Center for Residential and Community Services
University of Minnesota
207 Pattee Hall
150 Pillsbury Drive, S.E.
Mineapolis, Minesota 55455

The recommended citation for this paper is: Farzaneh-kia, H.F., Hill, B.K., & Lakin, K.C. Institutional versus community residential placement of mentally retarded people leaving home. Minneapolis: University of Minnesota, Department of Educational Psychology, 1983.

Institutional Versus Community Residential Placement of Mentally Retarded People Leaving Home

Brief #18 May , 1983

This research is supported by a grant (54-P-71173/5-04) from the Administration on Developmental Disabilities, Office of Human Developmental Services, Department of Health and Human Services and a grant (18-P-98078/5-01) from the Health Care Financing Administration, Department of Health and Human Services. Contractors undertaking such projects under government sponsorship are encouraged to express freely their professional judgment in the conduct of the project. Points of view or opinions stated do not, therefore, necessarily represent the official position of the Administration on Developmental Disabilities.

Abstract

A nationally representative interview study included 2,271 residents in a sample of 236 public institutions (PRFs) and community-based residential facilities (CRFs) for mentally retarded people was conducted in late 1978, early 1979. One hundred seventy two of the sampled residents had recently been admitted directly from their parents' homes, to their first ever placement in one of the sampled residential facilities. (81 to CRFs and 91 to PRFs). Characteristics of first admissions to PRFs and CRFs are presented. Less severe retardation predicted community placement if there was a community facility available with in a reasonable distance. Behavior problems were generally not predictors of any particular placement type.

Introduction

In the past two decades, tens of thousands of mentally retarded people have been transferred from large publicly supported institutions to smaller community-based residential facilities such as group homes, foster homes, and halfway houses. This movement has been promoted under a general philosophy of treatment referred to as normalization, and its companion social action, deinstitutionalization.

The deinstitutionalization of mentally retarded people has been defined as a three fold process: 1) preventing institutional admissions by developing alternative community-based services; 2) returning institutionalized residents to community settings; and 3) improving the conditions of residence and habilitation for those persons who remain institutionalized (NASPRF, 1974). Regarding this definition, efforts in meeting the second and third components are well documented; i.e., states have spent nearly two billion dollars in the last few years to improve the conditions of residence and habilitation in institutional settings (NASMRPD, 1980; Scheerenberger, 1982; Scheerenberger, 1983). The movement of residents from state institutions to community-based settings is also well documented (Lakin, Bruininks, Doth, Hill, & Hauber, 1982). Furthermore, there is strong indication that on the average, initial placements of mentally retarded people in extra-familial settings come at later ages than was the case even a decade ago (Lakin, Hill, Hauber & Bruininks, 1982). Less well documented are the conditions necessary for preventing initial placements to institutions for those retarded persons entering

the residential care system for the first time. To better plan and provide non-institutional responses to the needs of those persons presently entering the residential services system, it is important to differentiate the characteristics of those for whom a state institution is the first residential placement from those whose first placement is in a community setting.

There has been no recent research regarding factors differentiating between groups of mentally retarded persons placed in institutional vs. community-based settings directly from their homes. However, there has been considerable research documenting differences among resident populations of state institutions and other non-institutional facilities. For example, Eyman and Borthwick (1980) compared the characteristics of individuals residing in various institutional and community-based settings and found that severely mentally retarded people with attendant handicaps and maladaptive behavior are more likely to be found in public institutions than mildly retarded people, and that mildly retarded institutionalized residents are more likely than severely handicapped residents to be released to community-based settings. Scanlan, Arick, and Krug (1982) studied non-adaptive behavior of 144 severely handicapped adults living in state institutions, private institutions, group homes, and their parents' homes who were matched for chronological age, language age and sex. They found, that a key factor differentiating between community facility and institutional placements of severely handicapped adults was problem behavior. Hill, Bruininks and Lakin (in press) reported that although health problems were equally common in institutions and community

facilities in 1978, non-ambulatory residents and those with uncontrolled seizures represented twice the proportion of PRF populations as they do of CRF populations.

Unfortunately, in examining research related to differential placements of persons into institutional or communitybased residences only recent research can be utilized since the criteria of placements has been undergoing such rapid change in recent years. Earlier research such as that of Saegner (1960) becomes difficult to interpret in light of today's rapidly growing and increasingly comprehensive service system. At the time of Saegner's research, the question facing parents and other involved persons was whether to place a member outside the home. If the answer was yes, the placement was almost inevitably a state institution. Today the question goes beyond the initial decision about whether to place, because a broader variety of placement options now exist.

The present paper compares two groups of mentally retarded people who were admitted either to private community-based residences or state institutions in 1977 or 1978. The purpose was to identify variables related to the choice of one type of placement rather than another. It was hoped that such an analysis might aid in the targeting of future deinstitutionalization efforts.

Method

Sample

The sample from which the present data were drawn was a nationally representative sample of 2,271 mentally retarded residents of public (state) residential facilities and community

(private) residential facilities, selected through a two-stage probability design. The following criteria were used to define the two types of facilities:

> A public residential facility (state institution) is any state sponsored and administered facility which offers comprehensive programming on a 24-hour, 7 days-a-week basis.
>
> A community residential facility is 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; (c) independent living (apartment) programs which have no staff residing in the same facility and (d) public residential facilities.

The first stage of drawing the sample involved selecting a nationally representative sample of facilities with proportionate representation of facilities by size and census region. Seventy-five public facilities were sampled from a 1977 list maintained by the National Association of Superintendents of Public Residential Facilities (Scheerenberger, 1978); 161 community facilities were sampled from among 4,427 facilities identified in a 1977 national study of community (private) residential facilities (Bruininks, Hauber & Kudla, 1979).

The second stage of sampling involved selecting within each sampled facility a random sample of a predetermined number of residents so that the total sample size would be approximately

1000 public institution and 1000 community facility residents. This design was intended to provide an unbiased representation of all mentally retarded residents in public and community residential facilities in the United States on or about January 1, 1979. However, since only one of six private residential facilities in the United States with more than 400 residents participated in the study, this group of private institutions is underrepresented in the sample of residents.

Procedure

Interviews at the 236 facilities were conducted between September 1978, and April 1979. At each facility trained interviewers selected a predetermined number of mentally retarded residents according to a random sampling procedure. Demographic information about individual residents, including date of birth, date of admission, previous type of residential placement, age, height, weight, diagnosed degree of retardation, and diagnosis of epilepsy, autism, or mental illness was obtained from each resident's records. The staff person most familiar with each resident was then identified and interviewed about the resident. 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.

The present series of analyses include data gathered on 172 residents (among the total 2271) who had been admitted directly from home to their first residential placement during 1977 or

1978. The majority of data analyzed relate to demographic, physical and behavioral characteristics of residents. Factors involving family characteristics before residential placement could not be examined directly, even though they are known to be important to decision-making regarding placement of a retarded family member (Anderson, Schlottmann & Weiner, 1975). An indirect examination of family decision-making criteria was made by searching records and questioning residential facility staff about their knowledge of reasons for placement.

Results

Table 1 presents demographic characteristics of the 172 sample members who had lived with their natural family prior to their initial (1977-1978) placement in CRFs or PRFs. CRF admissions were older, heavier, and taller than PRF admissions; males outnumbered females in both groups.

Minority residents composed 21.1% of PRF and 16% of CRF initial placements. Sixty-five percent of those who were placed in PRFs were either severely or profoundly retarded, compared to 29.6% of CRF placements.

Place Table 1 about here

Table 2 presents information about handicaps in addition to mental retardation. The average number of secondary handicaps for PRF first admissions was 0.83 compared to 0.59 for CRF admissions; 6.5% of PRF residents were deaf or or had a severe hearing loss and 10.9% were blind or had a severe visual loss,

compared with 3.7% with hearing and 4.9% with visual handicaps among CRF residents. Seizures had been observed within 12 months prior to interviews for 27.5% of PRF admissions and 18.5% of CRF admissions. The average number of chronic health problems as categorized in the International Classification of Diseases was 0.22 among PRF and 0.09 among CRF first admissions. Health related (non psychotropic) drugs were prescribed for 17.6% of PRF admissions and 9.9% CRF admissions. Psychotropic drugs were prescribed for 25.3% of PRF and 11.19% of CRF admissions.

Place Table 2 about here

CRF first admissions' locomotor ability and arm-hand use were significantly less impaired than PRF residents'; 9.9% of CRF and 24.2% of PRF admissions were non-ambulatory.

Table 3 indicates that PRF residents were considerably less independent than those who were placed in CRFs; 49.6% of PRF admissions could not eat complete meals without spilling, more than half could not dress themselves independently, 40% were not toilet trained, and 75.8% could not go four blocks from home, school, or work alone or with peers without getting lost. Most CRF admissions were relatively self-sufficient with regard to self help skills, generally in the 80%-90% range depending on the specific behavior. However, only 45.6% could go four blocks from home independently.

Place Table 3 about here

As shown in Table 4, there were some statistically significant differences between CRF and PRF first admissions for the prevalence of major categories of maladaptive behavior. Self-injurious behavior such as head banging was reported for 12.4% of CRF admissions and 17.6% of PRF admissions; 18.5% of CRF admissions were reported to injure other people by kicking, biting, hitting, compared to 35.2% of PRF admissions. Public and community facilities had similar proportions of newly admitted residents who were reported to have purposely run away from home or broken the law within the year prior to the interview.

Insert Table 4 about here

Each resident's records were reviewed for some mention of why he or she had left home. Direct-care staff were also asked if they had personal knowledge of a reason for residential placement. Table 5 lists these reasons. A significantly larger proportion of PRF admissions ($p=.001$) were reported to have been placed because of parents' difficulty in managing their behavior, because the resident was too heavy to lift, too strong or too severely handicapped. Larger, though not statistically significant proportions of residents left home to a CRF because of health, family circumstances, because the CRF was thought to be a logical move for residents reaching young adulthood, or because of professional recommendations. It is interesting (and encouraging) to note that no residents were reported to have been placed in PRFs because of professional recommendation.

Table 6 lists reasons contained in records relating to why particular residential facility was selected over others. PRFs seem to have been given preference because they could serve a severely handicapped resident with behavior problems, or because they were the closer to natural family home. CRFs were more often selected because of their treatment program or because of someone's recommendation.

A regression analysis was performed in order to determine which, if any, of these descriptive variables could explain the variance in PRF versus CRF placement from home. A preliminary regression analysis included as predictors all variables presented in Tables 1 through 6. The final analyses included variables for which t-tests or chi square tests (Tables 1-6) indicated significant differences between PRF and CRF admission groups as well as variables that yielded significant Beta's in the preliminary analyses (those which differentiated PRF versus CRF placement only after controlling for other factors). The dependent variable was coded 0 (PRF placement) or 1 (CRF placement). Beta weights in regression on a dichotomous dependent variable are equivalent to variable weights yielded by a discriminant analysis of two groups.

Variables were entered in three blocks. The first block included all variables with $p<.05$ that described resident characteristics (Tables 1-4), except height and weight, excluded because of multi-colinearity among age, height and weight. The second block included reasons for leaving home (Table 5) and the third block included reasons for selection of a particular

facility (Table 6). The amount of explained variance attributed to each variable was its unique contribution after controlling for all other variables in its block and in prior blocks. The 16 variables in the analysis predicted 33.0% of the variance in PRF versus CRF placement (r^2=.57, F=4.49, 16/146 df, p<.0001). Table 7 lists four variables which had significant standardized regression coefficients (Betas). These variables accounted for 19% of total variance (58% of explained variance).

Neither age nor most usually identified behavior problems were significant predictors of placement type after controlling for ability. It appears that very severely handicapped residents or those with an apparently unmanageable behavior problem, running away, were more likely to be placed in a public institution, and this placement took place while the resident was relatively young. Children with higher ability, most of whom who remained at home until completion of school, were more likely to be placed in community residences if there was one within a reasonable distance of the parents' homes. The average age of a child first leaving home for a CRF was 21.9 years, perhaps explaining professional recommendations for an age appropriate adult residential placement in the community.

Discussion

A primary goal of deinstitutionalization is to prevent first admission to public institutions. From a public policy standpoint this effort must actually be of primary importance. Deinstitutionalization's two other processes--promoting release of residents already institutionalized and improving conditions for those who remain--would in the long run be obviated if first

admissions were eliminated. The purpose of this study was to identify factors that were differentially associated with PRF and CRF first admissions to assist in the targeting of community-based services for persons with characteristics that are associated with PRF placements. However, the results must be viewed as quite tentative because of small sample sizes, post-move data collection, and lack of information about residents' families.

Earlier efforts to understand parental decisions to institutionalize their children are limited for contemporary purposes by the fact that few community alternatives existed, making the decision to institutionalize a predetermined corollary of the decision to place a family member outside the home. However, it is unlikely that the decisions whether to place and where to place can be thought of independently. It has been suggested that decisions on where to place (or where to transfer a resident already in placement) are often limited by availability of facilities--in the past mostly institutions--despite what a resident's physical and behavioral needs might optimally suggest (Heal, Sigelman, & Switzky, 1978; Hill & Bruininks, in press; Hill, Bruininks, & Lakin, in press; Jacobson & Schwartz, 1983). Initial development of the community residences provided placement opportunities for mildly handicapped residents; recent community development is providing additional sites for severely handicapped individuals and individuals with behavior problems. The research supports continued need for such development, pointing to special targeting of community-based residential

services on a number of readily identifiable resident characteristics.

Community-based residences are particularly needed for severely and profoundly mentally retarded persons coming into the residential services system. In the present sample, this group contributed 46.5 of the first admissions to residential care, but their probability of an initial placement in a community-based facility was only .31. While such statistics in the past have been used to justify the ongoing need for institutional placements, it is important to ask, if 38% of the severely retarded first admissions and 25% of profoundly retarded first admissions can be initially placed in community-based settings, why can't the others? The data in this study provide no satisfactory answer for this question. While PRF and CRF first admissions differ in regard to self-help skills and maladaptive behavior, substantial numbers of CRF first admissions have behavioral characteristics that are similar to persons being admitted to state institutions. Nevertheless, variables associated with resident abilities and behavior problems remain the major factors predicting differential placements to PRFs and CRFs, suggesting that placements continue to be determined primarily according to availability of placements rather than appropriateness. The presence of special needs such as physical handicaps or health problems did not predict institutionalization, suggesting that the medical programs of institutional settings justifies such placements in relatively few instances. Data presented in the present report indicate that parents decide to place a child either because of difficulty

in managing behavior or because of family circumstances or because their child has reached an age at which most young people leave home. PRFs seem to be more often selected for the former reason, CRFs for the latter. But whatever the initial parent/professional reason(s) for extra-familial placement or the physical, behavioral or developmental characteristics of the placed individuals, the major affect of placement is upon the client. Since this research has shown that there are few characteristics of institution first admissions that are not represented among community-based facility residents, it suggests by implication that institutions fulfill few, if any, functions that are not fulfilled elsewhere by private, community-based settings. This realization when coupled with the increasingly established wisdom of the criterion of ultimate function (that is in the case that the best setting to train retarded people for community-based living is in a community-based living arrangement) suggests that the primary reason that people are admitted to state institutions is because a significant portion of the available beds are in such facilities. It seems clear that the solution to the continued placement of people in these facilities lies primarily in limiting the availability of such beds.

References

Anderson, V.H., Schlottman, R.S., & Weiner, B.J. Predictors of parent involvement with institutionalized retarded children. American Journal of Mental Deficiency, 1975, 79, 705-710.

Bruininks, R.H, Hauber, F.A., & Kudla, M.J. National survey of community residential facilities: A profile of facilities and residents in 1977. Minneapolis: University of Minnesota, Department of Educational Psychology, 1979.

Eyman, R.K., & Borthwick, S.A. Patterns of care for mentally retarded persons. American Journal of Mental Deficiency, 1980, 18, 63-66.

Heal, L.H., Sigelman C.K., & Switzky, H.N. Research on community residential alternatives for the mentally retarded. In N.R. Ellis (Ed.), International review of research in mental retardation (Vol. 9). New York: Academic Press, 1978.

Hill, B.K., & Bruininks, R.H. Maladaptive behavior of mentally retarded people in residential facilities. American Journal of Mental Deficiency, in press.

Hill, B.K., Bruininks, R.H., & Lakin, K.C. Heath and behavior of mentally retarded people in residential facilities. Journal of Health and Social Work, in press.

Lakin, K.C., Bruininks, R.H., Doth, D., Hill, B.K., & Hauber, F.A. Sourcebook on long-term care for developmentally disabled people. Minneapolis: University of Minnesota, Department of Educational Psychology, 1982.

Lakin, K.C., Hill, B.K., Hauber, F.A., & Bruininks, R.H. Changes in age at first admission to residential care for mentally retarded people. Mental Retardation, 1982, 20 (5), p.216-19.

(NARC) National Association for Retarded Citizens. A survey and study of state institutions for the mentally retarded in the United States. New York: NARC, 1963.

(NASMRPD) National Association of Mental Retardation Program Directors. Trends in capital expenditures for mental retardation facilities: A state by state survey. Arlington, VA: NASMRPD, Inc., 1980.

(NASPRF) National Association of Superintendents of Public Residential Facilities for the Mentally Retarded. Contemporary issues in residential programming. Washington, DC: President's Committee on Mental Retardation, 1974.

Saenger, G. Factors influencing the institutionalization of mentally retarded individuals in New York City. New York State Interdepartmental Services Branch, 1960.

Scanlon, C.A., Arick, J.R., & Krug, D.A. A matched sample investigation of nonadaptive behavior of severely handicapped adults across four living situations. American Journal of Mental Deficiency, 1982, 86(5), 526-532.

Scheerenberger, R.C. Public residential services for the mentally retarded in 1977. Madison, WI: Central Wisconsin Center for the Developmentally Disabled, 1978.

Scheerenberger, R.C. Public residential services for the mentally retarded in 1981. Madison, WI: Central Wisconsin Center for the Developmentally Disabled, 1982.

Scheerenberger, R.C. Public residential services for the mentally retarded in 1982. Madison, WI: Central Wisconsin Center for the Developmentally Disabled, 1983.

Table 1

Demographic Characteristics of First Admissions to Public and Community Residential Facilities for Mentally Retarded People

	CRFs (N=81)	PRFs (N=91)	t	x^2	P
Sex					
Male	70.4%	60.0%		1.45	.23
Female	29.6%	39.6%			
Weight (in pounds)					
M	124.7	90.0	-4.73		.001
SD	43.1	51.1			
Height (in inches)					
M	62.7"	53.7"	-5.89		.001
SD	7.8"	11.3"			
Race				2.72	.25
White	84.0%	78.9%			
Black	11.1%	18.9%			
Other	4.9%	2.2%			
Age at first admission			-3.50		.001
M (in years)	21.864	15.538			
SD	12.766	10.957			
Degree of mental retardation					
Borderline (IQ 69-84)	17.3%	3.3%		30.64	.0001
Mild (IQ 52-68)	29.6%	8.8%			
Moderate (IQ 36-51)	23.5%	23.1%			
Severe (IQ 20-35)	17.3%	28.6%			
Profound (IQ 19 & below)	12.3%	36.3%			

Table 2

Secondary Handicaps of First Admissions to Public and Community Residential Facilities for Mentally Retarded People

	CRFs (N=81)	PRFs (N=91)	t	X^2	P
Number of secondary handicaps			1.80		.073
M	.59	.84			
SD	.70	1.01			
Number of health problems	.09%	.22	1.89		.061
Blind or severe visual loss	4.9%	10.4%	1.45		.149
Deaf or severe hearing loss	3.7%	6.5%	.85		.399
Epileptic Seizure within last year	18.5%	27.5%	1.39		.167
Ambulatory (get around)					
walks without assistance	90.0%	70.3%		11.58	.003
walks with assistance	0.0%	5.5%			
in w-chair/crawls/confined to bed	9.9%	24.2%			
Hand and arm use					
has complete control	74.1%	59.3%		4.90	.086
need help	19.8%	26.4%			
no useful hand or arm control	6.2%	14.3%			

Table 3
Level of Independence of First Admissions to Public and Community Residential Facilities for Mentally Retarded People

	CRFs (N=81)	PRFs (N=91)	t	X^2	P
Does not eat meal with little spilling	20.0 %	49.6 %	4.19		.000
Does not dress self	21.0 %	50.6 %			.000
Not toilet trained	11.3 %	34.4 %	3.68		.000
Does not toilet independently	16.2 %	43.3 %	4.03		.000
Does not respond to simple words	11.1 %	33.0 %	3.52		.001
Does not follow simple directions	16.1 %	47.3 %	4.60		.000
Does not speak (or sign) in short sentences	25.9 %	49.5 %	3.24		.001
Cannot go out without getting lost	45.7 %	75.8 %	4.21		.000

Table 4
Prevalence of Maladaptive Behavior

	CRFs (N=81)	PRFs (N=91)	t	χ^2	p
Self injurious behavior	12.4 %	17.6 %	.95		.341
Hurts other people	18.5 %	35.2 %	2.47		.014
Purposely breaks or damages property	7.4 %	9.9%	.57		.56
Unusual behavior	23.5 %	33.0 %	1.38		.170
Breaking house rule	14.8 %	26.4 %	1.87%		.063
Refuses to go to school, work, or day placement	3.7 %	11.0%	1.81		.072
Has purposely run away from home	1.2 %	13.2%	3.02		.003
Has broken the law	1.2 %	3.3%	.89		.373
Injured self so seriously that needs medical attention	3.7 %	6.7%	.86		.389

Table 5

Reason Given for Leaving Home of First Admissions to Public and Community Residential Facilities for Mentally Retarded People

Reason	CRFs (N=81)	PRFs (N=91)	t	P
Problems managing child	11.1%	31.9%	3.44	.001
Health problems of child	6.2%	4.4%	- .52	.604
To provide more appropriate residence	50.6%	36.2%	-1.91	.058
Family circumstances (parental age, income)	56.8	50.6	- .82	.416
Recommended by professional	2.5	0.0	-1.50	.133

Table 6

Reason Given for Placement of First Admissions in a Particular Public or Community Residential Facility for Mentally Retarded People

Reason	CRFs (N=81)	PRFs (N=91)	t	P
Severe mental retardation	0	8.8%	2.78	.006
Secondary handicap/Epilepsy	4.9%	7.7%	.73	.464
Behavior problem	8.6%	24.18%	2.76	.006
This facility is particularly suited to residents needs	49.38%	35.16%	-1.90	.060
The facility is close to family/ guardian	4.9%	14.2%	2.06	.041
Family unable/unwilling to keep the resident	41.98%	38.46%	-.47	.641
Professional recommended	7.4%	0	-2.68	.008
Financial reason	1.2%	0	-1.06	.291
No other facility available	1.23%	2.2%	.48	.632

Table 7

Predictor of Placement in Public Versus Community Residential Facilities for Mentally Retarded People

Variable	Beta[a]	R^2 Change	Simple r	F
Ability	.32	.11	.40	.0001
Runs away	-.16	.03	-.22	.030
In this particular facility because it is closest to family	-.17	.03	-.15	.029
In this particular facility because professional recommend	.16	.02	.21	.023

[a]A positive regression coefficient predicts CRF placement

[b]Ability score on a 65 item adaptive behavior scale (M=30, SD=20 for all subjects)