DIRECT CARE AND TREATMENT

History of Direct Care and Treatment

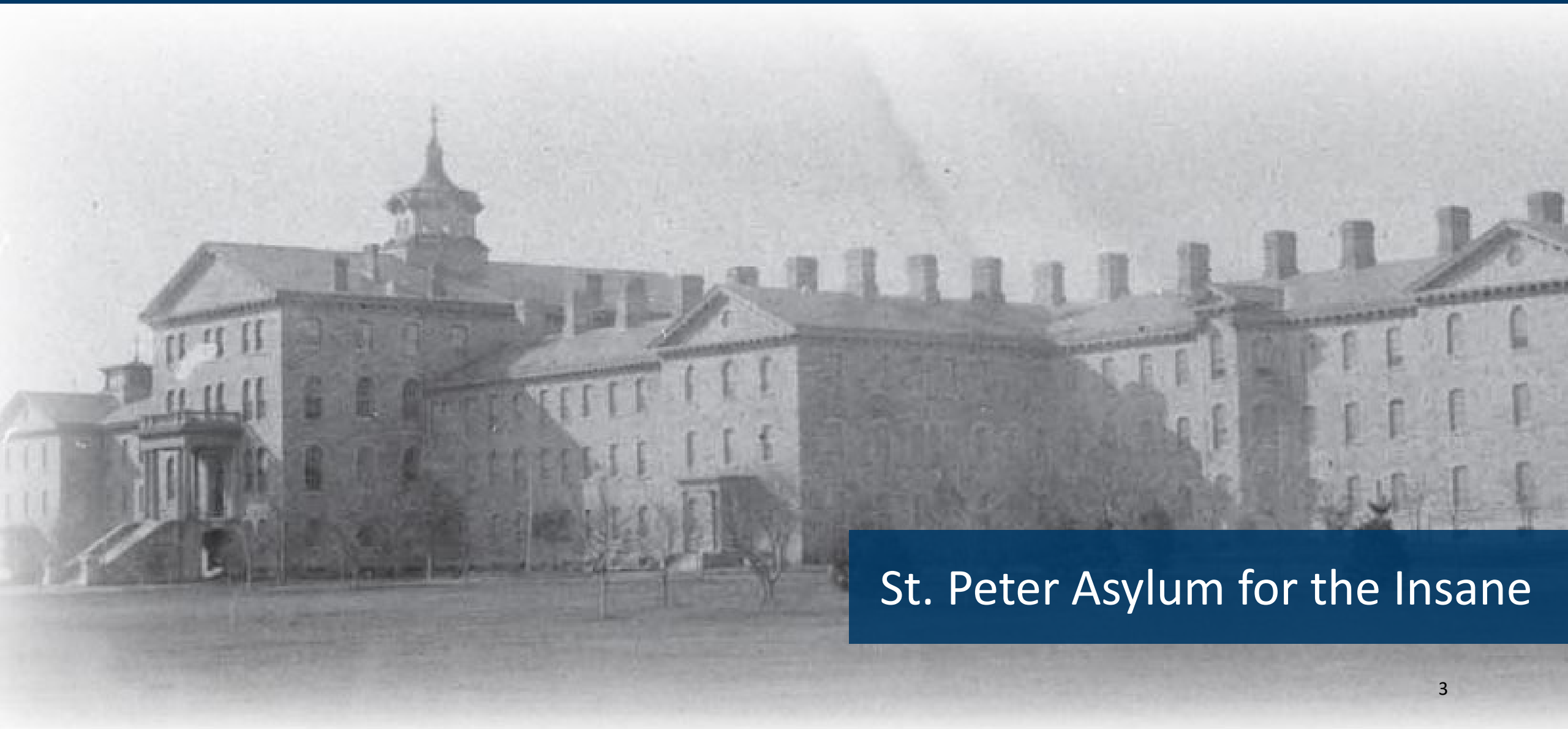
From State Hospitals to State Operated Services to Today

Chuck Johnson

DIRECT CARE AND TREATMENT

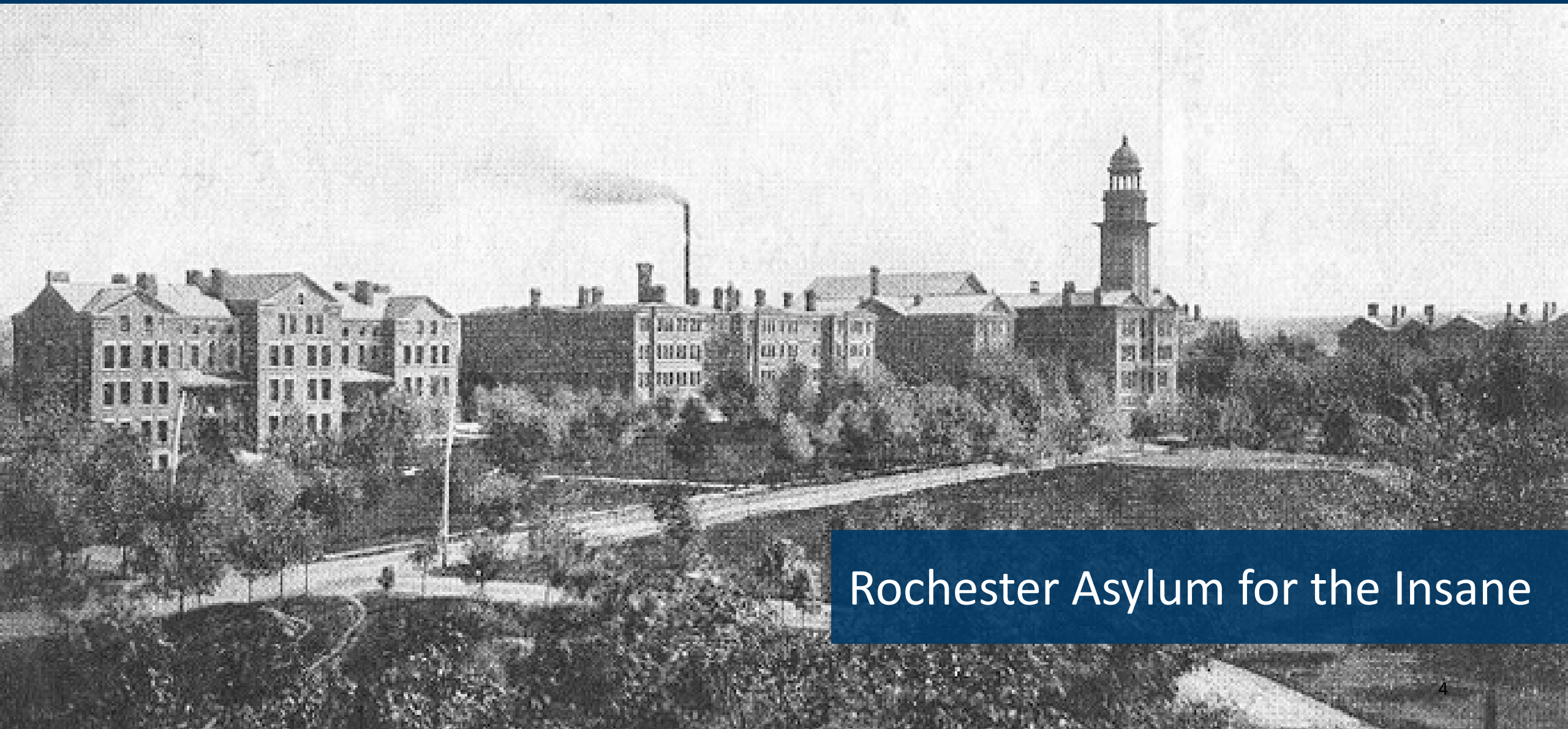
Institutionalization: The State Hospitals

The State Hospitals



St. Peter Asylum for the Insane

The State Hospitals

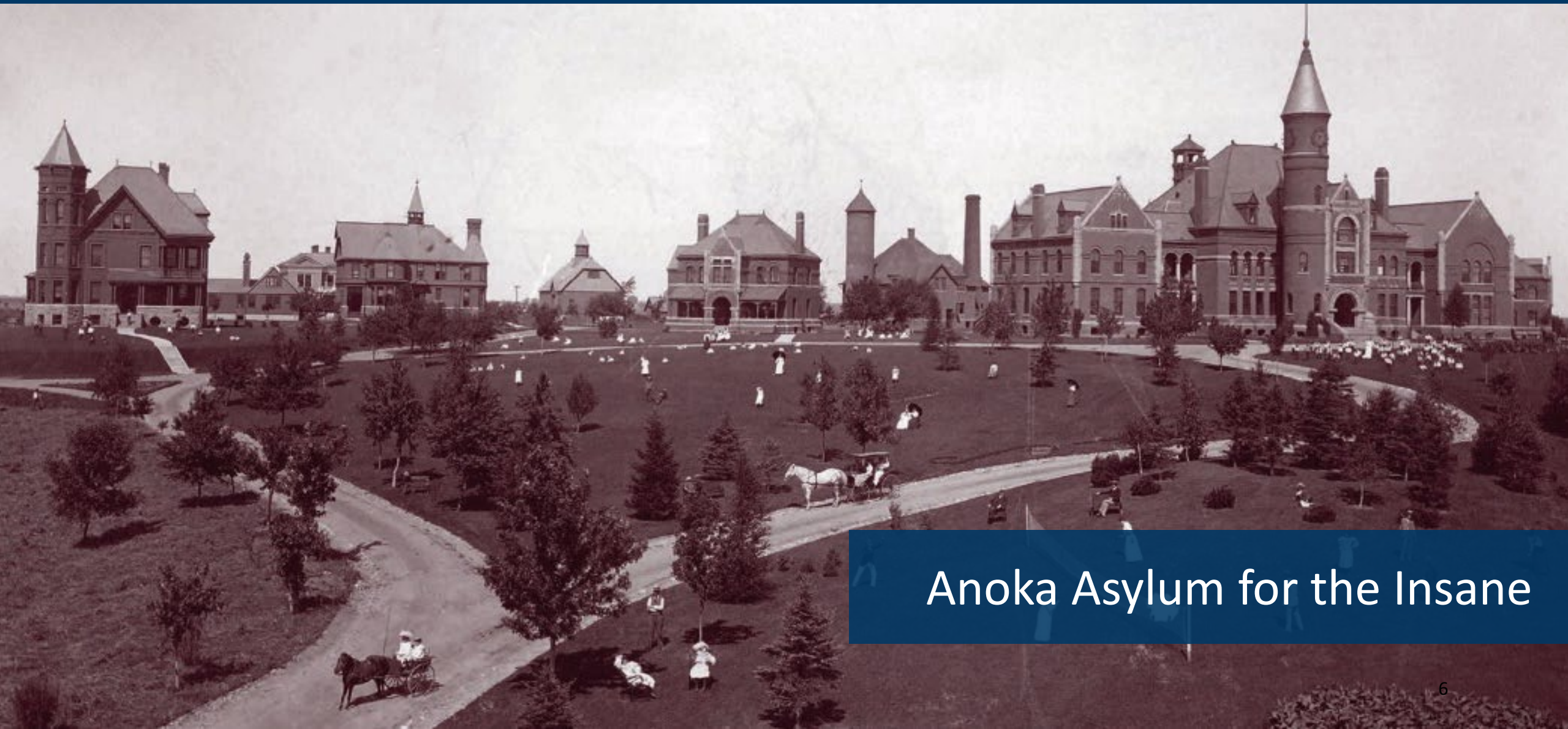


Rochester Asylum for the Insane

The State Hospitals

Fergus Falls Asylum for the Insane

The State Hospitals

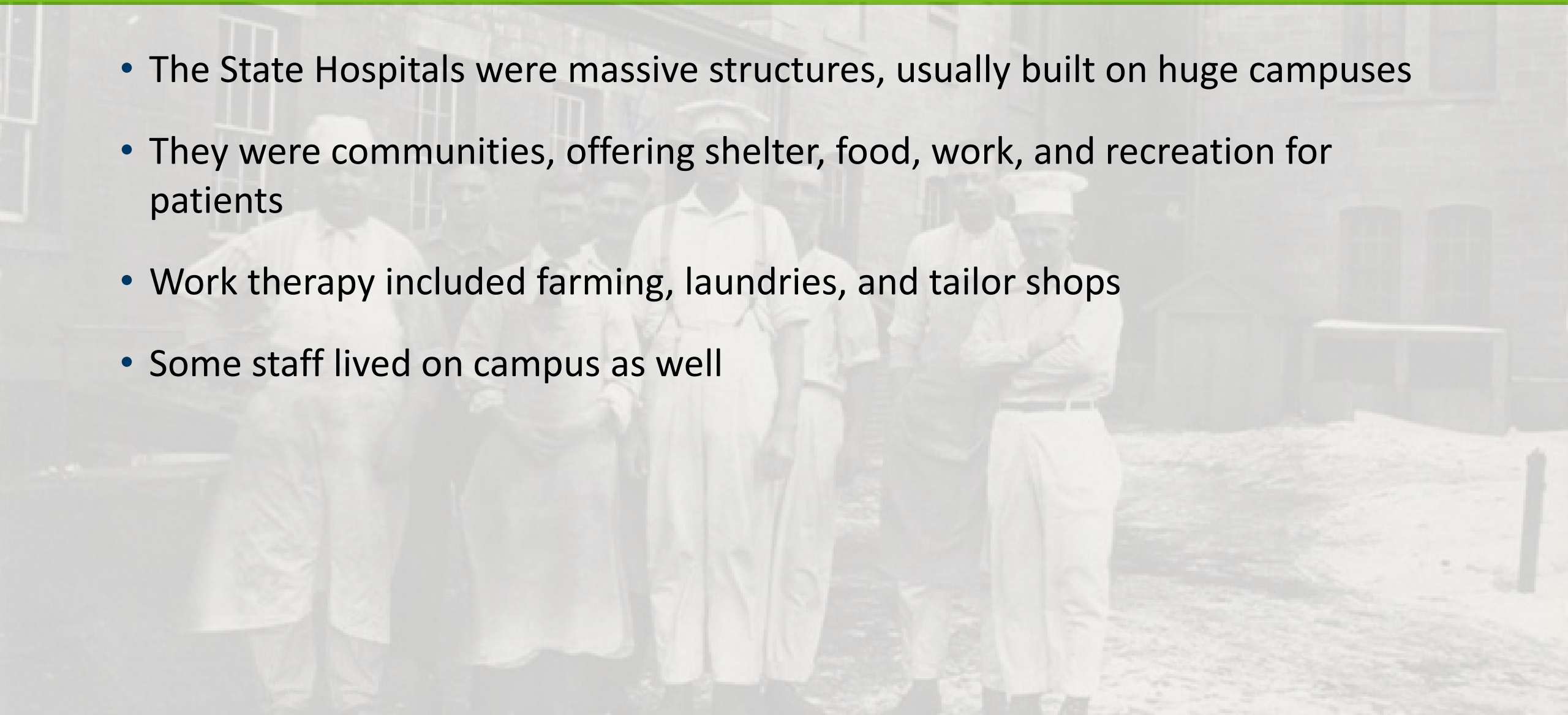


Anoka Asylum for the Insane

The State Hospitals

State Hospitals

Communities Unto Themselves



- The State Hospitals were massive structures, usually built on huge campuses
- They were communities, offering shelter, food, work, and recreation for patients
- Work therapy included farming, laundries, and tailor shops
- Some staff lived on campus as well

A Place for People that Didn't Fit

- State hospitals served as a place to put people that were deemed inappropriate to live in the community
- The hospitals had names that reflected the attitudes of the times, using words like "insane," "imbecile," and "inebriate"
- The prevailing theory of "treatment" was rest, work, outdoor activities. Some people did get better and return to the community.
- Often, treatment also included restraint, seclusion, and other actions we now consider abuse

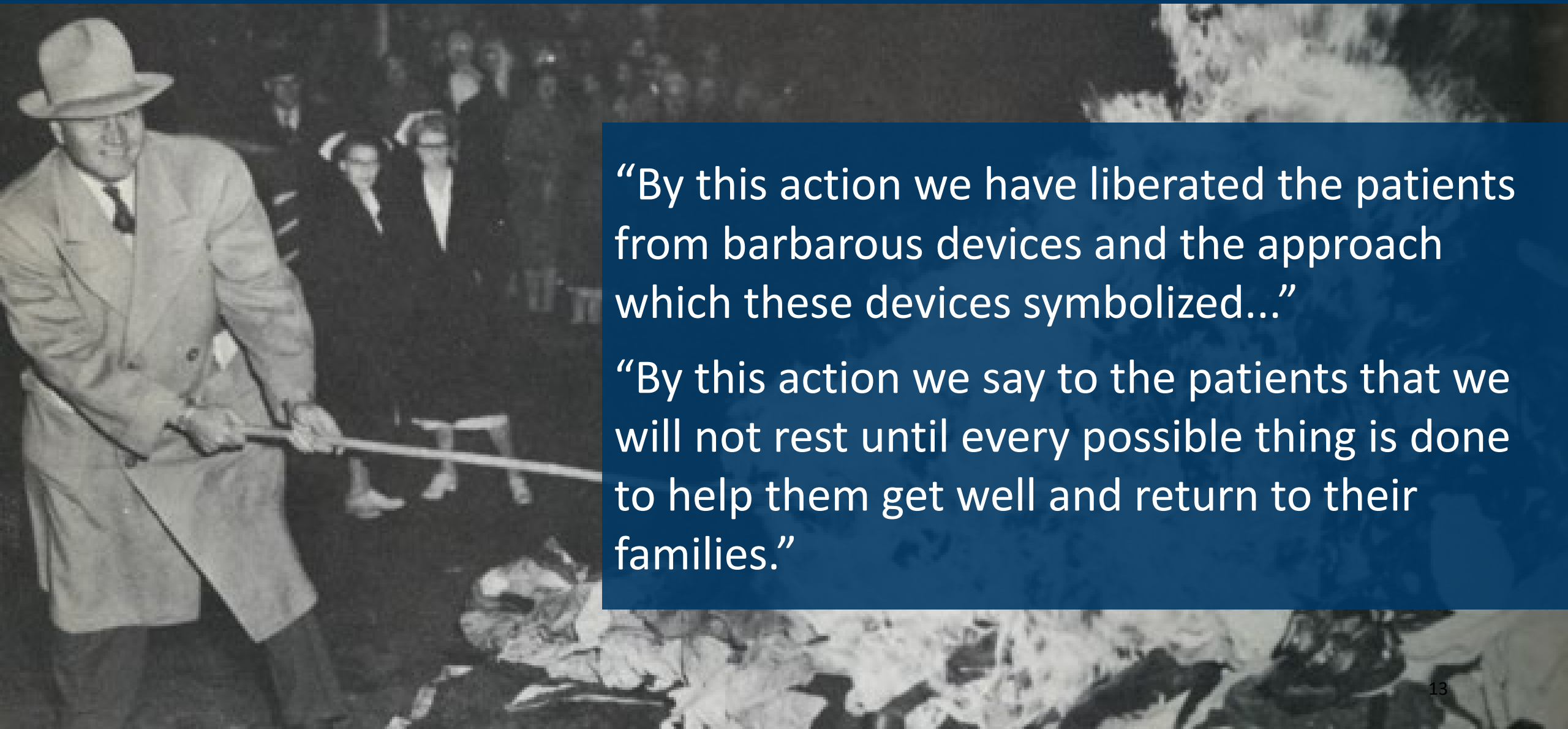
More Than Just Mental Illness

- While we think of the state hospitals as serving people experiencing serious mental illness, over time people with intellectual and developmental disabilities (IDD) became a significant population within the system
- Some facilities specialized:
  - Willmar State Hospital Farm for Inebriates
  - Gillette State Hospital for Crippled and Deformed Children
  - Walker State Tuberculosis Sanatorium
  - Cambridge Colony for Epileptics

Deinstitutionalization

Reform Sweeps Minnesota and the Nation

In Gov. Youngdahl's Words



"By this action we have liberated the patients from barbarous devices and the approach which these devices symbolized..."

"By this action we say to the patients that we will not rest until every possible thing is done to help them get well and return to their families."

A National Movement

- By the middle of the 20th Century, advances in treatment of mental illness and changes in public attitudes marked the beginning of the end for state hospitals
- In addition to medication advances, deinstitutionalization in Minnesota and nationally was driven by two factors:
  - A national movement focused on the rights of people with MI and IDD to live in the community
  - Scandals (national and local) at hospitals – overcrowding, understaffing, abuse
- But the State Hospitals did not go quickly or quietly. A period of uncertainty, constant change and ambiguity of mission followed

Deinstitutionalization in Minnesota

- New medications in the 1950s allowed many people experiencing mental illness to live in the community. In Minnesota State Hospitals:
  - Patient stays were shortened; people who may have spent their whole life in a state hospital might be discharged after a year or two
  - People experiencing mental illness in State Hospitals dropped from 11,500 in the late 1950s to 2,400 in 1972
- For the IDD population, fewer children were being committed as norms changed, and community supports were gradually developed. For State Hospitals:
  - The Welsch lawsuit, brought in 1972, led to the Welsch Decree in 1980 requiring all IDD to be moved out of State Hospitals
  - There were 2,650 IDD in State Hospitals in 1980, down from 6,000 in the mid-1960s. By 2003 there were only 32

Closing State Hospitals: The Conversation Begins

- In 1974, the Department of Public Welfare issued a report recommending the closure of all state hospitals, starting with five (unspecified) closures between 1975 and 1980
- Three closures did occur:
  - 1973 – Gillette transferred to Hospital Board
  - 1978 – Hastings, facility transferred to Vets
  - 1982 – Rochester, budget savings
- This started a conversation that would be ongoing for the next three decades

Transition to a Behavioral Health System

A New Approach

Jobs (and Mission)

- As downsizing progressed through the 1970s and 1980s, the focus shifted to jobs – maintaining state jobs in the communities that had hosted state hospitals for decades
- This was not a new issue: The 1866 battle St. Peter won for the first hospital was also about jobs
- It also started a period of shifting focus for the system as a whole, a period of redefining the mission and purpose of the system
- Inevitably, these two struggles – maintaining jobs and finding a clear purpose – brought more politics into the decision making

Regional Treatment Centers

- From the late 1960s and into the 1970s, state hospitals starting moving toward each campus providing an array of services
  - People with IDD were moved from a few overcrowded facilities into facilities with ample bed space due to the drop in census for people experiencing MI
  - Residents were generally moved to facilities closer to their homes
  - Campuses adopted substance use disorder treatment programs
- The idea was to have a set of state services – inpatient MI treatment, IDD residential care, and SUD treatment – for each region of the state
- State hospitals were formally renamed “Regional Treatment Centers” (RTC) in 1985
- By the mid-1990s, the system as a whole was known as “State Operated Services”

The Shift to Community Services

- In the 1980s and 1990s, human services began to shift to community-based services for people experiencing mental illness and people with disabilities
- State Operated Services started on a path to follow suit: To run services in the community paid for by the same government rates as other community service providers
- In 1988, SOS's substance use disorder programs – called CARE (Community Additions Recovery Enterprise) – began to bill for reimbursement under the same state rate system as other SUD providers

Minnesota State Operated Community Services

- Minnesota State Operated Community Services (MSOCS) started as a strategy to repurpose RTC staff to provide community services to people with disabilities: group homes, day programs and vocational services
  - The state needed to rapidly expand community services to comply with the Welsch decree; MSOCS helped meet this need while maintaining state jobs
  - This strategy leveraged Medicaid to pay for state-run community-based services
- The first state-run group homes were opened in 1986
  - 1997: Eastern State Operated Services established, managed by Cambridge and Faribault
  - 2002: MSOCS established, merging five regional programs

Downsizing Continues

- With the continuing reduction in census, two more RTCs closed in the 1990s:
  - 1993: Moose Lake
  - 1998: Faribault
- Both were converted to prisons, maintaining state jobs in the communities

Census and Focus Begins to Change

	FY87	FY03
Mental Health - Adult	1,032	501
Mental Health- Adolescent	37	52
MN Security Hospital	222	174
Psychopathic Personality	0	188
Forensic Transition		46
Forensic SNS		14
Developmental Disabilities*	1,656	32
Nursing Home	627	162
Traumatic Brain Injury		14
Chemical Dependency	529	227
Total:	**4,103**	**1,410**

*This category is exclusive to people with Intellectual and Developmental Disabilities who were institutionalized.

Community Behavioral Health Hospitals

- In 2003, the legislature created a regional planning process for community-based alternatives for people experiencing mental illness
- The state undertook a lengthy process of consultation with counties and other stakeholders, resulting in dramatic changes for SOS mental health
  - Regions identified needs for state-operated psychiatric hospital beds
  - Ten 16-bed Community Behavioral Health Hospitals (CBHHs)were opened between 2006-2008
  - The 16-bed model ensured the facilities were eligible for Medicaid reimbursement
  - Three CBHHs were converted to step-down residential programs (IRTS) and a fourth closed

The End of the State Hospitals

- As a result of these changes, three RTCs were closed
  - 2005: Fergus Falls
  - 2007: Willmar
  - 2008: Brainerd
- The Ah-Gwah-Ching Nursing Home in Walker was also closed and a new forensic nursing home was opened on the St. Peter campus in 2008

Minnesota Sex Offender Program

- In response to an increase in civil commitments under a 1939 statute, the Legislature creates the Minnesota Sexual Psychopathic Personality Treatment Center in 1993
- The program opens in Moose Lake in 1995, and is expanded in 2000
- In 2003, Dru Sjodin was murdered by a level III sex offender recently released from prison
- Commitments – pursued by county attorneys and approved by courts – skyrocketed
  - From 1999-2003, courts committed 56 people
  - From 2004-2008, courts committed 321 people

Census Changes

	FY87	FY03	FY24**
Mental Health - Adult	1,032	501	226
Mental Health - Adolescent	37	52	7
MN Security Hospital/Forensics	222	174	263
Psychopathic Personality/MSOP	0	188	737
Forensic Transition		46	64
Forensic SNS		14	
Developmental Disabilities*	1,656	32	0
Nursing Home	627	162	22
Traumatic Brain Injury		14	
Chemical Dependency	529	227	60
MSOCS - Residential, CSS, LB			257
Total:	**4,103**	**1,410**	**1,635**

*This category is exclusive to people with Intellectual and Developmental Disabilities who were institutionalized.
**Service categories are not consistent with categories used in 1987 and 2003. A cross-walk was used to align the categories across the time periods.

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A Series of Crises

- A series of crises rocked SOS in the early 2010s
- Two significant lawsuits – Karsjens and Jensen – put SOS under court jurisdiction
- Underfunding, understaffing, and restraint changes impact facilities
  - St. Peter Security Hospital: patient abuse report, conditional license, assaults on staff, patient-on-patient assaults
  - Anoka: aggressive patients from jail, CMS threatens to pull funding and certification
  - Employees fear for their safety and the safety of patients

Organizational Evolution

- Up until the late 1990s, State Hospitals, RTCs had operated mostly independently
- By 2010, some shared services were centralized, leadership over SOS had been elevated in DHS and regional leadership was created
- In 2016, Marshall Smith was appointed as CEO of State Operated Services, which was renamed Direct Care and Treatment
- DCT was reorganized into a health system focused on serving people other providers cannot or will not serve
  - Created an Executive Team led by the CEO and composed of the executive directors of each service line and systemwide leaders
  - Regional leaders were phased out
  - More fully centralized all critical services, including quality, pharmacy and compliance

Questions