Sharon Sandberg
Anoka State Hospital Oral History Project
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[Music playing]

Neal: Good morning.

Sharon: Morning.

Neal: I am Neal Holtan. This is part of the Anoka County Historical Society's Oral History Project on Anoka State Hospital. And, I am here interviewing Sharon Sandberg first and then Linda Walton afterwards. They are former colleagues and still friends. Thank you for coming in. So, let's start with you, Sharon, if you could please tell us where you grew up and went to school.

Sharon: I am a product of North Minneapolis and Robbinsdale. Graduated from Robbinsdale High School in 1958, at the beginning of what I would call the social justice era when people marched and had causes and so on. And, as a teenager, I was aware that there was a hospital for the mentally ill very close to me in Golden Valley, and patients were there a short period of time, but that is about all I knew about it. But, I was aware that there, much more aware I should say, of the mental hospital up in Anoka, and it looked like a locked castle-like, old, reclusive place. I knew that patients were there kind of as a last resort. They stayed many years. There were no drug therapies at that time in the early '60s. And, it was a place that I felt I wanted to be a part of. I wanted to help those people and I wanted to improve their quality of life. And, I knew something about it, because my mother's church circle delivered boxed cake mixes and frostings there for patients' birthdays. So, every month I would go up and deliver these with her, and I also had friends in the Robbinsdale band that went up and performed and entertained for the patients there.

I found that occupational therapy was a good match for me and it kind of fit right into my thoughts about what I wanted to accomplish as a career. So, I graduated from high school, attended McAllister College my first year and transferred to the University of Minnesota that had an OT program, and graduated from the U in 1962 then. And, during my time at the U, I had been fortunate enough to have an internship to do my three-month mental health affiliation at Anoka State Hospital. So, I had a good taste of it before I ever was there on staff. I found it a fascinating place. Their OT program was excellent and a lot of students came from across the country to have their affiliation there. And, the time I was a student there, we also had a doctor's daughter from India, so it was a far-reaching program and very sound.

After I graduated from the University of Minnesota, I got a call a couple of months later saying that one of the faculty at the State Hospital was going to St. Catherine's and she was going to be on the faculty there and did I want to apply for her position. And, I certainly did and I was accepted there, and so I became a staff therapist then at the State Hospital in 1962. At that time, being a part of that OT staff was very exciting. I was 22 years old and I worked with eight other people who all knew more than I did because they had been there longer and had the experience with the clients and so on. But, there were eight of them, most of whom lived right around the Anoka area as I did and have for 52 years. And, there were four students at the time that I became one of the staff therapists. Most of those gals, because they came from out-of-state, lived down in the nurses' dorm down on the river, right there on the campus. And, I remember what we wore to this day. I still have pictures, I show them to only special people. Long, white uniforms, white socks, white shoes, and in our pockets, we carried this huge ring of coveted keys, and that gave us access to the cottages or storage

areas, or OT clinics and the like. And, in the other pocket, everybody carried matches, because the clients were not allowed to have their own matches to light their cigarettes which they smoked throughout the day. And, we had to light everybody's cigarettes, and we did with our coveted matches. We worked Monday through Fridays, 8:00 to 4:30, not weekends, until back earlier in the '80s when I had returned and worked there again at that time. That had changed, and we then, at that point, did some evenings and weekend groups.

I think it was a close-knit group within therapy, and worked well. I was excited to work with a creative bunch of individuals who could think outside the box, would read the OT journals and come up with some ideas that they might want to try with some of the chronic folk that were indeed at Anoka State at that time. This was, the population there without any medication at the time, very early into the days of Thorazine, Stelazine, Haldol, better known as the Vitamin H. We saw lots of aggressive behavior or acting out or wild hallucinations, a lot of torment within the patients. And, that was a big part in what activities and all we had planned for them.

After I was on the staff for a couple of years, the then current Director of Occupational Therapy, Patricia Babcock, was asked to go to St. Mary's Junior College in Minneapolis and—now that is connected to St. Kate's, but, at that time was St. Mary's individual standing area college—and set up a certified OT assistant program at the college. And, she did that. She was a marvelous role model, a woman ahead of her time. I cannot say anything but wonderful things about the patients she helped and did special one-to-ones, reading, teaching people how to read and things on her lunch hour. And, she was a marvelous person. So, when she left, I had at that time was thinking about, oh, maybe this would be a good time for me to home and start a family. Well, Pat said, "You're not going anywhere. You're going to be the director." So, I did, and that again was another marvelous experience. But, I was young, there was a staff of, I think, eleven, eight, eleven therapists at that time, so I accomplished both an administrative role, had encounters with both the administrator and the medical director about the therapy program and ways to change or something I might want to improve or try. I found them always very receptive of things like that. And, then patient groups, that was also part of my responsibility, that did not stop. It was not purely an administrative role.

So, I did that until I was, then thought it was time to home and start a family, and later on in the mid-60s. And, at that time, I left the role of that, as director, to Mary Raulie [PH], who was a very qualified OT, who had been there, worked with her together and she took on that role for a number of years after I left and went home and started the family.

Neal: So, what years were you at the hospital?

Sharon: I was there as a student in '61. I started on staff there in '62, and did that for a couple of years and a couple more years up into '65-ish, when I left, and had the role of director at that time.

Neal: And, did you come back?

Sharon: I did return. I like to say that I have been to Anoka State Hospital three times on purpose, and I really truly mean that. Every time was challenging, but very rewarding. I would like

to advocate for any of those patients whenever I can, and that is why I chose to become involved in this project. I thought it was a superb place to work and enjoyed every bit of it. The last time I was there, latter part of the '70s until the very early '80s, and I saw a lot of changes. And, I hope to bring those up later.

Neal: For sure.

Sharon: Okay.

Neal: Before we go too much further, could you explain what occupational therapy is?

Sharon: I will start by saying what it is not. OT does not find people jobs, but we find them occupations that are at the level that their potential allows to be at. We try to get them at the highest level that they can function at, bring a higher quality of life, satisfaction. If they can do something simple, fine. It beats doing nothing at all. Activity begets activity, and OT started out working as reconstruction aids after, with the shell-shock vets in World War I. And, that pretty much grew it. I would see that as treating patients very similar today to what folks work with with PTSD. And, it was bringing people out, being able to emote some emotions, to get them involved in activity, to move, not sit, be involved with others and life again. And, then that, in 1930, I know, according to the records, OTs were hired to work at Anoka State, along with putting in a library. And, at that time, I would imagine that was a lot of custodial care, more diversional, probably OT products just helping them have some quality of life with normalcy that they could experience. Maybe being together with a small group or watching a film, something very basic, not a lot of individual goals, very specific at that time.

But, then once the medications came in in the early '60s and the behaviors were better controlled, the depression lifted, they were not as tormented by hallucinations, etc., they were more workable. And, then we went to a treatment-centered approach and much more specialized with specific goals that we could work on with the patients in a group. Maybe a goal would be increasing attention span or making sound decisions, and working with others, social interaction. And, really zeroed in on specific goals and needs that the patients had. And, we came up with activities, be they in group setting or a small group of three or four, and worked on those goals and achieved them with different kinds of activities.

Neal: And, were you able to observe that transition from the old to the new?

Sharon: Yes, definitely, yes. And, it was exciting to see, for example, going to team meetings and being able to talk about improvement in patients, not just were they still okay, did they need to get more exercise. We really zeroed in, honed in on specific things that patients needed to be able to do, to function at a higher level and feel better about themselves. And, we did a lot of things, groups to increase self-esteem, as well as decision-making skills or self-care, taking the regressed individuals and saying, "Do you have two shoes on today? Oop, no, Henry's only got one shoe. Well, let's find another shoe for Henry." And, made them aware of their personhood and their place with their peers. How to eat together, how it is inappropriate to walk across the table when you are eating, so remain seated. And, consequences for behavior, learning to take some responsibility for themselves when they could, at a level that they were at.

So, yes, I saw that. I saw a definite improvement. I saw the pleasure and the esteem that came to the patients that we worked with upon achieving those goals.

Neal: Did you and the staff talk about that transition while it was happening?

Sharon: Constantly, yes. And, starting people on medication, the psych drugs in the early days, was not an easy thing. And, if you go, burning straightjackets in '49 to ten years later putting people on meds, there is a big transition with that type of move. But, it was a healthy move, and it was a good move for the most part. There was less EST, electric shock therapy, that went on. It was not just kind of a routine thing. And, I saw lots of betterment in depression. I did not see lobotomies for post-partum depression. Those things changed, and it was good to see it and it was exciting to be able to plan and do things outside the box and try things that worked. And, patients said they worked and they got better. They were out and about.

Neal: And, were they more often discharged after the medications became available?

Sharon: Yes. But, I will qualify that by saying Anoka was still a place that either you went court-ordered, or you had no other place to go. And, a lot of patients that we worked with did not have close family ties. Families had worn out working with chronic mental illness that was not very treatable. There were not the drugs, and here they had their family member and they were exhausted. So, they were not anxious to take those family members home again. There were not the community resources, mental health centers abounding, advocates for mental health. So, that was difficult. So, going out into the community to live, and Linda will talk about the fair weather program later on. That was down the road into the '70s a little bit more when that started. And, that was more successful. But, up until that time, we were still dealing with that chronic population that had resided at Anoka for a number of years. So, yes, some went home, some went to nursing homes, some went to board and lodges, board and cares. If they were higher functioning and decided that they took their meds, they got better and now they did not have to take them anymore, as happened often, it was the revolving door, and they were back in the system at some other hospital or some other facility, and maybe back at Anoka again. So, it was not the success rate that one hope immediately, but it has gradually moved that direction.

Neal: Because of your student experience, did you feel that you were well-prepared to take on the job?

Sharon: I am not sure now that I am older, that I would think that anybody at the ripe old age of 22 really grasped what life was all about. What personal relationships and being haunted and tormented in your struggle with mental illness, in your relationships with other people, generally not being a very high income, not having support of family or friends, being unable to talk to people on the phone, you cannot order in a restaurant, that is tough. Those were tough things. But, I learned how to smoke, because I tried to relate to people and they all smoked, so I learned how to smoke. I learned how to take off a wedding ring, gaudy jewelry, a lot of makeup, did not have my hair done, wore more street clothes under uniforms, when we could just do a lab coat. I made of point of not sitting at a desk with a patient on the other side. I sat chair-to-chair, knee-to-knee. I never knelt in front of patients, that is a real vulnerable spot to be it. But, I learned that, I learned physical safety

and how to work with that with them. I think that is common sense. I have applied that in my own life years later. But, I learned what their scaries, I had a little bit of a peak of it, the insight to the scaries that they struggled with, and how that might be to deal with life as I knew it as normal.

So, I had a real appreciation for that. I have carried that with me to all my other jobs and I have, other positions I have had after my kids were older and went back. I worked primarily in mental health, drop-in centers for the mentally ill, worked academia with St. Mary's Junior College, with the students out on their psych affiliations, taught at Anoka Tech in their OT assistant program. And, only in the latter years, worked in gerontology, but I always was able to take those lessons, to know what it was like to have a disability that was very limiting, and how, different ways that I could approach this person, be respectful and help them still achieve their highest level of functioning and their quality of life. I learned it at Anoka, no place else.

Neal: And, who did you report to at Anoka? How did that structure affect you?

Sharon: As a student, it was Patricia Babcock, Director of OT. When I was a staff therapist, she was my supervisor. When I was director, I had the eight and I also had the student program that had four, I think four was about the max that we ever took there. Was that director, did the evals on the students and the monitoring of that as well as the groups and all. And, when I was back in the early '80s, it changed to not being supervised by the head of OT anymore, I was then responsible to a specific cottage that was headed by a clinical psychologist. So, Richard Flannigan was indeed my supervisor, and we did everything as the whole team was there. The weekly team meetings, same group of people. We were not hopping all over the campus to different team meetings. We had a specific group, and it was much easier to work with just a specific group of people, and we got to know our team members better. And, that was the approach that we had then. Not that I was not still within the OT department, but I was responsible to Dick Flannigan and that team for his cottage of the regressed men.

Neal: Do you think that team approach was helpful or better?

Sharon: I think it was better as long as we continued to have OT meetings once a week, because we needed to share our different activity ideas and, hey, I used this in my group and you might want to try that, or we got a donation of this, help yourself to the supplies. Or, I read a journal article and it said. So, we kept abreast as OTs, but we were responsible to a specific individual and team.

Neal: Were there special aspects of OT that you thought were especially helpful to the mentally ill?

Sharon: Definitely. And, OTs work in just a variety, a host of areas with peeds [PH] at home and drop-in centers and cardiac rehab and burn units, making adaptive equipment for prosthetic folks. And, a number of different adaptive and places and disabilities that require looking at the disability and not thinking of it as this is going to hinder. It is we are going to fix this and normalcy will be better, you will be able to function at a higher level. I think, since reintegration was an early new, again, outside the box idea, an OT named Lorna King, who was an OT in Arizona State Hospital that worked specifically with schizophrenics, and she discovered by observation when

watching them that they had difficulty with movement, sensation and balance. And, she thought, "Why not see if we stimulated those three areas of the brain, did we get improvement in those three areas?" She did and they did. And, she was studied and written up and they worked a lot. It is now a worldwide recognized sensory integration, and is a very good technique to use.

And, I got in just as Anoka was doing the cutting edge of that in the early '80s. And, I can remember the big, and I am sure people have seen clients working with a parachute, and everybody grabs a spot. Okay, you have got some tactile, some touch, and everybody is marching around. You have got synchronized walking as a group. You might have one of the patients in the center who is being the vestibular movement for sensation. You might see somebody being wrapped up with a parachute for firm touch against the skin and for dealing with sensation and all. We also had people placed on scooter boards, with ropes attached that staff could move them around. And, again, the stimulation and the movement affected the parts of the brain that had to do with movement and sensation and balance. And, there was definite improvements, and these type of techniques are used today with those with learning disabilities, as well as autism. I think that was one of the most striking new developments at OT.

But, there was also SMASH therapy, and Linda was there during that time when patients would throw glass in a very controlled, safe environment. And, working to emote feelings, anger management, if you will. And, then they spent an hour immediately following with a psychologist, a social worker, dealing with, in a therapy session with that person. So, those two come to mind. OTs get pretty good at thinking up how could I accomplish this and not have it look like work or exercise? If you need to work on more movement, maybe you go fishing and you cast. You do not always have to sit and count marbles and screws and stack cones that looks like an OT clinic per se. You can do things outside.

I used to do real hands-on therapy with the regressed men. They got together and I had them build a wagon, so they had to work together, they had to pound, they had to figure out how to do this. They had to hold boards and pound nails, and then with the wagon, we carried, filled it up with watering buckets and so on, and went down near the east side of the Miller Building to the garden. And, they had planted out this little garden. And, I thought, okay, here is immediate gratification with the food and all. And, they enjoyed that. We had a lot of tomato sandwiches at Anoka with the regressed men's group. We got outside whenever we could, which was air helpful to breath and out of the smoke, because there was a lot of sitting. On the front porch was a very populated front porch in the front of each cottage, and patients would sit there. They would stand there, they would sit on the big sloping edges of the stairways. If they smoked at all, they smoked there. They walked around the big circle, and if they were licensed to and had the money, they went down to the basement of the auditorium to the canteen. And, with the pigeons sitting up in the architectural gargoyles up over the fronts of the cottages. So, it gave meaning to more normalcy and more activities.

Neal: And, how did you relate to the other professional staff, the more medical people like the nurses, the physicians?

Sharon: I mentioned the team meetings that we had, and no matter where you worked, there was a team meeting associated with it. Generally, on a weekly basis, generally there was visiting psychiatrists that came out and led that group. There was a clinical psychologist assigned to that

area, a charge nurse or more were always there, somebody from recreation therapy. Maybe if they had a job, they had industrial therapy represented there to talk about specific, how was this patient doing in their work assignment. And, somebody from OT. And, if anything occurred in a group setting, therapists always went to nursing, that was charted in not only the OT's charting, but it was charted in the daily charting of that day. So, the word was always passed on, be a minor seizure, be it an outburst, be it a new behavior that we had not seen, any signs of tardive dyskinesia that we noted, all of that would be noted. And, it was kept up to cert, we did it. And, documentation was a constant, goals, who was going to help them achieve it, what were these goals, by what date, progress toward it, new goal, plan of discharge anticipated. So, there was a lot of communication.

We also, I think we talked more with, from OT, we worked with Linda, we worked with home ec, we worked with rec therapy, industrial therapy. I understand there was a music therapist within the rehab therapies at one point. And, psychology, if there were questions that we had on something diagnostic, we would have Gordy Olsen take a look and see what his impressions were. Education, some. So, and of course, we were friends of maintenance all the time, because some equipment always fell apart and we would call on them, and they were great. We knew all the masons and the plumbers and the carpenters and the painters. And, at Anoka, if you needed two rooms, they came and just put up a wall overnight, and the next day you had two rooms. But, they said, "We just make them kind of thin, because next week, you won't need it," and then they will come back. So, we got to know those folks and relied on them a lot to help us.

Neal: The treatment plan, were you part of putting that together?

Sharon: Absolutely, and you got into occupational therapy or rec therapy or industrial therapy, IT, by a referral from the physician. I mean, you did not touch anybody unless you had the piece of paper with the referral of this is what I am looking at, signed by the doc. And, it did not always come from him without my input. I would say, "I've noticed so-and-so, or he's in rec therapy and they think, you know, maybe he could be somebody that would need X group," that I was in charge of. And, then I would go to the doctor and ask, "This is what I'd like to try. I'd like to do an eval on him and let's see what we could do." Always good response from the doctors.

Neal: How prescriptive were they in determining or asking you to do treatments?

Sharon: I would say with the workload and the number of patients that they were responsible for, that would have been impossible to know the status of them all at any current point or a change. They had to rely on nursing, they had to rely on social service, psychology and the rehab therapies, and the groups that they spent their days and early evenings with to let them know what was happening. And, the more details I felt that we could feed them and let them know what was happening with their patients, the better relationship we had and the more folks we were able to contact and get into therapy.

Neal: As a physician in the past, I have often put on referrals to OT or PT, proceed as indicated. Did you have kind of a blanket go ahead like that, or…

Sharon: Eval and treat as indicated were the catch phrase, yes, but I only had so many hours to get the eval done, documented and then get back with this is what I saw as limitations. There are

some activities that I feel might help. This is how many times a week I would like to work with this person, anticipated discharge date. And, it always got approved. I mean, I do not remember ever getting no do not do that, or that sounds really inappropriate. They relied on the assessments, the evals that we did. And, sometimes we used an OT standardized test of some kind, could have been just observation, or give them—I will use Linda's—give them a recipe. What could they do with a simple recipe? Or, ask them to make a sandwich, or if I asked them to stir half of this with half of that, so I had some idea about how they could function, how they took direction. And, if that was to be a goal, then I set up activities that would help to accomplish that.

Neal: Did all the patients get OT?

Sharon: No. For some, not appropriate. Some severely depressed that were on a lot of EST or not well med-regulated, were not right away introduced to OT. A lot of the chronic population was, and I would like to share with you, that one of the most gratifying things that I ever did out there was to take a patient who had not been off the hospital grounds in over 20 years, and I took her down to Carl's Restaurant. It was on the corner of 2nd and Main, and was about the only place to buy food in Anoka at that point, in the '60s. And, I took her down there and she really spoke, a lot shaking, scared, looked very scared. And, she had had a very, very traumatic childhood with murder within the immediate family and so on. And, I said, "Okay, let's go an eat." And, she was willing to go in my car and go down and have lunch down there. She knew not how to order, why would you order thing if you had just been given food three times a day. There was no decision, she did not know fried from boiled from broiled from anything. Did not know what apple pie was, just knew to nod, and so she would do that. And, that was a real eye-opener on the level of population that was at Anoka within the chronic group over the years that I was there. And, to know that, how isolative that might feel and how scary if then the governor says, "Well, I guess we're going to de-institutionalize and people can be discharged and they can go in the community." Oh, my gosh, what a thought. And, that was not an easy thing to do.

Neal: You mentioned safety, and being aware of your surroundings. Did you personally experience any adverse events?

Sharon: No. And, I worked in OT my entire life. I have never been hurt by a patient. I learned well on how to be, as a student, by Pat Babcock. She said, "This is what you do, this is what you don't do." And, I followed her advice. You do not walk up, you do not invade space. And, I was very cautious with that. And, do not touch unless you feel that that is a really appropriate thing to do. Do not mother, do not talk down. Set your expectation. It is time for group, not do you want to come, because you would always get a no. Smoking and sitting outside with pigeons superseded OT on any given day. But, if, the only time that I got kicked out at, I approached a woman who was sitting on the basement floor of one of the cottages and I said, "Oh, hmm, it's time for OT." And, it wasn't time for OT for her and she just let out with a kick. But, I was standing far enough away to avoid it. I got spit on once from an individual in four-point restraint. I got too close, that was my fault. And, short of that, no, no sharp incidences, no nothing, no threats, no threats of bodily harm, no stalking experiences like that.

Neal: Maybe we could turn to community issues in Anoka itself. How do you think people in Anoka viewed the hospital?

Sharon: I think 50 years ago, 50 years ago when I moved to Anoka, newly married, bought a house, the State Hospital employed a lot of people, and so did Federal Cartridge and the thermo serve plastic coffee jug people, Westbend. Those were, I think, the three biggest employers. You would not want to be too nasty about Anoka State. It was your employer. On the other hand, as an individual, you might, if you did not maybe have a, for lack of a better, a good enough understanding of what mental health was, or illness was all about, you would see the overt, unmedicated, aggressive individual or yelling out. We had some mentally ill and dangerous that, MIND [PH] patients that were not yet placed at St. Peter. We had them in groups, and those would be scary folks to encounter downtown. Well, they were not downtown, but other folks that had passes to leave the grounds were. It is my understanding that they had some altercations with the business men at their front doors. And, so I would assume Main Street would, or any store would be concerned about unkempt persons hanging about, talking to themselves or doing, exhibiting what they would consider abnormal behavior in their place of business. So, I comprehend that. My heart lies, of course, on the other side. That these people needed help and compassion.

Neal: Did you find yourself defending the hospital as an employee?

Sharon: Yes.

Neal: Any examples?

Sharon: The most obvious would be at the time that Mary Gilbreath [PH] was murdered by a person from the State Hospital. Mary and I went to the same church, First Congregational Church, on Main Street, 3rd and Main, and she was, of course, waiting for women to pick her up to bring her to a church function that morning when she was attacked. It did not tear our church apart, but it was a very sad time. And, I can vividly remember the tone of the sermons for many weeks that went on about the need for compassion on both sides, Mary's family, as well as the attacker and his family, if he had one, and what would happen to that person. Shortly after that time, of course, the petition went around and oh, we have got to fence people in. There are instances recorded of patients climbing the fence to get into group, because the door was locked. Personally, I do not believe that is the answer, and I do not know that it did the community any good to put up a fence on part of the area. I do not know that it achieved the goal. I do not know that it achieved the goal of the community who wanted it there. But, it was a very sad time, and it was talked about a lot.

Neal: And, how did it finally get resolved, if it did?

Sharon: I do not think for some people it ever did. And, maybe it sparked a little bit more support for mental health areas. Maybe, nommie [PH] is been able to use it or worked with people that knew about that incident at that time. Our church now has, our communion table is in, it is a memorial gift in memory of Mary. And, every once in a while, her name comes up and especially about remember there to be compassion to both sides.

Neal: Maybe some questions to kind of wrap up. What led you to leave the hospital? You mentioned your family primarily.

Sharon: I decided to begin a family, and I kept in close contact, even when the kids were little, I worked for St. Mary's Junior College with Pat Babcock in her program there. And, I was the onsite supervisor for their mental health affiliations, which then we arranged to have at Anoka. Because, Pat knew it was a good spot and I knew Pat, she knew me, and she knew what the experience that the students would get there on the tweer [PH], certified OT assistant level. So, I did that and kept in touch with the staff of Anoka State and, because I would be there with their students and I would be in group, and I already knew who was leading the group and how did the student do. So, I got input from people I already knew about the function of the students. So, it was, worked well both ways.

I always stayed in mental health. I worked at the Apollo Center in St. Paul, which is a drop-in center for the chronic mentally ill. And, was, I think my title there was a social rehab director or something. Sounds like a party planner. And, while it was not special, traditional OT, it is the only spot that I did not have to ever document or get a referral from a doctor, because we could plan what the patients needed. If they needed to know how to cook, we come up with a cooking group. If they were crying, we sat down and dealt with that through some feeling type of group. If they were just sitting, we had dances. So, that was a great spot. A little untraditional, but a great spot. I worked at Golden, I went back to the Glenwood Hills, now the Golden Valley Health Center. I worked on adult mental health unit there, and I helped establish the women's unit, abused women, a lot of the women from Canada, because their insurance, they had no programs like that in Canada, and their insurance would cover it. And, they came down to Golden Valley for treatment there. And, I worked on the eating disorder unit that had also a lot of mental health issues, of course, in that. Probably the last ten years of my professional career, I worked with more folks in gerontology. Anoka County for senior services and adult protection, and again working with folks with dementia, a lot of mental health issues there, too, depression, heavy.

Neal: So, what advice would you give to people who want to be advocates for the mentally ill?

Sharon: Who want to be? Stand up and get involved. Everybody can do something to help the cause, to improve the lives of our fellow men. They are everybody's family. There was a little blurb on TV last night that somebody did a show on homelessness, and they dressed up family members and had their kids parade by. And, so they did not recognize them. They are out there and they are our family. They are our friends, they are our neighbors, they are our church people. I think the churches have done, they are doing a better job of having special workshops or speakers come in. And, they seem to feel comfortable now in the church atmosphere, bringing that up more. Anything that nommie does support, financial. Volunteer at the State Hospital. The Blind Society used to run the canteen. Now, I think a group of volunteers do and down in the new building. Save your books, save your supplies that they might use in some activity. I always said, if I win a million dollars, first thing I will do is buy a new green bus for the State Hospital so they can go for Dairy Queens. Donations of something that could help that. But, we are all kind of, we are all people and need somebody to, a reason to get out of bed in the morning. Somebody to sit next to, be involved in life and change the image of some of the, the images that have happened in the past and some of the media that you see now.

Neal: You have covered a lot of topics, and is there anything that we have forgotten to talk about that is important?

Sharon: I think that is a pretty good, birds-eye view of what is was, how it changed, and that therapy changed. We saw more addiction, more CD into the '70s, and Anoka used to be the center for TB in the state and all the mentally ill with TB went to the Burns Building in Anoka. That went away with the going away of TB, and CD entered. And, I think Anoka did a good job of trying to keep up and adjust to population change, drug change. And, I remember with LSD coming in, well, that was a scary thing, too, but Anoka adjusted and we had responsive outcomes to what was new on the horizon. It was, to me, Anoka is a very rewarding place, even for, and I do not know right now what the population is, but it was in the 1500s when I was out there, down to 400 or something when you left or so. I am not sure specifically, but de-institutionalization was a huge, huge thing that did not always work. And, there were not the community resources to handle that. I do not think there still are, and I think there will always be a need for some place for the folks that are not able to survive out there in our environment. And, whatever size that facility is, they need treatment and understanding and compassion as well.

Neal: Well, the time has sped by quickly, so I think we will take a little break before we start talking with Linda. Thank you for all your thoughts and memories and the overviews that you have given, and for years of service to the mentally ill.

Sharon: I would do it again. Thank you.

Neal: Thank you.

[End of audio]