THE NEW COMMUNITY RESIDENCE PROGRAM MODEL

A REPORT BY THE COMMUNITY RESIDENCE TASK FORCE

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I. INTRODUCTION

The Community Residence Program was designed to provide a range of residential services to mentally ill persons who cannot live independently in the community. The following recommendations were made by the Governor in his '83-'84 budget address concerning the provision of residential services appropriate for the mentally disabled population.

"The Bureau of Community Living [of the Office of Mental Health] will, for contracts effective July 1, 1983 and thereafter, develop revised policies, procedures, and guidelines for the Community Residence Program. Major areas to be addressed include:

- o A zero-based review of existing program goals and service models
- o The establishment of appropriate, cost-effective staffing patterns and staffing qualifications
- o The development and administrative application of admissions criteria
- o Length of stay and discharge criteria
- o The delineation of required linkages to other mental health programs and related services
- o The identification of funding sources which could assist in supporting the Community Residence Program"

A Task Force, comprised of OMH staff, community residence providers, facility representatives, a county representative, a representative of a municipal hospital and a regional office representative, was convened in September 1983 to complete two major activities:

1. Review the total array of residential alternatives for the mentally ill and identify a distinct role for Community Residences certified by the OMH.

2. Develop recommendations for revisions to the existing Community Residence Program and funding methodology with attention to the areas included in the Governor's recommendation. These areas focus on the need for greater definition of the goals of the program and greater accountability through program and funding policies for meeting stated goals.

The work of the Task Force followed a year of uncertainty with regard to the existing community residence program as the OMH and providers struggled to implement interim procedures and funding methodologies pending revisions to the program as called for by the Governor. Development of several aspects of the program design proposed in this paper began during this period of time.

A three part effort was designed to develop recommendations for changes to the current program/funding model.

Part I - Development of revised program model

Part II - Development of a funding model to support the program model

Part III - Development of new legislation and/or revised regulations and policies to accommodate the new program and funding models

Program and Fiscal Committees of the Task Force were designated to carry out Parts I and II. OMH staff from Counsel's Office, Division of Program Operations and the Divisions of Quality Assurance and Finance, and Support as well as legislative liaison staff have developed revisions to existing policy, regulation and law identified for Part III.

This paper represents the completion of Part I; the development of a revised program model.

II. Overview of Program Model

In order to address the issues included in the Governor's recommendation and to arrive at a new model the Program Committee employed a methodology based on developing answers to a logical series of questions.

1. Which residential alternatives exist to serve the mentally disabled?
2. Who is to be served in a community residence certified by the OMH?
3. What is the goal of community residence programs?
4. What are the types and levels of community residential care needed by the identified target population?
5. What treatment and support services does this population need?
6. What type and number of community residence staff are needed to provide these services?

A basic premise of the model recommended by the Task Force is that the design of a community residence program should be based on the profile of the patients to be served. Therefore, major emphasis is devoted to identifying the characteristics of the population appropriate for community residences. These characteristics served to determine level of necessary care, number and types of services to be provided as well as adequate staffing.

A major feature of the new model is its focus on the younger chronic population. This more unstable, active population has increased in numbers in recent years and has placed new demands on many aspects of the mental health service delivery system. Any attempt to design a community residence program

for this patient population must pay particular attention to the characteristics and service requirements of the younger chronic patient.

At the same time, significant numbers of other types of patients remain in the mental health system and are in need of residential services, e.g. older, more passive patients, requiring highly structured routines. The new model must have the flexibility to serve a variety of types of patients.

Several important changes in the Community Residence Program are proposed in the new model:

1. Patient behavioral and functional characteristics determine the level and type of community residence to which individuals are referred.
2. Program and staffing levels are gauged to community residence program types.
3. Many patients previously excluded from the Community Residence Program will be admitted, primarily to the most intense level of program, e.g. persons not fully self-medicating, persons not willing to participate in highly structured daily routines.
4. There is a relaxation of the requirement for all persons to attend activities outside the community residence 5 days a week. More on-site programming will be available to serve the more severely disabled or non-compliant resident.
5. There is increased emphasis on the improvement of functional abilities as well as movement toward independent living.

6. The goal of the program is linked to admission/discharge criteria and to appropriate review criteria.

7. Regular review of appropriateness of level of care will be conducted using the Functional Assessment Survey.

Recommendations for the alleviation of gaps in services emerge from comparing the residential needs of the mentally disabled population with available community living options, including the Community Residence Program. Such recommendations can be found in the next section and in the conclusion of this paper.

III. REVIEW OF THE EXISTING RESIDENTIAL SYSTEM

For long range planning purposes, the community residence continuum must be viewed as part and parcel of an extensive overall service delivery system for residential care. A commonality shared by many residential alternatives is the high percentage of residents who are current and former OMH patients served in these settings. For example, according to 1984 statistics there are almost 23,000 residents in Proprietary Homes for Adults (PPHA's); over 6,000 (27%) are former OMH patients. (Proprietory Homes for Adults fall under the category of Domiciliary Care for Adults - DCF's) In order to improve the quality of care received by these residents, the OMH has established on site community support teams in homes having 25% or more former OMH patients. The OMH also has recommended additional standards to protect the health, safety and well-being of mentally disabled persons residing in these programs.

A high concentration of former OMH patients also exists within single room occupancy hotels (SRO's). These hotels are run by private unlicensed operators and receive no direct public funding. It is estimated that 25-35% of SRO residents are former psychiatric inpatients with many more in need of psychiatric services.

Another residential option is Shelters for Adults. The latest OMH estimate indicates that 20% of the New York City shelter population have a history of hospitalization in state psychiatric centers. Currently there are treatment teams in a small number of New York City shelters in addition to some mobile outreach teams.

A wide range of living opportunities exist outside the Community Residence Program; however, appropriateness, availability and quality of care remain pressing issues. Of critical importance is the emergence of a changing population of mentally ill persons for whom current residential programs are not appropriate due to the nature of their illness. Characterized by a younger more active individual this population differs from the population most often served successfully in the current Community Residence Program.

The current Community Residence Program is divided into two components. The 24 hour supervised program is designed to receive patients directly from institutional care as well as the community and, at the same time, begin the process of assisting these patients in receiving necessary community support services. The second component of the Community Residence Program is the less restrictive supportive apartment program. This program is also designed to receive patients from the institution, supervised community residences, as well as other community settings and is intended as the last sheltered residential step before the resident begins to live in the community independently. Patients admitted to the Community Residence Program, in addition to residential services, receive in-house supports to assist in the relearning or learning of daily living skills. Direction in planning and participating in social and recreational activities is provided. A comprehensive service plan is developed for each patient outlining in-house as well as community support services which

are necessary and critical to the successful maintenance of each patient in the community. Attendance and participation in appropriate day activities is a requirement for continued stay in a community residence.

The newly characterized population at risk may not be appropriate for the community residence program as currently structured. A wider and more variable scope of community residential programs is indicated to serve this increasingly larger number of patients.

IV. PROPOSED PROGRAM MODEL

A. DESCRIPTION OF TARGET POPULATION

The Community Residence Program serves a population with a wide range of functional, clinical and behavioral problems. (Special Populations are addressed in Attachment A) To serve this population adequately and effectively requires a corresponding range of residential services. The process of matching client level of functioning to residential need was accomplished through analysis of the data obtained from the community residence patient assessment survey conducted in November/December 1982 in all residences and from a recently revised survey piloted in September 1983. The assessment included the areas of activities of daily living (ADL), community living skills, maladaptive, violent and dangerous behavior, psychiatric problems and drug and alcohol use. (See Attachment B)

The survey found distinct differences between clients currently living in supervised and supportive community residences. More important, the results supported the concept of a continuum of residential need. This continuum was broken into three levels, each appropriate for patients with different functional skills and characteristics. Clients placed into the lowest level (23% of the population) were considered to be the best candidates for supervised settings. Those placed into the highest level (55% of the population) were considered appropriate for supportive settings. The findings indicated that there is a middle group of clients (22%) who require a level of residential services distinctly different than those currently provided.

A strong correlation exists between a client's functional skill level i.e., community and ADL skills and the need for a supervised or supportive residential setting. Clients with lower functional levels require more supervision. However a significant number of "higher functioning" clients also were found to require a supervised setting as a result of behavior problems, inability to take

medications reliably, lack of motivation, emotional withdrawal or other serious psychiatric symptomatology. The appropriate match of clients to residential setting requires a multi-level analysis and ultimately relies on clinical judgement. In general, however, profiles of clients requiring the three levels may be differentiated in several broad categories. These are outlined below and illustrated with examples of cases.

Clients in Need of Supervised Setting

- o High degree of psychiatric problems. These include:
  - conceptual disorders
  - hallucinatory behavior
  - thought disorders
  - disorientation
  - emotional withdrawal
  - depression
  - anxiety
- o Most have difficulty with self-medication
- o Uncooperativeness
- o Majority have problems with nutrition, personal care, domestic activities
- o Very poor functioning in independent living skills. This includes:
  - very low employment potential
  - inability to carry out activities necessary to upkeep a home

- o Problems with alcohol and drug use
- o Interpersonal skills are very poor, including
  - assertiveness
  - conflict resolution
  - decision making
  - interaction with others

Supervised Level - Case Summaries

Case 1. A forty year old male who has been in psychiatric hospitals for more than ten years. The last five years have been spent moving between the hospital and a community residence. Ten hospitalizations in this period. He needs daily supervision in taking medications, and has received supervision in the last 30 days for uncooperative behavior. Psychiatric problems vary from moderate to severe in 10 of 18 areas. Personal care and domestic skills are generally adequate, however skills relating to independent functioning in the community are very low.

Case 2. A twenty-three year old female has been hospitalized three times totaling less than one year. She needs some supervision with medications and has required special one to one staff intervention in the last 30 days. Current psychiatric problems are in the mild to severe range in 14 of 18 areas. Her nutritional, personal care and domestic skills are all adequate, however, interpersonal skills, planning, and judgement are all inadequate. She has no history of violent or dangerous behavior. Most of her independent living skills are high but she cannot self medicate.

Clients in Need of Intensive Supportive Settings

- o Fewer and less severe psychiatric problems, than supervised clients. However severe problems exist in:
  - emotional withdrawal
  - depression
  - anxiety
  - uncooperativeness
- o Some problems with taking medication without supervision
- o Majority have problems with nutrition
- o Between a third and a quarter have personal care problems
- o Half have problems with household chores
- o Skills required for community living are moderate to good for most of these clients
- o Low employment potential
- o Some problems with alcohol and drug use

- Interpersonal skills are very poor, similar to Level I, including
  - assertiveness
  - conflict resolution
  - decision making
  - interaction with others

Intensive Supportive Level - Case Summaries

Case 1. Twenty-three year old female has been hospitalized for less than six months during two hospitalizations. Has lived in a community residence for less than six months. She needs some supervision in taking medications but has not required any one to one intervention in last 30 days. Has moderate psychiatric problems in 5 of 18 areas but no violent or dangerous behavior. She has good skills in the areas of nutrition and domestic skills but is inadequate in conflict resolution and exhibiting good judgement. She is rated as moderate in her abilities to work at a paying job or to seek assistance from others.

Case 2. Thirty-three year old male has spent between 6 months and a year in a psychiatric hospital. Last hospitalization lasted 4 months. He takes medication independently and did not require one to one intervention in the last 30 days. He had mild psychiatric problems in 2 of the 18 areas reviewed and exhibited no violent or dangerous behavior. He has serious problems in reacting to criticism or stress and in keeping appointments.

He also has slight problems with alcohol and drug use. He is inadequate in many areas of personal care, domestic activities and interpersonal skills. Exhibits poor use of leisure time.

Clients in Need of Supportive Settings

- o Fewer psychiatric problems than supervised and intensive supportive clients. However problems do exist in:
  - emotional withdrawal
  - depression
  - anxiety
  - uncooperativeness
- o Ability to medicate independently
- o Fewer problems with interpersonal skills than Level I and II; however, they still are present
  - assertiveness
  - conflict resolution
  - decision making
  - interaction with others
- o Few with current alcohol or drug problems Now LE see many
- o Potential to hold a paying job if given the opportunity
- o Generally good skills in community activities, household chores, personal care, health care

Supportive Level - Case Summaries

Case 1. Twenty-two year old male with no previous hospitalizations and not taking medication. Has minor to moderate psychiatric problems in 7 of 18 areas. No violent or dangerous behavior. Exhibits good skills in all ADL and independent functioning areas except interpersonal skills. Poor socialization skills.

Case 2. Thirty-five year old female has been hospitalized 3 to 5 times totaling less than 1 year. She has spent one year in a supervised community residence. She has no need for supervision in taking medications and has not required one to one intervention by staff. She has minor to severe psychiatric symptoms in 12 of 18 areas. Serious problems with reacting to criticism or stress but no violent behavior. All other ADL and independent skills are good except seeking assistance when needed and socialization and leisure skills.

B. PHILOSOPHY AND GOALS

The philosophy underlying the new model is that the Community Residence Program should assist patients with the development of skills necessary for successful reintegration into the community at a pace commensurate with their levels of functioning.

The goal of the Community Residence Program is:

Increased emphasis on the improvement of functional abilities to enable movement towards independent living (alone or with others) in a community based setting.

The Community Residence Program is designed to enable patients to obtain this goal through the following means:

- Reduction of psychiatric symptomatology in a community based setting.
- Acquisition of skills, knowledge and abilities needed to improve functional level.
- Development of good relationships with other people.
    - o Friends
    - o Relatives
    - o Helpers

The new model consists of three distinct programmatic levels, supported by one hospital based program level which serves as the necessary precursor to the community residence continuum. Specifically, the levels of community residences are Supervised Programs, Intensive Supportive Programs and Supportive Programs.

Each program level differs in target populations to be served, intensity of services offered, and the number of staff necessary to effectivly address the goals of the program.

C. DESCRIPTION OF CORE SERVICES AND STAFF INTERVENTION

Within the community residence continuum specific basic or "core" services exist which should be provided to all residents, regardless of the programmatic level in which they reside. These core services consist of:

1. Training in Activities of Daily Living
2. Admission/Discharge Planning
3. Behavior Intervention
4. Case Management
5. Counseling
6. Crisis Management
7. Follow-up
8. Medication Management
9. Room and Board
10. Socialization
11. Transportation

(For definitions see Glossary - Attachment C)

The provision of these core services is essential to maintaining or improving a residents' current functional capabilities while simultaneously providing the tools and supports necessary to progress toward independent living. These services are provided within a therapeutic living environment by staff who possess a knowledge of the unique problems of the mentally ill population and the expertise to effectively meet this population's needs.

Although all of the core services are provided across the community residence continuum, the intensity of the service will vary by programmatic level. To conceptualize the degrees of intensity, descriptors have been developed which directly correspond to the community preparation programs, which precede discharge from an inpatient unit, as well as to the three levels of community residences. For the purpose of this presentation these descriptors will be titled staff intervention levels.

The four staff intervention levels are:

1) Intensive training and assistance which directly corresponds to community preparation programs (part of inpatient care); 2) Training and assistance which directly corresponds to supervised programs; 3) Training and/or limited assistance which directly corresponds to intensive supportive programs; and 4) Monitoring which directly corresponds to supportive programs.

An individual receiving service within a community preparation unit or program would be in need of the most intensive level of service and/or intensive training and assistance. This means that direct instruction as well as intensive staff assistance and intervention would be constantly necessary to accomplish the majority of tasks which that person would be attempting. These activities would be oriented toward facilitating the development of necessary prerequisite skills and an understanding of the expectations for transitioning from inpatient care to the community.

As an individual enters the next programmatic level on the continuum, a supervised program, the intensity of service would be at the training and assistance level. This means that instruction as well as staff assistance and intervention are generally necessary to accomplish tasks. Such activities are oriented toward improving competence in basic skills and behavior. The person will possess basic skills but staff must still provide close supervision.

Admission into the next programmatic level*, an intensive supportive program, should indicate a lessening of the intensity of service or a need for training and/or limited assistance. This means that instruction as well as staff assistance and intervention are occasionally necessary to accomplish tasks. By this time the individual should be able to effectively function in the majority of the activities in which he/she is involved. There may, however, be periods of regression which require staff support. Most staff activities would be oriented toward reinforcing already learned skills and appropriate behavior.

The last programmatic level, a supportive program would require the least intensive level of service or monitoring. This means that staff direction is minimally necessary to accomplish tasks. At this level the individual is able to function independently in most situations. Staff monitoring activities would be oriented toward reviewing an individual's need and frequency for assistance and/or intervention.

* This does not imply that all residents must go through a sequence of placements. Residents, depending on readiness, may go to less restrictive placements directly.

It must be noted that the intensity of service at each programmatic level should not be measured by frequency of staff intervention alone. For example, this is true at the supportive level where the focus is not on assistance in accomplishing discrete tasks, but rather on assessing the ability to use skills and supports to cope with the expectations and pressures of independent living. The expertise of the staff at this level may determine whether or not the resident is able to successfully transition out of the program or continues to need a structured residential program.

The relationship between programmatic levels, core services, and intensity of service can be better understood through the following matrix. The matrix indicates, by the use of concrete examples, how the degree of staff intervention changes from one programmatic level to another.

	Levels of Staff Intervention			
	Intensive Training & Assistance	Training & Assistance	Training &/or Limited Assistance	Monitoring
	PROGRAM LEVELS			
	Community Preparation (Inpatient)	Supervised Living (24 hour Supervision)	Intensive Supportive Living (Daily Visits)	Supportive Living (1-3 visits a week
Core Services				
1. Training in Assistance in Daily Living Skills (ADL)	o classroom cooking instruction w/ "hands-on" assistance 1:1 Staff-MHTA, Rehab.	o staff & residents participate together cooking w/ "hands-on" Nutritional Consultant & CR Staff	o Resident prepares meals Staff trains & assists	o Resident prepares meals o Staff monitors program progression/ regression
2. Admission and Discharge Planning	Level of intensity of staff activities would remain constant across the four program levels Staff:Screening Teams	Qualified professionals available on staff or by written agreement with other mental health service providers		
3. Medication Management	o Staff will administer w/classroom training in self-administration	o Self-administration w/close supervision and cont'd training	o Self-administration w/continued training and/or assistance	o Self-administration w/ regular to periodic reviews

	Levels of Staff Intervention			
	Intensive Training & Assistance	Training & Assistance	Training &/or Limited Assistance	Monitoring
	PROGRAM LEVELS			
	Community Preparation (Inpatient)	Supervised Living (24 hour Supervision)	Intensive Supportive Living (Daily Visits)	Supportive Living (1-3 visits a wee
Core Services				
3. Medication Management (Con't)	Staff-M.D., RN or MHTA with appropriate certification.	Resident's MD and CR & OP staff Qualified professionals available on staff or by written agreement with other mental health service providers	Resident's MD and CR and OP staff	CR staff
4. Behavior Intervention	o "Classic" Behavior Modification Program to teach appropriate behaviors Staff:Treatment Team	o Many verbal interventions needed frequently CR Staff	o Some verbal reminders needed but frequency decreases	o Occasional Reminders
5. Counseling	o Individual & Group Counseling Staff:Treatment Team	o 1:1 frequent interaction using individual and group forum CR Staff	o 1:1 cont'd; frequency decreases replaced by group process	o 1:1 cont'd; frequency being reviewed

	Levels of Staff Intervention			
	Intensive Training & Assistance	Training & Assistance	Training &/or Limited Assistance	Monitoring
	PROGRAM LEVELS			
	Community Preparation (Inpatient)	Supervised Living (24 hour Supervision)	Intensive Supportive Living (Daily Visits)	Supportive Living (1-3 visits a week
Core Services				
6. Crisis Management	o Frequent intervention needed due to poor impulse controls o use of behavior modification techniques	o Frequent intervention replaced by timely counseling and behavior intervention o Frequent episodes on regular basis	o Occasional need for intervention due to diminishing # of episodes	o Review of frequency and intensity of interventions
	Staff:Treatment Team	CR Staff ----------		
7. Follow-up	The intensity of staff activity does not change across the continuum, but rather at times of discharge to independent living.			
	Staff:Social worker	CR Staff ----------		
8. Transportation	The intensity of staff activity does not change across the continuum, but rather on geographic location and accessibility of public transportation systems.			
	Staff:MHTA or Drivers	CR Staff ----------		

Core Services	Levels of Staff Intervention			
	Intensive Training & Assistance	Training & Assistance	Training &/or Limited Assistance	Monitoring
	PROGRAM LEVELS			
	Community Preparation (Inpatient)	Supervised Living (24 hour Supervision)	Intensive Supportive Living (Daily Visits)	Supportive Living (1-3 visits a wee
9. Room and Board	The intensity of staff activity does not change across the continuum based on program level or resident functioning, but rather on type and configuration of buildings and applicable building codes.			
	Staff:MHTA	CR Staff		
10. Case Management	The intensity of staff activity does not change across the continuum, but is rather a function of the particular needs and numbers of clients at a particular point in time.			
	Staff:Social Worker	CR Staff OP Staff or CSS Staff		

Levels of Staff Intervention			
Intensive Training & Assistance	Training & Assistance	Training &/or Limited Assistance	Monitoring
PROGRAM LEVELS			
Community Preparation (Inpatient)	Supervised Living (24 hour Supervision)	Intensive Supportive Living (Daily Visits)	Supportive Living (1-3 visits a week
Core Services			
11. Socialization o Client is told and shown by example how to eat in a restaurant o May be taken to restaurant to test ability	o Trial and error still occurring on frequent basis o Successes are still few but increase with practice	o Fewer errors occurring and frequency diminishing	o Occasional errors o Frequency being monitored
Staff:MHTA	CR Staff ----------		

D. STAFFING

Direct Staffing Criteria

Based on the resident characteristics discussed in the section IV A, Description of Target Population, and the levels of staff intervention included in Section IV C, the Description of Core Services and Intensity of Provision, a staffing methodology for direct staff has been developed. The methodology describes: 1) the functions that staff must perform; 2) the minimum qualifications for each type and level of staff; and 3) the numbers of direct care staff for each level of program.

1. Staff Functions

The role of the direct care staff in the delivery of core services differs only in degree and intensity across programmatic levels. Specific functions of direct care staff include:

- Case Management - staff provide necessary linkage to ensure that day treatment/day program, legal, medical, financial, and psychiatric services are available to the resident. This function is crucial in order to insure continuity of care within the overall service delivery system.
- Training in activities of daily living - staff provide supervision, assistance, training, and monitoring in ADL skills. Examples of these activities include: planning and preparation of meals, basic housekeeping, money management, use of community resources, e.g. transportation, YMCA, library, etc.

- Medication management - staff are responsible for storage, record keeping, administration and/or supervision, and training of residents in self administration of medication.
- Social and recreational activities - staff are responsible for planning, implementation, and supervision of activities.
- Admission and discharge processes - staff are responsible for screening of referrals, initial interviews and the actual intake process. Discharge responsibilities include review, evaluation, appropriate placement, and follow up upon discharge from the community residence. This admission/discharge function is usually assigned to a specific direct care staff, although variations occur within different community residence programs. Qualified professionals should be available on staff or by written agreement with other mental health service providers to provide clinical expertise to insure supervision of all direct care staff responsible for admission and discharge planning and monitoring of medication.
- Follow up - staff are responsible for insuring that residents receive the necessary degree of support to facilitate transition between program levels and independent living. This support may vary in degree and intensity according to individual cases and is subject to clinical judgement.

In addition to the above functions, direct care staff must be skilled in the following areas:

- o Counseling - staff are responsible for assisting residents in the development of the necessary skills required in decision making, problem solving, interpersonal issues etc. The focus of interaction is immediate and situational.
- o Behavioral Intervention - staff are responsible for intervening in situations which demand immmediate attention in order to 1) insure the safety of residents and staff and 2) provide feedback to residents concerning acceptable and/or unacceptable behavior.
- o Crisis Management - staff must be able to respond immediately to acute episodes of emotional distress in order to 1) contain resident regression and 2) insure safety of residents and staff

Additional responsibilities of direct care staff include:

- o Attendance and participation in meetings both within the community residence and with external entities such as referral sources, day/clinic providers, residents' families, etc.
- o Reporting and record keeping for individual caseload
- o Compliance with OMH rules and regulations and program policy and procedures

2. Staff Qualifications

The necessary qualifications of the direct care staff are the same, regardless of programmatic level. The dynamics of a community residence program

can best be described within the framework of a therapeutic environment. All activities conducted on-site are focused towards the enhancement of the resident's ability to function within the community, with the goal of eventual independence. This environment is characterized by intense interaction between staff and residents.

The implication of the above is the necessity to recruit staff with the following general characteristics:

- o high degree of flexibility
- o people oriented
- o high degree of empathy and sensitivity
- o high level for frustration tolerance

In addition, direct care staff are required to possess the necessary skills to do the following:

- o train or teach residents. Skills include the ability to instruct and/or assist residents in activities of daily living.
- o counsel residents. Skills include the ability to listen, to interpret, to direct the resident in problem solving, etc.
- o supervise residents. Skills include the ability to lead and direct individuals and groups in activities aimed at maximizing residents' rehabilitative potential as well as insuring their safety.

- o assess residents' functional abilities. Ability to observe residents and assess their level of skill at a given point in time is required. Ability to intervene and "re-train".

The following educational and experience requirements must be met by direct care staff:

- o Counselors - A minimum of a high school diploma and some experience in a mental health or related setting.
- o Senior Counselor - Direct care staff assigned specific responsibility for planning and implementing a rehabilitative, high expectancy program and/or individually designed service plans are required to have a bachelor's degree in human services, or be currently licensed as a registered nurse, or be currently licensed or certified in a mental health discipline, and have one year of experience working with the mentally ill. This position exists only in supervised programs.
- o The supervisor in a single site supervised program should have a bachelor's degree in human services, or be licensed as a registered nurse or be licensed or certified in a mental health discipline and have one year of experience working with the mentally ill.
- o The supervisor in both intensive supportive and supportive programs should meet the same requirements as the supervisor in the supervised setting.
- o For every three program supervisors in an agency, a manager may be added. This staff person is responsible for directing the activities of the program supervisors.

This individual should have at least a master's degree and current licensure or certification in a mental health discipline,

or

a master's degree in a human services discipline and one year of experience working with the mentally ill,

or

a master's degree and two years of experience working with the mentally ill,

or

a bachelor's degree in a human services discipline and current licensure or certification in a mental health discipline and one year of experience working with the mentally ill,

or

a bachelor's degree in a human services discipline and three years of experience working with the mentally ill,

or

a bachelor's degree and current licensure or certification in a mental health discipline and two years of experience working with the mentally ill,

or

a bachelor's degree and four years of experience working with the mentally ill,

or

licensure as a registered nurse and three years of experience working with the mentally ill.

Alternative experience or education may be substituted with the approval of the Office of Mental Health.

- o Clinical Supervision

  In order to insure that adequate clinical supervision and program direction are provided, each program shall have available on staff or by written agreement with other mental health service providers, qualified professionals who are certified or licensed in a mental health discipline and who possess sufficient experience working with the mentally ill to provide such clinical input.

3. Numbers of Direct Care Staff

a) Supervised Programs

In determining the numbers of staff that are required for a Supervised Program, the following factors were considered:

- o the majority of residents to be served within a Supervised Program resemble the profile of individuals described in the Target Population section.
- o with the likely movement of some of the less impaired current residents of supervised programs to the proposed Intensive Supportive Program, and the probable influx of those described above, the new population of the Supervised Program will be a more severely impaired, more management intensive population
- o the current range of existing supervised programs is from 8 to 24 residents

- o a therapeutic environment must be provided
- o the current scope of the Site Selection Law (OMH involvement for 1-14 Supervised beds and 4-14 Supportive beds at the same site)
- o the regulatory requirement for 1 overnight staff for 1-14 residents, and 2 overnight staff for 15-24 residents

Given the above, a review of the activities and the related time frames within which they occur was undertaken. This was accomplished by dividing the day into blocs of time that are meaningful to and typical of those activities. This data was based on site visits to numerous programs, and specific suggestions from current staff of supervised programs. The following blocs of time were defined and staff activities identified:

Monday - Friday

7 AM - 9 AM

- o awaken all residents
- o provide ADL assistance and training
- o prepare/assist in preparation of breakfast
- o supervise administration of medications
- o provide assistance with socialization skills
- o get residents to day activities on time
- o provide crisis management, where necessary

9 AM - 3 PM

For those residents not attending day activities on a given day (5 day/week day activities will not be required for all residents at this level):

- o provide ADL assistance and training
- o provide counseling
- o provide behavior intervention
- o provide transportation, where necessary, for appointments
- o provide crisis management, where necessary

For all residents staff must:

(Many of these activities may occur outside this bloc of time, ex. 3 p.m. - 5 p.m.)

- o maintain clinical records
- o attend to admission and discharge planning
- o provide follow-up services
- o attend staff meetings
- o participate in staff development
- o provide linkage and case management services
- o attend clinical meetings
- o maintain close contact with primary clinical entity to assure that the clinical treatment plan and the community residence service plan are in concert

3 PM - 7 PM

- o provide counseling as residents return from day programming
- o provide ADL assistance and training
- o provide behavior intervention
- o plan evening social/recreational activities
- o provide transportation to off-site social/recreational activities
- o provide crisis management, where necessary
- o supervise administration of medication
- o assist with socialization skills
- o prepare and assist in preparation of dinner

7 PM - 11 PM

- o supervise administration of medication
- o provide transportation from social/recreational activities
- o provide counseling
- o conduct house meetings
- o provide behavior intervention
- o provide ADL assistance and training
- o assist with socialization skills
- o assist with preparation of snacks
- o provide crisis management, where necessary

11PM - 7 AM

- o provide overnight coverage
- o provide crisis management, where necessary

Saturday - Sunday

9 AM - NOON

- o assist with ADL activities as residents awake
- o assist in preparation of breakfast/lunch
- o supervise administration of medications
- o provide assistance with socialization skills
- o plan social/recreational activities for the day
- o provide behavior intervention
- o provide counseling
- o provide crisis management, where necessary

NOON - 1 AM

- o transport to participate in off-site social/recreational activities
- o supervise administration of medication
- o provide ADL assistance and training
- o provide behavior intervention
- o provide counseling
- o assist with socialization skills
- o prepare and assist in preparation of dinner, snacks
- o provide crisis management, where necessary

1 AM - 9 AM

- o provide overnight coverage
- o provide crisis management, where necessary

The next step was to determine the minimum staffing required to provide both coverage and the ability to provide the core services during each time interval, and the optimal number of residents such staffing could safely and adequately serve.

Referring to Table 1 - Direct Care Staffing for an 8-Bed Supervised Program, and considering the activities which occur during each bloc of time each day, it was determined that a minimum of 206 staff hours are required for coverage, and that such single coverage for 130 hours/week, supplemented by double coverage for 38 hours/week, can serve a maximum of 8 people at this level of impaired functioning.

Although there seems to be a trend within the provider community towards a 35 hour work week for staff, there remains a wide distribution among providers of from 35-40 hours/week. Based on a survey by OMH, and supported by site visits, it appears that a 37.5 hour work week is the average for current providers, and this is the number used throughout this paper.

The 206 staff hours per week that provide minimum staffing for 8 residents convert to 5.5 Full Time Equivalents (FTE's) when divided by the 37.5 hours in a work week.

TABLE 1: SUGGESTED DIRECT CARE STAFFING FOR AN 8 BED [illegible]

MON - FRI:	7 AM - 9 AM	9 AM - 3 PM	3 PM - 7 PM	7 PM - 11 PM	11 PM - 7 AM	TOTAL
	2 hour bloc x 1.5 staff (1 staff 7-9) = (1 staff 8-9)	6 hour bloc x 1 staff =	4 hour bloc x 1.5 staff (1 staff = 3-7) = (1 staff = 4-6)	4 hour bloc x 1.5 staff (1 staff = 7-11) = (1 staff = 9-11)	8 hour bloc x 1 staff =	29 staff hrs./ day x5 days 145 staff hrs./ weekdays
	3 staff hours	6 staff hours	6 staff hours	6 staff hours	8 staff hours	

SAT - SUN:	9 AM - NOON	NOON - 1 AM	1 AM - 9 AM	TOTAL
	3 hour bloc x 1 staff =	13 hour bloc x 1.5 staff (1 staff noon - midnight) = (1 staff 3-9)	8 hour bloc x 1 staff =	30.5 staff hrs./ day x2 days 61 staff hrs./ weekdays
	3 staff hours	19.5 staff hours	8 staff hours	

A. Total Staff Hours Available/Week = 145 (M-F) + 61 (S-S) = 206

B. Converted to FTE's = $\frac{206 \text{ avail staff hrs./week}}{37.5 \text{ hrs/work week}} = 5.5$

C. Relief Staff = 13% x 5.5 FTE's = .7

D. Total FTE's for 8 Beds = 6.2

E. Coverage Summary for 8 Residents

1. 56 hrs./wk. - single coverage, sleeping hours
2. 74 hrs./wk. - single coverage, waking hours
3. 38 hrs./wk. - double coverage, waking hours

This 5.5 FTE's for 8 residents assumes each staff person works 5 day/week, 52 weeks/year. This not being the case, time off must be estimated, and provision made for additional FTE's to provide relief coverage. The following assumptions were made concerning a typical community residence staff fringe benefit package concerning days off/year with pay:

- o 10 days vacation
- o 10 days sick leave
- o 5 days personal leave
- o 10 days paid holidays

This totals 35 days, which, when multiplied by 7.5 hours/day, yields 262.5 hours/year for which coverage is needed for each staff. When 262.5 hours is divided by 1950 hours (the number of hours/year for which staff is paid) a Relief Percent or Relief Factor of 13% results. Once basic staffing coverage is determined in FTE's for any size program at any level of program, an additional 13% FTE must be added for funding purposes.

Thus, the basic 8-bed program with 5.5 FTE's staff for coverage, must be increased by 13% or .7 FTE's for relief, giving a total staff requirement of 6.2 FTE's for 8 beds.

The next step was to determine what additional staff was needed for each resident above 8. Given the rehabilitative objective of this new model, with its well-defined service package and appropriate staffing levels for the basic 8-bed program, the model allows for an increase in staffing at an even rate as the number of residents increase. That rate was determined to be an additional

hour of staff time/day for each additional resident. One hour a day times 7 days a week divided by 37.5 hours a work week = .2 FTE's for each additional resident above 8.

Table 2 displays the recommended staffing for Supervised Programs of 8-24 beds. Tables 3-6 show some suggested deployment of direct care staff by blocs of time for programs of 14, 16, 18, and 24 beds.

The following statements are made:

- the minimum program size is 8 beds, funded for 6.2 FTE of direct staff
- each additional resident above 8 is matched by an additional .2 FTE (1 hour per day of service)
- after basic staffing is determined for each program size, a Relief Factor of 13% is added for funding purposes
- maximum program size should continue to be 24 beds
- it should be OMH policy to give priority to those proposed programs in the 12-14 bed range
- whenever there is only one staff person on duty, there should be a second backup person available via beeper at all times
- programs for special populations such as physically disabled or multi-disabled (MR/MH) may require additional staffing based upon the degree of the secondary disability.

TABLE 2: SUMMARY OF DIRECT STAFFING FOR SUPERVISED PROGRAMS 8 - 24 BEDS

Number of Residents	Core Staff for First 8 Residents		Additional Staff For More Than 8 Residents:	Relief Staff (13% of FTE's)	Total Staff
8	5.5		0	.7	6.2
9	5.5		.2	.7	6.4
10	5.5		.4	.8	6.7
11	5.5		.6	.8	6.9
12	5.5		.8	.8	7.1
13	5.5		1.0	.8	7.3
14	5.5		1.2	.9	7.6
15	7.0		1.4	1.1	9.5
16	7.0	Additional	1.6	1.1	9.7
17	7.0	1.5 FTE	1.8	1.1	9.9
18	7.0	added	2.0	1.2	10.2
19	7.0	for over-	2.2	1.2	10.4
20	7.0	night	2.4	1.2	10.6
21	7.0	coverage	2.6	1.2	10.8
22	7.0	7 days/	2.8	1.3	11.1
23	7.0	week	3.0	1.3	11.3
24	7.0		3.2	1.3	11.5

TABLE 3: SUGGESTED - DIRECT CARE STAFFING FOR A 14 BED SUPERVISED PROGRAM

MON - FRI:	7 AM - 9 AM	9 AM - 3 PM	3 PM - 7 PM	7 PM - 11 PM	11 PM - 7 AM	TOTAL
	2 hour bloc	6 hour bloc	4 hour bloc	4 hour bloc	8 hour bloc	34 staff hrs./ day
	x	x	x	x	x	x5 days
	2 staff =	1 staff =	2 staff =	2 staff =	1 staff =	170 staff hrs./ weekdays
	4 staff hours	6 staff hours	8 staff hours	8 staff hours	8 staff hours	

SAT - SUN:	9 AM - NOON	NOON - 1 AM	1 AM - 9 AM	TOTAL
	3 hour bloc	13 hour bloc	8 hour bloc	40 staff hrs./ day
	x	x	x	x2 days
	2 staff =	2 staff=	1 staff =	80 staff hrs./ weekend
	6 staff hours	26 staff hours	8 staff hours	

A. Total Staff Hours Available/Week = 170 (M-F) + 80 (S-S) = 250

B. Converted to FTE's = $\frac{250 \text{ staff hrs/week}}{37.5 \text{ hrs/work week}} = 6.7$

C. Relief Staff = 13% x 6.7 FTE's = .9

D. Total FTE's Needed For 14 Beds = 7.6

TABLE 4: SUGGESTED - DIRECT CARE STAFFING FOR A 16 BED SUPERVISED PROGRAM

MON - FRI:	7 AM - 9 AM	9 AM - 3 PM	3 PM - 7 PM	7 PM - 11 PM	11 PM - 7 AM	TOTAL
	2 hour bloc x 2 staff =	6 hour bloc x 1.5 staff = (1 staff 9-3) (1 staff 12-3)	4 hour bloc x 2 staff =	4 hour bloc x 2 staff =	8 hour bloc x 2 staff =	45 staff hrs./ day x5 days 225 staff hrs./ weekdays
	4 staff hours	9 staff hours	8 staff hours	8 staff hours	16 staff hours	

SAT - SUN:	9 AM - NOON	NOON - 1 AM	1 AM - 9 AM	TOTAL
	3 hour bloc x 2 staff =	13 hour bloc x 2 staff=	8 hour bloc x 1 staff =	48 staff hrs./ day x2 days 96 staff hrs./ weekend
	6 staff hours	26 staff hours	16 staff hours	

A. Total Staff Hours Available/Week = 225 (M-F) + 96 (S-S) = 321

B. Converted to FTE's = $\frac{321 \text{ staff hrs/week}}{37.5 \text{ hrs/work week}} = 8.6$

C. Relief Staff = 13% x 8.6 FTE's = 1.1

D. Total FTE's Needed For 16 Beds = 9.7

TABLE 5: SUGGESTED DIRECT CARE STAFFING FOR AN 18 BED SUPERVISED PROGRAM

MON - FRI:	7 AM - 9 AM	9 AM - 3 PM	3 PM - 7 PM	7 PM - 11 PM	11 PM - 7 AM	TOTAL
	2 hour bloc x 2 staff =	6 hour bloc x 2 staff =	4 hour bloc x 2 staff =	4 hour bloc x 2 staff =	8 hour bloc x 2 staff =	48 staff hrs./ day x5 days 240 staff hrs./ weekdays
	4 staff hours	12 staff hours	8 staff hours	8 staff hours	16 staff hours	

SAT - SUN:	9 AM - NOON	NOON - 1 AM	1 AM - 9 AM	TOTAL
	3 hour bloc x 2 staff =	13 hour bloc x 2 staff=	8 hour bloc x 1 staff =	48 staff hrs./ day x2 days 96 staff hrs./ weekend
	6 staff hours	26 staff hours	16 staff hours	

A. Total Staff Hours Available/Week = 240 (M-F) + 96 (S-S) = 336

B. Converted to FTE's = $\frac{336 \text{ staff hrs/week}}{37.5 \text{ hrs/work week}} = 9.0$

C. Relief Staff = 13% x 9.0 FTE's = 1.2

D. Total FTE's Needed For 18 Beds = 10.2

TABLE 6: SUGGESTED DIRECT CARE STAFFING FOR A 24 BED SUPERVISED PROGRAM

MON - FRI:	7 AM - 9 AM	9 AM - 3 PM	3 PM - 7 PM	7 PM - 11 PM	11 PM - 7 AM	TOTAL
	2 hour bloc x 2.5 staff =	6 hour bloc x 2 staff =	4 hour bloc x 2.5 staff =	4 hour bloc x 2 staff =	8 hour bloc x 2 staff =	51 staff hrs./ day x5 days 255 staff hrs./ weekdays
	5 staff hours	12 staff hours	10 staff hours	8 staff hours	16 staff hours	

SAT - SUN:	9 AM - NOON	NOON - 1 AM	1 AM - 9 AM	TOTAL
	3 hour bloc x 3 staff =	13 hour bloc x 3 staff=	8 hour bloc x 2 staff =	64 staff hrs./ day x2 days 128 staff hrs./ weekend
	9 staff hours	39 staff hours	16 staff hours	

A. Total Staff Hours Available/Week = 255 (M-F) + 128 (S-S) = 383

B. Converted to FTE's = $\frac{383 \text{ staff hrs/week}}{37.5 \text{ hrs/work week}} = 10.2$

C. Relief Staff = 13% x 10.2 FTE's = 1.3

D. Total FTE's Needed For 24 Beds = 11.5

b) Intensive Supportive Programs

The new Intensive Supportive Program is designed to bridge the service gap between those residents requiring 24 hour supervision and those capable of functioning in a more independent setting requiring only 1-3 visits/week by staff.

This new programmatic level will provide a resident with daily visits, but does not require overnight supervision. However, agencies with clustered housing situations in which apartments are within close proximity of each other (for example units within the same building) may wish to provide on site overnight coverage within the constraints of Intensive Supportive Program funding. Such an intermediate level of service seems appropriate, given the profile of individuals described in Intensive Supportive. Both the existing supportive program, with its mandated three visits a week per resident, and the proposed Supportive Program, with its range of 1-3 visits per week per resident, assume an average visit consumes 2.3 staff hours, and builds their staffing ratios accordingly. The Intensive Supportive Program, however, for staffing purposes, assumes a staff visit consumes only 2 hours, a reduction of 13% from current supportive programs. The rationale is that since visits will occur daily, shorter interactions will not adversely affect the resident, thus making the service more cost effective.

If seven visits a week per resident is multiplied by 2 hours (the length of each visit), and the product divided by 37.5 hours per work

week, the result is .37 FTEs, which is the staff to resident ratio for this program. The Relief Factor is also computed, and added to the staffing ratio. Table 7 - Summary of Direct Staffing for Intensive Supportive Programs shows the recommended staffing for program sizes of 8 through 40 residents, at intervals of 2.

TABLE 7: SUMMARY OF DIRECT STAFFING FOR INTENSIVE SUPPORTIVE PROGRAMS*

Number of Residents	Number of Visits/Wk	Hrs./ Visit (x 2)	Number of Hours/Wk (: by 37.5)	No. of FTE's	Relief Factor (13% of FTE)	Total Staff FTE's
8	56		112	2.98	.39	(3.4)
10	70		140	3.73	.48	(4.2)
12	84		168	4.48	.58	(5.1)
14	98		196	5.23	.68	(5.9)
16	112		224	5.97	.78	(6.8)
18	126		252	6.72	.87	(7.6)
20	140		280	7.47	.97	(8.4)
22	154		308	8.21	1.07	(9.3)
24	168		336	8.96	1.16	(10.1)
26	182		364	9.71	1.26	(11.0)
28	196		392	10.45	1.36	(11.8)
30	210		420	11.20	1.46	(12.7)
32	224		448	11.95	1.55	(13.5)
34	238		476	12.69	1.65	(14.3)
36	252		504	13.44	1.75	(15.2)
38	266		532	14.18	1.84	(16.0)
40	280		560	14.93	1.94	(16.9)

* The supervisor position as described in the staffing qualifications section is not included in the FTE figure

c) Supportive Programs

For the new model, the Supportive Program has been expanded to include those residents requiring 1,2, or 3 visits per week.

At this point in time, it is impossible to estimate with any accuracy what numbers or percent of residents currently in community residences will require the traditional 3 visits per week, and how many will require 1 or 2. Recent data gathered by the Functional Assessment instrument showed that about 4% of the current community residence residents appeared to be ready for independent living. If this proposed Supportive Program currently existed, these clients would be likely candidates for 1 or 2 visits per week.

Once the new Supportive Program becomes operational, an individual program will possess the flexibility to provide an appropriate level of service based on the current needs of the residents. Given the nature of the illness, it is not uncommon for a supportive level resident, on a short term basis of several days to several weeks, to require intense intervention to prevent re-hospitalization. Such intervention would involve daily, or even twice daily visits by program staff, often lasting many hours each.

The new flexibility will allow program staff to begin the process of reducing visits from 3 to 2 to 1 for those residents demonstrating the ability to move through the system. Such capability should significantly contribute to the rehabilitative process, and may reduce

re-hospitalization caused by client inability to adjust to the sudden change from 3 visits per week to total independence.

Additionally, staffing flexibility will allow for the mix of residents to constantly change. Any person appropriate for supportive living may be admitted rather than limiting admission only to those needing a specific number of visits per week. The needs of the individual client and those of the referring agencies can best be served by this approach.

Input from the provider community strongly suggests as reasonable an OMH estimate that on the average, the current supportive program, with its mandated 3 visits per week, consumes about 7 hours of staff time, or 2.3 hrs./visit. Given the potential resident mix, it is reasonable to expect that this new Supportive Program can be staffed on a basis of an average of 2.5 visits a week per resident, with the same 2.3 hours per visit. If 2.5 visits per week is multiplied by 2.3 hours per visit, and the product divided by 37.5 hours per work week, the result is .15 FTE's/resident, which is the ratio used to determine staffing for the new Supportive Program. The relief ratio also is computed and added to the staffing ratio.

In order to have the flexibility advantages previously described, this program must be staffed to provide no less than 2.5 visits per week to all residents in the program. Anything less precludes the ability to provide the required service when a very high proportion of clients in a program at a given time require 3 visits per week.

This situation may be common based on an analysis of functional assessment data.

When the resident mix includes those who are receiving 1 or 2 visits per week, the staff time available for the visits may be used to plan the resident's move to independent living. Staff activities may include an increased emphasis on establishing contacts for the resident with generic service agencies in the community, insuring continuity of existing day programming or employment, and assisting in the search for adequate and decent independent housing.

Table 8 - Summary of Direct Staffing for Supportive Programs displays the recommended staffing for program sizes of 8 through 40 residents, at intervals of 2.

TABLE 8: SUMMARY OF DIRECT STAFFING FOR SUPPORTIVE PROGRAMS*

Number of Residents	FTE's for Basic Coverage (# of Residents x .15)	Relief Factor (13% x FTE's)	Total Staffing FTE's
8	1.2	.16	1.4
10	1.5	.20	1.7
12	1.8	.23	2.0
14	2.1	.27	2.4
16	2.4	.31	2.7
18	2.7	.35	3.1
20	3.0	.39	3.4
22	3.3	.43	3.7
24	3.6	.47	4.1
26	3.9	.51	4.4
28	4.2	.55	4.8
30	4.5	.59	5.1
32	4.8	.62	5.4
34	5.1	.66	5.8
36	5.4	.70	6.1
38	5.7	.74	6.4
40	6.0	.78	6.8

* The program supervisor position as described in the staffing qualifications section is not included in this FTE figure

Indirect Staffing Criteria

Functions and qualifications of staff are identical across the three levels of program.

a) Staff Functions

Specific functions of Indirect Staff include the following:

1. Executive Direction
2. Secretarial/Clerical
3. Accounting and Bookkeeping
4. Statistical and Fiscal Reporting
5. Reimbursement/Entitlements/Patient Resources
6. Budget Preparation
7. Personnel Transactions
8. Public Relations
9. Program Review and Evaluation
10. New Program Development
11. Contract Negotiations
12. Development of Policies and Procedures
13. Staff Development

b) Staffing Qualifications

Qualifications for indirect staff are determined by their specialized functions.

The qualifications for executive directors are usually established by the Board of Directors. They typically include an advanced degree with experience in staff supervision, community work, budget preparation, etc.

E. DESCRIPTION OF PROGRAMMATIC LEVELS

Community Preparation Unit/Program

Target Population: Inpatients potentially appropriate for community residence placement

Goal: Development of prerequisite skills necessary for transition to community

Auspice: State-operated or general hospital

Setting: On-grounds - State operated psychiatric facility
Separate living unit (recommended); or general hospital

Services and Staff Intervention Level: All core services at the Intensive Training and Assistance level of staff intervention
Any additional regulatory or statutory requirements applicable

Staffing: Inpatient staff appropriate to provide the core services and any additional mandated services. Specific staffing ratios will be delineated in facility plan (See comments)

Comments: It is highly recommended that a preparation program take a psychoeducational approach. An education process concerning the illness and the needed medications is highly desirable. This type of realistic preparation can be particularly helpful to all patients, especially the young chronic patient.

Although it is recommended that each State-operated psychiatric facility establish a separate living unit designated as a community preparation unit, it may not be feasible for every facility.

Each facility will be mandated, however, to provide services which address the community preparation functions.

General hospitals will be encouraged to develop community preparation programs.

Supervised Program

Target Population: Individuals with characteristics as identified in Profiles of Clients by Residential Need for Supervised Programs.

Goal: Improving competence in basic skills and behavior, with focus on movement to supportive or independent setting.

Auspice: Voluntary-operated, State-operated.

Setting: Single-site dwelling.

Services and Staff Intervention Level: All core services at the training and assistance level of staff intervention

Staffing: Minimum of 8 bed program will require 6.2 Full Time Equivalent (FTE) Direct Staff with an additional .2 FTE required for each additional client served
Maximum of 24 bed program will require 11.5 FTE Direct Staff

Comments: If special population groups such as individuals with recent histories of violence, dangerousness or arson, ex-offenders, or sex offenders are to be served by supervised living programs, the programs must be located on the grounds of a State-operated psychiatric facility.

Multi-disabled (MH/MRDD) and physically disabled populations may be served by supervised programs. A case by case review of degree of disability will determine where the program will be located as well as the need for enriched staffing. Whenever possible these populations should be mainstreamed into regular community residence programs.

Intensive Supportive Program

Target Population:	Individuals with characteristics as identified in Profiles of Clients by Residential Need for Intensive Supportive Programs.
Goal:	Reinforcing skills already learned and appropriate behavior with focus on movement to a supportive or independent setting.
Auspice:	Voluntary - operated.
Setting:	Clustered apartments (preferred), scattered - site apartments.
Services and Staff Intervention Level:	All core services at the training and/or some assistance level of staff intervention.
Staffing:	Staffed to provide daily visits of 2 hours to each resident. Constant staffing ratio of .42 staff/resident with on call beeper back up.

Comments:

Supportive Program

Target Population:	Individuals with characteristics as identified in Profiles of Clients by Residential Need for Supportive Programs.
Goal:	Assessment of individual need for and frequency of assistance and/or intervention with focus on movement to independent living.
Auspice:	Voluntary - operated.
Setting:	Scattered-site apartments.
Services and Staff Intervention Level:	All core services at the montioring level of staff intervention.
Staffing:	Staffed to provide 1-3 visits/week/resident, depending on need. Constant staffing ratio of .15 staff/resident with on call beeper back up.
Comments:	

F. ASSESSMENT OF FUNCTIONAL LEVEL AND DETERMINATION OF RESIDENTIAL NEED

Functional Assessment Survey

A Functional Assessment Survey has been conducted in each of the last three years in all community residences. The Survey instrument has undergone continual development and modification in an effort to improve its sensitivity to the population served in community residences. This year the Survey was again modified after consultation with a work group of community residence providers.

The FAS includes 101 questions which comprise five major sections. These include psychiatric history and medication, psychiatric problems, maladaptive, violent and dangerous behavior, daily living skills and independent functioning.

Determination of Residential Need

A Residential Need Index (RNI) which estimates the intensity of residential services required has been developed through the use of a subset of 17 items from this survey (FAS). Items which make up the index were determined through the analysis of clinical judgement of the relative importance of specific client characteristics in determining an individual's appropriate residential need (a technical paper is in preparation). A field study was conducted to test the

degree to which clinical judgement would agree with the statistically derived RNI. Results indicate agreement may be expected in 85% to 90% of the cases. The RNI provides a score ranging from 1 to 100. Residents with scores in the lowest third (1-33) will generally require a supervised setting those in the 34-66 range require an intensive supportive setting. Those in the upper range require a supportive setting.

Relationship Between RNI and Functional Profiles

The target population section presented earlier in this paper presents functional and clinical profiles of residents appropriate for each of the three residential levels. These profiles are directly related to the Residential Need Index. That is, on the whole individuals with an RNI of 1-33 will have many of the characteristics outlined in the Level I Profile. Those with an RNI of 34-66 will have the characteristics outlined in the Level II Profile and an RNI score of 67-100 will represent a Level III client.

The Functional Assessment Survey and the Residential Needs Index will be referred to in the sections entitled Admissions and Discharge Criteria and Determination of Appropriate Utilization of the Community Residence.

G. ADMISSION/DISCHARGE GUIDELINES AND CRITERIA

The delineation of specific admission and discharge criteria for community residences has historically proven to be a difficult task. First, the program has grown very rapidly since 1978. Secondly, the characteristics of the population served in community residences continue to change, reflecting the effects of OMH policies on admission to and discharge from its psychiatric centers. Also, the immense diversity in social and economic factors, housing availability and mental health resources across the state make it impractical, if not impossible, to set client specific criteria. Finally treatment philosophy and practice differ among agencies as they do across the field of mental health.

In spite of these problems and issues, increased efforts have been directed towards understanding and describing the population being served. General admission and discharge guidelines are now set for community residences. More specific admission and discharge criteria, coupled with the use of client assessment information and case review, are suggested for each level of the new model.

General Admission Criteria for the Community Residence Program

Individuals must meet all the criteria which follow:

1) At least 18 years of age
2) A primary diagnosis of psychiatric illness
3) Not a primary diagnosis of alcohol or drug abuse
4) The potential to improve functional skills
5) Inability to live independently in the community
6) No immediate potential or likelihood of serious harm to self

7) No immediate potential or likelihood of serious harm to others

8) Agreement to adhere to an individual service plan

9) Agreement to adhere to the rules and regulations of the program

10) Evidence that the individual is medically suited for the program

Specific Program Criteria

1. Supervised Programs - admission to a supervised program may occur if an individual's case review indicates the need for 24 hour supervision for the reasons which include, but are not limited to, one or more of the following:

   (a) Severity of psychiatric problems prevents placement in intensive supportive or supportive programs;

   (b) Evidence of low functional levels in activities of daily living and/or independent living skills;

   (c) Supervision required to self administer medication;

   (d) Limited potential or likelihood of serious harm to self and/or others.

2. Intensive Supportive Programs - admission to an intensive supportive program may occur if an individual meets each of the following criteria:

   (a) Case review indicates the need for daily face-to-face staff visits, but not for 24 hour supervision for one or both of the following reasons:

      (i) Evidence of low to moderate functional levels in activities of daily living and/or independent living skills, or

(ii) Some supervision required to self administer medication.

(b) Low potential or likelihood of serious harm to self and/or others.

(3) Supportive Programs - admission to a supportive program may occur if an individual meets each of the following criteria:

(a) Case review indicates that individual does not need daily supervision but needs at least one to three face-to-face staff visits per week for one or both of the following reasons:

(i) Evidence of moderate to high levels in activities of daily living and/or independent living skills but the individual needs some support in these areas, or

(ii) Occasional reminders are required to self administer medication.

(b) Very low potential or likelihood of serious harm to self and/or others.

(c) High motivation for independent living.

General Discharge Criteria For The Community Residence Program

Discharge Criteria - Discharge may occur if a resident meets one of the following criteria:

(1) Ability to live in a less restrictive setting; or

(2) A serious and continued threat to the safety of self and/or others in the program because of violent behavior or severe drug or alcohol problems; or

(3) Severity of psychiatric problems requiring hospitalization; or

(4) Continued refusal to follow the rules and regulations of the program; or

(5) Medical problems which require a level of care other than a community residence; or

(6) Resident voluntarily withdraws from the program.

Specific Program Guidelines

1. Supervised Programs

   (a) Case review indicates resident no longer requires 24 hour supervision, or

   (b) Resident shows sufficient improvement in functioning to move to a more independent living situation, or

   (c) Resident shows insufficient improvement in functioning after two review periods*, or

   (d) Resident has regressed and requires a more restrictive living situation.

2. Intensive Supportive Programs

   (a) Case review indicates resident no longer requires daily supervision, or

   (b) Resident shows sufficient improvement in functioning to move to a more independent living situation, or

   (c) Resident shows insufficient improvement in functioning after two review periods, or

   (d) Resident has regressed and requires a more restrictive living situation.

* Review Period = One Year

3. Supportive Programs

(a) Case review indicates resident no longer requires weekly supervision, or

(b) Resident shows sufficient improvement in functioning to move to a more independent living situation, or

(c) Resident shows insufficient improvement in functioning after two review periods, or

(d) Resident has regressed and requires a more restrictive living situation.

H. DETERMINATION OF APPROPRIATE UTILIZATION OF THE COMMUNITY RESIDENCE LEVELS: RESIDENTIAL PROFILE MONITORING SYSTEM (RPMS)

The Community Residence Program will provide three levels of residential services. These are differentiated by the type and needs of the clients served, which in turn affect the intensity of services and the number and qualifications of the staff required. The primary purpose of the Residential Profile Monitoring System (RPMS) is to assure that in aggregate a program is serving the population for which it has contracted to serve. In addition, the RPMS will monitor any changes in a program's resident population i.e., movement towards serving either a lower functioning group or a higher functioning group. The RPMS will also provide the Office of Mental Health with a statewide, regional and local assessment of residential need which can be used in program planning.

The RPMS relies upon the data collected from the periodic Functional Assessment Survey (FAS). More specifically it considers the Residential Need Index (RNI) which is computed from a subset of items on the survey.

The RPMS will compare on a periodic basis, the overall functional mix of clients served in an agency <u>against</u> the expected functional mix for the program level it has contracted for i.e. supervised, intensive supportive, supportive.

The functional mix of clients <u>currently</u> served by an agency is determined by the range of RNI scores for all residents in the program. In general, individuals served in Level I will score between 1 and 33 on the RNI, Level II between 34 and 66 on the RNI and Level III between 67 and 100.

Guidelines for the acceptable mix of residents for each level are as follows:

Level I - Supervised

Two Thirds of the residents must score in the 1 to 33 range.

One Third of the residents may score in the 34 to 100 range.

Level II - Intensive Supportive

Two Thirds of the residents must score in the 1 to 66 range.

One Third of the residents may score in the 67 to 100 range.

Level III - Supportive

All residents may score in the 1 to 100 range.

Generally speaking the system has built in flexibility. At all program levels the guidelines permit a mix of residents. The guidelines outlined above were developed after analysis of the resident mixes which are currently found in the existing community residence program.

Implementation of the RPMS

The Functional Assessment Survey will be administered at least once a year in every program. A copy of each program's survey will be forwarded to the central office (or regional offices) where program aggregate profiles will be compiled. Those programs in which profiles indicate a mismatch between client functional levels and program type may be required to justify the discrepancy. A program audit may be required. Agencies serving residents who appear to be inappropriately placed for several review periods may be required to provide program justification.

I. COMMUNITY SCREENING PROCESS

OMH policy places the responsiblility for discharge planning with the state psychiatric center director. Directors of local mental health and social services departments particpate in the discharge planning process. Similarly, certification standards for local hospitals mandate that a discharge plan be developed for persons leaving inpatient care. The intent of these policies is to ensure that needed services are arranged prior to a patient's release from an inpatient setting. Residential services are among the most critical services to be addressed in a discharge plan. Frequently arrangements for residential care are confounded by the lack of information on available, appropriate community residence placements. Similarly, community residence providers require information on numbers and types of patients available for placement to adequately plan a service response.

The new model for Community Residences is designed to match patients with program levels and to encourage movement toward independent living. Since adequate communication between community residence providers and the various inpatient facilities is required for the plan to work, it is recommended that a regular forum for screening individuals for placement in a community residence be identified. The locus of responsiblility and the particular manner of fulfilling this requirement should be decided locally.

Experience has shown that regular meetings, convened for the purpose of screening patients for community placement are particularly effective in the timely placement of persons awaiting discharge. Other arrangements, consistent with the discharge planning process, may be acceptable. For patients and providers alike, it is imperative that the chosen community screening process be responsive and able to ensure quick turn around on placement decisions.

J. RESPITE/EMERGENCY HOUSING

Respite housing is needed for both the community residence population as well as the general mentally disabled population living in the community. Respite housing is intended to provide a sheltered living environment for persons having an established housing arrangement who for a finite period of time ($\leq$ 14 days) require another housing accommodation.

Respite may be needed for a variety of reasons. Clients living with family may need respite due to a family vacation or family crisis. Those living independently may need a more structured environment for a short period of time. Residents of supportive community residence programs may need respite because of difficulty with roommates or the need for a more structured environment for a finite period of time. Regardless of the precipitating factor, the goal of respite housing is to provide temporary relief to the client, provider or family.

Emergency housing is intended for mentally disabled persons without an established living arrangement. The goal of an emergency housing program is to arrange for a long term living situation as well as establish linkage to the appropriate support services. Currently the state operated Crisis Residence Program is intended to serve these functions.

Until a full review of the current Crisis Residence Program is achieved, it is suggested that respite housing be provided by the voluntary sector through a regional or area consortium arrangement. It is recommended that providers of supervised community residence programs establish geographic consortiums to provide time limited respite to community residence clients as well as other mentally disabled in need of this service. Consortium agreements among providers would include letters of agreement concerning respite placements and payment for

service. Community clients in need of respite would be required to pay a fee based on a proration of the SSI amount received or a private pay schedule. A client in need of respite should be referred to a Crisis Residence only if (1) there is no respite bed available or if (2) there is no capacity for fee payment.

It must be noted that neither respite housing nor emergency housing is intended to serve persons experiencing active acute psychotic episodes.

Pending the outcome of the consortium arrangement and the completion of the Crisis Residence Progam review, the issues of respite and emergency housing will be examined in depth.

K. RECOMMENDATIONS

- Development of an implementation plan that allows reasonable time for existing programs to convert to the new model.
- Initiate regulatory change in order to support the new model.
- The new model will apply to all beds becoming operational after July 1, 1984.
- Due to the episodic nature of mental illness coupled with the characteristics of the defined target populations, it is recommended that a bed reservation system be developed. The purpose of reserved beds is to make provision for the continued availability of community residence services for residents who are temporarily hospitalized ($\leq$ 30 days). The bed reservation system should provide for a maintenance of income to the providing agency for a limited period of time.
- The Office of Mental Health and the Department of Social Services must work in concert to more adequately address the housing needs of the mentally disabled. For example, redefine, restructure and expand such options as Residential Care Facilities for Adults, Residences for Adults, Enriched Housing and Shelters for Adults. More specifically, it is suggested that Residential Care Facilities for Adults be targeted for a more active population and the age requirement for Enriched Housing be lowered.

- Promote the conversion of existing SRO's serving the mentally disabled to innovative models similar to the Friends of St. Francis model. [redacted]
- Intensified advocacy at the federal level to increase housing subsidies or set-asides designated for the mentally ill.

SPECIAL POPULATIONS

Throughout the work of the Task Force, the issue of development of community residence programs targeted for special populations continually surfaced. It is clear that the term "special population" must be clarified.

Thus far, several groups have been called special populations. These groups consist of persons having a diagnosis of mental illness as well as having an additional problematic special characteristic. A listing of these special characteristics is as follows.

1) Aging out of the youth system and aging in to the adult system
2) Young chronic
3) Geriatric
4) Mental retardation
5) Physical disability
6) A recent history of drug or substance abuse
7) A recent history of violence, dangerousness or arson

For the Community Residence Program these special populations raise very different programmatic issues. Some may need a truly different service package, some may need the same service package more intensely administered, some may need the same service package but the location of the residence is an issue and for some the severity of the special characteristic may make a community residence placement completely inappropriate.

The following is a discussion of each of the above special population groups.

1) Aging out/in - These individuals are between 18-21 years of age. If there is no secondary disability, these persons should be mainstreamed into the generic community residence continuum. However many individuals within this population have a secondary disability.

Appropriateness of placement in a generic community residence would be determined by the severity of the secondary disability. (See 4 and 5 below)

2) Young chronic - the new Community Residence Program has designated the younger, more active client as a primary target population. Although this population has not been clearly defined and therefore difficult to serve, it is anticipated that relaxation of the five day outside program requirement coupled with a more appropriate staffing pattern will better meet the needs of this client population.

3) Geriatric - the standard community residence service package is appropriate for the physically well elderly. There is no need to design a special program for this population; however, the age mix in the residence must be closely monitored. As the infirmities of the aging process occur, these clients will be referred to Family Care/Personal Care, an HRF or SNF.

4) MH/MR diagnosis - Appropriateness of a standard community residence program would be determined by the degree of the client's secondary diagnosis. If retardation is mild, the individual should be mainstreamed into the generic community residence continuum. If retardation is such that the client can not be mainstreamed, but is still appropriate for community living, the appropriate placement would be in a community residence having the standard service package; however, the service package would need to be administered with greater intensity. The intensity of service delivery and the uniqueness of the secondary disability would necessitate a richer staffing pattern which would include a mental retardation consultant. The severity of the secondary disability, the client mix in the residence and the size of the residence combine to dictate the number and type of staff needed beyond the basic community residence staffing pattern.

5) Physically disabled - As in 4 above, if the secondary disability is mild and/or the client is well adapted, the individual can be mainstreamed into the generic community residence continuum. However, if the physical disability prevents this, the client still requires the standard community residence service package but may require more "hands on" physical assistance. This would require enriched staffing. Thus, the type and degree of the secondary disability, the client mix in the residence and the size of the residence combine to dictate the number and type of staff needed beyond the basic community residence staffing pattern. Should the physical disability require major physical plant renovations, these programs, voluntary or state operated, may have to be located on the gounds of a state physiciatric center.

6) Drug or substance abuse - First it must be clear that the Community Residence Program is not intended to serve addicted persons. Those individuals with a primary diagnosis of mental illness and having a recent history of drug or alcohol abuse would be served in a community residence with a standard service package. However, these persons might be served in a state or voluntary operated community residence on the grounds of a state psychiatric center (social control). But for a drug or substance consultant, it is anticipated that this clientele would not require an enriched staffing pattern. When the incidence of drug or substance abuse has ceased for approximately six to nine months, these persons should be reviewed for referral into the generic community residence continuum.

7) Recent history of violence, dangerousness or arson - these individuals must be served on the grounds of a state psychiatric center (social control) in a state or voluntary operated community residence with a standard service package. It is anticipated that these individuals will not require a richer staffing pattern. These persons should be reviewed on an individual case by case basis for referral into the generic community residence continuum.

As described above, for the most part, special populations do not require special service packages. Special characteristics may require greater intensity of service delivery (staffing), a special consultant or a special location. It is anticipated that demonstration projects to begin to address the needs of special populations will be developed over the next year.