

SUMMARY FINDINGS OF THE 1978-1979 IN-DEPTH NATIONAL INTERVIEW SURVEY
OF PUBLIC AND COMMUNITY RESIDENTIAL FACILITIES
FOR MENTALLY RETARDED PEOPLE

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INTRODUCTION

During the past five years, the Developmental Disabilities Project on Residential Services and Community Adjustment has undertaken national studies of residential facilities and homes serving mentally retarded people. In response to the need for basic information about the changing patterns of residential services, the project established four priority areas to collect national data, including (a) the administrative characteristics of facilities, such as costs, personnel, practices, and policies, (b) the demographic, physical, and behavioral characteristics of people in residential facilities, (c) movement statistics including factors related to first admission and readmission to residential facilities, and (d) the placement of former residents of public residential facilities.

The first phase of the project consisted of two national mail surveys of residential facilities:

- (1) National Mail Census of Community Residential Facilities. During 1977-1978, 4,427 community residential facilities participated in a national mail census. Data on facility characteristics such as type, ownership, opening year, and bed capacity were collected, as well as resident characteristics such as age, sex, admission criteria, and number of admissions, readmissions, and discharges.
- (2) National Mail Census of Public Residential Facilities. During 1977-1978, 263 public residential facilities participated in a national mail census performed under subcontract with Richard C. Sheerenberger, Ph.D., Director of the Central Wisconsin Center for the Developmentally Disabled in Madison, Wisconsin. Information was collected on a similar set of facility and resident data items.

The outcome of the first phase of the project was an identification of, and basic understanding of the residential patterns in the United States. In order to gather more specific detail on a greater number of areas, such as resident characteristics (adaptive behavior, physical characteristics, maladaptive behavior) and facility characteristics (cost, personnel, and administrative practices), the second phase of research was designed. Using the results of the mail censuses, a national probability sample of facilities and current residents was selected. Several resident subgroups, such as new admissions, readmissions, discharges, and current residents, were also selected. This survey was completed during 1978-1979 with 75 public and 161 community residential facilities participating and approximately 2,000 residents included from these facilities located throughout the United States. The major components of this study were:

- (1) Probability Sample Survey of Community and Public Residential Facilities. The administrator of each facility was interviewed about the facility characteristics, staffing, admission policies, administrative practices, and long range plans. Information was also gathered on the finances, staff composition, and staff turnover of the facility.
- (2) Probability Sample Survey of Residents. A sample of residents was gathered from the facility's records. For each selected resident, an interview was completed with a staff member who was most knowledgeable about the resident's physical and behavioral characteristics, day programming, service utilization, and service needs.

A final issue recognized by the project was the community placement of mentally retarded people released from public residential facilities. Several other studies were conducted to examine the issues of resident movement, community adjustment, and personnel turnover a year after the second phase, and these surveys comprise the third phase.

This brief report presents selected findings from the national interview sample survey of public and community residential facilities for mentally retarded persons conducted from September, 1978 through April, 1979 and the follow-up of direct care staff respondents conducted during the summer of 1980. A general description of the methodology employed is provided, followed by a profile of the residents and the facility. More detailed information on the findings summarized in this brief is available in the related project reports listed in the references section.

METHODOLOGY

Sample Design

A two-stage probability sample design was developed in cooperation with the Sampling Section of the Survey Research Center at the University of Michigan's Institute for Social Research. In the first stage, a sample of 78 public and 180 community residential facilities were selected so that the probability of selection was proportionate to the number of mentally retarded residents and so that the distribution of sample facilities across census regions and size classes was in close agreement with the distribution of the national resident population (Hess, 1979a, 1979b).

The public residential facilities (PRFs) were selected from the directory of 263 facilities who participated in the 1977 survey of PRFs conducted by Dr. Richard C. Scheerenberger in cooperation with the University of Minnesota Developmental Disabilities Project on Residential Services and Community Adjustment. That survey included all facilities meeting the following definition:

A state sponsored and administered facility which offered comprehensive programming on a 24-hour, 7 days-a-week basis as of June 30, 1977. (1978, p. 2)

Community residential facilities (CRFs) were selected from among 4,427 facilities that participated in the 1977 national mail census. All of these facilities met the following definition:

Any community-based living quarter(s) which provides 24-hour, 7 days-a-week responsibility for room, board, and supervision of mentally retarded persons as of June 30, 1977, with the exception of: (a) single family homes providing services to a relative; (b) nursing homes, boarding homes, and foster homes that are not formally state licensed or contracted as mental retardation service providers; and (c) independent living (apartment) programs which have no staff residing in the same facility. (Bruininks, Hauber, & Kudla, 1979, p. 11)

In the second sampling stage, five sample groups of residents were systematically and independently selected. The two primary groups were current residents of CRFs and current residents of PRFs:

Current Resident. Any mentally retarded person on the rolls of a facility as of the night prior to preparing the sample list, and for whom a bed was held on a 24 hour-a-day basis, even though he or she might have been temporarily away on overnight leave or in a hospital. Residents on trial placement at another facility were excluded. (Hauber, Bruininks, Wieck, Sigford, & Hill, 1981, p. 26)

Within PRFs three additional samples were selected:

New Admission. A mentally retarded resident who had been admitted for the first time to a sample facility during the time period of July 1, 1977 through August 31, 1978. (Hauber, et al., 1981, p. 26)

Readmission. A mentally retarded resident who had been admitted for the second time or more to a sample facility during the time period of July 1, 1977 through August 31, 1978. (Hauber, et al., 1981, p. 26)

Released Resident. A mentally retarded person who had left, been transferred, formally released or discharged from a sample facility (for reasons other than death) during the time period January 1, 1978 through August 31, 1978. The person was no longer officially on the rolls of the facility; or the facility no longer maintained a bed for the person's use. (Hauber, et al., 1981, p. 26)

Survey Instruments

The eleven instruments used in the Phase II study were based upon research issues identified in the literature and reviewed by a national panel of 30 people knowledgeable about services for mentally retarded persons. Many sources were used in the development and review of specific questionnaire items, and each item was again reviewed by outside experts. Field procedures and interview content were field tested in a sample of Canadian residential facilities, and interview questions and format were revised as a result. A second field test was conducted in a group of United States facilities to assure that final survey instruments and procedures were optimal.

An administrator interview questionnaire, financial questionnaire, staff composition list, staff separation list for a 30-day period, and building description sheets gathered information about each facility and its administrative characteristics.

Demographic information about individual residents, including date of birth, date of admission, previous type of residential placement, age, height, weight, and diagnosed degree of retardation, was obtained from each resident's records and recorded on a Personal Record Sheet.

Interviews about residents were conducted with direct-care staff persons who were most directly involved with the resident's day-to-day care for at least two months prior to the survey. Each interview, which lasted approximately one hour, covered topics such as program plans, day programs, leisure time activities, family and social contact, specialized services, characteristics of the residential environment, and physical, health, and behavioral characteristics of each resident.

Characteristics of the residential facility's physical and treatment environment were also evaluated. The physical environment of a facility was rated by the interviewer after a walking tour of the facility. The dining area, living room area, bathroom, bedroom and yard were each rated on a five-point scale that ranged from "very home-like" to "non-home-like." Because large facilities had several living units with varying characteristics, the number of physical environment scales completed per facility ranged from 1 to 25.

Each staff person who was interviewed was also asked to evaluate the degree to which residential programs promoted resident autonomy and activity using nine items originally part of Jackson's (1969) Characteristics of the Treatment Environment (CTE) and more recently, were included in a revision of this scale by Silverstein, McLain, Hubbell, and Brownlee (1977). The number of CTE scales completed per facility ranged from 1 to 32.

In the follow-up of direct-care staff (Phase III) a questionnaire requesting information on the occupational status of staff one year later was mailed to the contact person at each facility.

Data Collection Procedures

Trained interviewers from the Survey Research Center of the University of Michigan conducted onsite interviews under the supervision of the field office at

Ann Arbor. The project staff at the University of Minnesota collaborated with the University of Michigan in ensuring quality control in conducting the study. Step-by-step procedures were developed by the University of Minnesota staff in guiding the interviewers through the visit. Training materials were also provided by the Minnesota staff to assure standardized procedures in handling each interview. In addition, two comprehensive (236 page) instruction books were developed separately for the public and community facilities. A complete description of the field procedures is described elsewhere (Hauber, Bruininks, Wieck, Sigford, & Hill, 1981).

Nonresponse, Weighting, and Estimation Procedures

Tables 1 and 2 present a summary of the Phase II sample execution results. Several facilities that declined to participate or had closed after the time of original selection were replaced by other facilities of the same size and from the same geographic region. At the time of the study there were six community residential facilities in the United States that had more than 400 residents. Only one of these facilities agreed to participate in the study. After an extensive but unsuccessful effort to recruit these non-participating facilities, project staff decided to keep the one participating facility in the study, made no adjustment for nonresponse of the other large facilities, and reported that CRFs with more than 400 residents are underrepresented.

The sampling design specified the appropriate number of residents to sample within each facility. No adjustment was made for nonresponse of individual residents (response rates were all above 90%). A weight adjustment was made for facility nonresponse and for disproportionate sampling (cf. Hauber, et al., 1981). The estimation procedure employed for this survey consisted basically of inflating the sample counts by the reciprocal of the probabilities of selection. Specific weighting procedures varied across subject areas and type of analysis. (See reference list for major project reports that give specific details.)

Data Processing

Several series of editing checks were performed during the course of the Phase II survey. They included field follow-ups for missing and inconsistent data, extensive manual and computer editing of the survey instruments to assure that all responses were accurate, consistent, logical, and complete.

RESIDENT PROFILE

Personal Characteristics

In PRFs, 55.4% of residents were male; in CRFs, 60.1% of residents were male. Almost 17% of CRF residents and 10% of PRF residents were less than 16 years old. Thirty percent of PRF new admissions and 17% of readmissions were less than 16 years old. Racial or ethnic minorities constitute 13% of CRF residents, 18% of all PRF residents, 28% of PRF new admissions, and 20% of PRF readmissions.

Table 1

Summary of Facility Participation
in 1978-1979 National Interview Study

Facilities	Originally selected	Participants	Replacement facilities	Final participants
CRFs	180	154	7	161
PRFs	78	72	3	75

Table 2

Summary of Resident Participation
in 1978-1979 National Interview Study

Group	Originally designated	Participating residents
CRF current residents	1024	965
PRF current residents	983	953
PRF new admissions	220	211
PRF readmissions	210	192
PRF releases	497	478

Additional Handicaps

PRF residents (56%) were more likely than CRF residents (41%) to have handicaps in addition to mental retardation. A significantly greater proportion ($p < .01$) of PRF residents (22%) than CRF residents (13%) had had an epileptic seizure during the past year. Physical handicaps or cerebral palsy occurred among 26% of PRF and 21% of CRF residents. Nineteen percent of PRF and 11% of CRF residents were non-ambulatory. In CRFs, 6% of residents were blind or severely visually impaired, and 3% were deaf or had a severe hearing loss; in PRFs, the percentages were 8.6% and 5.3%, respectively.

Health

Eighteen percent of CRF residents and 20% of PRF residents were reported to have chronic health problems. Circulatory system disorders, including heart and blood pressure problems, were the most common health problem, affecting 7.2% of CRF and 7.6% of PRF residents. During a one-year period, approximately 90% of all residents had received a physical examination; 28% had seen a doctor because of a temporary illness such as a cold or flu, and 12% for treatment of a chronic illness. Six percent of CRF and 18% of PRF residents were treated for an accident or injury. Treatment for temporary and chronic illnesses as well as for accidents or injury was more often reported for PRF residents ($p < .01$) than for CRF residents.

Level of Retardation

Residents' records indicated that 75% of PRF and 38% of CRF residents were diagnosed as severely or profoundly retarded.

Behavioral Characteristics

Seven percent of CRF and 19% of PRF residents were nearly totally dependent; an additional 8% (CRF) and 22% (PRF) actively cooperated but required physical help or manual guidance to perform most activities. Seventy-seven percent of CRF and 46% of PRF residents talked with at least a few words; while 9% and 6% were reported to be very difficult to understand. Formal sign language was the usual communication mode for approximately 2% of all residents; 10% of CRF and 21% of PRF residents usually pointed or used gestures.

Fifty-one percent of CRF residents and 28% of PRF residents could go four blocks from home or school or walk alone or with peers without getting lost; 38% of CRF and 14% of PRF residents were able to find a planned destination in the community.

Maladaptive Behavior

Maladaptive behaviors were more prevalent among PRF residents, particularly among PRF readmissions, than among CRF residents ($p < .01$). Overall, 47% of CRF residents, 60% of all PRF residents, 69% of PRF new admissions, and 68% of PRF readmissions were reported to exhibit at least one type of maladaptive behavior. Most maladaptive behavior elicited verbal responses from staff; the resident was asked to stop, more suitable behavior was rewarded, or the behavior was ignored.

Leisure Activities

An examination of residents' participation in leisure activities during a seven-day period revealed that CRF residents were more likely to have used community resources such as shopping centers or restaurants, but PRF residents were more likely to have seen a movie, attended a party or concert, or to have gone for a walk; CRF and PRF residents were equally likely to have attended religious services or to have gone on a field trip. Eleven percent of PRF and 26% of CRF residents had engaged in more personally oriented leisure activities such as hobbies and individual projects.

A desire for additional leisure activities was reported for 38% of PRF and 32% of CRF residents. Problems with obtaining additional leisure activities included the unavailability of some desired activities at the facility or in its locale as reported for 15% of CRF and 9% of PRF residents. Personal characteristics of residents such as ability level, health, and behavior problems interfered with leisure activity participation for less than 6% of all residents. The most frequently cited problem was that there was "no one to accompany the resident" for 12% of CRF and 16% of PRF residents.

Contact with Friends and Family

A reported 88% of CRF and 35% of PRF residents get along well with peers within their facility. Forty-two percent of CRF and 63% of PRF residents have no friends at all, even among other residents and staff. Only 16% of CRF and 5% of PRF residents had visited with a friend from outside the facility during a one-week period prior to the interview. Contact with non-handicapped peers occurred on a monthly basis for 16% of CRF and 3.6% of PRF residents. Twenty-seven percent of CRF and 12% of PRF residents had friends among their peers; 15% of CRF and 19% of PRF residents had staff friends (on line staff during off duty hours); 12% of CRF and 6% of PRF residents had volunteer friends. Less than 1% of either group of residents had a friend among their neighbors.

Sixty-six percent of CRF and 53% of PRF residents have some contact with their families. Staff felt that distance, other family obligations, or family characteristics were the major factors limiting family contact. Generally, the longer a resident had been at a facility, the less frequent family visits became.

Program Participation

Of the 60.7% (PRF) and 84.0% (CRF) residents who attended structured day programs outside the living unit, 17.3% (PRF) and 32.7% (CRF) attended a work related program, 19.6% (PRF) and 29.2% (CRF) attended a school program, and 16.1% (PRF) and 20.2% (CRF) participated in a Day Activity Center (DAC) program.

Sixteen percent of CRF and 39.3% of PRF residents did not attend any structured day program outside the living unit. Of this group, 10.4% of PRF and 4.4% of CRF residents received homebound instruction (defined as "certified teachers come into the living unit to conduct a homebased education or stimulation with him/her"); the remaining 28.8% of PRF and 11.6% of CRF residents had neither homebased instruction nor an outside structured day program.

Program Characteristics

The percentage of CRF residents who attended a day program away from their residential facility included 79.3% of those involved in work programs, 56% of those attending school programs; and 66.2% of those attending DACs. For PRF residents, the percentages attending day programs away from the facility were 14.5% of those in work placements, 21.9% in school programs, and 3.6% in DAC programs.

The major type of work program reported for both PRF (52.6%) and CRF (67.2%) residents was sheltered workshops. Sheltered employment in non-workshop settings employed 8.1% of PRF and 5.3% of CRF residents. These jobs were usually on the facility grounds with pay rates from a few cents an hour to almost minimum wage. More CRF (9.9%) than PRF (4.6%) residents were reported to be working in competitive employment situations.

In DAC programs for PRF residents, the two most frequently cited activity components were physical development activities (31.5%), academic/preacademic skills (23.5%), basic self-care (22.8%), recreation (17.3%), and crafts (15.4%). For CRF residents, the five most often cited components were independent living skills (38.7%), academic/preacademic skills (38.1%), recreation (36.1%), basic self-care (34%), and physical development activities (26.3%). (Percentages total more than 100% because up to four components were coded for each program.)

Supplemental Programs

Supplemental programming outside the living unit, in addition to a major outside day placement, was reported for 17.2% of PRF and 22.3% of CRF residents. For PRF residents, the most frequently cited program components were recreational activities, physical development activities, self-care, academic/preacademic skills, and sensory stimulation; for CRF residents, they were physical development activities, recreational activities, self-care, academic/preacademic skills, and work related programming.

Professional educators provided the homebased educational or stimulation programming for 91% of the PRF and 69.4% of the CRF residents participating in such programs. The three most frequently cited components of these programs were similar for PRFs and CRFs: physical development activities, academic/preacademic skills, and self-care skills. Physical therapy and sensory stimulation were also mentioned as important components.

Non-Participants

Approximately 29% of PRF and 12% of CRF residents did not participate in a program outside the living unit nor did they receive homebased instruction. The four most frequently cited daytime activities of these PRF residents were: plays/games (35.9%), sits/sleeps (33.8%), self-care programming (25.1%), and walks/exercises (21.6%). For CRF residents, the activities were plays/games (42.8%), sits/sleeps (36.6%), crafts (17.8%), walks/exercises (13.4%), and colors/paints (11.6%). (Percentages total more than 100% because of multiple responses.) It is readily apparent that many of these activities are relatively unstructured and non-developmental; in addition, aimless activities such as tearing newspapers and wandering around were mentioned as major daily activities for 12.5% of PRF residents not involved in an outside day program.

Reasons for Non-Participation

Reasons cited for residents' lack of participation in outside day programs included resident incapacity (inability to participate due to profound retardation,

short attention span, etc.) for 34.5% of PRF and 14.8% of CRF cases. Resident medical or health problems were cited for 19% of PRF and 23.1% of CRF residents, suggesting the need for improved day services to this population sector. The third major reason cited was ineligibility for the appropriate program (residents did not meet admission requirements, such as age) cited for 19.8% of PRF and 14.8% of CRF cases. Unavailability of programming due to lack of resources (lack of staff, non-existence of appropriate program, program full) was also cited, as were behavior problems for 16% of PRF and 6.5% of CRF residents.

HIGHLIGHTS FROM RESIDENT PROFILE

- More PRF and CRF residents are male than female.
- CRFs have a higher percentage of residents less than 16 years old than do PRFs.
- PRF residents are more frequently multiply handicapped than CRF residents.
- Approximately one in five of CRF and PRF residents have chronic health problems.
- PRF residents are generally more severely impaired than CRF residents.
- Specific maladaptive behaviors are more prevalent among PRF residents than CRF residents.
- CRF residents are more likely to utilize community resources than PRF residents.
- Only 1 in 6 CRF residents and 1 in 20 PRF residents have weekly visits from friends living outside the facility.
- Only 1/3 of PRF residents and 1/2 of CRF residents have contact with their families.
- Most CRF and PRF residents have day programs outside their living units.
- Most CRF residents attend day programs away from their facility.
- Most PRF residents attend day programs on the grounds of their facility.
- Sheltered workshops are the most common day placement.
- Most residents participate in one major day program.
- PRF residents are more likely than CRF residents to have no day programming.
- Resident inabilities are the most frequently cited reasons for not participating in day programs.

FACILITY PROFILE

Revenue, Expenses, and Capital Investments; Per Diem Costs

CRFs. The total revenue for CRFs was \$484 million. Government funds, consisting of about \$35.5 million county and regional dollars and substantial amounts of state and federal monies, accounted for 72% of the total. Residents and families contributed 19%; donations made up the remaining 9%. Payroll expenses accounted for 52% of a total \$518 million in expenses; capital expenditures were responsible for 12%, and other expenses for 36%. Average per diem costs in CRFs were \$15.51 (1-5 residents) to \$16.40 (6-15), \$18.86 (16-32), \$25.50 (33-64), and \$25.09 (65+).

PRFs. The total revenue for PRFs during 1977-78 was \$2.63 billion. Government sources, primarily the state, and to a lesser degree, federal government, contributed 98% of PRF revenue; the remaining 2% came from residents, families, and contributions. Of PRF total expenses of \$2.7 billion, 79% were payroll expenses, 5% were capital investments, and 16% were other expenses, including food, utilities, etc. Average per diem costs were \$60.05 (<500 residents), \$41.68 (500-999), \$47.81 (1000-1599), and \$46.82 (1600+).

Selected Factors Related to Cost

CRFs. Four factors were significantly related to variation in CRF per diem costs: the level of staffing and services provided, the type of ownership, resident characteristics of age and level of retardation, and staff turnover. Higher costs were reported by CRFs that offered a full range of services; the level of services and staffing ranged from family run, with an average per diem of \$11.85 to staffs which included direct care and administrator, facility medical, educational, and social services support staff at a cost of \$31.47. Two aspects of ownership affected per diem costs; family run CRFs were significantly less costly (\$12.56 per diem) than proprietary (\$23.21) and non profit (\$24.16) CRFs, and CRFs which were not members of systems or "chains" of facilities were significantly less costly (\$17.72 per diem) than those which were (\$22.75). CRFs that served adults had lower costs (\$18.39 per diem) than those which served children (\$24.74). CRFs which served mainly mildly or moderately retarded individuals were less costly than those with a high proportion of severely and profoundly retarded persons.

Size was positively correlated with per diem costs, with the smallest CRFs having the lowest costs; this was probably due to the large number of services offered in the larger CRFs.

PRFs. Three factors were significantly related to variation in PRF per diem costs: the staff resident ratio, geographic location, and number of years of operation. Higher costs were associated with a higher staff/resident ratio; the average per diem ranged from \$30 (.33-.65 ratio) to \$44.66 (.66-.99), to \$54.00 (1.00-1.32), to \$84.57 (1.33+). Geographic location in the Northeast census region was associated with higher costs; there was a significant difference in per diems between the Northeast (\$62.19) and the South (\$41.75). PRFs that opened from 1 to 6 years ago had significantly higher per diems than older facilities.

Findings on size and cost were mixed. The smallest PRFs (<500 residents) had the highest cost (\$60.05), the next largest (500-999) had the lowest, and the two largest (1000-1599) and (1600+) had rates in between of \$47.81 and \$46.82.

While occupancy rates were not significantly related to cost, facilities with less than 100% occupancy rates did show greater per diem costs, a factor likely to be of future significance as the number of residents in PRFs declines.

Cost Function Analysis

Cost function analysis was performed to examine the relationships between and among the different factors affecting per diem costs and to arrive at a model that would best explain the variation in costs in each group of facilities. Three analyses were performed: one each on PRFs and CRFs using a common set of predictors, and one on CRFs using additional factors unique to CRFs alone.

The PRF model explained 47% of the variance in per diems. Four variables were very significant determinants of per diem rates: 1) the staff to resident ratio, 2) location in the Southern census region, 3) the number of years in operation, and 4) admission of adults only. These factors are listed in descending order of importance; the first was positively correlated with per diem costs, while the last three were negatively related.

The CRF model based on common predictors accounted for 24% of the variance in per diems. In the CRF analysis based on common predictors, per diem was most highly correlated with five factors: 1) the proportion of severely or profoundly mentally retarded residents, 2) staff turnover, 3) size, 4) metropolitan location, and 5) staff to resident ratio. The second factor was negatively correlated with costs.

When the additional factors applicable only to CRFs were added to the analysis, 38% of the per diem variance was explained. Four factors were most significantly related to variation in per diem costs: 1) the index of staff/services ratio, 2) family ownership, 3) the proportion of severely or profoundly mentally retarded served, and 4) staff turnover. Only the second and fourth factors were negatively correlated with cost.

Annual Rates of Turnover

Administrators were asked to indicate from their own records, knowledge or best estimate the crude separation rate for their facility. The crude separation rate was defined as:

$$\frac{\text{number of employees who left during year prior to interview}}{\text{average number of positions during year prior to interview}} \times 100$$

Turnover figures were obtained from administrators of 71 of the 75 (95%) PRFs and from 104 of the 128 (81%) of non-family operated CRFs (33 CRFs in the national sample were owner-operated). The mean annual rates of turnover in these PRFs and CRFs were 32.8% (SD=27.6) and 54.2% (SD=51.0), respectively.

A second measure of turnover was attained through a list of all direct-care staff leaving their jobs during a one-month period in 75 (100%) PRFs and 126 (98%) non-family operated CRFs. This figure was multiplied by 12 and divided by the total number of direct-care staff to yield an estimated annual turnover rate of 35.8% in PRFs and 80.3% in CRFs.

Multiple regression analyses were carried out to assess the proportions of total subsample variances in employee turnover that could be accounted for by organizational and locational factors. Among PRFs and CRFs with 65 or more residents, organizational and locational factors accounted for 44% and 53% of the variances, respectively. Among CRFs with 64 or fewer residents, these factors accounted for only 16% of the variance. The unemployment rate in the county where the facility was located was the single factor most highly related to turnover, as estimated by administrators in PRFs and large CRFs ($r = .44$, $p < .001$ for PRFs, $r = .53$, $p < .003$ for large CRFs). That is, the lower the availability of other work in the area of the facility, the higher the likelihood of direct-care staff remaining on the job. One other factor found highly related to turnover was the number of direct-care staff (turnover tended to be higher among the largest of the CRFs with 65 or more residents). Other major factors accounting for turnover in PRFs were: 1) years since initial opening (those which had been in operation longer had built a better complement of more stable employees), 2) starting pay (higher rates of starting pay were related to greater stability), and 3) location (facilities in urban areas had higher turnover).

Among both public and non-public facilities the correlation between staff turnover and the ratio of direct-care staff to administrative staff was in the direction of greater proportions of administrative personnel relative to direct-care personnel where turnover was higher ($r = .19$, $p < .05$ for PRFs, $r = .14$, $p < .08$ for CRFs).

Length of Service

Administrators of 201 residential facilities (99% of facilities with non-family direct-care staff) kept a record for one month of all direct-care staff separating from each facility. Among 75 PRFs the median length of service of separating employees was 10.1 months, and among 126 CRFs the median was 5.8 months. Among all PRFs and CRFs, over one-half of direct-care staff left their jobs before completing a full year of employment.

Factors Related to Employee Stability

A number of personal factors were also found to be related to employee stability in a one-year follow-up of the occupational status of 1035 direct-care staff of the public and community facilities in the sample. Among these were:

- Age (older employees were more stable, $N = 995$, $\chi^2 = 47.52$, $p < .01$).
- Education (the less formal education the more stable employees tended to be, $N = 1001$, $\chi^2 = 42.54$, $p < .01$).
- Length of service (employees with longer lengths of service tended to be more stable, $N = 968$, $\chi^2 = 127.69$, $p < .01$).

- Age at initial employment (the older the employee at initial hiring, the more stable s/he tended to be over the follow-up period, $N = 963$, $\chi^2 = 10.41$, $p < .01$).
- Geographic stability (controlling for chronological age, the longer employees had lived in the vicinity of the residential facility the more stable they tended to be, $r = .27$, $p < .01$).
- Prior specializing training (at all education levels, employees who were initially hired with no prior training for the position tended to be more stable, $N = 996$, $\chi^2 = 24.53$, $p < .01$).
- Stated reason for initially accepting position (employees who initially accepted the position because of its economic benefits, simple availability, convenience, etc., and those who accepted the position because of past rewarding experiences, general interest, or personal satisfaction in working with handicapped adults or children were found significantly more stable than employees who accepted the position for the opportunity to utilize special training, advance within a profession, and receive or utilize experience in a specialized field, $N = 972$, $\chi^2 = 12.16$, $p < .01$).
- Owning/operating one's own facility (of the 33 primary caretakers, 31 were still operating a family care home one year later).
- Two elements of job satisfaction: satisfaction with the amount of pay for the amount of work ($\chi^2 = 20.03$, $p < .05$) and satisfaction with opportunities for advancement ($\chi^2 = 21.64$, $p < .01$) were consistently associated with job tenure.

Discriminant function analyses was performed to assess power of demographic and experiential characteristics and personal perceptions of job satisfaction to differentiate between employees who stayed or left their jobs within a one-year period. These factors were found to be considerably more predictive of job status among CRF direct-care staff than was the case for PRF employees (32% of the variance accounted for in CRFs versus 11% of variance in PRFs). However, among both groups demographic and experiential characteristics were much more predictive of turnover than was job satisfaction (4% of the variance accounted for by job satisfaction versus 7% accounted for by demographic and experiential characteristics in PRFs; 9% of the variance accounted for by job satisfaction versus 22% accounted for by demographic and experiential characteristics in PRFs).

Resident Admission Characteristics

CRFs. A minority of CRFs have state, county, or city residency requirements, while 64.9% of facilities for 1-5 persons, 73.6% for 6-15 persons, 81.8% for 16-32 persons, and 86.7% of facilities for more than 65 persons report having no residency requirements. Of those which did have residency requirements, 13.5% of those with 1-5 residents, 8.8% with 6-15, 18.2% with 16-32, and 13.3% with 65+ residents require state residency; county residency is required by 21.6%, 15.8%, and 18.2% of those with 1-5, 6-15, and 33-64 residents. City residency is required by only 1.8% of the 6-15 resident group.

Smaller CRFs are split between single sex facilities and those which accept both males and females, while there is a high percentage of coed facilities among the larger CRFs. For CRFs with 1-5 and 6-15 residents, 46% and 62% are coed; CRFs with 16-32, 33-64, and 65+ residents are 87%, 91%, and 88% coed.

The largest CRFs (over 65 persons) report a mean minimum age of admitted residents as 14; mean minimum ages for 1-5, 6-15, 16-32, and 33-64 residents are 26, 21, 18, and 26, respectively. The mean maximum ages of residents admitted are 71, 77, and 76 for facilities with 1-5, 6-15, and 16-32 residents; the ages are 58 and 65 for those with 33-64 and 65+ residents.

The majority of CRFs of all sizes accept residents who are mildly or moderately retarded. Of those with 1-5 residents, 82% accept mildly and 74% accept moderately retarded; for 6-15 residents, the rates are 78% and 81%; for 16-32 residents, 78% and 87%; for 33-64 residents, 64% and 91%; for 65+ residents, 83% and 90%. Larger facilities are much more likely to accept severely or profoundly retarded residents than the smaller CRFs. Severely retarded residents are accepted by 41% of facilities for 1-5 persons, by 67%, 61%, 91%, and 83% of those for 6-15, 16-32, 33-64, and 65+ residents.

PRFs. The vast majority of PRFs surveyed accept both males and females; 100% with less than 1,000 residents, 91% with 1,000 to 1,599 residents, and 92% with over 1,600 residents are coed.

The mean minimum ages of residents admitted to smallest (less than 500) and largest (greater than 1,600 residents) facilities were 5 and 7 years; for the mid range of institutions (500-999 and 1,000-1,599 residents), the ages were 16 and 20. The mean maximum age for facilities with less than 500 and from 500-999 residents were 86 and 88; those over 1,000 had no maximum ages.

Resident Stability and Movement

CRFs. The majority of CRFs have an average length of stay for residents of more than 3 years. Average stays of more than 3 years were reported as follows: 1-5 (71%), 6-15 (65%), 16-32 (70%), 33-64 (82%), and 65+ residents (89%).

Of CRFs with 1-5 residents, 31% have a waiting list; of those with 6-15, 16-32, 33-64, and 65+ residents, 43%, 53%, 64%, and 73% have lists. The average number of waiting list applicants is 11, 7, and 12 for the first three sizes, and 25 and 23 for the last two sizes of CRFs.

A wide range of CRF staff initiate resident transfers to other facilities; overall, program directors and direct-care staff are most frequently cited as the persons initiating the transfer. Residents themselves were responsible in 21.7%, 15.4%, and 15% of CRFs for 1-5, 6-15, and 16-32 persons, and in 9.1% and 12.5% of CRFs for 33-64 and 65+ residents.

PRFs. An average length of stay of more than 3 years is reported by 61% of PRFs with less than 500 residents, 92% with 500-999 and 1600+, and 91% with 1000-1599 residents. The mean number of waiting list applicants is 37, 42, 27, and 60 for the four groups in order of size. A variety of persons are responsible for initiating and completing arrangements for resident transfers; overall, the

social worker on staff was most frequently mentioned across facility sizes for both tasks. The transfer was initiated by the resident in 5.9% of facilities under 500, 9.1% in those with 1000-1599 residents, and not at all in the other two groups. Discussion of the transfer with the resident and/or family occurs in 100% of the PRFs.

Forty percent, 42%, 53%, and 47% of the PRFs in the four size categories report that "adjustment to a new facility, its rules, and the change in routine and people" is the primary problem experienced by residents released from PRFs. Of PRFs under 500 residents and 500-999 residents, 17% and 16% rate behavior problems as the primary problem, as do 20% and 22% of the two larger size groups of PRFs. Lack of support services in the new facility is cited by 24%, 10%, and 13% of the first 3 groups of PRFs; 8%, 5%, 13%, and 11% of the PRFs report that social interaction problems are the primary problem. In 76%, 65%, 68%, and 58% of the PRF size groups, the facility itself provides follow-up services for released residents.

Seventy-six percent of the small (under 500), 100% of the medium (500-1599), and 92% of the large (over 1600) facilities report readmitting residents who were once released. Behavior problems were cited by 42%, 35%, 29%, and 45% of the four groups, as the primary reason for readmission; adjustment problems were cited by 25%, 27%, 24%, and 9% of the four groups of PRFs.

Direct-Care Staff Characteristics

CRFs. With 68% reporting, the average percent of direct-care staff with prior experience working with the handicapped or in residential services is 71% and 70% in facilities with 1-5 and 6-15 residents, 45% in those with 16-32, and 36% in those with 33-64 and 65+ residents. Mean starting salaries vary little; the range is from \$3.43 to \$3.70 per hour.

PRFs. With 94% reporting, the PRF percentages of direct-care staff with prior experience are 31% for those with less than 500 residents, and 16%, 20%, and 29% for those with 500-999, 1000-1599, and over 1600 residents. The range of mean starting salaries is from \$3.83 to \$4.24 per hour. The majority of direct-care staff has a high school diploma; 13% and 19% in PRFs with less than 500 and 500-999 residents, and 23% and 22% with 1000-1599 and 1600+ residents have less than a high school education.

Nearly all respondents feel that direct-care staff need additional training: 94%, 92%, 95%, and 100% of PRFs with less than 500, 500-999, 1000-1599, and 1600+ residents reported this need. Two training topics were cited by PRFs in all size categories: behavior management was selected by 66%, 52%, 47%, and 58% of the PRFs in each size category; and the area of health, first aid, and medical topics was selected by 6%, 4%, 16%, and 25%.

Neighborhood and Community Opinion about Facilities

CRFs. Across all size categories, the vast majority of CRF respondents indicated that neighbors have a favorable or very favorable opinion about the residential facility. A similar high regard was reported by the respondents for the local community. Only 2-7% of the neighbors or local community had a very unfavorable opinion.

PRFs. For PRFs, a majority of both neighbors and the local community regarded the facility favorably. A range of 4-14% of the four groups of respondents stated that the neighbors or community viewed the facility unfavorably.

Characteristics of the Physical Environment

Ratings of the characteristics of the physical environment (CPE) were assessed by interviewers upon completion of the onsite visit (see page 4 for further explanation). Scores ranged from one to five--one denoting a very homelike environment and five reflecting a less homelike environment. An average score was derived for each facility. CRFs were then regrouped by size: 1-5, 6-15, 16-63, and 64+ residents.

CRFs as a total group showed significantly lower average scores (more homelike environments) than did PRFs ($p < .01$). These differences were consistent for all living areas ($p < .01$) and the outside yard ($p < .05$). Within CRFs there were significant differences in average CPE scores among facility size groups ($p < .01$). Physical environments of the larger facilities were rated less homelike.

Characteristics of the Treatment Environment

A revision of Jackson's Characteristics of the Treatment Environment (CTE) was used to measure levels of autonomy and activity afforded to residents in facilities participating in the study (see page 4 for further explanation). Each direct-care staff member interviewed completed the CTE and an average score was derived for each facility. CRFs were again reclassified into size groupings: 1-5, 6-15, 16-63, and 64+ residents. Possible scores on each subscale and the total CTE ranged from 0 to 97 (scores of 100 were coded as 97) with larger scores representing more positive treatment environments.

CRFs were reported to encourage more client autonomy than did PRFs ($p < .01$). CRFs also promoted more resident activity than did PRFs ($p < .01$). Autonomy subscale scores and total CTE scores significantly varied with size of CRF facility ($p < .01$). CRF facilities with 6 to 15 residents scored highest on all CTE measures, followed by CRF size categories 1-15, 16-63, and 64+ residents.

HIGHLIGHTS FROM FACILITY PROFILE

- Most public and community facilities do not have residency requirements for admission.
- Most residential facilities accept both male and female residents, with a noticeable trend for smaller CRFs to admit residents of one sex.
- Both types of facilities accept mildly and moderately retarded residents. Large facilities tend to accept more severely retarded residents.
- Most CRFs and PRFs have an average length of stay for residents of more than 3 years.

- Adjustment to new facility and routine is seen as the primary problem faced by residents released from PRFs.
- Behavior problems are the most commonly cited reason for readmission to PRFs.
- The range of starting salary for direct-care staff for CRFs is \$3.43-\$3.70 an hour and for PRFs starting salary range is \$3.83-\$4.24 an hour.
- CRF and PRF directors reported that both neighbors and the local community viewed facilities favorably.
- The total revenue during 1977-78 for CRFs was \$484 million and for PRFs was \$2.63 billion. Reported expenses were higher.
- Three factors were significantly related to variation in PRF per diem costs: the staff/resident ratio, geographic location, and the number of years in operation while there were four factors significantly related to variation in CRF per diem costs: the level of staffing and services provided, the type of ownership, resident characteristics of age and level of retardation, and staff turnover.
- The most important combination of variables accounting for variance in PRF per diems were: staff to resident ratio, location in the Southern census region, number of years in operation and admission of adults only.
- The most important combination of variables accounting for variance in CRF per diems were: index of staff/services ratio, family ownership, the proportion of severely or profoundly mentally retarded served, and staff turnover.
- Staff turnover is high in both PRFs and CRFs.
- Multiple measures show turnover to be higher in CRFs than PRFs.
- A number of organizational and locational factors appear related to facility rates of staff turnover.
- Most staff leave residential facilities before working one year.
- A number of personal experiential and job satisfaction factors appear related with turnover of individual staff members.
- Self-employed care providers are much more stable than salaried staff.
- CRFs tend to be rated more homelike by interviewers than were PRFs.
- Staff reported that CRFs promote more autonomy and activity than PRFs.

This brief report highlights only a few of many findings from a national probability sample survey on the status of public and privately operated residential facilities and the mentally retarded people they serve. This study was completed with the gracious consent and substantial time investment of 236 facilities and facility administrators, and well over 1,000 facility staff. Their substantial contribution is not only acknowledged, but it is deeply appreciated.

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