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Classification of Residential Facilities for Mentally Retarded People

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Abstract

This paper describes the development of a taxonomy of residential facilities for mentally retarded people based on program model, size, and operation. Data are presented on the use of the classification system in a national survey of residential facilities in the United States. Program models are defined and national summary data are provided. Classificatory problems are discussed and suggested refinements to the taxonomy are presented.

In the past two years there has been considerable discussion about the importance of uniform national data sets for planning and monitoring services for mentally retarded people. Calls for the establishment of such sets can be found in the professional literature (see a recent editorial by Rowitz in Mental Retardation [1984]) and in the recommendations of government advisory panels (see the reports of the Education/Training Committee, National Institute of Handicapped Research [1983] and National Council on the Handicapped [1983]). However, in the area of residential services, there are at least three problems in establishing uniform data sets. First, each state has a unique licensing/classification system which is seldom comparable to those of other states. To exemplify this, Table 1 provides a partial list of licensing categories identified by the Center for Residential and Community Services (CRCS), University of Minnesota, in an unpublished 1983 state mental retardation agency survey. Second, variations within state licensing types in facility size, level of care, and programming are often as great as variation between types (see Baker, Seltzer, & Seltzer, 1977; Landesman-Dwyer, 1981; Landesman-Dwyer, Sackett, & Kleinman, 1980, King, Raynes, & Tizard, 1971). Third, there seems to be little consensus as to what taxonomy should be used in a uniform classification system.

Despite the widely recognized diversity within and among extra-institutional programs, or perhaps because of it, most research in residential services induces dichotomized classification, most commonly between public institutions and "group homes" (Janicki, Mayeda, & Epple, 1983) or "community residential facilities" (Bruininks, Hauber, & Kudla, 1980; O'Connor, 1976). Nevertheless, the presumption of meaningful distinctions within a binary classification system consisting of public residential facilities and community residential facilities appears increasingly unwarranted. Public

Table 1
Partial List of State Licensing Categories: 1983

Adult boarding facility	Group boarding home	Residential retardation center
Adult congregate care	Group home	Residential school
Adult family boarding home	Group home for MR/behavior disorder	Residential training center
Adult group home	Halfway house	Residential training home
Alternative care service	Home for the aged	Residential treatment center
Alternative community living res.	Hospital & training center	Retardation center
Alternative intermediate service	ICF	Sheltered boarding homes
Alternative living units	ICF general	Skilled nursing facility
Board & care	ICF-private	Small family group home
Boarding & rooming home	ICF/DD	Small family home
Boarding home	ICF/MR	Social rehabilitation facility
Care home	ICF/MR for children	Special group home
Certified private school	Independent living/training	Specialized care facility
Child group home	Intermediate care facility	Specialized child group home
Children's group home	Intermediate health care facility	Specialized community residence
Community based residential facility	Large family home	Specialized home care
Community care home	Large group living	Specialized living center
Community group home	Licensed shelter home	Specialized nursing home
Community ICF/DD	Mental health center	State center
Community ICF/MR	Mental health institute	State center for human development
Community IMR facility	Minimally supervised home	State group home
Community living arrangement	Nurseries	State hospital
Community living facility	Nursing care facility	State hospital & training center
Community living/training facility	Nursing facility	State hospital/school
Community MR residential facility	Nursing home	State hospital/training center
Community residence	Nursing home/ICF-MR	State institution
Community residence-ICF/DD	Personal care home	State ICF
Community residence-supervised	Private group home	State ICF/MR
Community residence-supported	Private institution	State regional center
Community SNF	Private ICF/MR	State rehabilitation center
Comprehensive center	Private MR facility	State school
Comprehensive nursing home	Public group home	State school/hospital
County home	Regional center	State school/training center
Developmental center	Residential care facility	State training school
Developmental home	Residential care facility for MR	Subsidized boarding home
Domiciliary care	Residential center	Sunland center
Extended family care	Residential child care institution	Supported living arrangement
Family care provider	Residential habilitation center	Therapeutic community residence
Family home	Residential homes/center	Training programs
Foster boarding home/children	Residential learning center	Transitional community living
	Residential nursing home	

entities operate hundreds of relatively small community-based residences in addition to large institutions; some private facilities typically included among "community residential facilities" are larger than many of their public counterparts; both public and private facilities rely virtually exclusively on public funding programs for their support.

A number of systems for classifying residential facilities were reviewed by Heal, Novak, Sigelman, & Switzky (1980). Scheerenberger's taxonomy (1978, 1983) to collect data on previous and subsequent placements of new admissions and releases from state institutions has been one of the most frequently used classification lists. It includes natural family home, foster/family home, group home, private residential facility, semi-independent living, independent living, boarding home, community psychiatric program, general medical hospital, public residential facility, hospital for the mentally ill, nursing home, correctional facility, school for the blind and, in previous years, county home, community ICF, rest home, and work placement. Baker, Seltzer, & Seltzer (1977) developed a classification system that was based on both program type and size. Facility types included small group home (1-10), medium group home (11-20), large group home (21-40), mini institution (41-80), mixed group home, group home for older adults, foster family care, sheltered village, workshop-dormitory, and semi-independent units.

The Center for Residential and Community Services (CRCS) conducted national surveys of residential facilities for mentally retarded people in 1977 and 1982 (cf. Bruininks, Hauber, & Kudla, 1980; Hauber, Bruininks, Hill, Scheerenberger, Lakin, & White, in press). In the 1977 survey CRCS attempted to use state licensing categories and Scheerenberger's typology to classify facilities. High variability in state licensing categories and the lack of operational definitions, however, made interstate aggregations by facility type impossible. Therefore, for its 1982 national census, the Center adopted

a modified approach to classification, presented in this paper. This typology is was based on three variables: program model, size, and operator.

Program Model. A unified system of data gathering and reporting requires a taxonomy that accommodates the significant variations in state residential programs, yet yields reliable and comparable information across states. Primary criteria for program models relate to the level of care or supervision of residents, to models of habilitation, and to degree of specialization. Based on reviews of other taxonomies and experience in the 1977 national survey, CRCS adopted eight basic program models (types of facilities) for its 1982 national census study: supported natural home, foster home, group residence, semi-independent living facility, supported independent living, board and supervision facility, personal care home, and specialized nursing facility. (Supported living programs were not included in the study described here and are therefore not discussed in this paper). In order to accommodate diversity within and among states, survey respondents were asked to classify themselves (their facilities) into the category that was most reflective of their program. Program models, presented in Table 2, are discussed in the "Results" section of this paper.

Size. Size is frequently discussed as an important factor in the nature and effectiveness of services for developmentally disabled people (Balla, 1976; Baroff, 1980). However, much of the research in this area has tended to view size as a treatment variable rather than as a demographic variable in attempting to relate it to client development (e.g., Landesman-Dwyer, Berkson, & Romer, 1979). While small size does appear related to superior developmental achievement, the effects of size are more directly felt in the organization and environment of a facility than in its treatment program (Rotegard, Bruininks, Gorder, & Lakin, in press). Therefore, size is

Table 2
Residential Program Models

Original definitions	Proposed definitions
Residential facility[a]	
Any living quarters which provided 24-hour, 7 days-a-week responsibility for room, board, and supervision of mentally retarded people as of (date), 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 programs which have no staff residing in the same facility	
Program models	
A home or apartment owned or rented by a family, with one or more retarded people living as family members (e.g., foster home)	A residence owned or rented by a family as their own home, with one or more mentally retarded people living as family members (e.g., foster home)
A residence with staff who provide care, supervision, and training of one or more mentally retarded people (e.g., group residence)[b]	A residence with staff who provide care, supervision, and training of one or more mentally retarded people (e.g., group residence)
A residence consisting of semi-independent units or apartments with staff living in a separate unit in the same building (e.g., supervised apartments)	A residence consisting of semi-independent units or apartments with staff living in a separate unit in the same building (e.g., semi-independent living program)
A residence which provides sleeping rooms and meals, but no regular care or supervision of residents (e.g., boarding home)	A residence with staff who provide sleeping rooms, meals, and supervision, but no formal training or help with dressing, bathing, etc. (e.g. board & supervision facility)
A residence in which staff provide help with dressing, bathing or other personal care, but no formal training of residents (e.g., personal care home)	A residence with staff who provide help with dressing, bathing or other personal care, but no formal training of residents (e.g., personal care facility)
A nursing home (e.g., ICF or SNF)	A facility that provides daily nursing care with primary emphasis on residents' health care needs (e.g. nursing home)

Note. Not included in this study were (a) Supported independent living: staff visit periodically, but do not provide day-to-day supervision; and (b) Supported families: A family that receives in-home or community based services or financial support for the purpose of permitting a handicapped relative to live at home.

[a] A "facility" was defined as one or more buildings that were on adjacent property, and shared staff, meal preparation, or laundry services.

[b] Short term facilities (average length of stay at least 30 days), cooperative villages, and residential schools, if coded "other," were included with group residences.

considered in this taxonomy as a subclassification within program models. Total number of residents under supervision (mentally retarded, mentally ill, elderly, etc.) provides the best indicator of size. Licensed bed capacity is an inadequate measure of size, especially state institutions, which frequently operate far below the licensed capacity and in foster homes, for which official licensing limits (usually four or six residents) do not necessarily reflect the number of residents an individual provider is actually willing to accept. On the other hand, the number of mentally retarded clients does not adequately reflect size in facilities with heterogeneous resident populations (e.g., nursing homes, boarding and supervision homes, and personal care homes) or multiple units (e.g., large psychiatric hospitals with small mental retardation units).

A special analysis of interview data gathered in a 1978-1979 national study of the environmental/treatment conditions of 236 public and private residences (see Rotegard, Hill, & Bruininks, 1983) was conducted to establish appropriate size categories for this taxonomy. A five item Physical Environment Scale with which, after a walking tour, interviewees rated bedrooms, bathrooms, dining rooms, living rooms, and yards on "home-likeness" significantly differentiated facilities size 7-15 vs 16-63, $F(1,72)=12.3$, $p<.001$; size 16-63 vs 64-299, $F(1,74)=7.5$, $p=.008$; and size 64-299 vs 300 or more $F(1,102)=13.1$, $p<.001$, controlling for resident ability. A nine item revision of Jackson's (1969) Characteristics of the Treatment Environment (Silverstein, McLain, Hubbel, & Brownlee, 1977), a scale which assesses resident autonomy and activity, also differentiated these size categories, although not after controlling for resident ability.

Operator. The distinction between private and public (mostly state) facilities is of importance primarily for administrative and historical reasons. For the past 100 years, most data collection efforts have centered

on state and private institutions (Lakin, Krantz, Bruininks, Clumpner, & Hill, 1982). The goal of deinstitutionalization also makes the number of people in large publicly-operated facilities important as a matter of public policy. Finally, many reimbursement policies officially or tacitly distinguish among proprietary/profit, nonprofit, and government operation.

Method

The 1982 CRCS survey included all facilities and homes which met the following definition of a residential facility for mentally retarded persons:

> Any living quarter(s) which provided 24-hour, 7 days-a-week responsibility for room, board, and supervision of mentally retarded people as of June 30, 1982, 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.

The mailing list of facilities/homes was constructed between January 20, 1982 and August 15, 1982. The Mental Retardation Program Director was initially contacted in each state to identify the types of residential programs available for mentally retarded people and to identify those state and regional agencies and, if necessary, provider agencies that would need to be contacted to construct a complete registry of all facilities meeting the operational definition in each state. Over 600 sources were required to complete the national registry. When completed, each state registry was returned to the state agency program director or designated agency contact person for verification of accuracy and completeness.

Questionnaires were mailed to all identified facilities in September, 1982. Two mail follow-ups were conducted in September-October 1982, succeeded by several special follow-ups of selected groups of facilities. Telephone interviewing of all nonrespondents began in December 1982, and ended in June

1983. Each questionnaire was edited following mail return or telephone interview. Nonresponding facilities, as well as those who returned incomplete or inconsistent information, received a telephone follow-up (approximately 85% of all questionnaires).

Specific editing rules were generated during the course of the survey to clarify ambiguities in the original program model definitions. Occasional questions about the original definitions were voiced by foster parents who noted they provided training and might therefore be considered group residences. Conversely, a few large family-operated group residences with paid staff considered residents to be part of a family and indicated the facility to be a foster home. Small group residences housed in apartment buildings (e.g., cluster apartments for severely handicapped residents) sometimes described themselves as supervised apartments even though residents were not semi-independent. Some group homes that were ICF-MR certified checked "nursing home" because the example of a nursing home included "ICF." As a part of editing, all foster homes with more than 10 residents, all semi-independent living programs with 3 or fewer residents, and all facilities indicated as nursing homes were reviewed individually.

Results

Of 22,150 facilities contacted (including 5,073 facilities followed up from a 1977 survey), 15,633 were confirmed to meet the survey's operational definition. A small number of these facilities (864 or 5.5%) did not participate. Follow-up calls to state licensing agencies confirmed the nonparticipant's eligibility for inclusion in the study and provided the licensed bed capacity and number of retarded residents of these facilities. Population statistics presented in this paper, therefore, are for all 15,633 facilities.

During the survey period 317 facilities returned two questionnaires, primarily because of duplicate inclusion of facilities on the mailing list or because of delays in the mail that resulted in an unnecessary second questionnaire being sent and returned. In 56% of these instances, second questionnaires were completed by different direct care or administrative staff members; 73% of second questionnaires were completed at least 4 weeks after the first. Although second questionnaires were not edited or followed up according to standard editing rules, an overall 85.5% rate of agreement was found in the way respondents classified their facilities. Intraclassification rates varied from 77% for 65 foster homes (as defined by the edited questionnaire) to 93% for 227 group residences. It is believed that reliability in classification would have exceeded 85.5% had second questionnaires also gone through standard editing procedures.

The following paragraphs describe each facility category in relation to summary data from the CRCS 1982 national survey, presented in Table 3. In this table, only a limited number of type by size by operator combinations are presented. Group residences (49% of all facilities) are divided into 5 size categories. Facilities with 16 or more residents are further classified as either privately or publicly operated. Foster homes are not subgrouped because of homogeneous size and 100% private operation (by definition). Other facility types are not subgrouped because relatively few were eligible for this survey (i.e., were specially licensed or contracted as mental retardation facilities).

Foster homes. The primary characteristic of a foster home is its superimposure on an existing household. Foster care providers offer their service in their own homes to one or more handicapped residents who are not family members. All states have "generic" foster care programs that serve

mostly children, sometimes including handicapped children. These programs are typically administered at the county level. Many states, however, also sponsor specialized foster care programs for developmentally disabled people. Most specialized foster programs serve handicapped adults as well as children; in fact only 37% of their residents are children, many of whom have been previously institutionalized. These programs offer stipends to care providers that are generally higher than those provided in generic foster care programs but substantially lower than reimbursement to group residences. Foster care providers are usually expected to have specialized experience or ongoing training as part of their licensing requirements.

The results of this study indicate that foster homes tended to be small (average 2.8 handicapped residents, 2.6 retarded residents) with the most favorable resident/direct care staff ratio of any facility type (1.9). They offered unusually low cost care, primarily because of high levels of donated "staff" time and capital costs (especially housing). Although foster homes were reimbursed at a rate less than half that of small group residences ($16.15 vs. $38.31 per resident per day), the proportion of severely and profoundly retarded residents, nonambulatory residents, and residents who were not toilet-trained or who could not talk was actually greater in foster care homes than in small group residences.

While the goal of generic foster parents is to do whatever they can to reunite foster children with their natural parents, specialized foster placements tend to be long term. Approximately 17% of foster home residents are released each year, including an estimated 8.8% whose release was unreported because their previous foster home moved or closed in the year prior to June 30, 1982 (Hill, Lakin, Hauber, Bruininks, & McGuire, in press). Residents of specialized foster homes were less likely to have moved between June 1981 and June 1982 than were residents of small group residences.

Group residences. The group residence category includes public and private facilities ranging in size from two residents to more than 2,000 residents. Group residences generally consist of living units that are owned or rented for the purpose of providing residential and habilitation programs by a staff (live-in or shift) that is paid a wage. Most group residences (84%) had fewer than 15 residents. However, the vast majority (80%) of the individuals in group residences were in facilities with more than 16 residents; 53% were in facilities of more than 299 residents.

While a high level of care and supervision is generally assumed to be required of large group residences to provide for their more severely impaired populations, reported counts of direct care staff members and residents typically in the facility at 7:30 p.m. demonstrated that large group residences, with the exception of large private residential schools, had among the least favorable ratio of residents to staff.

Resident movement data for 1982 indicate a substantial growth in the number of occupied beds in small group residences (1-15 residents), particularly in facilities with 6 or fewer beds. There was a small increase in residents of private facilities with 16-299 beds, and a net decrease in the largest private and in all public facility categories.

Semi-independent living programs. In semi-independent living programs, residents have their own living quarters (usually with handicapped roommates), with staff near-by and "on-call" in the same building. Residents take care of many of their own needs, but some may need training or supervision in certain areas of decision making, domestic skills, or community independence (e.g., meal preparation, use of public transportation, banking, etc).

The average semi-independent living facility in 1982 had 10 handicapped residents with two direct care staff on duty in the same building on a weekday

Table 3

Characteristics of Six Types of Residential Facilities
for Mentally Retarded People in the United States:
June 30, 1982

Characteristics	Spec. Foster	Group Residence: small 1-6	small 7-15	small Total	large private 16-63	large private 64-299	large private 300+	large private Total	large public 16-63	large public 64-299	large public 300+	large public Total	Semi-Indep.	Board & Superv.	Personal Care	Spec. Nursing	Total
Facility characteristics																	
Number of facilities	6,587	3,557	2,857	6,414	680	199	7	886	92	109	168	369	306	185	583	303	15,633
Number of residents	18,252	15,982	27,606	43,588	20,721	22,148	3,199	46,068	3,321	16,071	115,551	134,943	3,155	2,559	7,956	24,521	281,042
M	2.8	4.5	9.7	6.8	30.5	111.3	457.0	52.0	36.1	147.4	687.8	365.7	10.3	13.8	13.6	81.1	18.0
SD	1.9	1.4	2.3	3.2	13.2	42.0	137.2	55.7	13.3	67.6	355.6	383.9	8.8	20.3	19.8	61.8	83.0
Number of MR residents	17,147	15,701	26,317	42,018	17,343	20,354	2,650	40,347	2,646	14,999	105,326	122,971	2,870	1,264	4,070	12,982	243,669
Operator																	
Private/proprietary	100.0%	28.6%	25.3%	27.1%	52.2%	44.2%	28.6%	50.2%	0.0%	0.0%	0.0%	.0	13.4%	94.6%	90.4%	70.6%	62.2%
Non-profit	.0%	64.0%	63.2%	63.6%	47.8%	55.8%	71.4%	49.8%	0.0%	0.0%	0.0%	.0	80.4%	4.3%	4.8%	23.1%	31.2%
Public	.0%	7.4%	11.5%	9.2%	0.0%	0.0%	0.0%	.0	100.0%	100.0%	100.0%	100.0%	6.2%	1.1%	4.8%	6.3%	6.6%
Residents per direct care staff at 7:30 PM weekday	1.9	2.9	4.9	3.8	7.8	7.7	4.2	7.7	8.7	7.3	6.0	7.1	5.2	6.2	6.6	7.9	6.3
Reimbursement/resident/day																	
Without day program	$16.02	$39.54	$33.17	$35.60	$32.10	$36.52	-	$34.08	$35.55	$93.61	-	$60.51	$25.92	$15.97	$16.67	$47.22	$31.76
With day program[a]	$29.58	$72.00	$60.56	$62.70	$54.87	$53.69	$72.78	$56.83	$95.29	$94.58	$84.48	$85.88	$50.14	-	$21.67	$52.25	$80.05
Total	$16.15	$41.22	$36.66	$38.31	$39.23	$45.69	$72.78	$45.15	$81.30	$94.55	$84.48	$85.84	$27.40	$15.97	$17.05	$49.81	$61.89
Movement																	
New admissions	19.0%	29.0%	23.9%	25.7%	19.3%	12.9%	12.7%	15.7%	28.6%	11.3%	4.6%	5.9%	31.9%	12.7%	14.7%	14.4%	12.8%
Readmissions	.9%	0.9%	1.4%	1.2%	1.7%	1.0%	0.9%	1.3%	4.0%	4.9%	1.4%	1.9%	1.0%	.9%	2.3%	2.7%	1.6%
Releases	7.9%	12.0%	14.2%	13.4%	13.8%	10.1%	14.1%	12.0%	35.2%	16.9%	10.1%	11.4%	18.5%	13.0%	8.5%	8.0%	11.5%
Deaths	.9%	0.6%	0.5%	.5%	0.8%	0.7%	1.2%	.8%	1.1%	1.0%	1.5%	1.5%	.3%	.9%	.8%	2.3%	1.2%
Est. move due to close	8.8%	7.3%	4.9%	5.8%	4.1%	1.2%	0.7%	2.4%	3.8%	1.1%	0.4%	.5%	9.4%	6.8%	5.7%	2.6%	2.7%
Est. net 12 month change	2.3%	10.0%	5.7%	7.3%	2.3%	1.9%	-2.4%	1.7%	-7.5%	-2.8%	-6.0%	-5.6%	4.9%	-7.1%	2.0%	4.3%	-.8%
Opened within 4 1/2 years	46.7%	70.7%	47.2%	60.0%	21.8%	13.4%	0.0%	19.7%	22.7%	9.2%	1.2%	8.8%	62.5%	21.4%	27.4%	23.4%	48.6%
Resident characteristics																	
Age																	
< 22	37.4%	25.8%	16.4%	19.8%	32.1%	30.7%	41.6%	32.0%	31.0%	27.0%	21.0%	22.0%	7.7%	5.9%	10.2%	38.2%	24.8%
22-39	32.0%	51.6%	54.4%	53.3%	41.1%	44.2%	27.7%	41.8%	37.3%	49.9%	50.6%	50.2%	65.4%	38.3%	31.6%	33.6%	47.0%
40-62	23.1%	20.5%	25.7%	23.8%	22.2%	21.6%	24.8%	22.1%	25.2%	20.0%	23.3%	22.9%	25.5%	40.5%	41.1%	21.8%	23.3%
63+	7.6%	2.2%	3.5%	3.0%	4.6%	3.5%	5.9%	4.1%	6.5%	3.2%	5.6%	5.0%	1.5%	15.3%	17.1%	6.4%	4.8%
Level of retardation																	
Borderline/mild	25.9%	25.1%	31.8%	29.3%	29.6%	23.9%	29.7%	26.8%	21.6%	8.9%	6.3%	7.0%	61.8%	47.1%	31.2%	9.2%	16.8%
Moderate	37.7%	37.1%	38.4%	37.9%	31.7%	29.7%	20.0%	29.9%	31.7%	17.6%	11.8%	12.9%	32.5%	33.6%	39.8%	16.2%	22.8%
Severe	26.0%	25.6%	21.9%	23.2%	22.6%	24.6%	29.2%	24.0%	24.4%	27.0%	23.9%	24.3%	5.3%	17.6%	20.6%	26.2%	24.0%
Profound	10.4%	12.2%	7.9%	9.5%	16.2%	21.8%	21.1%	19.3%	22.3%	46.5%	58.0%	55.8%	.4%	1.7%	8.4%	48.5%	36.5%
Functional limitations																	
Nonambulatory	9.3%	7.4%	4.1%	5.3%	13.4%	14.5%	20.5%	14.4%	14.8%	27.7%	25.4%	25.5%	3.7%	2.7%	5.4%	48.3%	19.5%
Cannot talk	24.9%	23.0%	14.1%	17.4%	22.1%	25.2%	29.1%	24.1%	27.1%	46.7%	50.1%	49.1%	3.7%	4.8%	16.1%	54.0%	36.7%
Not toilet trained	13.1%	9.4%	5.1%	6.7%	14.6%	16.6%	21.7%	16.1%	18.4%	39.5%	38.3%	38.0%	.1%	3.9%	6.5%	49.0%	26.7%

[a] Facilities that reported reimbursement including day programs may have included other services as well.

evening. Per day reimbursement, difficult to reliably assess for semi-independent living programs because residents often received subsidized rent or were subsidized directly and paid their own living expenses, was somewhat less than for small group residences. Semi-independent living programs typically serve high functioning adults, and teach specific skills to promote transition to independent living. This emphasis was reflected in approximately 32% resident movement per year. The active training components of these programs are also reflected in the substantially higher costs than boarding or personal care programs which serve more severely impaired residents but are less likely to provide intensive training.

Board and Supervision Facilities. Board and supervision facilities generally provide sleeping rooms, meals, some housekeeping, and "a watchful eye," but not formal training. Although most boarding homes are "generic programs" that are open to anyone who pays to stay in them, the present study included only boarding homes that were specially licensed or contracted to provide care and supervision for one or more mentally retarded persons. Most states require board and supervision homes to be certified by the departments of health and welfare for safety, but do not require individualized program plans for licensure. The board and supervision homes in the 1982 survey served only about .5% of the population of mentally retarded persons in the study. Few of these residents were under 22 years old, and relatively few were severely handicapped. About half the residents in the surveyed facilities were not mentally retarded. These facilities were generally private/proprietary, had been in operation for many years, and were reimbursed at a rate close to that of residents' monthly SSI payments.

Personal care homes. Personal care homes provide supervision and personal care (e.g., help with eating, dressing, bathing, going to the toilet, getting out of bed into a chair), but not nursing care. Small family-run

personal care homes sometimes resemble foster homes. Large personal care homes are often called congregate care or rest homes. Personal care homes that provide limited personal care (e.g., help with eating and dressing, but not toileting or bathing) are sometimes called domiciliary care homes.

About one half the residents of the surveyed personal care homes were mentally retarded. Presumably aged/disabled persons made up the bulk of the others. This type of facility, with less than 2% of the total mentally retarded population studied, served primarily mildly/moderately retarded persons (70%).

Nursing homes. Nursing homes provide full-time personal care and nursing services. They have at least one nurse on duty daily. Although generic nursing homes serve mostly elderly people, it is estimated that over 50,000 developmentally disabled people in the United States live in nursing homes (Lakin, Bruininks, Doth, Hill, & Hauber, 1982). However, unpublished data from the 1974 National Nursing Home Survey of the National Center for Health Statistics indicated that 50% of these people were 63 years or older. The 1982 national survey of residential facilities found 12,982 mentally retarded people in self described nursing homes with special mental retardation licenses or contracts. Unlike the residents of generic nursing facilities these residents tended to be young and severely or profoundly retarded. About 38% were 21 or younger as compared with 25% of the general residential population; 75% were severely/profoundly retarded and 48% were non-ambulatory.

A discriminant function analysis of the six program models (equal prior probabilities), using the independent variables shown in Table 3, correctly classified 64% of 12,112 facilities (those with no missing data). Correctness of classification ranged from 90% of foster homes, 84% of specialized nursing facilities, and 74% of semi-independent living facilities to only 25% of board

and supervision facilities. Forty one percent of board and supervision facilities were classified as foster homes, and 21% as personal care homes. Twenty five percent of group residences (with high functioning residents) were incorrectly classified as semi-independent living programs.

Discussion

This paper has proposed a three tiered system of classification of residential facilities, based on program model, size, and public/private operation. A test of reliability in classification among 317 facilities that completed two mail questionnaires indicated 85.5% agreement in facility classification according to the taxonomy.

However, a discriminant function analysis frequently confused board and supervision facilities, foster homes, and personal care homes. The problem in differentiating program models is not uniquely statistical, nor confined only to programs serving retarded clients. A recent report of the U.S. Department of Health and Human Service's Office of the Inspector General (1982) stated:

> The major finding from the Inspector General review of the Keys Amendment is that there is widespread confusion over the distinction between boarding homes and board and care homes.... Boarding homes are residences that simply provide their residents a place to sleep and food while board and care facilities not only offer board and room, but also some form of protective oversight.... Thus, the owner of a board and care facility might check to see if a resident on medication was taking it according to directions, or help him or her obtain transportation for a doctor's appointment... [O]ur very rough estimates indicate there are 30,000 board and care facilities nationwide, compared with 300,000 boarding homes. (p. iv)

The same report, however, equated the terms "board and care" with "domiciliary care," a type of personal care (p. 10). The present study intended to classify homes that provided personal care as "personal care homes" and facilities that did not provide personal care as board and supervision facilities. All eligible respondents indicated in a screening question that they had "24-hour, 7 days-a-week responsibility for room, board, and supervision of one or more mentally retarded persons." Therefore we must

assume that board and supervision facilities did provide supervision. However, it is also likely that some provided personal care (e.g., 3.9% of their residents were not toilet trained).

In addition, because the foster home definition did not prescribe levels of care, supervision, or training, but instead focused on the notion of residents living as part of a family in the provider's own home, there was some tendency for small family operated group facilities to select this definition, or for some foster homes to choose an alternate definition based upon training (group residence) or care (personal care home).

These findings prompted refinements in program model definitions, shown in Table 2, as the national survey progressed. Although these categories are still not universally definitive and rely on respondents using the one "that best applies" to their facilities, they do seem to have offered a reasonably concise and nationally applicable taxonomy of facility types, that along with the size and ownership subcategories permit an apprehensible summary of national statistics, while permitting state by state comparisons.

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