

MINNESOTA STATE EMPLOYEES UNION

AFFILIATED WITH  
THE AMERICAN FEDERATION OF STATE  
COUNTY, AND MUNICIPAL EMPLOYEES, AFL-CIO



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STATEMENT

BY

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BEFORE THE

COMMITTEE ON FINANCE

U. S. SENATE

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Mr. Chairman:

Thank you for the opportunity to appear before you today to talk about various trends and policies in the quality of care of persons who are mentally retarded. My Union's membership is comprised of a large number of state employees whose direct responsibility is that very care, training and safety of retarded citizens in Minnesota State Hospitals. The over 3,500 state hospital employees who AFSCME represents in Minnesota, and on whose behalf I speak today, wish to deliver a clear, unequivocal message to this committee and to all policy makers whether at Federal or State levels concerning the care of the retarded. This message is that state employees are concerned about the quality of care which the mentally retarded receive, and that quick fix, all or nothing proposals for the type of care given the retarded must be avoided. It is now clear that the unrelated events of limited economic growth and conceptual failure in the mental health system are changing the character of mental health care. The negative examples of change which we have seen include increasing numbers of homeless individuals [formally in state hospitals] and the self serving fast talk of entrepreneurs setting up community residences.

Two specific federal policies, one already enacted and the other now being debated are reference points for my Union's concern. S.2053, the Community Living Amendment Bill, is an example of the all or nothing approach. As introduced this proposal would eliminate all forms of institutional care - state operated and private, hospital and community.

services. Needs assessment and resource allocation for the most needy mentally retarded people have not been adequately considered under Minnesota's waiver. What problems does this create?

Two weeks ago I visited a non profit ICF-MR facility of ten residents in rural Todd County in Minnesota - about 50 miles from Brainerd State Hospital. About one-half of this group home's residents were former patients at Brainerd State Hospital. I spent three hours talking with the staff. They related stories of inadequate care; of custodial care; of non-existent staff training; of staff turnover near 100%; of frustration and despair. The staff of that group home saw the over worked county social worker once a year at case review time," and then not even at the group home itself. The spokesperson for the employees was a bright, young, articulate woman who summed up her deep concern by telling me about the latest resident who, released from the state hospital, just appeared on their door step one day. There was no orientation on him. No connection with hospital staff to help the group home work with the resident. She said bitterly that neither the residents or the staff were going anywhere. They were stagnating. I submit that this kind of situation is not unusual in Minnesota and that under the pressure of anticipated cost savings from the Title 19 Waiver - an assumption which is being looked at more and more skeptically by state officials - we will have more of this warehousing and standing still in the community in the future.

The capacity of given states and localities to handle necessary transitions under this approach have not been carefully considered. Neither has the role of state hospitals been fully appreciated or the types of care such institutions provide been taken into account. AFSCME Council 6, AFL-CIO, must make it clear that we are not opposed to community placement of the retarded. What we oppose are proposals which masquerade as progressive steps when they are not. This includes schemes that emphasize a financial bottom line but have a dubious potential for assuring quality of care to the mentally retarded. Another such policy is the Title 19 Waiver (Section 2176, Omnibus Reconciliation Act of 1981) as designed by the Minnesota Human Service Department. Under their waiver, Human Service's Commissioner Leonard Levine proposed to reduce beds for the mentally retarded in the state hospital system by 1,000 by 1987. [11-3-83 Minneapolis Tribune]. A thousand beds is about half of the present state hospital system. The highly touted Title 19 Waiver assumes large numbers' of Minnesota state hospital residents and sizable numbers of private ICF-MR residents can be transferred to less restricted settings.

To be sure, movement is possible. Less restrictive and less costly alternatives need to be developed. But the falacy of Minnesota's waiver is that, first it can quickly transfer residents to the community at substantial savings and second that the needs of the more severely and profoundly retarded, many with behavioral problems will place no demand on community resources. If you were to talk to county social workers as I have you would quickly realize that resources are currently not there in the community to handle the wide range of problems of those now demanding

Long term care, be it residential or non-residential must be based on sufficient services and dollars following the needs of the mentally retarded. To say that services won't come cheap should be of no surprise. Community care which was designed to improve and replace institutional care at lower costs, turns out in some instances to cost more for more severely impaired people. And the upward trend for the cost of all services is rising. Title 19 Waiver euphoria notwithstanding, the Rice County Minnesota private DACs recently asked the county board for a \$2.00 per hour raise for their staff, citing the need to cut the high staff turnover which was harming continuity of service and the clients. The county board approved a dollar an hour raise.

The long and short of it is that costs in the community are approaching costs in the hospital. Costs in the community will increase and again this should be no surprise because sufficient, trained staff and adequate physical facilities and good management are not cheap. Quality care is not cheap. We can invest in an adequate system now or later. Failing to do it now will mean continuing to foster the hidden costs from high staff turn over and dead end programs.

My Union believes that a more sensible approach is to use old resources in new settings, thus avoiding the loss of trained state employees or the reduction of services to clients most in need. To these ends my Union had actively pursued a legislative effort modeled extensively after the experience of Rhode Island, Massachusetts, and other states that have chosen to transfer institutional resources into community care settings.

Rhode Island has done this by providing state operated, small living arrangements in homes and apartments for one to four mentally retarded persons. This has been done while maintaining state staff and existing Union contract benefits.

Dr. Robert Carl, Rhode Island's Director of Mental Retardation, has summarized that state's approach when he said: "I agree wholeheartedly that ... we must evacuate the institutions for the mentally retarded. Unfortunately, like most good thoughts, it is easier to say than to accomplish."

AFSCME Council 6 does not agree that the state hospital system should be abandoned, but never the less and for good reasons our Union took Dr. Carl up on his challenge by proposing in the 1984 Minnesota Legislature that our state begin to deinstitutionalize employees along with hospital residents. Like Dr. Carl we believe that: (1) state and public employees are not inherently evil or lazy or unmotivated and will perform as well as their training and supervision allows; (2) anybody who has invested five years in a job or career has some motivation to keep that job; (3) the stability in the care giving work force is one of the critical variables in successful communitizing formally institutionalized persons; (the transfer of staff and clients who know and like each other under circumstances that optimize staffs stability enhance chances of client success; (4) state institutional employees care about their charges and; (5) many state staff would be loath to perform quality service for their clients if success guaranteed loss of a job well done.

AFSCME in Minnesota was instrumental in 1984 in getting out legislature to take the first step in what we hope will be the successful transfer of state hospital clients and staff to the community. Our bill, which is appended, focused on the economic consequences of policies to eliminate the state hospital system and called upon state government to begin to address the situation with a comprehensive study of the future of the state hospital system, including the option of state operated and staffed community based services for the retarded.

Please note that this legislation is not a measure to accelerate or justify consolidation or closure of state hospitals or a measure to whittle this state's commitment to the direct care of the retarded. Our Union views this quite differently. We see this legislation and the administrative steps now being taken to implement the legislation as an opportunity to forge a new alternative, in which our membership is aggressively involved in developing its own future and in shaping the kind of quality care that mentally retarded people will need and deserve in the years to come.

Sec. 19. [246.0231 INTERAGENCY BOARD.]

*Subdivision I. {LEGISLATIVE POLICY.} It is recognized that closure and consolidation of state hospitals have negative economic effects upon public employees and communities. It is the policy of the state that deinstitutionalization policies shall be carried out in a manner that ensures fair and equitable arrangements to protect the interests of employees and communities affected by deinstitutionalization of state hospitals.*

*Sitbd. 2. [INTERAGENCY BOARD.] There is established an interagency board to be known as the institutional care and economic impact planning board. The board shall consist of the following members: the commissioners of public welfare, administration, employee relations, economic security, energy and economic development; the director of the state planning agency; and other appropriate agency heads. The board shall be directed by the director of the state planning agency with assistance from the commissioner of public welfare in consultation with the other agency heads.*

*Subd. 3. [STUDY.] A comprehensive study shall be conducted by the interagency board to provide information on topics to include, but not be limited to, the following:*

*(1) projected displacement of state hospital employees because of deinstitutionalization by number, location, and job classification;*

*(2) the extent to which displacement can be mitigated through attrition, retirement, retraining, and transfer;*

*(3) the development of cooperative arrangements between the state and local units of government in the carrying out of these goals;*

*(4) the necessary changes in the biennial budget to effect any fiscal and policy recommendations of the plan;*

*(5) the necessary interagency agreements among and between appropriate departments and agencies as needed to effect the recommendations contained in the plan; and*

*(6) the energy efficiency of all state hospital buildings.*

*Notwithstanding the provisions of sections 13.43 and 13.46, the state planning agency shall, for purposes of the study required by this subdivision, have access to private personnel data and private client data as necessary to carry out the mandates of this act until June 30, 1985.*

*Subd. 4. [PLAN.] The board shall develop a plan. The plan shall include proposals which protect the general interests of employees and communities affected by the deinstitutionalization of state hospitals, including proposals that attempt to preserve employment rights and benefits, provide training and retraining of employees and, to the extent possible, promote the employment of these employees. In addition, the plan shall propose specific methods for assuring minimal impact on the economic life of communities affected by the deinstitutionalization of state hospitals. The plan shall provide specific direction with respect to the following:*

*(1) retention of collective bargaining agreements including seniority, vacation, health insurance and other contractual benefits, and pension rights;*

*(2) maximum utilization of state hospital employees in the provision of noninstitutional services to the mentally retarded;*

*(3) negotiated agreements with exclusive representatives addressing job security issues, where deinstitutionalization causes displacement of employees;*

*(4) development of noninstitutional, state-operated or nonstate-operated services for the mentally retarded, including community based intermediate care facilities for the mentally retarded, supported living arrangement semi-independent living arrangements, day activity services, and other services;*

