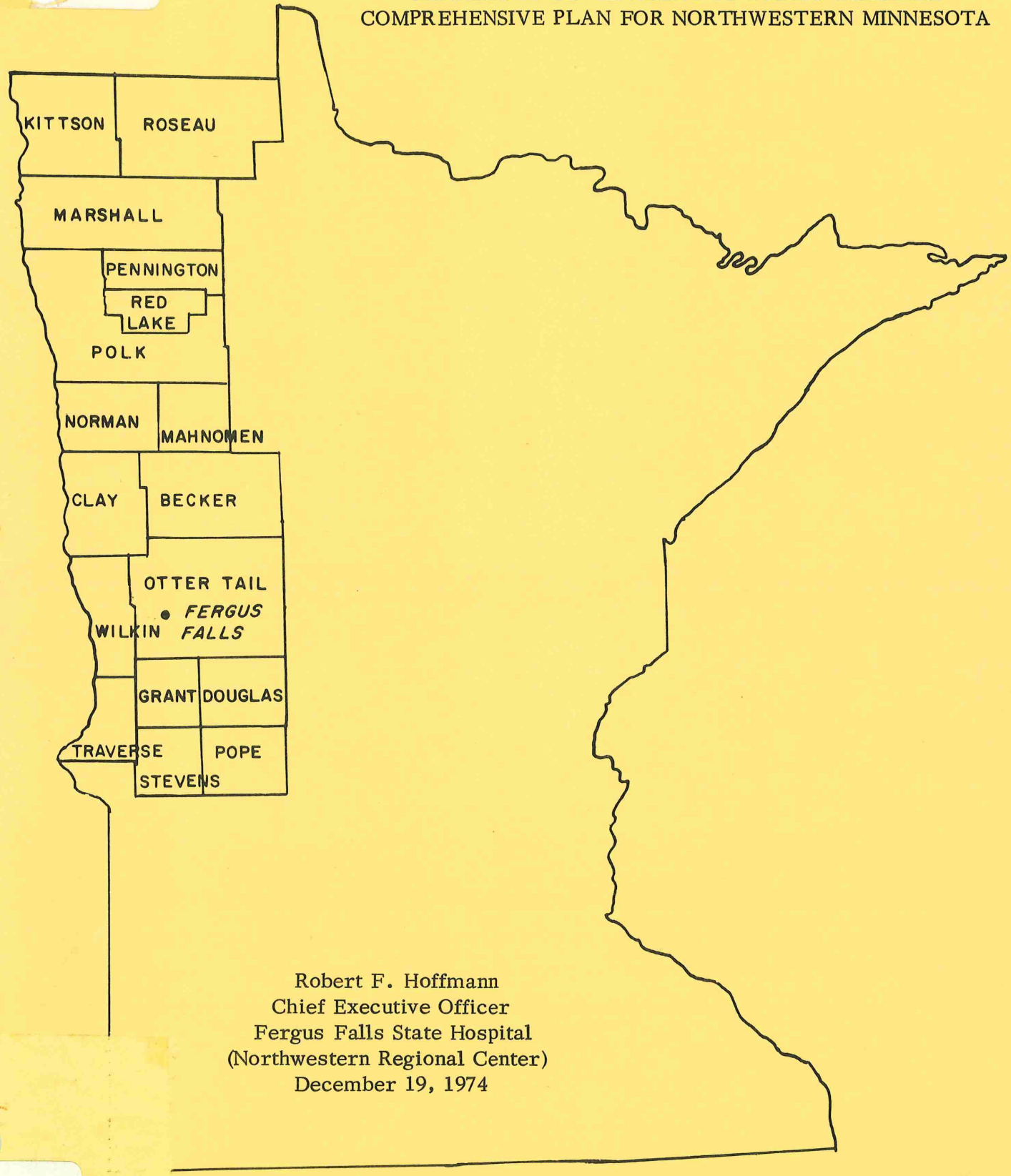
A RESPONSE
To The
MINNESOTA DEPARTMENT OF PUBLIC WELFARE
COMPREHENSIVE PLAN FOR NORTHWESTERN MINNESOTA



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December 19, 1974

INTRODUCTION

By way of introduction to this report, it should be stated that served by the Fergus Falls State Hospital are three major disability groups - the chemically dependent, the mentally retarded, and the mentally ill. Each disability grouping has two or more (up to five) unit programs designed to meet the needs of subgroupings of each of the major casualty groups.

The Fergus Falls State Hospital has a large number of patients, a large staff, and in every sense of the word, is a complex organization dealing with a multitude of difficult and demanding social problems. Since, in this report, it is impossible to answer all your questions or present to you all the information concerning the hospital's function, we encourage you to visit any unit you wish and we will assist you in obtaining the additional information you desire. We will be pleased to spend as much effort as is necessary in helping you understand the purpose and operating of this treatment facility.

Purpose of this Report

The first purpose of this report is to present to you the State Department of Public Welfare's Comprehensive Plan and the revisions of that plan by the Lakeland Area Committee.

As you have by now read, the State Department of Public Welfare has proposed a plan calling for the closure of four state hospitals, one of which is the Fergus Falls State Hospital. This plan was in many ways a surprise to us. The section of that plan that relates to the Fergus Falls area reads as follows. (See pages 2, 3 & 4. The italicized print indicates the changes proposed by the Lakeland Area Committee.)

The Comprehensive Plan as presented by the State Department of Public Welfare has a number of positive and negative aspects. Our purpose here is not to discuss these on a point by point basis. We would like, however, to direct your attention to one major inconsistency. This inconsistency refers to the fact that the State Department of Public Welfare has been supporting regionalization and the surrendering of centralized control to the various regions in the state for some time now. The inconsistency occurs when the State Department of Public Welfare supports moving in the direction of local regional control but then tells the region what that control will be. In our situation, the Department has stated to Regions I and IV that they do not need a state hospital. It would appear more consistent then to say that it is up Regions I and IV to recommend the utilization of this facility in the

DEPARTMENT OF PUBLIC WELFARE COMPREHENSIVE PLAN
WITH REVISIONS BY LAKELAND AREA COMMITTEE - DEC. 13, 1974

Fergus Falls State Hospital:

For some years, public and private agencies within the area served by the Fergus Falls State Hospital have, as illustrated by the Lakeland Group Home project, exhibited an interest and readiness to experiment with alternate methods of delivering human services, including experimenting with different administrative and management arrangements to support a network of human service delivery agencies. In recognition of this fact and in consideration of the declining population at Fergus Falls State Hospital and the Department's objective of phasing out of direct management of state hospitals, the following actions are recommended as they pertain to the Fergus Falls State Hospital:

1. Noting the community programs and resources that are currently available within the Fergus Falls receiving area and the interest in and potential for developing additional community-based services in the area, it is the Department's position that the ~~mentally-ill-and-chemically-dependent-programs-at-the~~ Management of the Fergus Falls State Hospital ~~can-be-phased-out-by-July-1,-1977,~~ be converted and ~~the-mentally-retarded-program-as-of~~ to local control by July 1, 1978.

2. In order to implement this phase-out and assure maximum community participation in the development of alternatives, it is recommended that:

   a) The Legislature authorize the establishment and funding of a committee to be established no later than July 1, 1975, composed of one county commissioner or county

commissioner designee from each of the 17 counties included in the Fergus Falls State Hospital receiving area, and four members to be appointed by the Commissioner of Public Welfare.

plus a representative of the Commissioner to act as liaison between the Commissioner and the Committee with authority to act on the Committee's recommendations.

b) The committee shall appoint a chairman and such subcommittees from within its total membership as it deems appropriate, recognizing that a progress report from the committee is to be made to the Department and the Legislature in February, 1976. A final report including recommendations shall be submitted to the Department no later than October 15, 1976, and to the appropriate legislative committees no later than November 15, 1976. Once the report has been filed with the Department and the appropriate legislative committees, the management committee will cease to function unless the tenure of the committee is extended by action of the 1977 Legislature.

c) The report referred to above shall reflect:

i) A determination regarding the number of mentally ill, mentally retarded, chemically dependent and other handicapped and disabled individuals who reside within the 17 counties in question, including projected estimates regarding such populations.

ii) A determination regarding the appropriate manner and method by which community-based services to the

population can be provided. Such determination shall include identification of a total array of needed community service and program alternatives to serve the populations indentified with recommended deployment of such program and service alternatives throughout the 17 county area.

iii) Further evidence of continued development of innovative methods and programs, beyond the facilities and programs now existing in the community, to indicate progress toward further deinstitutionalization.

iv) Recommendations as to how the service and treatment programs of the area are to be administered and funded.

The above recommendations and actions are predicated on the assumption that the area and citizens within the area are in the best position to determine services needed, as well as delivery and administrative-management arrangements. The report and recommendations of the committee, along with the Department's assessment of the status of the total state hospital system, can be reviewed and acted upon during the 1977 session of the Legislature.

continuum of human services. This inconsistency then is the basis for the revisions by the Lakeland Area Committee. If the Department is serious about local regional control, then certainly these revisions will be acceptable.

The remainder of the report deals first with fiscal year 1973-74 patient movement. The next portion deals with present inpatient population characteristics. The last section is comprised of a mini-report on the mental retardation group home project.

PATIENT MOVEMENT DATA FOR FISCAL YEAR 1973-74

Table I concerns basic patient/resident movement data. From this data, a number of significant comments should be made. First, it is seen that 502 chemical dependency admissions and 540 chemical dependency discharges represents a sizable number and in terms of number of persons served, represents the hospital's largest treatment program. The average daily patient population for chemical dependency for fiscal year 1973-74 was 72. The majority of the admissions to the Chemical Dependency Program are short term, 40 days or less. Secondly, it is seen that the hospital patient population dropped by 64 during fiscal year 1973-74 (920-856). The majority of that drop (38) occurred in the Chemical Dependency Program, 11 in the Mental Retardation Program and 15 in the Mental Illness Program. It is further noted that November 30, 1974 reveals an inpatient population numbering 527. This number is only one less than the average daily patient population for fiscal year 1973-74. During the past five months, there has been a relative increase and stabilizing effect in the hospital patient population. A third comment concerns the data at the bottom of Table I where there is shown a break down by program and county for the November 30, 1974 inpatient population. It is seen that at any one time there are few residents from any one county in any of the Chemical Dependency Treatment Programs.

Patient Population Characteristics: Chemical Dependency and Mental Illness

To help clarify Table II, the following definitions are given. Treatment Failures refers to patients who have been in inpatient treatment programs, either private or state and have had to return for further treatment. Legal Problems refers to persons having DWI's, writing checks with insufficient funds, theft-burglary, and disorderly conduct.

The first program presented in Table II is the primary treatment program for chemical dependency. (The majority population has an inpatient stay of less than 40 days.) It is seen that 39% of the patients in this program have failed one or more prior inpatient treatment incidents. The majority, 59%, have had legal problems in the community. In the HOPE Program (a 5 month treatment program), it is seen that 97% of the resident population have been former treatment failures, and higher incidence of legal problems, 94%.

The LIV Program is designed for patients who maintain some degree of controlled drinking only in a structured setting. All LIV residents have been prior inpatient treatment failures, all have had legal problems and all have

Table I

ADMISSION/DISCHARGES BY COUNTY AND
DISABILITY GROUP FOR FY 1973-74

County	Total Admissions	M.I. Admissions	C.D. Admissions	M.R. Admissions	Total Discharges	M.I. Discharges	C.D. Discharges	M.R. Dischgs.
Becker	123	20	100	3	135	22	112	1
Clay	92	32	56	4	91	32	53	6
Douglas	77	30	44	3	78	31	45	2
Grant	16	6	10	0	22	7	14	1
Kittson	14	8	6	0	16	10	5	1
Mahnomen	18	9	9	0	24	10	10	4
Marshall	19	6	12	1	23	11	11	1
Norman	22	12	9	1	28	13	9	6
Otter Tail	189	82	103	4	210	83	121	6
Pennington	31	11	19	1	31	11	19	1
Polk	50	26	23	1	56	29	21	6
Pope	47	16	26	5	42	17	24	1
Red Lake	5	2	3	0	9	5	3	1
Roseau	26	11	14	1	22	8	14	0
Stevens	24	6	11	7	20	4	14	2
Traverse	14	3	9	2	15	2	12	1
Wilkin	33	5	27	1	39	6	29	4
Non Resident	56	34	21	1	59	33	24	2
Total	856	319	502	35	920	334	540	46

Average Daily Patient Population
For FY 1973-74 $\frac{140}{MI}$ $\frac{72}{CD}$ $\frac{316}{MR}$ Total Average Daily Patient Population=528

RESIDENTS November 30, 1974 (Includes those in hospital and on ext. visit)

Lakeland Area (Region IV)

County	Total	MI	M-R	Primary	HOPE	LIV
Becker	40	12	20	4	3	1
Clay	50	10	27	2	7	4
Douglas	41	8	23	5	4	1
Grant	15	3	6	1	2	3
Otter Tail	98	28	52	12	4	2
Pope	15	7	8	0	0	0
Stevens	16	2	8	5	0	1
Traverse	7	1	6	0	0	0
Wilkin	23	8	12	3	0	0
Sub-total	305	79	162	32	20	12

North West Area (Region I)

County	Total	MI	M-R	Primary	HOPE	LIV
Kittson	20	6	13	0	0	1
Mahnomen	13	3	9	0	1	0
Marshall	21	5	12	3	1	0
Norman	25	6	17	0	2	0
Pennington	14	7	6	0	1	0
Polk	59	12	40	2	3	2
Red Lake	20	1	17	0	1	1
Roseau	26	5	16	3	1	1
Non-resid.	24	9	10	2	3	0
Sub-total	222	54	140	10	13	5

Total All Counties 527 133 302 42 33 17

failed in work rehabilitation placements in the community. These residents represent the hard core of the hard core alcoholics.

Both the HOPE and LIV Programs originated as a result of the community defining a need for such programs. These programs have slow turnover and low patient population numbers. Thus they must serve, in order to be economically feasible, relatively large geographic population areas.

The Psychiatric Medical Rehabilitation Unit has our most chronic mentally ill patient population. From Table II, it is seen that 23% of the residents of this treatment unit have had lobotomies (brain surgery). For the most part, these surgical procedures were to eliminate overt aggressive behavior. This residual patient population still exhibits overt acting out behavior such as screaming, pushing, loud verbal abuse, wandering, etc. Twenty percent of this chronic patient population comes to the hospital not so much for psychiatric care as for neurological conditions. There are no community facilities for such disorders after the patient's financial resources are depleted and until the illness progresses to a stage where they are nursing home candidates. These problems include automobile accidents and other injuries. In one instance, a young woman has been paralyzed with loss of speech due to an automobile accident. She needs considerable physical and speech therapy and special education on a long term basis. These services are available to her at the hospital and placement in the community is not recommended because her needs are greater than what the community can provide in a nursing home setting. Incidently, this young woman is making considerable progress. She was transferred to our facility after she could no longer be maintained in a private hospital.

The vast majority (81% or 60 out of 74) of the patients on the Psychiatric Medical Rehabilitation Unit display aggressive behavior. This behavior consists mostly of hitting, pushing, screaming, and stealing. Twenty seven percent of the residents presently occupying this unit have been in nursing homes and have returned or entered the hospital because their behavior could not be controlled or tolerated in the nursing home. Behavior such as wetting in heat registers, stealing food, pushing or hitting companion residents, screaming and wandering are descriptive of the reasons for their returning from nursing home placements. Presently, eight have been referred for community placement for some time and it has been difficult for the counties to find suitable placement because of this unacceptable behavior.

The Cottage Psychiatric Program has a high prior treatment failure group, 86% (48 out of 56). Also, it is seen that 48% (27) of the Cottage population have entered from or returned from nursing and boarding home placements. Again, overt aggressive behavior is a major characteristic of this patient population (48% or 27 of 56). Twenty one percent (12) have in their history legal problems. From this data, it is seen that the Cottage Program also has a relatively hard core, high risk patient population. Although,the reasons for return to the Cottage Program are varied.

Table II

PATIENT POPULATION CHARACTERISTICS BY DISABILITY GROUP

December 11, 1974

Drug Dependency and Rehabilitation Center - Primary Program	
Total Population	46
Men	44
Women	2
Percent readmission on former treatment failures	39% (18)
Percent with or who have had legal problems	59% (27)
Drug Dependency and Rehabilitation Center - HOPE Program	
Total Population	33
Men	30
Women	3
Percent who have been prior treatment failures	97% (32)
Percent with or who have had legal problems in community	94% (31)
Drug Dependency and Rehabilitation Center - LIV Program	
Total Population	17
Men	17
Percent who are prior treatment failures	100% (17)
Percent with or who have had legal problems in community	100% (17)
Percent who have failed in a community work placement	100% (17)
Psychiatric Medical Rehabilitation Unit	
Total Population	74
Men	41
Women	33
Percent who have had brain surgery	23% (17)
Percent who have neurological and not psychiatric disabilities	20% (15)
Percent who are now referred for placement	11% (8)
Percent who display major behavior problems agression-out	81% (60)
Percent who failed in nursing home placements	27% (20)
Percent who are on major medications	77% (57)
Cottage Psychiatric Program	
Total Population	56
Men	38
Women	18
Percent who have failed in community nursing homes/boarding home placements	48% (27)
Percent who have failed prior inpatient treatment programs	86% (48)
Percent with overt aggressive behavior problems	48% (27)
Percent with or who have had legal problems	21% (12)

Perhaps the most striking feature of the chemically dependency and mental illness patient population is the difficult nature of the problems they present in the community and bring to this treatment facility. Most of the patients are readmissions. Most have presented severe problems to their communities. And finally, most need extended periods of treatment and care. What this means is the Fergus Falls State Hospital is a back up facility to community agencies when they can no longer deal with the problems presented by certain community members. The back up role is an important function to the community. There are also so few from any one county or grouping of counties that it appears a central facility best serves this need.

THE FERGUS FALLS STATE HOSPITAL, STATE REGIONAL RETARDATION CENTER REPORT ON NEEDS FOR THE PRESENT MENTAL RETARDATION POPULATION

The State Regional Retardation Center began operation in 1969 and during the past 4½ years, the Center has discharged 117 mentally retarded residents to community group homes located throughout our 17 county receiving area. We have further discharged another 94 residents to nursing homes, boarding homes, and family homes. These persons were the highest functioning individuals we had at this facility. This has had many ramifications, (for instance, it has placed a strain on community services, such as DAC's and county social service centers) however, this report will deal only with one aspect of those ramifications, that being those residents who have not been successfully placed in a community setting. These residents are the more profoundly retarded and/or have most severe behavior or health problems. In short, we have discharged those who need the least and those who need the most remain. * Seventy-four percent of our current population are classified as severely and profoundly retarded (33% severe and 41% profound). There are statistics available which delineate characteristics of each level, but space will not allow a comprehensive listing. However, a small list will help demonstrate this:

*There are several ways to demonstrate this. The easiest is to question what percent of our population is comprised of the lower level mentally retarded persons and compare it to the total population. This can be accomplished in the following manner: mental retardation is classified in terms of five levels, borderline, mild, moderate, severe, and profound. If we combine the numbers of residents in the bottom two levels (severe and profound) at our facility and compare them to the numbers of residents in the top three levels, we find the following: in 1971, severe and profound comprised 63% of our total MR population; in 1972 this group comprised 71% of our total population; they presently comprise 74% of our total MR population. (Using only those below age 21, the severe and profound levels comprise 82% of that particular patient population. What this means is that as these individuals become adults, the proportion of severely and profoundly retarded will be even further increased.)

63% of the profoundly retarded cannot drink without help
41% are not toilet trained at all
85% need help in dressing
74% need help in undressing
89% need help in putting on or removing shoes
93% cannot leave their residential area without becoming lost
82% have difficulty in ambulation
84% do not talk

Using the above statements, one conjures up an accurate conceptualization of a profoundly retarded person as one who needs help in eating, dressing, undressing, bathing, and toileting. In addition, the profoundly retarded invidual cannot leave his living area without becoming lost or confused and he does not talk. We currently have 125 profoundly retarded persons living on campus.

Using the same approach as above, one finds that the "typical" severely retarded person has the same deficiency as the profoundly retarded, but they are slightly less disabling. For example, a severely retarded individual needs help in eating, dressing, bathing, etc. in order to maintain their present level of functioning. Our job with both of these types of persons is clear - first, we must care for them; secondly, we must educate-train them so that their level of self care skill increases. This needs to be done so that they will not be dependent upon someone to care for them for the rest of their lives, but this progress is slow and demanding of staff. However, it cannot be stressed too strongly that these people will not learn these skills by accident, nor will they learn these skills in a lecture hall, or a classroom with thirty other students in it. They will learn these skills only in high-impact programs using the latest in technological knowledge and professionally trained personnel. It is found then that approximately three-quarters of our population is profoundly and severely retarded. The remaining one-quarter of our population is primarily represented by residents who have some severe behavior problems which keep them from community placement or those who have actually failed in a community placement. The residents which comprise this remaining one-quarter are borderline and mildly retarded. In addition to being retarded, they have behavior problems such as sexually acting out, setting fires, stealing, physical aggression against others, terminal neurological disorders with associated dysfunctional social behavior, uncontrollable seizure problems, severe medical disease, psychotic and suicidal behavior, etc. In short, they are defined by the communities involved as being undesirable for community placement. This does not mean that these people will never be placed in the community as we do work with these people on their particular problems. They are reassessed four times a year in quarterly team reviews with representatives from their respective communities present. It does remain, however, a reasonable assumption that problems of this nature will continue and that there will be a continuing need for programs to deal with specific antisocial behaviors and/or severe physical debilitating conditions.

It is a sound conclusion that those mentally retarded residents remaining at Fergus Falls State Hospital demand more specialized services and programs than those who are presently living in the community. It then follows that if these residents currently at Fergus Falls State Hospital are to be placed in the community, these specialized services and programs which they need must first be developed in the community. Constant communication with the community through

quarterly reviews, area boards, etc. are the mechanisms through which community resources for this next level mental retardation population will be developed. We have placed in the community (specifically in group homes) a larger proportion of our MR resident population than any other state hospital. We have in our seventeen county receiving area proportionately more residential facilities (mostly group homes) for the mentally retarded than any other hospital receiving area in Minnesota. Along with these major accomplishments comes the fact we also have a less placeable present mental retardation population than any other hospital. What this means is that if we are to place the next level of residents, the community must provide more than DAC programs and a positive homelike environment of a group home. Placements will then need 24 hour supervision - ready accessibility to high impact behavior shaping programs. We support this concept. We also realize that sparsely populated rural geographic areas pose unique problems such as efficient accessibility to speech therapy, occupational therapy, physical therapy, extensive medical care, etc. In a metro area such geographic accessibility problems are more easily dealt with. In northwest Minnesota such problems are not overcome so easily. The cost, in addition to the logistical problems, makes the simple statement "development of community services" become a complex expensive problematic reality. These problems, however, do not daunt our desire to push to the maximum limits the community based treatment etiology.

An Attempt to Compare Costs

We have at the Fergus Falls State Hospital no residential unit where the residents are functioning at a community acceptance level. Thus, even though the costs shown in this report are from our highest functioning unit, the functioning level of that unit is lower than the functioning level of residents who have been placed in community group homes. Also, even though every attempt was made to develop comparable costs, the institutional cost includes certain standards of care and services which cannot be separated out as they are a part of the salary of the staff which work under those standards. The cost of maintaining sanitary standards in the kitchen, nutritional standards, building standards, etc. cannot be separated and thus must be included in the cost comparison. Another factor which cannot be separated is the fact that the residential staff used in this example include one LPN per 32 residents and one RN per 64 residents. It also includes the fact that the majority of the remaining staff represented are licensed technicians.

Table III

COMPARATIVE COSTS FOR HIGHEST LEVEL FERGUS FALLS STATE HOSPITAL MR RESIDENTS WITH THOSE MENTALLY RETARDED IN COMMUNITY GROUP HOMES

Community:		Institution:	
Group Home cost per diem, Otter Tail County	7.40	Resident Living[2]	9.55
Day Activity cost per diem, Otter Tail County	7.22	Resident Education	7.45
Transportation to and from DAC[1]	3.25	Resident Education Maintenance Cost[3]	.70
	$17.87		$17.70

The above figures indicate that basic costs for basic needs are somewhat comparable, whether the person lives in a group home or in a regional facility. This means that the future need for regional facilities must be defined in terms of whether or not the institution or the community can best meet the needs of each specific retarded individual. This is a basic philosophy inherent in all contemporary standards which deal with retardation.

SUMMARY: Today there exists a separate, defined need for both community and centralized residential facilities. The population in each type of facility (community and regional) are gradually becoming more unique to each type. In comparing basic lodging and education costs of present group home facilities and the Fergus Falls State Hospital highest level resident living area, we find no significant differences. This indicates that placement for this highest level group is not so much a financial decision, as a service provision and service need decision. As you move, however, to the next lower functioning level retarded individual, the cost for community placement care would increase greatly for comparable service.

1. This cost is the cost that Fergus Falls School District pays for the residents within the School District receiving area to go to and from the DAC in Elizabeth.
2. Resident living includes all the aforementioned standards, plus all other costs such as food (1.20), laundry (.20), housekeeping (.50), plant maintenance (1.30), property and related expenses (.40), food service worker salary (1.10),and salary for daytime residential staff only (4.85; night supervision is a separate cost of approximately 1.35 a day, however, since no group home provides night time coverage, it was not included in this particular cost).
3. This is an estimate that allows for $2,500 per year in an education program for equipment and supplies for approximately 45 students, 252 school days per school year.

SPECIAL REPORT: COMMUNITY GROUP HOME FOR THE MENTALLY RETARDED

The following is a more specific report on the mentally retarded persons who have been placed in community group homes throughout our seventeen county area. With the assistance of community agencies and the hospital research department, we have closely watched and studied our area group home project. We would like to share with you some of this information. It is important both in the encouragement of its success and in the learning from its failures.

Table IV

MR PLACEMENTS FROM FFSH INTO COMMUNITY GROUP HOMES

Total placed April, 1970 through November 30, 1974	117
Total returned from group home placements	22
Proportion of successful placements	81%
Proportion of placement failures	19%

The local community agencies and the Fergus Falls State Hospital can be proud of the extensive effort they have put into the placement of 11 mentally retarded persons into community group homes. The experience to date has been that 81% of these placements have been successful. This, too, demonstrates a continuing cooperative effort among the hospital, county social service department, and community mental health centers and the community agencies in development of this group home project.

It has not all been a success, however, and the fact that one out of five (19%) placements are unsuccessful is of concern. This suggests that a number of the residents placed are high risk placement individuals. This concern is consistent with the increased proportion of profoundly and severely retarded that the Fergus Falls State Hospital now finds in its resident population. Again, however, it should be stated that even though the hospital and community takes risks, the hospital is 100% behind the concept of community placement and feels such risks are worth the gains which have been realized.

MR READMISSIONS FROM COMMUNITY GROUP HOMES

10 returns in first 36 months

12 returns in past 18 months

MR Admissions (July 1973 - through - November 1974)

1st admissions	=	32 (65%)
Readmissions	=	17 (35%)
		49 (100%)

We are now experiencing a readmission phenomena somewhat similar to that of the mental illness and chemical dependency disability groups. In fact, in the past five months the number of readmissions for the mentally retarded equalled the number of first admissions. This is a new experience for the hospital. Strongly suggested here is that the Fergus Falls State Hospital has reached a lower core mental retardation population with a much higher risk of community placement failure.

As we try to place the more difficult residents, the revolving door effect of hospital-community care comes into play for the mentally retarded population much the same as it has for the mentally ill and chemically dependent. Once you reach this point community facilities will have to provide even greater supervision and care if more residents are to be placed in the community and if we want to keep the readmission rate as low as it has been in the past. The problems of providing this increased care and the cost involved must be considered.

The increasing readmission rate for the mental retardation population placed in the community, although of great concern, will not deter the Fergus Falls State Hospital from continuing to take such placement risks. We believe in the concept of community based care. All things being equal, the community is the place for our retarded residents. This does not blind us, however, to the program and economical problems involved with community based care for the profoundly and severely retarded. We are looking very closely at placement failures from group homes. We are very much cognizant of the present limits of group homes and providing certain types of care and services to a needful population. Specifically, we are concerned about the medical care provided in community placements in group homes, we are concerned about occupational therapy, physical therapy, speech therapy, etc.

Summarized below are reasons for residents returning from group homes: Aggressive behavior--threatening group home parents and other residents, breaking windows, starting fires, running away, and taking others' personal property; inappropriate personal habits - toileting problems; hyperactive tendencies - restlessness, agitation, and the demanding of attention; numerous medical problems; interpersonal relationship problems; unacceptable sexual behavior.

Summary

We have tried to share with you our concern about the State Department of Public Welfare's Comprehensive Plan. Specifically, that this plan takes from Region I and IV the opportunity of having a state hospital or at least the opportunity to consider the decision of whether these regions feel the Fergus Falls State Hospital is a necessary community resource or not. If the State Department of Public Welfare is serious about decentralized control, then the decision of utilization of the Fergus Falls State Hospital should reside with the local regions. The amendments to the Commissioner of Public Welfare's Comprehensive Plan have been made on the basis of giving control to the local area.

In the presentation of the inpatient/resident population, our intent has been to show you that the highest level functioning residents have been

discharged from the Fergus Falls State Hospital. We are now basically down to a more disabled patient population. This is true for all three disability groups - the mentally retarded, the mentally ill, and the chemically dependent. In the future, community placements will be much more difficult and the return rate for those placed in the community will be considerably higher.

If we are to discharge the next lower level mentally retarded resident, we must then have community facilities which offer more supervision and programming than presently exist in community group homes. Such increased services at the community level will be costly and geographic population disbursement will be a major problem in terms of efficient, effective community programming. In many respects regional facilities offer the most viable alternative for the more disabled individuals. This is principally true because no one county or small group of counties have enough "patients" to utilize efficiently local long term treatment facilities. Until the community comes up with alternative modes of treatment delivery, the regional facility seems to be the most practical and programmatically sound treatment facility for the more disabled population.