REPORT OF THE
M-ED RESIDENTIAL TASK FORCE
JULY 1988

DEPARTMENT OF HUMAN RESOURCES
MENTAL HEALTH DIVISION
PROGRAM OFFICE FOR MENTAL
OR EMOTIONAL DISTURBANCES
STATE OF OREGON
DEPARTMENT OF HUMAN RESOURCES
MENTAL HEALTH DIVISION

REPORT OF THE
M-ED RESIDENTIAL TASK FORCE

Prepared by:

Vicki Skryha, M.S.W.
LuRee Krygier, M.S.W.

Program Office for Mental or Emotional Disturbances

J.D. Bray, M.D.
Assistant Administrator

July 1988
To All Interested Persons:

The M-ED Residential Task Force was appointed to study and make recommendations relating to one of the most important challenges in providing community-based support for chronically and severely mentally ill persons: the provision of decent shelter with adjunct support services. The Task Force took its job seriously and did a fine job defining target populations, analyzing strengths and weaknesses in the current system, and recommending strategies to improve housing and residential services for those persons who are not adequately served.

I encourage your careful attention to the contents of this report. I also invite you to join in a cooperative effort to improve community-based residential services and move closer toward establishing the "ideal spectrum" of housing options identified in the report.

I also would like to express my appreciation for the time and effort contributed by the Task Force members. Their diverse perspectives and wealth of knowledge has made this a document of which Oregon can be proud.

Sincerely,

J.D. Bray, M.D.
Assistant Administrator
Program Office for Mental or Emotional Disturbances

JDB:VS:li

Enclosure
M-ED RESIDENTIAL TASK FORCE REPORT

TABLE OF CONTENTS

EXECUTIVE SUMMARY

I. Introduction

II. Identification of Target Groups and their Housing Needs

III. An Ideal Residential Spectrum for the State of Oregon

IV. The Current System -- Strengths and Barriers

V. Summary and Recommendations

REFERENCES

APPENDICES

A. List of Task Force Members

B. Oregon Definitions of "Chronically" and "Severely" Mentally Ill


D. Summary of Target Groups and Their Residential Service Needs

E. Summary of Estimated Residential Resource Needs

F. Summary of Strengths and Barriers Within the Current System

G. Summary of Strategies Recommended by Task Force

Views and recommendations contained in this report are those of the Task Force and don't necessarily represent the Mental Health Division.
In October 1986, the Program Office for Mental or Emotional Disturbances of the Oregon Mental Health Division assembled a Residential Task Force to study issues and make recommendations concerning housing and support services for persons with chronic and severe mental illnesses. The charge of the Task Force was to describe characteristics of clients relating to residential service needs, identify an ideal spectrum of residential services, delineate gaps and barriers in the current residential service system and determine the number and type of new resources needed.

Task Force members affirmed that shelter is an integral part of everyone's daily life. The importance of the home environment is underplayed in the current mental health system. This has contributed to overcrowding in state mental hospitals, inappropriate placement in jails, homelessness and unreasonable burdens placed on families. More attention needs to be paid to the provision of adequate housing with services.

Task Force members estimated that 8,000 community residential program beds and 725 crisis-respite beds are presently needed by the approximately 42,000 Oregonians with chronic and severe mental illnesses who are at risk of psychiatric hospitalization. Four target groups were identified as follows: (1) the Multiple/Extreme Needs Group, (2) the Functionally Limited/Non-Accepting Group, (3) the Functionally Limited/Service Accepting Group, and (4) the Ongoing Support Group. Several special subgroups were also identified which included individuals with additional impairments, dual diagnoses or other special needs which often constitute barriers to residential placement.

While acknowledging that many clients live in existing community housing, institutions and other less desirable places (e.g. jails and homeless shelters), Task Force members identified the ideal spectrums of community residential alternatives (i.e. those utilized on a transitional or long-term basis) and crisis-respite alternatives (i.e. those utilized on a short-term basis). While a community residential alternative is needed by the 8,000 persons comprising the identified target groups, all 42,000 Oregonians who have chronic and severe mental illnesses may utilize a crisis-respite alternative at some time or another. As of June 30, 1989, only 1,600 state-funded community residential alternatives and 500 crisis-respite alternatives will exist, representing 20% and 69% of the need, respectively.

Although Oregon is to be commended for its progressiveness in establishing semi-independent living programs, decreasing the number of substandard state-funded programs and utilizing subsidized housing resources, many barriers and gaps exist in the current system. These include (1) system and coordination problems, (2) restrictive financial conditions, (3) staffing/provider dilemmas, (4) lack of community support, and (5) administrative barriers. Task Force members identified a total of thirty-two barriers and prioritized the lack of adequate funding levels for existing programs and the need for additional resources as the most pressing problems.
Five broad strategies are recommended to improve residential services:

I. The State should formally adopt guiding principles outlining the values and philosophies which should direct the development and provision of housing programs for chronically and severely mentally ill persons.

II. The funding of programs should be increased to competitive levels to insure stable staffing and operation of existing programs and feasible development of needed, new resources.

III. To insure "quality for state dollars" and maximum leveraging of additional outside resources, training and technical assistance should be made available in a manner both affordable and accessible to staff and developers of housing programs.

IV. Additional residential resources should be aggressively developed in accordance with prioritized needs and through a coordinated effort which insures that services are "attached" to affordable housing.

V. The pursuit of new residential resources, system changes, administrative remedies and improved coordination should be accomplished through leadership and human resources available within or through the M-ED Program Office.

Twenty-three specific, implementation-oriented substrategies are identified which Task Force members believe will result in a more efficiently operated and comprehensive array of residential services. Implementation of the strategies are expected to result in decreased overcrowding at state mental hospitals, a reduced number of homeless mentally ill persons and an improved quality of life for severely and chronically mentally ill Oregonians who now reside in substandard or inappropriate living situations.
CHAPTER I

INTRODUCTION

Home is the place where,
When you have to go there,
They have to take you in.
I should have called it something
You somehow haven't to deserve.

Robert Frost, 1914
I. INTRODUCTION

The M-ED Residential Task Force was assembled in October of 1986 to study issues and make recommendations concerning housing and support services for persons with chronic and severe mental or emotional disturbances. The goals for the Task Force were identified by the M-ED Program Office of the Mental Health Division as follows:

1. To describe client characteristics which determine the need for various levels of residential placement or service.

2. To study and discuss these client characteristics as applied to persons currently residing in institutions, community residential programs and community settings at large.

3. To examine and identify the residential options needed with attention paid to special subpopulations.

4. To identify issues and gaps in current residential programs.

5. To determine how many and what kinds of residential programs and housing support services are needed to meet existing needs.

Persons recruited to serve on the Task Force represented geographical areas throughout the state; hospital and community settings; mental health professionals, family members and primary consumers; and community mental health program (CMHP) staff as well as residential program providers. A list of TF members is included as Appendix A. The various perspectives represented by this diverse group of individuals were instrumental in developing a comprehensive understanding of clients, needed resources and system barriers.

The Task Force met over a period of about twenty months. Task Force members discovered that describing client needs, identifying an array of needed resources and analyzing the current service system was no easy task. Initially, the Task Force split into two work groups: a Client Needs Subcommittee and a Residential Spectrum Subcommittee. The Client Needs Subcommittee did preliminary work identifying the characteristics of persons with psychiatric disabilities while the Residential Spectrum Subcommittee identified an array of needed resources and current system barriers. The Task Force then reconvened as a whole and refined the concepts developed.

The drafting of the report began in October 1987. To insure the utility of the report, Task Force members wanted to do a good job of estimating the size of Target Group populations and the numbers of needed resources. This was difficult and required research. Studies done in other states as well as data available within Oregon were considered. The estimates which emerged were based on the best data available and discussions among Task Force members through which consensus was reached. It is anticipated, however, that the estimates, Target Group descriptions and ideal spectrum of services will be refined as experience is gained and more information becomes available.
PHILOSOPHY

Much discussion of values and philosophy was interspersed throughout the Task Force meetings. Some specific values and goals articulated by Task Force Members include the following:

1. **Choice of Housing.** Whenever possible, a client should be actively involved in choosing his/her place of residence. Persons should not be prevented from moving to the home of their choice.

2. **Individualized Treatment Plan for Housing.** Each resident of a housing program should have a plan which addresses strengths, desires, skill deficits, problem behaviors and resource needs. The plan should be negotiated periodically with the resident's direct involvement and be consistent with the overall treatment plan. The resident should have a copy of the plan for reference.

3. **Availability of Support Network.** Promoting a "sense of community" among peers and/or neighbors and insuring the availability of a support network is important and should be promoted in all housing settings.

4. **Expectations.** A positive, hopeful attitude should be communicated to clients by service providers in order to foster self-confidence for independent living capability. This should be done responsibly with mutual consideration given to the client's desires and assessed abilities and needs.

5. **Client Rights.** These should be identified, explained, mutually understood and applied to all housing situations. Clients should be accorded full rights as citizens.

6. **Balance of Control.** Staff and consumers of housing programs should define their roles in terms of responsibilities and goals for their respective setting. An attitude of partnership rather than authority/dependency should be fostered.

7. **Most Empowering Setting.** Wherever possible, a client should be integrated into a community by living in existing, independent housing. Non-facility-based support services should be available to compensate for skill deficiency areas and to encourage participation in a social support network. The housing coupled with support services should equal the "most empowering setting" for the resident. Structured options (including the hospital) should be reserved for those individuals unable to live in existing, independent housing with (or without) available support services.

8. **Housing Stability.** Clients should not have to lose their homes due to temporary rehospitalization or destabilization.

9. **Crisis Prevention.** It is painful and disruptive for consumers to experience a mental health crisis in order to have access to services. The focus should be on prevention and early intervention through the availability of community support services.
10. **Community Education.** People with psychiatric disabilities have a right to live in the community. Service providers should advocate for this right and also be responsive to local communities. Positive public relations should be employed when planning and siting special housing resources. Efforts should be made to portray a positive image of persons with mental illness in the media so community programs can be seen as an asset rather than a threat.

11. **Quality.** State-funded residential programs should meet established licensing standards. Housing and support services should be planned and provided in a manner which insures that identified clients' needs are met.

12. **Equitable Funding.** In order to provide quality services, programs must be adequately funded. Expectations must be in line with resources. Also, payment must be competitive with other similar state-funded services/positions. The structure of funding systems should facilitate delivery of desired services.

13. **Administrative Rules.** These should reflect stated values and goals for housing programs and provide incentives for the provision of quality services. They should be concise, understandable and directed at facilitating provider compliance.

14. **Flexibility.** Funding and licensing must adapt to changing needs and circumstances. There should be an ongoing attempt to expand services to meet the needs of those consumers not adequately served by existing resources.

15. **Incentives.** There should be incentives within the structure of funded services to provide quality as well as the identified types of needed services. Incentives should also be available to consumers who are motivated to move on to less service-intensive housing options.

16. **Innovation and Creativity.** Efforts toward new resource development and the enhancement of existing resources should not be constrained by history, existing procedures, and current program models. Responsible innovation and creativity should be encouraged. Information-sharing of new service provision methodologies should be promoted and facilitated.

17. **Geographical Distribution of Resources.** Residential resources should be distributed throughout the state so consumers can receive services in their home communities whenever possible. Less populated counties should establish facilities on a regional basis.

These values and goals provide a conceptual framework for the development of residential programs and housing-related support services for persons with psychiatric disabilities in the State of Oregon.
ORGANIZATION OF REPORT

An effort has been made to provide information in a concise, readable format. However, Task Force members found their assignment to be more complex than originally anticipated. In order to provide adequate detail, this report has become quite lengthy. To facilitate its use by those who wish to glean the main conclusions, an Executive Summary is provided at the beginning, and a summary has been added to each chapter. The final chapter summarizes and integrates the entire report and appendices provide outline summaries of estimating methods, target populations, resource needs, current system strengths and barriers, and the recommended strategies and substrategies.

Task Force members experienced some problems with semantics and a tension between terms currently used and understood and those which should be adopted as improvements are made. For example, in our current system, "Residential Care Facilities" and "Adult Foster Care Homes" are the currently funded structured alternatives, but the ideal spectrum of community residential alternatives includes ten different 24-hour staffed program models. Similarly, whereas the state currently funds "Semi-Independent Living Programs," the Task Force has identified eight "Supported Housing" program models. The tension in terminology has been accommodated by using existing terms when discussing the current system and using the proposed categories of "supported," "structured," "special skilled" and "crisis-respite" when recommending improvements.
CHAPTER II
IDENTIFICATION OF TARGET GROUPS AND THEIR HOUSING NEEDS

No one can develop freely
In this world and find a
Full life without feeling understood
By at least one person.

Paul Tournier
II. IDENTIFICATION OF TARGET GROUPS AND THEIR HOUSING NEEDS

In order to develop a plan for meeting the housing needs of people with psychiatric disabilities, the population must be defined and described. This task fell with the Client Needs Subcommittee of the Task Force whose focus was to describe psychiatrically disabled persons who need assistance in their living environments, identify various subgroups based on client characteristics, and determine the types of residential services needed to assist them with maintaining community tenure.

Who Are the "Psychiatrically Disabled"?

For the purpose of the Task Force, persons with "psychiatric disabilities" include those individuals meeting the Oregon Mental Health Division's definition of "chronically mentally ill person" and other individuals who are "at risk" of psychiatric hospitalization and who have become known as "severely mentally ill." The Oregon definitions of "chronically mentally ill person" and "severely mentally ill person" are included in Appendix B.

"Chronically mentally ill persons" have diagnosed psychotic disorders such as schizophrenia, manic-depression or severe depression. "Severely mentally ill persons" don't meet the diagnostic criteria in the "chronically mentally ill" definition yet they have persistent serious mental and/or emotional problems which limit their functioning level. Severely mentally ill individuals include those with severe personality disorders and organic brain dysfunctions. They often reside in state mental institutions or fall through the "cracks" in community service systems.

An estimated 42,000 Oregonians meet the above definition of "persons with psychiatric disabilities." Of these, 18,000 are estimated to have a "chronic mental illness" and 24,000 are estimated to have a "severe mental illness." Utilizing available research studies and needs assessments, Task Force members attempted to identify how many of the estimated 42,000 need residential programs and/or support services related to housing acquisition and maintenance.

How many psychiatrically disabled persons need support in their living environments?

Not all people with psychiatric disabilities need or desire special living environments or support. In fact, many housing needs assessments estimate that the majority of people with severe and persistent psychiatric disorders can and/or do live independently in local communities.

Dr. E. Fuller Torrey, a nationally known expert on schizophrenia (the most common chronic psychiatric disability) has developed the concept of "The Rule of Quarters." Bill Uhlhorn, a Task Force member and author, summarizes this concept in his book, Creating a Caring Community, as follows:

1 These figures are rounded from data obtained through a survey of local community mental health programs conducted by the M-ED Program Office of the Oregon Mental Health Division in early 1988.
"The rule of quarters says that of all people diagnosed and hospitalized with schizophrenia, one-quarter will get completely well, the middle two-quarters will get partially well and the final quarter will not get well.

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Will Get Well</th>
<th>Will Get Partially Well</th>
<th>Will Not Get Well</th>
</tr>
</thead>
<tbody>
<tr>
<td>1% - 25%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26% - 50%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>51% - 75%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>76% - 100%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

will get well will get partially well will not get well
will need will need housing and support, will need continual and support and support and ongoing support
will move out of the system and many of the people will be able to live independently on flexible and an as needed support services are available basis in those places where they spend the major amount of their time

The rule of quarters applies to all persons with mental illness over their entire lifetimes. In planning residential services, it's necessary to estimate the number of people needing each residential alternative at any given point in time. Some people will need identified residential alternatives for limited or intermittent periods of time and others will need them on an ongoing basis. The challenge is to determine how many of each alternative is needed at this point in time.

A review of recent efforts nationwide to assess residential service needs was done. Those studies which presented data in a way that could be applied to the Oregon population were presented to Task Force members. A California Legislative Work Group (1986), in conjunction with the Mental Health Association of California, conducted one such effort. They determined that for every 100,000 Californians, the following minimum number of residential "beds" were needed:

- 24-hour Acute, Intensive Care (Hospital and Non-Hospital) 15 Beds for 310 persons/year
- Short-term, Crisis Residential Care 10 Beds for 220 persons/year
- 24-hour Transitional Residential Care 30 Beds for 60 persons/year
- Long-Term Care (Rehabilitative and Maintenance) 60 Beds for 60 persons/year
- Out-of-Home Placements (Including Supervised and Semi-Independent Living Programs) 150 Beds for 170 persons/year
In summary, for every 100,000 persons in California, the Legislative Work Group determined that 15 "intensive, acute" beds, 10 "non-acute, crisis" beds and 240 other community residential beds are needed. The California ratios apply to all persons needing publicly funded mental health services regardless of age.

These ratios applied to the Oregon population yield the following estimates of need:

<table>
<thead>
<tr>
<th>Crisis-Respite Alternatives</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive, Acute Crisis Residential (e.g., local inpatient services)</td>
<td>404 Beds</td>
</tr>
<tr>
<td>Non-Acute, Short-Term Crisis Residential (e.g., family or group crisis home)</td>
<td>673 Beds</td>
</tr>
<tr>
<td>Other Community Residential</td>
<td>6,456 Beds</td>
</tr>
<tr>
<td>TOTAL</td>
<td>7,129 Beds</td>
</tr>
</tbody>
</table>

A survey conducted by an Ohio Mental Health Housing Task Force (1986) took a different approach. A sample of 1,105 Ohio Department of Mental Health consumers were assessed to determine their current living situation and "what would be their best residential setting." The results are as follows:

<table>
<thead>
<tr>
<th>LIVING SITUATION</th>
<th>CURRENT SETTING</th>
<th>BEST SETTING</th>
</tr>
</thead>
<tbody>
<tr>
<td>With family</td>
<td>36</td>
<td>20</td>
</tr>
<tr>
<td>Living independently</td>
<td>34</td>
<td>40</td>
</tr>
<tr>
<td>Institutional settings, including hospitals and nursing homes</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Supervised group homes or board and care homes</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Supervised apartment and boarding houses</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>Temporary housing or homeless</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Living with friends who maintain household</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Crisis, respite or interim care</td>
<td>*</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

(* = Less than 1 percent)

---

2 The certified, estimated population of Oregon, as of July 1, 1987 was provided by the Center for Population Research and Census and is 2,690,000.

3 This number is a projection of need for adults and children. Because the "California Model" leaves it up to local communities to establish proportions needed by adults and children, it was not possible to derive a figure for adults only.
While only 14% were currently residing in supervised or supported housing alternatives, 31% were estimated to need a community residential program. An additional 3% were indicated to need institutional settings (i.e., hospitals or nursing homes) and another 3% to require "crisis, respite or interim care."

A 1981 housing needs assessment of Multnomah County, Oregon, collected data similar to that of the Ohio Task Force (Krygier, Newcomer, Pratt and Skryha, 1982). Data was obtained from staff of Multnomah County mental health clinics and subcontract agencies from a sample consisting of 581 clients defined as "chronically mentally ill." Survey information on each client's current living situation and the alternative "most appropriate to his/her needs" yielded the following results:

<table>
<thead>
<tr>
<th>HOUSING TYPE</th>
<th>CURRENT</th>
<th>MOST APPROPRIATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>With Family</td>
<td>30%</td>
<td>24%</td>
</tr>
<tr>
<td>Living Independently</td>
<td>32%</td>
<td>26%</td>
</tr>
<tr>
<td>Supervised Setting (RCFs and AFCs)</td>
<td>15%</td>
<td>20%</td>
</tr>
<tr>
<td>Semi-independent and boarding homes</td>
<td>16%</td>
<td>24%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>7%</td>
<td>6%</td>
</tr>
</tbody>
</table>

The Multnomah County data indicates that while 31% of the clients were living in supervised or supported housing alternatives, these types of residential services were needed by 44%. These percentages are higher than those in the Ohio study. A probable explanation is that the Ohio sample was not limited to "chronically mentally ill" persons but included less disabled individuals who received mental health services.

Another study was done in Kitsap County, Washington. Of an estimated 367 chronically mentally ill persons and 817 "seriously disturbed" individuals, a sample of 63 clients were surveyed. Based on a functional assessment of these clients, the following percentages were derived:

- 3% Need Acute Hospitalization
- 21% Need Intensive, Long-Term Care
- 29% Need Transitional Residential Settings
- 11% Need Congregate or Group Care
- 25% Need Semi-Independent or Independent Settings
- 12% Can Live Independently

4 "RCFs" or Residential Care Facilities" and "AFC" or "Adult Foster Care" were the only types of structured residential programs available.
In summary, these Kitsap County results (which are derived from the functional assessment instrument) indicated that about 80% of the clients need supervised or supported housing. The surveyors also investigated consumer preferences and determined that only 10% desired structured, group living options while 90% preferred to live independently with additional “in home” support services available. These results illustrate a tension which exists between “professional, diagnostic assessments” and the settings which consumers desire and will accept as their homes.

With results from these studies as a framework, Task Force members grappled with determining the numbers and percentages which best describe the needs of Oregonians with psychiatric disabilities. It appears that a larger percentage of chronically mentally ill than severely mentally ill persons need supervised and/or supported housing options. It’s also apparent that not all consumers will desire and/or accept an alternative which is deemed as “appropriate” by a mental health professional. As was mentioned earlier, some persons will require a structured setting for a limited duration while others will need support and/or supervision on an ongoing basis.

Crisis-respite alternatives are short-term by nature and are used by a greater number of individuals. Community residential programs, on the other hand, are homes for a longer period of time and can be transitional or long-term. For planning purposes, it therefore makes sense to consider “crisis-respite alternatives” and “community residential programs” separately.

With respect to crisis-respite housing, the California data estimates that 25 beds serving 530 persons annually for each 100,000 people are needed. The Ohio survey estimates that 3% of the mental health client population will need this service. Applying the California ratio to the Oregon population yields a projected need of 673 crisis-respite beds statewide to serve 14,268 persons annually. Using the Ohio percentage, 3% of an estimated 26,000 persons5 with psychiatric disabilities was used resulting in about 780 individuals who need crisis-respite alternatives at a given time. Averaging the “California” and “Ohio” derived amounts yields an estimate of 726.5 needed crisis-respite beds. Task Force members agreed to use 725 as the estimated number of crisis-respite beds needed by Oregonians with psychiatric disabilities.

Community residential program estimates are more variable. Applying the California ratio to the Oregon population results in a need for an estimated 6,456 beds to serve 7,801 persons annually. The Ohio, Multnomah County and Kitsap County studies estimated that 31%, 44% and about 80% of clients, respectively, need supervised and/or supported housing. The Ohio study reflected the needs of a broader mental health client population than

5 Because the Ohio survey was based on individuals enrolled in services at a given point in time while the estimated 42,000 Oregonians with psychiatric disabilities was not, the estimate was reduced to 26,000 based on the assumption that 100% of the 18,000 chronically mentally ill persons require ongoing services while only one-third of 24,000 severely mentally ill persons would be enrolled in services at a given time.
the Multnomah County study which was limited to chronically mentally ill persons in the state's most urban county. The Kitsap County study utilized a functional assessment instrument to predict needed residential placement. This assessment tool has not been adequately validated and does not take client preferences into account. The Ohio percentage (31%) can be applied to the total estimated number of persons with psychiatric disabilities in Oregon to obtain an estimated 8,060 individuals who are either chronically mentally ill or severely mentally ill and need community residential alternatives. The Multnomah County and Kitsap County percentages applied to the Oregon population yield considerably higher numbers (11,440 and 20,800 respectively). Task Force members agreed that the Ohio percentage, rounded to estimate that 8,000 Oregonians with psychiatric disabilities need community residential alternatives, was the best estimate to use at present.

Characteristics of Those Needing a Residential Service

Individuals needing support services related to their living environment are a varied group. The needed level of support ranges from on-site skilled services 24-hours per day to once-a-week home visits by para-professional staff. Limitations accompanying a psychiatric disability in one or more of the following areas are characteristic of those individuals requiring special living environments or support in independent housing units:

1. **Behavior Problem** (e.g., ranging from social and coping skill deficits to a history of firesetting or assaultive actions),

2. **Skill Limitations** (e.g., ranging from a lack of daily living or survival skills to a grave inability to perform basic self-care activities),

3. **Psychotic Symptomatology** (e.g., ranging from hearing voices which interfere with performance of routine activities to experiencing ongoing incapacitating hallucinations and delusions for which a medication regimen has been ineffective), and

4. **Physical Health or Mobility Limitations** (e.g., health conditions requiring medical supervision and care or physical disabilities which require the assistance of an attendant).

It is important to note that each person with a psychiatric disability is different. The severity of limitations experienced vary greatly among individuals. The dynamics of mental illness are such that the limitations can be extremely severe at some times and barely noticeable at others. These characteristics make establishing a prognosis very difficult.

While it is understood that each person with a psychiatric disability is a unique individual, the identification of target groups is useful for the purpose of planning services. The Subcommittee identified **four general target groups** as follows:
The Multiple/Extreme Needs Group
- The Functionally Limited/Non-Accepting Group
- The Functionally Limited/Service Accepting Group
- The Ongoing Support Group

In addition to these four general target groups, many "special need" subgroups of psychiatrically disabled persons exist. They include:

- The Elderly
- The Homeless
- Hearing Impaired Individuals
- Blind or Visually Impaired Individuals
- Non-English Speaking Persons
- Dually Diagnosed - Alcohol/Drug Abusers
- Dually Diagnosed - Mentally Retarded/Developmentally Disabled Persons
- Those Involved in Forensic Programs/Corrections System
- Personality Disordered Individuals
- Those Afflicted with Rare or Life Threatening Diseases
- Those with Organic Brain Syndromes
- Emerging Emotionally Disturbed Young Adults

As the Subcommittee discussed the Target Groups, they determined that "Special Populations" generally fit into one of the four target groups. However, if attention is not called to "special needs" and efforts made to accommodate them, they tend to get neglected in the planning process and "fall through the cracks" in the service delivery system.

It should be noted that although individual members share common characteristics and needs, these Target Groups are heterogeneous rather than homogeneous. Each Target Group is comprised of individuals with varying skill deficits, functioning capabilities, problem behaviors and other characteristics. No one type of housing is the answer given the diversity of individuals within a Target Group. It's difficult to predict what proportion of individuals could benefit from intensive, rehabilitation-oriented services on a shorter term basis (1-5 years) and be able to move on to less supervision and support. Therefore, individuals may require different housing alternatives and/or varying levels of supervision and support over time as their disability(ies) and symptomatology fluctuate.

Each target group and the special populations identified by the subcommittee are described below. A summary of the estimated number of persons in Target Groups and resources needed appears in Appendix C.

FOUR TARGET GROUPS

I. THE MULTIPLE/EXTREME NEEDS GROUP

This group presents the greatest challenge to housing providers and services planners. They are individuals whose symptoms are not easily controlled by medications and who tend to be more active and difficult to engage in treatment. They tend to spend longer periods of time in state hospitals. These characteristics combine with a variety of problem behaviors and a lack of adequate community resources to make the acquisition of community-based housing extremely difficult.
Tony and Stewart Exemplify Members of This Group

Tony experienced his first psychiatric breakdown at age 25. He had attended high school, served in the army, married and became the father of two children. Since 1966, Tony has been admitted to state mental hospitals seventeen times. His present residence is Dammash State Hospital where he has resided since 1983. At age 47, Tony is generally passive and requires prompting to care for his basic needs. He has ongoing delusions about electrical activity in the atmosphere and its piercing effect on his body. His medications have proved ineffective in alleviating these symptoms. Tony also experiences falling spells which have been diagnosed to have no physiological cause. These have resulted in serious head injuries, yet he adamantly refuses to wear protective headgear. Tony has been refused admission by foster care and residential care facility providers due to his extensive care needs. Nursing homes have denied him admission because of his falling spells and lack of ongoing "nursing care" needs. Tony needs an intensive, rehabilitation-oriented residential program with specially trained staff, a program which currently doesn't exist in Oregon.

Up until age 16, Stewart lived a normal, happy life with his family. His paranoia and anxiety then became apparent and led to strange behavior and an inability to cope with his normal routines of school and social activities. Although he was provided private psychiatric care, Stewart's paranoid schizophrenia and unwillingness to accept a diagnosis of severe mental illness led to his refusal of medications and further treatment. His condition worsened and his behavior became increasingly verbally and physically assaultive. He threw a chair through a window, tried to run over a friend with a car and chased his mother with a knife. He moved to downtown hotels and was evicted from one after another as a result of assaultive and bizarre behavior. He became unkempt and dirty. A waitress's remark set off a violent outburst that resulted in his damaging the restaurant and nearby shops. Stewart, at age 20, was found "guilty except for insanity" of the resulting felony charge and was sentenced to eleven years at Oregon State Hospital under the jurisdiction of the Psychiatric Security Review Board. With medication and treatment, Stewart's propensity toward violence can be reversed. Hospitalization is a costly long-term solution to Stewart's care needs. However, nonhospital alternatives which offer security and staff trained in special treatment and behavior management techniques are unavailable. Now stabilized and looking forward to eventual community re-entry, Stewart needs a rehabilitative, secure residential program where he can receive treatment and learn social and daily living skills.

*Estimated Number* - 1,500 Oregonians

*Age Range* - 18 to 60 years old

6 These and other vignettes provided in this chapter are based on actual individuals receiving services in Oregon's mental health care system. Their names and some other identifying information have been changed to protect their confidentiality.
Diagnosis - Most have a primary diagnosis of schizophrenia. Over half also have a cognitive deficiency (such as organic brain syndrome) or a personality disorder. Many have a history of alcohol or drug abuse. Some have physical disabilities or limitations. Very few are diagnosed bipolar.

Characteristics - These include persistent delusions and hallucinations; tendencies toward combative/assaultive behavior; at risk of wandering off/getting lost; a lack of self-care and social skills; behaviors which present a fire hazard (ranging from careless smoking to impulsive fire-setting); and/or incontinence or other health-related conditions. Most have repeatedly failed to maintain community tenure.

Current Residence - These individuals tend to be long-term or repeat users of state mental hospitals. Length of hospital stay typically ranges from 1-3 years. Some are homeless; some are inappropriately housed in foster homes or group homes (which are not staffed to provide adequate support and intervention); others live in substandard, proprietary room and board settings, SRO hotels or shelters.

Needs in the Residential Setting

- Room and Board
- Comprehensive functional assessment to determine survival skills and deficits.
- Individualized residential Plan of Care which addresses key skill deficits and problem behaviors through a consistent treatment approach on a day-to-day basis.
- Long-term, structured, supervised program for some; transitional, rehabilitative, supervised program for others (some may be able to move to less restrictive settings after 1-5 years of intensive intervention while others have organic or other deficits which will cause them to require ongoing care and behavioral supervision).
- Some may require medical, nursing or other health care services.
- Staff trained in behavior management and therapeutic counseling techniques.
- Clinical supervision and psychiatric consultation should be available.
- Social activities, groups and opportunities to learn and practice daily living skills.
- Some require a secure environment (i.e., fenced or locked) to prevent wandering off or running away.
- For some, maximum fire and life safety equipment must be part of physical plant.
Other Treatment Needs

- Physical health assessment and ongoing care for physical health problems.
- Psychiatric medication-monitoring.
- Socialization, recreational, educational and/or vocational opportunities, as appropriate.

(Note: Because these individuals require intensive treatment and intervention services in their place of residence, treatment coordination and overall case management should be provided by facility staff in coordination with the resident's prescriber.)

Recommended Alternatives

- 65% need SPECIAL SKILLED Community Residential Programs including:
  - Skilled Nursing Facility - Psychiatric Emphasis
  - Intermediate Care Facility - Psychiatric Emphasis
  - Intensive Residential Treatment Facility
  - Small Intensive Treatment Home

- 35% need STRUCTURED Community Residential Programs including:
  - Hospital-Based Supportive Housing
  - Family-Style Care - Special Needs/Treatment Emphasis

- 0% need SUPPORTED Community Residential Programs

- All may require a Crisis-Respite Care Alternative from time to time.

II. THE FUNCTIONALLY LIMITED/NON-ACCEPTING

Individuals in this group fit the recently popularized characterization of the "young adult chronic." They are "revolving door" hospital users (i.e., have numerous short-term hospitalizations). They tend to deny their mental illness, resist affiliation with the formal mental health service network and are often hospitalized through the involuntary commitment process. Abuse of alcohol and/or drugs is very common.

Matthew and Caitlan Exemplify Members of This Group

Matthew experienced his first schizophrenic symptoms at age 14. He and his family did not know how to interpret his "funny thoughts," however, and Matthew continued to be active in school sports and was selected to play first chair violin in his high school orchestra. He was first hospitalized at age 17 and has had 9 hospitalizations.

- 16 -
since then averaging 5 months each in duration. The social and living skills Matthew had prior to age 14 have disappeared over the years as he struggles day to day with his illness. Now at age 27, Matthew denies his mental illness and escapes his increasingly apparent skill limitations through occasional drug use. He often enrolls in college courses with high hopes but ends up dropping out as pressures cause his symptoms to increase. His yearning to be independent, his unwillingness to acknowledge his problems and his refusal to accept formal assistance have resulted in failed group home and apartment program experiences. His family is left with the burden of meeting his heavy support needs, and Matthew has become overly dependent on them. However, when his behavior deteriorates, Matthew has a tendency to become assaultive. The family's resources are eventually depleted, and the result is another hospitalization. Matthew needs an intensive apartment program with specially trained staff who assume non-authoritarian roles where he can learn to accept his limitations and receive assistance and training while feeling independent. Few programs of this kind are available, especially for young, drug abusing mentally ill persons.

Caitlan was a bright, young woman whose interests included wildlife preservation and ecology. Like so many of her peers, she used pot and alcohol in an attempt to dull the confusing thoughts and voices she experienced as a result of her schizophrenia. She lived at home until she was 20 years old, but times were rough for both her and her family as she struggled to be an adult. She tried living in group homes but complained about staff treating her like a child. She turned to substance abuse to cope with these conflicts and eventually was evicted for "behavior problems." By age 24, Caitlan had been hospitalized fifteen times. The last hospitalization was for suicidal thoughts and lasted only a few days. Caitlan refused to go back to the group home where she previously resided. She ended up going to live in an unsupervised boarding home. One night, she borrowed car keys and was found dead the next morning in a closed garage with the car's motor running. Caitlan needed either a highly specialized adult foster care home or a supervised apartment program. These programs would have caregivers to provide both the support and limit-setting necessary to have helped Caitlan achieve adulthood while retaining a sense of self-respect.

**Estimated Number** - 2,500 Oregonians

**Age Range** - 18 to 40 years old

**Diagnosis** - Schizophrenia, bipolar disorders, various personality disorders. Substance abuse is common.

**Characteristics** - These typically include a strong desire to be independent; a tendency to deny their mental illness problem; a minimal to moderate level of self-care and social skills; a tendency to be active and sometimes assaultive; difficulty engaging in mental health treatment; questionable medication compliance; a tendency to over-estimate or inadequately plan for independence and then experience failure; and/or a lack of vocational skills.
Current Residence - These individuals are often in and out of hospitals, or possibly have never been hospitalized but live "on the fringe." While in the community, they may be homeless, involved in the criminal justice system for petty crimes, living in SRO hotels, substandard apartments or boarding homes, or living with family members.

Needs in the Residential Setting

- Minimum of obvious supervision and structure.
- Support and assistance provided in informal ways and seen as a means toward achieving greater independence.
- Outreach intervention by visiting staff or peers for some; on-site staffed programs for others (staff role should be non-authoritarian).
- Activities which encourage personal/social development, maturity and responsibility.
- Room and board provided in accordance with individual needs/desires.
- Services which encourage the establishment of peer support networks.
- Opportunities to build and/or maximize daily living skills in natural settings through informal instruction or with the assistance of peers.
- Activities and atmosphere which encourage abstinence from alcohol and drugs while meeting social and other needs which led to abuse.

Other Treatment Needs

- Treatment for alcohol and drug abuse problems, provided in non-traditional, outreach-oriented ways.
- Outreach-oriented case management which minimizes "professional" roles.
- Recreational, educational, vocational training and placement opportunities.
- Psychiatric medication-monitoring.
- Health screening and care.
- Social activities appropriate to age and interests.
Recommended Alternatives

- 25% need SPECIAL SKILLED Community Residential Programs including:
  - Intensive Residential Treatment Facility
  - Small Intensive Treatment Home

- 25% need STRUCTURED Community Residential Programs including:
  - Residential Treatment Facility—Transitional Emphasis
  - Family-Style Care—Special Needs/Treatment Emphasis

- 50% need SUPPORTED Community Residential Programs including:
  - Boarding Home
  - Partial Day-Staffed Facility
  - 24-hour Staffed Apartment Program
  - Tenant Support Apartment Program (less than 24-hour staffing)
  - In-Home Services
  - Independent Living Support Services

- All may require a Crisis-Respite Care Alternative from time to time.

III. THE FUNCTIONALLY LIMITED/SERVICE ACCEPTING GROUP

This group includes those individuals whose skill deficits and problems bar them from independent living but whose relatively cooperative nature makes them good candidates for residency in many housing programs. They tend to have more insight into their problems and more interest in learning skills and moving toward more independence. Their prognosis for benefitting from housing programs is high.

George and Jane Exemplify Members of This Group

George spent most of his young adulthood in the State hospital. Now 54 years old, he has resided in various community-based group homes for the past 20 years. George is distinguished by his ability to play the flute and speech problems which make him hard to understand. His schizophrenia manifests in imaginary illnesses and a tendency to secretly purchase various over-the-counter cures which can be harmful when combined with his prescribed medications. His recent experimentation with drugstore remedies led to a short hospital stay. Upon discharge, George moved into an unsupervised boarding home which, on the surface, seemed similar to his last group home. When his case manager visited a few weeks later, George was found in a fetal position with medication bottles tucked under his armpits. The room was extremely littered. George had not bathed in weeks and appeared very frightened. After he was comforted that no one would hurt him, George asked to move. George currently lives in a Residential Care Facility and has no plans for independent living. He relies on staff to remind him when to take his medications, come to meals and bathe. George is well-liked and has begun playing his flute again.
By the time she was nineteen, Jane had lost both parents. Her mother died of tuberculosis in a mental hospital and her father died later of undetermined causes. After living with various relatives and unable to obtain work, Jane was hospitalized in 1948 as a result of a psychotic episode. Since then, Jane has been hospitalized 9 times, once for 21 years. She was in her 40's when a community placement in a foster home was arranged. Brain damage resulting from shock therapy given during early hospitalizations combined with the disabling effects of schizophrenia and long-term institutionalization, make it improbable that Jane, now age 59, will ever be able to live completely on her own. For the last few years, Jane has lived in a Residential Care Facility. She is described by staff as cooperative but in need of reminders to do the things necessary to care for herself. Jane enjoys the social atmosphere in her present home and can be expected to live there or at a similar facility throughout her life.

**Estimated Number** - 1,500 Oregonians

**Age Range** - 30-60 years old

**Diagnosis** - Schizophrenia or bipolar disorders

**Characteristics** - These individuals have typically come to accept their mental illness; are cooperative with a negotiated treatment plan; are easier to engage in treatment; are willing and able to learn coping and daily living skills; respond well to social, recreational, vocational and educational opportunities; and lack self-confidence, independent living and social skills, and a social support network.

**Current Residence** - They are typically in and out of hospitals or have possibly never been hospitalized yet have an ongoing inability to survive independently in the community. While in the community, they may be homeless, victims of crime and society's abusive element, living in SRO hotels, substandard apartments or boarding homes, or living with family members.

**Needs in the Residential Settings**

- Some will benefit only from environments providing a high degree of supervision and structure during the assessment and rehabilitation period. Others can live fairly independently if skill training, social support from peers, friendly visits from a case manager, assistance with resource acquisition, and crisis intervention capability is available. The more dependent or fragile persons will need a long-term supportive environment.

- Support and assistance with skill acquisition.

- Room and board provided in accordance with individual needs/desires.
Activities which encourage establishment of friendships, peer support networks.

Activities which encourage personal/social development, maturity and responsibility.

Opportunities to build and/or maximize daily living skills in natural settings.

Other Treatment Needs

Outreach-oriented case management.

Psychiatric medication-monitoring.

Recreational, educational, vocational training and placement opportunities.

Health screening and care.

Social activities appropriate to age and interests.

Recommended Alternatives

15% need SPECIAL SKILLED Community Residential Programs including:
- Intensive Residential Treatment Facility
- Small Intensive Treatment Home

35% need STRUCTURED Community Residential Programs including:
- Family-Style Care - Special Needs/Treatment Emphasis
- Relative Foster Care (family is provider)

50% need SUPPORTED Community Residential Programs including:
- Partial-Day Staffed Facility
- 24-Hour Staffed Apartment Program
- Tenant Support Apartment Program (less than 24-hour staffing)
- In-Home Services
- Support to Families Providing Housing
- Independent Living Support Services

All may require a Crisis-Respite Care Alternative from time to time.

IV. THE ONGOING SUPPORT GROUP

This group includes individuals who have a level of survival skills which enables them to live in community settings with minimal support. However, without a minimal level of ongoing support these individuals are likely to experience decompensations and utilize a higher level of care alternatives.
Shannon and Sue Exemplify Members of This Group

When Shannon arrived in Eugene ten years ago, she had no food, shelter, family or friends. She lived on the street and experienced the high and low mood swings typical of untreated bipolar disorder. She was eventually jailed because of her bizarre behavior which created a nuisance. She was transferred to the state hospital and remained there for six months. Eventually, Shannon was placed in a foster home and became a client of the local mental health clinic. After two years of supportive care, Shannon was referred and accepted for her own apartment in a new semi-independent living program. She is currently in her fourth year of residency there. She is surrounded by friendly neighbors who understand her now minor "ups and downs." Her neighbors also have mental illness, and with the support of a Resident Manager and Skills Trainer, the fifteen tenants in this complex have become a support network to one another. Shannon has become active in a socialization club, is receiving vocational training and sings in her church choir. She describes her apartment as "the best place I've ever lived." When asked if she'd like to live totally on her own, she expresses a fear that she couldn't make it without the nearby support.

Sue grew up in a middle income family in Grants Pass. Whereas her siblings enjoyed the usual social and personal growth which accompanies adolescence and early adulthood, Sue was different. She heard voices which told her she was an awful person. Sometimes she thought the C.I.A. was after her or that she was a disciple of Jesus. Her odd behavior confused, frustrated and eventually alienated her family. At age 20, Sue experienced her first psychiatric hospitalization. For the next 11 years, the majority of her life was spent in institutions. A little over 4 years ago, she returned to Grants Pass without money, friends, a work history or a place to live. Fortunately, she was enrolled in the county mental health program and received semi-independent living support services from a local nonprofit agency. Staff helped her to find housing and trained her to cook, shop, budget and take her medications. Currently, Sue receives rent assistance which enables her to live in a nicely furnished house. She works in a sheltered workshop and has made friends through participation in the local day treatment program. Her parents attend the local family support group and have learned to understand and accept Sue's mental illness. Sue has come a long way, but she still relies on weekly visits with a skill trainer to help her shop, pay bills and problem solve other challenges of community living. She says, "I tried to do it on my own, but never made it. Now, with support, I'm making it."

Estimated Number - 2,500 Oregonians

Age Range - 18-65 years old

Diagnosis - Schizophrenia, bipolar disorders, various personality disorders.
Characteristics - These persons typically need support in their living environment in order to maintain community tenure. They need assistance with such areas as self-confidence, coping with environmental stressors, budgeting, meal preparation, housekeeping and socialization. They tend to have poor impulse control, difficulty differentiating reality from fantasy and problems making appropriate judgments about everyday situations.

Current Residence - They generally reside in a community setting. They may utilize hospitals and/or crisis-respite alternatives on a short-term basis. Some live in structured settings; some in semi-independent living programs; some in marginal housing with visiting case management support; others live in substandard settings, SRO hotels or shelters but could benefit from availability of minimal services.

Needs in Residential Settings

- Room and board provided in accordance with individual needs/desires.
- Support and assistance with skill acquisition and/or maintenance.
- Supportive counseling and encouragement.
- Assistance with problem-solving.
- Most require environments with minimal supervision and structure. Where structure is provided, it is centered on meal times or social/leisure activities.
- Activities which encourage establishment of friendships, peer support networks.
- Activities which encourage personal/social development, maturity and responsibility.
- Opportunities to build and/or maximize daily living skills in natural settings.

Other Treatment Needs

- Outreach-oriented case management.
- Psychiatric medication-monitoring.
- Recreational, educational, vocational training and placement opportunities.
- Health screening and care.
- Social activities appropriate to age and interests.
Recommended Alternatives

- 40% need **STRUCTURED** Community Residential Programs including:
  - Residential Treatment Facility - Maintenance Emphasis
  - Relative Foster Care (family is provider)
  - Family-Style Care - Maintenance Emphasis

- 60% need **SUPPORTED** Community Residential Programs including:
  - Boarding Home
  - Fairweather Lodge (communal work program)
  - Partial-Day Staffed Facility
  - 24-Hour Staffed Apartment Programs
  - Tenant Support Apartment Program (less than 24-hour staffing)
  - Support to Families Providing Housing
  - Independent Living Support Services

- All may require a Crisis-Respite Care Alternative from time to time.

**SPECIAL POPULATIONS**

Some persons with psychiatric disabilities have additional limitations, conditions or circumstances which make the acquisition of appropriate community housing an even greater challenge. The subcommittee identified several "special populations." These are identified and discussed below along with implications for community housing programs.

- **The Elderly**
  These are individuals who have special needs due to their advanced age and frailty. Physical health problems are more common among the elderly. Programming appropriate to age is important. For example, an emphasis on social/recreational activities enjoyed by senior citizens is desirable rather than an emphasis on vocational attainment.

- **The Homeless**
  These are individuals whose basic need for shelter is not met. Before realistic assessment and treatment interventions can occur, adequate shelter, food and health care (if indicated) must be arranged. People of all ages, backgrounds and previous circumstances have been known to become homeless. Many homeless individuals either have no family or support system, or have lost contact with family and friends. Two general kinds of housing are needed by homeless persons: (1) transitional programs and (2) affordable permanent housing. Transitional programs are time-limited and provide room and board and services directed at obtaining the necessary resources to make possible a permanent housing placement. Affordable, permanent housing may include any of the full range of alternatives (in accordance with the individual's needs).
o **Hearing Impaired Individuals**

These individuals are deaf or have trouble hearing. They require staff who are trained to communicate in sign language and fire/life safety accommodations (e.g., flashing lights rather than an alarm system). Alternative telephone, doorbell and other equipment may also be required.

o **Blind or Visually Impaired Individuals**

These individuals have lost their sight or have vision problems which make them legally blind. They require staff who understand and can compensate for their sight limitations. The residential environment must be adapted to compensate for their inability to see (e.g., written directions also available in braille, textured doorknobs on exit doors, and equipment such as clocks and ranges which feature audio or tactile signals in lieu of visual ones).

o **Non-English Speaking Persons**

These individuals communicate in a language other than English and have difficulty understanding English. Cultural differences may also exist and make treatment difficult. Staff who speak the individual's language or the use of an interpreter is advised. Sensitivity to cultural differences in programming is also important.

o **Dually Diagnosed - Alcohol/Drug Abusers**

These are individuals who have varying degrees of psychological or physical dependence on alcohol or non-prescribed drugs. These persons vary in the degree to which they acknowledge their substance dependency and the degree to which they are willing to accept treatment for their problem. Those who are willing to abstain from alcohol and/or drugs and actively participate in a treatment program can be housed with non-abusers in non-specialized programs if trained, supportive staff are available. Less cooperative persons with drug and/or alcohol abuse problems can disrupt a household or tenant community and interfere with the progress of other residents. Specialized residential programs for mentally ill and substance-abusing persons which effectively combine substance-abuse and mental health treatment modalities should be pursued.

o **Dually Diagnosed - Mentally Retarded/Developmentally Disabled Persons**

These include persons who are developmentally disabled or mentally retarded. They often went through school in special education classrooms. They have less ability in cognitive and intellectual functioning. They are often vulnerable to abuse and may need special protection. In the living environment, they may need additional instruction and help with written materials. Training for staff on program methods that work with mentally retarded or developmentally disabled persons would be helpful.
Those Involved in Forensic Programs/Corrections System

Many of these individuals are sentenced to treatment in a special forensic psychiatric hospital program after having been found "guilty, except for insanity" of a criminal offense. Others are receiving inpatient psychiatric treatment funded through the Department of Corrections or outpatient mental health services under the supervision of a parole or probation officer. Crimes committed range from misdemeanor charges to serious felony offenses. These persons vary in the degree to which they may be compliant with treatment or dangerous and in need of intensive supervision. Security is an obvious community concern and many providers are hesitant to serve these individuals due to liability exposure. For some individuals, community placement may not be an appropriate option; however, many are no threat to the community and remain closely supervised to assure assistance if problems begin to develop. Community needs should be assessed on an individual basis in accord with a person's level of functioning and to insure the safety of the community.

Personality Disordered Individuals

People with "personality disorders" are characterized by a lack of development in one or more aspects of their social behavior. The most common of these disorders are borderline personality, dependent personality, anti-social behavior, passive-aggressiveness, paranoia, compulsive behavior and schizoid personality. Different personality disorders require different treatment approaches. In the residential setting, consistency of approach, an understanding of how the disorders manifest themselves and a supportive but non-reactive staff approach are generally preferred.

Those Afflicted with Rare or Life-Threatening Diseases

Some rare and untreatable diseases manifest psychiatric symptoms along with other health-related symptoms. One example is Huntington's Chorea. People with this disorder lack muscle control and risk self injury. Residential programs need to make environmental modifications (e.g., elimination of any sharp or hard objects onto which residents might fall) or provide special equipment (e.g., protective helmets). Persons with Huntington's Chorea may also require assistance with personal care and have health needs which require specialized nursing assistance.

Another group of individuals in this category includes persons with AIDS. Precautions directed at preventing the transmission of this disease must be taken (e.g., extra cleaning and sanitation).

Those with Organic Brain Syndrome

This is a broad category which includes persons with dementia and delirium. Alzheimer's disease is one cause of these symptoms and causes confused, erratic behavior. Younger persons with brain
injuries are also included. They typically experience impaired judgment, memory loss and misguided behavior. People with Organic Brain Syndrome often require assistance with personal care and behavior supervision. For some, nursing care with a psychiatric emphasis may be necessary. Younger persons with head injuries need rehabilitative services in settings where they can live with others of similar ages.

**Emerging Emotionally Disturbed Young Adults**

These individuals became mentally or emotionally disabled as children or adolescents and continue to need services upon reaching adulthood. Becoming eighteen years old disqualifies them from programs for children and adolescents; however, they have typically not attained a level of maturity equal to that of other young adults. They're too old for youth programs yet too young to be served effectively in adult programs. These emotionally disturbed young adults need additional training in social and daily living skills which takes into account their delayed maturity.

**SUMMARY**

The Task Force decided to use the term "psychiatrically disabled" to collectively describe the "chronically" and "severely" mentally ill persons prioritized for service through state-funded mental health programs. There are an estimated 42,000 psychiatrically disabled Oregonians, 18,000 of whom have a "chronic mental illness" and 24,000 who have a "severe mental illness." The majority of these individuals are able to live in existing community housing alternatives if community mental health services are available. However, an estimated 8,000 of these individuals need transitional or long-term residential services ranging from 24-hour supervised programs with highly skilled staff to weekly skills training visits to apartments by paraprofessional staff. All psychiatrically disabled persons are considered "at risk" of psychiatric hospitalization and may use a short-term (i.e. crisis-respite) alternative at one time or another. An estimated 725 crisis-respite beds are needed.

Behavior problems, skill limitations, psychotic symptomatology and/or physical health and mobility limitations are characteristic of individuals who need residential services. These limitations vary in their severity and duration. Some individuals will need residential services on an ongoing basis while others will need them on a short-term or transitional basis.

The four target groups and their estimated resource needs have been identified as followed:

- The 1,500 individuals in the Multiple/Extreme Needs Group need 65% special skilled and 35% structured community residential alternatives.
- The 2,500 individuals comprising the Functionally Limited/Non-Accepting Group need 50% supported, 25% structured and 25% special skilled community residential alternatives.
o The 1,500 individuals in the Functionally Limited/Service Accepting Group need 50% supported, 35% structured and 15% special skilled community residential alternatives.

o The 2,500 individuals comprising the Ongoing Support Group need 60% supported and 40% structured community residential alternatives.

"Special need" subgroups were also identified and include:

- The elderly;
- The homeless;
- Hearing impaired individuals;
- Blind or visually impaired individuals;
- Non-english speaking persons;
- Dually diagnosed - alcohol/drug abusers;
- Dually diagnosed - mentally retarded/developmentally disabled persons;
- Those involved in forensic programs/corrections system;
- Personality disordered individuals;
- Those afflicted with rare or life threatening diseases;
- Those with organic brain syndromes; and
- Emerging emotionally disturbed young adults.

Individuals in the special need subgroups, who need community residential alternatives, are included in the four larger target groups but require special accommodations in the residential settings, specially trained staff or other adjustments to service delivery.
"There is no place like home."

Dorothy, *The Wizard of Oz* by Frank Baum
III. AN IDEAL RESIDENTIAL SPECTRUM FOR THE STATE OF OREGON

The Residential Spectrum Subcommittee of the Task Force convened over several months. Its tasks were to analyze current housing options; describe limitations and needs within currently available resources; and identify the variety of residential options which should exist. Chapter IV will deal with strengths and barriers of the current system. This chapter will summarize the "ideal residential spectrum" which evolved as the "Residential Spectrum Committee" and "Client Needs Committee" summarized and discussed their findings and identified necessary residential programs and housing support services.

RESIDENTIAL ALTERNATIVES

There are five general types of shelter used by people with psychiatric disabilities in Oregon:

1. Existing Community Housing - These are the houses, apartments and hotel rooms available to all community members on an ability-to-pay basis.

2. Community Residential Programs - These include a variety of programs which have "in-home" services available to the individual ranging from provision of meals and laundry services to skill training and treatment.

3. Crisis-Respite Care - These are local community alternatives to placement in a state mental hospital.

4. Institutionalization - This includes state mental hospitals.

5. Other - This includes jails, prisons, homeless shelters and the street.

The Task Force concentrated on Community Residential Programs and Crisis-Respite Care as defined above. However, since many people with psychiatric disabilities utilize the other alternatives, a brief discussion of them is warranted.

Existing Community Housing. The availability of housing varies from community to community. While it has not generally been considered the responsibility of mental health professionals to impact the availability of existing housing, it should be noted that the vast majority of persons with psychiatric disabilities who are served in state-funded programs are poor and have considerable difficulty acquiring safe, sanitary and affordable housing. Case managers often have the task of helping a consumer find an affordable place to live. Because there are many low-income persons competing for increasingly scarce low rent housing, it has become more and more difficult to locate adequate, affordable places to live. Because there is a direct relationship between the quality of a
person's living environment and his/her mental health stability, support of efforts to increase low rent housing options should be an agenda for mental health service providers and advocates.

Institutions. A comprehensive discussion of residential programs needs to acknowledge that persons with psychiatric disabilities do live in state hospitals from time to time. Hospitals have an appropriate role, and in fact, many possible roles which include:

- **Acute Intervention** - Treating individuals experiencing an onset of severe mental or emotional distress;

- **Stabilization** - Providing an environment and services which enable the individual to regain coping ability and get symptoms under control;

- **Care for People with Multiple Disabilities** - Serving individuals with complex needs (e.g., a psychiatric disability and mental retardation, substance abuse problems, physical health problems, mobility impairments, hearing loss and/or vision loss);

- **Asylum** - Providing a safe, protective environment for individuals too frightened, fragile or nonconforming to reintegrate within the community; and

- **Secure Environment** - Serving individuals who are dangerous to themselves or others.

Almost anything done in a hospital can be accomplished at the local community level. An important consideration, however, is at what cost. "Costs" to be considered include those associated with (a) acquiring and equipping a facility, (b) operating the program, (c) potential risks to a community, and (d) the inability to meet other needs due to limited resources. It would be helpful to clarify through state policy the role(s) of state hospitals. This would facilitate the differentiation of responsibilities among state hospitals and community programs and promote more effective collaboration.

Other Shelter. Because inadequate affordable housing and residential services exist, persons with mental illness become homeless or end up in jails or prison. While making their home on the road or in a correctional facility is not desirable, persons with psychiatric disabilities do find themselves using these alternatives.

**THE IDEAL SPECTRUMS**

The ideal spectrums of residential services for persons with psychiatric disabilities includes alternatives which vary as follows in their duration and focus:
- Long-term: Indefinite duration (typically three or more years) focused on providing a home on an ongoing basis.

- Transitional: Time-limited duration (typically three months to three years) focused on preparing the resident for a more independent living environment.

- Short-term: Very time-limited duration (typically less than one month) focused on re-stabilizing individuals when an increase in symptoms and/or stress makes continued living in the current situation unfeasible or undesirable.

"Community Residential Programs" include long-term and transitional alternatives whereas "Crisis-Respite Care," by definition, is short-term. Because Community Residential Programs are permanent or semi-permanent, housing options while Crisis-Respite options are always temporary, it seems most appropriate to conceptualize each of these categories as having its own spectrum of alternatives rather than being part of the same larger spectrum.

It should also be noted that while Community Residential Programs serve the needs of persons included in the target groups identified in Chapter II, Crisis-Respite Care might be utilized by any psychiatrically disabled person. All psychiatrically disabled persons, by definition, are at risk of hospitalization.

Community Residential Programs. The Residential Spectrum Subcommittee identified residential program models that are needed. Some of these already exist and others are new and need to be developed. With the understanding that the array of community residential programs will need to be flexible and change in accordance with varying consumer needs, the following programs were identified as necessary components of the ideal residential spectrum (they are roughly in order from least structured/restrictive to most structured/restrictive). They can be conceptualized in three general groupings: supported, structured and special skilled.

1. SUPPORTED. These include the least structured/restrictive options, many of which are non-facility-based and/or not 24-hour staffed. They include:

   A. Independent Living Support Services
   B. Support to Families Providing Housing
   C. In-home Services
   D. Tenant Support Apartment Program (less than 24-hour staffing)
   E. 24-Hour Staffed Apartment Program
   F. Partial-Day Staffed Facility
G. Fairweather Lodge (communal work program)

H. Boarding Home (Room and Board only)

II. STRUCTURED. These include moderately structured alternatives which provide 24-hour supervision and generally employ caregivers with minimal training. They include:

   I. Family-Style Care⁸ - Maintenance Emphasis
   J. Relative Foster Care (provider is family)
   K. Family-Style Care⁸ - Special Needs/Treatment Emphasis
   L. Residential Treatment Facility - Transitional Emphasis
   M. Residential Treatment Facility - Maintenance Emphasis
   N. Hospital-Based Supportive Housing

III. SPECIAL SKILLED. These include the most structured, 24-hour supervised alternatives. There is a more intensive treatment component, and staff will be professionals or specially trained caregivers. They include:

   O. Small Intensive Treatment Home
   P. Intensive Residential Treatment Facility
   Q. Intermediate Care Facility - Psychiatric Emphasis
   R. Skilled Nursing Facility - Psychiatric Emphasis

These are more fully described in Table I on pages 31-32. It should be noted that these models are not mutually exclusive but overlap. Many of them can be seen as having a long-term and/or transitional emphasis. Any model can be adapted as a "specialized" resource to meet a particular special need.

⁸ This term includes programs currently called "Adult Foster Care."
### TABLE I

#### IDEAL COMMUNITY RESIDENTIAL ALTERNATIVES SPECTRUM *

#### I. SUPPORTED Community Residential Alternatives:

<table>
<thead>
<tr>
<th>Alternative</th>
<th>Who Served</th>
<th>Description of Service Program</th>
<th>Staffing Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Independent Living Support Services</td>
<td>Psychiatically disabled persons who live in independent housing units but need ongoing support, assistance and training.</td>
<td>Specialized case manager/team serving clients in scattered units or clusters of apartments. Focus is to create peer support network through social activities/groups.</td>
<td>Outreach-oriented case manager(s) capable of teaching skills. Staff: client ratio not to exceed 1:15.</td>
</tr>
<tr>
<td>B. Support to Families Providing Housing</td>
<td>Psychiatically disabled person who receives support and care from and lives with family.</td>
<td>Provision of support, consultation and possibly relief coverage for families who house a psychiatically disabled family member.</td>
<td>Specialized case manager or staff consultant.</td>
</tr>
<tr>
<td>C. In-Home Services</td>
<td>Psychiatically disabled persons who live in independent or supported housing but need regular assistance with budgetting, meals, cleaning, etc.</td>
<td>Ancillary service which is arranged to provide required assistance on regular, visiting basis.</td>
<td>Homemaker/Money Manager/etc. depending on client's needs.</td>
</tr>
<tr>
<td>D. Tenant Support Apartment Program</td>
<td>Psychiatically disabled persons who tend to socially isolate, need assistance/training/support and prefer apartment living.</td>
<td>Provision of onsite support, assistance and training without 24-hour supervision in small apartment complex or cluster of units in larger building.</td>
<td>Supportive landlord and 1 or more staff to provide services.</td>
</tr>
<tr>
<td>E. 24-Hour Staffed Apartment Program</td>
<td>Psychiatically disabled persons who require support, assistance and/or training on a frequent or unpredictable basis.</td>
<td>Provision of onsite support, assistance and training with staff available on 24-hour basis in small apartment complex or cluster of units in larger building.</td>
<td>Resident Manager and additional staff depending on needs and number of clients.</td>
</tr>
<tr>
<td>F. Partial-Day Staffed Facility</td>
<td>Psychiatically disabled persons who prefer group living, require frequent services but not 24-hour staff availability.</td>
<td>Services provided in congregate living arrangement ranging from meals and housecleaning to support and training with less than 24-hour staffing.</td>
<td>1 or more staff depending on needs of residents and number in household.</td>
</tr>
<tr>
<td>G. Fair-weather Lodge</td>
<td>Psychiatically disabled persons who need/want to live in supportive, group quarters and desire work opportunities as part of program.</td>
<td>Communal work program in congregate facility with cooking, chores and income-generating business activities shared among residents, and staff provide assistance with problem-solving and technical expertise.</td>
<td>1-2 staff who regularly visit facility to provide consultation, support and assistance.</td>
</tr>
<tr>
<td>H. Boarding Home</td>
<td>Psychiatically disabled persons who can manage their medications, money and other affairs but need meal and housekeeping services.</td>
<td>Facility or home where meals and housekeeping services are provided but not care, supervision or other services.</td>
<td>Facility owner/manager, cook/housekeeper(s).</td>
</tr>
</tbody>
</table>

#### II. STRUCTURED Community Residential Alternatives:

<table>
<thead>
<tr>
<th>Alternative</th>
<th>Who Served</th>
<th>Description of Service Program</th>
<th>Staffing Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Family-Style Care – Maint. Emphasis</td>
<td>Older and/or dependent psychiatically disabled persons who are unable to meet basic needs independently.</td>
<td>Resident family caregiver provides 24-hour supervision, room, board, care and assistance with the activities of daily living on long-term basis.</td>
<td>Trained family provider and relief caregivers.</td>
</tr>
<tr>
<td>J. Relative Foster Care</td>
<td>Psychiatically disabled persons who require care and it is mutually desirable to live with family.</td>
<td>Family provides 24-hour supervision, room, board, care and assistance with daily living activities to a relative on a long-term basis.</td>
<td>Family member(s) and relief caregivers.</td>
</tr>
</tbody>
</table>

* Each of these program models assumes that a complete range of Community Support Services (e.g. case management and medication monitoring) are available for all residents.
## TABLE I (CONTINUED)
### IDEAL COMMUNITY RESIDENTIAL ALTERNATIVES SPECTRUM

#### II. STRUCTURED Community Residential Alternatives (continued):

<table>
<thead>
<tr>
<th>Alternative</th>
<th>Who Served</th>
<th>Description of Service Program</th>
<th>Staffing Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>K. Family-Style Care-Treatment Emphasis</td>
<td>Psychiatrically disabled persons who have special needs (e.g., hearing impaired, blind, mobility impaired) and/or need skill development.</td>
<td>Skilled family caregiver provides 24-hour supervision, room, board, care/skill training and special services as individually determined on transitional or long-term basis.</td>
<td>Skilled family provider, possibly additional staff, and relief caregivers.</td>
</tr>
<tr>
<td>L. Resid.-Treatm.-Transit.-Emphasis</td>
<td>Psychiatrically disabled persons who are younger and/or need skill development before able to manage basic needs in more independent settings.</td>
<td>24-hour supervised, non-medical facility providing room, board and rehabilitative services directed toward preparing residents for more independent living.</td>
<td>Administrator, Residential Counselor(s), Residential Aide(s) and Night Manager(s).</td>
</tr>
<tr>
<td>M. Resid.-Treatm.-Maint.-Emphasis</td>
<td>Older and/or dependent psychiatrically disabled persons who are unable to meet basic needs independently.</td>
<td>24-hour supervised, non-medical facility providing room, board, care and assistance with the activities of daily living on a long-term basis.</td>
<td>Administrator, Care Coordinator, Residential Aides, Cook/Housekeeper(s), Night Manager(s).</td>
</tr>
<tr>
<td>N. Hospital-Based Resid.-Program</td>
<td>Psychiatrically disabled persons who don't need the medical care of the hospital but are too frightened or unwilling to live in the community.</td>
<td>Can be done with most models. The key is to develop housing on or near hospital grounds so continuity of hospital support services is assured.</td>
<td>(See applicable model.)</td>
</tr>
</tbody>
</table>

#### III. SPECIAL SKILLED Community Residential Alternatives:

<table>
<thead>
<tr>
<th>Alternative</th>
<th>Who Served</th>
<th>Description of Service Program</th>
<th>Staffing Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>O. Small Intensive Treatm. Home</td>
<td>Psychiatrically disabled persons with serious behavior problems/skill deficiencies of a non-medical nature.</td>
<td>24-hour supervised, non-medical facility providing room, board, treatment and other services to enhance/maintain resident's psychiatric adjustment. Serves five or fewer.</td>
<td>Resident Manager, Residential Counselor(s), Residential Aide(s). All specially trained.</td>
</tr>
<tr>
<td>P. Intensive Resid.-Treatm.-Facility</td>
<td>Psychiatrically disabled persons with serious behavior problems/skill deficiencies of a non-medical nature.</td>
<td>24-hour supervised, non-medical facility providing room, board, treatment and other services to enhance/maintain resident's psychiatric adjustment. Serves six or more.</td>
<td>Administrator, Residential Counselors, Residential Aides, Cook/Housekeeper(s), Night Manager(s). All specially trained.</td>
</tr>
<tr>
<td>Q. Intermed. Care Fac.-Psych. Emphasis</td>
<td>Psychiatrically disabled persons with health problems and/or behavior problems which threaten health status.</td>
<td>24-hour supervised nursing home providing room, board, care and services to enhance/maintain psychiatric status and physical health problems.</td>
<td>Nursing Home Administrator, Psychiatric Nurse, Specilized Nurse Aides, Psychiatric Consultation, Cook/Housekeepers.</td>
</tr>
<tr>
<td>R. Skilled Nursing Facility-Psych. Emphasis</td>
<td>Psychiatrically disabled persons with serious or acute physical health problems.</td>
<td>Same as above, except with more intensive level of medically trained staff and emergency response capability.</td>
<td>Nursing Home Administrator, Psychiatric Nurses, Specially Trained Nurse Aides, Psychiatric consultation, M.D.s, Cook/Housekeepers.</td>
</tr>
</tbody>
</table>
CRISIS-RESPITE CARE

These programs are directed at preventing or diverting individuals from state mental hospitalization. They are "short-term" alternatives and serve two levels of need:

- **Acute** - Persons experiencing an acute psychiatric disturbance and at immediate risk of hospitalization.

- **Sub-Acute** - Persons one step removed from impending hospitalization but not stable enough to maintain residency in existing community housing or community residential programs. This category includes persons just discharged from the hospital, those just beginning to experience an exacerbation of symptoms, those needing respite from a stressful living environment or those without resources and facing homelessness.

Program models which comprise an ideal spectrum of Crisis-Respite Care alternatives include:

A. Mobile Crisis Support

B. Specialized Motel/Hotel/Other Temporary Housing

C. Respite Beds in Other Residential Programs

D. Specialized Emergency Shelter Services

E. Family Crisis Home

F. Group Crisis Home

G. Emergency Beds in Nursing Home Settings

H. Holding Room in Secure Community Setting

I. Local Inpatient Hospitalization

These are more fully described in Table II on page 34. Crisis-Respite alternatives are not intended to stand alone. Linkage to ongoing service resources is imperative. Crisis-Respite alternatives, like the state hospital, can become overutilized when insufficient community residential programs and other services exist. A critical aspect of each Crisis-Respite program is "discharge planning" which assists clients in obtaining permanent housing and services in accordance with their individual needs (Stroul, 1987).
<table>
<thead>
<tr>
<th>Alternative</th>
<th>Who Served</th>
<th>Description of Service Program</th>
<th>Staffing Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Mobile Crisis Support</td>
<td>Persons experiencing acute psychotic/emotional distress or subacute distress who are clinically judged capable of remaining in current residence.</td>
<td>Crisis outreach services provided at client's residence to individual experiencing crisis and their support network. Onsite support is either available or arranged (will typically be a family member or friend).</td>
<td>Crisis intervention professionals; psychiatrists available for medication-monitoring. Trained peer worker/family member/other available on site.</td>
</tr>
<tr>
<td>B. Motel/Hotel/Other Temporary Housing</td>
<td>Persons who are psychiatrically disabled and without housing who are clinically judged to be experiencing a manageable level of stress.</td>
<td>Comfortable, clean, safe and secure housing in a non-supervised setting. Mental health services on visiting basis to provide support, assessment and assistance with resource acquisition.</td>
<td>Willing, supportive and capable landlord. Back-up assistance from mental health professionals and psychiatric consultation.</td>
</tr>
<tr>
<td>C. Respite Beds in Other Residential Programs</td>
<td>Persons experiencing subacute exacerbation of stress and/or symptoms.</td>
<td>Temporary placement in a residential program which generally provides longer term housing and services.</td>
<td>As required for the residential program type. Back-up assistance from mental health staff and psychiatric consultation.</td>
</tr>
<tr>
<td>D. Specialized Emergency Shelter</td>
<td>Homeless persons who have a psychiatric disability and are experiencing &quot;manageable&quot; acute or subacute distress.</td>
<td>Supervised &quot;dormitory-style&quot; overnight accommodations with crisis intervention and information and referral services available on site.</td>
<td>Shelter supervisor(s); residential counselor(s). Back-up assistance from mental health professionals and psychiatric consultation.</td>
</tr>
<tr>
<td>E. Family Crisis Home</td>
<td>Persons experiencing &quot;manageable&quot; distress or symptoms.</td>
<td>Trained &quot;natural helper&quot; family to provide room, board, crisis stabilization support and 24-hour supervision in their home.</td>
<td>Trained family. Back-up assistance from mental health staff and psychiatric consultation.</td>
</tr>
<tr>
<td>F. Group Crisis Home</td>
<td>Same as E.</td>
<td>24-hour supervised non-medical facility providing room, board, care and services to stabilize psychiatric distress and physical health problems.</td>
<td>Resident Manager/Resident Counselor(s). Back-up assistance from mental health staff and psychiatric consultation.</td>
</tr>
<tr>
<td>G. Emergency Beds in Nursing Home Settings</td>
<td>Persons experiencing physical health problems along with an exacerbation of symptoms or stress.</td>
<td>24-hour supervised nursing home providing room, board, care and services to stabilize psychiatric distress and physical health problems.</td>
<td>As required for nursing home. Staff trained in psychiatric care. Back-up assistance from mental health staff and psychiatric consultation.</td>
</tr>
<tr>
<td>H. Holding Room in Secure Community Setting</td>
<td>Persons experiencing acute psychotic or emotional distress and unable to care for basic needs or potentially harmful to self or others.</td>
<td>Comfortable, safe, secure room in setting close to immediate psychiatric intervention, such as emergency room in psychiatric hospital. 24-hour supervision, meals and crisis stabilization services.</td>
<td>Trained crisis intervention workers on site when room in use. Back-up assistance from mental health staff and psychiatric supervision.</td>
</tr>
<tr>
<td>I. Local Inpatient Hospitalization</td>
<td>Persons experiencing acute psychotic or emotional distress and unable to care for basic needs or potentially harmful to self or others.</td>
<td>24-hour supervised, secure psychiatric hospital. Therapeutic and medication interventions directed at rapidly stabilizing client and returning them to community housing.</td>
<td>As required for hospital psychiatric ward.</td>
</tr>
</tbody>
</table>
SUMMARY

Five general types of shelter are used by people with psychiatric disabilities in Oregon: (1) existing community housing, (2) community residential programs, (3) crisis-respite care, (4) institutionalization and (5) other places including correctional facilities, homeless shelters and the street. The Task Force focused on community residential programs and crisis-respite care, and identified ideal spectrums of alternatives for these two general categories.

Community residential programs provide long-term and/or transitional living situations and services. They include "supported," "structured" and "special skilled" alternatives. Supported community residential programs are the least restrictive options, and are mostly non-facility-based and non-24-hour staffed. Supported alternatives include independent living support services, partial day-staffed facilities and boarding homes. Structured community residential programs are moderately structured, provide 24-hour supervision and generally employ minimally trained direct care staff. Structured alternatives include adult foster care homes and transitional- or maintenance-emphasis residential treatment facilities. Special skilled community residential programs are the most structured alternatives; they are 24-hour supervised, include a more intensive treatment component, and have professional or specially trained staff.

Crisis-respite alternatives provide short-term housing and services for persons experiencing acute or sub-acute psychiatric distress. Crisis-respite alternatives range from local inpatient hospitalization to temporary housing with mobile crisis support available on site, as needed.
CHAPTER IV

THE CURRENT SYSTEM — STRENGTHS AND BARRIERS

Every problem contains the seeds of its own solution.

Stanley Arnold
IV. THE CURRENT SYSTEM — STRENGTHS AND BARRIERS

It was less than ten years ago that residential services became part of the Mental Health Division's responsibility. In 1979, 29 "group homes" for the mentally ill transferred to the Mental Health Division from the Adult and Family Services Division. Until very recently, residential programs for psychiatrically disabled persons primarily consisted of Residential Care Facilities (or "group homes"), Adult Foster Care Homes and Semi-Independent Living Programs. Crisis-respite alternatives were also developed and operated on a small family home basis or through utilization of vacant beds in Residential Care Facilities.

The availability of residential services has fluctuated over the years. Figure 1 on page 41 shows the number of contracted slots for Fiscal Years 1983-84 to 1987-88. Since FY 1983-84, the number of Residential Care Facility beds declined by 172 (25%), while Semi-Independent Living Program services have doubled. The availability of Adult Foster Care has remained fairly constant until recently. The turnover rate of Adult Foster Care providers has been increasing, making Adult Foster Care a difficult service element to maintain.

Boarding homes operate on a proprietary basis and their availability is difficult to track. As a result of publicity given to problems occurring in these once unregulated homes, the State Legislature and some local jurisdictions have passed bills or ordinances to govern their operation. This increased regulation combined with financial constraints has resulted in the closure of many boarding homes. Data available for the Southeast Portland area illustrates this. The number of boarding homes decreased from fourteen in 1983 to four in 1987. Correspondingly, the percentage of clients residing in boarding homes dropped from 21% to 8%.

The general picture of Oregon's residential services for the psychiatrically disabled in recent years shows a decline of structured residential resources while semi-independent living programs have increased. While there has been an increasing emphasis on reducing state hospital utilization, there have been fewer and fewer of the community residential alternatives available which have traditionally been used to transition people with psychiatric disabilities from the hospital to community settings. Table III shows the living arrangements to which general psychiatric patients of state mental hospitals were discharged. Only 10% of those discharged after a first admission and 14% after a readmission were placed in residential programs. Hospital social workers attribute these low percentages to limited availability of resources rather than low levels of need.

Paul J. Carling, Ph.D., Director of the Center for Change through Housing and Community Support at the University of Vermont, has studied national trends. He estimates that residential programs across the country have

---

9 Information from a Housing Needs Assessment conducted at Southeast Mental Health Network, Inc., the Multnomah County subcontract agency serving the S.E. Portland geographical area.
Figure 1

Availability of MED Residential Resources
Fiscal Years '83-'84 to '87-'88

- 721 implemented as of 6/88 due to phase-in.
# 260 actually served due to special payments and provider turnover.
increased from "fewer than 500 a decade ago to perhaps 6,000 today." Over half of the current programs were developed in the 1980s.10

As a result of the Task Force's work, advocacy efforts and studies on the needs of difficult clients, new programs and some flexibility in funding of programs have recently been approved. These include "psychiatric emphasis" Intermediate Care Facility beds, an Intensive Residential Treatment Facility for dual diagnosis (mentally ill and substance abusing) consumers and "intensive case management" services tied to supporting individuals in existing community housing resources.

Additional history on residential programs in Oregon for people with psychiatric disabilities has been well documented elsewhere (MHD report on Community Residential Programs for the Mentally Ill, 1986). This section of the report, therefore, concentrates on the strengths and barriers of the current system.

STRENGTHS

The positive characteristics of residential services for psychiatrically disabled persons in Oregon will be reviewed first. They can be summarized as follows:

1. **Emphasis on Semi-Independent Living.** In contrast to many other parts of the nation where group homes and other structured residential programs dominate, Oregon has established a funding category for and promoted the development of Semi-Independent Living Programs. These programs vary widely throughout the state from "visiting staff" to "on-site staff" models, but all provide skill training and support services to consumers at their place of residence and encourage the maintenance of permanent, decent living situations.

2. **Fewer Substandard Facilities.** The overall quality of state-funded programs has increased as inspections which monitor compliance with licensing requirements have improved. Substandard programs, which could not meet the requirements after receiving consultation and being given time to make improvements, have been closed.

3. **Target Population Is Being Served.** Entry to residential services has been increasingly restricted to "chronically mentally ill" consumers at risk of hospitalization. A recent study (State Mental Health Division Report on Community Residential Programs for the Mentally Ill, 1986) found that state-funded residential programs serve the more severely disabled members of the "chronically mentally ill" population. Eighty-five percent (85%) of residents in state-funded programs had state hospitalizations averaging 3.8 prior admissions with an average length of stay of about 290 days. This sharply contrasts to statistics for all General Psychiatric patients in state hospitals, 89% of whom are discharged within the first 90 days of admission.

---

10 Quote was taken from "Implementing a Supported Housing Approach: Final Report of a Meeting of State Mental Health Directors," February 1988, prepared by Paul J. Carling and Susan F. Wilson.
TABLE III*
Living Arrangements of
General Psychiatric Patients at Discharge
Oregon State Mental Hospitals
Fiscal 1988

<table>
<thead>
<tr>
<th>Living Arrangement</th>
<th>Salem Area Number</th>
<th>% of Discharged</th>
<th>State Number</th>
<th>% of Discharged</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A: First Admissions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alone or Friend</td>
<td>81</td>
<td>35.2%</td>
<td>486</td>
<td>34.8%</td>
</tr>
<tr>
<td>Family</td>
<td>86</td>
<td>37.4%</td>
<td>469</td>
<td>33.5%</td>
</tr>
<tr>
<td>Residential Program (a)</td>
<td>21</td>
<td>9.1%</td>
<td>141</td>
<td>10.0%</td>
</tr>
<tr>
<td>Local Correction(b)</td>
<td>14</td>
<td>6.1%</td>
<td>54</td>
<td>3.8%</td>
</tr>
<tr>
<td>Hospital or Institution(c)</td>
<td>12</td>
<td>5.3%</td>
<td>97</td>
<td>6.9%</td>
</tr>
<tr>
<td>Room and Board or</td>
<td>10</td>
<td>4.3%</td>
<td>103</td>
<td>7.3%</td>
</tr>
<tr>
<td>Emergency Shelter</td>
<td>6</td>
<td>2.6%</td>
<td>52</td>
<td>3.7%</td>
</tr>
<tr>
<td>Other or Unknown</td>
<td>10</td>
<td>4.3%</td>
<td>103</td>
<td>7.3%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>230</td>
<td>100.0%</td>
<td>1,398</td>
<td>100.0%</td>
</tr>
<tr>
<td>B: Readmissions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alone or Friend</td>
<td>196</td>
<td>37.4%</td>
<td>880</td>
<td>41.5%</td>
</tr>
<tr>
<td>Family</td>
<td>95</td>
<td>18.1%</td>
<td>449</td>
<td>21.2%</td>
</tr>
<tr>
<td>Residential Program (a)</td>
<td>106</td>
<td>20.2%</td>
<td>300</td>
<td>14.1%</td>
</tr>
<tr>
<td>Local Correction(b)</td>
<td>23</td>
<td>4.4%</td>
<td>71</td>
<td>3.4%</td>
</tr>
<tr>
<td>Hospital or Institution(c)</td>
<td>28</td>
<td>5.4%</td>
<td>89</td>
<td>4.3%</td>
</tr>
<tr>
<td>Room and Board or</td>
<td>48</td>
<td>9.2%</td>
<td>160</td>
<td>7.5%</td>
</tr>
<tr>
<td>Emergency Shelter</td>
<td>28</td>
<td>5.3%</td>
<td>168</td>
<td>8.0%</td>
</tr>
<tr>
<td>Other or Unknown</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>524</td>
<td>100.0%</td>
<td>2,121</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: Mental Health Division Program Analysis Section computer printout, "Discharges by Discharge County by Living Arrangement from 7/1/85 through 6/30/86."

\(a\) Includes Adult Foster Homes, Residential Facilities, Intermediate Care Facilities (skilled or semiskilled nursing facilities), SSD Foster Care, A&D Halfway Houses, and Semi-Independent Living Programs.

\(b\) Includes Jails and other local holding facilities, e.g., courts.

\(c\) Includes state hospitals, general hospitals, veterans' hospitals, Oregon Health Sciences Center, juvenile detention centers, and juvenile training schools.

* This Table is reproduced from a report entitled Salem Area Institutions, prepared by the Bureau of Government Research and Service, University of Oregon, 1987.
4. **Model Programs.** Many Oregon residential service providers have been locally and nationally recognized for the creativity and progressiveness of their program models. The influence of the Oregon Community Support Project in the early 1980s and the "pioneering" spirit of dedicated individuals contributed to the development of these model programs.

5. **Data Base Now Available.** Several studies have been done and reports produced. Better information is now available on the types of programs needed; the needs of difficult-to-house, repeat hospital users; and the characteristics of persons served in existing programs. This data can be used to facilitate planning and decision-making.

6. **Quality of Life Is Good.** On the whole, those consumers residing in state-funded community programs are reasonably safe, well fed and clothed, and have reasonable access to mental health care. In contrast to the many homeless or substandardly housed people with psychiatric disabilities, the basic needs of clients in state-funded residential programs are being met.

7. **Effective Utilization of Subsidized Housing.** Staff of community programs have learned how to access subsidized housing resources. Their efforts have included working with local housing authorities, developing HUD 202 projects and working with the State Housing Agency.

**BARRIERS**

Despite the strengths in the current system of residential services, there are areas which need improvement. Barriers or weaknesses fall into five general categories: a) system and coordination issues, b) restrictive financial conditions, c) staffing/provider dilemmas, d) lack of local community support, and e) administrative barriers. The specific areas needing improvement are summarized as follows:

**A. System and Coordination Issues.**

A-1. **Limited Availability of Resources.** In general, there are not enough residential programs to meet the needs of psychiatrically disabled consumers. This is true in terms of both the quantity and type of housing. In other words, both additional slots and more variety in options are needed. Many individuals who need and desire a community residential program cannot get in due to the high demand and occupancy rates. A summary of the number and type of residential slots needed appears in Appendix E. Not all counties have a full array of needed resources while a couple of counties have too much of one type of residential program and not enough of others. This can result in an influx of persons from other communities to these "high-impact" counties while the "home communities" continue to have difficulty meeting needs locally and the high-impact counties gain additional numbers of individuals to serve. An analysis of the distribution of resources appears in Table IV. Proportionately, larger numbers of resources exit in the Salem and Portland metropolitan areas.
Table IV*

Licensed Facilities and Capacity of M-ED Residential Care and Residential Training Facilities
September 24, 1986

<table>
<thead>
<tr>
<th>REGIONb</th>
<th>FACILITIES^</th>
<th>CAPACITY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NUMBER</td>
<td>% OF STATEWIDE</td>
</tr>
<tr>
<td></td>
<td>STATEWIDE TOTAL</td>
<td></td>
</tr>
<tr>
<td>Salem Metro Area</td>
<td>11</td>
<td>38.0%</td>
</tr>
<tr>
<td>Portland Metro Area</td>
<td>12</td>
<td>41.4%</td>
</tr>
<tr>
<td>Eugene Metro Area</td>
<td>2</td>
<td>6.9%</td>
</tr>
<tr>
<td>Rest of Valley</td>
<td>1</td>
<td>3.4%</td>
</tr>
<tr>
<td>Northwest Oregon</td>
<td>1</td>
<td>3.4%</td>
</tr>
<tr>
<td>Southwest Oregon</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Eastern Oregon</td>
<td>2</td>
<td>6.9%</td>
</tr>
<tr>
<td>State Total</td>
<td>29</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: Mental Health Division, M-ED Program Office (September 24, 1986).

^ Includes residential care facilities, residential training facilities, and one small intensive treatment home in Portland.

b To facilitate the analysis, the state was divided into seven substate regions defined by the following groups of counties:

- Salem Metro Area: Marion, Polk
- Portland Metro Area: Clackamas, Multnomah, Washington
- Eugene Metro Area: Lane
- Rest of Valley: Benton, Linn, Yamhill
- Northwest Oregon: Clatsop, Columbia, Lincoln, Tillamook
- Southwest Oregon: Coos, Curry, Douglas, Jackson, Josephine
- Eastern Oregon: Eighteen counties east of the Cascades

* This Table is reproduced from a report entitled Salem Area Institutions, prepared by the Bureau of Government Research and Service, University of Oregon, 1987.
A-2. **Lack of Comprehensive Needs Assessment Data.** Although we know we need more and better distributed resources, we do not know exactly how many people need which kinds of housing programs. Although data is available on specific subgroups of the population (e.g., "hard-to-place" Dammasch patients), there is no comprehensive picture of needs throughout the State.

A-3. **Scarcity of Affordable Housing.** Most communities have many fewer low-rent housing options than are needed. Competition for these is fierce. Waiting lists for subsidized housing are long. Persons with mental illness do not tend to be good advocates for their needs and often end up homeless or in substandard settings.

A-4. **Impact of Having Reduced Hospital Census Tied to Funding for Residential Programs.** Although no one would deny that priority for residential placement should be given to state hospital users, limiting access to this group creates a system wherein persons with psychiatric disabilities must become more ill and experience repeated hospitalizations before they can access services. This is neither humane nor cost-effective.

A-5. **Lack of Coordinated Planning for New Resources.** Housing program development generally involves at least two separate funding sources: (1) one directed at acquiring the facility or physical structure and (2) one directed at paying for the services to be provided to residents. There is no mechanism for coordination between these resource allocators. In addition, the physical structure development process can take several years, and the State Mental Health Division (MHD) which typically provides service funding, has been unable to guarantee funding availability so far in advance. The result has been inadequately funded resources which cannot serve the more disabled consumers.

A-6. **Problems With Continuity of Service Provision.** When a Residential Care Facility closes, what measures can be taken to facilitate development of a replacement program? What planning can be done to insure that the new program will endure and the quality of its services will be assured? There is a trend in some counties to acquire a facility which is publicly owned (or owned by a non-profit entity) and recruit staff to work there (agency-operated model) rather than to contract with a provider who then is responsible for finding the facility and operating the program (private contractor model). The advantage of the agency-operated model is that the facility is stable and residents do not have to move when the staffing changes. In the private contractor model, all is lost and you have to begin from scratch when the contract is terminated.

Similarly it has been difficult to recruit and retain foster care providers and insure continuity of this service element. Until competitive service payment rates are provided, it is unlikely that this situation will improve.
A-7. **Title XIX Waiver Program.** The more structured residential programs are partially funded with federal Title XIX monies. In order for these funds to be made available, residents must be assessed and found to need certain nursing home-type services but capable of receiving these services in a less structured setting. The Title XIX Waiver imposes much paperwork and some restrictions on the residential service system.

A-8. **Complicated Service Payment Systems.** While overall management responsibility for residential programs serving the mentally ill was transferred from the Adult and Family Services Division (AFS) over the past ten years, income eligibility determination and partial responsibility for service payment approval has remained with AFS. The result is a complicated system of paying providers for services.

While all providers collect rent (and board fees, as applicable) from residents, service payments are paid directly to the provider in the case of Residential Care Facilities but are paid to the resident in the case of foster care. Because AFS checks sometimes do not arrive promptly (especially in the case of emergency placements), a foster care provider may provide several weeks of care only to find that the resident elopes with the check as soon as it arrives. This becomes a difficult situation to remedy.

A-9. **Coordination with and Access to Other Services.** Residents in residential programs are often recipients of multiple services. Problems with overall service coordination and lack of agreement on treatment goals are not uncommon. In other cases, needed Community Support Services are not available or access is denied due to long waiting lists. In some residential facilities, several residents may attend day programs while others needing and desiring participation in a day program cannot get in.

Some persons with psychiatric disabilities have housing needs best met through a non-M-ED resource. For example, a psychiatrically disabled person with a dual diagnosis of mental retardation might be better served in a group home for mentally retarded persons, or an elderly mentally ill person might be best served in a home for the aged. It is often hard to arrange these placements due to insufficient resources, lack of cooperation and budget concerns.

A-10. **Problems with Merging the Residential Case Management Function with Community Support Services.** Because service availability and coordination was problematic, the Residential Case Management Service Element was eliminated and the function was incorporated into the "Community Support Services (CSS) Element." While this action makes sense at a conceptual level, adequate funding and planning did not accompany the effort. Thus, the two "high impact" counties (Marion and Multnomah) must sustain higher CSS caseloads without corresponding compensation. In addition, planning activities (e.g., revising CSS administrative rules to incorporate
residential case management accountability and studying the impact on CSS caseloads and facility admissions/utilization did not take place.

A-11. Need Better Protective Services. A more effective system for investigating and acting upon protective service complaints is needed. Assigning and defining responsibility, offering training to those designated responsible and providing funding for staff are necessary.

A-12. Lack of Assessment' and Rehabilitative Services. Most existing structured residential programs were developed to serve more dependent, deinstitutionalized persons. They provide room, board and care. Inadequate attention has been paid to assessing residents' strengths and needs and providing rehabilitative services.

B. Restrictive Financial Conditions.

B-1. Poverty Level of Clients. A basic problem with obtaining housing is economic. Most clients do not have the financial resources required to purchase the housing and support services they need. The report of the National Housing Task Force (1988) notes that one in seven Americans live below the poverty line (i.e., has an annual income less than $5,572 for an individual). The annual income of psychiatrically disabled person who receive General Assistance or SSI (disability benefits) is $2,700 to $3,700 annually.

B-2. Inadequate Funding Levels for Existing Residential Programs. Residential programs for the psychiatrically disabled are funded at lower rates with higher expectations than most comparable state-funded programs for other populations. This creates a disincentive when providers are recruited, staff are hired and programs try to operate within budget limits. This problem is illustrated through the following comparisons:

- Adult Foster Care providers for the M-ED population receive an average service payment rate of $190.00 per client per month. Adult Foster Care providers serving the frail elderly receive an average of $270.50 per client per month. When comparing two providers serving 5 clients each, the one serving the elderly would receive $4,830 more per year than the one serving persons with psychiatric disabilities. A 1986 survey of M-ED providers found that 54% of them were considering terminating their M-ED contracts and/or becoming Senior Services Division providers (Kingfair, 1986).

- Direct Care Staff wages are funded at $4.52/hour in Residential Care Facilities (RCFs) and are substantially lower than wages for Psychiatric Aide I and II positions, funded at $6.71-9.08 per hour, at the state hospitals even though job responsibilities do not vary to a degree that warrants the difference. RCF direct care staff wages would
have to be increased by 49-101% for equity to be achieved with Psychatric Aide wage rates. RCF direct care staff wages are currently so low that staff trying to support themselves typically qualify for such low-income benefits as Section 8 rent subsidies and winter fuel subsidies. This situation makes it difficult to retain quality staff and results in high turnover rates, long periods where vacant positions go unfilled, and burnout among other staff who must work extra-long hours.

Similarly, Semi-Independent Living (SIL) programs are funded at a level which limits their effectiveness with the more skill deficient clients. While SIL programs are often viewed as serving only the higher functioning clients, this becomes a self-fulfilling prophecy because the level of funding provided limits the type of clients who can be served to those who can survive in an independent living situation with only about one to four hours per week of support services. Programs which have supplemented state-funding have proven to be successful in serving more disabled clients. If a funding range could be established for SIL programs, a broader range of clients' needs could be addressed. In particular, those more dysfunctional clients in need of increased support to develop coping and daily living skills could effectively be served if a higher slot rate were available.

In summary, if adequate funding were available, state-funded residential programs would be more effective in serving the target population: chronically mentally ill persons at risk of rehospitalization. There is currently a wide gap between the funding level of the most common, structured community residential programs (RCFs) and state hospitalization. RTFs receive an average of $21/day (of which $12 is the state-funded service payment and $9 is the room and board fee collected from the resident). In contrast, it costs about $125/day to maintain someone at a state hospital.

B-3. Lack of Funds for Start-Up Expenses. When new programs are funded, there is not always enough funding made available for start-up expenses. Inadequate funding for program development expenses can result in a program being established on an unstable foundation. Staff orientation and training; acquisition of furnishings, equipment and supplies; establishment of policies, procedures and records; and screening and orientation of residents can all be adversely impacted if adequate start-up support is not made available.

B-4. Financial Catastrophes. Because residential programs operate on such tight budgets, the costs of a major structural repair, lawsuit or other unanticipated large expense could cause a program to go bankrupt and close. Though the Mental Health Division has occasionally been able to make grants available when non-compliance with licensing regulations results from lack of fiscal resources, this assistance has not been consistently available.
B-5. **Liability Concerns/Escalating Insurance Costs.** Like other service providers, residential providers have become increasingly concerned with liability, especially as the resident population has become more severely disabled and potentially problematic. The cost of liability insurance has escalated, and its availability has become increasingly scarce. Another result of liability exposure concerns are increased costs for additional recordkeeping and staff coverage.

C. **Staffing/Provider Dilemmas:**

C-1. **Staff Burnout.** Considering that residential staff are paid the lowest of all mental health positions, that staff are required to stay on site through lunch hours and breaks and that the work can be intense and demanding, it is not surprising that "burnout" occurs frequently.

C-2. **Staff Turnover.** Due to demanding workloads and low wages, it is not unusual for residential programs to experience high staff turnover. Some programs continually advertise for staff and experience turnover in positions as often as every six months. Residential facility staff positions are commonly viewed as the mental health field's entry level jobs. Staff often either burnout or move to higher paying jobs as they become available.

C-3. **Recruitment Difficulties.** Once a program is conceptualized and funded, it is often very difficult to recruit quality providers/staff. Replacing staff who resign or a provider whose contract is terminated is also a challenge. These difficulties derive from inadequate salaries and fringe benefits and the lack of other incentives. Along with better wages and benefits, the availability of relief staff coverage and ongoing training would also help to make the job more attractive.

C-4. **Need for Relief Staff/Respite for Providers.** When foster care providers want to take a vacation or time off to attend to personal matters, they must hire someone at minimum wage or more, or rely on a willing relative to fill in. Other 24-hour-staffed programs similarly incur additional costs for relief help. The cost of relief staff should be funded through increased service payments to providers.

C-5. **Need for More and Better Training.** Licensing regulations require that staff/providers receive initial and ongoing training, yet there are few affordable and locally available training opportunities. While the State Mental Health Division has developed a series of training videos for residential providers and sponsored conferences relating to developing housing resources and improving residential service delivery, gaps between need and availability remain wide. When state-sponsored training is available, it's hard for providers and residential staff to attend since there is no funding for relief staff. In addition, family members who provide housing to a relative should have access to training.
C-6. Residential Caregivers Have Low Status in the Mental Health System. Some mental health professionals do not regard residential service providers as credible members of the "treatment team." This "status" differential seems to arise from differences in educational backgrounds, lack of service coordination and the isolation that stems from separate geographical locations.

C-7. Provision of Medical Services by Non-Medically Trained Persons. Non-medically trained staff in facilities perform resident health care tasks which some medical professionals believe should only be performed by licensed and trained personnel. This raises both quality of care and liability concerns.

D. Lack of Community Acceptance

D-1. Community Resistance. A negative stigma of mental illness still reigns in the minds of most community members, and even those who are supportive of community residential programs in general do not want one on their block. Public education is needed to combat the negative stigma. In addition, housing program developers must learn to be persistent, tactful and employ good public relations as new programs are established in local neighborhoods.

D-2. Exclusionary Zoning. A distinction can be made between discriminatory and reasonable zoning practices. In general, "family model" and apartment programs should be allowed as a right in zones allowing other similar structures. However, larger programs with shift staffing which propose to locate in single family neighborhoods can reasonably expect to comply with special zoning requirements (such as conditional use permits) as would small businesses or other unusual occupancies. Discriminatory zoning practices do exist in Oregon, and to correct these, legislative changes or other legal remedies should be pursued. Where zoning practices are reasonable, housing program developers should learn the requirements and utilize the opportunity to employ good public relations techniques and educate community members. Training and technical assistance in this area would be helpful.

E. Administrative Barriers

E-1. Lack of Flexibility in Funding Mechanisms. The same funding rate system is used statewide regardless of cost differences on budget line items occurring among communities and facilities. For example, the cost of recruiting and retaining quality staff is higher in some communities than others. Facilities operated as part of a larger non-profit corporation may have administrative overhead and fringe benefit expenses that do not exist in private proprietary operations. Rent or mortgage payments on recently acquired facilities are likely to be higher than for older established facilities due to inflation. Physical plant
maintenance expenses are higher for older facilities than newer facilities. There are many other variables which affect facility budgets.

E-2. Problems With Compliance and Enforcement. Everyone agrees that it is desirable for quality programming to exist. On occasion, however, for a variety of reasons, service provision in a facility can become substandard. It then becomes the responsibility of the State and local CMHP to take corrective action. Roles and responsibilities can become confused; a protocol for taking corrective action needs to be established and implemented. In some cases, problems could be averted if technical assistance and consultation were available.

Although inspections and enforcement have improved overall, there are not enough staff to perform the function. The results are inspections occurring behind schedule and delayed availability of inspection reports.

E-3. Lack of Flexibility to Meet Special Needs. Until recently, most state-funded residential programs served a variety of clients with a "generic" program of services. It has become apparent that there are subgroups within the severely psychiatrically disabled population which have special service needs. If some programs were encouraged to "specialize" in their service models, needs of particular subgroups (e.g., deaf persons, substance abusers) could better be met.

A second issue in this category is the need for increased flexibility. How can the residential service system modify its programs as the needs of the population change over time? How can new knowledge and technological advances be better incorporated into the existing service system?

E-4. Inequitable Licensing Fee Structure. Due to recent legislative changes, all foster care providers must now pay an annual licensing fee of $20/bed. (Previously, no fee was required.) This fee goes to the Senior Services Division regardless of the population served by the provider. This fee is high for M-ED foster care providers when one considers that they are paid much less than SSD foster care providers and that the larger RCF providers only pay an application fee of $60 every two years (e.g., $2/bed per year for a 15-bed RCF).

E-5. Requirements in Administrative Rules Are Not Consistent with Funding Levels. Expectations for services as spelled out in Administrative Rules generally exceed what is feasible given the financial resources available. This dilemma results from the desire to have quality programs coupled with the unavailability of adequate funding to insure their continuity and stability.
E-6. Controversy Over Content of Administrative Rules. What is the appropriate level of detail for administrative rules? In some cases, the rules seem overly prescriptive, in others not prescriptive enough. Rules which are excessively detailed and prescriptive become barriers to foster care provider recruitment and make compliance and monitoring a time-consuming and difficult process. When local jurisdictions adopt rules which are more stringent than the State's version, problems with provider recruitment and funding discrepancies are compounded.

A second issue concerns the inclusiveness of administrative rules. Should there be one rule for all larger facilities or separate rules governing different types of facilities? A single, more comprehensive rule is easier to develop administratively but separate, more program-specific rules are easier for providers to understand.

PRIORITIZING BARRIERS

As a means to begin developing recommendations, the Task Force participated in an exercise wherein they were asked to rate barriers as "hard to resolve," "easier to resolve" and "priority to resolve." Each Task Force member had five "votes" for each category. The results of the exercise are as follows (number of votes received is indicated in parentheses; items which received three or fewer votes are not listed):

- The hardest to resolve barriers:
  - B-1: Poverty level of clients (9)
  - A-1: Limited availability of resources (6)
  - A-3: Scarcity of affordable housing (6)
  - B-2: Inadequate funding levels for existing programs (6)
  - B-5: Liability concerns/escalating insurance costs (5)
  - D-1: Community resistance (4)

- The easiest to resolve barriers:
  - C-5: Need for more and better training (7)
  - E-3: Lack of flexibility to meet special needs (6)
  - A-9: Coordination with/access to other services (4)
  - E-1: Lack of flexibility in funding mechanisms (4)

- Priority barriers to address:
  - B-2: Inadequate funding levels for existing programs (7)
  - A-1: Limited availability of resources (7)
  - A-3: Scarcity of affordable housing (4)
SUMMARY

The Mental Health Division has had responsibility for residential services for less than ten years. Since 1983, there has been a 25% decline in structured residential resources (residential care facilities and adult foster care homes) while semi-independent living program services have doubled. More stringent regulation of boarding homes has reduced the availability of this alternative in some counties. While there has been an increasing emphasis on deinstitutionalization, there has actually been a decreasing number of the residential alternatives which have traditionally been used to transition people from state hospitals to community living.

The strengths of the current system include the state's progressive emphasis on semi-independent living alternatives, a decrease in substandard programs and effective utilization of subsidized housing resources. Numerous barriers were delineated and fell in five categories: (1) system and coordination issues, (2) restrictive financial conditions, (3) staffing/provider dilemmas, (4) lack of local community support and (5) administrative barriers. While fiscal-related barriers are seen as the hardest to address, barriers related to availability of training, administrative inflexibility and coordination are seen as easier to resolve. Because it is hard to maintain and develop resources within current funding levels and because the need for additional resources is great, the Task Force identified inadequate funding levels for existing programs and the limited availability of resources (in terms of type, quantity and geographical distribution) as the priority barriers to address.
CHAPTER V

SUMMARY AND RECOMMENDATIONS

You take my house
When you do take the prop
That doth sustain my house;
You take my life
When you take
The means whereby I live.

William Shakespeare, *The Merchant of Venice*
V. SUMMARY AND RECOMMENDATIONS

The previous chapters have detailed the philosophies and values which should guide the delivery and development of residential services, the characteristics of the Oregonians with psychiatric disabilities who need support in their living environments, the types of residential services which are needed, and the strengths and barriers of the current system. The major findings will be summarized before recommendations are delineated.

Summary of Findings

Shelter is an integral part of everyone's daily life. An adequate place to live is particularly important to people with psychiatric disabilities since they are often especially vulnerable to environmental stressors. While it is estimated that 69% of persons defined as psychiatrically disabled (i.e., "chronically" or "severely" mentally ill) and in need of treatment can live in independent existing community housing resources if services such as case management and medication-monitoring are available, the remaining 31% need assistance in their living environment ranging from on-site skilled services 24-hours per day to weekly home visits by a friendly paraprofessional. While some of these individuals will need the "special housing" services on an ongoing basis, others will need the support and services during the early stages of the onset of their illness or only at times when symptoms and stress levels increase.

To translate the percentages noted above to numbers of people, it is estimated that 42,000 adult Oregonians currently have psychiatric disabilities. On any given day, 26,000 of these individuals will be in need of mental health services. While finding affordable, decent housing may be problematic, up to 18,000 of these citizens needing mental health services will be able to live in their current community living situations, if adequate support services and treatment are available through the local community mental health program or a private mental health service provider.11

---

11 The psychiatrically disabled include an estimated 18,000 "chronically" and 24,000 "severely" mentally ill persons. The "severely" mentally ill persons included in the 42,000 are expected to need services on an intermittent basis while the "chronically" mentally ill need services on an ongoing basis. Three severely mentally ill persons will, on the average, use a service slot over a year while only one chronically mentally ill person will use one service slot over a year. Therefore, only 26,000 of the 42,000 psychiatrically disabled people will need (and use, if available) services at any given point in time.
The remaining 8,000 Oregonians with psychiatric disabilities will need some degree of support and structure in their living environment. Currently, state-funded programs house or provide housing-related services to 1,595 individuals. Included in this number are mentally ill persons residing in community-based residential care facilities (530), adult foster care homes (265), and housing supported through semi-independent living program services (800). Figure 1 on page 37 summarizes how the number of these resources have fluctuated over the years. An additional 875 persons reside in state mental hospitals.

In addition to state-funded residential programs, individuals with psychiatric disabilities utilize boarding homes which are operated on a proprietary basis. Because use of these options is not monitored in any systematic way, it is difficult to determine the number of individuals for whom these privately operated arrangements are available at present. Many of these boarding homes have been identified as substandard operations. Because data on the number of decent boarding homes is unavailable, they are not included in estimates appearing in this report.

Approximately 6,400 Oregonians with psychiatric disabilities are currently in need of state-funded residential services. These individuals are either inappropriately institutionalized, homeless, living in substandard (and often abusive) housing or living with family members who can't meet their high level of care needs. Many of these individuals have multiple needs which can't be served in existing residential alternatives. A question remains as to how many and what kinds of new housing programs are needed for these individuals.

The "ideal" spectrum of community residential programs was conceptualized in three general groupings: supported, structured and special skilled (refer to pages 29-32). Currently available alternatives comprise only small parts of the entire spectrum. One large gap in needed resources lies in the special skilled category. Few housing options in this category for persons with chronic mental illness exist. Establishment of these facilities requires the funding of higher per diem rates than currently exist, yet may still represent a savings when compared to the cost of inpatient care in a state mental hospital. While some other states have almost over-utilized "nursing homes" for the mentally ill, in Oregon, it has been difficult to access this level of care when needed. Secure and intensive treatment-oriented options are needed as well as the more traditional medically-oriented options.

In the "structured" and "supported" categories, more diversity and better funding levels as well as an increase in the overall number of program slots are needed. There is more experience with structured and semi-independent housing programs throughout Oregon. Indeed, many examples of model programs exist. Yet programs geared to serve clients with special needs and the increased availability of programs in most geographical areas remain a priority.

Increased availability of local crisis respite housing alternatives is also needed. Because few exist, additional resources in all non-inpatient categories are needed and should be funded adequately.
Because "numbers" are needed for planning and budgeting, the task force attempted to estimate the types and numbers of needed residential program slots. From the various existing data sources and studies, and based on experience and direct work with clients, the following rough estimates were made for the number of new residential "slots" needed:

<table>
<thead>
<tr>
<th>Type of Resources</th>
<th>TOTAL NEEDED*</th>
<th>EXISTING</th>
<th>ADDITIONAL NEEDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special Skilled Resources</td>
<td>1,825</td>
<td>30</td>
<td>1,795</td>
</tr>
<tr>
<td>Structured Resources</td>
<td>2,675</td>
<td>795</td>
<td>1,880</td>
</tr>
<tr>
<td>Supported Resources</td>
<td>3,500</td>
<td>800</td>
<td>2,700</td>
</tr>
<tr>
<td>Crisis-Respite Resources</td>
<td>725</td>
<td>500</td>
<td>225</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>8,725</strong></td>
<td><strong>2,125</strong></td>
<td><strong>6,600</strong></td>
</tr>
</tbody>
</table>

* The derivation of these need estimates is summarized in Appendix E.

In addition to needing more resources and more variety in resources, Task Force members found that current programs are inadequately funded and undue amounts of time go toward provider/staff recruitment. Because M-ED residential services are not competitively funded, providers convert to serving other populations and individual staff leave to take higher paid and often less demanding positions elsewhere in the mental health service system.

Another area of need is technical assistance and training. The state-of-the-art in residential services for people with psychiatric disabilities has shifted from "board and care" to "rehabilitation and supported housing." In order to be more effective in serving residents, staff must be trained to provide rehabilitation-oriented services and to provide support to consumers in innovative, nontraditional ways. Technical assistance is also needed to enable mental health service providers to access affordable housing for their clients. Many providers also need assistance with planning and establishing new programs.

The Task Force identified many administrative and/or service coordination barriers to implementing the ideal residential spectrum. These must be addressed and rectified before progress can be made. In order to increase flexibility in service provision, changes to the statutes and administrative rules must be made. Funding mechanisms need to be studied and made more efficient. Protocols for planning new services in better coordinated ways must be established. Issues of liability and the restricted availability of insurance must be addressed. Protective services procedures and responsibilities need to be clarified to insure residents' rights and well-being. Finally, siting difficulties relating to zoning restrictiveness must be addressed.
To address existing housing needs and barriers the Task Force identified five broad strategies. These are summarized below. It should be noted that neither the strategies nor the substrategies are listed in any order of priority.

I. The State should formally adopt guiding principles outlining the values and philosophies which should direct the development and provision of housing programs for chronically and severely mentally ill persons.

II. The funding of programs should be increased to competitive levels to insure stable staffing and operation of existing programs and feasible development of needed, new resources.

III. To insure "quality for state dollars" and maximum leveraging of additional outside resources, training and technical assistance should be made available in a manner both affordable and accessible to staff and developers of housing programs.

IV. Additional residential resources should be aggressively developed in accordance with prioritized needs and through a coordinated effort which insures that services are "attached" to affordable housing.

V. The pursuit of new residential resources, system changes, administrative remedies and improved coordination should be accomplished through leadership and human resources available within or through the M-ED Program Office.

Each strategy is discussed below. The recommended implementation steps are identified as "substrategies" and are also discussed.

Strategy I: Adoption of Guiding Principles

Task Force members found it helpful and important to articulate values and goals which should direct housing efforts for psychiatrically disabled persons in Oregon. Incorporating these into state policy will insure that housing programs for the psychiatrically disabled operate under standards which insure quality and dignity.

Substrategy I-A: Obtain Administrative Sanction of Guiding Principles. The values and goals should be incorporated into state policy as guiding principles. They should be presented to and adopted by key Administrators in the State Mental Health Division, the Department of Human Resources and the Governor's Office.

Strategy II: Implement Competitive Funding Levels

When compared with similar programs serving other populations (e.g. Veterans, children, frail elderly) or salaries of staff positions with similar job responsibilities, providers of residential services for the psychiatrically disabled are paid at inequitably low levels. This makes the recruitment and retention of staff and providers extremely difficult.
In addition, service payment systems are complicated, relief staff (or "respite") for providers is currently not funded and grants to bring facilities into compliance with building codes and fire/life safety requirements are not routinely available.

**Substrategy II-A: Bring RCF Wages to Psychiatric Aide Levels.** Funding of Residential Treatment Programs for the psychiatrically disabled should be increased so direct care staff are paid at the same salary level as state hospital Psychiatric Aide positions. Facility Administrators should be paid at the same salary level as state hospital Psychiatric Aide Supervisors. Personnel and administrative expenses should be funded at 35% instead of current rate of 21%.

**Substrategy II-B: Bring AFC Rates into Parity with Those of Other Divisions.** Funding of Adult Foster Care services for the psychiatrically disabled should be at a rate commensurate with that paid for Foster Care services purchased by other Divisions within the Department of Human Resources.

**Substrategy II-C: Increase and Vary SILP Rates to Implement Intensive and Specialized Services.** To encourage more intensive, outreach-oriented services to more functionally-limited clients and to enable the delivery of services in rural areas, funding of Semi-Independent Living Program services should be at a higher average rate and be variable to allow implementation of different models at different costs.

**Substrategy II-D: Improve Service Payment Systems.** A work group should be assembled to determine ways to streamline and improve service payment systems. Providers, CMHP staff, consumers, family members, State MHD staff and fiscal/contracting experts should be represented as members of the work group.

**Substrategy II-E: Fund Relief Staff.** Relief staff or other means of providing "respite" for residential care givers should be funded so coverage can be insured when caregivers attend training sessions, become ill, need time off to attend to personal matters, or take vacations.

**Substrategy II-F: Create a Grant Fund for Emergency Facility Improvements.** A grant fund should be established to provide emergency grants for facility improvements necessary to prevent closure and remedy building code or fire/life safety requirement violations.

**Strategy III: Training and Technical Assistance**

In order to insure that programs are effectively established and operated, technical assistance and training must be available. This is a quality assurance strategy which will insure maximum outcomes for state dollars spent. Expertise exists within the State of Oregon, but there are no mechanisms for assuring its availability when and where needed. Several problems result: (1) insufficient training is available to housing program staff; (2) too little emphasis is placed on assessment, skill training and rehabilitation of residents; (3) federal and private
resources are underutilized, and (4) information-sharing and problem-solving which would facilitate the establishment of new programs is not available.

Substrategy III-A: Provide Regular Training to Residential Service Providers. Training for housing program staff should be offered at minimal or no charge on a quarterly basis at five geographically distributed locations throughout the state. Topics should focus on upgrading residential staff's skills.

Substrategy III-B: Provide Technical Assistance to Improve Availability and Quality of Residential Resources. Technical assistance should be provided or arranged to facilitate efficient program development; maximize utilization of federal, private and other resources; and help service providers experiencing difficulties to creatively address problems.

Strategy IV: Development of New Resources

The Task Force estimates that housing programs are only available for 20% of the Oregonians with psychiatric disabilities who need them. While additional services of every type are needed, the most acute needs are for the special skilled residential programs. A general scarcity of affordable low-rent housing is a problem which forces many psychiatrically disabled persons into substandard or inappropriate housing or homelessness. Increased variety in the types of residential alternatives available and an improved geographical distribution of resources are necessary. When establishing new resources, adequate funding for start-up expenses must be provided or ill-prepared staff, inadequate facilities and furnishings, and financial difficulties are likely to result.

Substrategy IV-A: Implement Incremental Service Expansion. A goal for developing an additional 6,375 slots of community residential services and 225 slots of crisis-respite alternatives by 1997 should be adopted and incrementally implemented. On a biennial basis, housing program needs should be assessed by a Residential Advisory Committee and priorities set for the types of residential programs to be established next. Based on current knowledge, the following "blueprint" is proposed:

<table>
<thead>
<tr>
<th>TYPE OF RESIDENTIAL ALTERNATIVE</th>
<th>SUPPORTED</th>
<th>STRUCTURED</th>
<th>SPEC. SKILLED</th>
<th>CRISIS-RESPITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Level</td>
<td>800</td>
<td>795</td>
<td>30</td>
<td>500</td>
</tr>
<tr>
<td>1989-1991</td>
<td>+675</td>
<td>+470</td>
<td>+449</td>
<td>+56</td>
</tr>
<tr>
<td>1991-1993</td>
<td>+675</td>
<td>+470</td>
<td>+449</td>
<td>+56</td>
</tr>
<tr>
<td>1993-1995</td>
<td>+675</td>
<td>+470</td>
<td>+449</td>
<td>+56</td>
</tr>
<tr>
<td>1995-1997</td>
<td>+675</td>
<td>+470</td>
<td>+448</td>
<td>+57</td>
</tr>
<tr>
<td>TOTALS</td>
<td>3,500</td>
<td>2,675</td>
<td>1,825</td>
<td>725</td>
</tr>
</tbody>
</table>

- 61 -
Substrategy IV-B: Create New Programs as Pilot Projects. An increased variety of residential programs should be developed to fill current service gaps and meet special needs. New program models should be developed as pilot projects and evaluated for their effectiveness.

Substrategy IV-C: Adopt and Implement Regional Development Strategies. To enable people with psychiatric disabilities to reside in their home communities whenever possible, an equitable geographical distribution of resources should be pursued. All counties should have “supported” housing resources and at least one “crisis-respite” alternative. "Structured" resources should be available in all large counties and on a regional basis for groups of smaller counties. "Special skilled" resources should be available on a regional basis or a statewide basis in the case of single highly specialized facilities.

Substrategy IV-D: Increase Access to Affordable Housing. Recognizing that most psychiatrically disabled people are poor and have difficulty finding decent, affordable housing, and that inadequate housing can increase stress and exacerbate symptoms, the State Mental Health Division should actively support the development of affordable housing for M-ED persons. These efforts should include prioritizing allocation of service funding for “affordable alternatives,” determining the feasibility of creating a "Mental Health Housing Authority" (similar to the one in Colorado) which allocates and monitors rent subsidy vouchers for psychiatrically disabled persons, and working with other local, state and federal agencies to encourage increased access to low-rent housing for psychiatrically disabled persons.

Substrategy IV-E: Implement Routine Provision of Start-Up Funding. Start-up funding should routinely be made available when new programs are developed. These funds should adequately finance facility acquisition and preparation costs, use of consultants, agency's cost to implement program development activities, staff training, and initial resident screening and orientation.

Strategy V: Make System and Administrative Improvements

To implement new program models, increased flexibility, and improved service payment systems and to address other "administrative" and "systems coordination" barriers, leadership and direction must be provided within the M-ED Program Office. Effort will be required to improve protective services, address restrictive zoning practices and community opposition, investigate liability risks and creative insurance strategies and coordinate overall planning for new resources.

Substrategy V-A: Implement Balanced Approach to New Funding. Development of new resources should be pursued in a planned way based upon identified client needs and priorities. Development of new resources should not supercede the necessity of adequately funding existing services and training current service providers. Where constraints on the availability of resources exist, a
balanced approach should be taken wherein funding levels of current programs, availability of training and technical assistance, and the establishment of new resources are all incrementally increased.

Substrategy V-B: Establish Residential Advisory Committee. Because residential program issues are complex and require technical expertise, and because planning for residential services has been sporadic and diffuse, an ongoing Residential Advisory Committee should be established. The Committee would provide a forum for the discussion and review of residential service policy, setting priorities for new service development, and providing technical expertise on residential service issues. The M-ED Residential Task Force could easily evolve into the proposed Residential Advisory Committee.

Substrategy V-C: Convene Work Group on Administrative Rule and Statute Revisions. A work group should be convened to review and recommend revisions of the Administrative Rules and statutes which govern housing programs. Because new program models and increased flexibility have been proposed, Administrative Rules and Statutes will need to be revised to reflect these changes. The Statutes and Administrative Rules which govern existing residential programs could also benefit from a thorough review.

Substrategy V-D: Increase Licensing Capacity as New Demands Are Established. As new program models are established and increased numbers of programs exist, quality assurance and licensing protocols should be reviewed, revised and expanded. Structured and special skilled facilities require health and sanitation inspections. The workload of the M-ED Residential Licensing Specialist recently increased when the requirements for foster care inspections changed from biennial to annual site visits. Additional staff will be needed to assist with the expanded workload.

Substrategy V-E: Promote Facilitative Zoning Practices and Community Education. An effort should be made to address restrictive zoning practices and promote community acceptance. State MHD staff should work with the Department of Land Conservation and Development to revise the statutes governing siting of residential programs. The development of positive promotional materials should also be pursued. Opposition is often related to fears which arise from insufficient knowledge.

Substrategy V-F: Improve Protective Services to Remedy Abuse and Neglect. The availability of protective services should be expanded. Roles and responsibilities at the local level should be clarified especially those for staff of private agencies. Training is needed to insure use of appropriate investigation and documentation techniques.

Substrategy V-G: Improve Coordination and Communication Relevant to Housing. Because the development and operation of housing programs typically involves many agencies and individuals, coordination and communication should be improved and streamlined.
This could be accomplished by: (a) Designating a "housing Coordinator" within the M-ED Program Office; (2) Developing a brochure which identifies who to contact for different issues; (3) Systemizing information-sharing (e.g., through newsletters, routine mailings and the proposed Residential Advisory committee); and (4) Maintaining a centralized inventory of housing resources.

Substrategy V-h: Address Liability Concerns and Insurance Costs.
The definition of risk and assignment of responsibility for liability in residential programs needs to be clarified. Quality assurance mechanisms are necessary for the minimizing of liability risks. Insurance costs have escalated for providers. The State MHD should assist in investigating creative solutions to the problem of obtaining affordable insurance coverage.

Substrategy V-I: Improve Access to and Utilization of Resources.
Although residential resources are generally well-utilized, barriers sometimes exist. Examples are the lack of guaranteed mental health services for persons accepted for residential services and the difficulty of obtaining out-of-county placements even when openings exist. To remedy these access problems, a coordinated service delivery protocol should exist which (1) Insures availability of case management and medication-monitoring for all persons receiving residential services; and (2) "Regionalizes" access to residential resources through intergovernmental agreements specifying shared responsibilities for resources and clients.

Task Force members believe that implementing these strategies will result in a more comprehensive array of residential services which are more efficiently provided and more effective in meeting consumers' needs. Projected outcomes include decreased overcrowding in state mental hospitals, a reduced number of homeless mentally ill persons and an improved quality of life for psychiatrically disabled Oregonians who now reside in substandard or inappropriate living situations.
REFERENCES


Kingfair, C. Unpublished results of M-ED Foster Care Survey.

Krygier, L; Newcomer, S; Pratt, K. and Skryha, V. Housing Needs in the Chronically Mentally Ill in Multnomah County. Research thesis is partial fulfillment of the requirements for the degree of Master of Social Work, Portland State University, 1982.


Report on Community Residential Programs for the Mentally Ill. State of Oregon, Department of Human Resources, Mental Health Division, Program Analysis Section, December 1986.


APPENDICES

A. List of Task Force Members
B. Oregon Definitions of "Chronically" and "Severely" Mentally Ill
D. Summary of Target Groups and Their Residential Service Needs
E. Summary of Estimated Residential Resource Needs
F. Summary of Strengths and Barriers Within the Current System
G. Summary of Strategies Recommended by Task Force
**APPENDIX A**

**RESIDENTIAL TASK FORCE MEMBERSHIP LIST**

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary Eva Culver*</td>
<td>Chairman, Residential Committee</td>
<td>Mental Health Association of Oregon, 1098 Leigh, Eugene, OR 97401</td>
</tr>
<tr>
<td>Dave Cutler, M.D., Director</td>
<td>Community Psychiatric Training Programs</td>
<td>Department of Psychiatry, Oregon Health Sciences University, 3181 S.W. Sam Jackson Park Road, Portland, OR 97201</td>
</tr>
<tr>
<td>Vern Faatz*</td>
<td>Clackamas County Mental Health</td>
<td>Education Hall, PO Box 12, Marylhurst, OR 97306</td>
</tr>
<tr>
<td>Blake Fischer-Davidson**</td>
<td>Program Coordinator</td>
<td>Housing Development Specialist, Education Hall PO Box 12, Marylhurst, OR 97306</td>
</tr>
<tr>
<td>Maggie Gareau*</td>
<td>Residential Specialist</td>
<td>Multnomah County Department of Human Services, Social Services Division, 426 SW Stark Street, 6th Floor, Portland, OR 97204</td>
</tr>
<tr>
<td>Nancy Hart-Fishwick</td>
<td>Residential Coordinator</td>
<td>Lane County Mental Health Program, 1901 Garden Avenue, Eugene, OR 97401</td>
</tr>
<tr>
<td>Cathy Hilger, Residential Specialist**</td>
<td>Multnomah County Department of Human Services</td>
<td>Social Services Division, 426 S.W. Stark Street, 6th Floor, Portland, OR 97204</td>
</tr>
<tr>
<td>Chris Johnson, Director</td>
<td>Yamhill County Mental Health Program</td>
<td>412 North Ford Street, McMinnville, OR 97128</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Lundsten, Director</td>
<td>Social Services</td>
<td>Oregon State Hospital, 2600 Center St. N.E., Salem, OR 97310</td>
</tr>
<tr>
<td>Diane Luther, Executive Director</td>
<td>Mental Health Association of Oregon</td>
<td>325 13th N.E., Salem, OR 97301</td>
</tr>
<tr>
<td>Jeffrey Schwartz</td>
<td>Psychiatric Social Worker</td>
<td>Dammasch State Hospital, P.O. Box 38, Wilsonville, OR 97070</td>
</tr>
<tr>
<td>Vicki Skryha***</td>
<td>Clackamas County Mental Health</td>
<td>Southeast Mental Health Network, Inc., 2415 SE 43rd, Portland, OR 97206</td>
</tr>
<tr>
<td>Garrett Smith*</td>
<td>Residential Manager</td>
<td>Mental Health Services, 710 West S.W. 2nd, Portland, OR 97204</td>
</tr>
<tr>
<td>Peggy Stedman, Chairman</td>
<td>Residential Committee</td>
<td>AMI of Lane County, 2420 Pioneer Pike, Eugene, OR 97401</td>
</tr>
<tr>
<td>Terry Tucker</td>
<td>Residential Network Coordinator</td>
<td>Josephine County Mental Health Program, 714 Northwest &quot;A&quot; Street, Grants Pass, OR 97526</td>
</tr>
<tr>
<td>Bill Uhlhorn, Executive Director</td>
<td>Eugene Emergency Housing, Inc.</td>
<td>2981 Willamette, Eugene, OR 97405</td>
</tr>
</tbody>
</table>
Bob Joondeph  
Managing Attorney  
Mental Health Program  
Protection and Advocacy Center  
310 SW 4th Avenue, #400  
Portland, OR  97204

Jerry Wang, Executive Director  
The Mind Empowered, Inc.  
c/o Oregon Advocacy Center  
310 SW 4th Avenue, 6th Floor  
Portland, OR  97204

Barbara Weamer, Acting Residential Supervisor  
Marion County Mental Health  
3180 Center St. N.E.  
Salem, OR  97301

LaVon Wilson, Residential Coordinator  
Residential Services Unit  
Eastern Oregon Psychiatric Center  
2600 Westgate  
Pendleton, OR  97801

Linda Yegge, Acting Program Supervisor  
Marion County Mental Health  
3180 Center St. N.E.  
Salem, OR  97301

* Members who resigned prior to completion of TF's work.

** Members appointed to replace resigenees.

*** Member who resigned when hired to write TF Report.

Staff to the Task Force

Elmer Kramer, Manager, Community Programs  
LuRee Krygier, Program Coordinator, Community Programs  
Vicki Skryha, Temporary Program Coordinator, Community Programs

Program Office for Mental or Emotional Disturbances  
Mental Health Division  
Department of Human Resources  
State of Oregon
OREGON DEFINITIONS OF "CHRONICALLY" AND "SEVERELY" MENTALLY ILL

The definition of "chronically mentally ill person" is as follows:

(1) "Chronically mentally ill person" means a person who is 18 years of age or older and who satisfies both of the following criteria:

(a) Severe mental disorder as identified by a psychiatrist, by a licensed clinical psychologist or by a non-medical examiner certified by the Mental Health Division. Must be diagnosed as having a Schizophrenic, Major Affective or Paranoid Disorder (DSM III diagnosis of 295.1, 2, 3, 4, 6, 7, 9; 296.2, 3, 4, 5, 6; or 297.1, 3), or another severe mental disorder with a documented history of persistent psychotic symptoms other than those caused by substance abuse; and

(b) Impaired role functioning, consisting of at least two of the following:

(A) Social role: an inability to function independently in the role of worker, student, or homemaker;

(B) Daily living skills: an inability to engage independently in personal care (grooming, personal hygiene, etc.) or community living activities (handling personal finances, using community resources, performing household chores, etc.); or

(C) Social acceptability: an inability to exhibit appropriate social behavior, which results in demand for intervention by the mental health and/or judicial system.

The definition of "severely mentally ill person" is as follows:

A "severely mentally ill person" is defined as follows (definition used in 1988 Critical Mass Survey):

(1) A "severely mentally ill person" is defined as an adult who is Priority 1," in need of services," has a "severe mental disorder," and does not meet the functional limitations in the definition of "chronically mentally ill."

(a) "Priority 1" means those adults who, in accordance with the assessment of professionals in the field of mental health:

(A) Are at immediate risk of hospitalization for the treatment of mental or emotional disturbances; or
(B) Are in need of continuing services to avoid hospitalization; or

(C) Pose a hazard to the health and safety of themselves or others.

(b) "In need" means the individual will seek services voluntarily or will use services involuntarily annually.

(c) "Severe mental disorder" means a psychotic disorder or other mental disorder of comparable severity. "Psychotic" means a gross impairment of reality testing as defined in the DSM-III glossary.
APPENDIX C

SUMMARY OF ESTIMATING PROCESS FOR DETERMINING THE POPULATION SIZE
AND RESIDENTIAL SERVICE NEEDS

The following outline summarizes the Task Force's process for estimating
the number of psychiatrically disabled persons in Oregon and needed
residential services. Additional detail is provided in Chapter II.

1. Defining the Population

   A. Oregon's population is 2,690,000.

   B. The estimated number of psychiatrically disabled adults is
      42,000.2
         1. 18,000 of these persons are chronically mentally ill (CMI).
         2. 24,000 of these persons are severely mentally ill (SMI).

II. The number of Psychiatrically Disabled Adults estimated to Need
    Residential Services

   A. Based on a rate per 100,000 as developed by a California
      Legislative Work Group:3
      1. 25 Crisis-Respite Beds per 100,000; applied to Oregon
         population, this ratio results in an estimate of 673 beds.
      2. 240 Community Residential (transitional or long-term) Beds
         per 100,000; applied to the Oregon population, this ratio
         results in an estimate of 6,456 beds.

   B. Based on a percentage of the target population, the results of
      an Ohio Survey were used:4
      1. 3% need Crisis-Respite Care; applied to the estimated
         number of psychiatrically disabled in Oregon, this results
         in an estimated 726.5 beds.
      2. 31% need Community Residential (transitional or long-term)
         Beds; applied to the estimated number of psychiatrically
         disabled in Oregon, this results in an estimated
         8,060 beds.5

   C. Confirming Estimates for Oregon:
      1. Task Force members agreed to use an estimate of 725 needed
         Crisis-Respite beds for Oregon. (This number includes all
         alternatives to state mental hospitalization for short-term
         treatment.)
      2. Task Force members agreed to use an estimate of 8,000
         needed Community Residential beds for Oregon. (This
         includes all transitional and long-term alternatives.)
This is the certified, estimated population of Oregon as of July 1, 1987. It was provided by the Center for Population Research and Census, Portland State University.

This figure was rounded from preliminary data obtained through a survey of local community mental health programs conducted by the M-ED Program Office of the Oregon Mental Health Division in early 1988. "Psychiatrically-disabled" adults include both "chronically" and "severely" mentally ill persons as defined in Appendix B.

The work of the California Legislative Work Group began in Spring, 1979, in response to a California Assembly Permanent Subcommittee on Mental Health and Developmental Disabilities hearing. A coalition of mental health providers and consumers was established to develop recommendations for appropriate mental health care in California. The California Mental Health Association was asked to facilitate the group. A needed array of services was identified and standards set for minimum capacity needed per 100,000 general population. The group's work has been reviewed and revised over the years. Figures applied to the Oregon population were taken from the most recent draft report (dated July 1986). The standards include levels of service needed for adults (general psychiatric, forensic and geriatric) and children but leave it up to local communities to identify numbers needed for different age/target population groups.

The "Ohio Survey" was conducted to facilitate the work of the Ohio Mental Health Housing Task Force, a group appointed by the Ohio Department of Mental Health to promote better housing options for clients. A sample of 1,105 individuals from the Ohio Department of Mental Health total caseload of 120,400 people was surveyed. The Task Force began meeting in 1984 and published their report in 1986.

The Ohio Survey was based on needs of individuals enrolled in services at a given time, while the estimate in I.B. above is based on the number of persons who use services on an ongoing or intermittent basis. Therefore, target population estimates were adjusted to correspond to the Ohio surveyed population as follows: (1) because the 18,000 CMI persons are expected to use services on an ongoing basis with one person filling one slot over the course of a year, this number was left intact; and (2) because the 24,000 SMI individuals are expected to use services intermittently (at a rate of 3 persons/slot annually), one third (or 8,000) was used. Thus, the Ohio survey percentages were applied to an estimated 26,000 Oregonians who would be enrolled in services (if available) at a given time.

Two other surveys yielded a percentage of individuals needing residential services which could be applied to the Oregon population. A 1982 survey of chronically mentally ill persons in Multnomah County indicated that 44% needed a residential service. A Kitsap County, Washington, survey indicated that about 80% of clients needed residential services (ranging from structured to
supported independent living programs) while only 10% desired structured, group living alternatives as long-term alternatives. The Ohio percentage was used since it was a moderate figure and included both chronically and severely mentally ill persons.
APPENDIX D
SUMMARY OF TARGET GROUPS AND THEIR RESIDENTIAL SERVICE NEEDS

The following outline summarizes the Task Force's identification of target groups within the larger population of psychiatrically disabled persons and the distribution of services needed by each target group. Additional detail is provided in Chapter II.

I. Characteristics of Those Needing a Residential Service (can include one or more of the following)

A. Behavior problem (ranging from social and coping skill deficits to firesetting or assaultiveness)

B. Skill limitations (ranging from a lack of basic daily living skills to a grave inability to perform self-care activities)

C. Psychotic Symptomatology (ranging from hearing voices which interfere with performance of routine activities to ongoing, incapacitating hallucinations and/or delusions for which a medication regimen has proved ineffective).

D. Physical health or mobility limitations (including health conditions which require medical supervision and care, and physical disabilities which require the assistance of an attendant).

II. Target Groups Descriptions and Needed Community Residential Alternatives

A. The Multiple/Extreme Needs Group

1. Description: These individuals have symptoms which are not easily controlled by medications. They tend to be more active and less willing to engage in treatment. Most have a diagnosis of schizophrenia, and over half also have a cognitive deficiency or personality disorder. Many have a history of alcohol and drug abuse. Behavior problems typically include combative or self-injurious behavior or a tendency toward wandering off and getting lost. Self-care and social skills are minimal. Physical limitations, incontinence or other health-related conditions may be present. These persons tend to be long-term, hard-to-place patients in state mental hospitals.

2. Estimated Number: 1,500 persons

Community Residential Alternatives are utilized on transitional or long-term basis. They include resources ranging from weekly visits by skill trainers to 24-hour supervised facilities with highly skilled staff. Three general groupings of community residential alternatives are (1) supported, (2) structured, and (3) special skilled. Additional discussion is found in Chapter III.
3. Community Residential Alternative Needs:
   a. Supported Beds: None
   b. Structured Beds: 525 (35%)
   c. Special Skilled Beds: 975 (65%)

B. The Functionally Limited/Non-Accepting Group

1. Description: Individuals in this group fit the recently popularized characterization of the "young, adult chronic." They are "revolving door" hospital users who often enter the system through the involuntary commitment process. They tend to deny their mental illness, abuse alcohol and/or drugs and avoid contact with the traditional, formal mental health service system. They are characterized by a strong desire to be independent, a minimal to moderate level of self-care and social skills and a lack of vocational skills. Their medication compliance is questionable. They tend to over-estimate or inadequately plan for independence and then experience failure. While in the community, many are homeless, involved in the criminal justice system, living in substandard housing and boarding homes or living with family members. Diagnoses include schizophrenia, bipolar disorders and various personality disorders. They tend to not accept or not last in traditional, mixed aged, structured residential programs.

2. Estimated number: 2,500 persons

3. Community Residential Alternative Needs:
   a. Supported Beds: 1,250 (50%)
      (Note: This level of service is often all that these individuals will accept but specialized, more intensive programs than currently exist are needed.)
   b. Structured Beds: 625 (25%)
   c. Special Skilled Beds: 625 (25%)

C. The Functionally Limited/Service Accepting Group

1. Description: These individuals are typically middle aged or older and have come to accept their mental illness. They tend to be more dependent and cooperative and easier to engage in treatment. Although skill deficits and other problems bar them from independent living, they are willing to learn coping and daily living skills and respond well to social, recreational, vocational and/or educational opportunities. They are often characterized by a lack of
self-confidence and a nonexistent social support network. They are in and out of hospitals or have possibly never been hospitalized yet have an ongoing inability to survive independently in the community. While in the community, they may be homeless; victims of crime and society's abusive element; living in hotels, substandard apartments, or boarding homes; or living with aging family members. Typical diagnoses are schizophrenia and bipolar disorders.

2. Estimated Number: 1,500 Oregonians

3. Community Residential Alternative Needs:
   a. Supported Beds: 750 (50%)
   b. Structured Beds: 525 (35%)
   c. Special Skilled Beds: 225 (15%)

D. The Ongoing Support Group

1. Description: These individuals have a level of survival skills which enables them to live in community settings with minimal support. When the minimal level of ongoing support is withdrawn, however, they experience decompensations which place them at risk of hospitalization and increase their likely use of more structured alternatives. They need support and assistance to increase and maintain self-esteem, their ability to cope with environmental stressors, and to problem-solve daily living challenges. They may have poor impulse control, a tendency toward forgetfulness or perseveration, and difficulty differentiating reality from fantasy. Typical diagnoses include schizophrenia, bipolar disorders and various personality disorders. They generally reside in the community but utilize hospitals and/or crisis-respite alternatives from time to time. Some appropriately live in existing structured settings while others benefit from semi-independent living programs. Other live in substandard settings, shelters or with family members but could benefit from better quality housing and/or minimal, ongoing services.

2. Estimated Number: 2,500 Oregonians

3. Community Residential Alternative Needs:
   a. Supported Beds: 1,500 (60%)
   b. Structured Beds: 1,000 (40%)
   c. Special Skilled Beds: None
E. Special Populations

1. Description: These are individuals who fit one of the general descriptions provided above but have additional needs which can't be met in "generic" residential programs unless special accommodations are made. They include the following:

   a. The elderly;
   b. The homeless;
   c. Hearing impaired individuals;
   d. Blind or visually impaired individuals;
   e. Non-english speaking individuals;
   f. Dually diagnosed - alcohol/drug abusers;
   g. Dually diagnosed - mentally retarded/developmentally disabled;
   h. Those involved in forensics programs/corrections system;
   i. Personality disordered individuals;
   j. Those afflicted with rare or life threatening diseases;
   k. Those with organic brain syndromes; and
   l. Emerging emotionally disturbed young adults.

2. Estimated Number: Included above in Target Group estimates. (It's unknown how many individuals needing residential services fall into each "special population" category and how many fall into more than one category.)

3. Community Residential Alternative Needs: Numbers are included in Target Group estimates; however, it is important to note that specialized services or accommodations are necessary to meet particular needs. These may include structural adaptations to buildings and grounds, interpreters or bilingual staff, special training for staff, availability of consultation, and special health care or sanitation procedures.

III. Crisis-Respite Service Needs

A. Description of Need: Use of crisis-respite resources is not limited to members of the target groups identified above as needing community residential alternatives on a transitional or long-term basis. All psychiatrically disabled persons are considered to be at risk of psychiatric hospitalization, and therefore, are potential candidates for a crisis-respite residential service.
B. Crisis-Respite Resource Needs: A capacity of 725 beds is the estimated need. Length of stay in crisis-respite resources is short-term, ranging from 1 day to 1 month in duration, and typically 10 days or less. Thus, several individuals will use each crisis-respite bed annually.

Crisis-Respite Alternatives are utilized on a short-term basis. They serve persons experiencing acute and sub-acute psychiatric disturbance and range from mobile crisis support provided in a person's current place of residence to local inpatient hospitalization. Additional discussion is provided in Chapter III.
APPENDIX E

SUMMARY OF ESTIMATED RESIDENTIAL RESOURCE NEEDS

I. Resources are needed by target groups as follows:

A. Needed Community Residential Program Beds

<table>
<thead>
<tr>
<th>TARGET GROUP</th>
<th>SUPPORTED</th>
<th>STRUCTURED</th>
<th>SPECIAL SKILLED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple/Extreme Needs</td>
<td>-0-</td>
<td>525</td>
<td>975</td>
</tr>
<tr>
<td>Functionally Limited/Not Accepting</td>
<td>1,250</td>
<td>625</td>
<td>625</td>
</tr>
<tr>
<td>Functionally Limited/Service Accepting</td>
<td>750</td>
<td>525</td>
<td>225</td>
</tr>
<tr>
<td>Ongoing Support Needs</td>
<td>1,500</td>
<td>1,000</td>
<td>-0-</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>3,500</strong></td>
<td><strong>2,675</strong></td>
<td><strong>1,825</strong></td>
</tr>
</tbody>
</table>

B. Needed Crisis-Respite Care Beds

An estimated 725 beds are needed and will potentially be used by all psychiatrically disabled persons.

II. Existing Resources and Need for New Resources

A. Community Residential Alternatives

1. Need 3,500 Supported Beds
   * we currently have 800 SILP slots contracted
   * we need 2,700 additional, new Supported beds

2. Need 2,675 Structured Beds
   * we currently have 795 RCF and AFC slots
   * we need 1,880 additional, new Structured beds

3. Need 1,825 Special Skilled Beds
   * we currently have 30 psychiatric emphasis ICF beds
   * we need 1,795 additional, new Special Skilled beds
B. Crisis-Respite Alternatives

* need 725 beds

* we currently have about 400 local inpatient beds, 50 holding rooms and 50 other local crisis-respite alternatives

* we need 225 additional, new crisis-respite beds
The M-ED Residential Task Force identified both strengths and barriers within the current system of providing residential services for psychiatrically disabled persons. The following are discussed in detail in Chapter IV of the Task Force Report (July 1988):

STRENGTHS:

1. Emphasis on Semi-Independent Living
2. Improved monitoring has led to fewer substandard facilities
3. Target population (former state hospital patients) is being served in state-funded programs
4. Model programs exist throughout Oregon
5. Data exist on the types of programs needed and the characteristics of currently available resources
6. Quality of life is good for residents of state-funded programs
7. Subsidized housing resources have been effectively utilized

BARRIERS:

A. System and Coordination Issues (* indicates top priority to address)

*A-1: Limited availability of resources (quality, type and geographical distribution)

A-2: Lack of comprehensive needs assessment data

A-3: Scarcity of affordable community housing

A-4: Impact of having reduced hospital census tied to funding of program (individual must become more ill and experience repeated hospitalizations before service is available)

A-5: Lack of coordinated planning for new resources (availability of housing resources not tied to support service dollars)

A-6: Problems with continuity of services when providers discontinue programs

A-7: Title XIX waiver program imposes "red tape" and restrictions

A-8: Service payment systems are complicated and cumbersome
A-9: Coordination with and access to other services needed by residents is neither guaranteed nor facilitated.

A-10: Merging residential case management with community support services led to higher caseloads without additional compensation in Multnomah and Marion Counties.

A-11: Better protective services are needed.

A-12: Most current structured resources lack an emphasis on assessment and rehabilitation.

B. Restrictive Financial Conditions

B-1: Poverty level of clients.

*B-2: Inadequate funding levels for existing residential programs.

B-3: Lack of funds for start-up expenses.

B-4: No emergency financial assistance when program experiences a catastrophe.

B-5: Liability concerns and escalating insurance costs.

C. Staffing/Provider Dilemmas

C-1: Staff burnout.

C-2: Frequent staff turnover.

C-3: Recruitment difficulties.

C-4: Need relief staff/respite for providers.

*C-5: Need more and better staff training.

C-6: Residential caregivers have low status in mental health system.

C-7: Provision of medical services by non-medically trained persons exists and can be problematic.

D. Lack of Community Acceptance

D-1: Community resistance.

D-2: Restrictive and/or cumbersome zoning requirements.

E. Administrative Barriers

E-1: Lack of flexibility in funding mechanisms.

E-2: Problems with compliance and enforcement.

E-3: Lack of provisions to meet "special" needs.
E-4: Inequitable licensing fee structure

E-5: Administrative rule requirements are not consistent with funding levels

E-6: Level of detail and application of administrative rules raise concerns
Five broad strategies and several substrategies have been identified by the Task Force. Neither the strategies nor the substrategies are listed in any order of priority.

STRATEGY I: ADOPT GUIDING PRINCIPLES

Substrategy I-A: Obtain administrative sanction of guiding principles

STRATEGY II: IMPLEMENT COMPETITIVE FUNDING LEVELS

Substrategy II-A: Bring residential care facility wages to psychiatric aide levels
Substrategy II-B: Bring adult foster care rates into parity with those of other DHR divisions
Substrategy II-C: Increase and establish range for semi-independent living program rates to implement intensive and specialized services
Substrategy II-D: Improve service payment systems
Substrategy II-E: Fund relief staff for caregivers
Substrategy II-F: Create a grant fund for emergency facility improvements

STRATEGY III: IMPROVE AVAILABILITY OF TRAINING AND TECHNICAL ASSISTANCE

Substrategy III-A: Provide regular training for residential service providers
Substrategy III-B: Provide technical assistance to improve availability and quality of residential resources

STRATEGY IV: DEVELOP NEW RESOURCES

Substrategy IV-A: Implement incremental residential service expansion
Substrategy IV-B: Create new programs as pilot projects
Substrategy IV-C: Adopt and implement regional development strategies
Substrategy IV-D: Increase access to affordable housing
Substrategy IV-E: Implement routine provision of start-up funding
STRATEGY V: MAKE SYSTEM AND ADMINISTRATIVE IMPROVEMENTS

Substrategy V-A: Implement balanced approach to new funding (when new funds become available, current slot rates, training and new resources should all incrementally increase)

Substrategy V-B: Establish residential advisory committee

Substrategy V-C: Convene work group on administrative rule and statute revisions

Substrategy V-D: Increase licensing review capacity as new demands are established

Substrategy V-E: Promote facilitative zoning practices and community education

Substrategy V-F: Improve protective services to remedy abuse and neglect

Substrategy V-G: Improve coordination and communication relevant to housing

Substrategy V-H: Address liability concerns and insurance costs

Substrategy V-I: Improve access to and utilization of resources