in all existing institutions. Reducing the population according to the program above, the recreation department can be able to cover relatively more patients. Further programs being worked out along the same line as now and especially facilities for physical training, gym-nastics, sports, swimming, etc.

4. All the necessary treatment facilities.

All the existing hospitals have worked out good programs for the treatment but all areas do not have the capacity to reach every patient who is in need of it.

Every hospital has an infirmary. Faribault in an old large building but not well suited for the purpose. Each hospital has a department for physical therapy and a good program for this, but it is also too small to cover the needs. And especially by building new facilities for children, this aspect should be taken into account. In the same way, facilities for speech therapy (if it is possible to get it) group therapies musical therapy, etc., should be covered (as done in an excellent way in the new Rehab building at Brainerd).

In summary, some of the three existing hospitals have the capacity they cover today. They all need a radical reduction in population, The remodeling plans for these institutions ought to be worked out in connection with the area they will serve, and an estimate which buildings in the future may be used for ward units, which for workshops, and which buildings are to be torn down.

Concerning Brainerd: New building ought to be for special ward units for children and in order to complete the building at Brainerd, I would recommend the building of a separate children's institution at Brainerd for about 120-150 children, more as a village for children with small ward units. The program to be based on a philosophy of the children's hospital at Vangeds, Copenhagen.

At Cambridge and Faribault, the situation is different. Both these hospitals are far too big, and, their geographic position seems to make it convenient that they cover the most populated metropolitan areas. These areas will exceed 500,000 in population, and it seems to me convenient to use Faribault and Cambridge as institutions for adults in these areas, and to build new hospitals for children. If possible these hospitals ought to be situated in Hennepin and Ramsey Counties. The central office for the region as an outpatient clinic ought then to be built in connection with these new hospitals.

The new hospitals for the region being planned and not covered by the above mentioned institutions ought to be planned according to the population area they have to cover.