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DEPARTMENT OF PUBLIC WELFARE

TO: Hon. Harold LeVander, Governor

February 8, 1967

Legislative Building Commission

Building Subcommittee, Senate Finance Committee

Building Subcommittee, House Appropriations Committee

Mr. Roland Hatfield, Commissioner, Department of Administration

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

SUBJECT: Plan for Utilization of Facilities

I am pleased to submit for your consideration the following report of alternative plans for the future utilization of institutional space and related matters, as we have developed them in the Medical Services Division of the Department of Public Welfare.

I should say to begin with that I believe the time has come for a definite resolution of this matter and a decision one way or the other; that I believe this must ultimately be a public decision made through the legislative process, and not by the professional experts without validation from the body politic; and that I will abide by the decision that is made and do my best to implement it.

It is apparent that some way must be found to correct the widening imbalance that exists between the part of our institutional program serving the mentally ill and that of serving the retarded. Related closely to this issue is the question of the future of Hastings State Hospital, both as to whether it should continue to exist and if so, for what purpose.

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I see three main choices facing us at the moment. I describe these in relation to the Hastings question and attempt to relate other contingencies and factors to this. I have labeled these choices Plan A, Plan B, and Plan C, which deal respectively with the prospect of discontinuing Hastings entirely as a mental institution, with converting Hastings entirely to serve the mentally retarded, and with development of Hastings and other mental illness hospitals into multipurpose, regionally-oriented facilities.

Plan A: Discontinuance of Hastings as a mental institution.

The physical plant at Hastings may well be so deteriorated that there is nothing to be gained in keeping it going for any purpose. Thus, the useful portions (e.g., laundry) might be relocated or sold and the remainder torn down entirely. Or the institution might be suitably repaired and converted to some non-related purpose, such as a state college, that would not be so costly.

Were this to be done, the remaining patients at Hastings could be relocated at various hospitals, hopefully those serving the patients' counties of residence. The present receiving district of Hastings could be redesignated as follows: Ramsey and Washington Counties to Anoka State Hospital, and Dakota County to Rochester State Hospital.

This leaves unanswered the problem of overcrowding in the mental retardation facilities. Furthermore, this plan is in my opinion too drastic, as it would destroy a smoothly functioning organization. In common with Plan B, it would also disrupt the regional plan and place an extremely heavy burden on Anoka to serve the entire metropolitan area (see below).

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Plan B: Conversion of Hastings to serve the retarded exclusively

Under this plan, the redistribution of resident patients from Hastings and the redesignation of the receiving district would be the same as under Plan A (Ramsey and Washington to Anoka, Dakota to Rochester).

Conversion for the retarded is not an altogether easy question. It is one thing to continue a group of residents in facilities that are familiar if inadequate; it is quite another to deliberately transfer a group of new patients into poor facilities on the grounds of giving them a fresh start, or relieving them from poor living conditions where they may have been previously. Viewed in this perspective, one would have to ask what favor we would be doing transferees from Faribault to bring them into the existing facilities at Hastings.

Thus I believe that for a transfer to carry out its stated purpose of relieving and hopefully improving the lot of the patients, new and adequate facilities at Hastings would have to be provided in any event.

Then the question is, What kinds of facilities for what kinds of patient? Adult, ambulatory retarded could be accommodated generally speaking in the type of facility that serves the adult mentally ill. Stated another way, it would appear that a facility for the mentally ill that is of superior design would be adaptable for a similar group of retarded persons; likewise a facility that is of inferior design, that connotes for example the dungeon or warehouse, would be more or less equally bad for both groups.

Transfer to Hastings of mentally retarded children or severely physically impaired children and adults would no doubt involve even more radical rebuilding plans.

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One of the interesting "sub-plans," relating possibly more appropriately to Plan C, is the development at Hastings of a children's village which could be established as a quite separate operation from the part of the hospital that would serve mentally ill and/or retarded adults.

In this connection, it should be stated that the greatest bulk of the existing mentally retarded institutional population are adults (approximately 2/3 or 4,000/6,000 patients are classified in Programs V and VI, which are the two large ambulatory adult groups). The group creating pressure for admissions, on the other hand, and the most feasible and logical focus or target group for community programs, are children, usually severely impaired.

The main defects in Plan B, in my opinion, are three in number:

- (1) It disrupts a scheme for the regional organization of services that we have been working on for the past five years. This is not of tragic consequence, as plans are meant to be changed as circumstances may require. Of more serious moment would be the implications for the future, as it would appear that the long-range plan for the state generally calls for the regionalization of programs (see State Planning Report, 1965-67).
- (2) It places the burden of providing a back-up resource for mental illness hospitalization requirements on one hospital, Anoka, to cover the entire metropolitan population of two million persons. Whether one 700-800 bed hospital could do this is very questionable. Such a proposal would not be outside the realm of possibility, but it would be very daring.
- (3) The most serious defect, in my opinion, is that logically the relief it would provide to the mentally retarded institutions would be limited to

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the conversion of Hastings, that would provide at most around 500-600 beds during the next several years. That is, inherent in the suggestion is the notion that no single institution should serve both mentally ill and mentally retarded. Thus, if the matter were pursued to its logical end, there would be no future in this approach once Hastings were converted, until such time as some other mentally ill hospital were to be scheduled for complete conversion.

I have not listed another problem about Plan B, which exists to some extent in any plan that would redesignate mental illness hospital space for the mentally retarded. This is the problem of staff and to some extent community attitudes, which unfortunately see a process of "downgrading" in the accommodation of mentally retarded patients. In my opinion the process of total conversion of any hospital will produce these reactions in an extreme form that could have very untoward consequences as to staff morale, exodus of professional persons, etc.

Plan C: Partial conversion of all mental illness hospitals to serve the mentally retarded.

This is the plan which the Department of Public Welfare regards as preferable. It has been evolving in its present form for almost two years, though the regional concept goes back to 1962. This plan has been worked out with the collaboration of the Mental Retardation Planning Council, the Mental Health Planning Council,* and the Minnesota Association for Retarded Children. It

*Recommendations 2A.4 and 2A.5 from the Comprehensive Mental Health Plan for Minnesota: 1965 (Part One, B, I) read as follows:

"2A.4 Feasibility of studies with regard to integrating selected patients from the mental retardation hospitals into populations of the mental illness hospitals will be undertaken. (This is expected to begin during the 1965-66 fiscal year at Moose Lake State Hospital, under the careful scrutiny of research methodology, involving patients from Cambridge State School and Hospital and Brainerd State School and Hospital).

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has been endorsed by our top policy advisory committee, the Mental Health Medical Policy Committee. The plan was presented at an earlier stage of development to the Legislative Building Commission on May 5, 1966.

Briefly, Plan C calls for diversification of the mental illness hospitals to accommodate a broader range of problems on behalf of the region for which they serve as a resource. To begin with, accommodation will be provided for a large number of ambulatory, adult retardates who now reside in the three mental retardation hospitals. Some consideration will be given to the eventual possibility of admitting a larger number than at present of adult retardates directly from the community. Later on, we will explore the possibility of regionalizing programs for alcoholics and establishing them in all our hospitals; and we will develop better and more specific programs for antisocial persons and for children and youth.

Plan C capitalizes on and enhances the regionalization of service programs.

Plan C also offers the advantage of flexibility and immediate implementation. For example, we told the Legislative Building Commission on May 5, 1966, that we would envision the transfer of 520 adult retardates from mental retardation to mental illness hospitals during the decade 1966-1976. Under Plan C, stemming from our studies since last May, we now envision the transfer of at least this number during the 1967-69 biennium. We have established a special committee and

2A.5 Long-range space utilization plans will be continuously studied. For example: designation of hospitals or portions of hospitals for the mentally retarded, sex offenders, and other special problem groups; the concept of 'all purpose' institutions which would serve both mentally ill and mentally retarded persons in a given geographical area ..."

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a timetable for this first phase, which we call HAFPS Project, and hope to begin the actual transfers of patients by July 1, 1967. Thus if Plan C is not acceptable we should know about it very soon so that present plans can be changed.

Timetable

1967-69

The first move will be to relocate some 450 patients now at St. Peter State Hospital to the hospitals serving their home district or discharge them direct to the community. This will free up space so that the two geriatrics buildings and Bartlett Hall could be very handily used for adult retardates in a quite attractive complex which could be run as a separate program.

Concurrently, Fergus Falls State Hospital will remodel currently empty space to accommodate 120 patients. This remodeling may well require some modest increase in the amount of building funds scheduled for Fergus Falls State Hospital.

Suitable patients will be selected from Faribault to be transferred to Fergus Falls and St. Peter. These transfers will be made with the regional plan foremost in mind; that is, the patients transferred will be those from the districts served by the particular hospitals to the fullest extent possible.

During this biennium, Anoka and Hastings will participate in the plan mainly by receiving relocated patients from St. Peter. In the case of Hastings, it is believed this can be accomplished within the present staff and building conditions, at the rate of absorption of about five patients per week. All the

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mental illness hospitals will participate in the relocation program.

Sometime during 1967-68 it is contemplated to relocate the present tuberculosis facilities at Anoka to the Glen Lake State Sanatorium. This may require some modest costs in developing the necessary security facilities at Glen Lake to accommodate the so-called recalcitrant tuberculous persons and prisoners who are suffering from tuberculosis. This transfer will make available 60 remodeled beds at Anoka to the general service.

We recommend completion of the building program at Hastings, so that they will have a basic core unit of 200 good, new beds adaptable for both mentally ill and mentally retarded ambulatory adults, together with supporting services.

During the 1967-69 biennium Moose Lake State Hospital will consolidate its experience of conducting an integrated program for the retarded (Cambridge-Moose Lake Project) -- where the mentally retarded patients go right in the regular psychiatric wards -- and will very likely continue along similar lines in relation to Brainerd State School and Hospital.

During the 1967-69 biennium we will have a chance to study the future prospects of the Anoka, Rochester, and Willmar State Hospitals in regard to this overall Plan.

We have already initiated studies to determine the feasibility of discontinuing the surgery program at Anoka. This would free at least 35 beds and would streamline and simplify the hospital program. This proposal would then concentrate the entire state institutional surgery program at Rochester State Hospital. At the

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present time, experts seem to disagree as to the feasibility of such a move. The opening of Cottages 6-7 and the release of Cottage 8 (tuberculosis) together with discontinuance of the surgery program at Anoka would free many beds which might be used for ambulatory retardates and in the case of the Burns Building bedfast retardates as well.

Rochester would appear to offer many interesting possibilities for programming. In my view, it would be regressive to utilize the space at Rochester for straight residential care unless this were tied together with research and teaching programs. Last winter we established the Rochester State Hospital Utilization Committee to study the future possibilities at Rochester, with a view to seeing how the state institution there could be affiliated with the Mayo Clinic and Foundation, the other teaching facilities at Rochester, and possibly even a second medical school, and supported by federal construction and staffing funds, as basic steps in establishing a research and teaching program in mental retardation and related problems, a Neurological Institute so to speak. Complete utilization of Rochester State Hospital for residential care would mean dispossessing certain community programs that are now based in the hospital facilities. We would appreciate legislative guidelines to determine what are the limits within which a state mental hospital may be permitted to house a variety of other, related programs.

Willmar will be carefully watched in the final phases of its remodeling program to make sure that the proposed facilities can be used for the mentally retarded. Developments at Willmar will be related generally to the future of alcoholism programs in Minnesota.

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Summary, 1967-69.

Approximately 450 patients will be transferred from Faribault State School and Hospital to St. Peter State Hospital, and 120 patients from Faribault State School and Hospital to Fergus Falls State Hospital.

Anoka, Hastings, and other state hospitals will accommodate some 450 patients relocated from St. Peter. This will leave St. Peter with three buildings serving some 450 retardates, and the remainder serving as a mental illness facility for the south central region.

Moose Lake will continue on its present course of providing an integrated program.

Studies will be carried out as to the best future use of Anoka, Rochester and Willmar State Hospitals.

Hopefully construction will proceed at Hastings with a view to its eventual service for both mentally ill and mentally retarded.

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Depending on the outcome of the above studies, Hastings, Rochester, Willmar, and Anoka will also be used to serve groups of retarded. Such usage will be related to the type of available space and to the regional plan.

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Regional Centers for mentally retarded children

A logical extension of the regional plan, recommended by Dr. Hallvard Wislie, our consultant from Norway during the summer of 1966, will establish new facilities for mentally retarded children in the seven state regions. These would be small units accommodating no more than 400 patients in each. Federal funds could be used to

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underwrite some portion of construction and very likely staffing costs. The design would be along the lines of small, homelike residential units built especially for children. We have recommended that money be appropriated in 1967 for site selection studies for the East Metropolitan region; the two leading choices at present would appear to be on the grounds of either the Gillette State Hospital or the Hastings State Hospital. At the latter, the children's complex would be in addition to any facilities for mentally ill and mentally retarded adults that would be built there.

We would suggest, furthermore, that it might not be premature to consider starting site selection studies for some other state region, for example, northeastern Minnesota, for the purpose of establishing the type of small facility for mentally retarded children described.

This is as good an opportunity as any to repeat what we wrote to the Legislative Building Commission on September 30, 1966, and reiterated in later testimony, that in our view additional buildings on the grounds of the Faribault State School and Hospital would be an unwise investment. We believe this same money (\$2 million proposed by the Legislative Building Commission report to the 1967 legislature) should be used to complete the work at Hastings and inaugurate the site selection studies described.

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Experience of other states

What are other states doing? This question always arises when some new program is being proposed. It would seem that where mentally retarded patients reside on the grounds of a mental illness hospital, they are normally housed in separate

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units in a separate, identifiable, visible program geared specially for their needs for better or for worse. Often this situation arises for reasons not related to the essential problem. For example, in some southern states, such arrangements may exist for reasons of racial segregation. Sometimes the situation has arisen because of jurisdictional reasons; for example, retardates under the age of 21 may be handed at one set of facilities under the Mental Retardation Bureau, and are transferred as adults to the mental illness hospitals under the Mental Health Bureau. Lessons from the experience of other states would appear to point strikingly in the direction of not separating the mental health and mental retardation authorities if this type of diversification is contemplated; and of making sure that the staff of the hospital which is opening its doors to the retarded has been adequately trained and emotionally prepared for the event. One state with close similarity to Minnesota is Iowa, where an identical disparity of available space exists, thus leading to the move to transfer retardates into a mental hospital. This is being done now on a pilot basis at one hospital (Mt. Pleasant), with the expected problems of attitude that had to be overcome, but with good results for the transferred patients in their richer environment. The mental retardation facility at the particular mental hospital is administered as a separate non-integrated unit.

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The strategy for community involvement

I am excited by the vision that the Governor expressed in the meeting in his office on February 2, 1967. That is, the hope (if I heard him correctly) that the entire base of care operations could be moved away from the institutions as we know them to a community-oriented system. I think it would be a tremendous

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goal over the next thirty years to be able to enter the Twenty-first Century essentially out of the large institution business altogether, with small, intensive treatment centers for children and residential units only for persons presenting some threat to the public safety and/or those who simply do not respond to any known method of treatment or rehabilitation. Otherwise, it seems to me that there is no reason why the greatest part of the problem of major mental disorder cannot be dealt with at the community level.

If such a shift in the base of operations is sought, I would recommend for your attention three measures which have been introduced in this legislative session that, if enacted, will have enormous strategic impact:

- (1) SF 85, HF 161, that will remove the per capita on state matching for community mental health programs.
- (2) SF 318, HF 457, that will remove the per capita on state matching for daytime activity centers for the retarded, and accomplish certain other ameliorations of that law.
- (3) SF 314, that will redistribute the cost of care -- that is, the formula for state and county sharing of costs -- for the retarded who are not in state facilities in a way that will encourage the development of community resources.

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cc - Mr. Morris Hursh

Mental Health Medical Policy Committee