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Journal
Hospital and Community Psychiatry, 41(11)

ISSN
0022-1597

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Publication Date
1990

Reprinted from Hospital & Community Psychiatry

Characteristics of Sheltered Care Facility Operators in California in 1973 and 1985

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During the past 20 years, sheltered care homes have become the primary supervised community residence for mentally ill patients outside of licensed hospitals. To determine factors associated with sheltered care operators' remaining in business, follow-up interviews were conducted in 1985 with operators of 151 sheltered care facilities in California whose operators had been surveyed in 1973. Fifty-five of the original operators continued to operate the facility at 12-year follow-up, and 96 were new to the facilities since 1973. Compared with the original operators, the new operators were younger and better educated, were more likely to be men, and were more likely to be totally dependent on the business for their income. Operators who were members of local associations for sheltered care operators were more likely to have remained in business over the 12-year period, as were those who owned facilities with more than six beds.

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During the 1950s and 1960s, deinstitutionalization created a new configuration of services for chronic mentally ill persons. Treatment delivery systems increasingly shifted their focus from state-hospital-based care to privately owned community-based services in a continuum of acute, transitional, and follow-up care. Sheltered care homes, which may be identified as board-and-care homes, family care homes, halfway houses, or psychosocial rehabilitation facilities, proliferated and became the primary voluntary supervised residence for mentally ill patients. Currently, about 25 percent of chronic patients have residential placements in these facilities, a larger proportion of the population of chronic patients than is found in state mental hospitals (1).

In general, research on sheltered care has addressed the consequences of deinstitutionalization for patients who still require some protective oversight (2). Much of this research has focused on halfway houses and psychosocial rehabilitation facilities, which constitute only 3 percent of sheltered care facilities (3). Research on board-and-care and family care homes has emphasized characteristics of the facilities' residential environment (4–7) and problems of professional caretakers, such as psychiatrists, social workers, and psychologists, who work in these settings (8–10). A study by Blaustein and Viek (7) is one of the few that addresses the characteristics and concerns of facility operators.

This paper reports the results of a 12-year follow-up study of operators of a sample of sheltered care facilities in California whose operators were surveyed in 1973. During the early 1970s, operation of sheltered care facilities was a burgeoning cottage industry, part of the growing trend toward private ownership in mental health enterprises (11–14). The operators were often low-status hospital employees who, like patients, had been "deinstitutionalized" as hospitals reduced their census. They converted marginal housing, such as old motels, into sheltered care facilities or turned their private homes into residences for disabled populations, including mentally ill patients (3).

In this paper, we describe the characteristics of persons who were attracted to the occupation in the early 1970s, examine factors predicting who remained in the occupa-

tion in 1985 and who had left, and describe what happened to those who had left. Finally, we examine the differences between operators who were still in business at follow-up and those who had entered the business since the original survey.

Methods

This research is based on a probability sample of 214 sheltered care facilities in California in 1973 (3). The operator and a sample of residents at each facility were interviewed. All homes were contacted again between 1983 and 1985, and the current operator was interviewed. If an operator who participated in the 1973 survey no longer managed the facility, we attempted to locate and interview him or her as well as the facility's current operator. Details of the sampling and study procedures have been reported previously (3).

The analyses reported in this paper are based on responses to 22 questions from the original survey that were most closely related to facility operator characteristics. These questions covered demographic characteristics of the operator, including sex, age, race, education, marital status, and occupational background, and characteristics of the community in which the facility was located. Data were also collected on whether the operator owned the facility, the operator's participation in local and state associations for operators and the extent of contact with other operators, the operator's reasons for entering the business, the proportion of the operator's income derived from the facility, and the operator's opinion about the purpose of the facility.

Study groups. Of the 214 facilities surveyed in 1973, a total of 156 were still open in 1985. Follow-up interviews were conducted with the operators of 151 of these facilities (97 percent). A total of 55 operators (36 percent) remained from the original sample, and 96 (64 percent) were new to the facilities since 1973.

Operators who had been surveyed in 1973 and were still in business in 1985 were compared with those who had left the business since 1973 and with those who had been in the business less than 12 years as of the 1985 survey.

Variables. The dependent variable for analysis of the 1973 cohort was whether the operator was still in the business or had left by 1985; the characteristics included in the survey questions constituted the independent variables. For analysis of the 1985 cohort, the independent variable was whether the operator had been surveyed in 1973 and thus had been in the business more than 12 years or was new to the business since then. The characteristics specified in the survey questions were the dependent variables.

A separate analysis was conducted to investigate what happened to operators who left the business. Operators who could be contacted were asked their reasons for leaving, and the date and circumstances of their departure were coded for analysis of the conditions under which they left. Measures of resident satisfaction from the original survey (3) were considered in interpreting the validity of complaints by facility operators about the influence of burdensome state regulations on their decision to leave the occupation.

Results

The 1973 operator cohort. Becoming the operator of a sheltered care facility constituted an occupational advance for members of the 1973 cohort, many of whom had been hospital attendants or vocational nurses. As operators of sheltered care facilities, three-quarters of the group had achieved a higher socioeconomic status than in their previous occupations (3). Ratings of socioeconomic status were made using Reiss's classification (15), which is based on an index of mobility in occupational status (professional, business managerial, skilled worker, semiskilled worker, and unskilled worker).

The typical operator was female (72 percent of the sample), married (65 percent), and white (71 percent). She was over 50 years old (58 percent) and had completed high school (56 percent). She owned the facility she operated (62 percent). Her motivation for entering the business was "to help people" (46 percent). As an older operator, she was more likely to manage a smaller facility. Only 10 percent of the operators under age 33 managed residences with fewer than six beds. This percentage more than doubled among operators age 34 to 49 and tripled among those age 50 and older ($\chi^2 = 6.76$, df = 2, $p < .05$).

Although the typical operator was white, blacks constituted 22 percent of all facility operators and owners—more than three times their representation in California's general population (7 percent) (16). The concentration of black women was even greater; 34 percent of the women operators were black.

Operators who remained in the business. A total of 55 of the 214 operators surveyed in 1973 (26 percent) were still in business in 1985. The size of the facility in 1973 was associated with whether operators left the business. Although large facilities (those with more than six beds) were more likely to remain open at follow-up ($\chi^2 = 9.23$, df = 1, $p < .003$), operators of small facilities (those with six or fewer beds) remained in the business at a higher rate (36 percent) than operators of large facilities (22 percent) ($\chi^2 = 13.88$, df = 1, $p < .05$).

Being black was a significant predictor of whether operators of small facilities stayed in business. Sixty-five percent of black operators of small facilities were still in business in 1985, compared with 24 percent of their white counterparts ($\chi^2 = 11.4$, df = 2, $p < .01$).

Ownership of the facility predicted staying in business among operators of large facilities. Thirty-six percent of those who owned their facility remained in business, compared with 6 percent of nonowners ($\chi^2 = 19.32$, df = 1, $p < .001$).

Financial independence from facility-generated income also predicted staying in the business. Only 18 percent (N = 61) of the operators who were totally dependent on the facility for their income in 1973 still operated the facility at follow-up. Of those reporting that they were primarily dependent on facility-generated income, 31 percent stayed in the business (N = 45). Of

those who were partially dependent, 32 percent stayed (N = 84), and of those who were not at all dependent, 5 percent stayed (N = 20) (Data for one operator are missing.) ($\chi^2 = 8.96$, df = 3, $p < .03$).

Peer affiliation was also a predictor of remaining in business. Thirty-seven percent of the operators who were members of local associations (N = 63) were still in business at follow-up, compared with 22 percent of operators who were not members (N = 163) ($\chi^2 = 4.64$, df = 1, $p < .05$) (Data for 13 operators are missing.). Of the operators who reported that other facility operators were helpful to their residents, 33 percent stayed in business, compared with 18 percent of those who reported that other operators were not involved in meeting the needs of their residents ($\chi^2 = 6.11$, df = 2, $p < .05$).

Operators who left. Of the 159 operators who left the business between 1973 and 1985, a total of 83 were interviewed in the follow-up study. Thirty operators had died during the 12-year period. No information was available for 46 operators. Age was not a statistically significant predictor of leaving, but the majority of those who left and were interviewed (60 percent) were 50 years old or older. They were predominantly white (77 percent), married (66 percent), and female (72 percent). Most had operated large facilities as employees, rather than as owners (56 percent).

Slightly more than half of the respondents who left the business reported that they left to retire. All others continued to work at a variety of other occupations. In choosing their next occupation, at least 72 percent capitalized on skills they had used in operating a sheltered care home, including provision of social services (21 percent), real estate and property management (15 percent), business management (15 percent), building trades (13 percent), cooking (8 percent), and other occupations, such as legal research, teaching biology, and manufacturing cosmetics (28 percent).

Three major reasons given for leaving the business were health (40 percent), state regulations (25 percent), and income (16 percent). Among employee-operators, the most common reason for leaving was health, cited by 49 percent. Owner-operators emphasized the negative impact of state regulations; 33 percent of this group cited these regulations as their reason for leaving. Facilities whose operators cited the burdens of state regulations did not differ from other facilities in reports of residents' satisfaction in the 1973 survey, suggesting that the operator's dissatisfaction was not due to inadequate levels of care.

Long-term and new operators at follow-up. Characteristics of operators from the 1973 cohort who remained in business in 1985 and thus had more than 12 years in the business are shown in Table 1, along with the characteristics of operators who had been in the business less than 12 years. Significant differences were found in racial characteristics. Among the operators from the 1973 cohort, none were Asians and 41 percent were black. Nineteen percent of the new operators were Asian, and 10 percent were black.

Compared with operators from the 1973 cohort, new operators were more likely to manage large facilities but less likely to own the facility they managed. Moreover, new operators were four times as likely to be totally dependent on the sheltered care business for their income and were more likely to be involved in a statewide association for facility operators.

There were significant differences between members of the 1973

Table 1
Characteristics of long-term and new operators of sheltered care facilities, by percentages

Characteristic	Long-term operators (N = 55)	New operators (N = 69)	χ^2	df	p
Race			23.78	3	.001
White	52	57			
Black	41	10			
Asian	0	19			
Other	7	14			
Male	20	37	3.56	1	.059
Education (years)			24.14	3	.001
0 to 11	40	7			
12	20	13			
13 to 16	33	56			
More than 16	7	24			
Manages large facility (more than six beds)	64	91	12.09	1	.001
Owns facility	84	41	21.14	1	.001
Depends on facility for income			22.01	3	.001
Totally	17	56			
Primarily	14	14			
Partially	67	27			
Not at all	2	3			
Purpose of facility			22.87	3	.001
Family atmosphere	85	51			
Nice environment	9	23			
Treatment setting	2	9			
Therapeutic community	0	17			
More than one purpose	4	0			
Member of local association for facility operators	30	20	1.13	1	.287
Participates in state association for facility operators[1]			6.20	2	.05
Very active	24	54			
Somewhat active	57	23			
Not active	19	23			

[1] N = 21 for long-term operators; N = 26 for new operators

cohort and new operators in their reasons for managing a sheltered care facility. The modal response for both groups was to provide a family atmosphere. However, only new operators reported that their aim was to provide a therapeutic environment. New operators were also more likely to indicate that one of their purposes was to provide treatment.

Discussion

The sheltered care facility operators who were first interviewed in 1985 were selected from homes sampled in the 1973 study, which may not be representative of sheltered care facilities in 1985. However, comparisons between operators in the 1973 cohort who were still in business in 1985 and operators who were first interviewed in 1985 suggest a trend away from a small-family-business orientation in sheltered care to a more specialized salaried occupation by 1985. Black operators, who were more likely to have remained in business in small facilities, were an exception to this trend.

Economic conditions in California during the 12-year period between the original survey and the follow-up contributed to this outcome. Self-employment increased in the early 1970s (17), and residential property was relatively inexpensive. Sheltered care became a private growth industry and a good occupational alternative for low-status property owners or investors, particularly for blacks.

With the rapid rise in residential property values in California in the late 1970s, this opportunity dissipated. Employment in the 1980s centered on low-paying service jobs (17), which presented an attractive way to enter the business and professional world in the context of the concurrent economic recession. The sheltered care facilities that survived into the 1980s tended to be larger facilities that employed a better-educated group of younger men and new immigrants from Asia and the Pacific islands.

In both the 1973 survey and the 1985 follow-up, operators reported that their major purpose was to provide a family atmosphere for residents. The 1985 survey revealed significant changes in attitudes and motives that attested to an increasingly professional orientation to mental health care among new operators. A changing business climate, characterized by larger facilities, fewer owner-managers, and managers' increased dependence on the business as their primary source of income, contributed to this shift in attitudes. Operators who had entered the business since 1973 were more active in state associations, a trend that testified to the new operators' interest in political activities beyond their local communities.

Operators' increasing professionalism may have important consequences for the residential environment of sheltered care facilities. The contrast between the social status of facility operators in 1973 and 1985 recapitulates the century-old debate about who is competent to manage homes for the mentally disabled (18). In the 19th century, for example, the lay Quaker Samuel Tuke, who established the renowned York Retreat, challenged the dominance of experts on "madness." He advocated "retired habilitation" over specialized institutional treatment.

Is the decline of nonprofessional, home-style service delivery a portent of better service, or will the trend reestablish the parochialism that community-based care was supposed to remedy? Level of professional care and size are particularly important factors in determining the quality of life for residents of sheltered care facilities. Policymakers should take these characteristics into consideration in guiding development of residential care systems that support high-quality, long-term care for chronic mentally ill persons in the least restrictive environment.

Acknowledgments

The authors thank Joyce Adair Bird, Warren Schoenfeld, and Carol Silverman. The research on which this paper is based was supported in part by the National Institute of Mental Health and the Robert Wood Johnson Foundation.

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