THE FUTURE OF MINNESOTA'S STATE HOSPITAL SYSTEM

a report prepared for the
Honorable Albert H. Quie
Governor State of Minnesota

by the

Department of Public Welfare
Centennial Office Building
St. Paul, Minnesota 55155

November, 1982

Executive Summary

This report was prepared in response to a request from the Governor of Minnesota to the Minnesota Department of Public Welfare to submit a report on the future of the state hospital system in Minnesota. Reports on the physical facilities at each hospital are being prepared separately by the Department of Administration. A summary of each physical facility report appears in Appendix B.

Since the Department had prepared two previous reports on the future of state hospitals (in 1973 and 1979) and the time to respond was limited, this report relies primarily on existing data and material prepared for the report by DPW staff and each state hospital.

Data on the area served, capacity, client population, and utilization rates of Minnesota's eight state hospitals are presented (Chapter II), as well as summary information on state hospital budgets and staff.

Factors that affect the role of state hospitals in general (such as relevant court decisions, recent funding cuts for public clients, the programmatic needs of each disability group, and overall state population trends) are discussed in Chapter III.

The Department of Public Welfare's plan for the future of state hospitals is presented in Chapter IV. This plan calls for phasing the state out of the direct operation of these institutions, to be replaced by governing boards. These governing boards would have authority and responsibility for allocating available state hospital funds either into hospital programs or alternative services in the community.

Although divesting itself of administrative control, the state would continue to provide funds to regional and local programs serving chronically and severely impaired mentally ill, mentally retarded, and chemically dependent persons. Where special populations are too small to justify regional treatment programs, consideration would be given to maintaining single, statewide. programs such as the Minnesota Security Hospital and the Minnesota Learning Center as state-operated facilities.

The report also reviews the effects of previous state hospital closures (Chapter V), including the recent closure of Rochester State Hospital. The impact of the Rochester closure is still being studied, and several groups are still actively involved in planning for the use of that facility and for needed services in that part of the state.

Finally, the Appendix to this report presents individual reports prepared by each state hospital describing in detail the impact that the closure of that facility would have on clients, counties, staff, and the community. Chapter VI provides an introduction to and summary of these individual hospitals* reports.

Based on a review of the current state hospital system, the factors affecting the role of state hospitals in general, the effects of previous closures, and the projected Impact of any additional closures, the Department of Public Welfare recommends that no state hospitals be closed by the 1983 legislature. Instead, the Department is preparing legislation to establish regional governing boards for each state hospital, as recommended in its plan for the future of state hospitals.

In the event that a further reduction in the total state hospital appropriation becomes unavoidable, it is recommended that the Governor and the Legislature pursue the option of cutting all eight institutions by a proportional share of the total rather than closing another hospital. This approach would assure that all regions of the state would participate equally in the reduction of mental health services, rather than penalizing one region while leaving services for the rest of the state essentially Intact. It is the Department's position that closure of a state hospital, because it is an important component of a region's continuum of mental health services, should be a matter of local/regional determination. It should be left to these groups to decide if they wish to continue a regional facility with reduced funding or close the hospital and divert the available resources into community programs.

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I. INTRODUCTION

In March, 1982, the Department of Public Welfare was requested by the Governor's Office to prepare a report on the future of Minnesota's State Hospital System.

In response to that request a Steering Committee was established by Ronald C. Young, M.D., Assistant Commissioner for Mental Health, to develop a design work plan for the report. Members of the Steering Committee were:

Ronald C. **Young, M.D.**	Assistant Commissioner, Mental Health Bureau
Terry Sarazln	Director, Mental Illness
Arde Wrobel	Division
Dennis Boland	Director, Mental Retardation Division
Roland M. Peek, Ph.D.	Director, Residential Facilities Division
Charles Turnbull	Director, Chemical Dependency Division
Joseph Solien	Director, Client Protection Office
	Director, Management Support Division Chief
	Executive Officer, Faribault State Hospital
	Chief Executive Officer, St. Peter State Hospital

Overall coordination for the report has been provided by Cynthia Turnure, Ph.D., Director of Planning, Research, and Evaluation, Chemical Dependency Division. Assistance has also been provided by Steven Barta, Office of Policy Analysis.

In view of the time available to prepare the report and the fact that there have been two previous Department reports on the same topic 1,2, it was decided not to undertake another major study at this time, but rather to rely primarily on existing information and material prepared for the report by Department staff and each hospital.

Report on Future of State Hospitals. St. Paul, Minnesota: Department of Public Welfare, 1973.

Residential Care Study. St. Paul, Minnesota: Department of Public Welfare, 1979.

The overall purpose of this report is to provide an overview of the current state hospital system (Chapter II), summarize the factors that must be considered that affect the role of state hospitals in general (Chapter III), present the Department's plan for the future of state hospitals in Minnesota (Chapter IV), summarize the effects of previous state hospital closures (Chapter V), describe the Impact that any additional closures would have on clients, counties, staff, and the community (Chapter VI and individual hospital reports in the Appendix), and provide the Department's recommendations regarding additional closures plus other actions needed to Implement the Department's plan for the future of the state hospital system.

In addition to this report, the Department of Administration is in the process of surveying the physical facilities on each state hospital campus. A detailed report on each facility will be completed by the end of September. The summary report for each hospital is included in Appendix B of this report. The full physical facility reports will be submitted to the Governor's Office as soon as they are completed.

In addition to the material presented in Chapter V on the effects of the closure of Rochester State Hospital in 1981, the Department is in the process of implementing a more comprehensive impact study on the Rochester closure. This study, being carried out by the Southeastern Health Systems Agency, should be completed by this fall. A report on the economic impact of the closing of Rochester State Hospital has also recently been completed by Winona State University 1, as summarized in Chapter V.

An Olmsted County task force made recommendations concerning the use of the former Rochester State Hospital and services needed in the area in December, 1981.2 At the present time a new Governor's Task Force is looking at possible uses for the Rochester facility, and District 9 of the Association of Minnesota Counties is looking at service delivery needs in the southeastern part of the state.

Besides the input provided by the Steering Committee, drafts of this report have been reviewed by each state hospital, the counties served by those hospitals, the Minnesota Association of County Social Service Administrators, the Association of Minnesota Counties, Council 6 of the American Association of State, County, and Municipal Employees and the Cabinet of the Department of Public Welfare. Comments and concerns of these groups have been incorporated in the final report.

The Department hopes that this report will provide useful Information to the Governor's Office and to other groups concerned with the future of Minnesota's state hospital system, including the newly-formed Advisory Task Force on the Use of State Facilities.

[1]Mary E. Rieder. The Economic Impact of the Closing of Rochaster State Hospital on the City of Rochester and the Region. Winona, Minnesota: Winona State University. 1982.

2 Rochester State Hospital Task Force Findings and Recommendations. Rochester, Minnesota: Rochester State Hospital Task Force, 1981.

II. THE CURRENT STATE HOSPITAL SYSTEM

This chapter presents a brief overview of Minnesota's current state hospital system. More detailed information on the specific programs and clients served by each hospital may be found in the Individual hospital reports in the Appendix.

Minnesota currently operates eight state hospitals, as shown on the map in Figure 1. Two of the hospitals (Cambridge and Faribault) serve only mentally retarded residents, while the others are multi-purpose.

The counties served by each state hospital are shown in Figures 2-4 and Tables 1-3.

As of June 30, 1982, there were 4,852 "utilized beds" in the eight state hospitals, as shown in Table 4. "Utilized beds" are beds that are set up, staffed, and ready to receive patients, as distinguished from "licensed" or "certified" beds, which may not be available for use due to staffing or other limitations.

Table 4

Capacity of Minnesota State Hospitals
as of June 30, 1982

Facility	Utilised Beds*	Certified Beds	Licensed Bed Capacity
Anoka	342	257	347
Brainerd	600	600	600
Cambridge	550	556	588
Faribault	810	810	845
Fergus Falls	613	717	717
Moose Lake	635	663	705
St. Peter	438	438	438
Security Hosp.	236	0	236
Willmar	628	644	644
TOTAL	4852	4685	5120

*Utilized Beds are beds that are set up, staffed, and ready to receive patients. Source: Residential Facilities Division, Department of Public Welfare

FIGURE 1 LOCATION OF STATE

HOSPITALS IN MINNESOTA

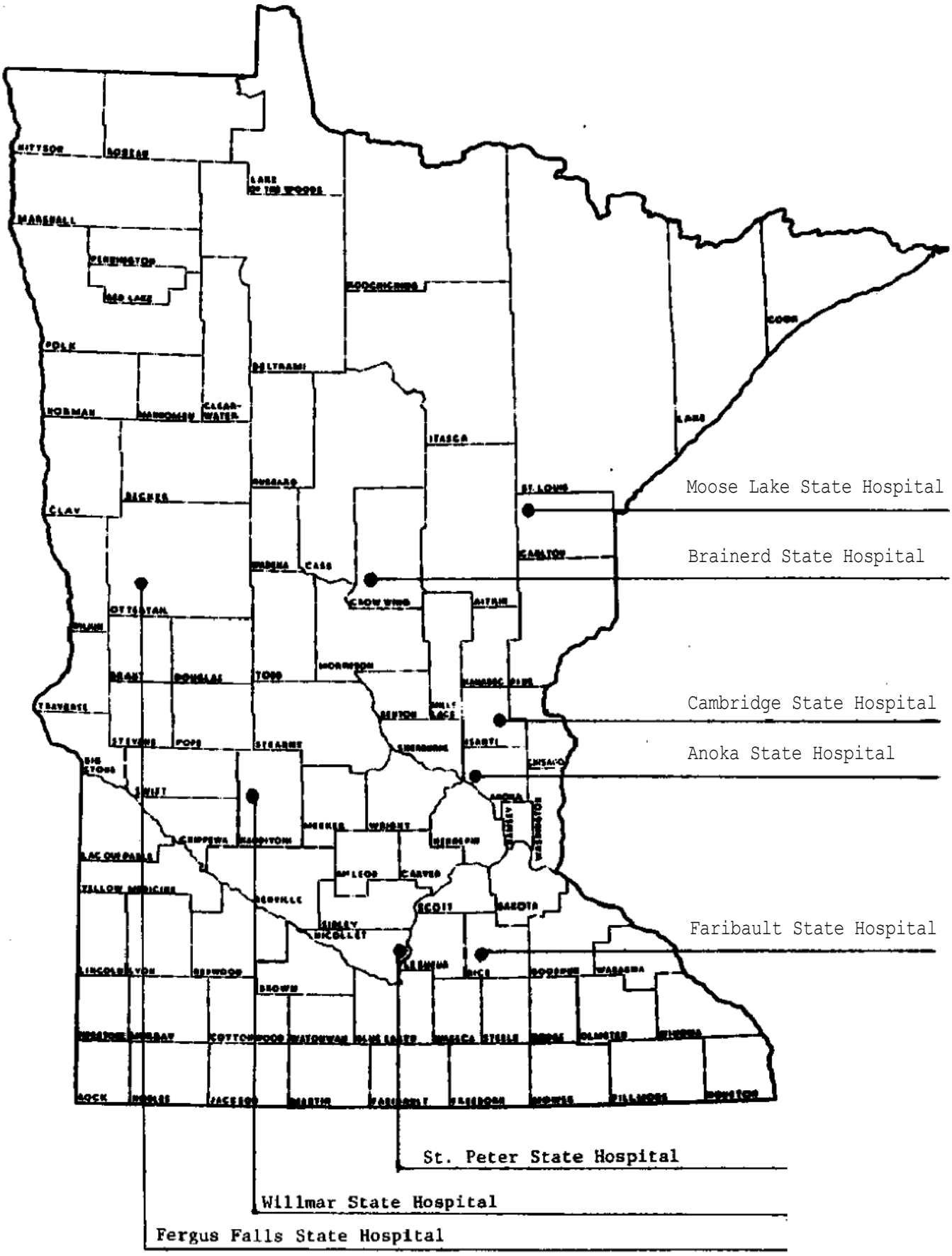

FIGURE 2

STATE HOSPITAL DISTRICTS - CHEMICALLY DEPENDENT

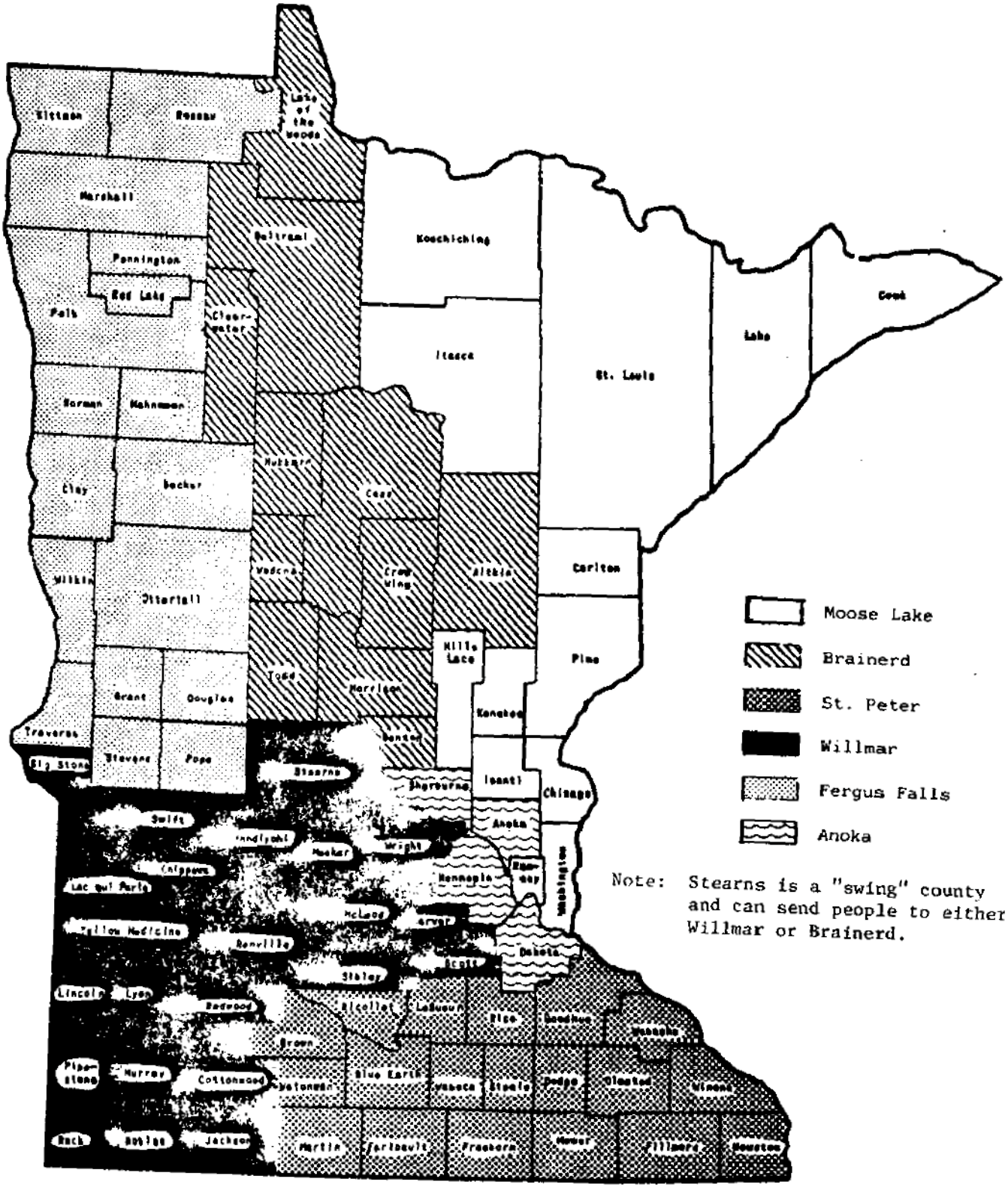

TABLE 1 STATE HOSPITAL RECEIVING DISTRICTS - CHEMICALLY DEPENDENT

Effective September, 1981

Fergus Falls State Hospital

Kittson
Roseau
Marshall
Pennington
Red Lake
Polk
Norman
Mahnomen
Clay
Wilkin
Traverse
Becker
Otter Tail
Grant
Stevens
Pope
Douglas

Willmar State Hospital

Big Stone Lac gui
Parle Yellow
Medicine Lincoln
Lyon Redwood
Pipestone Murray
Cottonwood flock
Nobles Jackson
Swift Chippewa
Renville Kandiyohi
Meeker Wright
McLeod Sibley
Carver Scott
*Stearns

Anoka State Hospital

Hennepin
Dakota
Anoka

Brainerd State Hospital

Lake of the Hoods
Beltrami
Clearwater
Hubbard
Cass
Wadena
Crow Wing
Aitkin
Todd
Morrison

Benton

Moose Lake State Hospital

Koochiching
Itasca
St. Louis
Lake
Cook
Carlton
Mille Lacs
Kanabec
Pine
Isanti
Chisago
Ramsey
Washington

St. Peter State Hospital

Brown
Watonwan
Martin
Nicollet
Blue Earth
Faribault
LeSueur
Waseca
Freeborn
Rice
Steele
Goodhue
Dodge
Mower
Olmsted
Fillmore
Wabasha
Winona
Houston

*Stearns is a "swing"- county and can send people to either Willmar or Brainerd.

FIGURE 3 STATE HOSPITAL RECEIVING DISTRICTS - MENTALLY RETARDED

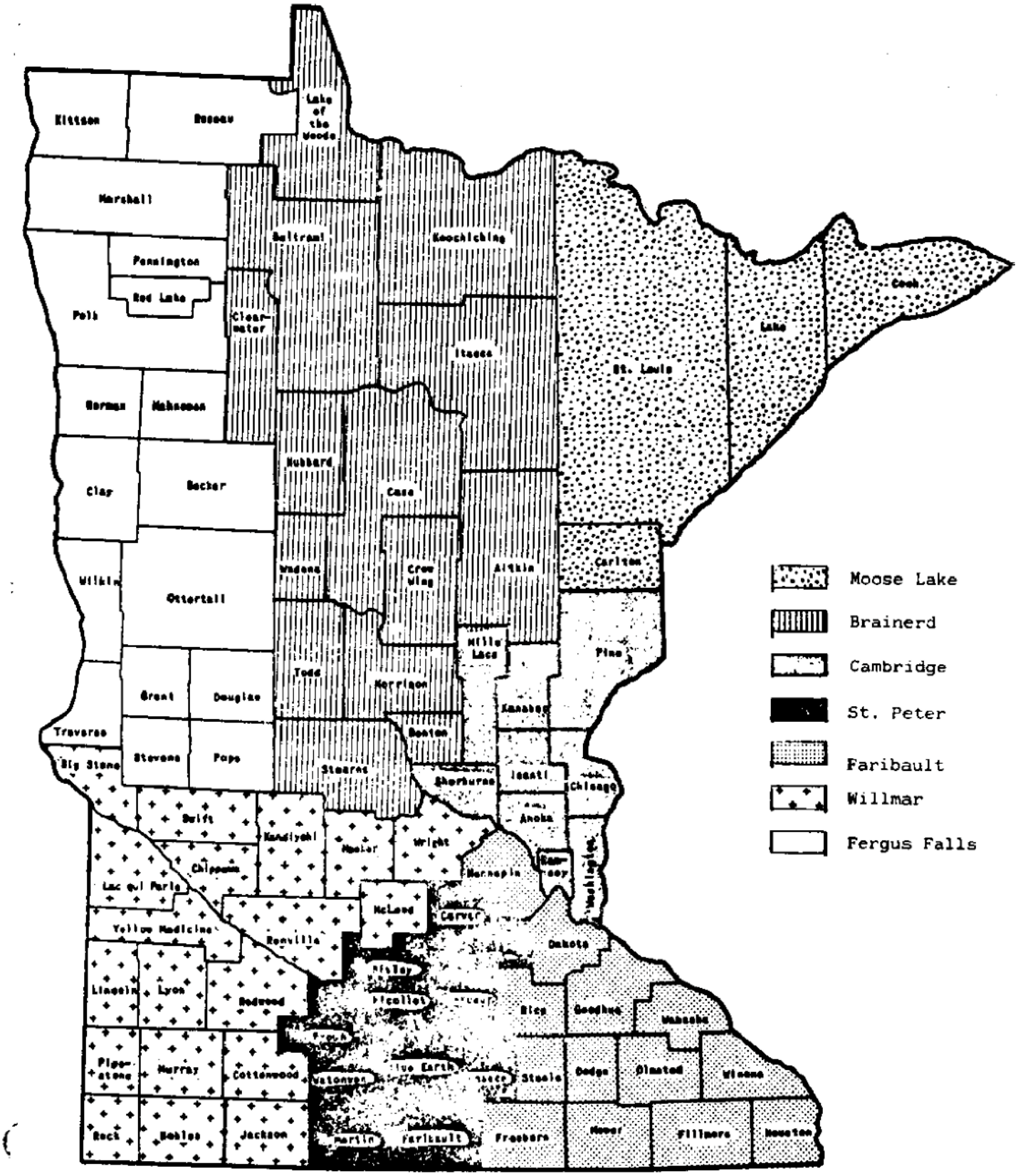

TABLE 2

STATE HOSPITAL RECEIVING DISTRICTS - MENTALLY RETARDED

Effective September, 1981

Fergus Falls State Hospital

Kittson
Roseau
Marshall
Pennington
Red Lake
Polk
Norman
Mahnomen
Clay
Becker
Wilkin
Traverse
Grant
Douglas
Otter Tail
Pope
Stevens

Willmar State Hospital

Big Stone
Swift
Lac qui Parle
Chippewa
Kandiyohi
Keeker
Wright
McLeod
Yellow Medicine
Renville
Lincoln
Lyon
Redwood
Pipestone
Murray
Cottonwood
Rock
Nobles
Jackson

St. Peter State Hospital

Carver
Sibley
Scott
Nicollet
LeSueur
Brown
Watonwan
Blue Earth
Waseca
Martin
Faribault

Faribault State Hospital

Hennepin
Dakota
Rice
Goodhue
Wabasha
Steele
Dodge
Olmsted
Winona
Freeborn
Mower
Fillmore
Houston

Cambridge State Hospital

Sherburne
Anoka
Ramsey
Washington
Chisago
Isanti
Mille Lacs
Kanabec
Pine

Brainerd State Hospital

Lake of the Woods
Beltrami
Clearwater
Hubbard
Wadena
Todd
Stearns
Benton
Morrison
Crow Wing
Aitkin
Cass
Itasca
Koochiching

Moose Lake State Hospital

St. Louis
Carlton
Lake Cook

FIGURE 4 STATE HOSPITAL RECEIVING DISTRICTS - MENTALLY ILL

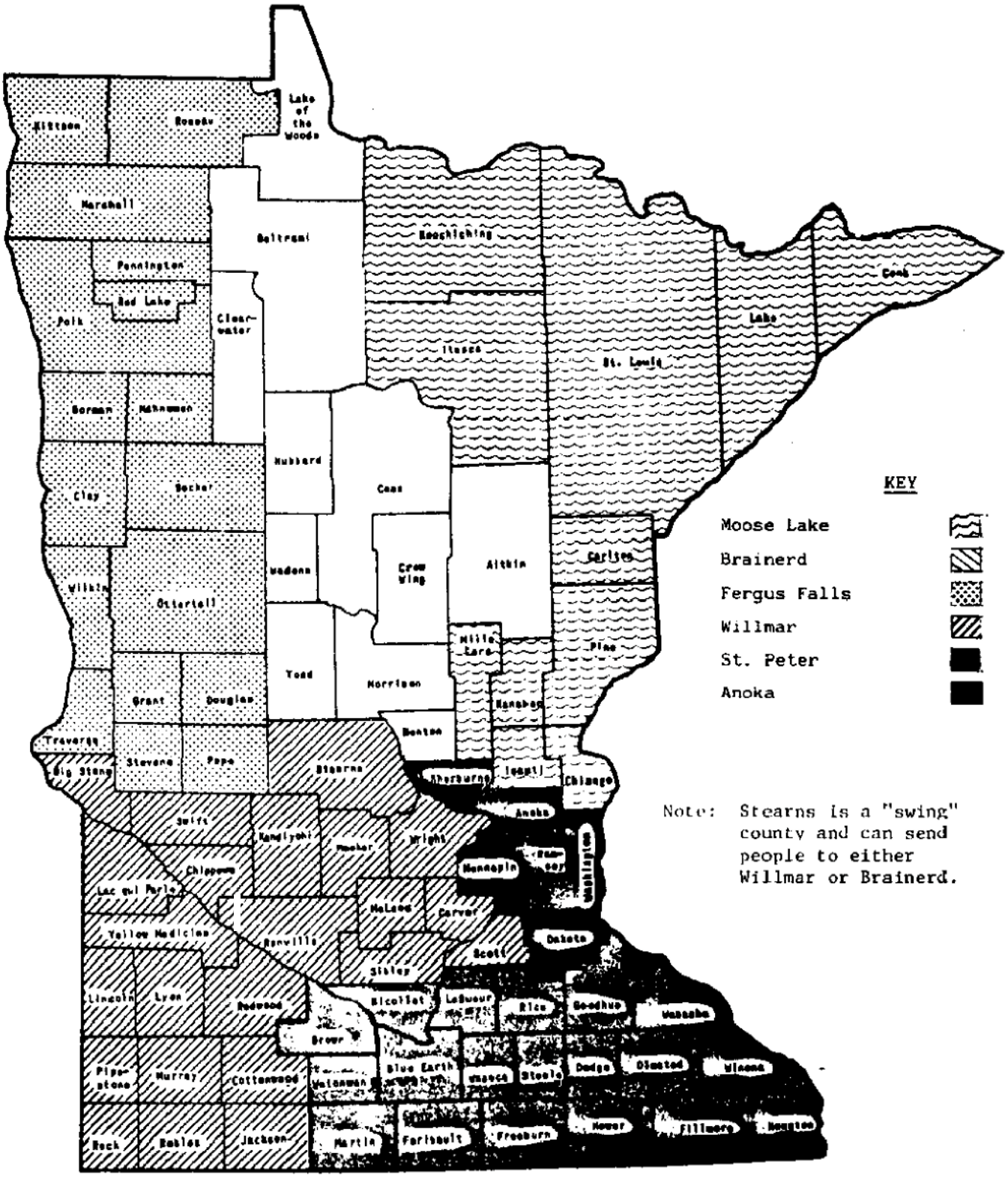

TABLE 3 STATE HOSPITAL
RECEIVING DISTRICTS - MENTALLY ILL

Effective September, 1981

Fergus Falls State Hospital

Kittson
Roseau
Marshall
Pennington
Red Lake
Polk
Norman
Mahnomen
Clay
Becker
Wilkin
Ottertail
Traverse
Grant
Douglas
Stevens
Pope

Willmar State Hospital

Big Stone
*Stearns
Swift
Kandiyohi
Meeker
Wright
Lac qui Parle
Yellow Medicine
Renville McLeod
Carver Sibley
Scott Lincoln
Lyon Redwood
Pipestone Murray
Cottonwood Rock
Nobles Jackson
Chippewa

Anoka state Hospital

Sherburne
Anoka
Hennepin
Dakota
Ramsey
Washington

St. Peter State Hospital

Brown
Watonwan
Martin
Nicollet
Blue Earth
Faribault
LeSueur
Waseca
Freeborn
Rice
Steele
Mower
Goodhue
Dodge
Fillmore
Wabasha
Olmsted
Winona
Houston

Moose Lake State Hospital

Koochiching
Itasca
St. Louis
Lake
Cook
Carlton
Mille Lacs
Kanabec
Isanti
Chisago
Pine

Brainerd State Hospital

Lake of the Hoods
Beltrami
Clearwater
Hubbard
Cass
Todd
Wadena
Crow Wing
Morrison
Benton
Aitkin

*Stearns is a "swing" county and can send people to either Willmar or Brainerd.

Table 5 shows the number of residents at each hospital as of June 30, 1982. The occupancy rate for the system as a whole (number of residents divided by utilized beds) was 88% at that time. The percentage of licensed beds in use at each hospital from September, 1980, through February, 1982, is shown in Table 6. It must be remembered that not all licensed beds are actually available for use at any given time.

Table 5
Population of Minnesota State Hospitals as
of June 30, 1982

Facility	MI	MR	CD	Other	Total
Anoka	235		70		305
Brainerd	83	327	51	38*	499
Cambridge		515			515
Faribault		763			763
Fergus Falls	115	257	131		503
Moose Lake	200	115	164		479
St. Peter Security Hospital	173 194	162	56		411
Willmar	303	166	109	5	583
TOTAL	1303	2325	581	43	4252

*Minnesota Learning Center

Source: Residential Facilities Division, Department of Public Welfare

The original FY 1983 total budget for the eight state hospitals was $140,511,492. The budget for each hospital is shown in Table 7. Approximately 70% of the state hospital budget is reimbursed via various third party mechanisms (e.g., Medicare, Medical Assistance, County, and court fees).

Starting in FY 1983 the Department is implementing a new billing system for the state hospitals with differential rates based on actual costs for the different disability groups. As of July 1, 1982, the per diem rates are $109.50 for MR, $83.65 for MI, and $65.55 for CD.

TABLE 6

Percentage of State Hospital Beds in Use September 1980 - February 1982, Based on Licensed Bed Figures for the Year *as* Reported to MHD and Population Figures Taken from the Monthly Average Daily Census Reports for September 1980 - February 1982.

	1980				1981				1982			
	Total	MI	MR	CD	Total	MI	MR	CD	Total	MI	MR	CD
Anoka												
January					92.0[1]	91.5[1]		93.3 [1]	91.1	90.7		92.2
February					93.7	95.4		88.9	89.9	89.9		90.0
March					93.1	95.8		85.6				
April					92.8	94.6		87.8	[1]			
May					90.0	89.6		91.1	Beds down as of 1/1/81			
June					90.3	91.9		85.6	closed. Re-			
July					84.5	87.6		75.6	flected licensed beds			
August					74.2	80.7		55.6	for			
September	65.5	62.2		77.3	86.5	86.5		86.7				
October	62.5	59.1		74.5	90.5	89.2		94.4				
November	63.3	60.4		73.6	91.4	91.5		91.1				
December	62,7	59.3		74.5	91.7	91.1		93.3				
Brainerd												
January	Note: 17 med. beds counted				92.5	78.8[2]	82.2	92.7	82.0	88.8	79.0	94.5
February	with MR beds (417 total) as				84.7	77.5	84.2	94.5	83.8	91.3	78.2	94.5
March	pop. is counted in MR column.				84.0	82.5	84.0	90.9				
April	Hospital total % of occup.				84.8	90.0	83.0	85.5	Average mo. pop. of MLC 68.74			
May	excludes MLC beds and pop.				84,7	96.3	81.0	89.1	over this year and one half.			
June					82.5	90.0	79.3	89.1				
July					80.0	87.5	79.2	76.4				
August					78.5	87.5	78.1	60.0				
September	72.0	71.3	90.3	83.6	83.0	91.3	80.0	89.1				
October	72.1	73.8	90.2	78.2	82.2	92.5	79.8	90.9				
November	73.0	78.8	90.0	83.6	82.2	95.0	80.0	92.7	(2) Remodeling of bldg. units			
December	72,2	81.3	87.0	87.3	81.5	93.8	79.2	90.9	caused fewer licensed beds			
									in 1981.			

These tables reflect the licensed capacity of the facilities. Licensed beds are the number of beds approved for use by the Minnesota Health Department on a yearly basis. This number does not reflect the number of usable ("utilized") beds on any given day , utilized being beds physically set up and staffed.

TABLE **6 (Continued)**

	1980				1981				1982			
Cambridge	Total	Ml	MR	CD	Total	MI	MR	CD	Total	MI	MR	CD
January					85.9		85.9		86.7		86.7	
February					85.7		85.7		86.9		86.9	
March					85.4		85.4					
April					85.4		85.4					
May					84.8		84.8					
June					85.4		85.4					
July					84.8		84.8					
August					83.2		83.2					
September	83.8		83.8		84.8		84.8					
October	83.0		83.0		85.5		85.5					
November	83.2		83,2		86.0		86.0					
December	83.2		83.2		85.9		85.9					
Faribault												
January					94.6		94.6		96.7		96.7	
February					94.4		94.4		95.4		95.4	
March					94.1		94.1					
April					93.5		93.5					
May					93.9		93.9					
June					93.1		93.1					
July					92.4		92.4					
August					92.8		92.8					
September	91.8		91.8		93.1		93.1					
October	91,8		91.8		95.2		95.2					
November	91.1		91.1		96.1		96.1					
December	90.4		90.4		96.1		96.1					

these tables reflect the licensed capacity of the facilities. Licensed beds are the number of beds approved for use by the Minnesota Health Department on a yearly basis. This number does not reflect the number of usable ("utilized") beds on any given day, utilized being beds physically set up and staffed.

TABLE 6 (Continued)

	1960					1981					1982				
	U*	Total	MI	MR	CD	U*	Total	MI	MR	CD	U*	Total	MI	MR	CD
Fergus Falls															
January						(88)	78.4	77.4	85.1	70.0	(93)	79.6	67.3	84.8	
February						(88)	78.5	79.2	85.8	68.2	(94)	80.1	63.7	84.5	
March						(86)	76.7	78.0	84.2	65.7					
April						(86)	77.0	75.0	85.1	67,4					
May						(85)	75.6	72.6	84.5	65.7					
June						(85)	75.5	70.8	85.4	65.2					
July						(84)	75.2	67.9	86.4	65.2					
August						(81)	72.5	63.1	83.5	64.4					
September	* (88)	77,4	75.0	84.5	69.5	(85)	75.5	66.7	86.1	67.4					
October	(88)	77.7	74.4	84.2	71.2	(87)	77.4	69.6	86.1	71.2					
November	(88)	77.7	73.8	83.9	72.1	(87)	77.1	67.9	86.7	70.8					
December	(90)	79.4	75.0	84.2	76.0	(89)	78.9	65.5	85.8	79.4					

*Higher % of total occup. is based on utilized figures 1980, 81 & 82.
1980 - 633 beds
1981 - 639 "
1982 - 613 "
Because of FFSH extensive remodeling this figure is shown.

Minnesota Security Hospital			
January		103.8	106.0
February		99.0	105.4
March		99.0	103.3
April		103.3	
May		104.3	
June		100.0	
July		95.7	
August		94.0	
September	112.0	98.4	
October	106.0	103.3	
November	101.6	101.6	
December	100.5	105.4	

These tables reflect the licensed capacity of the facilities. Licensed beds are the number of beds approved for use by the Minnesota Health Department on a yearly basis. This number does not reflect the number of usable ("utilized") beds on any given day, utilized being beds physically set up and staffed.

TABLE 6 (Continued)

	1980 1982				1981							
	Total	MI	MR	CD	Total	MI	MR	CD	Total	MI	MR	CD
Moose Lake												
January					68.3	48.0	90.1	79.2	70.0	53.7	85.9	80.8
February					70.1	49.6	90.2	83.4	70.9	55.2	85.3	78.1
March					71.6	53.1	88.2	80.2				
April					68.0	52.6	88.4	75.4				
May					67.5	52.7	89.4	71,5				
June					65.1	52.3	88.2	68.5				
July					57.0	49.1	85.3	52.7				
August					52.7	48.9	85.8	37.7				
September	66.4	41.6	92.3	90.4	64.3	58.1	57.0	67.3				
October	64.7	39.7	92.3	88.0	70.0	54.6	89.3	77.3				
November	66.0	38.2	90.9	95.7	70.2	54.8	85.4	79.1				
December	67.1	39.9	90.2	97.1	70.5	53.1	86.6	80.3				
Rochester												
January					65.7	53.9	66.5		60.1	60.1		
February					64.8	55.0	63.8		50.5	50.5		
March					65.7	55.5	65.4					
April					64.3	58.0	62.2					
May					62.6	57.0	63.2					
June					55.9	51.9	60.5					
July					52.6	50.1	58.4					
August					50.7	48.3	56.2					
September	66.2	58.5	78.5	80.0	43.3	43.3	43.6					
October	68.6	62.6	75.8	87.3	35.2	39.2	27.0					
November	68.0	64.9	71.0	80.0	29.7	39.7	8.6					
December	61.7	54.7	68.3	89.1	23.3	34.4						

These tables reflect the licensed capacity of the facilities. Licensed beds are the number of beds approved for use by the Minnesota Health Department on a yearly basis. This number does not reflect the number of usable ("utilized") beds on any given day, utilized being beds physically set up and staffed.

TABLE 6 (Continued)

	1980				1981				1982			
	Total	MI	MR	CD	Total	MI	MR	CD	Total	MI	MR	CD
St. Peter												
January					89.9	81.8	38.2	75.9	98.1	95.5	94.6	93.1
February					88.6	82.4	86.3	82.8	97.3	97.2	92.6	84.5
March					87.6	78.4	85,3	88.0	96.0	97.2	90.7	87.9
April					87.3	78.4	85.3	70.7				
May					88.7	80.1	85.3	77.6				
June					88.6	82.4	85.8	81.0				
July					82.8	79.5	84.8	44.8				
August					76.8	68.2	81.9	31.0				
September	92.1	81.3	91.7	63.8	86.7	77.3	84.3	86.2				
October	91.8	83.5	91.2	74.1	90.2	84.7	86.3	79.3				
November	90.2	82.4	88.7	82.8	94.5	88.0	92.6	86.2				
December	88.3	58.4	87.7	75.9	97.1	94.9	93.6	89.7				
Willmar												
January					87.1	84.6	91.0	89.8	88.0	87.4	93.2	83.1
February					86.2	85.2	88.1	87.3	89.6	89.9	92.1	85.6
March					86.5	86.8	87.6	84.7				
April					84.8	84.9	85.9	83.9				
May					83.6	83.8	85.3	81.4				
June					81.2	62.9	84.7	73.7				
July					80.9	79.9	84.2	79.7				
August					76.1	78.6	84.7	55.9				
September	82.5	79.5	5	78.8	84.1	81.0	93.2	87.3				
October	82.5	78.3	0	83.9	86.4	83.0	93.2	87.3				
November	82.3	78.5	7	79.7	86.2	83.2	93.8	84.7				
December	81.2	76.0	5	83.1	84.7	81.6	93.2	82.2				

These tables reflect the licensed capacity of the facilities. Licensed beds are the number of beds approved for use by the Minnesota Health Department on a yearly basis. This number does not reflect the number of usable ("utilized") beds on any given day, utilized being beds physically set up and staffed.

4/16/82 J. Gilbertson
Residential Services

Table 7
Total FY 1983 Original Budget for
Minnesota State Hospitals*

Facility	Budget
Anoka	$10,349.612
Brainerd	18,220,812
Cambridge	19,195,411
Faribault	27,316,505
Fergus Falls	16,123,800
Moose Lake	13,185,157
Rochester	19,071,492
St. Peter	15,816,650
Wlllmar	
TOTAL	$140.511,492

These amounts in most cases do not include carryovers in special equipment and repairs and replacements from FY 1982.

Source: Institutional Fiscal Management, Department of Public Welfare

The vast majority of the state hospital budget (88.8% in FY 1980) is spent on salaries, with the rest spent on food, fuel, medical and hospital supplies, utilities, repairs, and equipment. The state hospital system provided employment for 6,083 individuals as of June 30, 1982 (in 5,677 full-time equivalent positions).

III. FACTORS AFFECTING THE ROLE OF STATE HOSPITALS FOR EACH DISABILITY AND IN GENERAL

There are a number of factors that need to be taken into account in considering the role of state hospitals in Minnesota, both now and in the future. These include relevant court cases such as Welsch v. Noot, various funding cuts that are affecting public assistance clients, the programmatic needs of particular types of clients, and general state population trends. These factors are discussed briefly below.

A. The Mentally Retarded

1. The Welsch v. Moot Consent Decree of September, 1980, and the Department's Six Year Plan for the Mentally Retarded establish specific provisions for state hospital population reduction and community service development and ongoing provision. Specifically, the consent decree states that the overall institutional population of mentally retarded persons shall be reduced to:

   No more than 2600 by July 1, 1981
   No more than 2525 by July 1, 1982
   No more than 2375 by July 1, 1983
   Ho more than 2225 by July 1, 1984
   No more than 2100 by July 1, 1985
   No more than 1950 by July 1, 1986
   No more than 1850 by July 1, 1987.

   Specific regional planning, particularly related to the role of the state hospital in the continuum of care, is expected to address how the goals of these two factors are to be met regionally.

   Instructional Bulletin #81-53 establishes state hospital bed utilization goals for each county in order to achieve the reduction of the mentally retarded state hospital population statewide to 1850 by July 1, 1987.

2. Budget constraints at the county, state and federal levels of government may ultimately affect the rate of state hospital pop ulation reductions and community service provision. Local regional planning is expected to consider alternative approaches to compliance with the Consent Decree and Six Year Plan so that budget constraints will have the least possible detrimental effect on the mentally retarded population.

3. Programmatic needs for the mentally retarded population are deter mined by the counties of service or financial responsibility as provided in the Community Social Services Act and Rule 165. Specific case management responsibilities of the counties include all mentally retarded persons in need of community or state hospital-based services. Local regional planning is expected to address the future role of state hospitals in assisting counties in assessing needs of the county MR population, helping coordinate

needs assessment between counties, planning the reduction of state hospital population, and in the development of community services in accordance with the Six Year Plan and Consent Decree.

B. The Mentally I11

1. Funding Picture

Substantial reductions in social services/mental health services and in SSI/SSDI have reduced the public resources available for mentally ill people.

While Minnesota has been a relatively low user of these programs compared to other states, it appears that the federal government applied the same rate of re-determination to Minnesota as it has to states that have made proportionately greater use of the programs. There is growing evidence that many disabled people, including those with mental illness problems, are being transferred to categorical income maintenance programs and, in some instances, to state hospitals. The wholesale review and termination of SSI and SSDI recipients is one of the most serious threats to the income and stable functioning of former mental patients.

The ratable reduction in GAMC reimbursement for inpatient hospital care of mentally ill people to 55% of the usual and customary costs for 1978 has resulted in some local hospitals declining to accept patients whose care would be paid from GAMC. The Department will be submitting a report on the impact of this to the 1983 Session of the Legislature. It is not possible, at this writing, to make a definitive statement on the Impact of this reduction on state hospitals, but it is not unreasonable to assume that it will result in more people using state hospital mental illness services.

On the positive side, this year the Legislature reinstated GAMC reimbursement for day treatment services provided by community mental health centers. In 1981 it made a new biennial appropriation for community residential facilities which oust be licensed under DPW Rule 36 and it increased the appropriation for community support programs (DPW Rule 14) from $2 million to $5 million. These programs maintain several thousand mentally ill people outside of state and local hospitals. The Rule 14 projects have accomplished a 45% reduction in hospitalization compared to the clients' previous year's experience.

The closing of the Rochester State Hospital in May, 1982, significantly reduced the capacity of the state hospital system to serve mentally ill people. The southeastern counties formerly served by Rochester are finding the distances to other state hospitals and the related costs of transportation to be very burdensome.

The development of new Rule 36 facilities in Rochester and Winona will offset somewhat the loss of the Rochester State Hospital but they cannot entirely compensate for it.

2. Programmatic Needs

In spite of the continuing virtually full occupancy of the St. Peter and Anoka mental Illness units the statewide census figures have not significantly increased. This may be accounted for, in part, by the eligibility for Medical Assistance of many people with mental illness problems, particularly those with chronic problems.

However, the Hennepin County Medical Center inpatient psychiatric unit average daily census last year was 24. This year it is 45. Dr. Charles Dean attributes this to economic conditions, particularly the SSI/SSDI cutoffs. He reports a 47% increase over last year in people brought in by police and 100% increase in court-ordered evaluations. The Hennepin County Pre-Petition Screening Unit reports similar increases, for the same reasons. Comparable data are not currently available for other local hospitals. Such an increase is likely to be felt primarily in admissions at the Anoka State Hospital.

A dramatic increase in social service appeals, while not all by people with mental illness problems, reflects more restrictive policies by county social service agencies, another sign of the times. Some counties have adopted a policy of not using any residential treatment facilities other than state hospitals because of cost considerations, since the net cost of state hospital care is so much cheaper for the counties than the cost of community residential facilities.

In August, 1982, the new provisions of the Minnesota Commitment Act of 1982 took effect. Specifically, the counties must provide prepetition screening to assess individuals' mental status and to assist the courts in considering and using alternatives. How vigorously the courts and the counties use alternatives will have an effect on state hospital admissions. State hospital admission criteria would assist the courts in making more appropriate use of state hospitals.

Further efforts by the Department and the Legislature to obtain more equal liability by the counties for the cost of residential placements would eliminate or reduce any tendency to use state hospitals over other alternatives on the basis of cost considerations.

Regional planning to develop a full continuum of care could stimulate the growth and use of a variety of residential and nonreslden-tial services, particularly in rural areas where the alternatives are often limited. More flexible funding and equalization of costs will be necessary if this is to happen.

The current Rule 14 appropriation allows support of projects in 37 counties. This leaves 50 counties without access to state funds to develop comparable projects. The un-evenness of the availability of community resources such as this means that some residents of

the state have access to services not available to others, and it is likely to result in differential rates of admission to state hospitals.

C. The Chemically Dependent

1. Funding Cuts

Substantial reductions in various entitlement programs and for social service funding generally have greatly affected the capacity of state and county government to pay for the treatment of uninsured chemically dependent Minnesota residents. Prior to the current economic crisis, various measures existed to provide this service where necessary, although not without their problems and criticisms. General Assistance Medical Care (GAMC) would pay for the major portion of inpatient treatment in hospital settings. In certain settings, Medicaid was available to certain clients. Most counties were able to place clients in various privately-operated programs best suited to meet that client's needs. Finally, the state operated in-patient treatment programs in seven state hospitals involving approximately 700 beds.

Within the last year, GAMC reimbursement schedules have been reduced to cover 55% of the usual and customary fees based on billings for 1978. This has caused a large number of hospital-based chemical dependency programs to suspend treating public assistance clients to prevent them from operating at a loss. Provisional data comparing medical assistance payments for CD services during the first four months of FY 81 and FY 82 demonstrate the early impact of this change. While 85.5% of the charges were paid in FY 81, this percentage dropped to 77.3% in FY 82. Overall payments for CD services dropped 232 in the period covered. Since the major reduction in GAMC reimbursements did not occur until 10/1/81, these reductions will no doubt be substantially greater as additional data become available.

Medicaid reimbursements have not been a large source of CD treatment funding and do not appear to represent a potential area of increase in the near future.

Pressures to pay for a wide range of social services at the county level, combined with reductions in federal, state and local funds available to the counties, may ultimately produce the greatest reduction in actual dollars spent for CD services. Anecdotal evidence suggests that very few counties have been able to continue their past practices of treatment and aftercare placements, although this has not been reflected yet in the "maintenance of effort" data reported by counties under CSSA. Combining state and county payments under the Community Social Services Act (CSSA), the total for chemical dependency has been $19,346,000 in CY 79, $20,785,000 in CY 80 and $22,753,956 in CY 81. Informal indicators seem to imply the 1982 expenditures will be down substantially, however.

In mid-1981, the Rochester State Hospital closure resulted in the loss of 55 beds for *CD* treatment at that facility. This event, coupled with the other problems facing counties, has placed considerable pressure on some of the remaining six facilities. Forced to economize in every possible way, counties have apparently decided to increase their use of state hospital CD units while severely limiting their use of community facilities since they must pay only 10% of the cost for state hospital services. This has resulted in waiting lists as high as 140-150 throughout the system early in 1982 and the appearance of an earlier stage client at some state facilities. In recent months, the demand for state hospital CD beds has leveled off. This may be a result of more limited funds at community levels to identify clients, and a greater tendency for counties to more selectively refer to treatment those clients deemed most likely to benefit. Others may be referred to AA or simply may not be addressed.

2. Programmatic Needs

For the Immediate future, state hospital CD treatment programs represent the least costly way for counties to address CD treatment needs. In many instances this will be the only way counties will pay for CD treatment services. Since, from a county standpoint, cost for the service is a primary factor in making these decisions, the best interest of the client and the overall cost to the taxpayer are not always adequately addressed.

Unless some change occurs in how state hospital CD services are billed, CD units will find it necessary to adapt to a broad range of CD problems to meet the needs of early stage primary clients on through late stage chronics. While most of the units have been offering both primary and extended care services, they have traditionally Been the more difficult client who is less likely to respond to community-based programs.

A complicating factor for state hospitals will be the very limited and sometimes non-existent funds at the county to place persons in halfway house facilities upon completion of in-patient treatment. The options are to keep such persons longer (which is likely to be far more costly than a halfway house) or discharge them to the community without the needed support for maintaining their treatment plan. A third option would be for state hospitals to design lower cost settings on campus where lower levels of support are provided. Such efforts could not, however, replace the substantial need to re-acclimate clients to the community while receiving the support of a halfway house program.

Regional planning for the delivery of CD services, including a determination that actual program costs would be billed to counties, may possibly help to equalize community and institutional placements. With the establishment of admission criteria designed to more accurately assess the treatment needs of chemically depen-

dent and chemical abusing clients, these developments could lead toward a more responsive and effective system of CD services. However, unless some of these changes are made, state hospital CD programs will continue to represent the primary source of such services.

In both the private and public sector, major efforts are underway to establish admission criteria designed to more accurately assess the treatment needs of chemically dependent and chemical abusing clients. Specifically, the Department of Public Welfare is in the process of establishing criteria for determining the appropriate level of care for public assistance clients, as mandated by the Legislature. The advancement of outpatient programming as a very effective treatment modality for far less money is necessitating the rapid development of such criteria. In a very general sense, earlier stage clients with strong community and family support will likely be outpatient candidates, while the opposite will be true for in-patient care. The Implications for state hospitals remain dependent upon the financial capability of counties to place clients in community programs and to offer outpatient services in conjunction with in-patient care.

Two very difficult client problems facing the state involve the so-called chronic recidivist population and a not well-addressed population group now found in extended care settings. Domiciliary care facilities in scattered locations throughout the state have begun to address some of the chronic recidivist group. The number of beds available is substantially lower than the projected need, however. Many of these Individuals are frequent residents in relatively high priced state hospital beds. Most are costing the state even more through their regular appearance in local detox facilities.

While Minnesota may very well have successfully treated more chemically dependent persons than most states, even the best programs are by no means 100% successful. A growing number of individuals have tried and failed in both private and public primary treatment facilities. Often these persons exhaust their insurance coverage and become a public responsibility. Their history of failures frequently results in their placement in an "extended care" facility designed to more slowly approach this particular problem. While certainly some very productive efforts are being made to address this population group (particularly in the state hospitals), considerable attention must be given to ascertain how to more effectively treat this client.

Regional planning issues present problems when considering the overall role of state hospitals and CD services. More rural areas of the state frequently depend upon the state hospital and CD services since private facilities are too distant or non-existent. The recent growth of small programs, frequently hospital-based, in more rural communities must be addressed in planning for adequate CD services. Specialized service needs, e.g., for women,

youth, and the elderly, must be taken into account, as well as whether some approach to outpatient or day care can be delivered in rural Minnesota.

D. Overall State Population Trends

Age changes and other trends in Minnesota's overall population need to be taken into account in considering the role of state hospitals in the future. According to the State Demographer's Office,

> "The over 65 proportion of Minnesota's population will continue to grow, causing new and different service demands. Equally important will be the distribution of the elderly population.
>
> Many Minnesota counties had an elderly population of between 12 and 15 percent in 1970... Those same counties could have elderly populations of between 15 and 19 percent, or nearly a fifth, by 2000. These higher concentrations will be most often in rural, sparsely populated areas, based on projections of present trends - areas that probably will have little overall population growth.
>
> Statewide, projections show that through 2000 the most rapid increases in the over 65 group will come in the highest age categories, primarily the 80 and over group. The number of Minnesotans 65 and above will grow 25 percent from 1970 to 2000, but the number 85 and over will grow 48 percent. Projections also Indicate that women will represent a growing proportion of this elderly group.
>
> The over 65 group is a broad age category, and the needs of the most elderly in this group are very different from those of people who have turned 65 more recently. Senior citizens in the 60s and 70s might have health and transportation problems, lower incomes could make small and less costly housing desirable. Yet it is only in the upper end of the age spectrum, primarily after 85, that Independent living becomes difficult for a quarter of this population. National statistics show that in 1969, 26 percent of all women 85 and over lived in nursing homes.
>
> Policy decisions relating to health, transportation, housing, and welfare must be made with the growing elderly population in mind."[1]

[1]Office of the State Demographer. Faces of the Future. St. Paul, Minnesota: State Planning Agency, 1977, pp. 34-35.

As Minnesota's population ages the types of services that may be needed, and that state hospital facilities could potentially help provide, may be quite different than the services traditionally provided by state hospitals. As the general population continues to age it is likely, for example, that more nursing home beds will he needed. It may be beneficial in terms of program development, capital Investment, use of existing state facilities, regional planning, etc., to look at the projected requirements for specialty psychiatric services, specialty chemical dependency services, specialized nursing home services, specialized developmental disability services, and various dual or multiple disability services, rather than trying to decide If we need state hospitals as now configured and viewed as providers of relatively "unitary" or uniform services. The concept of state hospitals as part of regional service delivery systems, presented In the next section of this report, is consistent with this sort of planning perspective.

IV. THE DEPARTMENT OP PUBLIC WELFARE'S PLAN FOR THE FUTURE OF STATE HOSPITALS

The Mental Health Bureau recommends that no state hospitals be closed by the 1983 Legislature. Instead, it proposes that legislation be introduced which would establish governing boards for each state hospital. These governing boards would have authority and responsibility for allocating available state hospital funds either into hospital programs or alternative services in the communities.

In the event that a further reduction in the total state hospital appropriation becomes unavoidable, it is recommended that the Governor and the Legislature pursue the option of cutting all eight institution budgets by a proportionate share of the total rather than closing another hospital. This approach would assure that all regions of the state would participate equally in the reduction of mental health services rather than penalizing one region while leaving services for the rest of the state essentially Intact. It is the Bureau's position that closure of a state hospital, because it is an important component of the region's continuum of mental health services, should be a matter of local/regional determination. It should he left to those groups to decide if they wish to continue a regional facility with reduced funding or close the hospital and divert the available resources elsewhere into community programs.

This report was prepared in response to the question, "If the State decides to close another hospital, which one should it be?" Consequently, a great deal of time has been spent documenting the current role and function of each institution and attempting to project what specific impacts would occur upon closure.

It Is Important to recognize, however, that the question Implies a fundamental assumption: the State will continue to operate and fund the state hospital system as it has for more than 100 years and the prerogative of deciding whether a particular region of the State will have a treatment facility will remain within state government, not with local officials.

In 1866, when the first state hospital was built at St. Peter, Minnesota, it was intended to serve the entire State. Later additions to the state system also became statewide programs for the epileptic, "mentally defective", and "alcoholic". But in the past 20 years, this pattern has changed. Most of the institutions are now multi-purpose campuses serving regional catchments area. In addition, many community programs have been developed and supported with state, local and federal funds. The net result has been the emergence of two separate, distinct public mental health systems: the state hospitals which are funded directly by the Legislature and administered by the State Department of Public Welfare; and the county service system which is partially funded by the State, but administered by the counties.

County decision-making "drives" both systems. State hospital usage is determined primarily by events at the county level. For example, under Minnesota Law, county social services agencies play a key role in deciding whether indigent persons who need treatment are placed in a community facility or a state hospital. This decision-making process is influenced by many factors, such as the availability of alternative programs, proximity to the patient's home, community acceptance, and comparative costs. Understandably in recent months cost has been an increasingly prominent consideration in these deliberations. As with every level of government, counties are looking for ways to maximize the use of scarce resources.

With the present dual system, there are financial incentives for counties to use state hospitals rather than other facilities. In recent years counties have exercised remarkable restraint in not responding to this financial Inducement but the current budget constraints will encourage increased usage of state hospitals because those institutions are financed primarily with non-local dollars.

There is another important reason for considering a major change in the planning/administration/funding of the public mental health system: a state-run hospital system effectively removes a large percentage of the total mental health budget from meaningful county participation. The state, by unilaterally allocating a large percentage of the state's mental health resources into the state hospital system without county approval and control, limits the counties' ability to plan and develop services in a manner that is most appropriate for their areas of the State. This approach is contrary to the philosophy of the Community Social Services Act which encourages unified local planning and the delivery of social services through a block grant allocation to counties.

Before proceeding to the Department's plan for restructuring the state hospital system to meet the changing picture of the 1980s and beyond, some basic questions and answers relating to the state hospitals as a system will be presented:

1. Does Minnesota have too many state hospitals?

   At the present time there are eight state hospitals serving 87 counties representing a land area of 84,068 square miles. These facilities tend to be clustered towards the middle of the state where population densities are greatest, but most of them serve

relatively large geographical catchments area in out state Minnesota. As a result, many Minnesotans are currently traveling long distances to receive treatment and evaluation services in state hospitals because there are no other appropriate resources in their local communities.

Given the size of the geographic area served by the state hospitals and the current availability of alternative resources in the community and public funds to support these services, there is no excess of state hospital treatment facilities.

2. Does Minnesota have too many state hospital beds?

As noted elsewhere in this report, all eight state hospitals have operated near capacity during 1982. Projections indicate an increased demand for state hospital services in the coning months unless there is a dramatic improvement in the general economic climate and additional public money becomes available to fund alternative mental health services in the community.

The occupancy rate for the state hospital system has remained above 85% for the past twelve months and the number of admissions and discharges is 2.6Z higher for January-June, 1982, than the preceding six months.

By hospital industry standards, this occupancy rate is high, especially for a large decentralized system, with dozens of specialized treatment units, a variety of disability groups, many levels of care, and a wide range of ages. A system that emphasizes individualized treatment plans and modern, specialized services will find it impossible to keep all beds filled at all times.

State hospital chemical dependency treatment units, particularly, have been under intense pressure for admissions this year. Every CD program except Fergus Falls has had a waiting list for admission despite efforts to refer clients to other available resources.

Mental illness units are also operating at, of near, capacity. There have been periods during the past six months When voluntary admissions have been limited in order to accommodate court commitments - a practice which is contrary to accepted principles of early intervention and voluntary treatment.

During the past 20 years, as state hospital populations were being reduced, the Department of Public Welfare has pursued a policy of downward-adjusting the size of hospital campuses by vacating buildings and lands no longer needed for treatment programs. Surplus property has been made available to other agencies or sold. Unusable buildings have been scheduled for demolition.

In this same time span, the Department has proceeded to upgrade the environment of the remaining buildings. The overcrowded, antiquated hospital wards of the 1950s have been remodeled to meet modern standards for fire safety, privacy, program space, and humane living conditions. Compliance with federal certification and licensing rules has been achieved.

In summary, there is very little excess capacity in the state hospital system. Closure of another state hospital could not be accommodated in the remaining institutions without cutting off services to the disability groups currently served by the state hospitals.

3. Why are state hospitals so heavily utilized at the present time?

Two factors, the closure of Rochester State Hospital and the reduction of public financial support for mental health treatment in private facilities, have resulted in more referrals to and reliance upon the state hospital system. This is especially true for the chemically dependent and mentally 111 client groups, for which the average dally population increased by 59 (CD) and 43 (MI) respectively between Hay, 1982, and October, 1982.

Five hundred eighty beds and several specialty services were removed from the statewide system's capacity when Rochester State Hospital was phased down and closed this year. The full impact of this closure on southeastern Minnesota and the rest of the State is still being analyzed but a substantial number of both chronic and acute cases from southeastern Minnesota are now being accommodated in the remaining state facilities. Some long-term patients and residents were transferred from Rochester to other state hospitals; others were discharged and later readmitted elsewhere in the system; and the remainder have either found alternative treatment services in the community or have gone without them. The net effect upon the rest of the state hospital system has been an increased admission and occupancy rate.

Public funds for mental health treatment have diminished in the past year. It is more difficult for persons who depend upon public financial support to have their treatment paid for in private programs. The rate-able reductions in GAMC and the loss of Social Security Disability Benefits have caused the care of many mentally disabled persona to be shifted from the private/community mental health system into the state hospitals. Counties, hard hit by budget reductions, will be sending more public clients into the state hospital system because state and federal funds pay most of the cost in those programs.

4. What is the role of the state hospital system?

As a general rule, the state hospital system is the resource of last resort for persons whom the communities either cannot or will not treat, or if there is no local money to pay for

the services, i.e., to do what is "left over" from the other system. This type of role has made it very difficult for the state hospitals to maintain specialized tertiary programs or engage in long-range planning. With an integrated regional mental health system, appropriate roles and functions for the state hospitals could be decided in the context of an area-vide plan.

The Mental Health Bureau proposes that the following policy statement be used as the basis for restructuring Minnesota's mental health system:

PROPOSED STATE POLICY

I. All future decisions affecting the state hospital system will support the ultimate goal of phasing the state out of the direct operation of these institutions. Where continuing public control and direction is deemed advisable, state administration will be replaced by local/ regional governance.

II. Although divesting itself of administrative control, the state will continue to provide funds to regional and local programs serving chronically and severely impaired mentally ill, mentally retarded and chemically dependent persons.

III. Where special populations are too small to justify regional treatment programs, consideration will be given to maintaining single programs such as the Minnesota Security Hospital and the Minnesota Learning Center as state-operated facilities.

Rationale:

There are two compelling reasons for phasing state government out of the direct operation of programs:

1. It is an inherent conflict of interest for state agencies to directly operate one part of the mental health system (e.g., the state institutions), while also maintaining regulatory and funding control over the rest of the system. The state's unique relationship with its own institutions has, from time to time, made it impossible to maintain equality with non state-operated programs. Sometimes this special relationship has worked to the advantage of the state institutions; at other times the Institutions have been adversely affected. To achieve equality, direct administrative responsibility must be separated from the funding and regulatory responsibilities.

2. Local/regional administration offers mechanisms for integrating public mental health programs that are most responsive to regional needs rather than a state-directed system. For although services provided by state institutions are part of each region's continuum of care, the major decisions affecting these institutions - funding, caseloads,

capital improvements, staffing complements, and phasing down programs - are made at the state level. A more efficient and effective approach would be to give local/regional entities control over all public mental health funds. This would avoid the problem of maintaining two parallel public systems, each with its own authority and source of funding.

The principles, goals and objectives which provide direction for the Bureau'a plan are as follows:

Principle I

Persons living in all parts of Minnesota should have reasonable access to a full continuum of mental health services.

Goal: Each region of the state will have a comprehensive, balanced mental health service system.

Principle II

Mental health services should be provided in the least restrictive and most normal environment which is consistent with the individual's treatment/ rehabilitation needs.

Goal 1: The capacity of the mental health system to maintain and support persons with mental disorders in the general social environment will be increased.

Coal 2: The use of restrictive treatment settings will be reduced.

Principle III

To the maximum extent possible, planning and delivering mental health services should be a local/regional function with appropriate state level participation.

Goal 1: The financing and organization of Minnesota's public mental health system will be restructured in order to facilitate maximum local/regional coordination and control and thereby achieve more appropriate, efficient use of mental health resources.

Objective 1: Develop an administrative mechanism for allocating all state mental health funds to the regions on an equitable basis.

Objective 2: Establish each state hospital as a free-standing regional institution directed by a Governing Board from the hospital's catchments area. The decision to maintain or change the size and configuration of individual state hospitals will be made by the respective Governing Boards, based upon the region's needs for the institutions' services and the amount of funding available from its catchments area.

Objective 3: Reduce, to the maximum extent possible, the state's presence as a direct provider of mental health services.

Objective 4: Clearly define the state's role in (a) standards setting, (b) the provision of technical assistance, (c) statewide planning and data collection, and (d) monitoring the performance of the mental health system throughout the state.

Principle IV

For reasons of security, professional expertise, special physical plant requirements and the low Incidence of certain disorders, some mental health units such as the Minnesota Security Hospital should continue to serve the entire state as centralized programs.

1: Each special unit will have clear admission criteria and role and function statements.

2: The need and feasibility of an additional statewide adolescent MI unit or units will be determined.

Principle V

State mental health resources should be equitably distributed to all regions of the state.

Goal: Hospital catchments area and fund allocations will achieve equity between regions.

Principle VI

Any transition from the present state hospital system into a new configuration should be accomplished in a planned, orderly manner to minimize disruption to patients, staff, and communities.

Goal: Administrative mechanisms, guidelines and Incentives will he provided to all regions of the state in order to assure an effective local/state partnership and minimize the trauma of transition.

Principle VII

The planning and development of mental health services should stem directly from the identification of Individual treatment/rehabilitation needs of persons living in the catchments area.

Goal 1; Every patient/resident will have an Individualized treatment plan.

Goal 2: Every region of the state will complete a needs assessment for MI, MR, CD.

Goal 3: Treatment services will be developed and modified in accordance with aggregated data about specific needs of patients/residents in the catchments area as demonstrated through Individualized treatment plans.

Mental health programs in Minnesota and throughout the country face a major challenge in the months ahead. Federal and state budgets for social programs have already been reduced and will probably be cut further. Responsibility for planning and providing social services is being shifted to local governments with the expectation that these activities can be carried out more efficiently and effectively at that level. "Do more with less" is the hallmark of the times.

And it is becoming apparent that acceptable levels of essential mental health services cannot be maintained during this period of financial retrenchment without imaginative new approaches. That is why serious consideration must be given to a major change in the structure of the state's publicly-funded mental health system.

Minnesota's mental health programs can be significantly improved by integrating the state hospitals more closely into the county system.

V. EFFECTS OF PREVIOUS STATE HOSPITAL CLOSURES

During the past 25 years the following state hospitals or portions of state hospitals have been closed or transferred oat of the Department of Public Welfare;

. Sandstone State Hospital - closed 1959.

. Minnesota Residential Treatment Center, Lino Lakes - transferred to Corrections, 1970. . Owatonna State School - closed 1970. . Surgical Unit, Anoka State Hospital - closed 1971. . Gillette Children's Hospital - became a public corporation in 1973. . Tuberculosis Unit at Anoka - closed in 1971. . Minnesota Residential Treatment Unit, Anoka State Hospital - closed 1972. . Glen Lake Sanatorium - last provided service to tubercular patients in 1976.

. Lake Owasso Children's Home - turned over to Ramsey County in 1976. . Hastings State Hospital - closed 1978. . Rochester State Hospital - closed 1981.

The Department has been involved in closing two major state hospitals in the past five years (Hastings and Rochester). Plans and procedures have been developed and implemented to deal with the following activities and detailed records kept of those activities:

1. The relocation of those persons currently in treatment;
2. The relocation, re-employment, or severance of state hospital employees; and

3. The disposition of supplies, materials, and equipment, and procedures regarding fiscal matters and the disposition of records.

The Department of Administration has primary responsibility for disposition of the buildings and grounds of these facilities. The Governor has recently appointed a task, force to make recommendations concerning the use of the former Rochester State Hospital.

At the end of this section of the report is a memo summarizing the impact on staff of the closures of Hastings and Rochester State Hospitals (Attachment 1).

A one-year follow-up of employees affected by the Hastings closure was conducted by Gordon Olson, Ph.D., Chief of Psychology, Anoka State Hospital, during the period May, 1978 - May, 1979.[1] A summary of the results of this follow-up study is included at the end of this chapter (Attachment 2).

The Impact of previous state hospital closures on clients, counties, and the community is not so well-documented. In January, 1982, the Department of Public Welfare conducted a survey of counties in the area formerly served by Rochester State Hospital and ten other comparison counties. A summary of the results of that survey[2] may also be found at the end of this section (Attachment 3).

A report on the economic impact of the closing of Rochester State Hospital has also been completed, A summary of this report may also be found at the end of this section (Attachment 4).

In response to continued concern and questions about the impact of the Rochester closure, a more comprehensive impact study is now underway. This study will include interviews with former patients and their families, as well as with social service, court, law enforcement, mental health, and other relevant personnel. The study is being implemented by the Southeastern Health Systems Agency and should be completed by the fall of 1982.

[1]Gordon W. Olson. The Impact of Closure of Hastings (MN) State Hospital. Anoka, Minnesota: Anoka State Hospital, 1980.

2 Rochester State Hospital Impact Study: A Survey of County Social Service Agencies. St. Paul, Minnesota: Department of Public Welfare, 1982.

ATTACHMENT 1

of Public Welfare

Al Beck 6/22/82

Julie Chamberlin 7-2383
Assistant Personnel Director

Closure Impact on Staff - Hastings State Hospital and Rochester State Hospital (1)

The Department of Public Welfare has closed two state hospitals: Hastings State Hospital (HSH) and Rochester State Hospital (RSH). Since the Hastings Hospital was first to be closed, the process used and actions taken to effect the closure established some precedents, or a pattern, for any future closures. In both the HSH and RSH closures, there was considerable involvement of Central Office staff. The Personnel Services Office assumed primary responsibility for informing employees of options regarding continued employment, severance benefits, unemployment compensation, insurance and retirement rights and employment opportunities outside state government. Personnel staff also was delegated responsibility for and authority to place employees in jobs throughout the DPW system.

While there is marked similarity in the methods used in the RSH and RSH closures, there are also some notable differences. These differences can be attributed to the number of employees in each facility, the processes used to close out operations and release staff, the geographic locations of HSH and RSH, and the general economic conditions in the state.

On May 20, 1977, when the Minnesota Legislature directed the closure of HSH, there were 199 employees on the payroll. Forty-seven of these employees resigned prior to the actual closure. Placement of HSH employees was actually done in the last few weeks. In contrast, in Hay, 1981, when the Legislature directed the RSH be closed, there were 540 employees on the payroll. While the chemical dependency and surgical units were required to be closed by June 30, 1981, the remainder of the hospital's operations were gradually phased out. This meant a phase out of staff positions so that layoffs occurred on a regularly scheduled basis. The Department was able to identify vacant positions throughout the DPW system over an extended period of time, and reserve those positions for employees who wished to transfer. The HSH employees were transferred to Central Office and the

[1]Some of the figures in this memo have been updated based on the more recent Information in the final Rochester Closure Report.

State Hospitals and, if no vacancies existed, they were placed in over-complement positions. While HSH employees were given en absolute choice of transfer location, RSH employees were transferred to vacant complement positions. The extended time frame for locating vacancies in the system, enabled the Personnel staff to transfer employees to the first or second choice of location.

The decision to transfer RSH employees to existing complement vacancies and not to over-complement positions was baaed on economic considerations. The state's economic situation also adversely affected the ability of the Rochester community to absorb RSH employees into the work force. So while financial concerns do not seem to have been a major consideration in the Hastings closure, the state's financial problems definitely had an impact on the RSH closure.

The number of HSH employees was small enough so that each one was personally interviewed by Personnel staff and representatives of the several agencies. During the RSH closure, all employees were offered opportunities to interview with appropriate agency representatives but there was no absolute requirement established.

The geographic locations of the two hospitals had a definite impact on employees' decisions to transfer to other jobs in state service. Hastings is less than 25 miles from St. Paul. This makes it possible to commute on a daily basis with minimal inconvenience. Rochester is 85 miles from St. Paul and approximately 50 miles from Faribault. While there are some RSH employees commuting to Faribault State Hospital, the majority of employees who transferred were required to sell their homes and move to new communities. Many RSH employees could not afford to sustain this type of financial loss—in addition to the emotional stress of the closure and relocation.

One other difference of note is the difference of degree of Central Office involvement in the HSH and RSH closures. While the Central Office took the lead role in both closures, the involvement was less at RSH. The hospital's own personnel staff stayed until the hospital closed and carried a major share of the workload. At HSH there was no experienced personnel staff in place during the closure period. As a result, Central Office personnel staff carried the entire workload.

Brief descriptions of the personnel activities during the HSH and the RSH closures will further illustrate the similarities and differences in the approaches used.

Hastings State Hospital Closure

The Department began in July of 1977 to deal with personnel matters related to the closing of Hastings State Hospital. During that month, each employee was given a survey questionnaire to fill out and return. The questionnaire attempted to gain information from each staff member that would provide preliminary insight regarding who and how many were desirous of continuing in employment with the Depart-

meat of Public Welfare, continuing in employment with the State of Minnesota in departments other than Public Welfare, or taking the severance benefits as provided by law and terminating employment with the State of Minnesota. The results of this effort were not as illuminating as anticipated. It became apparent from this survey that there were too many issues remaining to be resolved for the employees to make concrete decisions regarding their futures. The attempt, however, did reveal a number of persons who definitely intended to sever their employment with the State of Minnesota, and there were few who indicated definite intent to relocate to other facilities operated by the Department of Public Welfare. These two figures remained reasonably consistent throughout subsequent employee surveys and Interviews.

During the period from July of 1977 until late in April, 1978, contacts with all members of Hastings State Hospital staff were many and varied. These contacts ranged from a meeting of the entire staff with a panel of representatives from the Department of Public Welfare, Department of Economic Security, and the Department of Personnel (this meeting was chaired by Commissioner Dirkswager), to individual interviews with each and every employee. Representatives from the Department of Public Welfare's Residential Services Bureau and Personnel Division, Department of Personnel, Department of Economic Security, Unemployment Compensation, Minnesota State Retirement System, Insurance Agency (Ochs) and the various Union Business Agents were made available to discuss with each employee the various options regarding continued employment, severance benefits, Insurance, retirement, rights, job opportunities outside of state government, and employment opportunities within the Department of Public Welfare. All Hastings State Hospital employees were given offers to continue in employment in the Department of Public Welfare system. All Hastings State Hospital employees were given an opportunity by the Department of Personnel to take advisory tests in other classifications, be referred to other state departments for employment, and be interviewed individually regarding his/her interest in continuing employment with the State of Minnesota.

A brief summary of the results of the 9 1/2 months of effort expended in attending to the personnel aspects of the closure activity is as follows:

1. A total of 199 persons were on the payroll roster of Hastings State Hospital during the period from May 20, 1977 through April 30, 1978.

2. The Department of Personnel interviewed 74 employees, gave 113 written examinations and 129 experience and training ratings to those 74 employees. In addition, 351 transfer cards were pre pared for 75 employees in 82 different classifications.

3. 152 Hastings State Hospital employees were formally offered jobs in the Department of Public Welfare.

4. 47 Hastings State Hospital employees were not offered jobs in the Department of Public Welfare because they resigned prior to a job offer being Made, had indicated definitely their wish to terminate their employment upon the closure of Hastings State Hospital or were on long-term disability leaves of absence.

5. 35 employees accepted continuing employment la the Department of Public Welfare either at state hospitals or in the Central Office.

6. 52 employees accepted employment in the Department of Veterans Affairs.

7. 5 employees accepted employment in other state departments.

8. 84 employees severed their employment and received all of the severance benefits provided by law.

9. 11 employees severed their employment but delayed their special severance benefits.

10. 12 employees resigned, were terminated, died or were on long-term disability leaves of absence prior to closure.

11. All employees who severed their employment with the State of Minnesota were referred to the Department of Economic Security Office in Hastings.

At the end of the year, the Department conducted a survey to ascertain the status of former HSH employees. The results of that survey are as follows:

112 Were employed
Veterans Home (48)
Other State Agencies (including DPW) (42)
Private Sector (22) 44 Lost contact with 8
Unemployed 23 Out of the work force 19
Retired 3 Deceased 1 In school

Rochester State Hospital

In June, 1981, the Minnesota Legislature directed the Department of Public Welfare to close Rochester State Hospital. The Surgical and Chemical Dependency Treatment Unite were to be closed by July 1, 1981 while the remainder of the hospital was to be closed no later than June 30, 1982. The Department's Personnel Services Office was given responsibility for providing services, assistance, and information to employees. In June, two half-day general information sessions were

held at RSH to inform employees of their options regarding continued employment with the state and the types of services/benefits available to them: unemployment compensation, job service assistance, continued insurance benefits, retirement, severance, and relocation cost reimbursement. The group sessions were chaired by the Deputy Commissioner, Wes Restad. Present were representatives from DPW Personnel Services, the Department of Employee Relations the Ochs Agency (insurance), Minnesota State Retirement, and the Department of Economic Security (unemployment compensation and job service). Participation in this first informational program was limited to staff in the Chemical Dependency Treatment and Surgical Units since those employees were scheduled for layoff June 30, 1981. Each employee was also given a survey questionnaire to fill out and return. The questionnaire was designed to provide basic information on employees' choices regarding severance or continued employment with the state.

In September, 1981, the Department repeated the informational program for the remainder of the RSH staff. Four general information sessions were held, followed by three days of individual employee conferences. Each employee was asked to fill out and return the standard questionnaire.

Over the period of one year, a variety of personnel services were provided to RSH employees. The Department of Employee Relations provided advisory testing for other job classifications. The DPW Personnel Services Office staff person spent one day each week at RSH, providing assistance to employees interested in transferring to other state service jobs and answering questions about the closure process. Personnel Services also prepared a qualified employee bulletin containing the names and brief resumes of 77 employees.

This bulletin was sent to every state agency and all major private sector employers in the Rochester area. The Rochester Post Bulletin newspaper printed the qualified employee bulletin, free of charge. Periodic surveys were taken to see if RSH employees needed, or wanted, assistance and/or information. Update bulletins containing the names and classifications of employees were periodically sent to other DPW state hospitals. The RSH Personnel Office staff remained with the hospital throughout the year. They took responsibility for all normal personnel activities as well, as scheduling employee layoffs and preparing status reports on personnel activities (layoffs, resignations, etc.). The RSH Personnel Director published a regular employee newsletter containing current Information on the closure.

A brief summary of the results of efforts expended in personnel activities is as follows:

1. A total of 538 employees were on the payroll as of June 1, 1982, the date the bill was signed by the Governor.

2. The Department of Employee Relations staff spent days conducting individual employee interviews, advisory tested 57 employees for a total of 327 different classifications.

3. 342 employees were laid off.

4. 67 employees resigned.

5. 3 employees were dismissed.

6. 2 employees died.

7. 17 employees retired (all took early retirement).

8. 83 employees accepted employment in the DPW Central Office and state hospital system.

9. 7 employees accepted employment with other state agencies.

10. 17 employees remain as a skeleton crew to maintain the facility until it is sold.

Since the "official" closure date for RSH is June 30, 1982, it is difficult to assess what impact the closure had on employees—and the actual personnel related coats of the closure. Any conclusions drawn at this time must be considered as tentative and any monetary cost figures as only estimates. The impact assessment cannot really be done for at least a year.

A preliminary calculation of costs related to the closure was done early in June, 1982. The sums listed below are close approximations of costs to date:

Miscellaneous	$ 13,350.02
Travel Status	5,115.04
Relocation Expenses	105,490.00
Severance	1,717,108.25
Vacation Paid Off	283,921.92
Deferred Severance (Unpaid)	(46,274.70)
Unemployment (through June, 1982)	515,708.47
Insurance (6 months coverage for em ployees on layoff)	9,251.21
TOTAL	$2,739,944.70

Actual costs for staff time and travel expense for DPW Central Office personnel staff and representatives of the other state agencies are not included in the sums listed above. Any calculation of these costs would have to include not only the time actually spent in Rochester but also the time spent in planning activities and meetings, development of materials (questionnaire, surveys, qualified employee bulletin, etc.), scoring advisory tests, contacting the DPW state

hospitals and other state agencies to identify job opportunities. The cost in time which would have been devoted to other projects and activities cannot be calculated and can never be recouped.

In the event of another hospital closure, the process used would be more similar to that of the RSH closure than HSH. If at all possible, the Department should keep the Personnel Office staff in place until the end. The hospital should require attendance at the general information sessions. Individual meetings, with representatives of the various agencies, should be optional, at the request of the employee. Completion of the initial questionnaire should be mandatory so as to provide early identification of those employees who want to continue working for the state. Many of the materials developed for the HSH and RSH closures should be modified and used again (questionnaires, survey forma, informational handouts). Contacts with the DPW Central Office and hospital system should be Initiated as early as possible, and should be followed up with regular updates of activities and names of available employees. Given the fact that this Department is expected to absorb all employees who are willing to transfer, it is important to have, in place, a system of monitoring vacancies. The circulation of qualified employee bulletins should be done at least quarterly. The response to the qualified employee bulletin published in the Post Bulletin leads to a recommendation that the Department pay for such advertising if such need arises in the future.

In summary, coat savings resulting from closure of state hospitals do not result for, at least, several years—If ever. Other types of less visible costs—lost staff time, former employees who never find re-employment, emotional stress on families required to relocate to other cities, can never be accurately measured.

JC/lw

ATTACHMENT 2

SUMMARY **OF PART** I, IMPACT OF CLOSURE ON EMPLOYEES

One hundred sixty-seven employees on hand at the time of closure of Hastings State Hospital were invited to complete a short questionnaire and to discuss their reactions to the closure; 74% responded. Their comments, both oral and written, expressed bitterness and anxiety related to legislative delay, closure mismanagement and confusion in personnel practices. Yet, it is noteworthy that no grievances were filed during this hectic period.

A one year follow-up survey located 76% and found 93% of those in the eligible work force to be employed, three fourths of them by the state. Comments in general indicated less job satisfaction than before, but there was far lees severe criticism of the closing process. While the plurality appears to have coped la varying degrees with the changes brought about by closure, the overall net economic and emotional effects on the employees tends to have been negative, much of which might have been obviated by better planning, communication and coordination.

From Gordon W. Olson. The Impact of Closure of Hastings (MN) State Hospital. Anoka, Minnesota: Anoka State Hospital, 1980

ATTACHMENT 3

Rochester State Hospital Closure Impact Study
Summary of Survey Results

Number of Clients Served: The survey showed that the number of clients accepted for service by the counties is increasing for the HI and CD programs but decreasing for MR programs. The increase in number of MI and CD cases is more rapid in the Rochester receiving area. The decrease in MR cases is lees substantial in the Rochester receiving area. Because sources of data were not standardized, great caution must be used in interpreting these results, however.

County Costs: County costs have increased in all categories except for CD costs in the comparison counties where there was a slight reduction in costs. For all programs the county costs had increased more in the old Rochester receiving area than they did in the comparison counties.

Clients Referred to State Hospitals: The CD data shows that the number of referrals increased for comparison counties and decreased in the Rochester counties. The MI data shows that the number of referrals increased in the Rochester area and decreased in comparison counties. MR referrals increased for both Rochester and comparison counties although the increase was more dramatic for Rochester counties. The survey results are difficult to interpret although the fact that the CD unit at Rochester ma already closed at the time of the survey while the MI and MR units were still open may have had an Impact on the results.

Clients Referred to Community Resources: The MR data shows that community referrals have increased slightly in Rochester area counties and decreased slightly in comparison counties. CD referrals have increased about 55% in both Rochester and comparison counties; MI referrals have increased more in the Rochester area counties than in the comparison counties. The data here seems to indicate that the closure of Rochester SH has resulted in greater number of referrals to community resources.

State Hospital Patient Days: The responses were too limited to draw conclusions from this information.

Costs for Community Resources: County costs for the use of community resources for HI and CD program increased substantially in Rochester counties with more moderate increases in the comparison counties. (CD cost increases were 89.9% in Rochester counties as compared to a 23.2% increase in costs for comparison counties). For MR programs the reduction in costs for community programs was much greater in comparison counties than for Rochester area counties. The data seems to indicate that the closure of a state hospital in one area of the state results in higher local costs for care in the community.

Local Transportation Costs: The costs for transporting CD clients to state hospitals from Rochester area counties has increased by 54% as compared to a decrease in costs for comparison counties. Transportation to CD community resources, on the other hand, has remained almost constant despite the increased use of community resources especially by the Rochester area counties. As noted below, transportation is one of the major problems identified by CD staff in the Rochester area. The number of responses to this question were too United on the MI portion of the survey to draw conclusions from the data. A number of MI staff did Identify transportation as a major concern in their written comments, however. The number of Rochester area counties responding to this item on the MR portion of the survey made analysis difficult. Responses from comparison counties indicate that MR transportation costs were substantially reduced for state hospital patients with only a slight increase in costs for transportation to community place-ment it should also be noted that Faribault State Hospital (serving the MR population) is closer to many of the counties in the old Rochester receiving area than St. Peter, the facility serving most of the Rochester area counties' MI and CD needs.

Problems and Service Needs Identified by the Rochester area Counties; Distance and transportation costs were identified on the MI and CD responses most often as a major concern of the Rochester area counties. MI staff also identified the lack, of space and more formal/legal admissions procedures as major problems. MR staff most often identified the lack of local services for low functioning clients or persons with behavior problems as major problems.

Conclusions and Recommendations

1. The counties' abilities to assess the impacts of the closure of Rochester State Hospital have been hampered by the lack of readily available and reliable information abut the client groups served by the state hospital system.

2. The Rochester catchment area counties' level of concern about the clo sure was dependent largely upon the number of placements the county needed to make in the state hospital system and the distance from the new state hospital now serving their area.

3. Closure of the state hospital appears to have increased the use of com munity resources and county costs for supporting these resources.

4. The distances of the new state hospitals from the former Rochester receiving area are causing a number of problems including increased transportation costs, the inability of staff to attend team meetings and participate in aftercare planning, reduced participation and visits by family members, inability to use the facility for crisis interven tion, and a reduction in voluntary admissions. DPW should carefully review county suggestions which could alleviate some of the problems being experienced.

5. There is some evidence, especially in the analysis of detox referral patterns, that the needs of some clients are not being adequately met. A follow-up study with specific clients should be considered in order to more adequately assess the extent of this problem.

From Rochester State Hospital Impact Study: A Survey of County Social Service Agencies. St. Paul, Minnesota, Department of Public Welfare, 1982.

ATTACHMENT 4

THE ECONOMIC IMPACT OF THE CLOSING OF ROCHESTER STATE HOSPITAL
OK THE CITY OF ROCHESTER AND THE REGION

When Rochester State Hospital closes its doors on June 30, 1982 over 500 jobs will be lost to the City of Rochester, and up to $7,314,000 in spending will be lost to Rochester businesses.

Based on a labor force of nearly 50,000 in Olmsted County, the loss of these jobs represents a permanent increase in unemployment of 1% unless new jobs are brought into the region. Even if the displaced employees find other jobs in the area, they will take jobs that could have been used to reduce the unemployment rate in the region or to expand the employment base.

The loss in spending will come from four sources: employee spending; institutional spending by RSH in the community; patient, family, and visitor spending; and volunteer spending and contributions. The breakdown of each of these elements is as follows:

Employee spending	$6,000,000
Institutional spending	765,000
Patient, Family, Visitor spending	488,000
Volunteer contributions and spending	61,000
Total	$7,314,000

The full budget for the hospital was estimated at about $12,000,000, with wages representing the bulk of the budget, $10,000,000, and $2,000,000 allocated for institutional purchases. To determine potential spending losses in Rochester, this amount was reduced by state matching for FICA, retirement matching, and unemployment insurance premiums; by employee deductions from wages of federal and state withholding taxes, union dues, retirement contributions, and life Insurance premiums; and by the amount of goods and services purchased outside the Rochester area by the hospital, yielding the reported figure of $7.3 million.

The full effect of the closing will not be felt Immediately by the Rochester business community because of gradual terminations, transfers by employees and unemployment benefits. As of December 1, 1981 of the 509 employees on staff in June, 1981, 232 have been terminated or have resigned, 59 have transferred (19 of whom have transferred to jobs that do not require relocation) and 218 remain working at RSH. Unemployment benefits are paid for either 26 or 39 weeks depending on the state unemployment rate at the time application is made. Benefits are equal to 50% of average weekly gross wages, up to a maximum of $177 per week. For many employees, unemployment benefits could be as much as two-thirds of their take home pay.

There will be a regional as well as local impact of the closing of the hospital. Employees reside in a seven county area of southeastern Minnesota. Of 492 employees for whom records were available at the time the data for this study was gathered, only 355 actually lived in the City of Rochester.

Olmsted County accounted for 413, while the remainder was distributed between Fillmore (18), Goodhue (9), Wabasha (26), Dodge (14), Winona (7), and Mower (5) counties.

The economic impact on job loss and spending would be lessened to the extent new jobs are introduced into the region.

From Mary E. Rieder. The Economic Impact of the Closing of Rochester State Hospital on the City of Rochester and the Region. Winona, Minnesota: Winona State University, 1982.

VI. THE IMPACT OF ADDITIONAL STATE HOSPITAL CLOSURES

One of the purposes of this report is to describe the impact that any additional state hospital closures would have on clients, staff, counties, and the community. In order to assess the impact of additional state hospital closures, the Chief Executive Officer of each hospital was asked to prepare a report describing what would happen if that facility were closed. These reports appear in Appendix A. The counties served by each state hospital were also given an opportunity to review drafts of these individual reports. Comments received from counties and other interested groups are included in Appendix C.

This approach was taken because it was felt that each CEO was in the beet position to describe the particular programs currently offered at hie facility, and also the relationship of that facility to the surrounding area and the rest of the state system. Thus, while these individual hospital reports vary somewhat in terms of style, length, organization, and approach, they should give the reader both detailed information on each hospital and its unique programs and information on the impact of closing that particular facility. Each CEO was asked to address the same factors in their individual reports, as shown in the outline in Table 8.

Table 8 Factors Addressed in Individual Hospital Reports

IMPACT OF ADDITIONAL STATE HOSPITAL CLOSURES

A. population Served (utilization by county)
B. Capacity Loot (where would current clients go?)
    1. Ability of rest of state hospital system to absorb clients
    2. Other community resources available for various types of clients
C. Impact on Clients
    1. Availability of Treatment
    2. Distances Involved (transportation problems/costs, effect on family participation)
    3. Commitments
    4. Other
D. Impact on Counties
    1. Transportation
    2. Participation in planning/aftercare
    3. Placement problems
    4. Commitments
    5. Costs

E. Impact on Staff

1. Relocation and Other Costs

2. Unemployment

F. Impact on Community

1. Services no longer available
2. State Hospital payroll
3. Estimated revenue lost to community

The individual hospital reports appear in the Appendix to this report. The reader is urged to refer to these reports for information on particular institutions and their catchment areas. This introduction will provide only a brief description of what the individual reports contain.

Each report describes the hospital, the geography and/or population of the catchment area, and some of the treatment options and services currently available. These factors indicate the general areas that would be affected by closure.

The services described would, of course, be dropped from the catchment area continuum of care in the event of a hospital closure. The reports discuss the number of hospital residents who would need to be placed elsewhere and the availability of alternative treatment resources in surrounding communities and the rest of the state hospital system. In some cases this would Involve considerable distances, a topic of concern both to clients and their families and to the county staff who participate in treatment planning and aftercare.

A frequent comment in the reports is that it is unlikely that the severely and profoundly mentally retarded could be placed in existing community programs. Other "hard to place" groups include the mentally retarded with behavior problems, the geriatric mentally ill, those in need of a security hospital setting (e.g., the mentally 111 and dangerous, sax offenders), adolescents with special treatment and/or security needs, and those with dual or multiple disabilities and handicaps (MI/MR/CD/physical).

The reports also cover several economic issues. In addition to loss to the local economy of the actual state hospital budget, the loss of jobs would contribute to area unemployment. In most cases the state hospital represents a considerable percentage of the area's work force and payroll. There is no single accepted formula to determine the economic effect of a large job loss on a community. Each hospital exists in a different economic climate, and the individual reports discuss this in terms of the effects of their hospital closure and the ability of the area job market to assimilate displaced employees.

These individual hospital reports, then, present a good deal of descriptive information about the hospital programs and receiving areas, as well as discussing a variety of closure impacts on clients, families, staff, and surrounding communities.

VII. SUMMARY AND RECOMMENDATIONS

This report has presented a great deal of information about Minnesota's current state hospital system; factors that must be considered in examining the role of state hospitals in general and for each disability group; the effects of previous state hospital closures; and the Impact that additional closures would have an clients, counties, staff, and the community. Perhaps of even more significance, this report has presented the Department of Public Welfare's plan for the future of state hospitals in Minnesota (Chapter IV).

Before additional state hospitals are closed, several questions should be asked: "Are there alternative mental health services available in the areas now served by the state hospitals?" "Is there a source of funding to pay for these alternative services?" "Are the alternative facilities {including the remaining state hospitals) within reasonable driving distances for patients, their families, and community agencies?"

Closure of another state hospital at this time will mean the loss of a major evaluation/treatment/rehabilitation resource to & sizable portion of the state, and a net reduction in mental health resources in the system as a whole. This would compound the present problem where there is not enough money to pay for needed services in both the state hospitals and the community.

In terms of specific recommendations, the Department recommends that no state hospitals be closed by the 1983 Legislature. Instead, it proposes that legislation be introduced which would establish governing boards for each state hospital. These governing boards would have authority and responsibility for allocating available state hospital funds either into hospital programs or alternative services in the community.

In the event that a further reduction in the total state hospital appropriation becomes unavoidable, it is recommended that the Governor and the Legislature pursue the option of cutting all eight institution budgets by a proportionate share of the total rather than closing another hospital. This approach would assure that all regions of the state would participate equally in the reduction of mental health services rather than penalizing one region while leaving services for the rest of the state essentially Intact. It is the Department's position that closure of a state hospital, because it is an important component of a region's continuum of mental health services, should be *a* matter of local/regional determination. It should be left to those groups to decide if they wish to continue a regional facility with reduced funding or close the hospital and divert the available resources elsewhere into community programs.

The Department is now in the process of drafting legislation for the 1983 legislative session to implement these recommendations. A copy of the proposed legislation appears in Appendix D.

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II. APPENDIX A - INDIVIDUAL **HOSPITAL REPORTS ON THE IMPACT OF ADDITIONAL CLOSURES**