POLICY ANALYSIS SERIES

ISSUES RELATED TO WELSCH v. NOOT / NO. 10

AN UPDATE TO POLICY ANALYSIS SERIES NO. 5

ADMISSIONS/READMISSIONS TO STATE HOSPITALS
JUNE 1, 1981 TO DECEMBER 31, 1981:
THE BEHAVIOR PROBLEM ISSUE

I. INTRODUCTION

Under the provisions of the Welsch v. Noot Consent Decree (1980), the State is required to reduce the number of mentally retarded persons residing in state hospitals to no more than 1,850 by mid-1987. The reduction in population is to take place according to a prescribed schedule. By the terms of the decree there were to be no more than 2,600 people with mental retardation residing in state institutions by July 1, 1981. The State has met that population reduction goal.

According to a census count in June 1981, there were 2,541 people with mental retardation residing in state hospitals (Mental Retardation Program Division, 1982). Although the Department of Public Welfare reports that the rate of discharges is currently slowing, DPW anticipates that the next stipulated reduction level (no more than 2,375 people by July 1, 1983) will be met.

There are now seven state hospitals serving people with mental retardation. During a special session of the 1981 Legislature a bill was passed which called for the closing of the state hospital at Rochester by June 30, 1982. All residents of the Rochester Social Adaptation Center were transferred or placed in alternative community placements, and the center was closed before January, 1982.

The purpose of this paper is to update an earlier report on behavior problems and state hospital admissions (Developmental Disabilities Program, 1981). That report contained a brief review of the literature related to behavior problems and movement trends; a summary analysis of admission/readmission reports from the state hospitals covering the nine-month period from September, 1980 to May, 1981; and an outline of the implications for state policy and planning related to the development of community residential services. The report concluded by summarizing a variety of programmatic and philosophical approaches to behavior management and the reduction of institutional admissions (Leismer, 1981).

II. METHODOLOGY

Like the earlier study, this analysis is based upon a review of state hospital admission/readmission reports. Inasmuch as admission reports

from the individual hospitals vary in content, quality and format, this is a summary analysis of admissions and readmissions and the circumstances leading to placement in an institution.

This analysis included all admission reports on file for the period June 1, 1981 to December 31, 1981. State hospitals reported 221 total admissions/readmissions during this seven-month period. Ninety-two (92) of those admissions were transfers from the Rochester Social Adaptation Center. The closure of the state hospital at Rochester also resulted in a number of other inter-hospital transfers when catchment areas were realigned[1] and the department's policy of regionalized placement was reviewed. In total, there were 119 transfers during the last half of 1981. Since these transfers represent movement within the state hospital system rather than movement into institutions these admissions have been excluded from this analysis. The primary emphasis of this report is admissions/readmissions from community settings.

III. RESULTS

During the seven-month period from June 1, 1981 to December 31, 1981 there were 102 (non-transfer) admissions/readmissions to Minnesota's seven state hospitals.[2] Moose Lake State Hospital reported the fewest admissions (N=4); Cambridge reported the largest number of admissions (N=31). Table 1 summarizes state hospital admissions by facility, type of admission and place of prior residence.

Personal Characteristics

Very little psychometric data were indicated in the 102 reports. State hospital social work representatives (MR Admissions Evaluation, 1981) estimated that 63 percent of all people admitted during calendar year 1980 were severely/profoundly mentally retarded; 23 percent moderately retarded; and 14 percent mild/borderline.

Sixty-one percent (N=62) of the 102 people admitted to state hospitals during the seven-month period were male; 39 percent (N=39) were female.

Eighty-three of the 102 reports indicated the age of the individual. The average age of those 83 people was 25.7 years. The oldest person was 70 years; the youngest was four years. Excluding respite care/parental relief admissions, the average age was 33.2 years (N=46). Thirty-seven reports indicated the age of people who were admitted for respite care. The average age of those 37 people was 16.3 years. The oldest was 50 years; the youngest was five years.

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[1] See the appendix for a map of the state hospital catchment areas.

[2] This analysis does not include the Minnesota Learning Center at Brainerd.

Table 1
Admissions to State Hospitals by Facility, Type and Prior Residence
June 1, 1981 to December 31, 1981
(total non-transfer admissions = 102)

Admission status	Brainerd	Cambridge	Faribault	Fergus Falls	Moose Lake	St. Peter	Willmar	Total N	Total %
Informal (non-respite)	0	6	4	3	1	1	0	15	14.7
Informal (respite)	5	20	4	3	0	3	16	51	50.0
Committed	6	3	3	1	2	3	1	19	18.6
Hold	1	1	1	3	0	0	4	10	9.8
Unspecified	0	1	5	0	1	0	0	7	6.9
Total	12	31	17	10	4	7	21	102	100.0
Type of admission								**N**	**%**
Readmission	7	19	12	0	3	1	7	49	48.0
New/unspecified	5	12	5	10	1	6	14	53	52.0
Total	12	31	17	10	4	7	21	102	100.0
Admitted from								**N**	**%**
Natural/adoptive home	6	20	1	3	0	3	12	45	44.1
Foster care home	0	0	1	1	0	1	1	4	3.9
ICF-MR	6	7	10	1	3	2	5	34	33.3
Nursing home	0	1	1	1	0	0	0	3	2.9
Public institution	0	0	1	0	0	0	0	1	1.0
Other	0	2	2	2	1	0	0	7	6.9
Unspecified	0	1	1	2	0	1	3	8	7.9
Total	12	31	17	10	4	7	21	102	100.0

		N	Percent
Sex:	Female	39	38.6
	Male	62	61.4
	Total	101	100.0

		N	Average	Range
Age:	Non-respite admissions	46	33.2 yrs	4 yrs to 70 yrs
	Respite admissions	37	16.3 yrs	5 yrs to 50 yrs
	Total	83	25.7 yrs	4 yrs to 70 yrs

Type of Admissions

As indicated in Table 1, approximately 65 percent (N=66) of all "non-transfer" admissions were informal admissions. A large proportion of those were classified as respite care/parental relief (77.3 percent; N=51). Nineteen (19) people were committed to state hospitals through court action and ten were admitted on physician's, emergency or peace officer's hold orders. Seven reports did not specify the type of admission.

Readmissions

Table 1 summarizes readmission data for the seven-month period. Not all reports indicated whether a person had resided in a state hospital prior to the current admission or if it was a first-time admission. Out of the 102 admissions, 49 (48 percent) were identified as being readmissions, i.e., at least 49 of the total 102 admissions were readmissions. It is likely that a number of the unspecified cases were actually readmissions.

Data on readmissions should have special significance for policy-makers and community-based service providers. In one sense it is a measure of both the effectiveness of existing community residential alternatives and deinstitutionalization efforts generally. To get a better idea of the extent of readmissions it is helpful to differentiate between short-term readmissions such as respite care and those readmissions which are associated with indefinite and/or potentially longer-term placements. Table 2 indicates that nearly 60 percent (N=29) of the 49 identified readmissions were for respite care/parental relief purposes.

Table 3 presents readmission figures by place of residence. Twenty-five of the 49 readmissions came from natural or adoptive homes. Ninety-two percent (N=23) of the readmissions from natural homes were for respite care purposes. Thirty-seven percent (N=18) of the 49 identified readmissions came from ICF-MR placements. Admission reports indicated behavior problems in 15 (83 percent) of the 18 readmissions coming from ICF-MRs.

Table 2
Readmissions to State Hospitals: Respite Care
June 1, 1981 to December 31, 1981
(total non-transfer admissions = 102)

Type of admission	Total admissions N	Total admissions %	Readmissions N	Readmissions %
Respite care	51	50.0	29	59.2
Non-respite care	51	50.0	20	40.8
Total	102	100.0	49	100.0

Place of Residence

Tables 1 and 3 indicate that over 75 percent of the people admitted to the state hospitals during the seven-month period came from two settings: natural/adoptive homes and ICF-MRs. Foster care homes accounted for four percent (N=4) of the admissions. Three people were admitted from nursing homes. Seven of the 102 people came from "other" settings, which included independent or semi-independent living arrangements, congregate living facilities other than ICF-MRs, and intra-hospital (inter-program) transfers.

Table 3
Readmissions to State Hospitals: Place of Residence
June 1, 1981 to December 31, 1981
(total non-transfer admissions = 102)

Place of residence	Total admissions N	Total admissions %	Readmissions N	Readmissions %
Natural/adoptive home	45	44.1	25	51.0
Foster care home	4	3.9	2	4.1
ICF-MR	34	33.3	18	36.7
Nursing home	3	2.9	0	0.0
Public institution	1	1.0	1	2.0
Other	7	6.9	2	4.1
Unspecified	8	7.9	1	2.0
Total	102	100.0	49	100.0

Table 4 presents respite care admissions by place of residence. Thirty-seven (82 percent) of the 45 admissions from natural homes were classified as respite care/parental relief. Three of the four admissions from foster care homes were similarly classified.

Table 4
Respite Care Admissions to State Hospitals: Place of Residence
June 1, 1981 to December 31, 1981
(total non-transfer admissions = 102)

Place of residence	N	Respite care	Percent of N
Natural/adoptive home	45	37	82.2
Foster care home	4	3	75.0
ICF-MR	34	6	17.6
Nursing home	3	0	0.0
Public institution	1	1	100.0
Other	7	2	28.6
Unspecified	8	2	25.0
Total	102	51	50.0

Behavior Problems

Table 5 presents a summary analysis of admissions related to behavior problems. An admission was classified as "behavior-related" if maladaptive behavior or behavior problems were cited within the report. Although admission reports varied greatly in content and quality, at least an indirect relationship between behavior and state hospital placement could be inferred when behavior was mentioned.

Forty-seven (46 percent) of the 102 reports indicated that the admission/readmission was related to behavior problems. Forty-eight reports stated that admissions were sought for reasons other than behavior, or were for respite care purposes. Seven reports did not specify any reason for admission. Twenty-nine (85 percent) of the 34 admissions from ICF-MR settings were behavior-related.

Behavior problems cited within the reports were similar to those reported in the earlier admission/readmission analysis (Policy Analysis Series No. 5, August 1981; pages 10-13).

Table 6 is a summary analysis of readmissions and behavior problems. Forty-three percent (N=21) of the 49 people who were identified as having resided at the hospital before were admitted for behavior problems. Twenty-seven (55 percent) of the 49 reports cited other reasons or respite care as the reason for an admission. One readmission report did not specify any reason.

Table 5
Admissions to State Hospitals: Behavior Problems
June 1, 1981 to December 31, 1981
(total non-transfer admissions = 102)

Place of residence	N	Behavior-related	Percent of N
Natural/adoptive home	45	9	20.0
Foster care home	4	1	25.0
ICF-MR	34	29	85.3
Nursing home	3	3	100.0
Public institution	1	0	0.0
Other	7	4	57.1
Unspecified	8	1	12.5
Total	102	47	46.7

Table 6
Readmissions to State Hospitals: Behavior Problems
June 1, 1981 to December 31, 1981
(total non-transfer admissions = 102)

Readmissions	N	%
Behavior-related	21	42.9
Not behavior-related	27	55.1
Unspecified	1	2.0
Total	49	100.0

Admissions from ICF-MRs

Admissions/readmissions from ICF-MR settings are of interest for two reasons: 1) Rule 34 facilities represent an important component of the community-based service system; and 2) Rule 34 facilities are licensed and paid to provide active treatment to residents on a 24-hour basis.[1]

In December, 1979 there were approximately 185 ICF-MRs serving just under 3,500 residents. There are now approximately 290 facilities serving some 4,700 residents. The importance of these facilities in providing appropriate

[1] 12 MCAR 2.034 (5 S.R. 429/5 S.R. 1888); also MHD 391-401 [Minn. Stat § 14.56 (1971)].

community residential alternatives and in furthering the state's deinstitutionalization efforts is obvious. The capacities of these facilities to manage and/or reduce the incidence of behavior problems--a major reason for institutional placements--is an important and timely policy issue.

Table 7 presents information on the size of the facilities in which the 34 people had been residing prior to admission. In three cases it was not possible to determine any characteristics of the facility. Although size is only one of many factors associated with normalized, community-based residential services and is not necessarily indicative of a non-institutionalized living environment, the literature suggests that attributes most influential in producing gains in adaptive behavior and general developmental growth are more likely to prevail in smaller facilities.[1] About one-half (N=15) of the admissions from ICF-MRs came from facilities which were licensed to serve 16 or fewer people. The average licensed capacity of the 31 facilities was 46 residents. The smallest facilities were licensed to serve six people; the largest 171.

Table 7
Admissions from ICF-MRs: Size Characteristics
June 1, 1981 to December 31, 1981
(total ICF-MR admissions = 34)

Licensed capacity	N	%	Range
1 to 6 residents	4	12.9	---
7 to 16 residents	11	35.5	7 - 16
17 to 32 residents	3	9.7	24 - 30
33 + residents	13	41.9	33 - 171
Total	31	100.0	6 - 171

Table 8 presents behavior-related readmissions from ICF-MRs. Eighteen of the 34 ICF-MR admissions were identifed as readmissions; 15 (83 percent) of those were admitted for reasons related to behavior.

[1] See Policy Analysis Series No. 2, April 1981; pages 7-9. See also Leismer (1981) quoted in Policy Analysis Series No. 5, August 1981; pages 15-19.

Table 8
Readmissions from ICF-MRs: Behavior Problems
June 1, 1981 to December 31, 1981
(total ICF-MR admissions = 34)

Readmissions	N	%
Behavior-related	15	83.3
Not behavior-related	2	11.1
Unspecified	1	5.6
Total	18	100.0

IV. SUMMARY

The following tables summarize the total admissions/readmissions during the sixteen-month period from September 1, 1980 to December 31, 1981. The data from the earlier admission report (Policy Analysis Series No. 5, August 1981) is combined with the information reported in this paper to present an overview of state hospital admissions during that year and a half.

From September, 1980 to December, 1981 there were 341 total admissions/re-admissions to state hospitals. One hundred-nineteen (119) of those admissions were inter-hospital transfers which resulted from the closing of the state hospital at Rochester. The primary focus of this paper is admissions from community settings. Since these 119 "admissions" represent movement within the system rather than movement into the system, they have been excluded from the analysis. The total number of "non-transfer" admissions/readmissions during the sixteen-month period was 222.[1]

Table 9 summarizes admissions/readmissions by state hospital, type of admission and place of residence. Cambridge reported the largest number of admissions during the sixteen-month period (N=65); among the state hospitals currently operating, Moose Lake reported the fewest admissions (N=9).

Personal Characteristics

Personal characteristics for the 34 people admitted to Cambridge during the first nine months were not available. Of the remaining 188 people admitted to state hospitals, 66 percent were male (N=123); 34 percent (N=64) were female.

Admission reports identified the age of 143 people. The average age of these 143 individuals was 25.9 years. The youngest person admitted during the sixteen-month period was two years; the oldest was 70 years.

[1] This number actually includes four transfers which took place within the first nine months of this report period. Since it is not possible to go back and subtract these four "admissions" from the earlier analysis, they have been included in this summary.

Table 9
Admissions to State Hospitals by Faciltiy, Type and Prior Residence
September 1, 1980 to December 31, 1981
(total non-transfer admissions = 222)

Admission status	Brainerd	Cambridge	Faribault	Fergus Falls	Moose Lake	Rochester	St. Peter	Willmar	Total N	Total %
Informal (non-respite)	2	11	15	9	4	1	4	3	49	22.1
Informal (respite)	14	39	9	11	0	1	6	22	102	45.9
Committed	11	8	4	1	2	0	3	1	30	13.5
Hold	7	1	2	3	1	0	2	6	22	9.9
Unspecified/other[1]	1	6	8	1	2	0	0	1	19	8.6
Total	35	65	38	25	9	2	15	33	222	100.0
Type of admission									**N**	**%**
Readmission	15	37	26	3	4	0	2	8	95	42.8
New/unspecified	20	28	12	22	5	2	13	25	127	57.2
Total	35	65	38	25	9	2	15	33	222	100.0
Admitted from									**N**	**%**
Natural/adoptive home	14	30	4	11	0	0	4	8	81	36.5
Foster care home	1	6	3	1	1	0	2	1	15	6.8
ICF-MR	16	16	20	6	6	2	6	9	81	36.5
Nursing home	0	1	1	1	1	0	0	1	5	2.2
Public institution	0	5	4	2	0	0	1	1	13	5.8
Other	1	6	5	2	1	0	0	0	15	6.8
Unspecified	3	1	1	2	0	0	2	3	12	5.4
Total	35	65	38	25	9	2	15	33	222	100.0

[1] Includes 8 admissions from the earlier report which were classified as "return from provisional discharge" and 4 admissions which were classified as transfers.

		N	Percent
Sex:	Female	64	34.2
	Male	123	65.8
	Total	187	100.0

	N	Average	Range
Age:	143	25.9 yrs	2 yrs to 70 yrs

Type of Admissions

Over two-thirds (N=151; 68 percent) of all non-transfer admissions were informal admissions. More than two-thirds (N=102; 67.5 percent) of those 151 admissions were for respite care/parental relief; and nearly 46 percent (N=102) of all admissions were classified as respite care.

Readmissions

Ninety-five (43 percent) of the 222 admissions were identified as readmissions, i.e., the individuals were identified as having resided at the hospital at least once before. The actual number of readmissions are probably higher than this analysis indicates. The reports did not always indicate whether an admission was a first-time admission or a readmission. Several reports stated that individuals had been admitted to other state hospitals--these were not counted as readmissions in this analysis.

Table 2 suggests that a high percentage of readmissions are classified as respite care/parental relief admissions.

Place of Residence

Table 9 figures show that most people admitted to state hospitals came from family homes (N=81; 36.5 percent) and ICF-MR settings (N=81; 36.5 percent). Admission reports summarized in this paper (N=102) indicate that approximately eight out of ten admissions from family homes were for respite care/parental relief purposes. Smaller proportions came from foster care homes (6.8 percent), nursing homes (2.2 percent) and other public institutions such as the Braille and Sight Saving School at Faribault (5.8 percent). Fifteen people (6.8 percent) came from "other" residences such as independent or semi-independent living arrangements, non-ICF-MR congregate living facilities, or community hospitals.

Behavior Problems

Table 10 reports admissions related to behavior problems. The figures do not include the 34 admissions to Cambridge State Hospital during the first nine months of the sixteen-month report period--no descriptive data on those individual admissions were available. Over half (54.3 percent; N=102) of the remaining admission reports (N=188) identified behavior problems. Forty-one percent (N=77) indicated reasons other than behavior, e.g., respite care; five percent did not specify any reason for admission.

Table 10
Admissions to State Hospitals: Behavior Problems
September 1, 1980 to December 31, 1981
(total non-transfer admissions = 222)

Admissions	N	%
Behavior-related	102	54.3
Not behavior-related	77	40.9
Unspecified	9	4.8
Total	188	100.0

Table 11 presents data on behavior problems and readmissions. Again, since descriptive data on admissions to Cambridge from September, 1980 to May, 1981 were not available, the 18 readmissions during that time period have been excluded from the analysis. Fifty-two percent (N=40) of the 77 readmissions for which descriptive data were available identified behavior as a reason for seeking placement in a state hospital. Forty-seven percent (N=36) of the readmissions were for reasons other than behavior.

Table 11
Readmissions to State Hospitals: Behavior Problems
September 1, 1980 to December 31, 1981
(total readmissions = 95)

Readmissions	N	%
Behavior-related	40	51.9
Not behavior-related	36	46.8
Unspecified	1	1.3
Total	77	100.0

As indicated in Table 2, a large proportion (60 percent) of readmissions were classified as respite care. Although many of these respite care/ parental relief admissions were also associated with behavior problems, it is helpful to examine more closely those readmissions which were not classified as "short-term." Table 12 presents non-respite care readmissions to state hospitals during the sixteen-month period from September 1, 1980 to December 31, 1981. Over 90 percent of the non-respite readmissions were associated with behavior problems.

Table 12
Non-Respite Care Readmissions: Behavior Problems
(total readmissions = 95)

Non-respite care readmissions	N	%
Behavior-related	33	91.7
Not behavior-related	2	5.5
Unspecified	1	2.8
Total	36	100.0

Admissions from ICF-MRs

Thirty-seven percent (N=81) of the 222 admissions came from ICF-MR settings. Facility characteristics were identified in 62 admission reports. The average licensed capacity (size) of those 62 facilities was 37.9 residents. The smallest facilities were licensed to serve six people; the largest 171. Over half (56 percent) of the people admitted from those 62 facilities came from a residence which was licensed to serve 16 or fewer people.

Table 13
Admissions from ICF-MRs: Size Characteristics
September 1, 1980 to December 31, 1981
(total ICF-MR admissions = 81)

Licensed capacity	N	%	Range
1 to 6 residents	7	11.3	---
7 to 16 residents	28	45.1	7 - 16
17 to 32 residents	5	8.1	24 - 30
33 + residents	22	35.5	33 - 171
Total	62	100.0	6 - 171

Table 14 presents behavior-related admissions from ICF-MRs. The analysis excludes admissions to Cambridge State Hospital during the first nine months of the sixteen-month report period--no descriptive data on those admissions were available. The table indicates that a very high percentage of the admissions from ICF-MRs are related to residents' behaviors. Eighty-two percent of all admissions were behavior-related; 87 percent of admissions which were identified as readmissions were related to behavior.

Table 14
Admissions from ICF-MRs: Behavior Problems
September 1, 1980 to December 31, 1981
(total ICF-MR admissions = 81)

Admissions	Total admissions		Readmissions	
	N	%	N	%
Behavior-related	59	81.9	27	87.1
Not behavior-related	12	16.7	3	9.7
Unspecified	1	1.4	1	3.2
Total	72	100.0	31	100.0

V. SUMMARY/IMPLICATIONS

The admission reports indicate that over half of all admissions to state hospitals are because of behavior problems. Moreover, nearly all people who are returned to state hospitals for reasons other than respite care are readmitted because of behavior problems.

Most admissions come from either family homes or ICF-MR settings. Although the number of people admitted from group homes may be small relative to the total number of residents living in ICF-MRs, those admissions represent people who were determined to be ready, and were accepted for community placement. Those admissions may suggest a need for training in behavior management and/or the development of community support services.

Deinstitutionalization involves not only moving people out of institutions but also establishing community support programs which will reduce or eliminate initial admissions and readmissions. Several studies show that behavior problems are a major reason for admissions/readmissions to public institutions. The results from these studies corroborate those findings. The continued success of Minnesota's deinstitutionalization efforts will depend greatly upon the development of behavior management skills and appropriate services in the community.

Several authors have outlined a number of strategies for managing behaviors in community settings:

- developing specialized behavior management services utilizing existing resources such as mental health centers and state hospital staff; or creating crisis/home intervention teams. These models have two purposes: 1) to provide necessary behavior modification programming in the communities where the problems occur; and 2) to involve parents and community staff in the treatment programs, thereby providing them with essential training.

- developing residential models specifically designed to serve people with adaptive needs. Not everyone may "fit" into existing residential environments. One example of an alternative model might be specially trained foster care homes. Service providers are first trained and then expected to work with people who have special needs.

- emphasizing the development of smaller, home-like residences. Many attributes of smaller facilities increase the likelihood that behavior-related problems can be avoided: staff activities tend to be more client-oriented; the potential for consistency in implementing behavior management techniques is greater given the lower staff-resident ratios; responsibilities for individual clients are not easily ignored in smaller group settings.

- developing appropriate respite care/family support services. It has been estimated that six respite care slots may prevent from six to 20 admissions or returns in a year. Appropriate help at the right time can help prevent problem situations from getting out of hand and may help prevent institutional placements. Crisis center hotlines, mutual support groups and trainer-in-the-home programs can help families cope with situations when behavioral crises arise in the home. Similar programs for residential program staff could be developed.

- developing effective individual program plans. Appropriate, individualized program plans focus upon client-specific needs. It is helpful to have available written, individualized methodologies when attempting to deal with specific behavior problems. Individualized program plans also help to ensure that all members of the interdisciplinary team are actively involved in the development and growth of residents

Most importantly, communities and service providers must develop a commitment to keeping people in the community, to creating a community-based system which works:

> To assure the availability of a comprehensive array of community-based residential and habilitative

> services for persons in need of supportive residential living, good leadership and a dogged commitment to successfully creating such a system is required. Staff have to be resolved to keep the "IN" door to the institution barred but to not deny services for persons in need. This means staff are going to have to be tenaciously solution-oriented rather than problem-oriented. Instead of regretfully accepting someone in the front door to the institution "because of a problem," staff must aggressively pursue alternative means for addressing the client's, family's, or provider's particular needs which resulted in a knock on the door. This also means that state or county agencies will have to increase their awareness of and sensitivity toward responding realistically to the major needs perceived by community providers . . .
>
> (Leismer, 1981; pp. 1-2)

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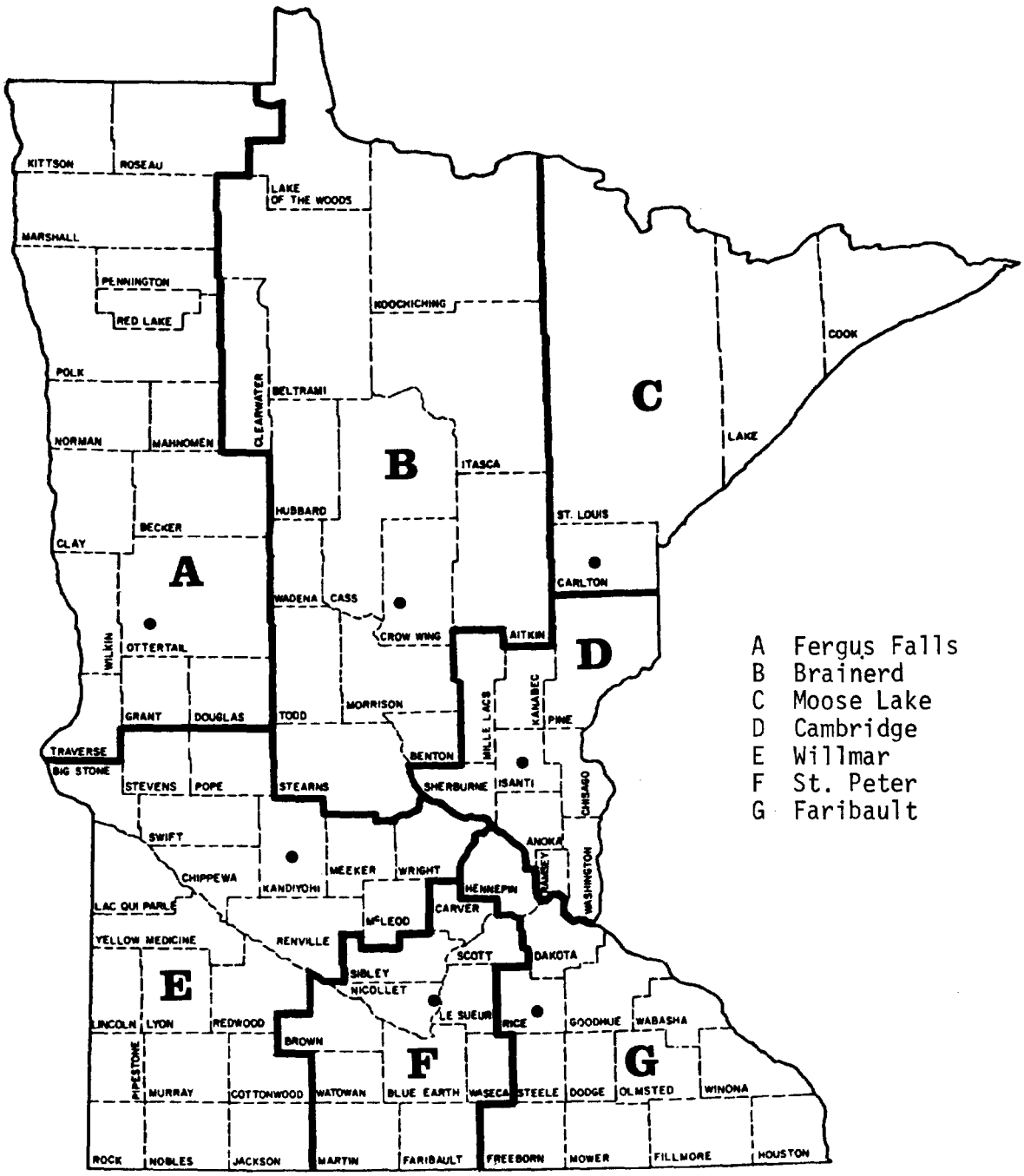
Richard Nelson, M.D., Council Chair - Colleen Wieck, Ph.D., Director

The purpose of this series is to enhance communication among state and local agencies, service providers, advocates, and consumers on timely issues. We encourage reader participation by giving us feedback on your ideas and perceptions of this problem. This paper may be cited:

Developmental Disabilities Program. Policy Analysis Series #10: (An Update to Policy Analysis Series #5) Admissions/Readmissions to State Hospitals June 1, 1981 to December 31, 1981: The Behavior Problem Issue. St. Paul, MN: Developmental Disabilities Program, Department of Energy, Planning and Development, April 9, 1982.

APPENDIX

Mental Retardation
State Hospital Catchment Areas



A Fergus Falls
B Brainerd
C Moose Lake
D Cambridge
E Willmar
F St. Peter
G Faribault