

HASTINGS STATE HOSPITAL UTILIZATION COMMITTEE

6 October, 1965
2:30 P.M.
at D.P.W.

Presents Fern Lavate (for John Broady) Katharine Crim Frances Ames
John Malban Hector Zeller Betty Hubbard Steve Kumagai
William Judkins (for Miriam Karlins) Ove Wangensteen
David J. Tail Sally Luther Richard Bartman

Dr. Tail opened the meeting by tracing briefly the background leading up to the necessity of establishing a Hastings State Hospital Utilization Committee. In general, the consistent decrease of hospitalized mentally ill in state facilities has caused some members of the Legislature to raise questions about the necessity of certain rebuilding programs, Whereas fewer beds are now required for the mentally ill, it appears that still additional beds must be made available for the mentally retarded.

Moose Lake State Hospital and Cambridge State School and Hospital, jointly with members of the Central Office staff, are exploring methods and programs in which residents of Cambridge will be relocated to Moose Lake. The decision in this instance has been made and the Committee at work is a "how to, or working" committee. The Hastings State Hospital Utilization Committee, by contrast, is responsible to conduct a study of a combined program, that is mentally ill and mentally retarded patients, to determine how Hastings State Hospital could best establish a program to serve come or all of the mentally retarded in a given geographical area.

Dr. Tail commented on the general movement in the direction of a diversified hospital program which would serve as a back-up facility for community agencies, such as serving as a regional mental health center, as a second-level of service for mental health facilities (as opposed to a second-rate mental health facility). Six current programs for mentally retarded were described as follows:

Program 1 - Child Activation Program:

This program is for children from birth to puberty who are non-ambulatory or bedfast. These children certainly usually suffer from major degrees of central nervous system damage and also often have gross external physical abnormalities. When in a setting that provides a large amount of physical care and a high level of environmental stimulation, often a significant number of these children become able to progress from a bed to a wheeled conveyance, may become able to crawl or walk with assistance, and show the development of a high level of affective responsiveness to others.

Program 2 - Child Development Program:

This program is for ambulatory children up to the age of puberty. This is a varied group and includes children who may be withdrawn and passive, may be overly active, or show evidences of cerebral dysfunction, and who show all degrees of intellectual handicap. These children do not have gross physical anomalies but may have mild congenital malformations. To be worked with effectively, this group needs to be broken down into a number of subgroups, but all these children benefit greatly from warm understanding relationships with adults and from various types of special education and activity programs.

Program 3 - Teen-age Program:

This program is for ambulatory children from puberty to approximately 16 years of age. This is a large and somewhat heterogeneous group, including adolescents who have various degrees of cerebral dysfunction and a wide range of intellectual handicap. In a state institution this group includes a high proportion who may be delinquent or borderline delinquent. These children require a special program because of the unique characteristics of adolescence, but the basic treatment modalities are much the same as for those in the child development program.

Program 4 - The Adult Activation Program:

This program is for bedfast and non-ambulatory patients who may be late adolescent, adult, and aged. These patients benefit greatly from care somewhat similar to that described for the child activation program. This group includes "grown-up" cerebral palsied children who may have had considerable assets overlooked because of their expressive difficulties. Needs in the orthopedic area may also be great. Many of these patients are able to be physically habilitated to the point of not requiring total care in bed but being able to get about in wheeled conveyances.

Program 5 - Adult Motivation Program:

This program is for ambulatory late adolescent, adult, and aged patients. Also many hyperactive, autistic, bizarre patients. The intellectual range of patients in this group is from "hot testable" to around 35 to 40. They are characteristically passive and withdrawn and manifest peculiarities of behavior such as rocking and making odd noises. Many of these patients show evidences of congenital cerebral underdevelopment and external congenital anomalies. They are, however, given adequate stimulation and opportunity and are able to enjoy a large number of occupational therapy and recreational activities. Occasionally a patient in this group is found to be able to participate in a sheltered work program.

Program 6 - Adult Social Achievement Program:

This program is for active late adolescents, adults, and aged. It includes those residents who have become overdependent on the institution as a result of long-term hospitalization} those who have various "character problems," such as antagonistic behavior or other difficulties in forming constructive interpersonal relationships? those who are able to achieve a high level of independence within the institution but have difficulty in developing social or work relationships outside the institution; and those who are potentially able to establish a satisfactory extramural adjustment but who have not acquired the skills required for such an adjustment.

Discussion then pursued various aspects of tackling this problem. The discussion evolved around the following general points:

1. Establishing a rather specialized program for one or more programs described above.
2. The factor of geographical location, that is, the objective of having the patient near his relatives.
3. Appropriateness of program for Hastings State Hospital staff and facilities.
4. A question of establishing a multiple program divided into adult and children, that is, one state hospital serving the entire spectrum of children services and another hospital serving the entire spectrum of adult needs.

5. The implications and long-range effect of the newly enacted Medicare program.
6. Consideration of establishing facilities to serve population expansion. For example, in 1980 three-fifths of the state's total population is anticipated to be residing in the Twin Cities-Metropolitan area and will consist of 4,000,000 people.
7. Ramifications and effects of the Comprehensive Community Mental Health Centers.

The Committee agreed that the job ahead was indeed a difficult one and the time factor posed an additional problem. The result and recommendations of the Committee would have an effect on the subsequent rebuilding program of the Hastings State Hospital. At present the Legislative Building Commission is scheduled to meet at Hastings State Hospital early in January. Though subsequent meetings will very likely follow, the committee should do what it can before the first of the year.

The next meeting was set for November 4, 1:30 p.m. at D.P.W. In the meantime several members of the Hastings State Hospital staff and other committee members will explore program possibilities and will also visit several of the institutions for the retarded.

Inasmuch as there is a potential involvement of the Anoka State Hospital in the final recommendations, the Committee agreed to include Dr. Docherty, Medical Director and Mr. Fischer, Administrator.

JOHN R. MALBAN,
Administrator

HASTINGS STATE HOSPITAL UTILIZATION COMMITTEE MEETING- October 6, 1965
Room 500, Centennial Office Building

Present: Dr. David Vail, Dr. Hector Zeller, Ove Wangensteen, Bill Judkins, Steve Kumagai, Jack Malban, Frances C. Ames, Kathryn Crim, Pern Levadi, Dick Bartman, Sally Luther, Betty Hubbard.

Dr. Vail gave a short history of events leading up to meeting. Sen. Popp had requested that D.P.W. study Hastings State Hospital to determine future use-

1. rebuild as hospital for mentally ill.
2. abandon entirely
3. use as hospital for mentally retarded
4. integrate m.r. patients into wards
5. designate some wards for m.r. only.

No. 2 definitely not being considered. Dr. Vail explained that since hospitals for m.i. are dramatically reducing populations, disparity between m.i. and m.r. hospitals has become increasingly marked. Faribault S.S. & H. over 600 patients more than approved capacity, for instance.

Some discussion of ways in which such a study could be undertaken. Vail now feels D.P.W. should do it rather than involve N.I.M.H. or some other outside agency. Vail again talked about concept of "diversified hospital", backing up mental health centers, daytime activity centers, and other community services for m.i. and m.r. He described "certain elements" in Minn. A.R.C. as being in favor of using Hastings as a small institution for the m.r. but that this was not the general feeling of the A.R.C. (?) He said that this plan would not be feasible. (Sally and I talked this over after the meeting and wondered if he made this statement because he knew that, of all the alternatives, except No. 2, this was by far the most threatening to the Hastings staff).

Hastings has 644 beds, 50% of them filled with geriatric patients. Medicare and Title XIX (medical assistance to the needy) will have great impact on this particular group, possibly reducing it to zero. Should the St. Paul-Ramsey Community Mental Health Center provide a short-term (3 to 6 mos.) treatment (in-patient) program, another fairly large group of patients would no longer be placed at Hastings. This kind of program is being seriously considered. This could leave the hospital with very few patients, few enough, perhaps, to be transferred to Anoka which is also in the greater Metropolitan area (Dakota, Ramsey, Washington, Hennepin, Scott, Carver, Anoka). Both Dr. Zeller and Jack Malban developed this possibility, so that the idea of an m.r. hospital at Hastings intruded itself again. Steve Kumagai, director of the Metropolitan St. Paul Hospital Planning Council, pointed out that since all hospital planning is directed toward keeping patients as close to their own homes as possible, a sharp change in patterns is indicated where St. Peter and Faribault are concerned. Actually, he pointed out, Hastings and Anoka should be the large hospitals because they serve half the population of the state. By 1980, they will be serving a population of 4 1/2 million.

Dr. Vail listed Dr. Bartman's six groups on the board. I pointed out that there was little likelihood that an adult-serving hospital could gear itself to care for Groups I and II. Everybody agreed that this was probably true. Dr. Vail said that a small research unit for the profoundly neurologically involved might be a possibility. I asked if he meant something like Rep. Flakne's proposal. Said he didn't understand what kind of child Flakne was talking about. Frances also said she was not clear about what kind of patient he meant.

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Bartman pointed out that Group V., the adult motivation group, might be integrated into a hospital for the mentally ill successfully because they display so many of the same characteristics as the m.i. patient.

I said that the patients in Group VI, adult social achievement program, would profit from a placement in the metropolitan area because they could use the workshop, day-time activity centers, and other community programs which might fit them for eventual community placement.

Dr. Vail remarked that Sen. Popp seems to believe that Hastings could be remodeled inexpensively to serve the retarded, whereas extensive, expensive renovation and rebuilding would be necessary for the m.i. He pointed out that this is not true. Malban and Zeller expressed quite a lot of concern about the business of designing buildings which would be appropriate for the m.r., if they are to give service to this group. Apparently, they have plans for a new 200-bed hospital (the Bldg. Commission recommended 100 beds, which is what they got..."Half a loaf", as Sen. Popp expressed it)/ Ove pointed out that they also have other funds with which to construct the tunnels, etc. for a new building.

Intake: 1. transfer from Cambridge and Faribault (would relieve crowding)
2. take directly from community (would cut down waiting list)

Dr. Zeller and Jack Malban have already discussed some of these things with the staff of the hospital, although Dr. Vail commented that it is too early to do this. Jack said that they felt it was better to discuss the matter openly rather than to have staff morale suffer because of much conjecture and "grapevine" rumor and distortion. He said they intended to let the staff know about this meeting, too, in order to keep them informed and reassured.

Dr. Vail said that the starting date for the opening of the Moose Lake-Cambridge project is March 1.

Dr. Zeller remarked that the only program which had been discussed for Hastings was the separate m.r. program. When he was assured by Sally that Hastings could also do an integrated program like Moose Lake, he said vigorously, "No, no. For us that kind of program would be impassible!"

A meeting was set for November 4, at 1:30 in Room 500, Centennial Building. Anoka people will be invited to get their reactions to the idea of "Child-serving hospitals" and "Adult serving hospitals", (with Anoka providing one kind of service, and Hastings the other, or with each of them providing a particular kind of specialized service to the m.r. of the greater metropolitan area).