STATE OF MINNESOTA

DEPARTMENT Public_Welfare_

Office Memorandum

TO Dr. David J. Vail

DATE: September 23, 1968

FROM Arthur S. Funke, Ph.D..

SUBJECT; Proposal for discussion at Meeting on Regionalization
Hastings State Hospital, October 25,1968

We have emphasized that area boards and county velfare boards have a broad "see to it" responsibility for a range of problems for the particular piece of geography they cover, in addition to whatever service responsibilities they may also have. County boards are responsible primarily for a public program for patients with statutorily defined problems. Area boards for a comprehensive, community-based mental health, mental retardation, inebriacy program for the area. Can we not apply this idea also to the state hospitals? Can we not match all or most of our hospitals to one or more of the eleven "economic regions" designated by the governor' and assign a "see to it" responsibility to each hospital for each region in regard to the state hospital care and treatment needs of all persons in the region?

It would not necessarily have to, itself, provide the care and treatment to meet these needs. Based on the capability of each hospital it could provide care and treatment for some patients and arrange for the utilization of. other appropriate facilities, e.g., other state hospitals, for others. In carrying this out, the hospitals having "see to it" responsibility could serve as a diagnostic and reception center for all or most types of patients. HSH has worked out such a plan regarding inebriacy.

Based on this general idea, the following is a proposal for eight regions which fit exactly one or more of the 11 economic regions designated by the Governor. (See maps attached)

1. Northwest Region (FFSH) •

   17 counties; estimated population = 289,700

   Ail of the Northwest Mental Health Center area falls in this region. Seven of the eight counties in Lakeland are in the region. Roseau and Big Stone counties are served by two area programs which have centers outside of this region.

   This region consists of economic regions 1 and 4 with centers at Thief River Falls and Moorhead. Nine counties from the present N.W. region would become part of the North Central region. One county would become part of the South-west region. One county now in the Southwest region would become part of the Northwest region.

2. Worth Central Region (BSE)

   11 counties; estimated population = 189,700

   All of Northern Pines area falls within this region. All but one of the Upper Mississippi area counties are in the region. The same is true for the

cont.,

Northland area.

This region consists of economic regions 2 and 5 with centers at Bemidji and Brainerd. This region would be formed by nine counties from the present Northwest Region and two counties from the present Northeast Region.

Northeast Region (MLSH)

5 counties; estimated population= 298,300

All of the territory served by the Range and Duluth areas fall in this region. One of the three counties served by Northland is in the region.

This region consists of economic region 3. The center is Duluth. The present 12 county Northeast Region would lose two counties to the North Central Region and five counties to the East Central Region.

East Central Region (CSH)

10 counties; estimated population = 244,400

The Five County area and the Central Minnesota (St. Cloud) area are completely within the region. In addition, Meeker county from the Vest Central area (Willmar) is included.

This region consists of economic region 7. The center is St. Cloud. This region would he formed by five counties from the present Northeast Region, two from the West Metropolitan Region and three from the Southwest Region.

Southwest Region (WSH)

17 counties; estimated population = 289,600

This region includes all of the Western area (Marshall) and the Southwestern area (Luverne) and all but one county from the West Central area (Willmar). It also includes one county from the Sioux Trails area (New Ulm)

This region consists of economic regions 6 and 8 with centers in Worthington and Willmar.

Three counties and part of Sherburne that are now part of the present Southwest Region would become part of the East Central region; one county in the present Southwest Region would become part of the South Central Region. Pope county, now in the Northwest region would become part of the Southwest region, and Big Stone county would move from the Southwest to the Northwest region.

South Central Region (St. PSH)

10 counties; estimated population = 253,200

The Minnesota Valley area (Mankato) is completely within this region. All but one of the counties in the Sioux Trails (New Ulm) area, and all but two counties in the Luther Youngdahl (Owatonna) area are in the region. One of the two counties in the Southern Minnesota area (Albert Lea) is in this region.

This region consists of economic region 9. Mankato is the center. Three

6. cont.,

counties presently part of the Southwest region become part of this region, and three of the present counties are lost: two to the Metropolitan region and one to the Southwest region.

7. Southeast Region (RSH)

10 counties; estimated population = 321,000

All counties in the Hiawatha (Winona), Zumbro Valley (Rochester), and Mower areas are in this region. In addition the region includes two counties from the Luther Youngdahl (Owatonna) area, and one from Southern Minnesota (Albert Lea).

Five area programs serve this region. One of these area programs serves two counties outside of this region, another serves one such county. This region consists of economic region 10. Rochester is the center. The present Southeast region would lose three counties to the South Central region.

8. Metropolitan Region (ASH, HSH)

7 counties; estimated population = l,668,4OO

This region includes four one county areas, Hennepin, Ramsey, Anoka and Dakota, plus possible future programs in Scott and Carver, and Washington counties.

This region consists of planning region 11. Minneapolis-St. Paul is the center. This region would consist of the present East Metropolitan region plus two counties in the present West Metropolitan region, plus two counties from the present South Central region.

We might decide to continue to split this region into East and West Metropolitan regions, but I don't think we should start with an assumption that this would be the best way of proceeding,

So far the above scheme accounts for nine of our ten hospitals. Faribault State Hospital has not been referred to. According to my scheme, I don't see how it could be a receiving hospital. It could certainly serve as a resource to the Southwest, South Central, Southeast and Metropolitan regions - perhaps actually establishing units on that basis.. In addition it might develop one or more specialized programs.

If the present boundaries of our *26* MH/MR areas were not changed (and I don't see any great need from DPW's point of view to change them), it would mean that six area boards would be working with two regions. West Central Mental Health Center at Willmar would have to work with three regions if it could not work out an agreement whereby it would take Pope County and Big Stone county would go to the Lakeland area in exchange.

If my scheme were to be accepted in general, it would not have to be implemented immediately or in all regions at the sane time.

1. It could serve as the basis for present transfers under CHAFFS. For instance, if there was a choice of transferring a Hubbard county or a Becker county

patient from BSH to FFSH, it would make more sense to transfer the latter. because Becker County would eventually be part of FFSH's region and Hubbard county would not.

2. It could serve as the basis for regional planning (per the governor's executive order that is now extant).

3. It could be implemented by each hospital (with the approval of the commissioner) at its own pace. A particular MI hospital for instance, could start by taking ME and/or inebriate transfers; later it could start taking certain new admissions of MR and/or inebriate patients (e.g., certain program types or alcoholics, but not drug abusers). A particular hospital might never admit - even for diagnosis and planning - every type of patient from its region.

   MR hospitals would not have to start admitting MI or inebriate patients at the same time that MI hospitals started admitting MR patients.

   Neither would changes affecting probate courts have to be made for more than one hospital at a time. Even for one hospital, changes in the hospital to which a county commits patients could be made county by county or for the mentally ill at one time and for inebriates at another time.

All of the above is to emphasize the flexibility of implementation within the basic plan. Such a plan should be a county-area-hospital-DPW plan not just a DPW-hospital plan. The proposed project of the Division Program Office (probably in the metropolitan region) could be a major factor in implementing the plan, but implementation would not have to wait for the results of such a project.

ASF/lm
Enc.
cc: Persons Attending Meeting on Regionalization, Oct. 25, 1968.

STATE OF *MINNESOTA*

DEPARTMENT PUBLIC WELFARE *Office Memorandum*

TO : David J. Vail, M. D. . DATE. October 21, 1968
Medical Director

FROM: Ardo M. Wrobel, Director
Mental Retardation Programs, Medical Services Division

SUBJECT: Proposal for Discussion at Meeting on Regionalization, Hastings State Hospital, October 25, 1968—-Pertaining to Mentally Retarded

At a planning meeting in preparation for the joint meeting of Goals and CHAFFS—BRML it was suggested that I prepare a memorandum outlining certain points of view related to regionalization and the mentally retarded.

It should be understood there is no disagreement with regard to the principles of regionalization as it pertains to state-operated residential programs for multiple disability groups. This includes agreement with the principles of stimulating community-based services and cooperative planning for (l) the individual and (2) for the regional problems of the mentally retarded, and (3) other factors commonly related to the regionalization concept.

There is, however, difference of opinion on the number of regions needed to accomplish this,

There are, in my estimation, certain advantages to increasing the number of institutions for the mentally retarded from three to five and reducing the number of institutions for the mentally ill from seven to five. This should bo explored rather fully. Points of advantage, as I see it, include (l) pairing of one of each specialty facility in a given catchment area; (2) program advantages between two facilities in a catchment area; and (3) greater opportunity for specialization for age and ability levels, of the mentally retarded.

Whether the 8-region or 5-region system or some other system is adopted, certain standards for program development should be established in order to assure that the framework of regionalization will allow, encourage, and promote delivery of specialized services needed by the mentally retarded.

From my point of view the following is important:

1. That the mentally retarded be housed separately from other disability groups.

2. That specific residential programming be planned and carried out by staff hired and assigned for that purpose.

3. That institution-wide programming off the patients' residential - wards be planned by staff employed for that purpose, but that delivery of such services may be by professional staff also serving other disability groups. This would emphasise the advantage of centralizing certain professional services that can be delivered in various combinations of disability groups based on the patients' level of functioning,

4. That diagnostic intake evaluation and discharge services be the responsibility of the Mental Retardation Program staff. This would not preclude that a common social service link with the county welfare departments and other community services could be developed.

5. That each regional facility employ a director of mental retardation programs with responsibility for supervision of residential care staff, development of program planning for all mental retardation units, and coordination of services provided by professional staff and community resources.

6. That the Mental Retardation Program Director and his staff have latitude in utilizing all resources of the regional facility and the community for the program advantage of patients under his charge. This would then open many possible combinations of services and residential placements—for example, temporary placement in a residential unit other than for the mentally retarded for specific program advantage or vice versa; (2) integration of certain mentally retarded persons with other disability patients if this is desirable in certain recreational crafts, educational or vocational services if they can benefit from such combinations; (3) utilization of existing community resources for in-hospital programming and assistance in promoting the developing of mental retardation facilities and services in the region and participation in various levels of regional, area and county planning for the mentally retarded.

7. That the process of developing a program for mentally retarded in each regional facility be deliberately spelled out and that each categorical group of mentally retarded be programmed according to all their physical, social, vocational, medical and emotional needs characteristic of that particular group.

8. That housing, in so far as possible, be on a small group basis catering to home-like residential environment and learning opportunities.

To: Persons Attending Meeting on Regionalization
October 25, 1968

From: Arthur S. Funke-

The meeting will be held at Hastings State Hospital, 9:00 A.M. - 3:00 P.M., October 25. The attendance will include Goals Seminar, and participants in CHAFFS from, the state hospitals, DPW Central Office, and representatives from county welfare, area programs, MAMH, MARC, and the State Planning Agency.

The meeting is concerned with both short and long terra planning in regard to both the total comprehensive, community-based program and that particular aspect of the overall program relating to state hospitals and transfers among them. The primary. focus will be on the question of regionalization of state facilities.

There are several facts and assumptions that should be made explicit to assure that there is a consensus on them.

1. There is currently both under and over-utilization of space in the state hospital system.

2. Patients should be hospitalized where they can best receive the in-hospital. services needed;

3. Patients should be hospitalized where they can best maintain or establish meaningful extra-hospital contacts (usually nearest their home)

4. Hospitalization should be viewed as time limited;

5. The degree of hospitalization (outpetient, partial, residential) should be no greater at any particular time than is necessary;

6. It should be made as practical as possible for county welfare departments to carry out their continuity of responsibility for patients through joint hospital-area board-county welfare planning;

7. It should be made as practical as possible for area boards to carry out their responsibilities for an area-wide comprehensive program through joint planning with county welfare departments and state hospitals as well as other agencies and groups;

8. We should plan for at least four age groups (Children, adolescents, adults, and the aged) and three problem areas (mental illness, including psychopathic personality, sex offender, and mentally ill and dangerous; mental retardation and inebriacy.

If we agree on the foregoing, these then seem to follow:

1. Regions should be as small as practicable in order to maximize the probability of patients maintaining or establishing extra-hospital contacts;

2. State hospitals should have the staff, and facilities to provide specialized programming necessary for different types of patients;

3. State hospital regions should conform as much as possible to Minnesota's Economic Regions or combinations or them;

4. State hospital regions should conform as much as possible to Minnesota's MH-MR areas or combinations of them.

There are at least two major issues:

1. To what extent should each state hospital continue to specialize in certain disability groups? The answer to this has direct implications for the number and size of regions.

2. What should be the geographic basis for regionalization? Minnesota's Economic Regions, Minnesota's Mental Health - Mental. Retardation Areas or some other scheme?

The following are two proposals for implementing the above. As far as the above pertains to the mentally retarded, the Director of the Mental Retardation Program Office, Ardo Wrobel, is in agreement. One proposes maintaining specialized institutions for the mentally ill and inebriates and specialized institutions for the mentally retarded; one of each for five regions of Minnesota. (See Wrobel's proposal)

The second proposal calls for eight smaller regions. In seven of the regions one of the present 10 mental illness or mental retardation institutions would be responsible for the state mental hospital care and treatment needs of all persons in the region. In the eighth region (the Twin City metropolitan region) two-hospitals would share such responsibility. One hospital, Faribault State Hospital, would continue to be a specialized facility for certain of the mentally retarded from four regions (See Funke's proposal)

Both schemes allow for cooperative arrangements between facilities based on the particular program strengths or weaknesses of each facility. It is also possible to think of these two schemes not as alternatives, but rather as one being a short range proposal and the other a longer range plan.

Whatever plan is developed, it is important to consider not only the technical aspects, but also the need to have the support of the legislature, the Governor, and key public and private agencies and organizations.

ASF/la

MEETING ON REGIONALIZATION

Summary of Mailed Material - October 25, 1968

Assumptions

Conclusions

Proposals

1. We are talking about directions in which we want to go - not necessarily immediate implementation.

2. Each facility should develop its own written plan for proceeding in whatever direction is decided on.

3. Immediate implications, e.g., the transfer of patients from particular counties, should be identified.

4. Proposals are not necessarily mutually exclusive alternatives, they have' different emphases. The first is written from a divisional point of view. The second from the point of view of one disability group.

Responsibilities and Scope of Function of Each State Facility.

Proposal #l

1. Emphasizes planning responsibility of the facility, carried out jointly with other agencies, for state residential care needs of the mentally ill, mentally retarded, and inebriate (children,adolescents, adults and elderly) in a region.

2. Recommends reception, diagnostic and case planning function carried out jointly. -

3. Recommends the actual provision of care and treatment by the facility when it is the best resource for a particular patient.

4. Recommends facility be responsible for arranging for care and treatment elsewhere when facility is not the best resource for a particular patient.

Responsibilities and Scope of Function of Each State Facility

Proposal #2

1. Emphasized specialized programming needs of the retarded.

2. Recommends that at this point in time, these needs can best be met, when state institutionalization is required, through separate regional state facilities for the retarded.

3. Recommends inter-hospital arrangements which will make the best use of the programming capability of particular hospitals regardless of the disability group into which a particular patient falls.

E. Delineation of Regions

Proposal #1

1. Emphasizes smallness of regions for regional planning, reception, diagnostic and case planning functions.

2. Recommends one hospital responsible for the above for each region (Metropolitan Region is an exception).

Delineation of Regions

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Proposal #2

1. Emphasis on reducing size of region covered by hospitals for the mentally retarded.

2. Emphasis on the specialized needs of the retarded.

F. Implementation

Implementation could be very flexible. In fact, Proposal #2 could be a step in moving toward Proposal #1. For instance, for regional planning purposes Proposal #1 could be followed, but for immediate service purposes Proposal #2 could be followed at least in modified form (particularly in regard to Hastings State Hospital and St. Peter State Hospital). .

In general, implementation could follow an individual plan by each facility.

ASF/lm

POSITION OF THE MINNESOTA MENTAL RETARDATION PLANNING COUNCIL ON THE USE OF STATE HOSPITALS FOR THE MENTALLY ILL TO CARE FOR THE MENTALLY RETARDED.

The Mental Retardation Planning Council has given lengthy and careful consideration to the role of state hospitals for the mentally ill in caring for the mentally retarded. The Council recommended further study of several alternative possibilities:

1. Integration of selected mentally retarded persons into mental hospital programs.

   An experimental program has been underway since the summer of 1965, integrating selected patients from Cambridge State Hospital into the program at Moose Lake State Hospital. Patients are all adults whose personality problems are such that the specialized psychiatric services of the mental hospital can be helpful to them. Because of the apparent success of this program, plans to extend it to other state hospitals have been developed by the Department of Public Welfare, the Minnesota Association for Retarded Children, and members of the Planning Council.

2. Conversion of one or more of the State's seven mental hospitals to a facility serving only the mentally retarded.

   The Council has taken the position that conversion of a state mental hospital to serve the retarded exclusively could be a major tragedy in that it would perpetuate an outmoded system of massive, impersonal "state institutions," substandard with respect to care, programs, and even space in which to live as a human being. The Council has recommended that all substandard buildings be razed at the earliest possible date and replaced with small, home-like regional facilities which will be an integral part of an overall regionalization — already begun with success — of such services as education programs, daytime activity centers, sheltered workshops, private residential facilities, and other community-based services.

3. Establishing separate programs and living quarters for the retarded on the grounds of mental hospital.

   The possibility of transferring a substantial number of patients from state institutions for the retarded to hospitals for the mentally ill, with separate programs and living quarters to be set up for the retarded, is currently under consideration by the Department of Public Welfare, which administers both kinds of facilities. Patient occupancy in hospitals for the mentally ill has been declining, while institutions for the retarded remain badly overcrowded.

   The Council has urged that such transfer should be made only after provision has been made to structure programs specifically geared to meet the special needs of the individuals being proposed for transfer. At best a program such as this should be utilized on a temporary basis until more appropriate facilities can be provided. It could, however, be an acceptable alternative as part of a much broader program to bring resi-

dents closer to their homes. The Council wishes to reiterate that sound professional judgements must fashion suitable programs prior to patient transfer in anticipation of the multitude of problems which may arise in each case.

Some important dimensions of programming are:

1. Goals.

   The primary goal in working with a mentally retarded person is to help him make maximum use of his limited capacities. Achieving this goal is often a matter of learning skills of everyday living, such as dressing, brushing teeth, feeding, and toilet training; of socialization, including work experiences; and of learning to adjust to physical handicaps. Not infrequently life-long care must be planned for the retarded person, with accompanying provision of the most home-like environment possible.

   On the other- hand, the mentally ill generally respond to modern psychiatric treatment and drug therapy in a relatively short time, and are thus helped to achieve their goal of returning to society better equipped to cope with the pressures of everyday living.

2. Staff training and interest.

   Professional and patient care staff working with the mentally ill are generally not equipped to work with the mentally retarded, and regard this work as a downgrading of their vocational skills. When faced with this challenge, many staff members have threatened to resign.. It is a difficult for them to adjust to the severe limitations and the relatively slow progress of the retarded patient, as well as to the rigorous, frustrating day-to-day demands of service to the retarded. Potential differs markedly from one retarded person to another. Even simple verbal communication is . often impossible. Special training and experience is needed to understand and deal with these differences. Prior to effecting any large scale shifting of residents, staff would have to be completely retrained.

3. Public attitude.

   Patients and responsible relatives of both mentally ill and mentally retarded residents are usually reluctant to have either disability identified with the other. This combining of dissimilar groups has been described as "mixing apples with oranges" or "playing a piano with a violin. In the past, mixing mentally retarded persons with the mentally ill has resulted in the retarded receiving second class service. They have usually been placed in the oldest and most undesirable facilities, those which are inadequate for treating the mentally ill.

In Minnesota, as in most other states, programs for the mentally retarded still lag far behind those for the mentally ill. There has been no significant change in administrative structure or staff to indicate that this situation will change. Present hopes lie in a widened public and professional interest in the retarded and the availability of federal funds for study, supportive services, and construction. Visible progress has been made primarily in those states which recognize mental retardation as a major disability and who have strengthened their administrative- leadership' in state government with responsibility to develop and supervise services.