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Dr. E. J. Engberg, Supt.
Faribault State School and Hospital

August 30, 1966

Th Honorable Harold Popp
Chairman
Legislative Building Commission
State Capitol
St. Paul, Minnesota 55101

Dear Senator Popp:

In response to the request of the Legislative Building Commission, I am pleased to write you this letter as an official statement by the Department of Public Welfare concerning our building request for 1967 as it pertains to the Brainerd State School and Hospital and the Faribault State School and Hospital.

This statement is based on studies carried out by our Department in conjunction with the Mental Retardation Planning Council and the Minnesota Association for Retarded Children. These studies, together with our experiences in the interim, do change substantially the original building requests of the two institutions. The background for these decisions is shown in the testimony given before the Legislative Building Commission on May 5, 1966.

1. Brainerd State School and Hospital

We hereby withdraw our request for two new patient buildings at Brainerd State School and Hospital, and ask that there be no further consideration of patient buildings at Brainerd State School and Hospital at this time.

2. Faribault State School and Hospital

We ask that the total of 325 replacement beds eventually scheduled for the Faribault State School and Hospital be built as small units along the lines suggested by our studies of facilities for the mentally retarded in the Scandinavian countries. I will return to this aspect in a moment.

Of this total of 325 replacement beds, the current request before you is for 200 beds. The need is urgent because of the severe overcrowding and the inadequacy of the present facilities.

We ask also that consideration be given to the possibility of locating these facilities not <u>at</u> Faribault but in close proximity to the population served by the Faribault State School and Hospital; that is, in the Twin Cities area. In addition to proximity to the population served, such a location would be close to major medical and educational resourc s.

Our studies suggest that the appropriate target group for this next series of 200 spaces or beds will be retarded children in the four-year-old range, whose retardation is severe, and who have additional physical handicaps or behavior disturbances, or both.

We would hope that for this age group we could construct a series of semi-independent 16-bed units arranged as a "children's village" around some modest but useful central educational, counseling, and rehabilitation services area. The 16-bed units in turn would be subdivided into 8-bed sub-units, discrete to the extent that each would have its own dining, hobby, and living areas.

Facilities such as we envision might appear quite costly at first glance, but we believe studies would show that good, home-like but substantial units could be constructed at <u>less</u> cost than the traditional hospital-type architecture we have customarily used. In this connection it appears that the legal and accreditation status of such units would be much closer to the "extended care facilities" and children's group care categories than they would be to the hospital category. This is of current significance, as the accrediting bodies and rocedures at state and national levels recognize that different levels of care exist, sometimes in the context of a single institution; as when a general hospital maintains an extended care facility. This new trend provides quite a leverage in planning for units that may b located on hospital grounds but do not have to come up to hospital specifications. Thus while we do not have precise cost figures available, I would surmise that we could construct the units at less than the $10-12,000 per bed cost that the State has reached in constructing hospital beds.

Similarly, we have no cost estimates as to staffing requirements. Very likely units like this will require a higher staff-patient ratio than our more typical large wards. The quality of care and the increase in effectiveness through a better grouping of patients will actually result in an eventual savings to the State. In other words, there will be less chance for regression to survival-level care, and a correspondingly greater chance for advancing group-level and individual-level care with the potential of achieving meaningful lives for the patients than our present design and staffing patterns permit.

I realize there are many difficulties and imponderables in this entire matt r, but this represents our present views and the official position of the Department of Public Welfare.

If you need further information, please let me know.

Yours sincerely,

Morris Hursh
Commissioner

cc - Mr. Harold Peterson
Dr. E. J. Engberg