Minnesota University Affiliated Program
on Developmental Disabilities

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

Longitudinal Change and Interstate Variability in the Size of Residential Facilities for Persons with Mental Retardation

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K. Charlie Lakin
Bradley K. Hill
Carolyn C. White
Elizabeth A. Wright

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Abstract

This paper reports on changes in the size and type of operation of residential facilities for persons with mental retardation in the United States over the past two decades. It also examines current (June 30, 1986) interstate variability in residential services along these same dimensions. Considerable progress is noted nationally in securing relatively small, community-based residential opportunities for persons with mental retardation. However, this progress was by no means uniformly realized in all states or with all types of facilities. Comments are made on standards for federal policy that would make the official national commitment to community-based services more consistently evident among all the states.

Acknowledgements

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Longitudinal Change and Interstate Variability in the Size of Large to Small Residential Facilities for Persons with Mental Retardation

During the past 20 years substantial change has taken place in the residential services provided to persons with mental retardation. The most notable aspect of this change has been the substantial decrease in the average daily population of state mental retardation institutions, from an average of 194,650 residents in Fiscal Year 1967 to 100,200 in Fiscal Year 1986 (White, Lakin, Hill, Wright, & Bruininks, 1987). The movement away from large state institutions as the primary source of long-term care for people with mental retardation has been stimulated by many factors. These include: 1) exposes of the dehumanizing, debilitating, and/or otherwise unsatisfactory conditions existing in public institutions by journalists, qualitative researchers, and third-party monitors; 2) parent-consumer advocacy for the right of persons with disabilities to live and participate in culturally typical communities; 3) demonstration by persons with mental retardation of their ability to adapt well to community settings; 4) documentation of consistently better developmental gains among persons with mental retardation moved from public institutions to community settings than among contrast groups remaining institutionalized; and 5) appreciation of the importance of training functional skills in the environments which are projected and/or desired to be the eventual settings of daily living (Lakin & Bruininks, 1985; Lakin, Hill, & Bruininks, 1985).

With the growing recognition in the 1960s and 1970s of the inadequacies of care in state institutions came a rapid "privatization" of long-term care for persons with mental retardation. The residential care industry had about 85% of its clients in state-operated facilities in 1967 (Lakin, Hill, & Bruininks, 1985). By 1986 only about 40% of the residents of mental retardation facilities were in state-operated facilities. But the movement away from near exclusive use of large state institutions has by no means guaranteed protection from all the conditions that were found unacceptable in public institutions. For example,

tens of thousands of those released from large public institutions in the last two decades have been housed in nursing homes, often with little more stimulation and even less habilitation than had been available in the large public facilities they left. Tens of thousands of other people were moved to large private institutions, with doubtful substantive improvement in the extent to which programs were individually oriented, socially integrated, and/or provided culturally typical experiences. The extensive use of residential alternatives that have failed to provide sufficient correction of the deficiencies attributed to state institutions has led to consideration of policy manipulable variables around which laws and regulations can be formulated that will significantly enhance the quality of residential services. Most often size (number of residents) has been the variable selected.

There are a number of advantages to the use of size as a variable around which policy and policy related research in residential services can be structured. First, it is a discrete, unidimensional and reliable variable. All interested parties can agree on the number of people living in a facility. More importantly there are a number of desired aspects of the residential experience that have been linked to size. Among a short list of important factors empirically associated with relatively small size are cultural normalcy of the living environment, frequency of use of neighborhood and community resources, friendships with persons other than fellow residents, frequency of family contract, resident autonomy, and development of independent living skills (Hill, Rotegard, & Bruininks, 1984; Rotegard, Bruininks, Gorder, & Lakin, 1985).

Because of its strong association with factors considered important to defining the quality of the residential experience, facility size is an increasingly evident variable in policy and planning activities at the federal, state, and local level. It is also the descriptor of residential facilities most widely used in efforts to describe the status and evolution of the nature of the residential settings in which persons with mental

retardation live. Specific size categories for both policy and data analysis purposes are, of course, arbitrary. But because of a number of laws and program regulations, the distinction between facilities of 15 and fewer residents and 16 and more residents has been most commonly used. Among the important areas in which distinctions are made between facilities of 15 and fewer and 16 and more residents are ICF-MR regulations, Food Stamp eligibility for facility residents, Fire Safety Code, S.S.I. regulations, and in the Medicaid Home and Quality Services Act, presently being considered by the Congress of the United States. For these reasons, and despite the fact that facilities of 15 residents are not particularly small by contemporary standards, the research on which this paper is based has followed the general convention by distinguishing between facilities of 15 and fewer residents (termed "small") and 16 and more (termed "large" or "institutions").

Method

This paper reports longitudinal trends and contemporary status in residential services based on a longitudinal data base developed by surveys of individual facilities and state agencies. In 1977 the Center for Residential and Community Services (CRCS), University of Minnesota, undertook a survey as of June 30, 1977 of all state-licensed, state-contracted, or state-operated residential facilities in the United States providing 24-hour a day care to persons who were mentally retarded. That survey obtained a national estimate of 247,796 residents with mental retardation in 11,025 facilities nationwide. A replication of the survey in 1982 enumerated 243,699 residents with mental retardation in a total of 15,633 facilities. The surveys of both 1977 and 1982 permitted identification of individual facilities by type of operation, total number of residents, and number of residents with mental retardation. The survey methodology for these studies is described in Lakin, Hill, & Bruininks, 1985.

In 1978 CRCS began a series of surveys of state mental retardation agencies. This Recurring Data Set Project initially included only data on state-operated residential facilities. In 1985 the scope of the survey was expanded to include ICF-MR residences, and in Fiscal Year 1986 to include nonstate facilities and residents. In this data collection both state and nonstate (includes private and county) facilities and residents are further broken down by facility size 15 and fewer and 16 and more. In 1986, 100% response rates were obtained from states on state-operated facilities and residents. A 94% response rate was obtained for nonstate facilities and residents. Data on all nonstate facilities from the 3 states unable to report those data were obtained from a special analysis of the 1986 Inventory of Long-Term Care Places (ILTCP). This supplemental data base was developed by the National Center on Health Statistics and the Bureau of the Census to function as a sample frame, effective as of Spring, 1986, for the National Medical Expenditure Survey. It was based on a master registry of facilities constructed according to the basic procedures used in the 1977 and 1982 CRCS census studies (National Center for Health Statistics, 1987). A major limitation of the ILTCP was a less comprehensive procedure to identify specialized foster care settings than was used by CRCS in its surveys (National Center on Health Statistics, 1987, p. 1). It is estimated that the Inventory undercounted residents with mental retardation in long-term care settings by about 6%, and these were primarily residents of specially licensed foster care homes for persons with mental retardation. But because the ILTCP was used to obtain counts of nonstate facilities and their residents in only three states, the effect of this limitation is very minor.

One difference exists between the 1986 and the 1977 and 1982 statistics presented. As in previous years, the 1986 statistics include residential placements of persons with mental retardation in facilities licensed, contracted, or operated by states for persons with mental retardation. However, previous surveys included only facilities providing 24-

hours-a-day, seven days per week care. In 1986, to better reflect changing models of residential care, and specifically the greater use of supported independent living models, the operational definition of a "residential facility" was broadened to include facilities which offered less than constant supervision, provided they met the other criteria of inclusion. A few thousand additional persons were thereby included in the 1986 survey who would not have been included in 1982.

Results

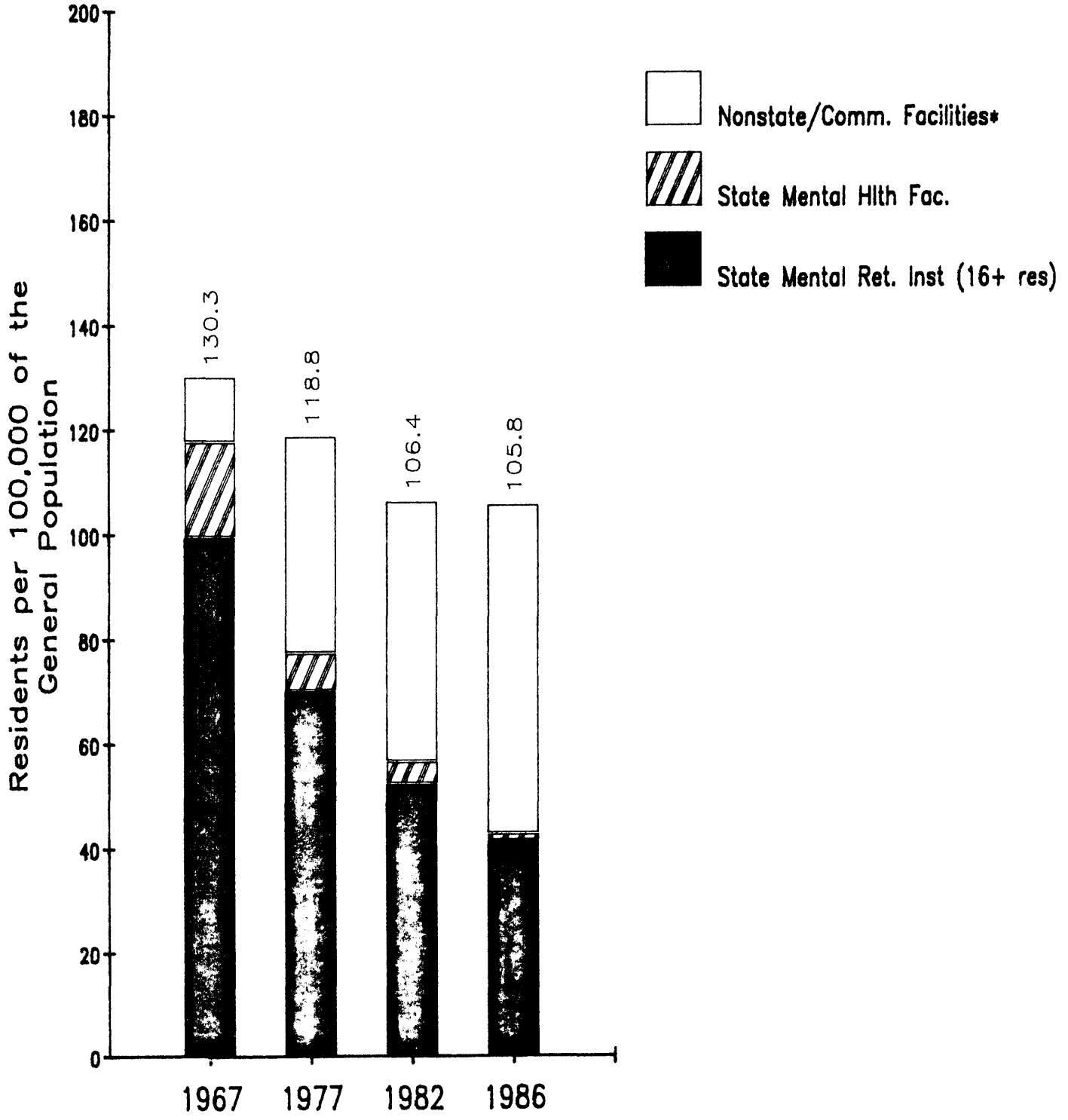
The total population in large state-operated mental retardation facilities on June 30, 1986 was 100,059. States reported an additional 2,990 persons with a primary diagnosis of mental retardation in state-operated institutions other than mental retardation facilities (almost exclusively mental health facilities). Therefore, the total population of persons with a primary diagnosis of mental retardation in all state institutions was 103,049. This represented a decrease of 4.8% from July 1, 1984 when the combined large state institution population was 108,287 (Lakin, Hill, Street, & Bruininks, 1986). The continual decreases since 1967 (described later) have brought the current number of residents with mental retardation in state institutions nearly back down to the number living in them 50 years ago. On January 1, 1936 there were 98,714 persons in state institutions, 91,754 in state mental retardation institutions and 4,942 in state psychiatric facilities (U.S. Bureau of the Census, 1937).

Although the total number of persons with mental retardation in state institutions is about the same as 50 years ago, residential services in general are obviously very different today. While a number of small community-based facilities existed in the 1930s (Lakin, Bruininks, & Sigford, 1981), they made up an extremely small part of the available residential placements at that time. In contrast, on June 30, 1986 facilities of 15 and fewer residents had a greater total mentally retarded population than state institutions (104,189 vs. 103,049).

Changing Types of Placement

Figure 1 shows the number of persons with mental retardation in residential care per 100,000 of the general population in 1967, 1977, 1982, and 1986 for state mental retardation institutions, for state mental health institutions, and for nonstate/community facilities (includes small state-operated group homes). Two significant trends are evident in these statistics. The first is the dramatic decrease in the rate of placement into large public institutions; the second is the significant decrease in the rate of placement into all types of residential facilities for persons with mental retardation. In 1967 there were 99.7 persons in state mental retardation institutions per 100,000 of the U.S. population; 18.1 persons with mental retardation per 100,000 in state psychiatric facilities, and 12.5 per 100,000 in nonstate/community facilities for persons with mental retardation (Lakin, Hill, & Bruininks, 1985). In 1977 the placement rate per 100,000 of the general population for state mental retardation institutions, state psychiatric institutions, and nonstate/community facilities was 70.2, 7.2, and 41.3 respectively (Lakin, Hill, & Bruininks, 1985). By 1986, there were 41.6 placements per 100,000 of persons with mental retardation in state mental retardation institutions, 1.3 placements per 100,000 in state psychiatric facilities, and 62.9 people in nonstate/community facilities per 100,000 of the general population. In terms of total persons with mental retardation in these settings, in 1967 there were 194,650 persons with mental retardation in state mental retardation institutions, 35,452 in state psychiatric facilities, and 24,355 in nonstate facilities. On June 30, 1986 there were 100,059 persons with mental retardation in state mental retardation institutions, 2,990 in state psychiatric facilities, and 151,849 in nonstate and small state-operated residential facilities (the latter defined as having 15 or fewer residents had a total of 4,616 residents on June 30, 1986).

Figure 1
Placements per 100,000 of the U.S. Population in State Mental Retardation Institutions (16+ Res.), State Mental Health Facilities, Private/Community Facilities



*(Includes state-operated group homes)

Figure 1 also shows a significant decrease in the overall rate of residential placement of persons with mental retardation since 1967. In 1967, there were 130.3 persons in state institutions and nonstate mental retardation facilities per 100,000 of the general population. By 1977 the placement rate had decreased to 118.8 and by 1982 it was down to 106.4 per 100,000. The 1986 placement rate per 100,000 was 105.8.

The primary factor in these decreases has been the rapidly decreasing number of children and youth in residential care facilities. In 1967 there were 95,300 children and youth (0-21 years) with mental retardation in state mental retardation institutions. By 1977 the total number of children and youth in state and nonstate facilities for persons with mental retardation was 91,200, or about 4,000 fewer than the number in state institutions alone in 1967. By 1982 the number of children and youth in state and nonstate facilities had decreased to about 60,400. In 1986, it is estimated from the Inventory of Long-Term Care Places (National Center for Health Statistics, 1987), with adjustments for undercounting of specialized foster homes using 1982 data, that the total number of children and youth in state and nonstate mental retardation facilities had fallen to 48,500, or in other words, to almost half the number of children and youth in state mental retardation institutions alone in 1967 (Center for Residential and Community Services, 1985; National Institute of Mental Health, 1968).

Changing Sizes of Mental Retardation Facilities

In the early years of efforts to depopulate state institutions, large private mental retardation facilities were frequently developed as alternative placements to public institutions. As a result, private mental retardation institutions (16 or more residents) increased in population from an estimated less than 25,000 in 1967 to more than 50,000 in 1977 (Lakin, Hill, & Bruininks, 1985). But statistics permitting concurrent breakdowns by size of both state and nonstate mental retardation facilities go back only to 1977. Despite the limited time period covered (the nine years between 1977 and 1986), very

substantial changes are evident in the available statistics. Figure 2 shows national totals for the number of persons with mental retardation in state and nonstate mental retardation facilities broken down by 15 and fewer residents ("small") and 16 and more residents ("large").

In 1977 there 40,433 persons with mental retardation in small residential facilities (16.3% of all residents). A total of 207,363 persons were in large facilities. By 1982, there were 63,703 residents in small facilities (26.1% of all residents) and 179,966 persons in large facilities. By 1986 there were 104,189 residents (41.3% of all state and nonstate facility residents) in small facilities. A total of 147,719 people were in large facilities. Although Figure 2 shows a pronounced trend toward smaller settings, the actual reduction in the number of residents in large facilities in nine years between 1977 and 1986 was only 29%.

Interstate Variability

In addition to major variations nationally in the sizes and types of facilities providing care at different points in the evolution of residential services systems in the past two decades, there also have been and remain major differences among states at any one time. Table 1 provides a summary of the state-by-state and national distribution of residents of state-licensed, contracted, or operated mental retardation facilities on June 30, 1986. Statistics are provided for large and small mental retardation facilities that are operated by state agencies and by nonstate (private and county) agencies.

The statistics in Table 1 show major differences among states in their total number of residents in large and small, state and nonstate facilities. They also show major differences in important areas of comparison, including 1) percentage of residents in nonstate facilities, 2) percentage of residents in facilities of 15 and fewer residents, and 3) average number of residents per facility.

Figure 2
Changing Utilization of Small and Large Residential Facilities for Persons with Mental Retardation/ Developmental Disabilities, 1977, 1982, 1986

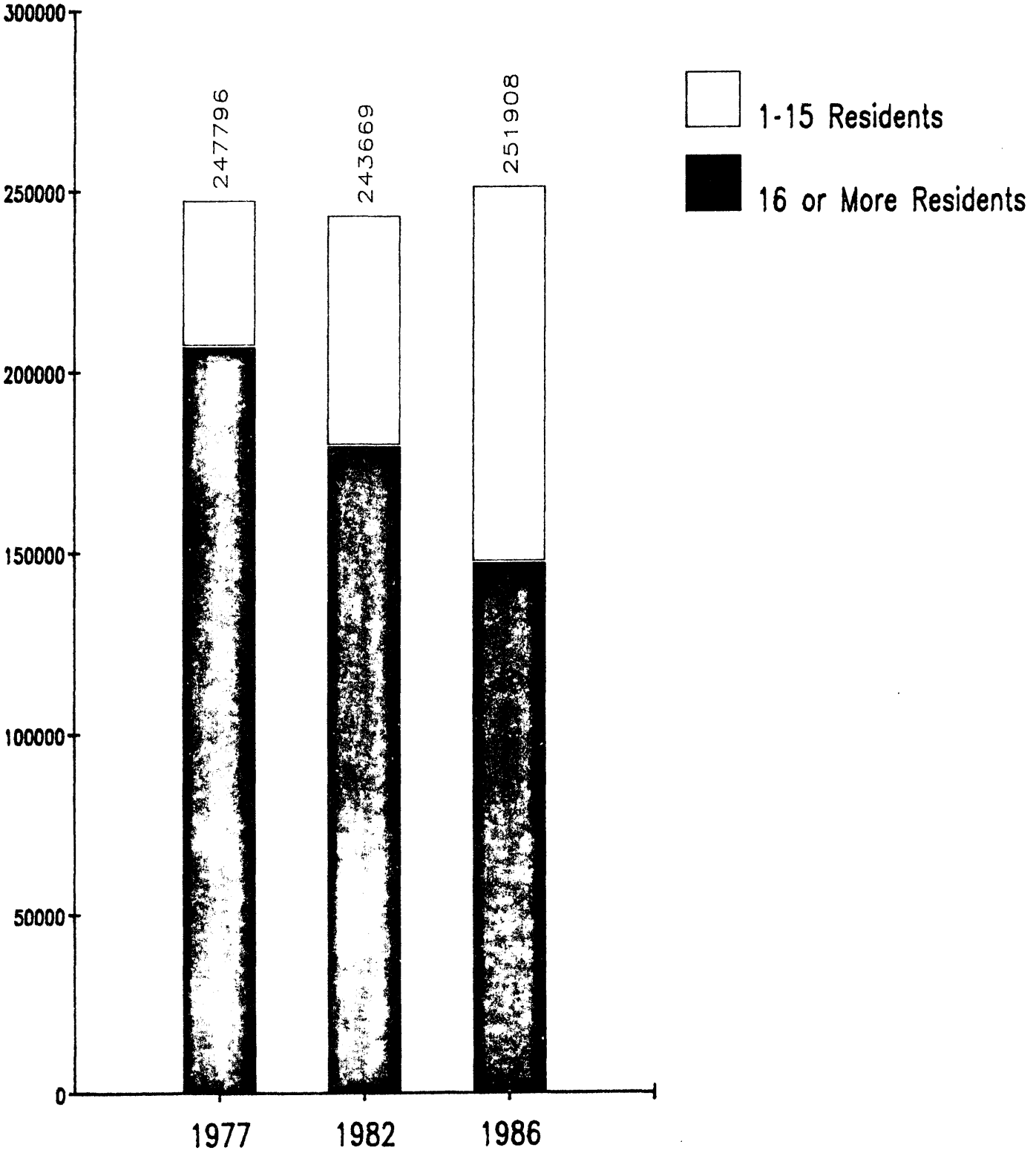


Table 1

All Facilities and Residents for 1986

	Facilities					Residents									
	Nonstate		State			Nonstate			State						
	15-	16+	15-	16+	Total Fac.	15-	16+	Total	15-	16+	Total	Total Res.	% Res. Priv.	% Res. in 15-	Ave. Res per Fac.
ALABAMA	104e	16e	0	5	125e	664	178	842	0	1,333	1,333	2,175	38.7%	30.5%	17.4
ALASKA	99	5	0	1	105	216	23	239	0	59	59	298	80.2%	72.5%	2.8
ARIZONA	246e	8	12	3	269e	1,327	245	1,572	66e	429	495e	2,067e	76.1%	67.4%	7.7
ARKANSAS	46	6	0	6	58	439	147	586	0	1,359	1,359	1,945	30.1%	22.6%	33.5
CALIFORNIA	3,909	368	0	8	4,285	15,786	4,894e	20,680e	0	6,902	6,902	27,582e	75.0%	57.2%	6.4
COLORADO	271e	6	0	3	280e	1,623	346e	1,969e	0	969	969	2,938e	67.0%	55.2%	10.5
CONNECTICUT	743e	11	44	13	811e	1,732e	242e	1,974e	347	2,438	2,785	4,759e	41.5%	43.7%	5.9
DELAWARE	145e	0	0	1	146e	288	0	288	0	394	394	682	42.2%	42.2%	4.7
D.C.	155	0	0	1	156	574	0	574	0	285	285	859	66.8%	66.8%	5.5
FLORIDA	533	84	0	6	623	3,112	2,871	5,983	0	2,094	2,094	8,077	74.1%	38.5%	13.0
GEORGIA	596	2	0	8	606	1,285	138e	1,423	0	2,127	2,127	3,550	40.1%	36.2%	5.9
HAWAII	218e	0	1	1	220e	454	0	454	8	279	287	741	61.3%	62.3%	3.4
IDAHO	99	16	0	1	116	353	529	882	0	287	287	1,169	75.4%	30.2%	10.1
ILLINOIS	854e	128	0	13	995e	2,506	6,459	8,965	0	4,475	4,475	13,440	66.7%	18.6%	13.5
INDIANA	470	14	0	9	493	1,915	684	2,599	0	2,302	2,302	4,901	53.0%	39.1%	9.9
IOWA	144	91	0	2	237	1,305	2,180	3,485	0	1,143	1,143	4,628	75.3%	28.2%	19.5
KANSAS	69	18	0	4	91	510	919	1,429	0	1,345	1,345	2,774	51.5%	18.4%	30.5
KENTUCKY	311	7	0	3	321	493	815	1,308	0	678	678	1,986	65.9%	24.8%	6.2
LOUISIANA	324	16	6	9	355	1,263	1,673	2,936	34	3,042	3,076	6,012	48.8%	21.6%	16.9
MAINE	476	30e	2	2	510	1,331	229	1,560	24	304	328	1,888	82.6%	71.8%	3.7
MARYLAND	784	3	1	7	795	2,276	67	2,343	13	2,203	2,216	4,559	51.4%	50.2%	5.7
MASSACHUSETTS	1,258	10	0	7	1,275	4,341	250e	4,591	0	3,438	3,438	8,029	57.2%	54.1%	6.3
MICHIGAN	1,122	34	0	8	1,164	4,810	1,145	5,955	0	1,930	1,930	7,885	75.5%	61.0%	6.8
MINNESOTA	745	54	0	7	806	4,090	2,392	6,482	0	1,780	1,780	8,262	78.5%	49.5%	10.3
MISSISSIPPI	59	5	31	5	100	232	605e	837e	216	1,628e	1,844e	2,681e	31.2%	16.7%	26.8
MISSOURI	421	152	2	9	584	2,189	1,884	4,073	16e	1,858	1,874	5,947	68.5%	37.1%	10.2
MONTANA	221	0	0	2	223	818	0	818	0	257	257	1,075	76.1%	76.1%	4.8
NEBRASKA	474	4	0	1	479	1,551	393	1,944	0	468	468	2,412	80.6%	64.3%	5.0
NEVADA	72	0	0	2	74	221	0	221	0	166	166	387	57.1%	57.1%	5.2
NEW HAMPSHIRE	172	1	0	1	174	791	23	814	0	198	198	1,012	80.4%	78.2%	5.8
NEW JERSEY	1,039	2	0	10	1,051	3,339	72	3,411	0	5,453	5,453	8,864	38.5%	37.7%	8.4
NEW MEXICO	106	0	0	2	108	673	0	673	0	482	482	1,155	58.3%	58.3%	10.7
NEW YORK	2,745	35	362	28	3,170	11,385	1,083	12,468	2,905	10,910	13,815	26,283	47.4%	54.4%	8.3
NORTH CAROLINA	260	8	0	5	273	1,013	424	1,437	0	2,880	2,880	4,317	33.3%	23.5%	15.8
NORTH DAKOTA	376	2	1	2	381	1,170	49	1,219	12	437	449	1,668	73.1%	70.9%	4.4
OHIO	1,029	110	0	14	1,153	3,955	4,005	7,960	0	2,895	2,895	10,855	73.3%	36.4%	9.4
OKLAHOMA	93	17	0	3	113	642	1,647	2,289	0	1,354	1,354	3,643	62.8%	17.6%	32.2
OREGON	326	6	0	2	334	1,327	261	1,588	0	1,294	1,294	2,882	55.1%	46.0%	8.6
PENNSYLVANIA	2,406	227	0	17	2,650	5,638	3,144	8,782	0	5,647	5,647	14,429	60.9%	39.1%	5.4
RHODE ISLAND	174	0	21	2	197	696	0	696	155	366	521	1,217	57.2%	69.9%	6.2
SOUTH CAROLINA	144	3	12	6	165	674	110	784	150	2,628	2,778	3,562	22.0%	23.1%	21.6
SOUTH DAKOTA	96	0	0	2	98	823	0	823	0	497	497	1,320	62.3%	62.3%	13.5
TENNESSEE	191	5	0	5	201	1,057	208	1,265	0	2,159	2,159	3,424	36.9%	30.9%	17.0
TEXAS	198	44	79	15	336	1,917	3,094	5,011	530e	8,267	8,797	13,808	36.3%	17.7%	41.1
UTAH	122	9	19	1	151	378e	604	982e	140	671	811	1,793e	54.8%	28.9%	11.9
VERMONT	250	0	0	1	251	488e	0	488e	0	195	195	683e	71.4%	71.4%	2.7
VIRGINIA	89	5	0	5	99	591	158	749	0	3,047	3,047	3,796	19.7%	15.6%	38.3
WASHINGTON	584	200	0	6	790	1,929	1,659	3,588	0	1,839	1,839	5,427	66.1%	35.5%	6.9
WEST VIRGINIA	442	13e	0	3	458	751e	119e	870e	0	485	485	1,355e	64.2%	55.4%	3.0
WISCONSIN	770	22	0	3	795	2,400e	1,650	4,050	0	1,969	1,969	6,019	67.3%	39.9%	7.6
WYOMING	32	2	0	1	35	232	42	274	0	414	414	688	39.8%	33.7%	19.7
Total	26,612	1,799	593	281	29,285	99,573	47,660	147,233	4,616	100,059	104,675	251,908	58.4%	41.4%	8.6

Percentage of residents in nonstate facilities. There has been very substantial growth in nonstate residential programs for persons with mental retardation in recent years. As shown in Table 1, on June 30, 1986 58.4% of the residents in mental retardation facilities in the United States were in nonstate facilities. That compared with about 37% in 1977 (Lakin, Hill, & Bruininks, 1985). Interstate variations were found to be large, with three states over 80% (Maine, Nebraska, and Alaska) and two states below 25% (Virginia and South Carolina). A total of 36 states had more than half their residents in private facilities on June 30, 1986.

Percentage of residents in small facilities. Accompanying the privatization of residential services for persons with mental retardation has been a rapid growth in the number of persons in relatively small facilities. Persons moved to private facilities from state facilities tend to go from large facilities to small facilities (nonstate facilities averaged only 5.2 residents on June 30, 1986). On June 30, 1977 only 16.3% of persons in mental retardation facilities resided in facilities of 15 or fewer residents. By June 30, 1986, 41.4% of all residents were in small facilities. Despite such rapid change 58.6% of persons with mental retardation in residential care were still in large facilities, with enormous variability among the states. On June 30, 1986, 4 states had over 70% of the residents in small facilities (New Hampshire, Alaska, Vermont, and North Dakota), 4 states had less than 20% of their residents in small facilities (Virginia, Mississippi, Oklahoma, and Kansas), and only 21 states had reached the point at which more persons were in small residential facilities than were in large ones.

Average number of residents per facility. Nationwide there has been a dramatic increase in the number of very small facilities since 1982, causing a rapid reduction in the average number of residents per facility. In 1977 there was an average of 22 persons per state licensed, contracted, or operated residential facility. By 1986 that average had decreased to 9. Although a limited portion of that decrease can be accounted for by the

1986 inclusion of supported living arrangements (less than 24 hour supervision), these decreases were primarily caused by two factors: 1) rapidly decreasing average population among a relatively stable number of large facilities, and 2) a rapidly increasing number of small facilities of a relatively stable average size. While the total number of facilities with 16 or more residents increased from 1,730 in 1977 to 2,080 in 1982, their total residents decreased from 207,363 to 147,719, from an average size of 120 in 1977 to 71 in 1986. The average number of residents in small facilities decreased only from 4.3 to 3.8, but the total number of small facilities increased from 9,300 to 27,200. Interstate variations in average facility size were large, from over 30 residents in five states (Texas, Virginia, Arkansas, Oklahoma, and Kansas) to less than 5 residents in eight states. While the national average number of residents per facility was 8.6, the average of the state averages was 11.9. This difference was the result of a tendency for the relatively large residential care systems to have a smaller average number of residents per facility.

Discussion

Residential care for persons with mental retardation in the United States is continuing a steady evolution from an institutionally-oriented to a community-based system. The three most important aspects of this process have been 1) the stable size of the total system, 2) the decreasing number of people in large state facilities, and 3) the rapid increase in number of small, almost exclusively nonstate, facilities.

When one looks at the total size of the public and private residential care system for persons with mental retardation over the past two decades it is hard not to be impressed with the stability of its size. Since 1967, including public mental retardation and psychiatric facilities (the latter being heavily used in 1967 for residential care of persons with mental retardation) and nonpublic facilities, the residential population of persons with mental retardation between 1967 and 1986 increased only from 254,500 (Lakin, Hill, Bruininks, 1985) to 254,900. Populations of state institutions continue to

decrease at a fairly steady rate of 4,000-5,000 per year, a rate that has been maintained for two decades. Capacity building in community settings remains in relative synchrony, providing a number of new places in community settings approximately equal to the decreasing state institution populations.

Although it may be perceived from these statistics that all is going well, there are some significant problems in residential services nationwide that must be addressed. First, although the population of residential care systems has not changed in 20 years, presumably the total number of persons with mental retardation has increased in general proportion to the increasing population of the nation as a whole. Much of the associated demand for residential services has been attenuated by the nation's remarkable success in increasing substantially the median age at which persons with mental retardation are first admitted to residential care (Lakin, Hill, Hauber, Bruininks, 1983) and in greatly reducing the total number of children and youth in residential care. But it appears, too, that much demand is simply ignored. A recent survey by the Association for Retarded Citizens-U.S. (Davis, 1987) reports a nationwide need for over 50,000 residential placements. While it is important in each individual case to explore alternatives to long-term care placements, it is probable, too, that there is a significant need to increase the overall capacity of community residential care systems to meet the legitimate needs of tens of thousands of people in the United States.

Second, while progress in the depopulation of large state institutions has been significant, reducing populations from about 150,000 in 1977 to 100,000 in 1986, reductions among large private institutions have been much slower, decreasing only from 51,600 in 1977 to 47,700 in 1986. Clearly a more concerted effort will need to be made at federal and state levels if deinstitutionalization is to include residents of all types of institutions.

Finally, although statistics show generally favorable progress in developing community services nationwide, progress is by no means uniform. Indeed, a number of states appear

statistically to have progressed little beyond where the nation on average was in 1977. In 1977 the average number of residents per facility was about 22; 7 states remain above that average today. While only one state is below the 1977 national percentage of total residents in small facilities (16.3%), on June 30, 1986 six states were still below 20%.

These observations suggest the need for a more concerted national policy to make community services more readily and uniformly available. Such a policy must assist in providing more uniform access to community-based services for all persons with mental retardation. States, with substantial assistance from the federal government, should have an obligation to provide an adequate supply of community-based residential and alternative services to meet the legitimate needs of a truly entitled group, much as is presently required in providing a free and appropriated education to persons with mental retardation who are of school age. Ignoring the needs of thousands for residential care is becoming an increasingly prevalent, albeit tacit, public policy in this country.

It is also important that the movement from institutions to community programs better include people isolated from community membership and participation by means of placement in private as well as in public institutions, at least to the extent that the former are publicly funded. Certainly the promise of community-based services should not be permitted to suffer semantic cooptation by those wishing to instill positive valence to programs which are not community-based and which suffer the same limitations as public institutions, the depopulation of which has been the almost exclusive focus of the deinstitutionalization movement nationwide.

There also clearly needs to be a national policy to better stimulate states which are not making reasonable progress toward increasing the opportunities for their citizens to benefit from community living. Such policy need not be oppressive to be successful, but it does need to reflect a seriousness about realizing national goals. When in its "Findings and Purposes" of the 1987 Developmental Disabilities Assistance and Bill of Rights Act,

Congress agreed that, "it is in the national interest to offer persons with developmental disabilities the opportunity, to the maximum extent feasible,... to live in typical homes and communities where they can exercise their full rights and responsibilities as citizens" (Sec. 101(a)(8)), it should not be a long wait for federal policy that promotes that national purpose.

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