

A Review of 32 Office of Mental Health Supervised Community Residences

NYS Commission on
 **QUALITY
OF CARE**
for the Mentally Disabled

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**New York State Commission on Quality of Care
for the Mentally Disabled**

PREFACE

Within New York State, supervised community residences are the largest single community residential alternative for persons with mental illness. For many persons with serious mental illness, these community group homes, with 24-hour staff supervision, offer an opportunity for developing skills and regaining confidence to live more independent lives in the community.

Responding to a specific request from the State Legislature, the study sought to assess the overall "health" of this growing community residential alternative for persons with mental illness. Today there are nearly 6,500 supervised community residence beds in New York State; by July, 1990, the State plans to expand the number to approximately 9,000 beds.

The study was based on unannounced inspections of 32 supervised community residences located across New York in urban, rural, and suburban communities and serving anywhere from 8 to 24 residents. Some residences provided a long-term residential setting, but most residences provided a transitional setting for periods of 12 to 18 months.

During our unannounced visits, we looked for the basic elements of a quality community residential alternative for persons with mental illness: a safe, clean, and attractive environment; attention to residents' personal clothing and hygiene needs; and a sound rehabilitative program which could help residents achieve greater self-sufficiency skills, such as cooking, cleaning, shopping, money management, attending to health needs, including self-medication, etc. Additionally, since a major objective of community residences is to facilitate the integration of residents into the community, Commission staff also inquired about relationships with neighbors and community organizations, and about the residents' use of community services and their participation in community activities. The Commission's survey also included reviews of the residences' expenditures and staffing levels,

consumer and staff satisfaction surveys, and interviews with neighbors and local organizations affiliated with the residences.

Finding 1: Community residences have great potential to provide quality care and rewarding rehabilitative opportunities for persons with serious mental illness, but many community residences do not live up to this potential in important respects.

As reflected in the report, the performance of the 32 community residences across the basic indicators assessed was mixed. Most encouraging, was the overall excellent performance of 10 of the 32 residences. These programs not only offered their residents a safe, comfortable, and rehabilitative place to live, but they were also well-accepted in their communities, as reflected by the excellent relationships the residents and staff enjoyed with their neighbors and community organizations and by the participation of residents in community activities.

In contrast, however, 5 of the 32 residences performed very poorly, failing to meet basic expectations in at least three-fourths of the areas assessed. The remaining 17 residences rated somewhere in between, some with a need for improvement in several areas. Although the nature and seriousness of concerns in these residences varied, the Commission was struck by the number of residences where basic housekeeping and maintenance had been neglected, where residents were not receiving adequate staff assistance in attending to their personal needs in clothing, personal hygiene or bedroom management, and where residents and staff alike appeared to have abandoned the rehabilitative mission of the community residence program. Many of these residences also remained essentially isolated in their communities, with little or no contact with neighbors or community organizations.

Finding 2: Where residences performed poorly, the failure to meet basic expectations could usually be traced to unclear management expectations and/or ineffective management oversight of and accountability for actual residence performance.

In searching for reasons behind the variable performance of the 32 community residences visited, we discovered that the availability of funds, individual facility characteristics (e.g., age, size, or location of the residence), and the disability levels of the residents in the programs were *not* significant factors. Aside from the handful of proprietary residences visited, all residences were allocated comparable funds. Additionally, the 10 very good residences represented a diverse group of large and small, old and new, and urban, rural, and suburban programs. These outstanding programs also served residents with a wide range of disability levels. The deficient programs also represented a similarly diverse grouping of residences.

Far more than any other specific factor, the variable performance of the residences seemed to reflect the values and expectations of their providers. In the poorer performing residences, for example, we were told that worn and unattractive furnishings were used so that residents might not become "spoiled" by a lifestyle they could not afford in the community. We were told people with mental illness preferred bedrooms in disarray. Others excused the lack of rehabilitative programs in daily living skills because the residents were too old or too disabled to learn or benefit from these programs.

Fortunately, the Commission had ample opportunity in the better residences visited to witness the benefits of community residences which focused on residents' strengths and which held out high expectations that residents could measurably improve the quality of their lives. In many of these residences, attitudes of managers, staff, and residents clearly echoed the sentiment that "the sky is the limit", and the outstanding conditions and services in these residences demon-

strated the potent influence of these high expectations.

Finding 3: Most critically, the study showed that when performance expectations were clarified, most residences could readily make needed improvements. These findings argue powerfully, both for enhanced internal quality assurance by residence providers and a more vigilant and directive OMH certification and monitoring processes for community residences.

Follow-up written reports of corrective actions from providers reinforced that positive change was both possible and quickly realizable -- when expectations were clarified. Within three months of our unannounced visits, virtually all of the providers, initially cited for significant problems, had reported substantial improvements. Moreover, the Commission's unannounced follow-up inspections to the five residences with the most serious problems, just six months after our initial visits, revealed a marked turnaround in the conditions and services in all five of these residences. Environmental improvements in the homes were dramatic and, in many cases, residents who were previously viewed as too old or too disabled to participate in programs to improve their daily living skills now were participating. Upon follow-up, four of these five residences rated "very good", and the fifth residence had also shown much improvement.

These follow-up findings provided strong testimony that all community residence programs have the capability of assuring quality conditions and services. They also clarified the critical role of providers and their staff in ensuring this high standard of care. Notably, very few of these programs received significant additional funding from the Office of Mental Health to engineer the reported and observed improvements.

Other findings of the study clarified the need for enhanced oversight and monitoring by OMH. In almost all areas, Commission inspections identified more problems affecting the day-to-day

lives of residents than recent OMH certification reviews. OMH staff also acknowledged that their certification process is variable across regions of the State, that their surveyors need better training, and that almost all program reviews are preceded by one to three week "notices" which hinder their ability to capture "everyday" operating conditions. The OMH certification process for these programs, and especially its primary reliance on announced inspections, clearly needs an overhaul.

Similarly, expenditure and staffing data collected in the course of this review strongly suggested a need for greater oversight of these issues by OMH. Expenditure data, for example, suggested that, although most of the residences were allocated comparable funding, their spending patterns varied substantially. Moreover, we found that underspending of allocated funds was associated with residences with poorer conditions and services. Some residences also appeared to be understaffed, and others seemed to assign more staff during the daytime hours when most residents were away from the residence than during the late afternoons and evenings when most residents were home. Additionally, many providers, as well as line staff, reported that training for community residence staff was usually inadequate, and that OMH, as well as providers, must seek more efficient and accountable mechanisms for staff training.

Finding 4: We need to listen to residents and staff who uniformly express dissatisfaction with daytime community programming options and to re-examine the limited range of these options and particularly their shortcomings in providing viable educational, rehabilitation, and vocational services, which is what most residents say they want.

Over the course of our visits to the 32 residences, we heard many complaints from providers, staff, and residents about the quality and appropriateness of day program services. These

services were often described as "unenjoyable", "boring", or "a waste of time", and all agreed that residents of community residences need more constructive, vocationally or educationally related activities to fill their days. Residents were especially critical of continuing treatment programs and sheltered workshops, and many indicated that they wanted "real jobs" or to attend school. Notably, residence staff generally agreed with these assessments, and they added that without more engaging and challenging day program services, many residents of their programs could not gain skills essential to more independent living. The clear message was that New York needs to redesign its day program options for persons with mental illness to provide more meaningful and productive rehabilitative training opportunities for clients.

Finding 5: In many areas of the State, significant subgroups of persons with serious mental illness, including the homeless and persons with concomitant drug and alcohol abuse problems, are often denied admission to community residences. Simultaneously, a significant subset of current residents of community residences appears ready for more independent living, but there are limited options to help them achieve this desired independence.

Many voiced concerns that program participation requirements, as well as strict admission criteria, often shut the doors of community residences to the homeless mentally ill, mentally ill persons with long histories of psychiatric hospitalizations, and mentally ill persons who also have alcohol or drug abuse problems. As a result of these barriers, often those individuals in a community most in need of a supervised mental health residential placement are denied one.

Many also questioned whether community residences provided a real avenue for independent community living for many persons with serious mental illness. They pointed out that transitional low cost housing with adequate sup-

ports was usually unavailable for residents ready to move on, and that providers were often faced with the poor choices of either maintaining residents in supervised programs who no longer needed them, or discharging residents without adequate supports or alternative housing. Many providers could cite numerous examples whereby discharge from their residences without adequate supports had led to a predictable cycle of poor transitions for former residents, and eventual re-hospitalization.

Strong and convincing arguments were made for New York to intensify its efforts in developing more flexible models for supporting persons with mental illness in the community. Advocates urged a loosening of overly-restrictive admission and participation requirements for community residences, and they simultaneously argued for specific programs which would help capable residents find, afford, and succeed in generic housing in the community. Without these services, many

perceived the community residence program as offering only "half-fulfilled" promises to persons with mental illness, seeking again to enjoy the full benefits of community living.

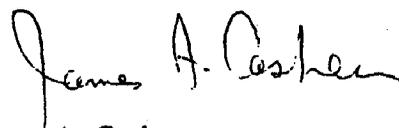
Throughout the course of this review, the Commission has shared its observations and specific findings with senior officials of the Office of Mental Health. These discussions, as well as the Office's response to a draft copy of this report (See Appendix C), indicate that the directions offered in the report are largely consistent with the views of the Office of Mental Health. In particular, considerable work by the Office has gone into conceptualizing and developing a broader range of housing and support services options for persons with mental illness. The Commission supports these initiatives, and urges Legislative and Executive support as well.



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Special thanks are extended to administrators, staff, and residents who so cordially accommodated Commission interview teams visiting their residences and to those individuals who reviewed and offered written comments on the draft report and its recommendations. The Commission would also like to acknowledge Dr. Richard C. Surles, Commissioner of the New York State Office of Mental Health, Sarah Rose, Associate Commissioner for Regional Operations and Community Services, and Lawrence Chase, Director, Bureau of Inspection and Certification for their support in the conduct of this review.

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CHAPTER 1

Introduction

In the fall of 1987, the Commission conducted unannounced site visits to 32 community residences for persons with mental illness. This review was conducted in accordance with the Commission's statutory responsibility to assure quality of care for persons with mental disabilities (§ 45.07, MHL), and in response to a specific request by the State Legislature to provide enhanced monitoring of community-based services.

In choosing the OMH community residence program for a systemic review, the Commission was mindful of the tremendous need for supportive housing for persons with mental illness, as well as the New York State Office of Mental Health's plans to develop 8,800 more community residence beds by 1996, bringing the State's total to 14,000.

Objectives and Methods

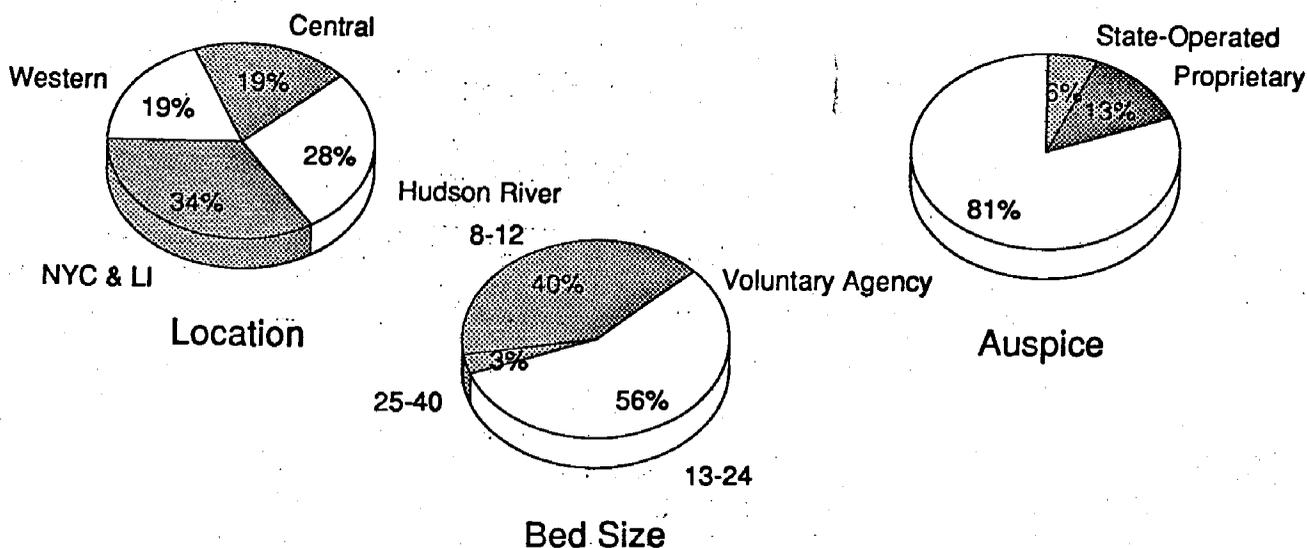
The reviews of the 32 residences focused on their ability to provide safe, comfortable, and supportive "homes" for their residents, as well as their provision of rehabilitative services and recreational and social activities. The Commission also sought to determine the degree to which the residence programs fostered

the residents' use of community resources and services.

Other significant components of the review included resident and staff satisfaction surveys, which offered residents and staff an opportunity to report their opinions anonymously to the Commission. Neighbors and community organizations also were solicited for their comments on the residences visited. Cost reports and recent OMH certification records of the 32 residences also were reviewed. Additionally, present on-duty staffing ratios, as well as "scheduled" staffing ratios at the residences, were analyzed.

Using an Office of Mental Health listing, the 32 residences visited were randomly chosen to ensure a representative sample of residences in different geographical regions of the State and of varying bed size. Residences also were selected to ensure representation of large, medium-size, and small provider agencies. Additionally, since the Office of Mental Health has announced its intention to expand the development of State-operated community residences, the two State-operated community residences in operation as of March 1987 were included in the sample (Figure 1).

Figure 1: Size, Auspice, and Location of Residences Visited



All Commission reviewers participated in a two-day training program prior to conducting the reviews. Reviewer observations were recorded on uniform survey instruments, and photographs were taken to document significant positive and negative findings. Teams of two or more Commission staff spent a minimum of seven hours in each of the residences reviewed, at least three of which were in the late afternoon *and* early evening when most residents were home.

Reporting the Findings

Serious life safety deficiencies which posed a threat to resident safety or well-being were reported immediately to the residence administrator. Shortly after the review, the residence/agency administrator received a letter summarizing the Commission's major findings and requesting a plan of correction for significant deficiencies. Copies of these letters also were made available to senior staff within the Office of Mental Health.

Subsequently, providers of all residences cited for significant deficiencies have submitted adequate re-

ports of corrective actions. The Commission also conducted unannounced follow-up reviews of the five residences which evidenced the most serious problems in our initial reviews. The follow-up visits revealed marked improvements in these homes. (See Report p. 15).

The body of this report presents the major findings of the reviews, the implications of the major findings, conclusions, and recommendations. Additionally, Appendix A, "Observations Inside the Residences", provides a more detailed summary of the actual conditions and services noted by Commission staff during their initial unannounced reviews of the 32 residences.

In the preparation of this report, Commission staff met several times with OMH staff to discuss the significant findings of the review, as well as the needed reforms and changes in the community residence program which they suggest. The Office of Mental Health also had the opportunity to review a draft of this report and the recommendations offered. The OMH written response is included in Appendix C of the report.

CHAPTER II

Major Findings

- **Ten of the 32 residences visited evidenced very few deficiencies across the 12 areas assessed and had no serious deficiencies. These residences provided strong testimony of the capability of the community residence program to offer persons with serious mental illness a safe, supportive, and rehabilitative place to live, while preparing for more independent living in the community.**

In these 10 residences, it was apparent that staff and residents worked together to ensure the house was well-maintained, clean, and generally free from safety and fire hazards, and that efforts had been made to furnish and decorate the common living areas of the residence to create a comfortable, home-like setting for the residents. Staff were equally attentive to important rehabilitative functions of the community residence. Training and assistance were offered to residents in improving and using daily living skills in cooking, shopping, housecleaning, doing laundry, money management, menu planning, and other tasks needed to live more independently in the community.

Residents in these homes also participated in day programs or vocational activities during the weekdays, and they enjoyed recreational and social activities in the evenings and on weekends. Clinical services in these residences, including medication administration and storage, training for residents in self-administering their prescribed medications, and record keeping also met all review expectations.

Although most of these 10 residences had a few problems in one or two areas, none had serious problems adversely affecting the quality of residents' day-to-day lives, and the few problems noted were quickly "correctable".

Also of importance, these 10 residences were geographically spread across New York State, with three in the downstate New York City/Long Island area and seven in upstate urban and rural communi-

ties. Some residences were located in downtown commercial areas; others were located in suburban neighborhoods and rural communities. These residences also varied in size from 8 to 24 beds, and they were operated by small, medium, and large agency providers. The findings suggest that community residence programs, when assured appropriate provider management and oversight, can serve as a very flexible modality in meeting the needs of persons with mental illness in New York's many geographically diverse cities and towns.

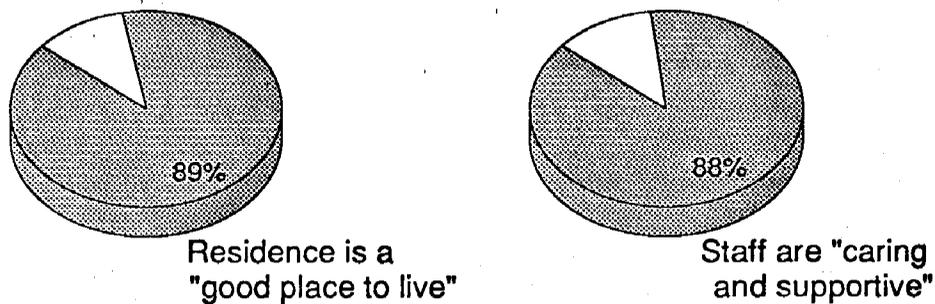
- **Resident and staff satisfaction survey responses indicated a high degree of both "consumer" and "work force" satisfaction with the residence programs visited (Figures 2 and 3).**

Nearly half (45 percent) of the residents in the 32 programs visited voluntarily responded to the Commission's survey, and the vast majority (86 percent) indicated that the community residence was a good place to live. An equally high percentage (88 percent) noted that residence staff were usually caring and supportive. Several residents offered unsolicited comments that they considered themselves lucky to be living in the residence, and one resident added, "[It was] a dream come true" (Figure 3).

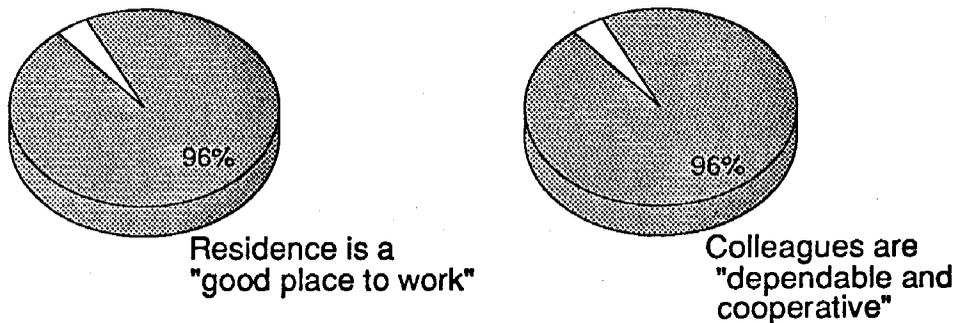
Responses from 144 staff members of the residences visited were equally positive. Over three-fourths of the staff (77 percent) indicated they were satisfied with their jobs and that they viewed the community residence as a good place to work. An additional 19 percent of the staff indicated that they were somewhat satisfied with their jobs.

Two-thirds of the respondents (67 percent) indicated that they believed their fellow staff members were always cooperative, dependable and willing to help other staff in sharing job responsibilities. Almost all of the remaining respondents (29 percent) indicated that this was somewhat true, with

**Figure 2: Resident Satisfaction With
Community Residences Visited
(n=222)**



**Figure 3: Staff Satisfaction With
Residences Visited
(n=144)**



only 3 percent of staff responding that their fellow staff members were rarely cooperative, dependable and willing to help other staff in sharing job responsibilities.

Survey responses further indicated a number of significant strengths of the work force in community residences. Eighty-seven (87) percent reported prior work experience with persons who had mental disabilities, and over half (55 percent) worked in the present residence or another residence operated by the same agency for at least one to three years.

Almost all of the staff responding also considered their job a career placement for two to five years (55 percent) or for more than five years (31 percent).

Less positively, a sizeable minority of staff (40 percent) indicated that they might choose to leave their jobs due to salary concerns. Information obtained during the review also suggested that non-competitive salaries may be more problematic for community residence providers in certain geographical regions of the State. In particular, providers located in communities with very competitive job markets reportedly suffered more from staff turnover due to non-competitive salaries. Providers who faced staff recruitment competition from State-

operated community residential and outpatient programs for persons with mental disabilities reportedly have especially grave problems, since in most cases the State offers far better salaries and benefit packages for comparable jobs.

■ Notwithstanding the excellent performance of 10 of the 32 residences and the generally high degree of staff and resident satisfaction across the residences visited, nearly two-thirds of the residences had significant problems in several of the areas assessed, and five of these residences evidenced serious pervasive problems adversely affecting the daily lives of residents (Figures 4 and 5).

Environmental Problems

Problems in basic housekeeping were noted at almost two-thirds of the residences visited. At the six residences with the most serious housekeeping problems, many common areas were very dirty. Floors were sticky and littered; furniture was dirty and very dusty; bathrooms were grimy or mildewed; and/or kitchen appliances (e.g., refrigerators, stoves) had not been cleaned in some time. At the

Figure 4: Environmental Performance of Residences Visited

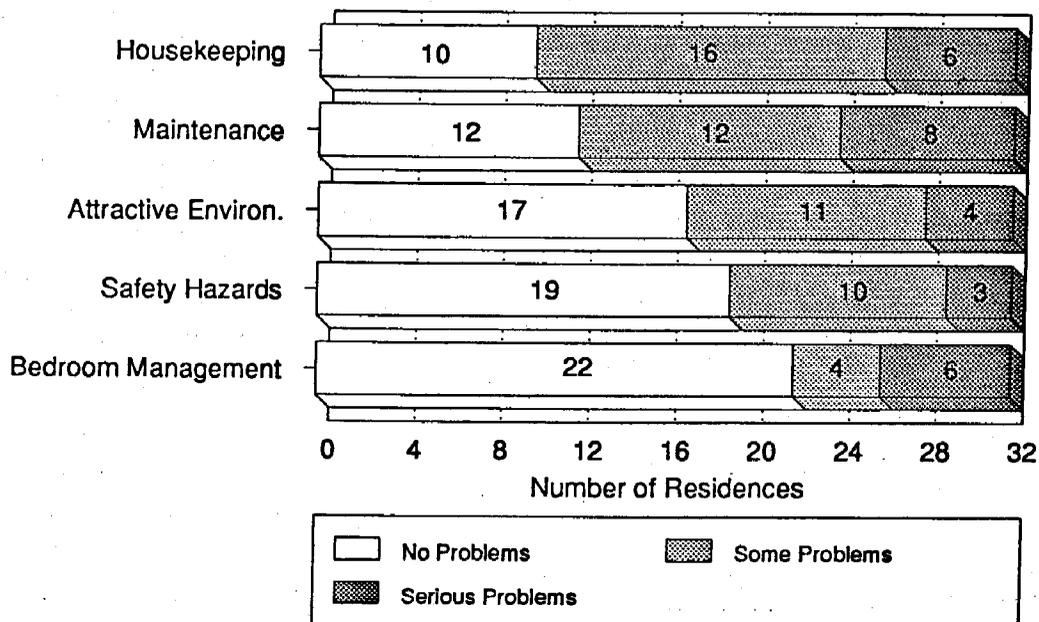
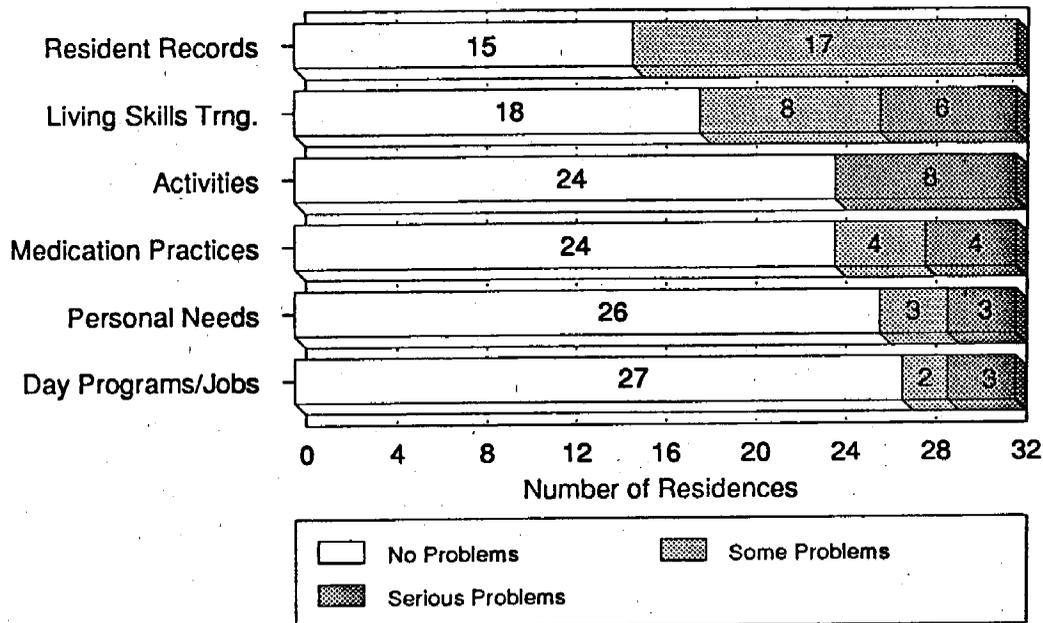


Figure 5: Programmatic Performance of Residences Visited



remaining 16 residences with housekeeping problems, day-to-day housekeeping was more adequate, but neglect of major spring cleaning type tasks, like carpet cleaning and window washing, presented significant problems in the overall appearance of the residence.

Maintenance problems noted in 20 of the 32 residences included significant problems in both the exterior and interior upkeep of the homes. Examples of maintenance problems included: yards littered with debris, broken windows, peeling interior and exterior paint, inoperable bathroom plumbing, and significant roof or plumbing leaks.

At 15 of the residences, attention to furnishings and home decorations in some or most common areas was inadequate, and in 10 of the residences many bedrooms were very dirty and disorderly. Carpets or floors were in need of a thorough cleaning, and clothing and personal hygiene items were strewn across rooms, lying in piles on floors, or stuffed in closets.

While not as prevalent as general housekeeping and maintenance concerns, fire or safety problems were noted in 13 of the residences. At 10 of these residences, problems centered on the inspection/

availability of fire extinguishers and/or one or two specific problems that could be promptly corrected. At three residences, however, the problems were more numerous and posed an immediate threat to residents' safety.

Examples of the fire/ safety hazards noted at the homes visited included: the blockage of fire exit doors with furniture; water from a leaking pipe dripping on wires of the fire alarm system; use of a light bulb with a wattage in excess of the capacity of the lamp, causing the lampshade to melt; and storage of a large wicker basket on top of a hot range hood. At five residences, we also noted that bi-monthly fire drills were not regularly conducted.

Programmatic Problems

Many of the residences also had problems in the provision of rehabilitative, recreational, and clinical support services.

- Fourteen (14) of the residences failed to provide residents with training and experience in shopping, cooking, menu planning, money management, doing laundry, and/or housecleaning.

- At eight of the residences, there were few opportunities for residents to participate in recreational and social activities in the evening and on weekends.
- At five of the residences, at least one-third of the residents did not participate in a planned outside vocational, clinical, or educational program during the week, as required by OMH regulations.
- At three of the residences, many residents appeared poorly-groomed or dressed, indicating limited staff assistance and/or training in basic personal hygiene.

Basic problems also were noted in resident records and/or medication-related support services at over half of the residences.

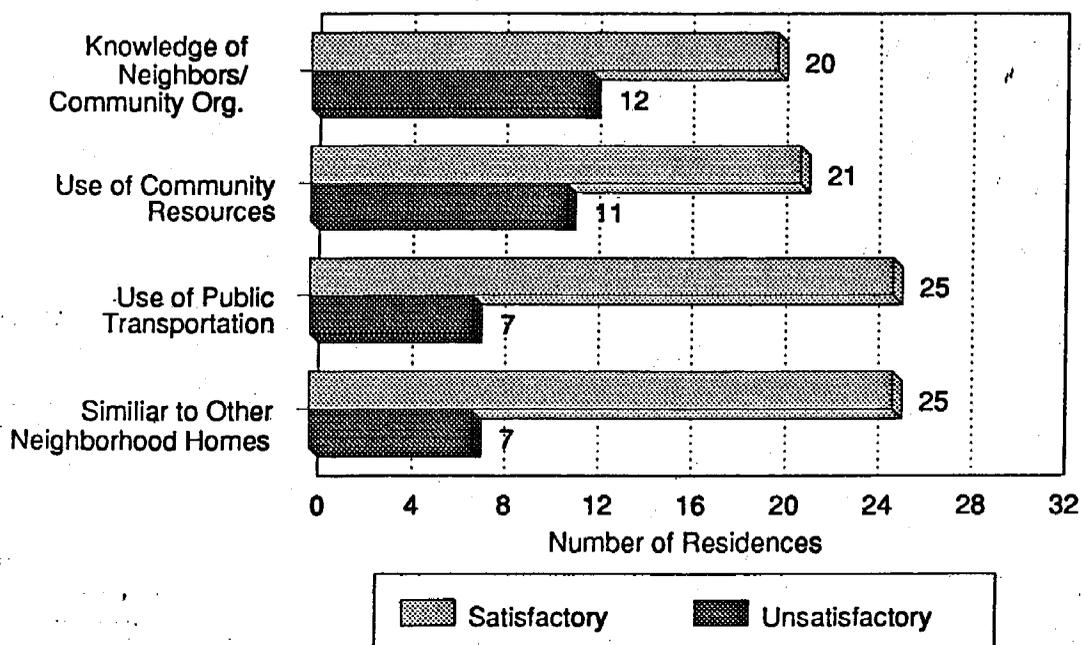
- At 17 of the residences, at least one-third of the sampled resident records lacked a current annual physical exam report, a current treatment plan or skills assessment, or the name of the residents' primary physician.
- At four of the residences, there was no system in place to train residents in self-administering prescribed medications.

- At two of the residences, central storage cabinets for medications were not secure, and at four other residences, residents had no secure place to store medications in their bedrooms.

■ Although half of the residences visited appeared well-integrated into their communities, and their residents clearly benefited from positive relationships with neighbors and community organizations, at the remaining residences, residents appeared to make little use of community resources and services, and/or the residences seemed isolated in their communities (Figure 6).

Sixteen (16) of the 32 residences scored well overall on the review's indicators of community integration. Residents used community-based medical and mental health providers, and regularly attended community activities for socialization and recreation. Residence staff usually were able to identify at least one community organization and one neighbor that were familiar with the residence and its residents. Additionally, the community resi-

Figure 6: Community Integration Performance of Residences Visited



dences looked similar to other houses in the neighborhood; e.g., non-institutional appearance, no conspicuous signs labeling residence.

The neighbors associated with 16 of the 32 community residences visited who responded to the Commission's inquiry also offered generally favorable comments. Eighty-four (84) percent were supportive of having the community residence in their neighborhood. Respondents also reported that most other neighbors viewed the residence favorably (40 percent) or somewhat favorably (22 percent). One-third (34 percent) of the neighbors also offered unsolicited comments indicating that the residents were quiet, respectful, and wonderful neighbors. Nearly one-half (47 percent) reported a positive change in attitude toward having the residence in their neighborhood since it had opened.

The responses of 34 community organizations associated with 20 of the community residences visited were also uniformly positive. Almost all of these groups (91 percent) stated that their association with the residence benefited the residents, and three-fourths indicated that the relationship was also beneficial to the organization. Approximately 65 percent of the community organizations provided recreational and social opportunities for residents, while others provided volunteer job opportunities or places to shop or receive services.

Notwithstanding these positive findings, however, at more than half of the residences visited, significant problems in fostering the community integration of residents were evident:

- At 11 of the residences, residents participated in few community activities and made little use of community resources.
- At three of the five community residences located on or adjacent to State psychiatric centers, residents did most of their socializing or recreating at the nearby psychiatric center.
- At 12 of the residences, either staff did not know the names of any neighbors, or the residences were located in rural communities or commercial areas where there were no neighbors.
- At five residences, staff did not know the names of any community organizations familiar with the residence.

Other concerns related to community integration were voiced by the residents. At two residences, residents complained about being transported in vans with the State emblem posted on the side, which they believed tagged them as "psychiatric center patients". Residents at two residences also complained about large signs in the front yard identifying the residence. At one State-operated residence this sign was particularly offensive to residents, as it mirrored the design of building signs at the nearby psychiatric center. CQC staff also noted large signs at several other residences which hindered the integration of these residences into the neighboring community.

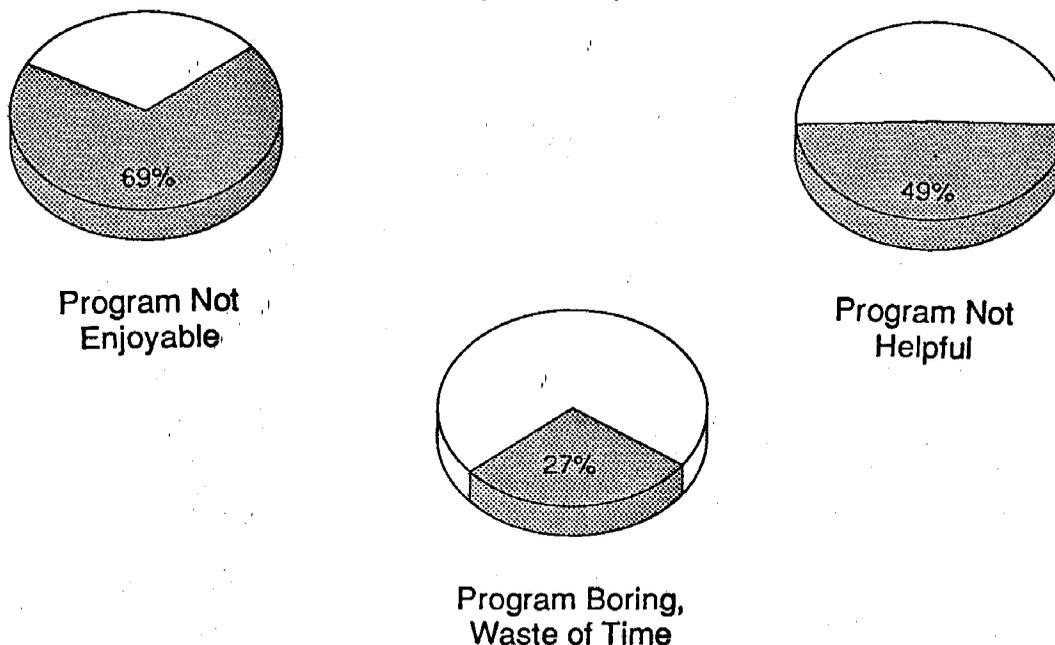
It is hard to assign "some" or "serious" problem ratings to these issues, as their actual impact on residents' day-to-day lives or their confidence and ability in assimilating into the community is considerably more abstract than other areas assessed in the Commission's review. At the same time, these concerns suggest a need for greater questioning of the overt and subtle ways community residences can promote or restrict the integration of persons with mental illness into the community.

- Another area of concern which surfaced during the review was the appropriateness of community day programs. Although our review did not include an assessment of day programs, we were struck by the consistency of criticisms of these programs by staff and residents of the community residences reviewed. (Figure 7).

Residence staff often noted that mental health and sheltered workshop programs in their communities were not well-suited to residents' needs and interests. Specifically, they stated that mental health day treatment and continuing treatment programs usually do not focus on the real-life basic living skills and educational deficits of the residents. Sheltered workshop programs, with a mixed clientele of individuals who are moderately to severely retarded, were similarly cited as not providing the type of vocational training and work experiences which could prepare residents for competitive employment.

Residence staff also reported that most residents did not enjoy or look forward to these programs.

**Figure 7: Resident Dissatisfaction
With Day Programs**
(n=222)



This perception was confirmed by responses to the Commission's "Resident Satisfaction Survey".

- Almost half of the residents (49 percent) indicated that their day programs were *not* helpful.
- Two-thirds of the residents reported that their day programs were *not* enjoyable.
- Over one-fourth of the residents (27 percent) responded that their day programs were boring, a waste of time, or "just a place to go because I have to leave the residence".

■ Other commonly-cited concerns of residence providers focused on the limitations of the available models of supervised/supportive housing in the OMH continuum which hinder the ability of the program to serve certain groups of individuals in need of supportive housing.

At many programs visited, providers offered unsolicited suggestions for more flexibility in the models of community residence programs. On the one hand, many providers pointed to specific sub-

groups of individuals with mental illness whom they were not able to serve well. These groups included the homeless mentally ill, persons in need of respite crisis housing, persons with alcohol and drug abuse problems, persons with AIDS, and persons whose long-term psychiatric disabilities suggested that they may not be able to move on to a more independent setting.

Although there are few specific OMH regulatory barriers to serving these populations in existing community residences, providers pointed out that traditional functional programs for community residences, as well as standard funding levels, often discouraged providers from making these individuals a priority service group. At the same time, providers acknowledged that these sub-groups of individuals constitute a substantial percentage of the persons with mental illness in their communities who need supportive housing.

Additionally, many providers, as well as residents, complained that once a resident graduated from a supervised residence program, and then a supportive apartment program, the resident was often unable financially to move to an independent apartment, because his/her SSI benefits would be reduced by at least 50 percent. Some providers also

noted that requiring a person with mental illness to make a transition to community living through moving among several different programs often contributed to adjustment problems. These providers advocated for more flexible apartment programs, whereby the level of staff supervision could be readily increased or decreased based on individual needs. They pointed out that such programs would facilitate and enhance the resident's transition into the community and foster his/her sense of independence and permanence in the residential setting.

In the past year, OMH has recognized the need to allow more creativity and flexibility in community residence programs with the establishment of some pilot programs for multiply disabled individuals and individuals with long histories of psychiatric hospitalizations, as well as several "independent" apartment programs for residents graduating from supportive apartments. Based on the frequency of provider comments encouraging these efforts, there appears to be a need to expand these initiatives.

- Analysis of available staffing indicated wide variations among the 32 residences in both present on-duty and scheduled staffing ratios (Figure 8).

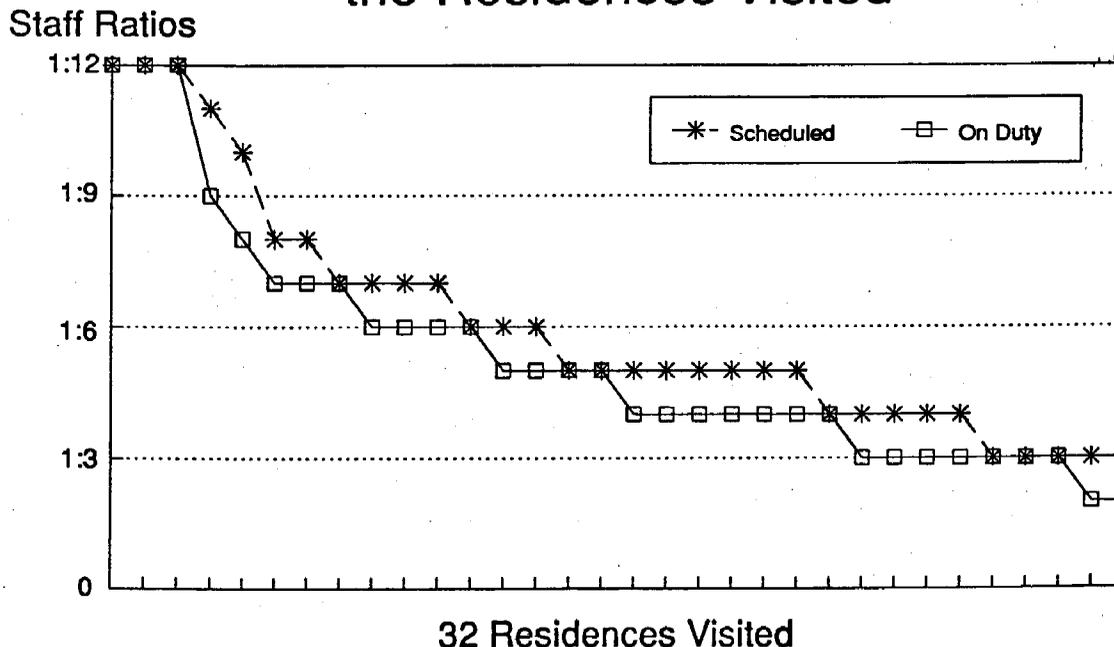
Late afternoon/early evening scheduled staff-to-resident ratios ranged from 1:3 to 1:12. Similar variations were noted in present-on-duty staffing ratios.

As a general rule, larger residences had significantly poorer late afternoon/early evening scheduled staffing ratios ($r = .60, p < .05$). Voluntary agency-operated residences also had richer staffing ratios than residences operated by the state or proprietary agencies ($X^2 = 17.05, P < .05$).

OMH staff clarified that voluntary and State-operated residences are afforded comparable authorized staffing levels. They hypothesized that the richer staffing ratios in voluntary agency residences may be due to more initiatives on the part of these agencies in using part-time staff and other flexible staff scheduling practices.

Richer or poorer staffing ratios were not, however, predictive of more or fewer problems in the residences, or of more or less disabled residents living in the residences. There was also no significant association between variations in staffing ratios and the geographical locations of the residences, or the size of their provider agencies; i.e., number of community residence beds sponsored by the provider.

Figure 8: Variable Late Afternoon/Early Evening Staffing Ratios at the Residences Visited



Additionally, although the Commission had anticipated that staffing ratios would be richer in the late afternoons and early evenings when most residents were home, this was not always the case. Whereas, at 47 percent of the residences, we did find richer staffing in the late afternoons/early evenings than in the mid-morning, at 31 percent of the residences staffing did not change for these two time periods. At 22 percent of the residences staffing ratios were actually poorer in the late afternoons/early evenings than in the mornings.

We also noted that at eight residences clinical staff were more likely to be scheduled during regular workday hours of 8:00 AM - 4:00 PM than during the late afternoon and early evening hours, when most residents were home.

- Although cost reports were available only for the 26 voluntary agency residences, even among this subset, annual per capita expenditures varied from \$15,323 to \$30,650, or 100 percent (Figure 9).*

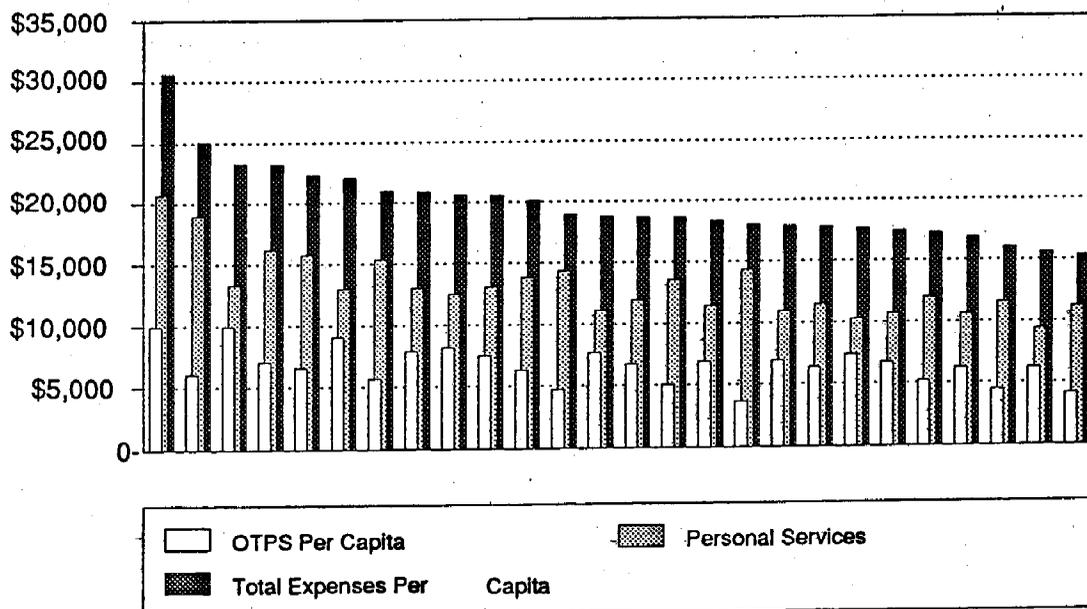
* The Office of Mental Health does not require proprietary residences, which are "flat-rate funded" through residents' SSI Congregate Care Level II allotments, to submit expenditure reports. Although OMH has recently started to gather cost data from its State-operated residences, these data, according to OMH officials, are not yet reliable for reporting purposes.

Analysis of the unexpectedly high cost variations among voluntary agency programs indicated that higher total per capita costs were significantly associated with better conditions and services in the residences ($r = .44, p < .05$). Conversely, programs with lower per capita costs tended to have more problems.

The analysis of cost variations further showed that lower per capita other-than-personal services costs were significantly associated with increased problems in housekeeping and maintenance at the residences. This finding suggests that, at least for voluntary agency residences, careful review of expenditures for maintenance and housekeeping may be warranted when significant problems are noted in these areas.

As a general rule, smaller residences and residences serving higher functioning clients also had higher per capita costs ($r = -.39, .50$ respectively; $p < .05$). Discussions with staff at some residences suggested that the unexpected relationship of higher program costs with higher client functioning levels

Figure 9: Total Per Capita, PS, & OTPS Annual Expenditures at the 26 Voluntary Agency Residences Visited



may be due to the belief held by some agency administrators that lower functioning residents, not expected to move on to more independent living, do not require intensive rehabilitative services.

Additionally, and unlike staffing ratios, variations in total per capita costs were associated with the geographical locations of the residences. Generally, costs increased as the distance from New York City decreased ($r = -.37, p < .05$). Unexpectedly, however, cost variations were not significantly related to variations in the size of the provider agency or staffing ratios.

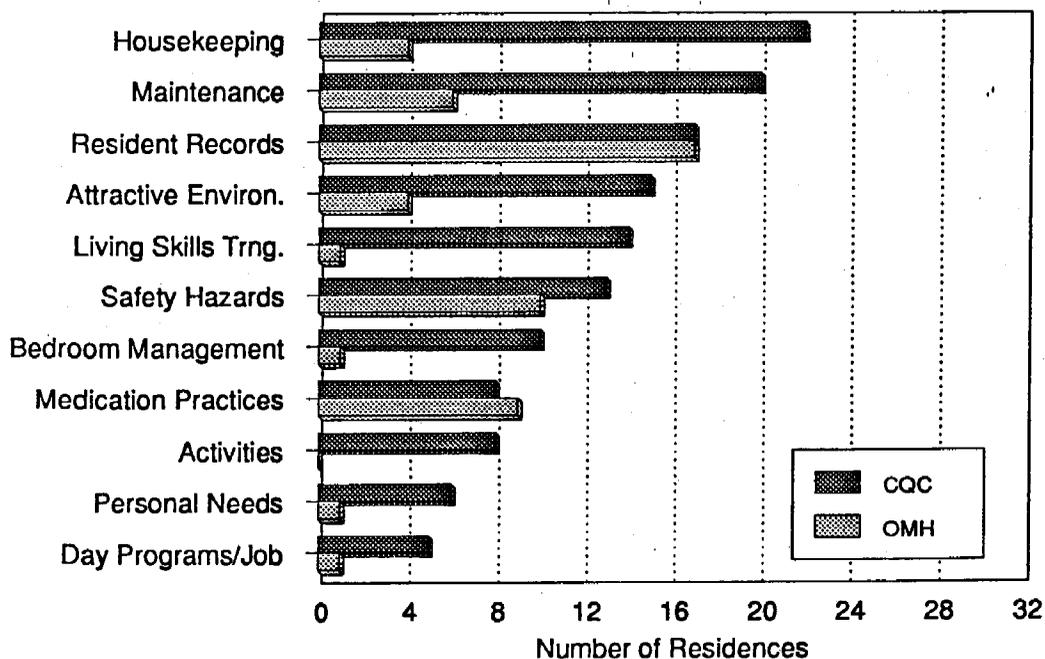
Follow-up discussions with OMH staff about the expenditure variations among the 26 voluntary agency programs, as well as the variation in staffing ratios, revealed that contracts for provider agencies, which include individual program budgets, are approved based on explicit and fairly comprehensive guidelines developed by OMH and distributed to all providers. In approving submitted contract budgets, OMH has also developed a computer program to identify maximum allowable budgeted costs. Contracts also specify authorized staffing by the number of certified beds in a program; however, they do not specify staffing ratios by day of week or shift.

Unfortunately, however, considerably less scrutiny is applied in reviewing actual annual expenditure reports, or during certification reviews, in assessing actual practices for scheduling staff or actual staffing ratios. OMH staff indicate that annual expenditure reports are screened to ensure that expenditures do not exceed bottom-line budget guidelines, but significant "under" spending is not flagged. Only recently, upon notification of the Commission's findings, have OMH staff begun developing guidelines to flag certain categories where reported costs are very low.

Similarly, except in unusual instances, certification review teams do not question staffing ratios or staffing scheduling practices. As a general rule, these decisions are left to the discretion of the provider.

■ The Commission's findings — especially at the residences with the most serious problems — raised questions about the capability of the OMH certification process to detect problems in community residences and to ensure that these problems are promptly corrected (Figure 10).

Figure 10: Problems Identified by OMH Certification vs. CQC Reviews



A review of the most recent OMH certification reports on the 32 residences revealed that these reviews primarily identified deficiencies in record-keeping and administrative procedures and policies, rather than other issues, such as maintenance, housekeeping, attractiveness of the residence, and the actual provision of rehabilitative and recreational services, which surfaced during the Commission's reviews.

More critically, recent OMH certification reports on four of the five residences with the most serious problems did not reference many of the deficiencies noted by the Commission, despite the close proximity of the times of the Commission's and OMH's reviews of these homes. The Commission also noted that certifications at six residences, all located in New York City, were one to three years out-of-date.

Closer review of OMH policies and practices, as well as OMH's available resources to conduct certification reviews, sheds light on the possible reasons behind the discrepant findings of the Commission's and OMH's reviews.

First, and most importantly, almost all OMH reviews are announced and, in most cases, agency providers are afforded one to three weeks prior notice of these visits. It is thus likely that residence providers are able to clean up, make many maintenance repairs, and purchase needed furnishings or decorations in advance of OMH visits.

Second, OMH also reports that, while individual OMH Regional Offices may offer some training to surveyors conducting certification reviews, no comprehensive training program is offered to surveyors statewide. They also acknowledge that the lack of a uniform training program has led to variable certification review team practices across and within the five OMH regions.

Third, examination of OMH certification protocols and review instruments indicated that, although the "official" survey process appears very comprehensive in most respects, attention to specific issues, including housekeeping, residents' personal grooming and clothing needs, and the home-like atmosphere of the residence, is limited. Paradoxically, other issues are examined so comprehensively by the "official" OMH protocol that it seemed doubtful that teams of two surveyors could actually complete the protocol effectively in the one-day review period.

Significantly contributing to the above problems is the serious shortage of available certification staff positions within OMH. Including the 10 additional items in the FY 1988-1989 Executive Budget, OMH will have only 28 staff to conduct certification reviews of the over 1,000 OMH-licensed community residence and outpatient programs, statewide. In contrast, OMRDD has approximately 81 surveyor positions to review 1973 programs, or nearly 50 percent more surveyor staff per programs to review than OMH.

The limited available surveyor staff positions prompted OMH's decision to skip the unannounced site visits to programs every two years, as required by its regulations, in all but very selective cases. Staffing shortages have also left little time for surveyor staff training, and they have encouraged OMH to shorten time frames and staff resources for individual program reviews.

In New York City, surveyor staff shortages are most critical, and many programs have not been visited by OMH staff in over three years. OMH acknowledges that 80-90 percent of its licensed community programs in New York City are now operating with out-of-date certifications. Recognizing the seriousness of this problem, OMH has recently contracted with a private consulting firm to conduct certification reviews in New York City.

- **Simultaneously, internal quality assurance mechanisms of many of the residences visited appeared inadequate to detect and correct apparent problems.**

Although most of the residence providers reported pre-existing internal monitoring procedures, at approximately two-thirds of the residences, the obvious nature of many of the problems noted indicated that these procedures were poorly implemented and ineffective. In particular, most of the environmental problems appeared longstanding and obvious to any visitor of the residences. While the problems in rehabilitative and recreational services would have required reviews and observations when residents were in the homes in the late afternoons/evenings and on weekends, a good internal quality assurance process also should have detected these concerns.

Additionally, it appeared, based on plans of correction submitted by the providers, that most pro-

viders, once notified of the Commission's findings, were able to quickly institute appropriate corrective action. As shown in Figure 11, provider plans of correction almost universally indicated prompt actions to improve housekeeping, make maintenance repairs, purchase new furnishing and decorations, and to take steps to augment rehabilitative and recreational services for residents.

Commission unannounced follow-up visits to the five residences with the most serious problems, just six months after our initial visits, also revealed marked improvements. In virtually all of these residences dramatic improvements in environmental conditions, as well as programmatic services, had occurred. (Figure 12)

Walls had been painted and repaired; major housekeeping improvements had been made; and in many cases rooms had been totally remodeled and redecorated. Chore programs also had been instituted or reactivated, and it was apparent from the improved environmental conditions in the homes that these programs were working.

Most heartening were the positive comments from residents and staff, alike, on our return visit. Residents praised the many additional activities

which were now available, as well as the improved conditions in the residence. Staff were also obviously proud of the improvements they had achieved in such a short time, and it was clear from their comments that expectations for quality care had been radically upgraded in day to day program management.

These reported and witnessed improvements, while commendable in their promptness and comprehensiveness, suggested that needed improvements in most of the residences were well within the reach of most program administrators. These actions further suggest that, with more aggressive internal management and oversight, many of the deficiencies cited by the Commission could have been averted.

- As a group, the proprietary community residences visited evidenced significant problems in meeting many of the rehabilitative, recreational, and clinical support expectations of the community residence program.

Of the four proprietary residences visited, *all* had problems in the provision of daily living skills

Figure 11: Reported Corrective Actions by the 32 Residences Visited

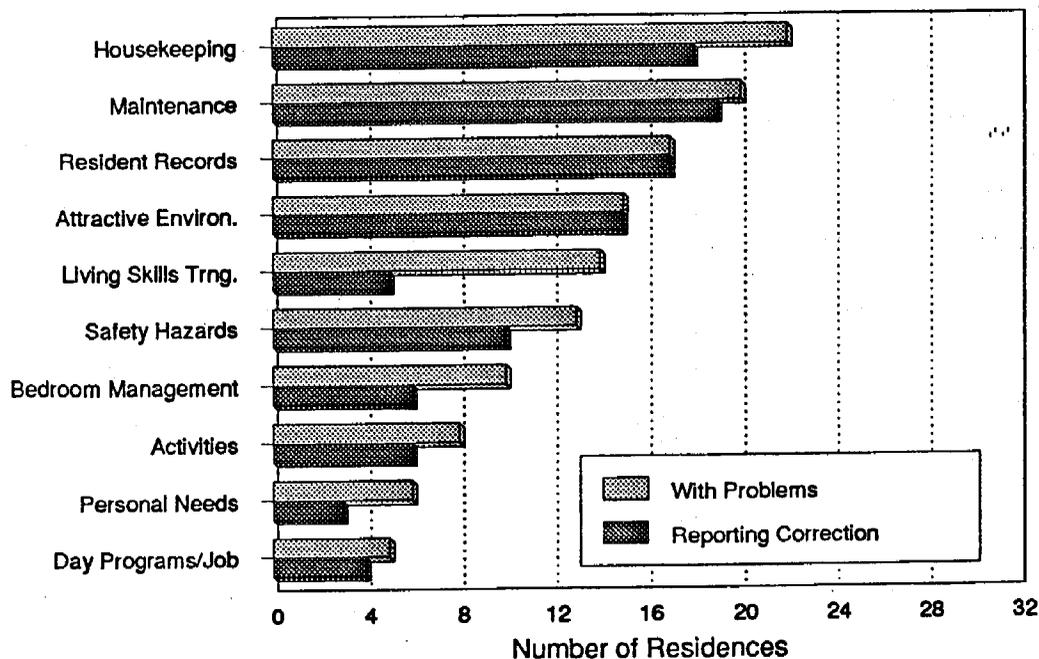
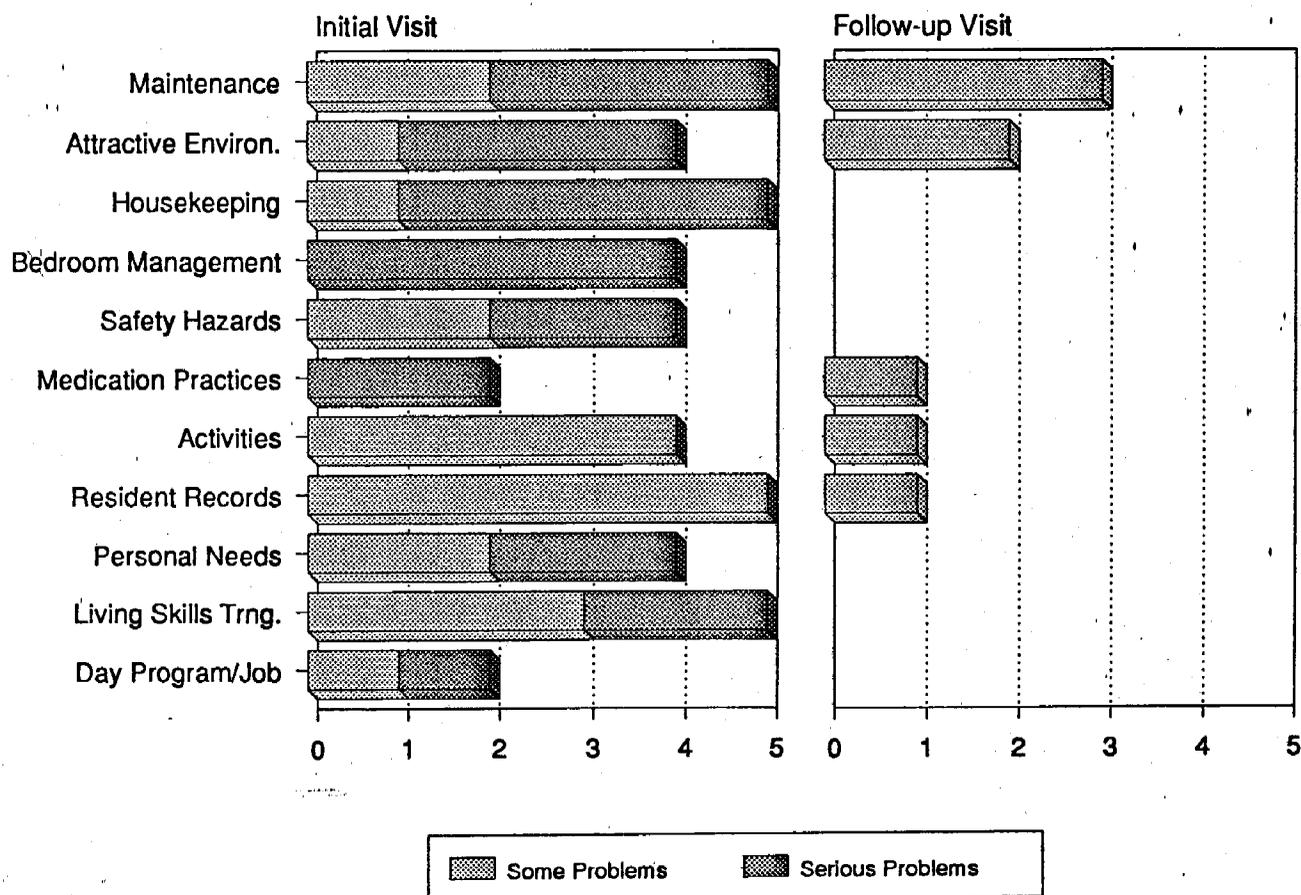


Figure 12: Follow-up Findings for Five Residences Initially Identified as Having Serious Problems



training; *three* had not been able to arrange meaningful daytime activities for at least one-third of their residents; and *three* also assured only very limited recreational opportunities for residents. *Three* of the four residences also had problems in medication administration practices and residents' records. Additionally, *all* four of these residences had made few efforts to ensure that their residents participated in community activities or used other community resources.

Notably, however, proprietary programs did not score poorly in all areas. In fact, in the areas of basic custodial care and attention to residents' personal needs, these residences, as a group, scored better than other residences reviewed. Only one of the four proprietary residences visited had any problems related to environmental conditions or residents' clothing or hygiene needs.

In part, this uneven performance of proprietary residences reflects the unusual conversion of these programs from large "family care homes" to community residences in 1975. This change took place in the wake of OMH's efforts to limit the family care program to smaller family type homes. At the time, OMH recognized that these 21 proprietary residences were dissimilar from the few existing community residences in their provision of rehabilitation services; but other priorities, including the development of basic regulatory standards for community residences and the expansion of the modality, as a whole, took precedence for OMH's attention.

Additionally, OMH realized that many of the residents of proprietary programs were older (over 55) than residents of existing and newly-developed community residences and that, unlike other community residences, proprietary residences were

more likely to be the long-term placement for their residents. Proprietary community residences also tend to be larger than voluntary agency- or state-operated residences, with an average capacity of 20 residents. OMH staff recognized that the different resident profiles and generally larger bed size of many of the proprietary residences would require special attention in the development of appropriate rehabilitative programs.

More significant than these historical events or the differentiating characteristics of proprietary residences and their residents, however, substantially lower reimbursement levels are a critical factor in influencing the poorer provision of rehabilitative services in these residences. State statute (§ 41.33 MHL) bars proprietary programs from special community residence funding and, therefore, proprietary programs receive only SSI Level II payments allocated to their residents as reimbursement. As a result, proprietary residences operate at less than 50 percent of the expenditure level of the least costly voluntary agency residence reviewed in this study, but are "theoretically" expected to meet the same expectations. OMH officials acknowledge the

inequity of this equation, and, to some extent, this recognition has also tempered the "real" expectations placed on proprietary providers.

The impact of the lower funding level for proprietary community residences was most apparent in their poorer staffing ratios. Late afternoon scheduled staff-to-resident ratios at three of the four proprietary residences were 1:12. In comparison, only two of the other 28 residences visited had late afternoon scheduled staffing ratios exceeding 1:8, and none had scheduled late afternoon staff ratios of 1:12 or greater.

In discussing these concerns with OMH officials, there was general agreement that the time has come to more effectively address the special concerns of the 21 proprietary community residences, which collectively serve approximately 400 individuals. Although no specific course of action was determined, suggestions ranging from adding CSS-funded rehabilitative staff to these programs to converting the status of the programs to residential care centers for adults, a new OMH residential modality which by statute can be operated by proprietary agencies, were discussed.

CHAPTER III

Discussion of the Major Findings

Nearly one-third of the residences visited by Commission staff clearly demonstrated the potential of the community residence model, as developed by the OMH, to provide a safe, nurturing, and rehabilitative place to live for persons with mental illness. Across the residences visited, the Commission also noted a generally high degree of resident and staff satisfaction with the residences, and an experienced and committed work force.

The review also revealed, however, that two-thirds of the residences visited fell short in demonstrating the potential of the community residence program. Some of these residences had failed to meet program expectations in only a few areas; others missed the mark in considerably more areas; and, 5 of the 32 residences visited evidenced significant problems in meeting expectations in at least 9 of 12 areas reviewed.

Variable Performance

Careful examination of the residences which met most expectations well, versus those that did not, further revealed that variables like program location and size were not significantly associated with variations in performance. The outstanding residences visited in this review were located across New York State, some in New York City and other densely-populated areas, some in suburban communities, and some in rural areas. These residences also ranged in size from 8-bed programs to 24-bed programs — the general census parameters for mental health community residences. The outstanding residences visited also represented a mixed group of large, small, and medium-size provider agencies.

Additionally, since all residences visited, with the exception of the proprietary residences, were governed by comparable OMH contract/funding guidelines, it did not appear that the availability of fiscal resources (versus actual per capita expenditures) was a critical factor in influencing the variable conditions witnessed. Finally, although deficiencies in one sub-area assessed, attention to residents' personal needs, were associated with residences serving lower functioning residents, in the remain-

ing areas, including environmental condition and the provision of other rehabilitative and clinical support services, there was no significant association between residents functioning level and the performance of the residences. Thus, it also appeared the residents' functioning level was not a significant factor influencing the variable conditions observed.

In view of these findings, it appeared that something far more fundamental was influencing the better or poorer performance of the residences visited — management expectations and effectiveness. The Commission visited some homes where glaring environmental deficiencies clearly had been tolerated for some time. In other cases, residence managers and provider agency administrators attempted to justify the failure to provide any significant rehabilitative activities. The Commission also came upon some residences where the articulated mission of the OMH community residence program to foster community integration had clearly been lost on program managers, who assured residents little use of community resources or services, and who had made few, if any, efforts to break down the isolation of the residence from its neighbors.

OMH Certification and Oversight Practices

It would be easy to target the OMH certification process for licensing and monitoring community residences for many of the failings of the residences visited. There are apparent flaws in this process. Available staff resources to conduct certification reviews are seriously inadequate; training programs for surveyors at best are variable; at worst, they are non-existent; and, the typical practice of primarily conducting only announced certification reviews clearly has severe accountability weaknesses.

Additionally, the Commission noted certain weaknesses in the OMH certification protocol, particularly in the assessment of housekeeping and environmental attractiveness issues. Finally, providers, as well as OMH staff, were quick to point out variability in the actual conduct of certification

reviews. This problem, caused in part by the limited training offered to surveyors, is compounded by the splintering of administrative direction over the certification process, whereby new programs are initially certified by OMH Central Office and program recertifications are administered by Regional Office Directors in each of OMH's five different Regional Offices. Available staffing resources, as well as the individual priorities of Regional Office Directors, have resulted in variable certification review practices in different regions of the state. For example, one Regional Office Director reportedly is promoting more unannounced reviews, while others — due to limited staff — have limited unannounced reviews to very select cases.

The review also indicated that tighter OMH oversight of community residences may be warranted in certain areas. Specifically, the 100 percent variation in total per capita expenditures among the voluntary agency residences visited raised concerns. The seriousness of these concerns was heightened by the significant correlation between lower per capita expenditures and poorer residence performance. It appeared that residences which were significantly underspending their allocated resources suffered. In particular, environmental deficiencies were significantly correlated with lower per capita other-than-personal services (OTPS) expenditures.

In addition, as a general rule, residences serving more disabled and dependent residents were spending less, both in terms of total per capita expenditures and per capita personal services expenditures. The subsequent finding, that staffing ratios in the residences were not also inversely related to the functioning level of the residents, offered little comfort, for it suggested that lower paid and more inexperienced staff may be assigned to residences serving the lower functioning residents. Together, these findings indicate a need for closer OMH scrutiny of actual expenditures, and not just "budget approval" for community residences. Relatedly, other findings indicating wide variations in actual staffing ratios and staff scheduling practices suggested that closer OMH monitoring of actual staffing practices may be desirable.

More active monitoring and training by OMH for providers in the provision of rehabilitation and recreational service and the fostering of community integration also appeared to be critical. In all cases, it was apparent that these problems had been long-

standing and, in many cases, providers and residence staff appeared surprised at the Commission's concern. This complacency with the limited developmental opportunities offered to residents and the limited efforts to foster positive relationships with neighbors and community organizations and services at a significant percentage of the residences reviewed, suggested that OMH expectations in these areas, while explicitly stated in regulatory standards, had not been vigorously communicated or effectively monitored at some programs by OMH officials.

These issues appeared to be particularly problematic for proprietary residences, which seemed neither oriented toward, nor equipped to meet the rehabilitative and community integration objectives of the OMH community residence program. These residences' history as family care homes, with fewer expectations in these areas, as well as their substantially lower funding levels, appeared largely responsible for these deficiencies. Simultaneously, the adequate performance of three of the four proprietary residences visited in providing comfortable, clean places to live and in attending to residents' personal needs appeared to justify more substantial OMH investment of resources in these programs, to enhance their potential to provide rehabilitative services to residents.

Staff Training Needed

Other findings of the review indicated that staff training programs for community residences need to be augmented. Between one-third and one-half of the 144 staff responding to the Staff Satisfaction Survey reported that they had not received training in many basic areas, including the nature of mental illness, psychotherapeutic medications, and patients' rights. This finding was particularly significant, given that over half of the staff responding had been working for the provider agency for at least one year.

Many factors, including staff turnover, the unavailability of relief staff for staff attending training programs, and the reportedly limited resources of providers to develop or send staff to training programs, appeared to influence the limited training provision. Successfully addressing these problems will require multiple strategies. OMH reports that some of these efforts are already underway. Train-the-trainer programs for community residence staff

have been increased, and new training programs to address the needs of residents with alcohol and drug abuse problems, as well as residents with AIDS, are being developed. OMH also is considering allowing greater access to State psychiatric center training programs for staff in community programs.

In addition to these efforts, a series of video tapes covering basic topics of a core curriculum for community staff should also be considered. These tapes could be made available to providers, and they would significantly ease the providers' difficulties in offering on-going training to new staff and in overcoming the difficulties of arranging relief staff. There also may be merit to OMH clearly articulating, and more carefully monitoring, orientation and inservice training requirements for community residence programs. These changes may further encourage providers to ensure adequate training programs.

More Relevant Day Services

Finally, both residents and staff of most of the community residences visited voiced their dissatisfaction with available day program services. Most residents and staff questioned the value of these programs, which insufficiently targeted the educational and vocational needs of residents. These complaints, like many of the other problems noted by Commission reviewers, appeared to be long-standing.

All of the above problems clearly require prompt attention and correction by OMH. Specific actions, including more unannounced certification reviews, the monitoring of residences' actual expenditures and staffing practices, and greater OMH management attention to the rehabilitative and community integration missions of community residences, could reap significant immediate benefits. At the same time, efforts to revitalize and redirect day program services will have significant benefits for the quality of residents' day-to-day lives, and also for the more cost-effective expenditure of taxpayers' dollars supporting these programs. Greater provision of provider and staff training also would add to the overall quality of OMH community residence programs. Especially since OMH plans a dramatic expansion of the community residence program over the next eight years, from 8,800 to 14,000 beds, these needed reforms and changes are clearly imperative.

Strengthening Residence Provider Management

Notwithstanding these needed actions by OMH, however, it is also clear that the ultimate well-being of New York's community residence programs for persons with mental illness rests in the hands of provider agencies and their staff. No amount of state agency oversight and no state certification process—however vigilant—can take the place of clear expectations, effective management, and dedicated and well-trained staff at the program level.

Over the course of its reviews of the 32 community residences, the Commission had the opportunity to witness the magic of these ingredients on program quality at many of the residences. It is also noteworthy that two of the ten residences evidencing excellent performance in meeting the expectations of the OMH community residence program were located in New York City and that, due to the limited availability of certification staff in this region of the state, these residences had not been visited by OMH staff in more than three years.

Additionally, and as evidenced in the prompt reports of substantial corrective actions at virtually all residences visited by the Commission, it appeared that almost all cited deficiencies were well within the reach of most providers to remedy quickly. With few exceptions, providers readily acknowledged the need to assure correction of cited problems and, in almost all cases, providers also seemed to have ready access to necessary funds to make specific environmental repairs.

What is disappointing is that it required an unannounced review by the Commission to prompt these corrective actions. Internal agency oversight and management at a number of the residences, and especially at those with the most serious problems, were clearly lacking. In many of the homes it appeared that management had either tolerated or overlooked significant problems for long periods of time.

It also appears that weaknesses in provider management, more directly than the absence of OMH guidelines or oversight, were responsible for the widely-varying expenditures and staffing ratios at the residences. With limited exceptions, providers were authorized to make these decisions. Whereas, in many cases this decision-making was

handled well by providers, in other cases it clearly was not. Apparent environmental repair work inside and outside some residences had been long neglected, as had major "spring cleaning" type house-keeping tasks, like window washing and carpet cleaning. In some residences, provider inattention to allocating needed funds to replace worn and broken furniture was also noted.

Many providers stated that these problems emanated from inadequate OMH maintenance and furnishing allowances for community residences, especially for residences which had begun operation more than five years ago, when available start-up/renovation funds were less adequate. Follow-up conversations with OMH officials confirmed that available maintenance funding historically had been a problem, but that recently a number of actions had been instituted to remedy the situation. These actions, more fully described in a letter from Mr. Robert Myers, OMH Director of Residential Services, in Appendix B, include:

- the creation of an Emergency and Deferred Maintenance Program during FY 1987-1988 to provide \$500,000 in special funds for programs with serious maintenance problems.
- amendments to § 41.38 MHL in FY 1987-1988, clarifying that residence programs could use the dedicated funding stream reimbursing 100 percent of property costs (e.g., rent, mortgage, utilities) referenced in the statute to finance maintenance repair work; and,
- encouraging providers — within available OMH Capital funds — to purchase leased properties and, thereby, overcome difficulties in ensuring that landlords make necessary repairs.

OMH officials also added, however, that maintenance funds (in lesser amounts) were always available in agency budgets, but that agencies had considerable discretion as to when and how to spend these funds. According to OMH officials, some providers were considerably more skillful and effective in budgeting for maintenance repairs and furniture replacement than others. This opinion seemed to be verified by the variable environmental observations witnessed by Commission staff.

Staffing decisions by some providers also appeared questionable. For example, at 15 of the 32

residences, equal or greater numbers of staff were assigned during the daytime hours, when most residents were away from the residence attending their scheduled day programs, than during the late afternoon and early evening hours when most residents were home. In other instances, specific provider staffing decisions appeared questionable. For example, one large provider which operated a clinic, several day programs, and a number of residences had internally promoted an assistant residence manager to a new position in the agency. The employee was moved to her new position before a permanent or temporary replacement in the residence was assured, leaving a serious gap in this already tightly-staffed residence and resulting in cancellation of some planned activities for residents.

Provider Expectations

More fundamental concerns in providers' basic expectations for community residence programs also surfaced at many residences. Seven (7) voluntary agency residences and all four proprietary residences had problems in providing residents with sufficient opportunities to maintain and develop basic living skills or to use community resources. Whereas, the problems noted in the proprietary programs were more understandable for reasons already delineated above, the problems in voluntary agency programs were more troublesome.

Specifically, the Commission was surprised at the array of excuses initially offered for these concerns. Residents' chronic psychiatric conditions, the pre-determination that residents would not move on to another more independent setting, and residents' senior citizen status — were all raised by providers as reasons why they had limited obligations to provide daily living skills training or community integration opportunities for their residents. Although, as in all rehabilitation programs, these opportunities in community residences should be tailored for individual residents' needs and abilities, several providers seemed to believe that the limited abilities of their residents released them from the fundamental mission of the community residence program — to help residents live as independently as possible. Although these issues were also reflective of the limitations in provider and staff training, they appeared to be more directly tied to a mindset clearly incongruent with the mission of the community residence program.

CHAPTER IV

Conclusions and Recommendations

The outstanding performance of 10 of the residences visited, as well as the high degree of resident and staff satisfaction, indicated the potential of the community residence program to help in filling a critical need for a supportive, nurturing, and rehabilitative setting for persons with serious mental illness to live in the community and to gain important daily living and socialization skills. The review also clearly indicated, however, that enhanced management oversight by the New York State Office of Mental Health and individual providers, is critical to ensure that all residences come to demonstrate this potential.

Particularly, as the OMH embarks on its ambitious plans to more than double the size of its current community residence program to 14,000 beds by 1996, taking steps to ensure a high quality of care and services in all community residences is critical. To this end, the Commission offers the following recommendations.

OMH Management Initiatives

1. OMH should continue its efforts to ensure more adequate orientation and in-service training opportunities for staff in community residences. In addition to efforts already underway, OMH should specifically consider:
 - the promulgation of core staff training requirements for direct care and clinical staff of community residence programs;
 - the development of training programs targeted to assisting residence staff in designing and implementing daily living skills training programs for residents who are very dependent, older, and/or resistant to developing greater independence in these areas;
 - the development of written guidelines and training sessions to sensitize providers to obvious and more subtle practices which foster or hinder the community integration of residents of community residences; and,
2. In conjunction with the planned expansion of community residence programs, OMH should also consider the development of an independent apartment program, with an enhanced SSI level payment, which could provide affordable, long-term supportive housing with flexible levels of support services and supervision for persons with mental illness, based on their needs.
3. OMH should continue to encourage creativity and flexibility in functional programs and authorized funding levels of community residence programs, to facilitate use of these programs by the homeless mentally ill, persons with long histories of psychiatric hospitalizations, and persons with concomitant disabilities of alcohol and drug abuse, AIDS, and mental retardation. Additionally, assuring the availability of crisis respite community residential beds, should be a priority for every county.
4. Consistent with the recommendations in the Commission's previous report, *Admission and Discharge Practices in Psychiatric Hospitals*,* OMH should re-evaluate the existing array of outpatient services in view of the changing needs and desires of patients served. Particular attention should be focused on the increased provision of educational programs and sup-

* *Admission and Discharge Practices in Psychiatric Hospitals*, New York State Commission on Quality of Care, April 1988

ported, volunteer, and competitive employment opportunities which patients are requesting.

5. OMH, with the cooperation of the Division of the Budget, should take immediate steps to strengthen the accountability of the certification process for community residence programs, including:

- the scheduling of more unannounced certification reviews;
- providing of comprehensive and uniform training for all certification surveyors statewide; and,
- instituting practices to ensure that residences with serious deficiencies which affect resident safety and the quality of residents' day-to-day lives are afforded the immediate attention they warrant, including prompt assistance in implementing needed corrective actions, as well as vigilant monitoring to ensure that needed actions actually are taken.

6. In addition to these immediate steps, OMH should also convene a task force of OMH staff, DOB staff, providers, recipients of services, and advocates, to address certain other concerns regarding the viability and accountability of the OMH certification process for all community programs, which will necessarily require more time and deliberation to resolve. Issues to be addressed by this task force should include, but not be limited to:

- an assessment of the staffing resource needs of OMH to assure an accountable certification process for community programs;
- the articulation of clear standards of substantial compliance for specific types of community programs, whereby non-compliance with these standards may jeopardize continued OMH licensure and funding of the program, if prompt corrective action is not assured;
- the appropriate organizational/administrative structure within OMH for program certification reviews and accountability;

- an evaluation of existing protocols for certification reviews to ensure that they target the most critical issues in assuring a high quality of care and treatment services in the programs reviewed;
 - guidelines for the conduct and frequency of announced and unannounced certification reviews, which recognize that past performance of programs may justify greater or less vigilant OMH oversight; and
 - a mechanism for monitoring systemic findings of certification reviews to identify significant trends which may indicate the need for systemic corrective actions, including additional or clearer regulatory standards, more provider training, or other changes/reforms.
7. OMH should take steps to ensure that annual expenditure reports of community residences are carefully reviewed to target significant under and over-spending of funds inconsistent with approved program budgets. "Outlier" expenditure patterns should trigger prompt OMH follow-up and investigation of the program. OMH should also ensure that annual expenditure reports of programs noted to have serious problems upon certification reviews are promptly and carefully reviewed.
8. OMH should apply similar scrutiny, both in the context of the reviews of annual expenditure reports and in the conduct of certification reviews, to actual staffing and staff scheduling practices of residences. In particular, residences not providing staff ratios consistent with their approved budgets, and residences providing richer or equal staffing during the daytime hours when most residents are away from the residence, as during the late afternoons and evenings when most residents are home, should receive careful attention.
9. OMH should take prompt action to address the long-term problems of many of the 21 proprietary community residences in meeting the rehabilitative and community integration expectations of the community residence program. The Commission recommends that

OMH consider flexible approaches for these providers which recognize the able performance of many to provide supportive and nurturing residential settings for residents, as well as the apparent inconsistency of the allocated funding versus stated expectations for these programs.

Community Residence Provider Initiatives

10. Providers of community residences should ensure a clear awareness and acceptance of the mission of community residence programs — **to promote the greatest possible independence and integration of residents in community living** — by all staff. In particular, providers should ensure that a resident's disabilities, psychiatric conditions, and/or age are not used to excuse staff or the residence program from fulfilling this mission. To this end, providers should also assure needed staff assistance and training for designing appropriate rehabilitative, recreational, and community activities for residents who may not be easily accommodated in traditionally-designed rehabilitative programs and community services.
11. Providers of community residence programs should ensure appropriate internal monitoring practices to detect and correct incipient problems in the community residences they operate. These practices — at a minimum — should ensure that senior management staff conduct frequent unannounced visits to programs to review key aspects of the program. Additionally, internal monitoring efforts should include opportunities for residents and staff, as well as neighbors and community organizations, to report their comments and suggestions at least annually.
12. Providers of community residence programs should prepare and periodically update schedules for maintenance repairs, furniture replacement, and major spring cleaning tasks in all community residence programs they operate. Providers should also ensure that there is an effective procedure in place, whereby needed maintenance repair work in community residences is promptly reported, prioritized, and completed.
13. Providers of community residences should ensure that efforts are continually made to promote the community integration of their residents. These efforts should include, but are not necessarily limited to:
 - efforts to promote resident use of community resources and participation in community activities;
 - attempts to become acquainted with neighbors and local community organizations and services;
 - attempts to ensure, wherever possible, that residents receive health and mental health services from community providers;
 - efforts to ensure that Community Advisory Boards actively promote the acceptance and integration of residents into their communities; and,
 - development of policies to eliminate "labeling" signs from vans and residences which tend to "tag" residents as psychiatric patients.

Appendix A
Observations Inside the Residences

Observations Inside the Residences

The major findings of the Commission's review take on more meaning when one reviews the actual observations and noted deficiencies in the residences visited. Although the best way to grasp these findings is by reading the individual letters reporting the Commission's findings, this summary attempts to highlight our most significant observations across the residences.

Environmental Conditions

At approximately one-third of the residences, the Commission found generally outstanding environmental conditions. These residences were well-maintained, inside and out, and yards and gardens often reflected the extra attention of staff and residents. In many cases, these houses were among the best-maintained in the neighborhood. Housekeeping showed evidence of regular efforts by staff and residents to keep up with daily chores, as well as the more thorough "spring cleaning" type tasks of window washing, carpet cleaning, etc. Most importantly, common areas of these residences; e.g., living rooms, lounges, recreation areas, and dining rooms, were attractively decorated and furnished, offering a comfortable, home-like setting for residents to live. Safety and fire hazards also rarely were noted in these residences.

In nearly two-thirds of the residences visited, however, "some" or "serious" problems were noted in environmental maintenance, housekeeping, bedroom, overall attractiveness, and/or fire and safety precautions.

Fire and Safety Hazards

Our review revealed fire and safety hazards at 13 of the 32 residences. In three of these residences, Residences #4, #14, and #23, the fire and safety hazards were judged to be "serious" and to pose an immediate threat to residents' safety.

In Residence #23, wires connected to the fire alarm system in the basement were exposed to water dripping from a leaky pipe. A loose wire, also was hanging off the top basement step, and the lint filter for the dryer was found discarded under the dryer. Additionally, a stove was removed from the upstairs kitchen, leaving an exposed circuit wire, and staff did not know if the circuit had been disconnected. Fire extinguishers were also more than six months overdue for inspection.

In Residence #14, two of the residence's three fire exits were blocked with furniture, and a large wicker basket was stored on top of the hot range hood in the kitchen. Old paint cans were stored in the basement and on the stairs of the back staircase, and charcoal lighter fluid was stored in the laundry room next to the laundry detergent.

In Residence #4, the use of a light bulb with excessive wattage in a floor lamp had caused the lampshade to begin to melt, and the numerous cigarette burns on the upholstered furniture and carpeting in the smoking lounge indicated that residents were extremely careless in their smoking. Additionally, in three of the eight resident records reviewed, some or all record documentation of the residents' ability to exit the residence in the event of an emergency was missing.

In ten other residences, fire and safety hazards were also noted. Although these hazards also required prompt correction, they tended to be isolated to a few areas of the residence. For example:

- In Residence #19, fire extinguishers had not been inspected since August 1986, and the fire extinguisher in the kitchen had been removed and not replaced.
- In Residence #26, bedroom curtains extended over extremely hot radiators, and exposed asbestos pipes were found in the basement storage area and hallway, which were used by residents to access the resident kitchen and laundry room.

- In Residence #28, a space heater, forbidden under OMH regulations due to potential fire hazards, was used to heat a staff office, and an open box of rat poison was unsecurely stored in the laundry room.

Housekeeping

Housekeeping concerns in common living areas were the most prevalent deficiencies cited across the 32 residences. In two-thirds of the residences visited, housekeeping problems were noted, and in six of the residences, "serious" housekeeping concerns were noted in most common areas. Problems noted in Residences #14 and #23 provide examples of the most serious housekeeping concerns observed.

In Residence #14, walls and ceilings were dirty and stained, and floors, rugs, and stairways needed a thorough cleaning. Piles of dirt, dust, and litter were found in sections of the living areas and in hallways. Floors in the two kitchens were sticky and stained with spilled food residue; counter tops, cupboards, and shelves were also sticky, greasy, and littered with crumbs; and some dishes found in cupboards were encrusted with food. The dining room ceiling, as well as the chairs and tablecloths, were also dirty and covered with a film of grease. Additionally, tubs, sinks, and corners of the bathrooms were stained with mold and mildew, and most tubs and sinks were encrusted with soap residue.

Similar conditions were found in Residence #23. Walls in every room were either dirty, stained, or smudged, and walls and ceilings in the two large bathrooms were mildewed. Most of the rugs in the common living areas were badly stained, and dirt, dust, and litter had accumulated along the baseboard radiators. Most of the furniture was very dusty, and mirrors were also smudged and dirty. Additionally, most of the bathroom sinks and toilets, as well as one bathtub, were grimy, dirty and/or stained with mildew.

In the other 16 residences, less serious housekeeping problems were noted. These problems were generally limited to a few areas of the residence and/or they reflected inattention to periodic "spring cleaning" types of housekeeping issues, rather than day-to-day cleaning. For example, in Residence #16, windows were dirty throughout the house, a

ceiling in one bathroom was covered with mildew, and linoleum floors in the kitchen and bathrooms were stained with ingrained dirt. And, in Residence #19, carpeting throughout the house needed a thorough cleaning, as did all the windows.

Bedroom Management

At 16 of the 32 residences, housekeeping problems were also noted in at least one-third of the bedrooms observed. In six of these residences, bedroom management problems were noted in at least half of the bedrooms observed.

For example, in Residence #2, carpets in four of the five bedrooms observed were badly in need of vacuuming. Clothing also was strewn in piles on the floor and in closets, and many dresser drawers had been removed from dressers and placed on the floor. Most bed pillows in the residence were also old and discolored, and many had a foul odor. Similarly, in four of the seven bedrooms observed in Residence #11, clothing also was piled in heaps on floors, in closets, or in unused fireplaces, and residents' personal hygiene supplies were found scattered throughout bedrooms, hallways, and bathrooms on sinks and radiators.

Maintenance

Twenty (20) of the 32 residences evidenced maintenance problems in need of management attention and, at eight of these residences, "serious" and pervasive maintenance problems had a significant adverse impact on the quality of life for residents. Residences #8 and #30 were typical of the residences cited for "serious" maintenance problems.

Upon arriving at Residence #8, CQC staff noted that the exterior trim of the house was peeling, that two sections of the house gutters had been removed, that the outside furniture was broken and unattractive, and that the back door had never been painted and was in poor condition. Inside the house, many ceilings were in poor condition and needed painting and/or repair or replacement. The bathroom tub drain was clogged and the tub was filled with stagnant dirty water. One toilet was missing a toilet seat, and two drawer sections of the kitchen cabinets had been removed, leaving an unsightly gap.

In Residence #30, the yard was littered with debris, several window panes were broken, and most window frames needed to be painted. Inside the residence, there were large holes and extensive peeling paint, and cracked plaster on walls in the hallways and resident bedrooms from water damage. Residents and staff also complained of the ongoing unavailability of hot water throughout the residence. Finally, a missing drain outside the dining room door created periodic flooding in the dining room.

While maintenance problems in the other 12 residences also required management attention, these problems concerned more limited areas of the residence. For example:

- In Residence #25, walls in two areas of the residence and one bathroom ceiling needed repainting; one toilet did not flush; a shower drain needed repair; fixtures on some sinks were old and loose; and, one sink drained slowly, due to an on-going septic system problem.
- In Residence #28, a bathroom leak in a fourth floor apartment had caused water damage to a wall in a third floor hallway, and in the residence's staff office, where medications were stored and administered to some residents, paint was chipped and peeling off the walls and large holes in the ceiling were filled with steel wool pads.
- In Residence #18, several windows needed exterior paint, and the ceilings in three bathrooms and the main entranceway to the house were water-stained and cracked, with peeling paint.

Attractiveness/Home-like Atmosphere

While most of the residences visited (17 of the 32) evidenced significant efforts by provider agencies, staff, and residents to create a warm, home-like, and comfortable environment, 15 of the residences visited did not share these attributes; and at

four of these residences, most common living areas were poorly decorated and/or furnished. Problems noted in Residences #6 and #11 provide examples of the residences with the most serious problems in providing an attractive, home-like atmosphere.

In Residence #6, except for a single picture, there were no decorations in resident lounge areas, and little care had been given to appropriate furnishings or furniture arrangement in these rooms. In the second floor lounge, the furniture was marred with cigarette burns; and in the MTV Room, straight-back chairs (the only furnishings outside of the television set) were placed around the perimeter of the room, creating a stark atmosphere. In the Piano Room, similar chairs were haphazardly scattered around the room, and the badly worn carpet and stained overhead pipes further detracted from the room's attractiveness. The Recreation Room of the residence also lacked wall decorations, as well as curtains.

Similarly, in Residence #11, few efforts had been taken to decorate living areas. For the most part, the massive walls in this large former mansion were barren of pictures and decorations, and the two large common living areas appeared stark and empty. In the residence's one huge common living area, the only furnishings included three small love seats and four chairs, and the few coffee and end tables were dirty and littered with cigarette ashes. In the other common living area, the TV room, the only furnishings included a love seat, a couch, and two bean bag chairs. Aside from being unattractive, the few pieces of furniture in these common areas were clearly inadequate for the home's 24 residents.

In the other 11 residences, attempts had been made to decorate common living areas, but these efforts were either inadequate to create a home-like environment, or they did not extend to all common areas in the residence. In Residences #12 and #24, for example, staff had made efforts to nicely decorate one or two common areas, but other common areas had been neglected. In these rooms, there were few, if any, pictures, plants, or other decorations and, in some instances, furnishings were dirty, marred with cigarette burns, or otherwise in poor condition.

Program Services

Aside from environmental conditions, the Commission's protocol also focused on the residences' performance in providing residents with opportunities to develop skills and abilities to promote their ability to live more independently in the community. This component of the review targeted:

- assistance to residents in personal hygiene and appropriate dress;
- provision of training and activities to assist residents in gaining or maintaining daily living skills, such as cooking, laundry, shopping, money management, house-keeping, etc.;
- arrangements for resident participation in day programs, competitive, sheltered, or supported employment, and/or volunteer activities during the weekdays;
- arrangements for in-house and community-based recreational and social activities during the evenings and weekends;
- safeguards and resident training for appropriate medication administration practices; and
- basic resident record keeping.

Resident Personal Needs

At 26 of the residences, the Commission found very satisfactory staff efforts in attending to residents' personal needs. In these residences, most residents were appropriately dressed and groomed, and all residents had an adequate supply of appropriate clothing and basic hygiene articles; e.g., toothbrush, toothpaste, soap, shampoo, brush/comb, etc. In addition, bathrooms were well-stocked with bathroom supplies; e.g., toilet paper, paper towels, and adequate supplies of clean bed and bathing linens were available.

In contrast to these 26 residences, three residences (#1, #2, and #14) evidenced serious problems in providing assistance and training to residents in attending to their personal needs. In

Residence #1, five of the ten residents were very poorly dressed in soiled and ill-fitting clothing, and seven residents also were poorly groomed. In addition, there were no supplies of toilet paper or paper towels in the common bathroom, and extra supplies of bed and bathing linens could not be located by staff.

In Residence #2, several residents also appeared disheveled and unkempt. Four (4) of the 12 residents needed to have their hair washed and groomed, and two of the men were unshaven. These four residents also were dressed in dirty, stained, and/or ill-fitting clothing. Additionally, in over half of the bedrooms observed in this residence, beds lacked linens and spreads, and blankets were dirty, and/or threadbare. Most residents of the house also did not have sufficient clean towels for bathing, and the residence had no extra supplies of bed and bathing linens.

Similarly, in Residence #14, many of the residents had greasy, dirty hair and offensive body odor, and some wore clothing which was soiled, torn and neither age- nor season- appropriate. Bed linens in many bedrooms were also stained and dirty, and few extra supplies of bed and bathing linens were available. Many residents also did not have a complete set of personal hygiene supplies. In addition, there were no toilet paper holders in any of the bathrooms.

At three other residences (Residences #4, #8, and #23), Commission staff noted problems only in the adequate provision of bathroom supplies or linens to assist residents in their personal hygiene. For example, in Residence #8, toilet paper holders were missing or broken in three bathrooms, and paper towels and extra supplies of toilet paper were not available in any of the bathrooms. Extra supplies of bed and bathing linens were also minimal in this residence, and some pillow shams and spreads were dirty and stained. In Residence #4, there was no toilet paper available in most of the toilet stalls throughout the residence. In Residence #23, three of the four bathrooms lacked toilet paper, and two bathrooms lacked paper towels. Unlike the three residences noted above, however, problems at these residences did not appear to have a direct adverse impact on most residents' appearance and dress on the day of our visit.

Daily Living Skills Training

A major purpose of community residence programs, as stated in NYS OMH regulations, is "to assist mentally ill persons to live as independently as possible through the provision of training and assistance in the skills of daily living, and by serving as an integrating focus for the mentally ill person's overall rehabilitation" (14 NCYRR § 586.1a). The regulations further elaborate that community residences are responsible for assisting residents in dining, dressing, money management, and use of community resources to enable residents to live as independently as possible.

While conducting our reviews of the residences, we asked staff if they provided training and assistance to residents in these areas, and if residents actually participated in the daily household chores of the residence, such as cooking, shopping, menu planning, housekeeping, and laundry. In addition, during our evening visit, we observed meal preparation and clean-up, and noted the actual extent of resident involvement. Our evening visits to the residences also provided opportunities to speak with residents about their activities relevant to daily living skills, and the training and assistance they received from staff.

The Commission noted that 18 of the 32 residences met all basic expectations in providing training and assistance to residents in these basic skills. Fourteen (14) of the 32 residences, however, had problems in meeting these expectations, and six of these residences, including three of the four proprietary residences, were seriously deficient in fulfilling this basic rehabilitation mission of community residences.

In five of the six residences with the most serious problems (Residences #1, #8, #18, #20 and #21), staff training, assistance, and monitoring were not provided to residents in most daily living skills, and staff, without the assistance or participation of residents, did most of the daily household chores of cooking, grocery shopping, menu planning, cleaning common areas and/or laundry. In these residences, daily living skills training was typically limited to basic hygiene and some bedroom management.

In the sixth residence, Residence #11, house staff described an extensive in-house program whereby residents, with the assistance of staff, participated in all household chores. Our observations

of the serious and pervasive housekeeping deficiencies at the residence, however, suggested that this program was not effectively implemented by staff. During our visit, which coincidentally fell on a "major housecleaning" day, we also noted that counselor staff spent most of the time in their offices, and we did not observe any residents doing their chores. Later, the agency director acknowledged that there were significant problems in effectuating the "chore program".

At the eight other residences where problems were noted in basic living skills training, more assistance was offered by staff, and residents participated in some household chores, but greater attention to skill training in certain areas was needed. For example, at four of these residences (Residences #5, #26, #27 and #30), residents did not participate in menu planning or shopping. In four other residences (Residences #2, #14, #23 and #24), housekeeping problems in common areas and bedrooms indicated that staff monitoring and assistance to residents in doing their assigned chores were poor. Additionally, at Residences #5 and #26, residents did not share in cooking meals, as this task was done by hired "kitchen staff" in these larger residences. Although staff in Residence #26 had made "cooking labs" available to residents, there were limited day-to-day opportunities for residents to apply these skills.

Day Program Attendance

OMH regulations (NCYRR § 586.6 [c]) also require individuals residing in community residences to attend outside mental health, vocational, or educational programs, to work in competitive or supported employment, or to participate in some other meaningful activity each week. At almost all of the residences visited (27 of the 32), Commission staff noted that residents were participating in these required activities. At five of the residences, however, at least one-third of the residents did not participate regularly in these activities, and at three of these residences, most residents did not participate.

For example, only two residents in Residence #1 attended a day program, while the other eight residents reportedly participated in an in-house program during the day. The posted schedule of activities for the in-house program, however, rarely listed more than one or two activities, and based on staff reports, often only a few residents participated in

these activities. In addition, house residents did not share in the daily household chores. During the day of our review, half of the residents slept until 10:00 a.m.; three others slept until 11:30 a.m.; and, the scheduled activity during our morning/early afternoon visit did not take place. For the most part, Commission staff observed residents sleeping and sitting in the small living room area chain smoking, although a few took walks in the neighborhood.

In Residence #18, only 8 of the 24 residents attended a formal day program, while 16 residents of retirement age chose not to attend a day program. Although the Commission appreciated this choice by the elderly residents, we were concerned that alternate in-house or community recreational and social activities were not available. During our visit, we observed these residents sitting in the common lounge area, watching television, smoking, or wandering the grounds of the residence.

In Residences #8 and #21, Commission reviewers also noted problems with day program attendance, but in these residences, the problem was limited to fewer residents. For example, in Residence #8, 6 of the 24 residents did not participate in any outside activity; and, in Residence #21, 5 of the 12 residents did not participate in any outside activity. At Residence #21, similar to Residence #18 noted above, all of the residents not participating were senior citizens (> 65 years). Again, the Commission staff concurred that participation in a daily structured program was probably inappropriate for these older residents, but we were concerned that few alternate in-house or community activities had been arranged. As a result, these residents spent most of their days, as well as weekends and evenings, with nothing to do.

In Residence #8, on the other hand, one-fourth of the residents reportedly were not enrolled in a day program, due to the lack of available programs in the community. According to the residence manager, program "slots" were difficult to obtain, and many day program providers either excluded residents from their programs, or allowed their attendance only two or three days a week. Like the other cases where residents did not have formal program arrangements, there were also few alternative in-house or community activities offered, and residents spent most of the time sitting idly, drinking coffee and smoking during the Commission's visits.

Additionally, although the Commission assessment was limited to day program participation by residents, our staff also frequently heard complaints about the appropriateness or meaningfulness of programs which their residents attended. Specifically, residence staff often noted that these programs were not directed toward helping residents obtain important daily living or vocational skills or toward aiding residents in remedying basic educational deficits. Residence staff also noted that many residents did not enjoy or look forward to attending these programs, but reluctantly participated, only because it was a requirement for staying at the community residence.

These negative staff comments about the appropriateness of available day programs also were supported by comments on the "Resident Satisfaction Survey". Of the 222 residents responding to this Commission survey, over one-fourth indicated that their day programs were boring or a waste of time (27 percent), and 20 percent indicated that their programs were "just a place to go because I have to leave the residence". Only 51 percent of the residents indicated that their day programs were "helpful", and less than one-third (32 percent) indicated that they were "enjoyable".

Recreational and Social Activities

Another important aspect of the review assessed the availability of recreational and social activities for residents to help them in using their leisure time appropriately, and to assist them in developing socialization skills and social relationships. Our review revealed that three-fourths of the residences visited (24 residences) offered residents a variety of evening and weekend in-house and community recreational activities. At many of these residences, a variety of different "in-house" and community activities were offered most evenings and weekends, and most residents participated in these activities at least three or four times a week. For example, at Residence #5, residents are offered a variety of activities, including: arts and crafts, needlework, exercise groups, dances, games, ping-pong tournaments, and VCR movies. Residents also regularly attend community activities, such as sporting events, concerts, fairs, and camping trips.

Residence #19 also provided residents with a variety of activities such as ping-pong, pool, games, cooking, movies, and shopping trips. In addition, weekend activities, including special vacation trips and concerts, are scheduled frequently, based on residents' interests.

At eight of the residences visited, however, extremely few opportunities for recreational and social activities were available. Outside of an occasional weekend trip planned in three of these residences, a few board games at one residence, and a pool table at another, there were few, if any, other leisure supplies or activities available for resident use. Residents had little to do but to watch television or listen to the stereo, and many complained of being bored. In two of these residences, not located within walking distance to the community or public transportation, idleness was even more problematic.

Medication Storage, Supervision, Training

Residences also were reviewed to determine if residents were appropriately supervised in taking their prescribed medications, if residents received training in managing and self-administering their medications, and if prescribed medications were securely stored in the residence. Of the 32 residences reviewed, the vast majority (24) had no significant problems in these areas. In the remaining eight residences, four had serious problems in these areas and four had some problems.

An example of a residence with serious problems was Residence #27. At this residence, CQC staff observed residence staff administering medications to residents using dirty paper cups, which were reused for several residents. In addition, the lock on the file cabinet drawer used for medication storage was inoperable.

In the other four residences noted to have some problems in this area, CQC staff noted no problems in medication administration or in the reported provision of training to residents in self-administering their prescribed medications, but numerous instances where individual residents' medications were unsecurely stored. In these residences, medications were stored in dresser drawers or on dresser tops, leaving them readily accessible to other residents. Two of these residences (Residences #19 and #20) did not have provisions for a secure space for

residents to store medications, while in a third residence (Residence #21), staff indicated that residents could request a lockable box, but that residents usually turned down this offer. In the fourth residence (Residence #5), lockable boxes for storing medications were provided to all residents, but residents rarely used them.

Additionally, Commission staff also noted that few of the resident records reviewed across the residences included documentation of rationales for medication changes or staff monitoring of residents for side effects from psychotherapeutic medications. While such documentation is not specifically required in OMH regulations for community residences, the Commission was concerned that the lack of this information could adversely affect the availability of treatment services in the event of a medical or mental health emergency, especially if the residents' primary physician was not available.

Record Keeping

The assessment of resident records was not a major focus of the Commission's reviews of the 32 residences. At each residence we examined a random sample of records for the presence of the following documentation:

- the name of the primary physician,
- an annual physical exam report, and
- a skills assessment and current service plan.

The number of records reviewed at each residence varied, depending on its census, but in all cases, CQC staff reviewed at least four records or records of at least one-third of the residents, whichever was greater.

Despite the abbreviated nature of this review and the fact that CQC staff did not assess the quality of service plans or their correlation with service needs as reported in skill assessments, over half of the residences (17 of the 32) evidenced some problems in one or more of the assessed areas for at least half of the records reviewed. Specifically, some records at six residences lacked the name of the resident's primary physician; some records at 11 residences lacked current annual physical exam reports; and, some records at eight residences lacked skill assessments or current service plans.

Notwithstanding these deficiencies, records in most residences did provide regular progress notes for residents and, with the exception of two residences, records reviewed were generally orderly and well-organized. Nonetheless, the Commission was concerned that some records at so many of the residences lacked one or more essential pieces of information. Additionally, CQC reviewers noted that medical histories in most records reviewed at 25 of the 32 residences were very brief and sketchy.

Although OMH regulations do not require comprehensive medical histories, as with the absence of rationales for medication changes and staff notes related to monitoring residents for side effects from psychotherapeutic medication, the Commission was concerned that the unavailability of such histories could adversely affect the provision of emergency medical or mental health services to residents, especially if their primary physician was not available.

Appendix B

**New York State Office of Mental Health
Correspondence Regarding Funding for
Community Residence Property Maintenance**



RICHARD C. SURLS, Ph.D., Commissioner

March 22, 1988

Ms. Nancy K. Ray
Director of Policy Analysis
Commission on Quality of Care
Twin Towers
99 Washington Avenue
Albany, New York 12210

Dear Ms. Ray:

I am writing as a follow-up to our meeting of March 15, 1988 in which we discussed issues related to the preliminary findings of the Commission's review of the Community Residence Program. The Office of Mental Health has devoted considerable attention and resources over the past two years to the issue of property maintenance. We have done so based on our appreciation of how funding levels and policy in this area impacts upon the quality of life for residents in community residence programs. The following is a summary of steps we have taken to improve the capability of voluntary provider agencies to meet the physical plant maintenance requirements of community residence sites:

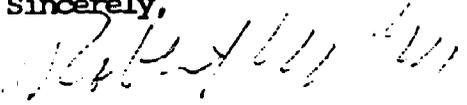
1. Emergency and Deferred Maintenance (EDM) Program - During FY 1987-88 the EDM Program was implemented providing \$500,000 in supplementary funding to selected provider agencies which demonstrated need based on life-safety and certification deficiencies.
2. Dedicated Funding for Residential Property Costs - To realize the full value of MHL Section 41.38, contract terms and budgeting instructions provide separate funding for 100% of reasonable residential property costs inclusive of rent, mortgage payments, utility costs and other costs associated with rental or ownership of real property. Within the contract terms there is a separate payment made for this cost category with no offsets based on revenues; further, there is a restriction on using these dedicated funds to supplement PS or OTPS needs. During FY 1987-88 we clarified this language to ensure that agencies which were using operating funds (MHL 41.44; PS and OTPS) for property maintenance costs could redirect those funds to appropriate operating costs by increasing the 41.38 obligation. Statewide this policy clarification resulted in an estimated increase of one-million dollars in the annual 41.38 allocation.
3. Flexible Maintenance Account - Provider agencies receive an annual maintenance amount as part of their 41.38 allocation based on their total number of beds. Beginning in FY 1987-88, agencies have been afforded total flexibility in distributing funds based on an annual assessment of individual site needs.

4. Property Ownership - The Office of Mental Health over the past two years has actively fostered policy changes supported by substantial capital appropriations to facilitate direct ownership of real property by voluntary provider agencies. Although the priority is on new bed development, existing programs may use capital funds to purchase sites which are currently leased or to relocate. In addition to funding for routine minor maintenance, provider agencies owning property receive as part of their 41.38 payment an amount for a capital reserve fund which can accumulate in an interest bearing account to provide sufficient resources to meet major capital repair needs. It is expected that use of this fund will extend the useful life of property and provide for a well maintained and functional residence. Further, by limiting our dependence on private landlords, it is expected that direct ownership, supported with adequate funding, will have the positive impact of providing sponsoring agencies with more direct control of their program space.

I hope this summary helps to clarify the issues which you have raised. As discussed, it should be noted that provider agencies have only realized the full benefit of these changes during this past year. We will realize over the next few years the long term benefits of these changes. It is our hope that these changes will be manifested in an improved quality of care.

Thank you for the opportunity to address this issue. Please feel free to call for further information.

Sincerely,


Robert W. Myers, Ph.D.
Director
Bureau of Residential Services

RWM:lo

cc: Sarah F. Rose

Appendix C
New York State Office of Mental
Health's Response to the Draft Report
and Recommendations



NEW YORK STATE
OFFICE OF MENTAL HEALTH

44 Holland Avenue, Albany, New York 12229

RICHARD C. SURLES, Ph.D., Commissioner

September 7, 1988

Clarence J. Sundram, Chairman
Commission on Quality of Care
99 Washington Avenue, Suite 1002
Albany, New York 12210

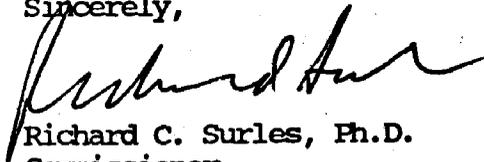
Dear Chairman Sundram:

Thank you for the opportunity to review the draft report summarizing the Commission's findings during visits to 32 supervised community residences for persons with mental illness. This report clearly illustrates the need for improvements in several areas of the operation and management of community residences across the state. However, I was pleased to learn that the community residence visits provided strong testimony of the capability of the community residence program to offer persons with serious mental illness a safe, supportive, and rehabilitative place to live, while preparing for more independent living in the community.

The attached OMH response to the Commission's report addresses each of the recommendations cited. In general, the recommendations appear to be consistent with newly formulated initiatives and policies OMH has currently undertaken.

I look forward to our continuing dialogue and hope to have your support and advocacy for changes necessary to meet the needs of the seriously mentally ill.

Sincerely,



Richard C. Surles, Ph.D.
Commissioner

cc: Bruce Feig, Executive Deputy Commissioner
Alice P. Lin, ACSW, DSW

1. COC Recommendation

The Office of Mental Health should continue its efforts to ensure more adequate orientation and in-service training opportunities for staff in community residences. In addition to efforts already underway, OMH should specifically consider:

- o the promulgation of core staff training requirements for direct care and clinical staff of community residence programs;
- o the development of training programs targeted to assisting residence staff in designing and implementing daily living skills training programs for residents who are very dependent, older, and/or resistant to developing greater independence in these areas;
- o the development of written guidelines and training sessions to sensitize providers to obvious and more subtle practices which foster or hinder the community integration of residents of community residences; and,
- o the development of a set of videotapes covering core topics (including the nature of mental illness, psychotropic medications, patient rights, abuse and neglect reporting and prevention, and behavior management) which may be shared with providers to facilitate basic orientation training for new staff.

Response

The goal of the Office of Mental Health is to provide comprehensive and systematic staff development opportunities statewide. Management plans for staff development and training have been cooperatively developed with each OMH Regional Office and local training offices. Ongoing training for both state and voluntary community residence staff will be included in these plans.

A statewide emphasis on training in rehabilitation principles and practices will be the focus not only in residential training but throughout the OMH system. The incorporation of a rehabilitative approach to dealing with individuals who are mentally ill will encourage a shift in staff attitudes and practices to foster community integration of residents.

A comprehensive community residence staff development training manual will be available by September 1, 1988. Joint regional training programs between state and voluntary agencies will be initiated. A "train the trainer" method will be initiated in order to train increased numbers of staff.

The Office of Mental Health is now utilizing instructional videotapes with accompanying printed material for populations such as mentally ill chemical abusers, geriatric clients, and the topic of patient management and agrees that videotapes covering core topics would be useful in conjunction with other training initiatives.

The Office of Mental Health will continue to expand its training initiatives in the voluntary sector. Calendars of all professional and paraprofessional training continue to be sent to voluntary agencies. An information system is in place and will generate its first quarterly report December 1988 (for the period October /November/December) and every quarter thereafter. This system will have the capacity to record numbers of staff from voluntary agencies attending specific training sessions. This data will enable OMH to target areas and types of training needed more efficiently.

2. QOC Recommendation

In conjunction with the planned expansion of community residence programs, OMH should also consider the development of an independent apartment program, with an enhanced SSI level payment, which could provide affordable, long-term supportive housing with flexible levels of support services and supervision for persons with mental illness, based on their needs.

Response

The Office of Mental Health is in agreement with QOC's recommendation regarding an expanded supported housing agenda. Supported housing is defined as the provision of flexible, long-term supports to persons residing in generic housing situations. This concept separates the basic need for housing from the need for support services. Housing will be developed in conjunction with the expansion of the Community Support Program to ensure that individuals placed in the community receive the supports necessary to make community placement successful.

The Office of Mental Health began movement toward development of a supported housing effort with implementation of the Independent Apartment Program (IAP) in fiscal year 1988-89. This program assists individuals in their move from certified housing by providing funding for apartment furnishings and initial rental and security deposits. Individuals enrolled in IAP also receive help in identifying affordable housing and are assisted through case management services.

In the absence of an enhanced SSI level, OMH will undertake the following initiatives to develop affordable housing for serious mentally ill individuals:

- o The Office of Mental Health is planning on generalizing the Independent Apartment Program to all seriously mentally ill individuals, rather than just "graduates" from certified programs.
- o The Office of Mental Health intends to provide a supported housing stipend to enable individuals to retain affordable housing of their choice.

- o The Office of Mental Health will continue to interface with other state agencies charged with creating housing (DHCR, DSS) to ensure that a portion of the apartment and single room occupancy units developed by those agencies is available to seriously and persistently mentally ill individuals. OMH capital matching funds will be provided to a predetermined number of units in selected new or renovated housing development projects to secure those units for OMH clients and to ensure that the rent charged for such units is kept at a level affordable to an individual living on supplemental security income (SSI).
- o The Office of Mental Health is working with the Department of Social Services to explore a means of accessing vacancies in adult homes for mentally ill individuals. Presently, approximately 8,700 of the 35,000 licensed adult home beds in the state are occupied by seriously and persistently mentally ill individuals. As of January 1988, approximately 30,000 of these licensed beds were actually available for placements and there were approximately 3,152 vacancies. These vacancies could provide a major source of housing for the mentally ill.
- o A manual will be developed which will describe the availability of financial assistance, development approaches, government subsidies, etc., to facilitate home ownership by mental health services consumers and consumer groups.
- o A family support program will be initiated with the goal of enabling mentally ill individuals to remain with their families when appropriate. OMH recognizes that the families of mentally ill individuals are often the primary and most valuable source of support for such individuals. However, very often the stress of caring for a mentally ill person at home becomes too great for a family and this support is withdrawn, with rehospitalization the most frequent outcome.

3. QOC Recommendation

The Office of Mental Health should continue to encourage creativity and flexibility in functional programs and authorized funding levels of community residence programs to facilitate use of these programs by the homeless mentally ill, persons with long histories of psychiatric hospitalizations, and persons with concomitant disabilities of alcohol and drug abuse, AIDS, and mental retardation. Additionally, assuring the availability of crisis respite community residential beds, should be a priority for every county.

Response

The Office of Mental Health will continue to encourage flexibility in community residence programs to serve targeted populations. There are many seriously and persistently mentally ill individuals who are unable or unwilling to accept the kind of structured program that is provided in community residences. There are still others who could be served in such facilities if existing programs were to be modified to meet their special needs. Homeless mentally ill individuals and persons with mental illness with histories of chemical abuse (MICA) and some high users of emergency and inpatient care are examples of this latter group.

The Office of Mental Health will target much of the new development in the community residence system to programs serving such populations. Funding will be requested for project specific enhancements to residential or community support programs to fund additional or more highly skilled staff.

In keeping with the development of an expanded support services network in the community, the Office of Mental Health will propose that the Family Care program develop a respite service capability for consumers. This program will provide funding to certain Family Care providers to offer planned respite of 3-14 days for consumers living with their families or relatives. Additional training and supports will be made available to these providers.

4. COG Recommendation

Consistent with the recommendations in the Commission's previous report, Admission and Discharge Practices in Psychiatric Hospitals, OMH should re-evaluate the existing array of outpatient services in view of the changing needs and desires of patients served. Particular attention should be focused on the increased provision of educational programs and supported, volunteer, and competitive employment opportunities which patients are requesting.

Response

The Office of Mental Health continues to re-evaluate the existing array of outpatient services in light of the changing needs and desires of individuals served. Toward this end, the following activities will be pursued:

- o OMH continues its efforts at developing innovative models for vocational, educational and work supported programs;
- o OMH is pursuing the consumer operated and self-help program models which include greater emphasis and more focused attention on consumer managed and developed programming;

- o OMH is reviewing the New York State Codes, Rules, and Regulations which provide the guidelines for the major outpatient programs operated by OMH: clinic treatment, day treatment, continuing treatment and day training.
- o OMH will refocus day programming so that it is oriented toward rehabilitation principles and practices to increase vocational opportunities.

5. QOC Recommendation

The Office of Mental Health, with the cooperation of the Division of the Budget, should take immediate steps to strengthen the accountability of the certification process for community residence programs, including:

- o the scheduling of more unannounced certification reviews;
- o the provision of comprehensive and uniform training for all certification surveyors statewide and,
- o instituting practices to ensure that residences with serious deficiencies which affect resident safety and the quality of residents' day-to-day lives are afforded the immediate attention they warrant, including prompt assistance in implementing needed corrective actions, as well as vigilant monitoring to ensure that needed actions are actually taken.

Response

The Office of Mental Health agrees unannounced visits are vital. Additional certification staff have been secured in the regions in this year's budget, so that the capacity for additional unannounced visits now exists. Additional staff are needed to make all of the visits (both announced and unannounced) which are required by law, and OMH is requesting this staff, as cited in the report.

The Office of Mental Health agrees that standardized protocols should be used by certification staff across the state, and that centralized training should be provided. A new unit has been established within the Bureau of Inspection and Certification which has been assigned the responsibility to begin to address this need in the current fiscal year.

The Office of Mental Health agrees that serious deficiencies should receive immediate attention, however, the report did not indicate instances where serious deficiencies were not addressed expeditiously by certification staff. Certification staff followed up on the deficiencies cited by the QOC to help ensure that agencies made corrections.

6. COC Recommendation

In addition to these immediate steps, OMH should also convene a task force of OMH staff, DOB staff, providers, recipients of services, and advocates, to address certain other concerns regarding the viability and accountability of the OMH certification process for all community programs, which will necessarily require more time and deliberation to resolve. Issues to be addressed by this task force should include, but not be limited to:

- o an assessment of the staffing resource needs of OMH to assure an accountable certification process for community programs;
- o the articulation of clear standards of substantial compliance for specific types of community programs, whereby non-compliance with these standards may jeopardize continued OMH licensure and funding of the program, if prompt corrective action is not assured;
- o the appropriate organizational/administrative structure within OMH for program certification reviews and accountability;
- o an evaluation of existing protocols for certification reviews to ensure that they target the most critical issues in assuring a high quality of care and treatment services in the programs reviewed;
- o guidelines for the conduct and frequency of announced and unannounced certification reviews, which recognize that past performance of programs may justify greater or less vigilant OMH oversight; and
- o a mechanism for monitoring systemic findings of certification reviews to identify significant trends which may indicate the need for systemic corrective actions, including additional or clearer regulatory standards, more provider training, or other changes/reforms.

Response

The Office of Mental Health is planning to revise Part 586 of the New York State Codes, Rules, and Regulations which governs the operation of community residence programs. This action is necessary to incorporate the New Model and other supported housing initiatives into the statutory framework. Through this regulatory revision process, OMH will solicit input from the broad mental health community, including advocates, providers and consumers of service.

Additionally, an internal unit within the Bureau of Inspection and Certification has been established to manage new resources received this year. This unit has developed a management plan which addresses several of the recommendations cited. For example, the Office agrees with the usefulness of unannounced visits and will support this approach for certification reviews.

7. OOC Recommendation

The Office of Mental Health should take steps to ensure that annual expenditure reports of community residences are carefully reviewed to target significant under-, as well as over-spending of funds inconsistent with approved program budgets. "Outlier" expenditure patterns should trigger prompt OMH follow-up and investigation of the program. OMH should also ensure that annual expenditure reports of programs noted to have serious problems upon certification reviews are promptly and carefully reviewed.

Response

In the process of devoting considerable attention to the issue of property maintenance over the past two years, the Office of Mental Health has initiated contracting guidelines which enhance the likelihood of targeted funds being appropriately expended. The Office has done so based on an appreciation of how funding levels and policy in this area impacts upon the quality of life of residents in community residence programs.

The following is a summary of steps which have been taken to improve the capability of voluntary provider agencies to meet the physical plant maintenance requirements of community residence programs and to separate operating from residential property funds:

1. Emergency and Deferred Maintenance (EDM) Program - During FY 1987-88 the EDM Program was implemented providing \$500,000 in supplementary funding to selected provider agencies which demonstrated need based on life-safety and certification deficiencies.
2. Dedicated Funding for Residential Property Costs - To realize the full value of MHL Section 41.38, contract terms and budgeting instructions provide separate funding for 100% of reasonable residential property cost inclusive of rent, mortgage payments, utility costs and other costs associated with rental or ownership of real property. Within the contract terms there is a separate payment made for this cost category with no offsets based on revenues; further, there is a restriction on using these dedicated funds to supplement PS or OTPS needs. During FY 1987-88 we clarified this language to ensure that agencies which were using operating funds (MHL 41.44; PS and OTPS) for property maintenance costs could redirect those funds to appropriate operating costs by increasing the 41.38 obligation. Statewide this policy clarification resulted in an estimated increase of one-million dollars in the annual 41.38 allocation.
3. Flexible Maintenance Account - Provider agencies receive an annual maintenance amount as part of their 41.38 allocation based on their total number of beds. Beginning in FY 1987-88, agencies have been afforded total flexibility in distributing funds based on an annual assessment of individual site needs.

4. Property Ownership - The Office of Mental Health over the past two years has actively fostered policy changes supported by substantial capital appropriations to facilitate direct ownership of real property by voluntary provider agencies. Although the priority is on new bed development, existing programs may use capital funds to purchase sites which are currently leased or to relocate. In addition to funding for routine minor maintenance, provider agencies owning property receive as part of their 41.38 payment an amount for a capital reserve fund which can accumulate in an interest bearing account to provide sufficient resources to meet major capital repair needs. It is expected that use of this fund will extend the useful life of property and provide for a well maintained and functional residence. Further, by limiting our dependence on private landlords, it is expected that direct ownership, supported with adequate funding, will have the positive impact of providing sponsoring agencies with more direct control of their program space.

The Office of Mental Health believes that the above steps were prudent management initiatives designed to provide sufficient resources to provider agencies on a site specific basis with minimal controls beyond the scrutiny applied to approving a prospective contract/budget. Further, we have attempted to remove the pressure from competing funding requirements by providing direct care salary enhancements over the past two years. As with any system, however, the Office depends on the good judgment and professional managerial skill of the provider agency to ensure the appropriate expenditure of funds. If serious deficiencies are identified with a particular provider, expenditure information is reviewed as part of the overall analysis of the agency, so that a corrective action plan can be developed.

8. CQC Recommendation

The Office of Mental Health should apply similar scrutiny, both in the context of the reviews of annual expenditure reports and in the conduct of certification reviews, to actual staffing and staff scheduling practices of residences. In particular, residences not providing staff ratios consistent with their approved budgets and residences providing richer or equal staffing during the daytime hours when most residents are away from the residence, as during the late afternoons and evenings when most residents are home, should receive careful attention.

Response

In many sections of the report, CQC argues for OMH to allow the providers flexibility in the provision of services. OMH regulations and the New Model mandate only overall staffing ratios, and for supervised beds, overnight staffing coverage.

The Office of Mental Health, in the Certificate of Need review process, requires adherence to these standards. In addition, proposed 24 hour/day, 7 day/week staffing tables are required with each application. OMH staff will "negotiate" with the provider to ensure that staffing anomalies do not occur.

The Office of Mental Health agrees that recertification reviews should look at actual staffing at the time of the recertification visit, particularly to correct chronic understaffing.

9. COC Recommendation

The Office of Mental Health should take prompt action to address the long-term problems of many of the 21 proprietary community residences in meeting the rehabilitative and community integration expectations of the community residence program. The Commission recommends that OMH consider flexible approaches to these providers, which recognize the able performance of many to provide supportive and nurturing residential settings for residents, as well as the apparent inconsistency of the allocated funding versus stated expectations for these programs.

Response

The Office of Mental Health agrees with this recommendation. The legislative prohibition against state aid to proprietary agencies precludes the type of contracting OMH uses with not-for-profit providers. The existing situation allows for two classes of community residences (one clearly substandard to the other in terms of resources and opportunities) and is not particularly equitable from the residents' perspective. OMH will consider enhancing services to residents of the homes through CSS funds. Given the age (mostly elderly) and characteristics of the majority of the population, services will have to be tailored to a group different from the voluntary operated community residence population.

The Commission on Quality of Care for the Mentally Disabled is an independent agency responsible for oversight in New York State's mental hygiene system. The Commission also investigates complaints and responds to requests concerning patient/resident care and treatment which cannot be resolved with mental hygiene facilities.

The Commission's statewide toll-free number is for calls from patients/residents of mental hygiene facilities and programs, their families, and other concerned advocates.

Toll-free Number:

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