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Public Residential Services for the Mentally Retarded

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I. INTRODUCTION

The purpose and role of public residential facilities for the mentally retarded (i.e., state institutions) have varied appreciably since Samuel Gridley Howe established the first publicly supported program in 1849. These changes have involved three critical aspects: (1) the primacy of residential programming, (2) **the** permanency of residential placement, and (3) the quality and nature of programs offered. The historical development of residential services, which will not be reviewed, has been extensively described by a number of authors (e.g., Scheerenberger, 1976a; Sloan and Stevens, 1976; Wolfsenberger, 1969). Current philosophical and legal concepts, however, emphasize that (1) residential placement shall occur only after all less restrictive alternatives have been tried, (2) residential placement will be of the shortest duration possible, and (3) individualized, comprehensive programs of care, treatment, and training shall be proffered to all residents, regardless of degree of retardation or multiply hand-

icapping conditions. Consequently, deinstitutionalization and institutional reform have become goals of national priority.

The ensuing presentation is intended primarily to present recent information and data concerning the status and trends among public residential facilities. In addition, some of the data will be examined in terms of regional differences throughout the country and some will be placed in historical perspective.

II. CURRENT STATUS AND TRENDS

In 1976, a survey of public residential facilities for the mentally retarded in the United States was conducted by Scheerenberger (1976b),[1] for the purpose of acquiring current information and data frequently requested by various agencies and to provide a basis for estimating progress in the areas of deinstitutionalization and institutional reform. The study involved six primary areas of inquiry: basic demographic data, population movement, placement/postplacement procedures and services, resident programs, parental participation, and administration, including budgeting and staffing.

A. Method

Basic information was gathered through the use of a long-form (33 items) questionnaire and a short-form (7 items) questionnaire. The latter was limited to: rated bed capacity and total number of .residents, date facility accepted its first resident, population according to sex, level of retardation, and chronological age, average daily population for the past 5 years, and budgetary information.

The long-term questionnaire was forwarded to each superintendent of a public residential facility (PRF) during the last week of May, 1976. As of June 30, 1976, there were 239 PRFs, i.e., state sponsored and administered facilities which offer comprehensive programming on a 24-hour, 7-day-a-week basis. A copy of the questionnaire as well as a statement of its intent was sent to the state coordinators requesting their support. A follow-up request was sent to nonresponding facilities during the second week of August, 1976. Finally, short-form information was elicited from the remaining superintendents who had not replied during September.

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B. Results

Each of the 239 PRFs responded. Of the 239 PRFs, two had not attained operational status at the time of the survey. Of the remaining 237 facilities, 167 completed the long form and 70 used the short form.

Eighty-seven percent of the PRFs were devoted solely to the mentally retarded and other developmentally disabled persons; 13% were units in larger mental health facilities. Most PRFs served a regional area (68.3%) rather than the entire state (31.7%).

The majority of PRFs (91.1%) provided programming for retarded persons of all ages and levels of retardation. However, 5.9% served only children (CA 0-17), and 3.0% provided for adults (CA 18+). In addition, 1.3% restricted admissions to males and 0.4% to females.

1. DEMOGRAPHIC DATA

a. Rated Bed Capacity

The total rated bed capacity of the 237 PRFs for FY 75-76 was 165,710.[2] The range was 10 to 3038 with a median of 573.

Data for both rated bed capacities and resident populations were distributed in a bimodal fashion with two skewed clusters, one at each end of the continuum. These two clusters reflected the characteristics of newer and older facilities. The 135 PRFs which were functioning in 1964 were substantially larger (range 35-3,038, median 1,037) than the 102 developed during the ensuing years (range 10-1,650, median 260).[3]

Further comparison of the 135 older facilities between 1964 and 1976 revealed a substantial decrease in total rated bed capacity from 180,113 to 132,717, a 26.3% reduction. The median number of beds dropped from 1185 to 1037.

Though the total rated bed capacity for the 237 PRFs exceeded the average daily resident population, 16% were overcrowded according to their individual rated bed capacities. The range in excess was 1 to 748 with a mean of 94 residents. Forty-seven percent of the overcrowded PRF's exceeded their rated bed capacity by more than 10%.

b. Actual Resident Population

The average daily population reported by 237 PRFs for FY 75-76 was 153,584. The range was 10 to 3093 with a median of 480, down from 585 in FY 73-74. The resident census on June 30, 1976, was 154,856.

[2]FY 75-76 was defined as July 1, 1975 through June 30, 1976.

Unless otherwise noted, all references to 1964 are from Scheerenberger (1965), and all references to 1974 or FY 73-74 are from Scheerenberger (1975).

As indicated previously, there was a distinct difference between older and newer facilities., The median number of residents in the older facilities was 782 and in the newer, 172.

Figure 1 shows the average daily resident population for the 237 PRFs for 5 fiscal years: FY 71-72 through FY 75-76. The reduction of 181,035 to 153,584 represents a 15:1% overall decrease.

The resident populations for the 135 older PRFs decreased from 192,493 in FY 64-65 to 125,428 in FY 75-76, a 34.7% reduction over the 11-year period.

The average decrease per year between FY 71-72, FY 72-73, and FY 73-74 was slightly over 4.0%, i.e., 4.01, 4.33, and 4.32, respectively. The rate between FY 74-75 and FY 75-76, however, was only 3.44%, indicating a gradual decrease in the overall reduction rate.

c. Sex Distribution

Of 154,856 residents in the PRFs, 54% were male and 46% were female. The slightly higher FY 73-74 percentage of males over females also was observed in 1964.

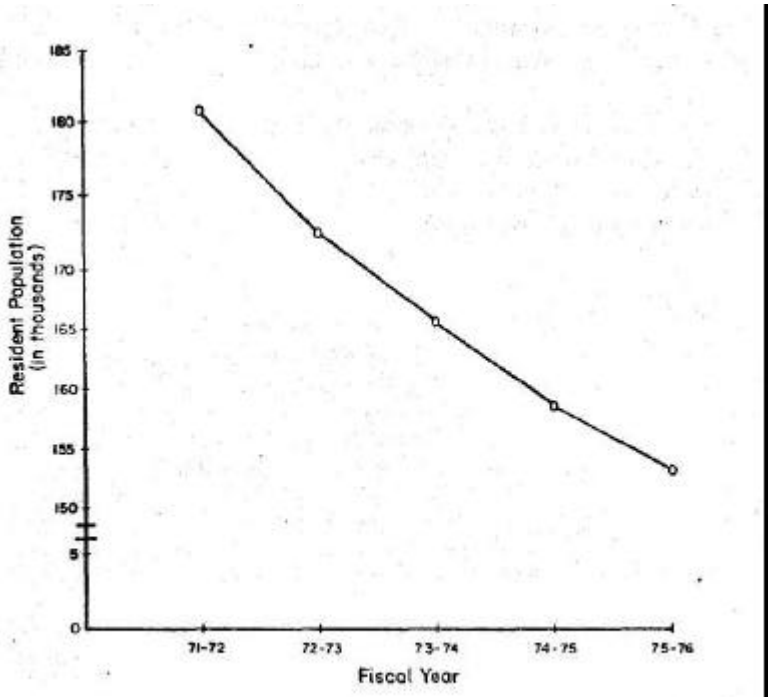

FIG. 1. Average daily population of 237 PRFs over a 5-year period.

TABLE I
COMPARISON OF RESIDENTIAL POPULATIONS ACCORDING TO CHRONOLOGICAL AGE

Chronological age	1964[a] (135 PRFs) %	1973–74[b] (172 PRFs) %	1975–76 (237 PRFs) %
0–2	1.5	.3	.3
3–21	49.2	42.3	36.3
22+	49.3	57.4	63.4

"From Scheerenberger (1965).
From Scheerenberger (1975).

d. Distribution by Chronological Age and Level of Retardation

Chronological age distribution as reported by the 237 PRFs was as follows: CA 0-3 years, .31%; 3-21, 36.30%; 22-61, 58.46%; 62 and over, 4.93%. With regard to degree of retardation, 43.96% of the residents were profoundly retarded, 28.87% were severely retarded, 16.03% were moderately retarded, 7.92% were mildly retarded, 2.22% were of borderline intelligence.

As shown in Table I, since 1964 there has been a significant increase in the proportion of residents over CA 21. In other words, residential populations are becoming older.

As shown in Table II, there has been a definite tendencey toward lower levels of intellectual functioning among residents since 1964. The difference between FY 73-74 and FY 75-76, however, is very slight and could result from sampling errors. Significantly, approximately 70%) of the resident population continue to be in the severe and profound categories of retardation.

TABLE II
COMPARISON OF RESIDENTIAL POPULATIONS ACCORDING TO LEVEL OF RETARDATION

Level of retardation	1964[a] (135 PRFs) %	1973–74[b] (172 PRFs) %	1975–76 (237 PRFs) %
Profound	27	41.1	44.0
Severe	33	30.0	29.9
Moderate	22	17.9	16.0
Mild	13	8.1	7.9
Borderline+	5	2.8	2.2

[a]From Scheerenberger (1965).
[b]From Scheerenberger (1975).

TABLE III NUMBER OF MULTIPLY HANDICAPPED RESIDENTS AS REPORTED BY 154 PRFs

Handicapping condition	*n*	% of Residents
Blind only	5,827	5.81
Deaf only	2,806	2.80
Blind and deaf	1,600	1.60
Emotionally Disturbed	13,340	13.30
Cerebral palsy	20,023	19.97
Epilepsy	29,839	29.75
Other physical handicaps	21,278	21.22
Subtotal	94,713	
More than one handicapping condition	33,562	35.44
Total number of residents with at least one multiply handicapping condition	61,151	64.56

e. Multiply Handicapping Conditions

As shown in Table III, approximately 61% of the residents as reported by 154 PRFs were multiply handicapped. Of these, 35.4% had more than one major accompanying disability.

f. *New Admissions (Excluding Respite Care)*

According to 167 PRFs, there were 6001 new admissions. This represented 5.41% of the total resident population of 110,854. The 5.41% was considerably **lower** than the 7.87% admission rate recorded for FY 73-74.

Fifty-three percent of new admissions were severely and profoundly retarded and 46.3% were in the less seriously affected categories. Thus, PRFs continue to admit and serve a relatively high percentage of moderately, mildly, and borderline retarded persons. Further, 63.7% of the mildly retarded and less affected were admitted through the prime school age range of 6-21, as were 58.3% of the moderately retarded. As noted in FY 73-74, admission data do not support **the** commonly held belief that new admissions are limited to the very young, severely or profoundly retarded person.

g. Voluntary/Involuntary Admission

Most of the 167 PRFs (70%) responding to this item admitted residents on both a voluntary or involuntary basis. In practice, however, few children or adults were admitted on an involuntary basis during FY 75-76. Of the 3398 children admitted by these PRFs, only 277 (8.0%) of the children were involuntary, and of the 2603 adults, only. 179 (7.9%) were involuntary.

TABLE IV
PRIMARY REASONS FOR READMISSION AS REPORTED BY 150 PRFs

Reason	*n*	%
Community rejection	20	13
Lack of community services	78	52
Activity centers and sheltered workshops	(18)	(23)
Behavior management programs	(20)	(26)
Counseling	(8)	(10)
Family support	(6)	(8)
Formal educational programs	(22)	(28)
Health services	(18)	(23)
Failure to adjust	74	49
Family unable to cope	24	16

h. Readmissions (Excluding Respite Care)

Readmission data were provided by 167 PRFs. Six facilities reported no returns during FY 75-76. The remaining 161 PRFs reported that 2178 persons were readmitted during the year. This represented 2.04% of the total associated resident population of 106,549. This readmission rate was 33% lower than recorded for FY 73-74. The readmission pattern was quite similar to that of new admissions, i.e., 47.3% of readmissions were severely and profoundly retarded; 52.7% were less affected children and adults.

Reasons underlying readmissions were reported by 150 PRFs (63%). As shown in Table IV, unsuccessful placements involved lack of community services, community rejection of the retarded, the family, and the retarded person. These results were quite similar to those reported in FY 73-74 with the exception that there appeared to be less community rejection, i.e., the percentage dropped from 22 to 13. Many of the respondents indicated that though residents had "failed to adjust" to community living, this failure frequently was the result of inadequate community services.

i. Waiting Lists

Of the 166 PRFs responding to this item, 54% indicated they did not have a waiting list at the time of the survey. The remaining 46% reported a total of 7161 persons on a waiting list. As shown in Table V, the respondents estimated that 61% of those on a waiting list could be programmed in the community if adequate services and accommodations were available. Again, a relatively high percentage of persons (45%) awaiting admission were in the moderate and mild categories of mental retardation.

TABLE V
WAITING LIST DATA AS REPORTED BY 77 PRFs

Level of retardation	Number on waiting list *n*	%	Number who could be served in community	% that could be served in community
Mild	1201	17	897	75
Moderate	1980	28	1615	82
Severe	2066	29	984	48
Profound	1914	26	880	46
Total:	7161	100	4376	61

Primary sources of admission referrals as recorded by 152 PRPs were social agencies and parents.

Length of time on a waiting list prior to admission again varied among PRF's. Approximately 29% of the 77 reporting PRFs indicated that the length of time was subject to severity of need and availability of appropriate programming. According to the remaining 55 PRFs, the average length of time on a waiting list ranged from 1 week to 5 years. Thirty percent indicated a minimum waiting period of 1 year.

2. COMMUNITY PLACEMENTS

a. Actual Community Placements

During FY 75-76, 80% of the respondents had realized some decrease in resident population as a result of community placements; 20% had not. With regard to the latter group of PRFs, the number of placements was offset by new admissions.

One hundred thirty-seven PRFs with a total residential population of 99,104 reported that 11,128 residents (11.*2%)* were placed from the residential facility during that year. Of these, 134 PRFs with a total resident population of 97,115 identified the nature of the alternative placement. As may be seen in Table VI, most of the former residents (62%) were moved to a nonresidential setting. The remaining 38% were transferred to other residential facilities. This pattern is almost identical to that in FY 73-74, i.e., 60% nonresidential, 40% residential.

b. Projected Placements

One hundred fifty-eight PRFs (67%) estimated that 10,779 individuals will be placed during FY 76-77. The 10,779 persons represented 10.7% of the total

TABLE VI
ALTERNATIVE PLACEMENTS AS REPORTED BY 134 PRFs

Placement	*n*	%
Independent living	124	1.36
Own home	2025	22.16
Relatives	209	2.29
Foster home	1341	14.67
Group home	1453	15.90
Boarding home	124	1.36
Work placement.	376	4.11
Community ICF	746	8.16
Rest or convalescent home	98	1.07
Nursing home	1429	15.64
County home	19	.21
Penal institution	17	.18
Mental hospital	109	1.19
Other PRFs	1055	11.54
Private residential facility for the mentally retarded	6	.07
Specialized residential facility (e.g., blind)	8	.09
Total	9139	100.00

associated residential population of 102,254. The projected placement percentage for FY 76-77 is similar to the 11.2% actual placements reported for FY 75-76. It also should be noted that both actual and projected placement percentages were approximately 10% greater than recorded for FY 74-75.

c. Parental Objections and Follow-Up

Of the 160 PRFs responding to this particular item, 11% indicated that they had received no parental objections to community placements during FY 75-76. The remaining 89% indicated some level of parental objection. In some PRFs, less than 1% of the parents objected to the community placement of their offspring, while other PRFs reported as many as 95% of the parents were opposed to such a transfer. The median percentage of objecting parents was 14.6%. Following counseling, the median percentage of objecting parents dropped to 5.4%.

In the event of continued parental objection, 67% of the 143 responding PRFs would or might retain the resident if he were a minor, and 47% would or might retain the person if he were an adult.

d. Return Options

One hundred sixty-five PRFs responded to this particular item. When a resident is on temporary discharge status, 106 PRF (64%) indicated that return was possible but only following a formal readmission conference. The remaining 59

PRFs permitted return without a formal hearing if the readmission was to occur within a specific period of time which ranged from 14 days to 3 years with a median of 5.9 months. Following permanent discharge, 38 PRFs indicated that return options were not available. Of the remaining 127 PRFs, a formal hearing would be required.

Nine PRFs (5%) indicated that any readmissions must involve a court decision. Of these 9, only 1 indicated that a formal court hearing was required for minors.

3. RESIDENT PROGRAMS

a. Individualized Programs

Of the 167 PRFs completing the long form, 89% indicated that an individualized program plan was written for each resident; 11 % had not completed this task at the time of the survey.

b. Residents Enrolled in Special Programs

Table VII, which is based on the responses of 168 PRFs, distributes the number of residents according to nine primary program areas. The unusual 111.2% figure pertaining to the enrollment of residents in some formal training program indicates that such services were offered to residents who were either younger or older than the school age range defined as CA 3 to 21.

Comparison with results obtained for FY 73-74 indicated substantial enrollment increases in formal education (84.9% versus 111.2%), language and speech therapy (32.8% versus 43.7%), and work activity programs or sheltered work-

TABLE VII
NUMBER OF RESIDENTS ENROLLED IN SPECIAL PROGRAMS AS REPORTED BY 160 PRFs

Program	*n*	%
Formal education and training	42,010	111.21[a]
Language and speech therapy	16,500	43.68[a]
Behavior management	15,736	15.79[a]
Work activity, sheltered workshop, vocational training	21,177	34.80[c]
Formal recreation	50,329	50.49[b]
Psychiatric	2,000	2.01[b]
Ambulation training	9,611	25.44[a]
Toilet training	19,611	19.67[b]
Self-feeding	20,682	20.75[b]

[a]Of 37,774 residents of school age (i.e., CA 3–21)
[b]Of 99,683 residents CA 3–61
[c]Of 60,859 residents CA 21–61

shops (25.9% versus 34.8%). Interestingly, a lower percentage of residents were enrolled in behavior management programs (31.1% versus 15.8%).

Extensive programming was provided for the severely and profoundly retarded. Comparison with similar data for FY 73-74 indicated that the percentage of severely and profoundly retarded enrolled in every program category had increased,-e.g., formal education/training, 60.8% in FY 73-74 to 69.7% in FY 75-76, language and speech therapy, 64.5% to 74.4%, behavior management, 60.5% to 66.2%, work activity programs/sheltered workshops, 41.0% to 57.0%.

Deficiencies, however, still exist. Based on the reports of 154 PRFs, 30% of the resident population required some additional program. Only 11 % of the PRFs indicated that all needs were satisfied. The greatest concern was for supplemental programming (e.g., occupational and physical therapy) for the severely and profoundly retarded.

c. Work Activity Centers, Sheltered Workshops, and Resident Employment

Of 166 PRFs, 54% stated that they had work activity centers. Of these, 81% were fully certified by the U.S. Department of Labor, 19% were not. Forty-five percent operated sheltered workshops of which 52% were fully certified by the U.S. Department of Labor.

In addition, 54% of the 166 PRFs had working residents as defined by the U.S. Department of Labor. Of the 2744 residents working for at least a minimum wage, 77% were employed by the respective PRF and 23% were employed by

d. Participation in Off-Campus Programs

Of the 160 PRFs reporting that residents were participating in some form of off-campus program sponsored by a community agency, 155 were able to distribute the participants by program. Accordingly, 16.1% of 99,162 residents were engaged or enrolled in a community recreational program, 7.9% in a social activity, 4.5% in school, 4.0% in church, and 1.2% in some form of gainful employment.

These results were similar to those reported for FY 73-74 but, for some unknown reason, remain below the levels reported by Rosen and Callan in 1972, i.e., recreation, 34%, social activities, 30%, educational activities, 10%, occu-'pational programs, 7%, and religious programs, 11%.

e. Locked Wards

Of 167 PRF's responding to this item, 37% reported that 9945 residents (9% of the total resident population) were retained in locked wards during the day. Safety and aggressiveness were the primary reasons given for locked wards. Many respondents indicated that this action was necessitated by limited staff.

4. SERVICES OFFERED TO NONRESIDENTS

Most PRFs proffer some service to nonresidents and/or their families from the community. Of the 167 PRFs responding to this item, only 15.6% had no provisions for nonresidents. Commonly offered services included training and self-help classes, medical and/or nursing services, various therapies, home visitations, and respite care. A comparison of the survey results for FY 75-76 with those reported in 1970 indicate that certain previously common service categories (e.g., diagnosis and counseling) no longer appear to be critical. It is assumed that this trend reflects upon an increasing availability-of such programs through other agencies in the community.

5. PARENTAL PARTICIPATION IN RESIDENTIAL ACTIVITIES

As clearly demonstrated by Table VIII, there has been a steady trend for parents to become more active in nearly all phases of residential programming. This is particularly evident in such areas as treatment and training as well as serving on various advisory committees.

As regards parental visitations with residents, the pattern has remained relatively constant over the past several years. As shown in Table IX, only 14.3% of the reporting PRFs indicated that 90-100% of the residents received at least one parental visit per year. The median was 63.3 which is slightly higher than that reported for FY 73-74, i.e., 59.3%.

TABLE VIII PARENT PARTICIPATION

	1970[a]		1974[b]		1976	
Activity	*n*	% (of 108 PRFs)	*n*	% (of 148 PRFs)	*n*	% (of 163 PRFs
Treatment	24	22	63	43	99	61
Recreation	64	59	67	45	90	55
Training	22	20	59	40	85	52
Religion	35	32	53	36	68	42
Sex education	7	6	29	20	39	24
Public relations	62	57	90	61	99	61
Fund raising	56	52	87	59	104	64
Advisory committees:			94	64	117	72
Administrative			(61)	(41)	(61)	(37)
Program			(57)	(39)	(69)	(42)
Advocacy/Human and civil rights			(69)	(47)	(90)	(55)
None	10	9	11	7	9	6

From Rosen & Bruno (1970, p. 22).
From Scheerenberger (1975, p. 41).

TABLE IX PARENTAL VISITS WITH RESIDENTS

Percentage of residents visited at least once a year	1974[a]		1976	
	n	%	*n*	%
90-100	22	15.4	23	14.3
80- 89	18	12.6	16	10.0
70- 79	21	14.7	27	16.8
60- 69	23	16.1	30	18.8
50- 59	24	16.8	22	13.8
40- 49	14	9.8	18	11.3
30- 39	7	4.9	12	7.5
20- 29	7	4.9	9	5.6
10- 19	5	3.5	1	.6
0- 9	2	1.3	2	1.3
Total:	143	100.0	160	100.0

[a]From Scheerenberger (1975).

5. ADMINISTRATION

a. Budgetary Data

The total budget for 231 PRFs was $1,975,744,620, excluding new construction or major remodeling and other costs beyond the allocated capital budget. Of this amount, 79.9% was spent on salaries; the remainder was encumbered for general operational costs, e.g., food, clothing, and heating.

Adding in the remaining six PRFs (3%) with a total resident population of 2214 based on their respective average state, per diems brings the total budget for the 237 PRFs to $2,004,702,177. As shown in Table X, the per diem costs varied considerably but had risen significantly over the past 2 years. The mean per diem in FY 73-74 was $24.43; for FY 75-76, it was $35.76, a 46.4% increase. For FY 75-76, the per diem costs ranged from $15.10 to $160.40.

Federal funding continues to be of consequence. Only 1 (.6%) of 151 PRFs reported receiving no federal funds. Though many PRF's were not completely familiar with their federal receipts, 33% were able to provide comprehensive answers for both FY 73-74 and FY 75-76. The data indicated that while the per diem costs for these PRFs rose from $24.43 to $35.97, a 47.2% increase, federal contributions rose from $3.41 per day to $13.99, a 310.3% increase.

b. Staffing

One hundred sixty-one PRFs with a residential population of 106,777 responded to the item concerning staffing. .Of these, only one indicated that no

TABLE X
PER DIEM COSTS

Per diem costs	FY 73–74[a]		FY 75–76	
	n	%	*n*	%
$ 0.00– 9.99	0		0	
10.00– 19.99	37	21.0	8	3.5
20.00– 29.99	75	42.6	49	21.2
30.00– 39.99	36	20.4	77	33.4
40.00– 49.99	16	9.1	48	20.8
50.00– 59.99	10	5.7	18	7.8
60.00– 69.99	1	.6	16	6.9
70.00– 79.99	1	.6	6	2.6
80.00– 89.99	0		3	1.3
90.00– 99.99	0		3	1.3
100.00–109.99	0		0	
110.00–119.99	0		1	.4
120.00–129.99	0		1	.4
130.00–139.99	0		0	
140.00–149.99	0		0	
150.00–159.99	0		0	
160.00–169.99	0		1	.4
Total:	176	100.0	231	100.0

From Scheerenberger (1975).

additional staffing was required. Budgeted positions, number filled, and additional positions needed are presented in Table XI. As will be observed, the most difficult-to-recruit positions were, in rank order: (1) physical therapists, (2) psychiatrists, (3) psychologists, (4) dentists, (5) occupational therapists, (6) social workers MSW, (7) speech and language therapists, and (8) recreational therapists. A significant number of additional positions were required in all categories, especially special educators, nurses, LPN's, and resident care workers.

A comparison of staffing ratios spanning an 11-year period of time is presented in Table XII. As will be observed, there has been a steady improvement in staff to resident ratios as they relate to medical personnel, therapists, social workers, and psychologists. The resident care worker to resident ratio has remained constant over the past 2 years. Curiously, the ratio of educators to residents has increased significantly since FY 73-74.

In addition to regularly budgeted staff, two other groups offer significant services to a variety of areas, including socio-recreational activities, instruction, and personal contacts. These are the foster grandparents and volunteers.

TABLE XI STAFFING (ACTUAL AND NEEDED) AS REPORTED BY 161 PRFs

Position	Presently budgeted positions	Positions filled	Positions unfilled		Additional positions needed	
			n	%	*n*	%
Physicians	728	658	70	10	124	17
Dentists	214	178	36	17	58	27
Psychologists	873	711	162	19	346	40
Social workers MSW	605	527	78	13	234	39
Social workers BA	900	809	91	10	229	25
Registered nurses	3616	3375	241	7	979	27
Special educators	2673	2508	165	6	1305	49
Vocational therapists	775	747	28	4	356	46
Recreational therapists	1389	1242	147	11	463	33
Occupational therapists	432	362	70	16	337	78
Physical therapists	392	296	96	25	286	73
Speech and hearing therapists	576	506	70	12	340	59
Chaplains	162	156	6	4	34	21
Resident care workers	55,227	51,580	3647	7	11,090	20
LPN's	4134	3879	255	6	1517	37
Psychiatrists	66	50	16	24	26	39

TABLE XII
COMPARISON OF STAFFING RATIOS

Professional category	FYs64–65[a] Staff:Resident (135 PRFs)	FYs73–74[b] Staff:Resident (140 PRFs)	FYs75–76 Staff:Resident (163 PRFs)
Medical (including physicians, dentists and RN's)	1:50	1:28	1:23
Resident care workers (including aides and and LPN's)	1:4.4	1:1.8	1:1.8
Educators	1:84	1:20	1:40
Therapists (including recreational, occupational, physical, vocational, and speech)	1:193	1:42	1:36
Social workers	1:314	1:84	1:71
Psychologists	1:501	1:161	1:122

[a] From Scheerenberger (1965).
[b] From Scheerenberger (1975).

With regard to foster grandparents, 72% of the 165 responding PRFs indicated that they had a Foster Grandparent program. During FY 75-76, a total of 6793 foster grandparents rendered 4,592,857 hours of service.

Of the 163 PRFs responding to the item concerning volunteers, only *2%* indicated they did not have such a program. The remaining PRFs reported that 99,537 volunteers contributed 2,446,307 hours of assistance.

6. COMMENTS

Comments will be limited to a few general impressions as they relate to deinstitutionalization and institutional reform. The data indicate that while progress is evident in both areas, much remains to be accomplished.

With regard to deinstitutionalization, the number of retarded persons requiring residential services continues to decrease, but at a slower rate than in former years. Other positive indicators include a reduced admission and readmission rate plus increased projected placement statistics for the forthcoming year.

While the resident population continues a gradual trend toward becoming both older and more seriously affected, many less affected persons (moderately retarded to normal) are still being served. Admission, readmission, and waiting list data also include a relatively high percentage of moderately and mildly retarded persons of all ages. Too many individuals returned to the community appear to be failing because of inadequate local services. Taken collectively, these findings clearly suggest that comprehensive community programs still need to be developed in many places throughout the country.

Residential reform was evident. This was reflected in the general reduction in rated bed capacity, better staff to resident ratios, increased enrollment of the severely and profoundly retarded in various programs, extended programming for adults, increased parental participation, and individual resident plans.

On the less positive side, continued deficits in resident programming, the apparent need for special services for the emotionally disturbed, and the relatively high percentage of retarded persons maintained in locked wards during the day, all indicate that substantial residential reform is still needed. Also, as indicated in the discussion on parental objections, the relatively common practice of retaining retarded persons in PRFs after they are capable of leaving needs to be re-examined.

III. REGIONAL COMPARISONS

The data previously presented described certain national trends. There were, however, distinct and significant differences between various sections of the country. For example, New York and New Jersey (Federal Region II) recorded that 1.01 retarded persons per 1000 population were in a PRF, while Alaska,

Idaho, Oregon, Washington (Federal Region X) recorded only 0.47 per 1000. The national average was 0.71 per 1000. It would appear that the northeastern states place greater reliance on residential programming than do other sections of the country.

Though there was little variance between the ten federal regions with regard to level of retardation; states west of the Mississippi were serving considerably more children and adolescents than were the northeastern states.

The data also indicated a wide variance in admission rates among the various regions. Admission rates for the midwestern states were considerably higher than those for either the northeastern or western states.

Similarly, there were significant differences between regions with regard to readmission rates. The southwestern states of Arkansas, Louisiana, New Mexico, Oklahoma, and Texas (Region VI) reported the lowest readmission rate (.7%); New York, New Jersey, and the midwestern states of Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin (Region V) reported the highest (3.3%).

With regard to fiscal expenditures, the highest average per diem rate ($41.93 per day) was recorded for Arizona, California, Hawaii, and Nevada (Region IX); the lowest per diem rate ($27.59) was reported by Arkansas, Louisiana, New Mexico, Oklahoma, and Texas (Region VI). Per capita costs per citizen per year were highest ($15.11) in New York and New Jersey (Region II), and lowest ($6.94) in Region VII which consists of Iowa, Kansas, Missouri, and Nebraska. The average per capita cost per year was $9.33.

The data per se did not provide an explanation for the observed differences with the exception of per diem costs. Since all facilities devote approximately 80% of their budgets to personnel expenditures, most of the per-diem-cost variance can be attributed directly to differing salary schedules.

IV. CURRENT TRENDS IN HISTORICAL PERSPECTIVE

As shown in Fig. 2, the development of public residential facilities for the mentally retarded has been spasmodic. Of the 237 operational facilities, 21 (8.9%) opened between 1850 and 1900, and another 64 (27.0%) accepted residents between 1900 and 1949. Thus, the majority of PRFs (n = 152, 64.1%) have been established over the past 26 years.

Figure 3 shows the rise in number of retarded persons in PRF's (end-of-reporting-year census) from 1850-1976. These data are based on a series of U.S. Department of Commerce (1906, 1914, 1926, 1931, 1932, 1934, 1935, 1936, 1937, 1938, 1939, 1945, 1976) census reports, as well as information provided by the U.S. Department of Health, Education, and Welfare (1954), Wolfensberger (1969), and Sloan and Stevens (1976). As shown, the ratio of mentally retarded

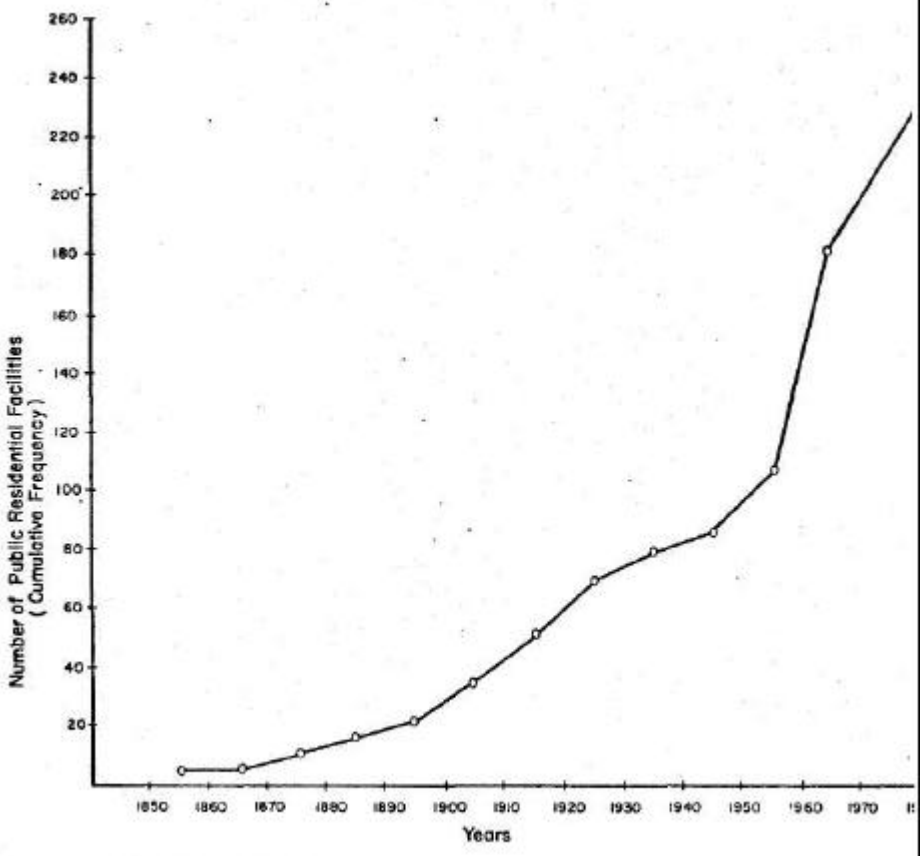

FIG. 2. Growth of public residential facilities in the United States.

persons in PRFs per 100,000 total population tended to increase steadily until approximately 1970.

The number of retarded persons in PRFs reported in earlier years by no means implies that those were the only retarded persons in a residential facility. For example, in 1910, 20,731 retarded persons were in special residential facilities and 13,238 were in almshouses (U.S. Department of Commerce, 1914). Almshouses, which were used rather extensively for the mentally retarded prior to 1910, were described as "social pest houses in which an undifferentiated collection of discards including the aged, the blind, the insane, feeble-minded persons, epileptics, alcoholics, orphans, foundlings, and chronic paupers were crowded together... like chickens in a coop" (Bremer, 1964, p. 48).

Perhaps the most significant change which has occurred over the past 50 years involves the residents' degree of intellectual impairment. In 1926, 37.0% of the residents were mildly retarded, 32.7% moderately retarded, and 13.4% severely

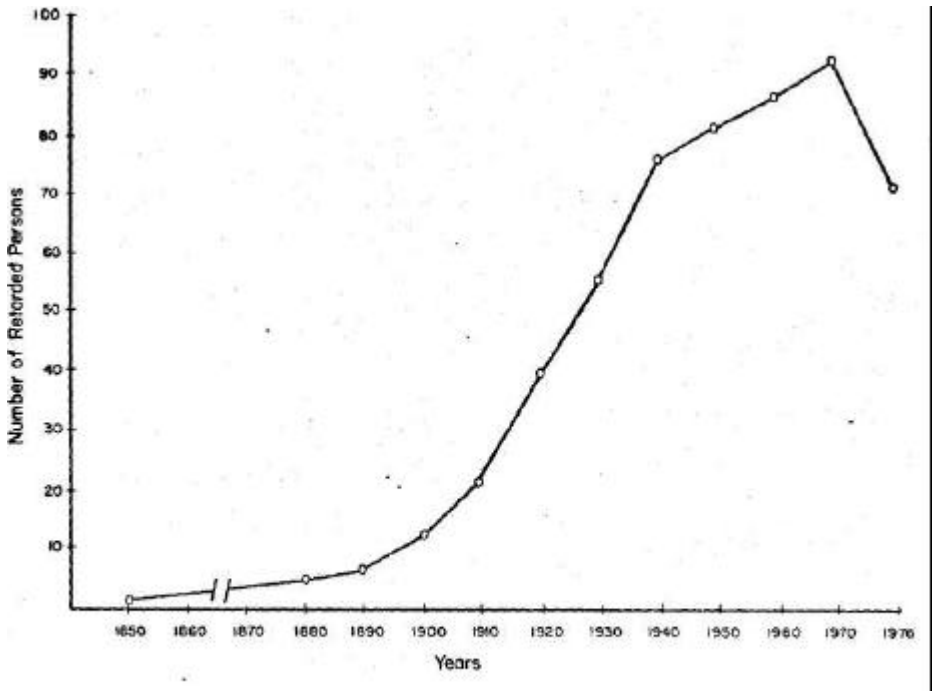

FIG. 3. Number of retarded residents in public residential facilities for the mentally retarded per 100,000 Total Population for the years 1850–1976.

or profoundly retarded (U.S. Department of Commerce, 1931). In 1976, the respective percentages were 26.0, 19.1, and 54.9.

Finally, costs of providing residential services, based on the same reports cited for Fig. 3, have increased substantially, even when the relative value of the dollar is taken into consideration (Fig. 4). Increased staffing accompanied by rising salaries and fringe benefits account for all but a small proportion of the elevated costs. To illustrate, the average per diem cost in 1926 was $.83 in contrast to $35.76 in 1976. Eighty-four percent of the difference between these two figures is due directly to increased personnel expenditures.

These historical comparisons indicate that the long-range trend toward relying on residential programming is gradually subsiding. Also, a more severely and profoundly retarded population is being served at an increasing cost.

V: SUMMARY

The major portion of information concerning trends was based on a study intended to gather current information on the status of public residential facilities

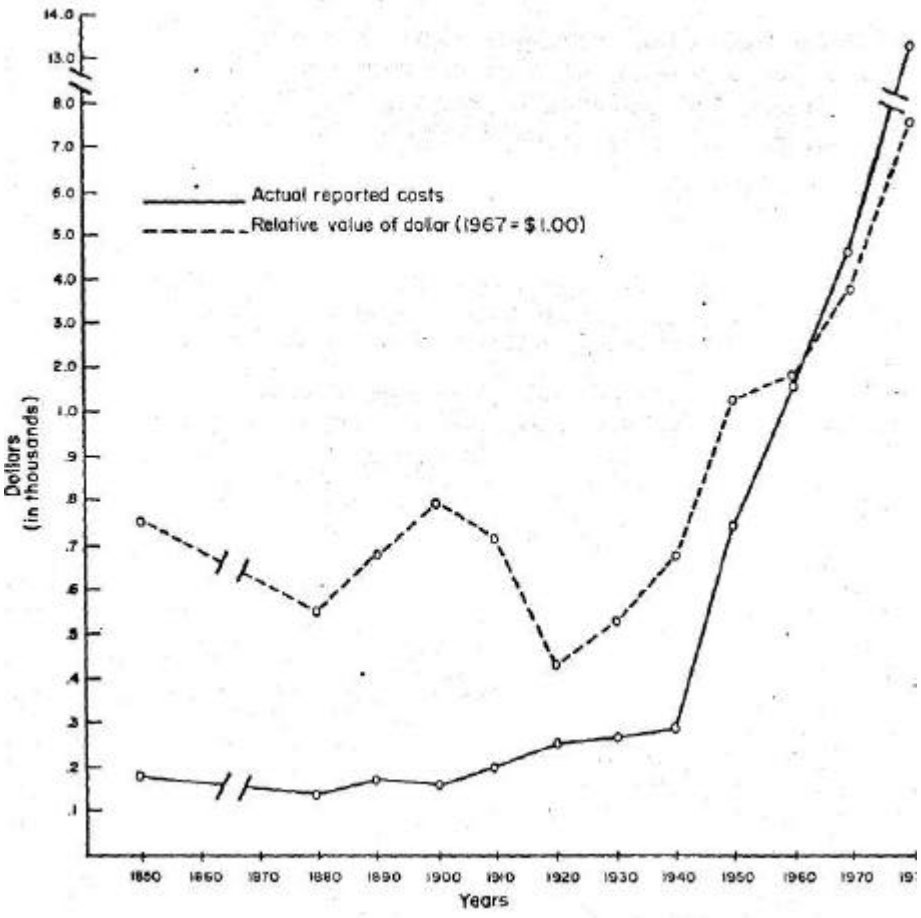

FIG. 4. Actual and relative per resident estimates of annual operational costs, for the years 1850-1976.

in the United States. Primary areas of concern were: basic demographic data, population movement, placement/post-placement procedures, resident programs, parental participation, and administration, including budgeting and staffing. Each of the 237 operational PRFs (100%) participated in the survey. The results were presented according to the primary areas of inquiries, and the overall implications were that, while progress is being made in each of these areas, much remains to be accomplished prior to the full realization of deinstitutionalization and institutional reform.

Analysis of data according to federal regions revealed marked differences in such areas as average daily resident population, new admission rates, readmission rates, and average per diem costs.

Finally, the current data when placed in historical perspective indicated a general trend toward placing less reliance on residential facilities, and populations being served are more severely and profoundly retarded. Costs associated with providing comprehensive programming for these residents have increased substantially.

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