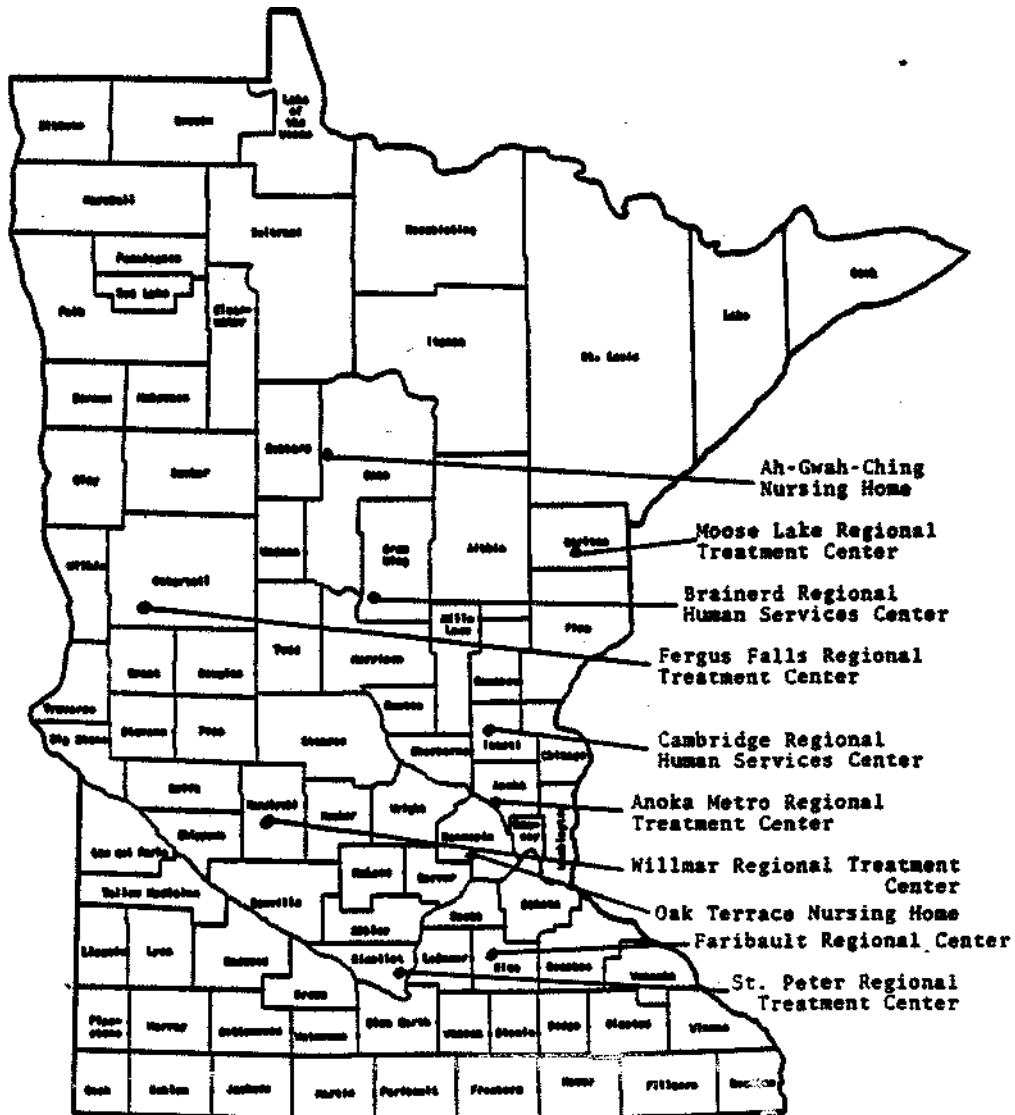


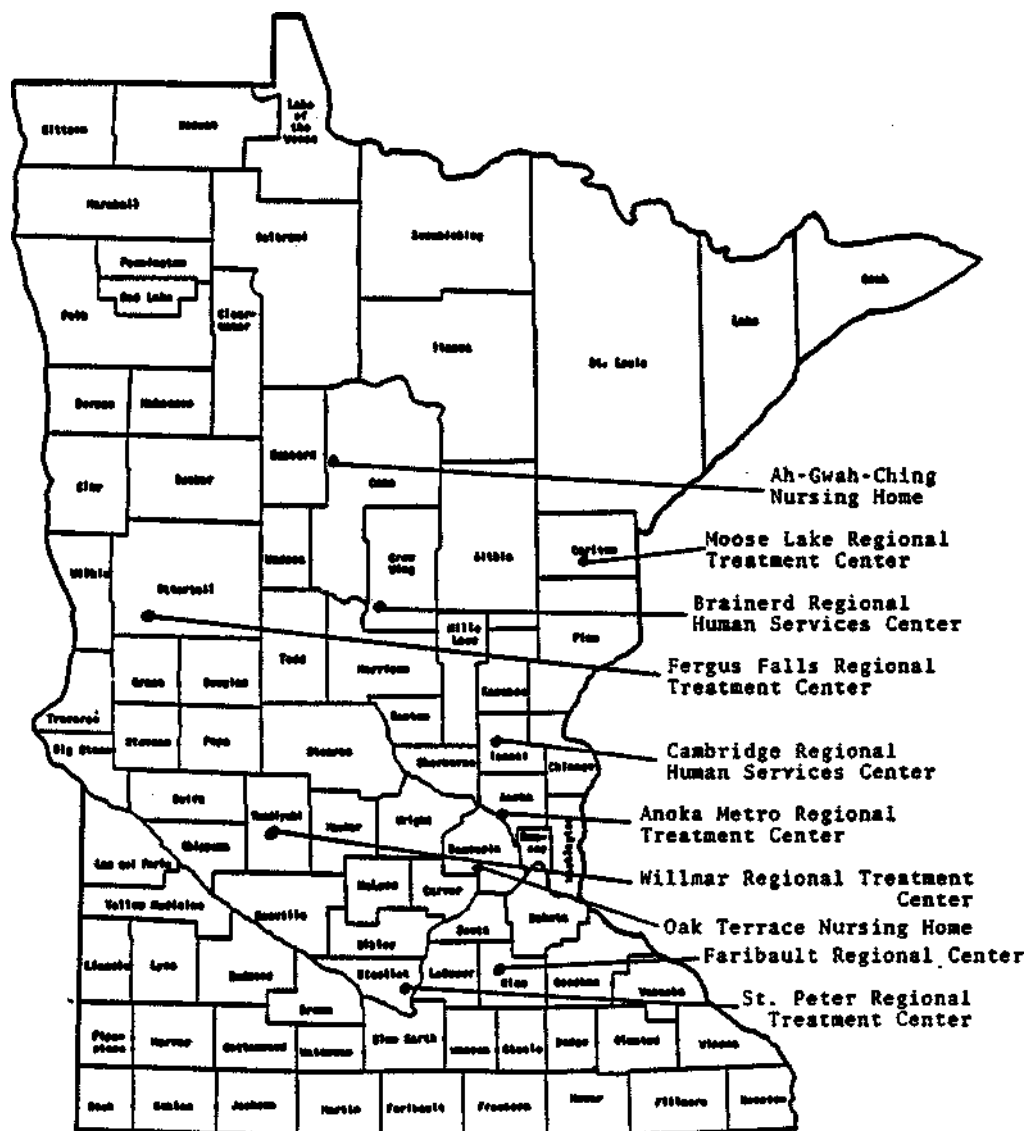
*REGIONAL TREATMENT CENTER
TASK FORCE*



*Report to the Health and Human Services Committee
of the Minnesota House of Representatives*

January 1989

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Peter Rodosovich, Chair.

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Research Department.

TABLE OF CONTENTS

Chapter	Title	Page
Forward	The Role of The Task Force	1
	Executive Summary	3
I	Regional Treatment Centers: Their History and Role	5
II	Evaluation of the System	9
III	Review of Individual Facilities	11
	• Ah-Gwah-Ching Nursing Home	13
	• Anoka-Metro Regional Treatment Center	15
	• Brainerd Regional Human Services Center	18
	• Cambridge Regional Human Services Center	20
	• Faribault Regional Center	22
	• Fergus Falls Regional Treatment Center	25
	• Moose Lake Regional Treatment Center	28
	• Oak Terrace Nursing Home	30
	• St. Peter Regional Treatment Center	31
	• St. Peter Security Hospital	33
	• Willmar Regional Treatment Center	34
IV	Community Services	37
V	Conclusions and Recommendations	41
Notes		45
Appendices	A: List of Abbreviations	49
	B: RTCs: Average Daily Populations	51
Resources		53

Forward

The Role of the Task Force

The Regional Treatment Center (RTC) Task Force is a task force of the Health and Human Services Committee of the Minnesota House of Representatives. Formed in the Spring of 1988, the goals of the task force are to examine Minnesota's system of RTCs and state nursing homes, become better informed about the system, and report to the committee on the role of the system in providing services to vulnerable populations in the future.

Chaired by Representative Peter Rodosovich, the task force included the following legislators: Representative Paul Anders Ogren, Chair of the Health and Human Services Committee; Representative Lee Greenfield, Chair of the Health and Human Services Division of the Appropriations Committee; Representative Tony Onnen; Representative Doug Swenson; Representative Steve Sviggum; Representative Kathleen Vellenga; and Representative Alan Welle.

The task force held the following meetings:

February 24, 1988	Discussion of organization and goals, planning for future meetings
June 20, 1988	Tour of Willmar RTC, Fergus Falls RTC, Ah-Gwah-Ching Nursing Home, and Brainerd RTC
June 21, 1988	Tour of Oak Terrace Nursing Home and Anoka-Metro RTC
July 18, 1988	Tour of Moose Lake RTC and Cambridge RTC
July 19, 1988	Tour of St. Peter RTC, Minnesota Security Hospital, and Faribault RTC
August 22, 1988	Discussion of tours, planning for tour of smaller community facilities
September 21, 1988	Tour of Dakota's Children, Shingle Creek Options, and Hammer Residence, meeting after tours
October 25, 1988	Discussion of tours and the care and treatment provided by each facility, planning for retreat to formulate final recommendations
December 8-9, 1988	Retreat at Afton House; review draft of task force report; develop recommendations to the committee

Executive Summary

Regional treatment centers are an integral part of the current system of providing services to vulnerable people in Minnesota. Developed to serve the needs of people who could not be served in their communities, they have been largely successful at fulfilling this mission. With the increasing development of community options, however, state policy makers continue to evaluate the role of the RTCs and consider a new mission for the future.

The task force has developed a number of recommendations which recognize both the importance of community integration of clients and the need for a regional presence within the service delivery system. These recommendations, which are developed more fully in Chapter V, are:

1. Regional treatment centers should continue to serve "residual* clients in a residential setting and to provide non-residential services to clients within the region.
2. Regional treatment centers should continue to provide crisis care and respite care.
3. Regional treatment centers should serve as focal points for training and education of people who work with vulnerable clients. They should provide consulting services to service providers and other agencies on a contractual basis.
4. A limited number of regional treatment centers should include secure facilities for the benefit of both clients and the community at large.
5. Planning for services should be done throughout the state at the regional level.
6. The best possible care should be provided to each client at the most reasonable cost to the client and to the state.
7. The legislature and the department of human services should be mindful of the need to develop additional community services and housing for people with mental illness.

The task force recognizes that any changes to the regional treatment centers have an impact that goes beyond the human services system itself. Changes in the RTC system will influence the lives of many state employees and their families, regional economic development, and land use in communities. While these and other issues will be of significance in making decisions about the RTCs, they are beyond the scope of this report.

Chapter I

Regional Treatment Centers: Their History and Role

Development of State Institutions

The first state hospital in Minnesota opened at St. Peter in 1866 to care for mentally ill people. In 1881, the first state school for mentally retarded people was established in Faribault. These hospitals were the response to a social reform movement linking the therapeutic concept of "asylum" with the good of society. Social reformers believed that in peaceful rural settings, people with mental illness and mental retardation would receive treatment and shelter from abuse and exploitation. At the same time, society would be protected from their sometimes threatening behaviors.¹

Minnesota's system of state hospitals expanded rapidly, with the opening of Fergus Falls in 1890, Anoka in 1900, Willmar in 1912, Cambridge in 1925, Moose Lake in 1938, and Brainerd in 1958.¹ The population of the hospitals peaked at 15,400 in 1960. Throughout these years, the state was the primary provider of services to people with mental disabilities.²

Deinstitutionalization and the Welsch Case

In the 1960's, however, a new group of social reformers argued for normalization: the idea that disabled people should live where they have the best opportunity to lead normal lives. Lives in institutions were not perceived as "normal," so people were moved from the state hospitals to community settings. This movement to the community is known as "deinstitutionalization". As a result of deinstitutionalization, the population of state hospitals fell from 15,400 to 8,400 by 1970.³

In 1972, state hospital residents followed the lead of other residents and advocates throughout the country by suing the state hospitals to accomplish reform. The suit was initiated by Patricia Welsch, a resident of the state hospital at Cambridge, and named all eight hospitals and the department of human services as defendants. The suit was certified as a class action on behalf of all people similarly situated. Throughout the litigation, the plaintiffs have been represented by Legal Advocacy for Developmentally Disabled Persons, a project of the Minneapolis Legal Aid Society.⁴

The Welsch case was precipitated largely by staff reductions in state hospitals. In 1977, the parties entered and the court approved a consent decree case focusing on institutional reform: improving the conditions and treatment at state institutions. When the case returned to court in 1980, litigation began to focus on reducing the population of state hospitals and fostering community services.⁵ A second consent decree was entered on September 15, 1980. This decree provided for reduction in the state hospital population from 2650 to 1850 by July 1, 1987; for specified staffing ratios, for procedures governing the use of major tranquilizers and certain behavior management practices, for discharge planning and evaluation, and for the appointment of a monitor to review compliance with the Decree.⁶

Rochester State Hospital, constructed between 1949 and 1961, was closed in 1982. The greatest impact of the Rochester closing was felt by people with mental illness (MI) while people with mental retardation (MR) were least affected by the changes. When Rochester closed, most MI clients were transferred to St. Peter; most MR clients were transferred to Faribault. Governor's Task Force on Use and Disposition of the Rochester State Hospital, Study and Recommendations, December 1982, pp. 22-24.

In 1987, prior to expiration of the court's jurisdiction over the case, the parties entered into another settlement agreement. This agreement, which remains in effect at the present time, includes the following terms:

1. No RTC will be licensed to serve children, defined as persons younger than 17 years of age. Children with mental retardation will be admitted to an RTC only in very limited circumstances.
2. The staff ratios agreed upon in the 1980 Consent Decree will be maintained at the RTCs.
3. The department will issue a report describing the training which it offered to various state and county staff people.
4. The department will issue summaries of efforts to improve physical therapy services and use of psychotropic medication in the RTCs. It will develop a protocol for monitoring side-effects of psychotropic medications.
5. The department will prepare a protocol for review of individual habilitation plans (IHPs) for persons in RTCs with special needs. It will evaluate community service needs of persons in RTCs with special needs.
6. The department will develop a protocol for review of an individual service plan for persons discharged from RTCs. The court order specifies requirements of the protocol.
7. For the period July 1, 1987, through June 30, 1989, either 100 people discharged or 25% of the total number discharged, whichever is less, must be people who are very physically handicapped, deaf, or have severe behavior problems.
8. The department will conduct field reviews of services to 250 people with mental retardation.
9. The department will issue a report of the adequacy of case management services.⁷

Other Forces for Deinstitutionalization

In February 1986, the Legislative Auditor reported on the deinstitutionalization of mentally retarded people. As part of the report, the auditor acknowledged the significance of the Welsch case in accomplishing changes in the care and treatment of people with mental retardation. At the same time, however, the auditor noted that the largest decline in state hospital populations came in the 7 years before Welsch was filed. He concluded that the case was only one of several forces which have changed state hospitals in the last 20 years. The 3 additional forces of importance are:

- the participation of state hospitals in the medical assistance (MA) program,
- the use of MA funds to develop community group homes, and
- the establishment of special education programs for mentally retarded children in local school districts.⁸

The availability of MA to pay for care to mentally retarded people in state hospitals begins with Congressional authorization in 1971. By 1975, all of Minnesota's state hospital programs were certified as ICFs-MR (intermediate care facilities for the mentally retarded) and were eligible for MA reimbursement. Because federal MA money was tied to measures of quality care, the state made substantial investments in upgrading hospital facilities and programs to ensure federal reimbursement.⁹

During the 1960s, several relatively large community facilities opened in St. Paul and other parts of the state. These community facilities served high-functioning persons, often from state hospitals, and made it possible for people to leave the hospitals and live in community settings. The new facilities also created options for mentally retarded people who might otherwise have entered state hospitals.¹⁰

The availability of MA fueled the development of community facilities. Between 1973 and 1980, an average of 30 new facilities opened each year. By March 1985, there were 337 community ICFs-MR with capacity for 5,180 people. In 1983, the legislature placed a moratorium on the development of community facilities with the intention of making additional money available for alternative home-and community-based services.¹¹

New opportunities for educational, developmental, and vocational programs in community settings have also affected state hospitals. In particular, development of special education programs to serve handicapped persons in their local school districts delayed or eliminated the need to admit some children to state hospitals. As the development of these programs enabled more children to stay with their families, the average age of admission to state hospitals steadily increased. In 1985, the average age of admission in Minnesota was 21.¹²

The Role of Regional Treatment Centers

The increasing availability of alternative services has raised questions about the role of the regional centers in the care and treatment of people with developmental disabilities. Certainly their role has changed over the years. Regional centers are no longer the only place for serving people with developmental disabilities. Nor are they the best place for serving people whose needs can be met in smaller facilities that are closer to home.

The regional treatment centers do, however, provide centralized locations for state-funded services that are not provided efficiently and economically by the private sector and/or cannot be provided in smaller settings dispersed throughout the state. Regional treatment centers meet a variety of significant needs by:

1. Insuring that services are available for the hard-to-serve client, such as people with developmental disabilities who are also medically fragile, those who exhibit extreme behavior problems, and those who are deaf.

2. Attracting professional staff to less populated areas of the state.

3. Offering training, consulting, and education services to staff at the centers and to people in the surrounding communities.

4. Providing both individuals and the community with needed security. A relatively small number of clients are committed as mentally ill and dangerous and/or are adjudicated through the criminal justice system. Because these individuals may pose a danger to the community or to themselves, they need to be isolated.

5. Coordinating services within a region.

6. Balancing quality care and reasonable cost.

7. Offering services to the larger community through the use of shared service agreements.

In any discussion of regional treatment centers, the paramount concern is the need of individual clients for appropriate care and treatment. No client should be placed in an RTC who can be better cared for in a community setting. RTCs are not warehouses for people. Their mission is not to keep people

employed or to insulate communities from the realities of vulnerability. They exist to serve a population whose needs cannot be met any better in any other place.

The role of RTCs is (1) to provide services to a fragile population, (2) to ensure that those services are available over time, and (3) to provide a base for services in the community. It is important for vulnerable people and their families and friends throughout Minnesota to know there is a central location where they can receive services, learn about community services, and find necessary training. It is important for the security of all people that the state exhibit its presence in a very visible way throughout the state.

Chapter II

Evaluation of the System

Minnesota's system of state regional centers and nursing homes offers a wide spectrum of services in number of very different settings. In order to develop its own impression and evaluation of the system, the task force made a preannounced visit to each RTC and state nursing home. Chapter III examines a variety of data about each facility and evaluates each in the light of the data and the site visit. This chapter explores advantages and disadvantages of the system as a whole.

Client Placement

RTCs accept residents not accepted by other facilities. This has long been viewed as one of the positive attributes of the state-operated facility. In most cases, members of the task force thought clients were appropriately served in the regional centers. There were some residents, however, who could have been placed in less restrictive facilities, had space been available.

Staff and Client Attitudes

One of the most positive aspects of RTC services as a whole is that they are caring services delivered by staff people who are interested in and respectful of the individuals they serve. In its site visits, the task force observed many staff people interacting with clients and difficult clients being served in a caring manner. The task force saw a large number of services being delivered, sometimes to a single client or two. Clients were relaxed and seemed comfortable in the settings.

There were a couple of places where clients did not seem to be involved with staff or with each other. Staff were disinterested and, in a couple of situations, patronizing.

Facilities and Atmosphere

In many RTCs the atmosphere is warm and comfortable. Rooms have been decorated to look as home-like as possible and to offer a stimulating environment in which to live and work. Most facilities have plenty of interior space for the number of activities they offer. In some places, the lack of air conditioning presented a serious concern for the health of clients and the comfort and morale of staff.

The grounds are often isolated from the communities. This can be positive, even necessary for certain clients. However, it is important to ensure some integration into the communities. With some facilities this integration was apparent; with Oak Terrace and Anoka especially, it was not.

Staffing

There is an apparent lack of direct care staff in some facilities. At the Cambridge facility, for example, members of the task force observed 8-10 people positioned on beds: there were not enough staff for individual care or interaction between staff and clients. This and other observations, in conjunction with anecdotal remarks about the number of people in management positions, raised a concern among task force members that there may be an inappropriate balance between management and direct care staff at some of the facilities.

Chapter III

Review of Individual Facilities

Each of the institutions reviewed by the task force has played a unique role in the delivery of services to vulnerable people in the state of Minnesota. Some institutions are unique in the programs they provide, others in their location or the populations they serve. This chapter of the report describes each of the individual facilities in the following ways:

1. Programs. What programs are offered and to whom?
2. History. How did this institution evolve over the course of time?
3. Staff. How many staff are employed at the facility?
4. DHS Proposal. What is DHS proposing for the future of the institution?
5. Task Force Evaluation. What observations did the task force make after visiting the facility?

Where additional information was available, there are also discussions of the physical plant (How large is the facility? How useful are the buildings?) and community comments on the future of the center. The institutions are presented in alphabetical order.

Ah-Gwah-Ching Nursing Home (AGC)

1. Programs¹³

- Nursing Care. 1987 Average Daily Population (ADP) - 320. AGC has 383 licensed beds, including 175 skilled beds, 168 intermediate beds, and 40 Rule 35 CD beds.

AGC provides services for the geriatric population and the chronic chemically dependent population of the entire state of Minnesota whose problem behavior makes them unacceptable in community nursing homes or other community facilities. Behavior problems include physical and verbal assaultiveness, sexually inappropriate behavior, socially inappropriate behavior, and chronic alcoholism.

2. History

AGC was a tuberculosis sanatorium from 1907 to 1962 at which time it was converted to a geriatric treatment center. The treatment center was established to provide maintenance care, supervision, and nursing care for residents of state hospitals who had stabilized but who could not return to the community. In FY86, 17% of the patients were admitted from regional centers, 28% from community nursing homes, 28% from the Veterans Administration, and 27% from other sources.¹⁴

3. Staff

According to the proposed biennial budget for 1987-89, 317 staff positions were funded in 1986. The estimated number for 1987 was 317, and 306 were requested for 1988.¹⁵

4. DHS Proposal¹⁶

The state should continue to provide residential care to mentally ill and elderly people who need nursing care and cannot be adequately served in the community because they (1) are medically fragile or clinically challenging and/or (2) exhibit severe or challenging behavior. In general, placements occur where no community alternative is available and are expected to last longer than 180 days.

There is no plan to expand the number of licensed nursing home beds operated by the state. However, some of the currently unoccupied but licensed bed capacity should be assigned to other regional centers for persons who are mentally ill but more appropriately placed in a bed licensed for nursing home care rather than in a bed licensed for hospital care.

Some increase in staff at AGC may be needed to provide active treatment to the nursing home residents who are mentally ill. This could be accomplished by maintaining the current staff level and relocating a small number of licensed beds.

DHS recommends continuing services to the elderly at AGC and relocating the CD program to Brainerd. Alternate service options include retaining the CD program at AGC and expanding technical assistance and outreach.

5. Task Force Evaluation

- **Positive.** Members of the task force were impressed with the enthusiastic staff and good, well-maintained facilities. The home seems to have good therapy programs where residents are very active. AGC is aesthetically the most pleasing of the state facilities. With its post office and other services, the home provides a sense of community despite its physical isolation from nearby areas.
- **Negative.** Members noted that buildings are generally well-maintained but that the basic structure is showing signs of age. The CD building in particular needs work.

Anoka-Metro Regional Treatment Center (AMRTC)

1. Programs

- **Mental Illness.** 1987 average daily population - 234.

AMRTC provides inpatient active psychiatric treatment of severely mentally ill people from **the** metro region, most of whom have been committed by the courts. Most MI patients have exhausted community hospital and outpatient program alternatives and are medically indigent.¹⁷

The MI program is licensed by DHS under Rule 36 and by the department of health (DOH) as a psychiatric hospital. The program consists of the following units:

- **Admissions Unit:** Providing intake, assessment, evaluation, treatment planning, and short-term treatment followed by transfer to the appropriate treatment unit.
- **Secure Intensive Care Unit:** Providing specialized treatment programming for patients requiring intensive care.
- **MI/CD:** Providing specialized programming for people with MI and CD.
- **Relationship:** Providing specialized programming for long-term chronically ill patients.
- **Gero-Psychiatric/Social Skills:** Providing specialized treatment¹ for elderly psychiatric patients and others who are vulnerable.
- **Behavior Modification Unit:** Providing specialized treatment for patients with specific behavior problems.
- **Step Level, Fairweather Unit:** Providing short-term step level treatment for patients who can be prepared for discharge within 3 to 6 months.¹⁸

- **Chemical Dependency.** 1987 average daily population - 80.

AMRTC programs facilitate the rehabilitation of people admitted for CD treatment by providing a structured therapeutic environment; diagnostic and overall needs; supportive health care services; group, individual and family conferences; education; appropriate referrals; aftercare planning and follow-up. The service area includes Anoka, Hennepin, Sherburne and Dakota counties.¹⁹

The CD programs are licensed by DHS under rule 35 and by DOH as a supervised living facility, Type B. The programs do not provide detoxification, which is a preadmission requirement. The primary treatment program averages approximately 30 days. Programming includes group and individual therapy, lectures and films, reading, and exposure to AA. groups. The extended treatment program is for people in the advanced stages of CD. Patients usually remain a minimum of 2 to 3 months. CD programs are segregated by gender on the belief that segregation by gender enhances the quality of treatment.

The Anoka facility was the fourth state hospital built in Minnesota and was first occupied in 1902. The population peaked at 1500 in 1954. Present population is about 300 patients although 96 additional patients were sent to other residential treatment centers in 1987 when MI beds were not available at Anoka.²¹

3. Physical Plant²²

There are 22 main structures and 9 small services structures on 2433 acres of land. Of the 22 main buildings, 14 were constructed from 1905-1918. The CD unit was built in 1980. 7 of the buildings contain licensed beds; all 7 are accessible to handicapped people. 4 of the patient buildings were constructed between 1912 and 1914.

95% of the property is zoned single family residential, and 5% is zoned multiple dwelling. Mixed zoning surrounds the building. The Anoka facility is located in the highest density area of the 8 state hospitals.

4. Staff

According to the proposed biennial budget for 1987-89, 419.2 staff positions were funded in 1986. The estimated number for 1987 was 419.2, and 381.6 were requested for 1988.

5. DHS Proposal²³

AMRTC is currently operating at or near 100 percent of capacity. This makes management difficult because (1) state facilities cannot refuse committed patients, (2) emergency admissions are frequently needed, and (3) persons with different needs or attributes affecting treatment may be inappropriately grouped.

Throughout the RTC system, physical plants are inadequate for treatment of the mentally ill according to contemporary standards. In many instances, buildings are not air-conditioned, are not accessible to the handicapped and others who have trouble with ambulation, do not facilitate staff interaction with patients, and do not facilitate use of space in accordance with contemporary treatment standards.

The location of current beds does not reflect the distribution of the population needing services. In relative terms, there are too few beds in the metro area. While there is some benefit to having centers located throughout the state, each facility must be large enough to maintain an adequate level of professional staff.

The Anoka facility is one of three facilities in "the worst condition". DHS recommends continuing services to the mentally ill and chemically dependent in a new metropolitan psychiatric hospital. Service options include service to the elderly. Critical issues are (1) need for a new physical plant and (2) location.

6. Statement of City of Anoka

The City of Anoka, through its City Manager and City Councilmember, has taken a position in favor of leaving the metropolitan MI/CD facility in Anoka. More specifically, the City states that:

- The State has a substantial capital investment in the Anoka facility, including a state-of-the-art CD facility. It is clear the MI facilities need substantial improvement in order to provide adequate care for residents.

- It is more economical to stay in Anoka at the present location than to relocate. Future operational costs will also be less expensive than at many other sites.
- The campus-like environment would not be easily duplicated anywhere in the metro area. This is a stable environment for CD and MI residents.
- The facility has community acceptance in Anoka.
- There is substantial integration with the Twin Cities medical community.
- Staff provide services to low-income residents of Anoka County on their own time on an out-patient basis.²⁴

7. Task Force Evaluation

- Positive. Task force members found many positive aspects to the Anoka facility, including the proximity of the institution to the metropolitan area and the degree of seclusion offered to residents who may be prone to violent behavior. The CD program offers a much-needed service for violent CD clients. The program, including the physical plant, is excellent. The secure intensive care unit is also in good physical condition.
- Negative. Overall, the residential facility is "terrible" with small hallways, cramped quarters, and other disadvantages. In addition, the relationship of the institution to the community is strained. One person described it as "cautious acceptance". Problems with the community may be a result of the difficult clientele served at the facility.

Brainerd Regional Human Services Center (BRHSC)

1. Programs

- Chemical Dependency. 1987 average daily population • 64. The CD program includes a culturally based treatment program for Native Americans.
- Mental Illness. 1987 average daily population - 65. The MI program serves a 12 county area.
- Developmental Disabilities. 1987 average daily population - 218 adults and 38 children. The DD program includes children at the Minnesota Learning Center, a 44-bed statewide residential treatment center for emotionally disturbed/behaviorally disordered adolescents (ages 8-17), as well as children in a 15-bed statewide residential program for deaf-blind children.
- Skilled nursing facility - 28 beds opened in 1989.²⁵

2. History

The Brainerd facility was opened in 1958 although the last building was not completed until 1967. At first, the entire campus was designed to serve developmentally disabled people in a 28-county region. The Minnesota Learning Center was established in 1970 and expanded in 1985 to serve all youngsters with behavior disorders, regardless of intellectual ability.²⁶

The CD and MI programs were added in 1971. The CD program includes a specialty unit for Native Americans. The MI program includes both acute and long-term programs as well as a locked ward.

The department of corrections is leasing a building at the Brainerd facility and purchasing professional and support services from the RTC.

3. Physical Plant²⁸

The Brainerd facility is the most recently constructed of the state RTCs. It includes 16 main structures and 7 small services structures on 198 acres of land. The general physical condition of the buildings is good to excellent. 11 of the buildings contain licensed beds.

The zoning is "public". The campus is surrounded by agricultural, rural residential, residential, and green space. Land south of the facility is zoned commercial.

4. Staff

According to the proposed biennial budget for 1987-89, 670.6 staff positions were funded in 1986. The estimated number for 1987 was 670.0, and 576.3 positions were requested for 1988.

5. DHS Proposal²⁹

DHS proposes to serve the mentally ill chemically dependent and elderly at the Brainerd facility; to serve the developmentally disabled through SOCS, day habilitation and training services; and to expand the nursing home. Service options include regional support services. Critical issues include capital, feasible management structure, renovation, and appropriate licensure.

DHS does not, in general, support treating children or adolescents in institutional settings but supports maintaining a small capacity for serving very troubled children with highly trained staff and intensive 24-hour care. These children have failed in many community programs for children and adolescents. DHS does not intend to expand the availability of this program. Future admissions will be limited to children age 12 and older. All children participate in a full education program at the RTC or in the local schools.

Facilities for treatment of people with mental illness are inadequate (See discussion of the Anoka facility).

Residential and habilitation services for persons with DD will be moved off campus by June 30, 1992.³⁰

6. Task Force Evaluation

- Positive. The task force found many positive aspects to the Brainerd facility and programs, including the Indian CD program which follows Indian customs and an energetic and enthusiastic staff. The laundry is a valuable shared service provided by the institution, and the heating system is very functional.
- Negative. The facility is stark and institutionalized, even though it is a newer facility. It is the opinion of the task force that the facility could be made more home-like without a large investment of money. The CD programs have problems competing with other programs.

Cambridge Regional Human Services Center (CRHSC)

1. Programs³¹

- Mental Retardation. 1987 average daily population - 371.

CRHSC serves developmentally disabled people from 9 counties: Mille Lacs, Kanabec, Pine, Sherburne, Isanti, Anoka, Chisago, Ramsey, and Washington. The Center provides a congregate living environment and conditions necessary to effectively train people in adaptive behaviors and independent living skills. Placement is based on vulnerability, age, intellectual level, social compatibility, maladaptive behaviors, and similarities of client needs. The following residential areas are available:

- McBroom - 96 licensed beds for male and female clients residing in 6 households. All are physically handicapped. The age range is 19-64 years. All clients are profoundly or severely retarded, cannot communicate, and need assistance to complete self-help skills. Most have major health problems.
- Boswell - 96 licensed beds for male and female clients residing in 6 households. All are severely or profoundly retarded. Some have multiple handicaps. All require 24-hour supervision.
- Ridgewood - 78 licensed beds. All are adults with severe or profound mental retardation. All are ambulatory but may have difficulty with barriers such as stairs. There is a wide range of self-help skills. All require 24-hour awake supervision.
- Building 11 - 72 licensed beds. Residents are between 24-60 years old and are from mildly to profoundly retarded. Most display maladaptive behaviors. All require 24-hour supervision.
- Dellwood North - 14 licensed beds. These clients have high levels of self-care skills, are independently mobile, and participate in the vocational activities offered by Rum River Ornamental Products and Services.
- SOCS. CRHSC has opened 3 SOCS homes since 1986, one in Braham and 2 in Ramsey County. The SOCS are funded through the MR waiver.

2. History

The Cambridge facility opened in 1925 as a colony for epileptics. By 1961, 2008 people were housed in 16 residential buildings. Since that time the population has steadily decreased because of the availability of local programs and a trend toward smaller, more home-like areas.³²

3. Physical Plant

Most buildings were constructed between 1925 and 1937 although over half of the total square footage was built after 1953. There are 26 main structures and 19 small service structures on 245 acres of land. Most buildings are in fair to good or good condition. 11 of the main buildings are used as residential facilities. The hospital is zoned professional/medical. Areas bordering the facility have mixed zoning.³³

4. Staff

According to the proposed biennial budget for 1987-89, 763.4 staff positions were funded in 1986. The estimated number for 1987 was 765.9, and 685.9 positions were requested for 1988. The staff allocation for 1989 was 678.86.³⁴

5. DHS Proposal

DHS proposes to stop providing residential services to DD clients at Cambridge. CRTC would provide day habilitation and training services. DD clients would live at SOCS. A service option is for the center to offer regional support offices. Alternative uses for the Cambridge facility are nursing homes, commercial activities (laundry, motor vehicle repair and maintenance), adaptive technologies, community/state educational system, housing, and corrections system. A critical issue is capital³⁵

Residential and habilitation services for persons with DD at Cambridge will be moved off-campus by June 30, 1992.³⁶

6. Task Force Evaluation

- Positive. The task force found better facilities than they had envisioned and better care of people than they had anticipated. Some students from the community college are living on campus in an exchange of services for housing. There is a good activity area. The program providing stimulation for hydroencephalics is a very positive service of the institution.
- Negative. The fact that Cambridge is a single diagnosis institution (DD) is a disadvantage. The size of the facility gives a feeling of isolation. There is less interaction with the community than is desirable.

Faribault Regional Center (FRC)

1. Programs³⁷

- Mental Retardation. 1987 average daily population - 590.

FRC provides specialized services for mentally retarded people who cannot currently be provided programs of care in the home and community, most often because of serious physical or health problems, or because of severely disruptive behavior. The FRC receiving district includes 13 counties: Hennepin, Dakota, Rice, Steele, Freeborn, Goodhue, Wabasha, Dodge, Olmsted, Winona, Mower, Fillmore, and Houston.

As of September 1988, 59% of the residents are profoundly retarded; 29% are severely retarded; and 11% are moderately or mildly retarded. A large number of the residents are also physically handicapped: 37% are non-ambulant, 51% suffer from seizure disorders, 12% are hearing impaired, 29% are visually impaired, and 58% exhibit behavior disorders. Of the licensed beds, 678 are ICF/MR beds; 35 are skilled nursing beds, and 35 are hospital beds.

- Each resident has an individual program plan, developed annually and reviewed monthly. The program plan is developed by an interdisciplinary team. The resident and his or her family and social worker participate in development of the program plan.

Eight residents participate in the Faribault School District's program for the trainable mentally retarded. FRC provides day habilitation services for the remaining residents. In the day program, residents develop skills associated with self-care, domestic living, social interaction, vocational skills, and other skills needed for community or independent living. The day program has a strong vocational emphasis and provides many work opportunities for clients.

2. History

The Faribault State Hospital was established in 1881 following a 2-year experimental program under the administration of the Minnesota Deaf School. Until the mid-1950's, it served the entire state. Population of the institution peaked at 3355 in 1955.³⁸ It is the second oldest state hospital in Minnesota.³⁹

3. Physical Plant

Faribault is the largest state hospital with 81 buildings on approximately 500 acres of land. Of 30 major buildings, 15 are used for residential services, 7 for training and habilitation, and 9 for administrative and support services. Over half of the buildings have been constructed since 1950. Of the 30 main buildings, 4 are dedicated to a specific function: food service, hospital, laundry, and power plant.⁴⁰

The physical condition of the older buildings is fair to good: the newer group is good to excellent. 15 buildings and a portion of the medical hospital are used directly as residential facilities. 7 of the residential facilities were built from 1917-1938. The others were built from 1947-1964.⁴¹

The zoning is high density residential. This code includes institutional, multiple family, community/residential care, dormitories, hospitals, and boarding care structures. The campus is surrounded by heavy industrial and open agricultural codes.⁴²

4. Staff

According to the proposed biennial budget for 1987-89, 1,064.2 staff positions were funded in 1986. The estimated number for 1987 was 1,052.2, and 969.7 were requested for 1988.

The FRC employs 1,089 individuals, including over 200 health and human services professionals and 530 health and program staff.⁴³

5. DHS Proposal⁴⁴

DHS initially proposed closing **FRC** altogether and moving the 520 residents to ICFs/MR and SOCS. More recently, DHS has proposed that the following services be available at the FRC:

- (i) 120 nursing home beds, up to 60 of which will be for people who are developmentally disabled and medically fragile.
- (ii) an additional 100 beds for people with developmental disabilities. These beds remain open through June 30, 1995.

In addition, DHS recognizes the interest of the Faribault community in siting a psychiatric facility at the RTC. The department is investigating the need for such services.

6. Community Proposal⁴⁵

The 1988 legislature authorized a community task force to recommend to the legislature expanded and alternative uses for the FRC. The 13 member task force presented its report to the legislature in November 1988. The report recommends that the FRC serve:

- A residual population of developmentally disabled clients. Residual clients are people with medical conditions and/or unstabilized behavioral conditions for whom an adequate and sufficiently concentrated medical, psychological, and/or therapeutic community network is not presently available. FRC would provide residential space, equipment, programs, and staff to serve 200 clients.
- A geriatric population. The FRC would expand its nursing home capacity by 100-125 beds to provide long term care to elderly people who are mentally ill, medically fragile, or clinically challenging.
- SOCS clients. FRC would develop and manage a network of licensed ICF-MR and waiver homes, each housing 6 people with developmental disabilities. Approximately 168-174 people would be served in 28-29 sites.
- Clients who need day programming. FRC would establish and administer day programs at 14 community-based sites, each location serving up to 16 clients.
- People with closed head injuries. FRC would develop (1) a 40-bed brain injury unit to treat people whose brain injuries have caused behavioral, cognitive, emotional, communicative, and mobility impairments, (2) an outpatient clinic for evaluating people with neurological and motor deficits, and (3) an adaptive equipment center program to design and make assistive devices for people with physical dysfunctions.
- People with mental illness. FRC would establish 2 20-bed units to provide comprehensive psychiatric inpatient and day treatment services for adults.

- The community through contractual agreements. FRC would make its professional expertise available to county social services agencies, providers of residential services, developmental achievement centers, and others through shared service or fee-for-service agreements.

7. Task Force Evaluation

- Positive. As a whole, the task force found the size of the facility to be a positive attribute inasmuch as it creates a sense of community. Members recognized, however, that the large size could be a disadvantage, especially because of the need for continual upkeep. Some of the buildings meet nursing home standards: this is an advantage for future planning.

Members commented on the excellent care provided to difficult populations, including medically fragile individuals and people who need nursing care. There is a good activity area and excellent interaction with the community. Shared services, such as the laundry, are also an advantage.

- Negative. The number of older buildings are a disadvantage, as is the fact that FRTC serves a single disability group.

Fergus Falls Regional Treatment Center (FFRTC)

1. Programs⁴⁶

- **Developmental Disabilities.** 1987 average daily population - 183. The FFRTC provides residential care, supervision, treatment and training services to mentally retarded clients. On June 30, 1987, the center was serving 175 clients, 123 of whom were profoundly retarded, 30 severely retarded, 12 moderately retarded, 7 mildly retarded and 3 with borderline retardation.

Developmentally disabled clients at the FFRTC have a variety of other disabilities. Of 158 clients, there are 60 on psychotropic medication, 16 visually impaired, 52 hearing impaired, 68 suffering seizures, 46 non-ambulant, and 41 with a dual diagnosis of MR/MI.

- **Mental Illness.** 1987 average daily population - 100. The MI unit admitted a total of 424 people in fiscal year 1987. The average daily census was 99. MI programs serve individuals in acute distress, those with dual diagnoses, and those who exhibit severe behavioral problems. The MI division emphasizes a holistic treatment approach which fosters development in all areas of the client's life ~ physical, psychological, social, spiritual, and emotional.

- **Chemical Dependency.** 1987 average daily population - 145. The Drug Dependency Rehabilitation Center of the FFRTC offers a full range of CD services for people who are chemically dependent and their families. The "New Life" outpatient program opened in March of 1987. "New Life" is the first outpatient CD program within a Minnesota regional treatment center. There were 1,513 CD admissions for fiscal year 1987.

- **Mental Health Resource and Training Center.** FFRTC serves as a mental health resource and training center, providing consultative and direct services to community agencies and individuals in response to client needs. The Drug Dependency Rehabilitation Center has entered into shared services agreements to provide CD services for Fergus Falls School District 544, Red River Serenity Manor Halfway House, and the Ortonville Family Treatment Center.

The Drug Center also provides a 53-week CD counselor training program. Students in the program earn credits through Moorhead State University or the Fergus Falls Community College.

2. History

Opened in July 1890, FFRTC is the third oldest service provider in the state residential facilities system. In 1969, the center became a multi-purpose treatment campus. In addition to its psychiatric program, treatment units were opened to help people with chemical dependency problems and to assist people with developmental disabilities. FFRTC has 565 licensed beds and is accredited by the Joint Commission on Accreditation of Hospitals. The receiving district for FFRTC includes the following counties: Kittson, Roseau, Marshall, Polk, Pennington, Red Lake, Norman, Mahnomen, Becker, Clay, Wilkin, Ottertail, Grant, Douglas, Traverse, Stevens, and Pope.⁴⁷

3. Physical Plant⁴⁸

FFRTC includes 40 main structures and 14 small service structures on 320.5 acres of land of which 164 acres are leased out as surplus farmland. 24 of the main buildings were constructed from 1890 to 1923, 4 were built in the early 1930's, and 12 between 1950 and 1964. Fergus Falls has the largest number of building constructed prior to 1930.

Of 27 buildings, 10 are rated poor, fair to poor, or fair. 5 are rated good to excellent or excellent. 11 buildings are used directly as residential facilities. 8 of these were built between 1890 and 1919. 10 of these do not comply with handicapped requirements. The hospital is zoned residential/agricultural. A variety of zoning codes surrounds the hospital, including heavy industrial, limited and service business, and multiple family residence.

4. Staff

According to the proposed biennial budget for 1987-89, 624.4 staff positions were funded in 1986. The estimated number for 1987 was 618.9, and 580.0 were requested for 1988.

5. DHS Proposal

DHS recommends that the FFRTC continue to serve mentally ill and chemically dependent people' on a re-capitalized campus. Service to the developmentally disabled population will be provided through SOCS, with day habilitation and training services made available at the center. Critical issues for FFRTC are the need for a new physical plant and a feasible management structure. The department proposal also comments that (1) the Fergus facility is one of 3 facilities most in need of recapitalization, and (2) none of the catchment areas as currently configured lends itself to combination with another, especially in regard to accessibility.⁴⁹

Residential and habilitation services for persons with DD will be moved off campus by June 30, 1992.⁵⁰

6. Coalition Response⁵¹

The Fergus Falls Regional Treatment Center Coalition supports legislation on the following policies:

- Residential Role-Family Option. Families should have the option to keep a client in residence at the RTC and served by programs in the RTC.
- True Regionalism-Decentralization-Unicameral Administration. The regional configuration must be maintained under a decentralized administration vesting in the CEO of each RTC general authority over the personnel and programs delivering services within the catchment area. The CEO would be responsible for all regional programs whether on-campus or community-based.
- Continued Role of State as Provider. Legislation must state that the state of Minnesota be a direct provider of services and must contain a geographic definition of a siting distance for SOCS from existing RTC campuses.
- Defined Residual Population. Legislation must provide a mechanism for achieving a meaningful definition of the residual population of developmentally disabled persons appropriate for care in the RTCs.
- Reject Timetable-Insure Community Readiness. Deinstitutionalization should be geared to the needs of residents and availability of community placements, not to a calendar-based fixed timetable.

7. Task Force Evaluation

- Positive. The location of the Fergus Falls facility is very important as there is a lack of alternative services in the region. Furthermore, the lack of other services and the size of the area served makes it necessary to serve all populations at the FFRTC. . Members found the

programs to be sound and the staff to be responsive and enthusiastic. They especially noted the crisis outpatient services.

- Negative. Although the buildings have been well-maintained, the out-dated design of the facility makes future use of the buildings very difficult.

Moose Lake Regional Treatment Center (MLRTC)

1. Programs⁵²

- **Developmental Disabilities.** 1987 average daily population - 89. The program for people with mental retardation utilizes a wide array of techniques directed toward carrying out an individualized program plan that has been developed for each resident. One of the primary objectives is to provide the most normalized environment possible with an emphasis on a broad range of learning experiences.
- **Mental Illness.** 1987 average daily population - 70. The center offers 2 programs. The Admission Program provides an initial assessment and evaluation and treat acute but generally short-term emotional disorders. The Life Adjustment Center helps individuals with chronic emotional disorders and those who may lack basic skills for leading a normal life in society.
- **Chemical Dependency.** 1987 average daily population - 150. The CD program concentrates on several categories of problems. The Acclimation Program deals with problems related to withdrawal from long or heavy use of chemicals. The Primary Treatment Program is intensive and short term, with the basic goal of helping the client deal with all chemicals in a responsible manner. The primary program is divided into 3 units, with placement depending on the degree of chronicity and involvement with the criminal justice system.

There is a Long Term Program for people with repeated treatment failures and a Family Life Program that provides residential treatment for client families and friends as well as a combination inpatient-outpatient program in conjunction with the Northland Mental Health Center.

There is also a CD program especially for women. Women are separated from men and from people in other programs for the initial phases of their treatment.

- **Psychogeriatric Program.** This program provides 2 distinct services to older clients. One unit treats geriatric CD clients and clients with short and long-term emotional disorders. The second unit treats clients with long-term emotional disorders with complicating medical-physical problems.

2. History

Moose Lake State Hospital opened in May 1938, with the center delivering primarily custodial care until the late 1950's and 1960's. At that time, chemotherapy made a more open hospital a reality and minimized the need for restrictive measures. The Moose Lake facility serves the northeastern part of the state, with the exact nature of the catchment area depending on the type of disability.

3. Physical Plant

MLRTC is the second most recent state hospital in Minnesota. There are 23 main structures and 7 small service structures on 175 acres of land. 10 buildings are used directly as residential facilities. The center is in good physical condition with no buildings listed as poor, fair to poor, or fair condition. The facility is zoned governmental or open. The area surrounding the facility is zoned park, light industrial and multiple dwelling.⁵⁴

4. Staff

According to the proposed biennial budget for 1987-89, 5233 staff positions were funded in 1986. The estimated number for 1987 was 530.3, and 5133 were requested for 1988.

5. DHS Proposal

Under the department's proposal, MLRTC would continue serving mentally ill and chemically dependent people on a recapitalized campus. People with developmental disabilities would be served through SOCS. The center would also offer day habilitation and training services. Critical issues for Moose Lake are the need for a new physical plant and a feasible management structure. The department proposal lists Moose Lake as one of 3 facilities most in need of recapitalization.

Residential and habilitation services for persons with DD will be moved off campus by June 30, 1991.⁵⁶

6. Coalition Response⁵⁷

The Coalition of Concerned Citizens for Moose Lake Regional Treatment Center has taken the following positions:

- Before reducing RTC services, there should be an open public policy development process.
- The Legislature should clearly delineate public policy relating to the role of the state in providing human health services by defining the role of the RTCs, the role of private and community-based providers, and assuring quality care.
- The practical needs of all concerned parties must be reconciled in developing and implementing new policies.
- DHS should plan how services will be provided, monitored, regulated, and funded and should identify its own role.
- The needs of citizens can best be served by a partnership among agencies, providers, RTCs, advocates, governmental units, and regulatory bodies.
- Taxpayers must be concerned about the quality of life for all people while at the same time recognizing the need for fiscal responsibility.

7. Task Force Evaluation

• Positive. The facilities were better than expected. Members do not see why DHS thinks the Moose Lake facility should be rebuilt. There is a good mix of clients, including women, people in all disability groups, seniors, and people with Alzheimers Disease. There is good integration with the community and good programming for mental health needs of the elderly.

The CD unit has a population similar to the population at Shakopee. Women in the program are segregated from others at the facility. They are then integrated into other programs after they have dealt with their chemical dependency problems. Members of the task force talked with women who felt they benefited greatly from this kind of program.

• Negative. This is one of the facilities where the ratio of middle management to direct care staff should be examined. See Chapter II for a more complete discussion of this issue.

Oak Terrace Nursing Home

1. Programs

- Nursing services for geriatric clients. OT is a 350 bed facility licensed by the Minnesota Department of Health and accredited by the Joint Commission on Accreditation of Hospitals, Long Term Care Division. It is also certified as a Medicare and Medicaid provider and is approved to receive Veterans Administration Contracts. OT provides rehabilitative treatment to adult clients who have behavior management disabilities. Because of their behavior problems, these clients are often denied admission to, or transferred from, community nursing homes and other facilities.⁵⁸

There are about 260 people at OT.⁵⁹

2. History

Oak Terrace Nursing Home was created by the State Legislature in 1961. Facilities are leased from Hennepin County for a period of 35 years, beginning January 1, 1962. The facility originally included the Glen Lake Sanatorium, which provided services for tuberculosis care until Spring 1976. The OT receiving area includes all of Minnesota.⁶⁰

3. Physical Plant

The plant is leased from Hennepin County, and some of the buildings are leased out to other organizations. The physical facility is very old and will be closed under the DHS plan. Because of the poor condition of the physical plant, admissions to OT have been curtailed. 61

4. Staff

According to the proposed biennial budget for 1987-89, 300.5 staff positions were funded in 1986. The estimated number for 1987 was 300.5, and 300.5 were requested for 1987.

5. DHS Proposal

DHS proposes relocating the capacity of OT to serve the elderly, some in affiliation with a new metropolitan psychiatric hospital. Critical issues for OT are the location of the facility and capital expenses.

It is recommended that OT be closed by 1992 and that the licensed beds be redistributed to other facilities operated by DHS. Nursing home capacity of 60 - 100 beds should remain in the metropolitan area. Small long-term care units may be operated at other regional centers if the screening of patients currently occupying hospital beds supports that change. Some Oak Terrace residents could be moved to these units.⁶²

6. Task Force Evaluation

- Positive. The proximity to the metropolitan area is an advantage of the Oak Terrace facility.
- Negative. The facility is so old and in such poor condition that good care is impossible. Employee morale is understandably low. The atmosphere throughout the facility is depressing. This facility is an example of institutional "warehousing".

St Peter Regional Treatment Center (SPRTC)

1. Programs

- Mental illness. 1987 average daily population - 158

The mental illness program is divided into 6 separate treatment units and housed in 4 buildings on the SPRTC campus. The program receives admissions from a 19-county area in southern Minnesota. The 6 units are:

- Shantz I East: General psychiatric acute admissions - 26 licensed beds. This unit is locked • and the program is designed for patients who require structure and supervision not available on an open unit because of acute psychosis, suicidal tendencies, and other disabilities.
 - Shantz I West: Diagnosis, treatment and discharge to the community - 34 licensed beds. This unit facilitates treatment of mental illness with the least amount of intrusion and restriction on the individual's life. This unit is also locked.
 - Shantz II West: Intensive Treatment Program for Sexual Aggressives (ITPSA), is a component of the Minnesota Security Hospital but is housed on the SPRTC campus.
 - Community South: Chronic mental illness in remission - 25 beds. Emphasis is on community placement and aftercare planning.
 - Community North: Activity and work oriented. Many of these patients work in occupational therapy, industrial therapy, or vocational rehabilitation jobs.
 - Pexton Independent Living Unit: Services to patients who continue to be dysfunctional in various psycho-social skills which are necessary in order for them to cope with community living.
 - Pexton Extended Care Unit: Psychogeriatric and functionally decompensated, physically handicapped persons. Most patients on this unit have difficulty with ambulation and/or sight and hearing.⁶³
- Chemical Dependency. 1987 average daily population - 54.

The Johnson CD program offers the following treatment programs:

- Primary Program. This 3-phase program focuses on acceptance of CD as a treatable disease, a family program, and steps 4 and 5 of the 12-step program and the beginning of aftercare.
- Outpatient Program. This program provides similar individualized services for those in need of intensive CD treatment but who are able to live in the community while in treatment.
- Hearing Impaired Program. This program offers comprehensive treatment for hearing impaired persons who are chemically dependent and their families.
- Extended Care: Relapse Prevention Program. This inpatient program is available to people who have been unable to maintain lasting sobriety.⁶⁴

The MI/CD division is accredited by the Joint Commission on Accreditation of Hospitals, licensed under DHS rules 35 and 36, and certified by the department of health and human services to receive Medicare and Medicaid.⁶⁵

- Developmental Disabilities. 1987 average daily population - 150.

The Minnesota Valley Social Adaptation Center is a state-operated residential facility serving the needs of mentally retarded people in south central Minnesota. The facility serves the counties of Blue Earth, Brown, Faribault, LeSueur, Martin, Nicollet, Waseca, Watonwan, Sibley, Scott, Carver, and the metropolitan counties. The function of the center is to provide a total living program that offers opportunities for individual development in ways that will add a dimension of independence to the daily living of the resident. The center offers a developmental continuum of training. The center can serve up to 170 residents at any time. These people are mentally retarded individuals who demonstrate a need for specialized programming that will enable them to return to a community setting.⁶⁶

2. History

The St. Peter State Hospital was opened in 1866 as the first state hospital for the treatment of people with mental illness. In 1911, the Minnesota Security Hospital was located on the St. Peter campus to house and treat mentally ill and dangerous men from the entire state. In 1967, the Minnesota Valley Social Adaptation Center was established for the mentally retarded. A unit for people with CD was established at St. Peter in 1970, and a state-wide hearing impaired unit for the mentally ill was opened in 1985.⁶⁷

3. Physical Plant⁶⁸

35 main structures and 8 small service structures are located on 743.6 acres of land of which 220 acres are leased out. Within the past 20 years, the facility has been transformed from the oldest to one of the newest facilities. The physical condition is generally excellent, except for a few older buildings and garages.

8 buildings are used directly as licensed bed facilities. All but 2 buildings meet requirements for the handicapped. The center is currently zoned residential multiple dwelling, as is the area surrounding the center.

4. Staff

According to the proposed biennial budget for 1987-98, 532.8 staff positions were funded for 1986. The estimated number for 1987 was 540.3, and 524.3 were requested for 1988.

5. DHS Proposal

DHS proposes that services to the mentally ill and chemically dependent populations continue to be provided at SPRTC. Services to the developmentally disabled population would be provided through SOCS, with the center providing day habilitation and training services. Critical issues are capital and feasible management structure.

6. Task Force Evaluation

- Positive. The new security facility is a positive addition to the institution.
- Negative. The atmosphere is not "homey". The buildings are tiled, which probably helps create this institutional feeling. The facility could be made more home-like without a large investment of money.

St Peter Security Hospital (Minnesota Security Hospital - MSH)

1. Programs.. 1987 average daily population - 222.TM

- The program provides court-ordered evaluations for competency to stand trial, the insanity defense, pre-sentence evaluations, and sex offender evaluation and treatment. Within the security hospital is a unit for up to 18 female patients.

The treatment center also has intensive treatment programs for aggressive patients and accepts transfers within the DHS from open regional centers for evaluation and treatment. The center supervises approximately 54 patients who are considered mentally ill and dangerous, or have graduated from the sex offender treatment program, or are serving time under the department of corrections but will return to the security hospital on indeterminate commitment status.

The program serves all 87 counties of Minnesota.

2. History

MSH was established in 1907 for the custody and care of the criminally insane. In 1931, the first free-standing MSH was erected. It was occupied until 1982 when a newly constructed facility was occupied.⁷¹

3. Physical Plant

MSH is new and is in excellent condition. The facility is the only complete security building on any of the 8 existing state hospital grounds. There are no other comparable buildings capable of housing court-determined security persons without major renovation costs.⁷²

4. Staff

According to the proposed biennial budget for 1987-89, 210 staff positions were funded in 1986. The same number was estimated in 1987 and requested for 1988.

5. DHS Proposal

DHS has no proposal for the MSH.

6. Task Force Evaluation

- Positive. The security hospital is a fine example of a modern secured facility.
- Negative. While not specifically a negative comment, any overview of the MSH raises the question of the psychopathic personality. There are no known cures for the psychopathic personality. For that and other reasons, it is not clear whether psychopaths belong in a treatment center or a correctional institution. While the task force recognizes this dilemma and the need of the state to develop a policy on the care and treatment of psychopaths, the issue is beyond the scope of this document.

Willmar Regional Treatment Center (WRTC)

1. Programs⁷³

- **Mental Health.** 1987 average daily population - 250.

A total psychiatric program is offered to all residents including diagnosis and services and other therapies as indicated. It is expected that all residents admitted to the treatment center will return to their home communities within a relatively short period of time. Care and treatment are provided in an open setting employing as many of the current treatment techniques as are feasible.

- **Chemical Dependency.** 1987 average daily population - 90

The CD facility includes 90 beds for primary treatment and 28 beds for extended care treatment. The program also serves persons who are heroin addicts or on methadone withdrawal on a statewide basis.

- **Adolescent Treatment.** 1987 average daily population - 40.

The adolescent treatment unit is a statewide psychiatric inpatient unit serving psychiatrically and behaviorally disturbed youth between the ages of 12 and 17. The unit includes a specialized segment called the Protective Component Unit, started in 1979 to provide treatment services to a small group of male adolescents requiring a secure setting. There are 36 licensed beds in the open unit, 20 for boys and 16 for girls. There are 6 licensed beds in the protective unit.

The adolescent unit school program is provided by the Willmar Public Schools and is designed to be an integral part of the treatment process.

- **Skilled Nursing and Rehabilitation Unit**

This unit provides a high level of nursing care to residents with debilitating physical and psychological conditions. It also provides skilled care to residents on a short-term basis until they are able to return to their designated program at the center or placement in a community facility.

- **Geriatric Rehabilitation.** Two 25-bed units.

These units provide rehabilitative treatment for mentally ill, behavioral/functionally impaired elderly clients who cannot be adequately treated in a community facility.

- **Developmental Disabilities.** 1987 average daily population - 102.

Glacial Ridge Training Center is the focal point for the delivery of essential services to mentally retarded people and their families in southwestern Minnesota. Services include short- and long-term residency, intensive training programs on an intervention basis, family education, TMR (trainable mentally retarded) school programs, and adult work activities.

2. History

WRTC was established in 1907 for the care and treatment of "inebriates" and received its first patient in 1912. In 1917 the program was expanded to serve people with mental illness. In 1951 the center was assigned a receiving district for referral of MI clients from 17 southwestern counties of Minnesota. The center continues to receive MI clients from 23 counties.

3. Physical Plant⁷⁵

Willmar State Hospital was the sixth state hospital in Minnesota. The institution has 39 main structures and 10 small services structures on 158 acres of land. Most of the buildings were constructed from 1912-1933 and are in good physical condition. The remainder were constructed from 1948-1979 and are in good to excellent condition. The activities building was constructed in 1982.

15 buildings are used directly as residential facilities. 9 of these do not fully comply with handicapped requirements although programs and activities are accessible to the handicapped. The institution is zoned as a governmental and institutional district. It is surrounded by agricultural land, heavy residential density, duplexes and single family homes, and a lake.

4. Staff

According to the proposed biennial budget for 1987-89, 677.6 positions were funded in 1986. The estimated number for 1987 was 678.6, and 647.1 positions were requested for 1988.

5. DHS Proposal⁷⁶

Under the DHS proposal, the Willmar facility would continue to serve people with mental illness and chemical dependency. It would serve people with developmental disabilities through SOCS and would provide day habitation and training services. A service option for Willmar is to provide regional support services. Critical issues are capital and a feasible management structure.

The DHS proposal also notes that 47 beds at Willmar are currently used for children and adolescents, ages 12-17. These children have the following characteristics:

- a. Unlikely to be safely maintained in community-based treatment settings.
- b. Aggressive and dangerous, including those who have committed crimes.
- c. Self-abusive and self-destructive.
- d. Borderline intellectual ability in combination with dangerous behavior.
- e. Emotionally disturbed in combination with chemical dependency.

DHS does not favor long-term congregate care for children or adolescents but recognizes a need for a small capacity for serving very troubled children who have no other options.

6. Community Position⁷⁷

The WRTC Regional Task Force is a coalition of counties with formally appointed representation from county boards and family service directors of counties in southwestern Minnesota. Organized expressly for the purpose of providing input into the state negotiations process, the task force supports a plan which meets the needs of patients.

In general, the DHS plan reflects task force perceptions of the future role of RTCs. The task force accepts without change the DHS proposals for the mentally ill and chemically dependent. The task force also supports:

- A Regional Board of Advisors to work with WRTC to provide ongoing input into the regional availability of services. The Board would include representatives of county government, social services departments, regional mental health centers, the legal system and private care providers.**
- Access by counties, mental health centers, and private care providers to WRTC professional resources of training and consultation. The task force identified the following outreach services: professional consultation, training, outpatient treatment, support services, aftercare, crisis management, assessment and evaluation, technical assistance, and research.**
- Residential capacity for short term emergency and crisis care for people with developmental disabilities as well as SOCS and day programming for the same population.**
- Increased capacity for the WRTC adolescent unit (not necessarily on campus), an increase in the number of secure beds on-campus in the Protective Component, and off-campus evaluation and treatment of seriously disturbed pre-teens in cooperation with other community resources.**

7. Task Force Evaluation

- Positive. The task force noted the creative use of buildings. This was the least "institutional" setting visited by the group: the physical plant was aesthetically pleasing. Willmar RTC maintains a significant regional presence. The heroin program is an important service offered at the facility.**
- Negative. The campus has some older buildings that detract from the overall facility.**

Chapter IV

Community Services

Community services have developed throughout the state in order to serve vulnerable people closer to their own homes and in more home-like settings. Services available include both residential and non-residential services. Residential services are more or less restrictive, depending on the needs of the client. Non-residential services include outpatient services, day treatment, training and work activities, and other services.

As more people move from treatment centers to the community, it is important to insure that services • are available where they are needed. This chapter of the report explores the types of facilities and services that are being developed. It does not evaluate or quantify the services that are now available.

Services for people with developmental disabilities.

The service system for people with developmental disabilities is more advanced than the systems for mentally ill and chemically dependent people. The system includes a variety of residential facilities as well as a number of day services. A partial list of such services includes the following:

- ICFs-MR (Intermediate Care Facilities for the Mentally Retarded)

Community ICFs-MR began opening in the early 1970's as a response to the deinstitutionalization movement. Unfortunately, ICFs often grew to be as large as the facilities they were replacing. As a result, they are quite institutional settings themselves.

Because of the proliferation of ICFs and the inability of most facilities to create a smaller, home-like atmosphere, the 1983 Legislature imposed a moratorium on further development of such facilities. The number of people with developmental disabilities who live in ICFs continues to exceed the number in any other type of residential facility. In 1987, 4,954 people were served in ICFs-MR; in 1988 (projected), 4,754; and in 1989 (projected) 4,554.⁷⁸

- SILS (Semi-Independent Living Services)

The purposes of SILS are (1) to train people for living independently or maintain them in a semi-independent living arrangement, and (2) to enable people currently residing or at risk of placement into ICFs-MR to be placed into more independent living and service settings. SILS services can be provided in a client's own home, apartment, or rooming house. In 1986 and 1987, 880 people were served by the SILS program.⁷⁹ 1,057 people are now receiving services.⁸⁰

- MR Family Subsidy

The family subsidy program is available for families who need financial assistance in order to keep their developmentally disabled children at home. 374 families receive the family subsidy.⁸¹

- MR Waivered Services

In 1983 the Minnesota Legislature authorized DHS to apply for a waiver from federal regulations to use MA for certain home- and community-based services for mentally retarded people. These services are alternatives to RTCs and ICFs-MR.

The waiver is used to fund supported living arrangements, including supervised apartments for one to four people; foster homes for children and adults; and group homes for 5 or 6 people. Approximately 1,600 people currently receive waived services.

- **DACs**

Developmental achievement centers for children and day activity centers for adults are day habilitation services which provide training and activities for people with mental retardation. DACs are generally available to people living in ICFs/MR and are reimbursed through the medical assistance (MA) program.

- **Supported Work**

Supported work offers disabled people an opportunity to work in one of a variety of settings, many of which are "normal" working environments. Supported work programs are operated by the department of jobs and training. Although they receive some federal and state funding, they are not reimbursed by MA.

Services for People with Mental Illness

In 1987, the legislature passed a comprehensive mental health services act, the goal of which is to provide a state-wide continuum of services to people with mental illness. The continuum includes case management, community support services, prevention and education, residential services, day treatment services, and outpatient services. The mental health system is being implemented in counties throughout the state but is not completely in place at this time.

Because the system is only now emerging and because communities vary considerably in their ability to offer a continuum of services to people with mental illness, it is difficult to provide an exhaustive list of services. The following programs are generally available:

- **Residential.**

DHS requires that any facility housing 5 or more people with mental illness be licensed under rules of the department (Rule 36). People with mental illness who are living in group facilities in the community will generally be living in "Rule 36 facilities" which provide programming and supervision in addition to room and board.

The task force believes that the residential needs of people with mental illness continue to be one of the central problems confronting the system. Some clients are living in group facilities licensed by the department of health. Under legislation passed in 1987, however, these facilities will need DHS licensure (which requires programming) by July 1989. Other clients are living independently but are not receiving services necessary for their continued mental health.

The task force is also concerned that, under the DHS plan of July 1988, clients with mental illness would be served in the institutions while those with mental retardation would be moved out. There are a number of policy questions that should be addressed in this regard. The unfortunate result of these recommendations is that community housing may be developed for people with mental retardation but not for people with mental illness.

- **Non-residential Services.**

These services include day treatment, case management, education and prevention, and outpatient services. In order for deinstitutionalization to be successful, the full continuum of these services

must be available state-wide. It is not the purpose of this paper to review implementation of the services act. The task force hopes, however, that the act will be fully implemented so that people with mental illness can live successfully in their own communities.

Services for People with Chemical Dependency

Because of the recent implementation of the CD revolving fund, the system of services to people with CD is changing dramatically. There is very little conflict about the appropriate balance of RTC and community services to people with CD. For these reasons, this paper will not discuss community CD services in any detail

DHS does license outpatient CD treatment as well as facilities and programs for people who are chemically dependent. The availability of these programs varies among communities throughout the state. The task force is hopeful that services provided through the revolving fund will be adequate to serve client needs.

Chapter V

Conclusions and Recommendations

Background

Although the role of the state institution has changed over the years, it is clear that the regional centers and state nursing homes currently play a key role in providing services to vulnerable persons throughout the state. The job of the task force, and ultimately the legislature, is to define the appropriate role for the institutions in the service system of the future.

In examining this issue, the task force recognized three important but very different characteristics of the institutions: (1) They are state-operated: that is, they assume a role for the state in providing services. (2) They are institutional: that is, they offer services in a large group setting. (3) They are regional: that is, they provide services to an area that is larger than a single county or municipality but smaller than the entire state.

The task force then reviewed current needs served by the facilities and asked the following questions: (1) To what extent should the state continue to perform this function? (2) To what extent should this function be performed in an institutional, or centralized, manner? (3) To what extent should this function be performed on a regional, rather than an individual or state-wide basis?

This chapter of the report summarizes the results of that inquiry. The task force did not reach conclusions or recommendations on each issue under consideration. Where conclusions and recommendations were reached, however, they are presented here.

Conclusions and Recommendations

It is the role of the state to insure that a complete system of services is available to vulnerable clients as needed throughout the state. The system must be focused on the clients themselves and must be prepared, when necessary or desirable, to offer direct services. In order to maintain quality services, the system must attract professionals to areas where services are delivered. The system must act as a training and education resource for communities in which clients are served. The system must provide security to the community-at-large and to clients within the system. Services offered through the system must be coordinated and must be available at the most reasonable cost. Each of these important features of the system is discussed in this chapter of the report.

1. Clients

The task force recommends that regional treatment centers continue to serve "residual" clients in a residential setting and to provide non-residential services to clients within the region.

The state has a responsibility to see that all clients are appropriately served. When the private sector does not fulfill this function, the state must be prepared to provide direct services. All decisions about how and where to serve clients must be directed by the best interests of the client. Each person should be served in the least isolated and most integrated setting that can serve the person's needs without endangering his/her health and well-being.

Over the past several years, many clients have been moved from RTCs to community settings. The task force supports the idea that clients should be served as close to home as possible and in a setting that is as home-like as possible. The task force further supports the movement of additional clients to

community settings as long as an appropriate setting is available and the client can be better served in the community.

The task force believes, however, that:

- Client moves should be dictated by the needs of the individual client and not by arbitrary quotas or timelines.
- There may be clients in the RTCs with medical conditions and/or unstabilized behavioral conditions for whom an adequate community network is not available. RTCs should continue to provide residential care and services to this "residual" population.
- The cost of placement is a factor to be considered when moving a client. While it is important to place each client in the least restrictive environment possible, the task force does not see this as a goal to be achieved at all costs.

Clients and their families should be served in locations reasonably close to their own homes. For this reason services must be available on a regional basis. It is impractical to think that each specialized service can be made available to clients at every location throughout the state. At the same time, clients are not well-served if services are available at only one or two locations in the state. The most effective and efficient way to ensure that all services are available where they are needed is for the services to be available on a regional basis.

2. Services

The task force recommends that, in addition to residual care, RTCs continue to provide crisis care and respite care.

Crisis care is care that is available in order to meet emergency situations efficiently and appropriately. The purpose of respite care is to relieve people who are caring for others on a regular basis. The state must insure that these specialized services are available.

Crisis care must be available in order to protect the vulnerable person from immediate harm or deterioration of his/her condition. Crisis care is also important for protection of the community. The importance of respite care is growing as more families care for vulnerable people in their own homes. If a system of home- and community-based services is to be successful, the primary caretakers must be assured of relief from their exhausting duties.

The nature of specialized services means that the client basis is uncertain and difficult to determine. At the same time, however, the services must be accessible to large numbers of people. For these reasons, RTCs are ideal settings for these services. Community facilities may be able to offer respite care. The task force supports such services where feasible.

3. Staff

The state must insure that professional services are available at the point of service delivery. If services are to be available in regions, staff must be available on a regional basis. It is thus necessary to consider ways of attracting high-quality professional staff to non-metropolitan areas of the state.

The task force believes that staff will be attracted to places that offer professional challenge, peer support, variety in work assignments, staff training, and opportunity for advancement. There is a "critical mass" of staff and services necessary to attract professional workers. This critical mass can be achieved by regional centers more easily than by smaller facilities.

4. Training, Education, and Sharing of Resources

The task force recommends that regional treatment centers serve as a focal point for training and education of people who work with vulnerable clients. They should provide consulting services to providers and other agencies on a contractual basis.

As part of its responsibility to insure that high-quality services are available to all clients, it is appropriate for the state to assume a role in staff training. In many areas, state staff are the only people who are trained to work with certain clients. It is very important that this reservoir of skill not be lost to the service system. The state can train staff who work directly with clients in private or state-operated settings. State staff can also act as consultants to others providing direct services. These services can be offered on a shared service or fee-for-service basis.

5. Security

The task force recommends that a limited number of RTCs include secure facilities for the benefit of both clients and the community-at-large.

The state has a responsibility to protect all its citizens. Many people who are developmentally disabled and others who are mentally ill or chemically dependent need protection from the larger community. An example is the group of women at Moose Lake who seek isolation as part of their treatment program. In other situations, the community must feel protected from people who are mentally ill and dangerous.

It is appropriate that the service system include at least one facility where people can be locked up. Because this population is limited, however, lockup capability does not need to be available in all regions. The task force suggests that the state continue to maintain at least one, and perhaps two or three, facilities where people can be locked up if necessary for the protection of themselves and/or the community.

6. Regional coordination of services.

The task force recommends that planning for services be done throughout the state at the regional level.

The state must insure that services are coordinated so that vulnerable people are well served and the system operates efficiently. Services should be coordinated at the regional level so that local communities can be involved in service planning and delivery. The best way to accomplish this goal is for each region to develop a regional planning committee that includes clients, providers, and government representatives. The committee can determine what is needed in the region and can develop ways to coordinate services within the region.

Regional planning committees can be very effective in planning the future of the treatment centers. They can assess the need for community homes, assist in siting and developing the homes, and track the movement of clients from the RTCs to the community.

7. Balance

The task force recommends that the best care be provided at the most reasonable cost to the client and to the state.

Reality demands that services be provided at the most reasonable cost consistent with quality care. Goals for each vulnerable population may differ from one another. In some situations, the goal is to improve functioning; in others, the goal may be to maintain the person comfortably. Appropriate goals should be considered when deciding on the optimum level of treatment for an individual client.

8. Mental Illness

The task force recommends that the legislature and the department of human services be mindful of the need to develop additional community services and housing for people with mental illness.

Many people with mental illness can be integrated into the community. However, any successful policy of integration is dependent on developing alternative housing and services in the community.

Appropriate housing for people with mental illness must consider clients' needs for treatment and other services. In many cases, clients will be able to live independently if adequate case management services are available. In other cases, clients will need a structured environment with professional help readily available. It is important that a continuum of housing options be available throughout the state.

9. Stability of the System.

Because of its responsibility to all citizens, the state must monitor services and be prepared to revoke the license of facilities that do not comply with state laws and rules. In order to maintain an effective monitoring power, however, the state must be prepared to care for clients when facility licenses are revoked. In order to perform this function, the state must remain capable of managing facilities and providing direct services to clients.

Endnotes

1. Deinstitutionalization of Mentally Retarded People. Office of the Legislative Auditor, State of Minnesota, Program Evaluation Division, February 1986. ("Auditor's Report")
2. Id, pp. 6-7.
3. Id., p. 6.
4. Id., p. 9.
5. Id, p. 11.
6. Welsch v. Gardebring. United States District Court, District of Minnesota, Fourth Division, Civil No. 4-72-451, Order dated July 31, 1987.
7. Id., pp. 8-10.
8. Auditor's Report, p. 11.
9. Id., pp. 11-12.
10. Id.
11. Id.
12. Id,
13. All program information for the AGC facility is from Fact Book: Minnesota State Regional Treatment Centers and Nursing Homes. Department of Human Services, State of Minnesota, January 1987, p. 17. (Tact Book) Average daily population figures for all facilities are taken from State of Minnesota Proposed Biennial Budget for Human Resources. 1987-89. ("Budget Book")
14. Fact Book, p. 17.
15. Staffing numbers for all facilities are from the Budget Book.
16. DHS Proposal of July 27, 1988.
17. Anoka-Metro Regional Treatment Center. June 1988 (8 page summary presented by AMRTC to members of the task force) ("Anoka Summary")
18. Fact Book, pp. 21-22.
19. Anoka Summary.
20. Fact Book, pp. 20-21.
21. Anoka Summary.
22. State Planning Agency, Policy Analysis Series Paper No. 1: Minnesota State Hospital Facilities and Alternative Use. St. Paul, Minnesota, January 1985, pp. 8-9. ("Facilities Paper")

23. DHS Proposal of July 27, 1988, pp. 11-13, and configuration chart.
24. City of Anoka, Statement, July 26, 1988, pp. 4-5.
25. DHS Proposal of July 27, 1988, p. 15.
26. Fact Book, p. 26.
27. DHS Proposal of July 27, 1988, p. 7.
28. Facilities Paper, pp. 10-11.
29. Except where noted, information in this section is from DHS Proposal of July 27, 1988.
30. DHS amended proposal, November 15, 1988, p. 17.
31. Program descriptions are from Cambridge Regional Human Services Center, a booklet published by the center, 1988. ("Cambridge Booklet")
32. Fact Book, p. 30.
33. Facilities Paper, p. 12.
34. Cambridge Booklet.
35. DHS Proposal of July 27, 1988.
36. DHS amended proposal, November 15, 1988, p. 17.
37. Program information is from Fact Book, p. 34.
38. Id.
39. Facilities Paper, p. 12.
40. Faribault Regional Center - Task Force Plan, November, 1988, pp. 10-11. ("Faribault Plan")
41. Facilities Paper, p. 12.
42. Id., p. 13.
43. Faribault Plan.
44. DHS amended proposal, dated November 15, 1988, pp. 3, 11, 16, and 17.
45. Faribault Plan, pp. iii-viii.
46. Program information is from Fergus Falls Regional Treatment Center - Annual Report Fiscal Year 1987.
47. Fact Book, pp. 38-41.
48. Facilities Paper, pp. 13-14.
49. DHS Proposal of July 27, 1988.

50. DHS amended proposal, November 15, 1988, p. 17.
51. Resolution of Proposal by Fergus Falls Regional Treatment Center Coalition in the Department of Human Services Regional Treatment Center Negotiation Process, September 23, 1988.
52. Program information is from Fact Book, p. 43-44.
53. Fact Book, p. 43.
54. Facilities Paper, pp. 14-15.
55. DHS Proposal of July 26, 1988.
56. DHS amended proposal, November 15, 1988, p. 16.
57. Minnesota RTC Negotiations Process Presentation. Prepared by The Coalition of Concerned Citizens for Moose Lake Regional Treatment Center, July 27, 1988, p. 4.
58. Fact Book, p. 49.
59. DHS Proposal of July 27, 1988, p. 15.
60. Fact Book., p. 49.
61. DHS Proposal of July 27, 1988, p. 15.
62. Id., p. 16 and configuration chart.
63. MI program information is from St. Peter Regional Treatment Center, a booklet prepared for the Health and Human Services Committee, July 19, 1988.
64. Id.
65. Fact Book., pp. 52-53.
66. Id.
67. Fact Book, p. 52.
68. Facilities Paper, pp. 15-16.
69. DHS Proposal of July 27, 1988.
70. Program information is from Fact Book, p. 55.
71. Id..
72. Facilities Paper, p. 16.
73. Program information is from Fact Book, pp. 60-61.
74. Id., p. 59.
75. Facilities Paper, pp. 16-17.

76. DHS Proposal of July 27, 1988, p. 12 and configuration chart.
77. Southwest Regional Plan. WRTC Regional Task Force, undated.
78. Budget Book, sec 1, p. 88.
79. Id. sec. 1, p. 94.
80. DHS Proposal of July 27, 1988, p. 20.
81. Id.
82. Id.

Appendix A

List of Abbreviations

AGC	Ah-Gwah Ching Nursing Home
AMRTC	Anoka-Metro Regional Treatment Center
BRHSC	Brainerd Regional Human Services Center
CD	Chemical Dependency (Chemically Dependent)
CRHSC	Cambridge Regional Human Services Center
DD	Developmental Disabilities (Developmentally Disabled)
DHS	Department of Human Services
DOH	Department of Health
FRC	Faribault Regional Center
FFRC	Fergus Falls Regional Center
FY	Fiscal Year
ICF-MR	Intermediate Care Facility for the Mentally Retarded
MI	Mental Illness (Mentally Ill)
MLRTC	Moose Lake Regional Treatment Center
MR	Mental Retardation (Mentally Retarded)
MSH	Minnesota Security Hospital
OTNH	Oak Terrace Nursing Home
RTC	Regional Treatment Center
SILS	Semi-Independent Living Services
SOCS	State-Operated Community Services
SPRTC	St. Peter Regional Treatment Center
WRTC	Willmar Regional Treatment Center

APPENDIX B

MINNESOTA REGIONAL TREATMENT CENTERS AVERAGE DAILY POPULATION 1986 - 1989

MENTALLY ILL

	<u>FY 1986</u>	<u>FY 1987</u>	<u>FY1988</u>	<u>FY1989</u>
Anoka	234	234	234	234
Brainerd	64	65	68	70
Fergus Falls	99	100	102	102
Moose Lake	69	70	70	70
St. Peter	152	158	160	160
Willmar	<u>254</u>	<u>250</u>	<u>240</u>	<u>240</u>
TOTAL	872	877	874	876

CHEMICALLY DEPENDENT

	<u>FY 1986</u>	<u>FY 1987</u>	<u>FY1988</u>	<u>FY1989</u>
Ah-Gwah-Ching	19	22	25	30
Anoka	78	80	80	80
Brainerd	63	64	62	64
Fergus Falls	137	145	145	145
Moose Lake	165	150	150	150
St. Peter	53	54	55	56
Willmar	<u>84</u>	<u>90</u>	<u>86</u>	<u>86</u>
TOTAL	599	605	603	611

MENTALLY RETARDED

	<u>FY 1986</u>	<u>FY 1987</u>	<u>FY1988</u>	<u>FY1989</u>
Brainerd	239	219	199	187
Cambridge	406	371	337	309
Faribault	627	590	560	530
Fergus Falls	200	183	162	148
Moose Lake	96	89	86	83
St. Peter	161	150	127	104
Willmar	<u>133</u>	<u>102</u>	<u>85</u>	<u>82</u>
TOTAL	1,862	1,704	1,556	1,443

CHILDREN AND ADOLESCENTS

	<u>FY 1986</u>	<u>FY 1987</u>	<u>FY1988</u>	<u>FY1989</u>
Brainerd	45	38	38	42
Willmar	<u>39</u>	<u>40</u>	<u>39</u>	<u>36</u>
TOTAL	84	78	77	78

GERIATRIC

	<u>FY 1986</u>	<u>FY 1987</u>	<u>FY1988</u>	<u>FY1989</u>
Ah-Gwah-Ching	318	320	320	320
Moose Lake	105	110	120	130
Oak Terrace	<u>323</u>	<u>325</u>	<u>325</u>	<u>325</u>
TOTAL	746	755	765	775

MINNESOTA SECURITY HOSPITAL

	<u>FY 1986</u>	<u>FY 1987</u>	<u>FY1988</u>	<u>FY1989</u>
	222	222	223	224

Source: State of Minnesota Proposed Biennial Budget for Human Resources, 1987-89.

Resources

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WRTC Regional Task Force. Southwest Regional Plan. Undated: