

# POLICY ANALYSIS SERIES

## ISSUES RELATED TO WELSCH v. NOOT / NO. 2

### THE SIZE OF COMMUNITY RESIDENTIAL FACILITIES: CURRENT GUIDELINES AND IMPLICATIONS FOR PLANNING

#### I. INTRODUCTION

Welsch v. Likins (1974) was one of several events during the past two decades which has helped give both substance and definition to deinstitutionalization efforts within the State of Minnesota. The suit was initiated in 1972 and sought to "...assert a due process claim compelling the state to seek out and develop less restrictive, community-based alternatives for the care and treatment of judicially committed mentally retarded persons" (Welsch v. Likins, 373 F.Supp. 487 1974). The long-standing suit culminated in a recent consent decree (Welsch-Noot, 1980) which requires the State to reduce the overall population of mentally retarded persons residing in state institutions by nearly one-third during the next six years. This mandated reduction brings to focus several complex and important issues (Developmental Disabilities Planning Office, 1981). As counties and communities begin to plan and develop community-based placement opportunities, fundamental questions about deinstitutionalization will arise. One of the more immediate questions concerns the type of alternative community living arrangements which must be developed--how many, what kind, what size.

#### A. Deinstitutionalization and "Normalization"

The National Association of Superintendents of Public Residential Facilities for the Mentally Retarded (1974) defined deinstitutionalization as a three-fold process:

1. prevent admission of people to public residential facilities by finding and developing alternative community residential facilities;
2. return to community residential facilities all public residential facility residents who have been prepared through programs of habilitation and training to function in appropriate local settings;
3. establish and maintain responsive residential environments which protect human and civil rights and which contribute to expeditious return of the individual to normal community living whenever possible.

The "normalization" principle is fundamental to the deinstitutionalization process. The principle holds that, by utilizing means which are as culturally normative as possible, it is possible to establish and/or maintain personal behaviors and characteristics which are more culturally normative (Wolfensberger, 1972). The key then is to provide

opportunities, patterns and conditions in everyday life which are as close as possible to the norms and patterns of mainstream society.

The "normalization" philosophy is supported by two corollary principles: the least restrictive doctrine (defined in several major court decisions) espouses the view that individuals ought to "be served under conditions that maximize opportunities to live and learn in normal settings in society; the developmental programming model "assumes that limitations of all retarded people are modifiable regardless of their degree of impairment" (Bruininks, Kudla, Hauber, Hill and Wieck, 1981).

#### B. "Normalized" Housing Options

These underlying principles seem to imply two things for the planning of residential facilities: (1) physical integration by way of small, home-like structures; and (2) social integration through thoughtful use of existing community resources in the areas of training, education, leisure and employment (Bruininks et al, 1981; O'Brien and Poole, 1978).

Housing under the normalization principle deviates from usual patterns and standards only to the extent that departures from the norm will better serve the needs of disabled residents. Under ideal conditions, residents with handicaps live in the same kinds of houses (size, location and design) as non-handicapped individuals (Roos, 1974).

"At least three overlapping dimensions of attitudes and philosophies can be discerned in building design. These are (1) the role expectations, the building design, and atmosphere impose upon prospective residents, (2) the meaning embodied in or conveyed by a building, and (3) the focus of convenience designed into the building, i.e., whether the building was designed primarily with the convenience of the residents, the community, the staff, or the architect in mind."

(Wolfensberger, 1976)

The developmental model suggests architectural designs which "...(1) facilitate and encourage the resident's interaction with the environment; (2) maximize interaction between staff and residents; (3) foster individuality, dignity, privacy, and personal responsibility; (4) furnish residents with living conditions which not only permit but encourage functioning similar to that of nonhandicapped community age peers" (D.D. Project on Residential Barriers, 1977). Various authors have suggested that residential dwellings should approximate the atmosphere, structure and appearance of similar, surrounding homes--any variations in design or function should "either compensate for handicaps, and/or maximize the likelihood of developmental growth" (D.D. Project on Residential Services, 1977; Roos, 1974; Noakes, 1974). This implies that the scale of support facilities should also conform to community norms.

## II. STATEMENT OF PROBLEM

The recent *Welsch v. Noot* consent decree (1980) has vested the State's deinstitutionalization efforts with new significance. County responsibilities to mentally retarded citizens have become more immediate. By the terms of the court-sanctioned agreement, future referrals to the State's eight institutional facilities will be greatly curtailed; moreover, approximately 800 persons currently residing in institutions will require some type of community placement between now and July of 1987. Counties therefore must develop community placement opportunities for persons coming out of state hospitals as well as those persons who might otherwise have been referred to institutional care.

### A. Policy v. Practice

Under Minnesota law (Minnesota Statutes 1980, Chapters 245, 252, 256E and 393), individual counties are responsible for planning and establishing after-care services (see also, DPW Rule 185). Counties will be called upon to develop community residential alternatives that fulfill the mandate of the *Welsch* decree which states in part that:

"Persons shall be placed in community programs which appropriately meet their individual needs. Placement shall be made in either a family home or a state licensed home, state licensed program, or state licensed facility except when...the most appropriate placement would be an independent community residence, such as an apartment."

(*Welsch v. Noot*, 1980, p. 8, paragraph 34)

"For those persons not returning to their homes, preference shall be given to placement in small residential settings in which the population of mentally retarded persons does not exceed 16 and to facilities which, although exceeding 16 in total size, have living units of no more than 6 persons."

(*Welsch v. Noot*, 1980, p. 8, paragraph 25)

Although the decree indicates a preference for small residential settings, the state is "not obligated to assure placement of any quota of residents in settings or living units of a particular size" (*Welsch v. Noot*, 1980, p. 8, paragraph 25). Consequently, there are no clear indications of the types, numbers, and sizes of facilities counties will be required to develop. Moreover, even though the several governmental licensing, construction and program review guidelines espouse the principles of normalization, least restrictive environments and the developmental programming concept, a wide discrepancy exists in the application of those principles both between and among the various levels of government. Counties and other potential developers must somehow make sense of the various rules, standards, and regulatory guidelines.

### B. Program Standards Regarding "Size"

DPW Rule 185 establishes county responsibilities for persons who are mentally retarded. Under Rule 185, the Commissioner of DPW

must determine the need, location and program for residential facilities. The size of the facility must "relate to the needs of the clients for services;" no facility for more than eight persons will be approved unless it can be clearly shown that residents will be better served in a larger facility and then only if the size of living units are for no more than six persons (12MCAR 2.185).

DPW Rule 34 applies to any facility or service engaged in the provision of residential or domiciliary services for mentally retarded individuals. Licensure requirements are applicable to all facilities serving more than four persons. Rule 34 facilities provide services on a 24-hour basis and include group homes, child-caring institutions, board and lodging homes, boarding-care homes, nursing homes, state hospitals, institutions and regional centers. A facility may consist of one or more living units. By rule definition, resident living units must be "small enough to ensure the development of meaningful interpersonal relationships..." The size of the living unit must be based upon the needs of the residents; there can be no more than 16 residents per living unit (a living unit may be a group home, foster home, ward, wing, floor, etc.). Primary living units may not have more than four persons to a bedroom (12MCAR 2.034).

DPW Rule 37 establishes guidelines under which the Department of Public Welfare makes "...grants to aid in the purchase, construction or remodeling of community residential facilities" for persons with mental retardation and cerebral palsy. The purpose of the program is to provide appropriate alternatives for such persons, "including those currently in state hospitals and nursing homes" and to allow them to "live in a home-like atmosphere near their families." One of the criteria under which grants are awarded is that facilities can house no more than 16 persons; no more than two facilities may be located together (12MCAR 2.037).

DPW Rule 8 establishes standards for group homes and licensing procedures for specialized facilities providing care "on a 24-hour-a-day basis for a select group of not more than ten children." Rule 8 standards prescribe no more than four children per bedroom (12MCAR 2.008).

DPW Rule 18 sets standards for the provision of semi-independent living services to people who are mentally retarded. Though the rule does not govern the living arrangements of clients, it affirms the normalization principle; i.e., that persons be provided "with the alternative which is least restrictive. This includes making available to the client patterns and conditions of everyday life that are as close as possible to the norms and patterns of the mainstream of society" (12 MCAR 2.018 - adopted May, 1981).

Supervised Living Facilities regulations promulgated by the Department of Health establish certain minimum standards for construction, equipment, maintenance, operation and licensure. These health standards defer to the licensure requirements of the Department of Public Welfare relative to the provision of appropriate space and arrangements for sleeping, dining, recreation and other common use activity areas; i.e., facility size is subject to DPW rule standards (7MCAR 1.391-1.401).

Federal SNF, ICF/MR Standards require that participating facilities meet state licensure standards. Consequently, no specific facility "size" standards have been established. The Health Care Financing Administration has, however, developed some very general guidelines. An ICF/MR facility must admit only that number of individuals that does not exceed: its rated capacity; and its capacity to provide adequate programming (42 CFR 442. Subpart G, Section 442.420). An ICF/MR "may not house residents of grossly different ages, developmental levels, and social needs in close physical or social proximity" unless such arrangements are "planned to promote the growth and development of all those housed together." Also, an ICF/MR may not segregate residents on the basis of physical handicaps. Residents must be integrated "with others of comparable social and intellectual development" regardless of certain physical or neurological limitations (Subpart G, Section 442.444). Section 442.447 specifies that, unless granted a variance, bedrooms must not accommodate more than four residents.

Federal Certificate of Need program regulations (42 CFR, Parts 122 and 123) have been developed in such a way as to "give each state substantial flexibility in determining how its certificate of need program will be implemented" (Federal Register, 24, 205, 69740. October 21, 1980). No specific "size" guidelines are prescribed. Under general federal standards, STATE HEALTH SYSTEMS AGENCIES must consider how facilities will meet individual resident needs. The quality and extent of proposed services is a major consideration. Within the general limitations imposed by DPW program rules and regulations, HSAs are able to exercise considerable latitude in determining the appropriate scale of proposed facilities, i.e., ascertaining how facility "size" might relate to resident care practices, facilitate individual growth and/or promote social integration. Facility size is determined by several factors: cost, resident programming needs, projected utilization, location, identified resident populations, accessibility/availability of necessary support services.

#### 1122 Review - Need Determination and Cost Containment (Federal Capital Expenditure

Review) procedural and criteria related requirements are similar to the minimum Federal requirements for state certificate of need reviews. 1122 regulations contain no explicit statements regarding facility size and/or resident populations. 1122 reviews assure that unnecessary capital expenditures are not incurred by/or on behalf of health care facilities (42 CFR 100). These determinations are subject to applicable state agency rules (e.g., DPW Rule 34 standards). 1122 reviews include an examination of operational potential, cost containment, financial feasibility, and service quality.

HUD Section 202 program loans are directed toward housing projects which serve elderly and handicapped individuals (24 CFR 885). Departmental policies attempt to limit the size and concentration of housing for physically handicapped persons. It is HUD's policy "to encourage housing for the physically handicapped which provides for their continued integration in the community...rather than permitting the segregation of the handicapped by themselves." Consequently, only pro-

posals for "small apartment complexes of six to 24 units or congregate group homes for occupancy of up to 12 persons" are generally approved. HUD has a similar policy regarding housing for developmentally disabled persons. Approvals are limited to small group homes: "Although group homes for up to 12 persons per site will be permitted, facilities for six to eight persons would be preferable, if feasible, as smaller projects can provide a more normal and home-like noninstitutional environment" (HUD Handbook 4571.1 REV, 1978). HUD policy further maintains that all projects intended for occupancy should be designed for independent living; thereby making a wide variety of housing types possible.

"Most proposals involving the developmentally disabled have proposed group homes. However, to be consistent with the basic objective of maximizing independence, proposals for the developmentally disabled which provide opportunities for more independent living will be encouraged... Housing...should be located in predominantly residential neighborhoods where other family housing is located...In all group homes, only one or two-person occupancy will be permitted in each bedroom unit" (HUD Handbook 1978).

Municipal Zoning Authority in Minnesota is derived from State Statute (Chapter 462). Section 462.357, subdivision 1 establishes the authority of municipalities to regulate the use of property within (and, in certain instances, adjacent to) their boundaries. Zoning authority is conferred upon municipalities in order that they might promote the "public health, safety, morals and general welfare..." The state has, however, established certain standards with statewide applicability:

"In order to implement the policy of this state that mentally retarded and physically handicapped persons shall not be excluded by municipal zoning ordinances from the benefits of normal residential surroundings, a state licensed group home or foster home serving six or fewer mentally retarded or physically handicapped persons shall be considered a permitted single family, residential use of property for the purposes of zoning" (Section 462.357, subdivision 7).

Chapter 462 states further that, "Unless otherwise provided in any town, municipal or county zoning regulation...a state licensed residential facility serving from seven through 16 mentally or physically handicapped persons shall be considered a permitted multi-family residential use of property for purposes of zoning" (Section 462.357, subdivision 8). Conditional use or special use permits may not be imposed on such facilities if they are more restrictive than those imposed on other, similar structures, except that "additional conditions are necessary to protect the health and safety of the residents of the residential facility..."

Chapter 252 establishes the authority of the Commissioner of DPW to "determine the need, location and programs of public and private residential and day care facilities and services for mentally retarded children and adults" (Section 252.28, subdivision 1). Subdivision 3 references Chapter 245: "No license or provisional license shall be granted when the issuance of the license would substantially contribute to the excessive concentration of residential facilities within any town, municipal-

ity or county of the state" (Section 245.812, subdivision 1). When determining if a license will be issued, the commissioner must "specifically consider the population, size, land use plan, availability of community services and the number and size of existing public and private community residential facilities in the town, municipality, or county..." (Section 245.812, subdivision 2). Under Section 245.812, subdivision 3, "A licensed residential facility serving six or fewer persons or a licensed day care facility serving ten or fewer persons" must be considered a permitted single family residential use of property.

The Minnesota Housing Finance Agency administers a program which provides non-profit sponsors with up to 100% permanent mortgage financing for the development of residential group homes. The program has several objectives; among these are: providing facilities that offer normalized life patterns; providing supervised living environments which permit training in self-sufficiency skills; providing living conditions which respond to residents' special needs while offering alternative life styles to institutionalization. Projects may house from six to 16 persons (Residential Group Home Program/MHFA, 1980).

### III. REVIEW OF LITERATURE

As the state continues its deinstitutionalization efforts and counties endeavor to develop community residential opportunities, it becomes important to establish a link between practice (implementation of Welsch/development of residential housing) and policy (normalization).

State policy statements and the Welsch decree both espouse the normalization principle and the doctrine of least restrictive alternatives. However, how do counties incorporate those philosophies into residential housing designs and community-based programming? Existing program standards generally provide only very broad guidance. Under what circumstances and conditions might the design of dwelling units contribute to the further development of residents? Does facility "size" bear any relationship to the quality of resident care? What constitutes a least restrictive, normalized environment?

#### A. "Size" and Its Impacts

Most of what has been written about the impact of "size" is inconclusive. Facility size has not been identified as a definitive predictor of care practices or resident behavior development (Balla, 1976; Bjaanes and Butler, 1974; McCormick, Balla and Zigler, 1975). Research indicates that size per se is neither the source of all ills nor the solution to all problems (Raynes, 1977). Culturally normative environments are defined by several considerations: social interaction, access to community resources/services, programming, staffing patterns, geographic location, etc. (Crawford, 1979; McCormick, Balla and Zigler, 1975; Dellinger and Shope, 1978); facility size is only one of several factors.

King, Raynes and Tizard (1971) suggest that the organizational structure and the type of institutions may be more important than size in influencing the patterns of care. They point out that even relatively small

hospital facilities, and facilities with small living units, can exhibit institutionally-oriented care patterns. They observe further, however, that "The history of mental institutions suggests that the larger the institutions have become, the harder it has been to eschew the obvious attractions of centralization and to maintain an appropriate balance with the social environment 'outside'."

Wolfensberger (1972) helped popularize the idea of small, specialized community-based residential programs as an alternative to traditional, multi-purpose institutional arrangements. By de-emphasizing comprehensiveness and centralization, more "normal" patterns of social interaction are encouraged. Neither superior care nor social integration is guaranteed, however, in small community settings (Balla, 1976; Baroff, 1980; Bjaanes and Butler, 1974). Inadequate community-based facilities do exist; likewise, excellent "larger" facilities are not uncommon (Raynes, 1977).

B. "Small" v. "Large"

The literature does suggest, however, that "smaller" community residences are generally preferable to larger establishments; that normalized environments are more readily established and maintained in smaller, community-based residential settings. Though small size per se is neither necessary nor sufficient to insure appropriate care, the following service attributes are more likely to prevail in smaller facilities and have been identified as being influential in producing gains in adaptive behavior and general developmental growth:

- individualized attention (Baroff, 1980);
- resident-oriented care practices (Balla, 1976; Baroff, 1980; King, Raynes and Tizard, 1971; McCormick, Balla and Zigler, 1975);
- absences of security features, existence of personal effects, privacy in bathroom and bedroom areas (Balla, 1976; Baroff, 1980);
- community exposure/social interaction (Crawford, 1979; Baroff, 1980);
- experienced, trained direct care staff (Dellinger and Shope, 1978; Baroff, 1980).

Citing the findings of a 1979 study (Eyman, Demaine and Lei), Baroff (1980) suggests that "the apparent value of locating residential settings within rather than apart from community resources, a condition more easily achieved in small residential settings, is...reflected in behavior gains in personal and community self-sufficiency as a function of residential proximity to community services...research appears to...show that such normalization elements as proximity of the residence with the neighborhood, appearance and internal comfort can produce real gains in adaptive behavior."



Baroff (1980) also reviewed the findings of seven other studies. Each sought to examine the relationship between behavior and size. Six of those studies indicated some advantages in smaller settings. One showed no difference; none indicated any advantages accruing to larger settings.

"It does seem that size makes some difference. Smaller residential settings, typically serving not more than ten persons, can necessarily be more responsive to individual needs. Moreover, their location in normal community residential neighborhoods allows easy access to the range of community experiences that can enhance social, vocational, and recreational skills and can foster greater independence. These same experiences are much more difficult to provide in the more physically isolated and autonomous settings of the larger institutions."

(Baroff, 1980, p. 116)

#### IV. IMPLICATIONS FOR PLANNING

Minnesota's 87 counties are charged with the responsibility for developing residential placement opportunities for many of the State's developmentally disabled citizens; and they must provide those opportunities within the constructs of the normalization principle--as espoused by federal, state and sub-state regulatory guidelines. The application of that principle is inconsistent both between and among the various regulatory and licensing authorities. There are no systematic guidelines relative to facility "size."

To some extent, imprecision and lack of clarity in regulatory standards may be unavoidable. Federal guidelines in most cases prescribe only minimum standards. Their application is broad politically as well as geographically. They must take into account the disparate nature of service delivery systems among the many states. Under these circumstances, lack of specificity is understandable--though no less confounding to state and local implementing agencies. Similarly, certain state standards are broad in application as well as definition (e.g., DPW Rule 34). The general nature of rules is not altogether unreasonable. Some programs must accommodate a wide range of disabilities and service needs. This lack of specificity, however, places much of the burden for determining the appropriateness of program and facility design upon developers. It is imperative then that counties and other decision-makers recognize the consequences of various policy decisions. Already some policy-makers have indicated a need for more standardized, coherent policy statements on "size" (see DD Residential Guidelines Task Force/Metropolitan Health Board, 1980).

The literature suggests that "size" may be an important factor in determining the degree to which normalization has been achieved; hence the development of individual residents. Additional analysis will help define the relationship between facility size and program policy objectives. Also, further analysis of size-cost factors will prove helpful to planners and developers as they begin to make important decisions about the future direction of residential services.

Facility cost is an especially important issue. Studies indicate that community care models may indeed be cost-effective alternatives to public institutional facilities. An analysis of national data (Wieck, 1980) indicates that the lowest per diem rates among community residential facilities were associated with the smallest homes which were family owned and operated and offered the least amount of support services. A study of "small" group homes in Minnesota (Heiner and Bock, 1978) also suggests that smaller facilities are capable of producing "positive client changes at a better rate than larger ones; and...without significantly higher costs." The findings from the Minnesota study are described as "preliminary". Further study of size-per diem relationships should prove enlightening.

Planning and other development efforts should endeavor to assess all "costs". Planners should be advised that cost and efficiency are defined in terms broader than dollars. Although difficult to prove empirically, "...it is entirely possible that economies of scale apply favorably to [larger facilities] relative to the meeting of basic needs but that this cost savings is at least partially offset by diseconomies relative to the provision of psychosocial developmental services" (Regional Institute of Social Welfare, 1976).

Policy-makers will no doubt wish to consider other factors as well: personnel/staff, location, community resources/services, the impacts of fiscal constraints/opportunities, developments in programming models, etc.

It seems clear that, by definition, "normalization" implies small, home-like residential dwelling units. The primary focus of all residential programs must be the care and support of developmentally disabled residents rather than the convenience of developers. "Small" facilities may not be the most appropriate setting for all persons returning to communities under the mandates of the Welsch decree. The doctrine of least restrictive alternatives does not necessarily always imply "small"--it does, however, suggest a resident-oriented, developmental program focus.

Where it is determined that larger facilities with specialized services are a more appropriate care setting, developers should direct their attention toward ensuring appropriately modeled "living units". The literature suggests that the organization and management of living units can have a profound impact upon the development of skills, adaptive behaviors and personal growth.

In all cases, residential program development will require thoughtful and informed planning. Political decisions (e.g., the allocation of resources) must measure up to the philosophical considerations embodied within the Welsch decree (e.g., normalization and the right to a least restrictive living environment).

"Superficially, the normalization principle might seem merely to apply to the life and circumstances of mildly handicapped people, or those not living in institutions. But it is wrong to think that living in the community can in itself be equated with being "integrated" into

society. The question still remains of how closely the life of mentally retarded people approaches that of "normal" members of that community. In fact, the normalization principle will have its most far-reaching consequences for retarded people presently living in hospitals and institutions."

(Nirje, "The Normalization Principle"  
Changing Patterns of Residential Ser-  
vices for the Mentally Retarded,  
p. 232)

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#### CURRENT GUIDELINES

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Welsch-Noot Consent Decree; United States District Court, District of Minnesota, Fourth Division. U.S. District Judge Earl Larson. September 15, 1980.

12 MCAR 2.185 (DPW Rule 185) County Board or Human Service Board Responsibilities to Individuals Who Are or May Be Mentally Retarded (State Register, Vol. 5, No. 33, 1263, February 16, 1981).

- 12 MCAR 2.037 (DPW Rule 37) Department of Public Welfare Rule for the Administration of Grants In Aid to Residential Facilities for the Mentally Retarded and Cerebral Palsied.
- 12 MCAR 2.008 (DPW Rule 8) Standards for Group Homes and Licensing Procedures.
- 12 MCAR 2.018 (DPW Rule 18)--Standards for the Provision of Semi-Independent Living Service (SILS) to People Who Are Mentally Retarded. (Published at State Register, Vol. 5, No. 47, 1,888, May 25, 1981.)
- 12 MCAR 2.034 (DPW Rule 34)--Standards for the Operation of Residential Facilities and Services for Persons Who Are Mentally Retarded. (Amendments to 12 MCAR 2.034: State Register, Vol. 5, No. 47, 1,889, May 25, 1981.)
- 7 MCAR 1.391-1.401 (Chapter Twenty-Three: MHD 391-401) Regulations for Construction, Equipment, Maintenance, Operation and Licensure of Supervised Living Facilities.
- 42 CFR 442  
Title 42 - Public Health/Chapter IV - Health Care Financing Administration  
Part 442 - Standards for Payment for Skilled Nursing and Intermediate Care Facility Services (reference: Section 1905(c) and (d) of the Social Security Act)
- 42 CFR 122/42 CPR 123  
Title 42 - Public Health/Chapter 1, Public Health Service  
Health Systems Agency and State Health Planning and Development Agency  
Reviews; Certificate of Need Programs (Federal Register, Vol. 45, No. 205, 69740, October 21, 1980).
- 42 CFR 100  
Title 42 - Public Health/Chapter 1 - Public Health Service  
Subchapter 1 - Medical Care Quality and Cost Containment  
Part 100 - Cost Containment and Quality Control  
(reference: Section 1122 of the Social Security Act (42 U.S.C. Chap 7)).
- 24 CFR 885  
Title 24 - Housing and Urban Development/Chapter VIII - Low Income Housing, Department of HUD  
Part 885 - Loans for Housing for the Elderly or Handicapped (Reference: Section 202 of the Housing Act of 1959, as amended, 12 U.S.C. 1701q)
- HUD Handbook 4571.1 REV, Section 202 Direct Loan Program for Housing for the Elderly and Handicapped (Transmittal No. 5). Chapter 1, Section 1-5, Washington, D.C.: U.S. Dept. of Housing and Urban Development. March 10, 1978.
- Apartment Development Division, "Group Residences for the Developmentally Disabled", St. Paul: Minnesota Housing Finance Agency/Apartment Development Division, 1980.

Minnesota Statutes, Chapter 462 - Housing, Development, Planning, Zoning.  
see Section 462.357, Subds. 1, 7 and 8

Minnesota Statutes, Chapter 245 - Department of Public Welfare/Public Welfare and Related Activities. see Section 245.812, Subds 1, 2, 3 and 4  
(Sections 245.61 to 245.69 authorize County Boards to make grants for local mental health programs; to establish/facilitate programs in mental health, mental retardation and inebriacy. Sections 245.781 to 245.812 - "Public Welfare Licensing Act" - establishes the authority of the Commissioner of DPW to license operators of day care and residential facilities. Sections 245.781 to .812 do not apply to a day care or residential facility serving fewer than five physically or mentally handicapped adults.)

Minnesota Statutes, Chapter 252 - Mentally Retarded and Epileptic; State Hospitals. see Section 252.28, Subd. 1 and 3.  
(Section 252.28 references the authority of the Commissioner of DPW to determine the need, location and program of public and private residential and day care facilities and services for mentally retarded children and adults.)

Minnesota Statutes, Sections 252A.01-.21 - "Mental Retardation Protection" directs the Commissioner of the Department of Public Welfare to supervise persons with mental retardation who are unable to fully provide for their own needs and to protect their human and civil rights by assuring a full range of social, financial, residential and habilitative services.

Minnesota Statutes, Sections 256E.01-.12 - "Community Social Services Act" establishes a system of planning for and providing community social services administered by the boards of county commissioners of each county.

Minnesota Statutes, Section 393.07 - "Public Child Welfare Program" mandates that county welfare boards administer a program of social programs and financial assistance to children who are confronted with social, physical or emotional problems requiring such protection and assistance.

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