HB
956

POSITION PAPER

HOUSE BILL 956

"An Act making a special appropriation to the Department of Health and Social Services for a mental health transitional facility in Anchorage; and providing for an effective date."

Federal law defines a transitional facility as:

"A program of transitional half-way house services for mentally ill individuals who are residents of its catchment area and who have been discharged from a mental health facility or would without such services require inpatient care in such a facility." Presently, this sector in the continuum of care for the mentally ill adult and adolescent in Alaska is deficient.

The State Plan and Governor's Mental Health Advisory Council all include such a program as high priority. The Department of Health and Social Services recognizes the need for a transitional facility in Anchorage. The chronic mentally ill require both housing and daily supervision to adjust to their return to the community. The present facilities in Anchorage do not provide either the appropriate environment or adequate daily programming. There is also a need for a transitional facility for emotionally disturbed adolescents.

We have a technical suggestion in terms of form. Since capital expenditures cannot be funded under the auspices of Alaska Statute 47.30.520-620, the Community Mental Health Services Act, any capital portion of the $450,000 should be funded under Alaska Statute 18.25.010 and be appropriated to Department of Health and Social Services, Division of State Health Planning and Development. Any program portion of the $450,000 should be funded under the Alaska Statute 47.30.520-620 and appropriated to Department of Health and Social Services, Division of Mental Health and Developmental Disabilities.

There is a statewide need for transitional facilities for the chronically mentally ill and emotionally disturbed adolescents. The Anchorage area provides an excellent pilot arena for a model program due to the presence of the Alaska Psychiatric Institute and the Anchorage Community Mental Health Clinic..

Recommended by: Verner Stillner M.D.

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Director, Division of Mental Health & Developmental Disabilities

Date: 3/18/80

Approved by: Helen D. Beirne

Helen D. Beirne, Commissioner
Department of Health & Social Services

Date: 3/18/80

Funding Information
General Fund $450,000
Other Funds - 0 -
$450,000

IN THE HOUSE BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

HOUSE BILL NO. S HB 956

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act making a special appropriation to the Department of Health and Social Services for a mental health transitional facility in Anchorage; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. The sum of $450,000 is appropriated from the general fund to the Department of Health and Social Services, division of mental health and developmental disabilities, for a mental health transitional facility in Anchorage.

* Sec. 2. The unexpended and unobligated portion of the appropriation made by this Act lapses into the general fund June 30, 1981.

* Sec. 3. This Act takes effect July 1, 1980.

TRANSITIONAL LIVING - A STEP TOWARD INDEPENDENCE

Just as a person's treatment plan must be individualized and based on his/her particular needs, so must a plan for living and housing be individualized. The planning and development of discharge goals should be obtainable, appropriate and started already at the time of admission. Individual needs and wishes provide the basis for planning and development of main discharge goals. One factor that has often been overlooked in treatment planning and for maximizing a client's chances for success in any kind of a rehabilitation program, is an assessment of the quality of the client's residential situation. Two major factors must be considered: (a) The client's current family situation, and (b) The extent to which the residential setting is conducive to rehabilitation. An inadequate and destructive family setting, such as involving excessive dependence on family members, or substandard boarding homes or apartment settings are seen as posing the greatest threat to any successful outcomes. If it is determined that at least for a temporary period a client would make more progress away from a family, or in a separate setting, or as an alternative to hospitalization, a community mental health center should be prepared to offer some alternatives.

Basically, staff should be aware of the possibility that the client may have special needs within the community, including: (1) A residential setting which provides appropriate support and offers the least restrictive environment; (2) A mutually caring relationship with one or more persons; (3) Opportunity for social and recreational activities; (4) Assistance to and education of family and significant others in relation to difficulties they may experience as a result of the client's return to his/her home; (5) Vocational guidance training and assistance in securing and holding a job; (6) Provision for useful daily activities for those who are incapable of holding a regular job; (7) Assistance in taking advantage of services as citizens of their respective communities, e.g., S.S.I. payments, food stamps, housing benefits, etc.; (8) A place to go to or person to call for help in dealing with problems with stress; (9) Medical and psychiatric treatment as necessary, including review and assessment of drug therapy; (10) A coordinator or a therapist to provide linkage between the various service delivery systems and the client to assure the client has access to all the needed services.

This link in services from hospital to community, or as an alternative to hospitalization, is missing in many communities. One of the more recent concepts is the development of a transitional living facility which is designed to fill the gap between the institution and the community, or in providing therapeutic services which do not require hospitalization. This facility is designed as short-term, highly therapeutic, with a basic goal of rehabilitating the client in as little time as possible to resume or begin "normal" community living.

This document is a proposal for the development of a transitional home facility for the Anchorage catchment area. The home will be directed toward people who are experiencing a situational crisis, as well as requiring services which are now offered by the Mental Health Center. The funding required for such a program will involve monies allocated for capital outlay for the purchase, construction or lease of a facility adequate for a maximum of twelve individuals who qualify for this program, as well as money to fund the program, to support operating costs, and staff required to operate a quality program.

All of this would be based on a premise that many of the people who are experiencing the types of situational crises which warrant admission to this program, would be without adequate financial resources to fully pay for these services. As such, we are estimating that the operating cost will require a substantial amount of public money as a means of alleviating admission to a psychiatric hospital, or other residential care facility.

Staff has been asked to provide an overview and to research the needs for transitional housing in Anchorage for citizens who require additional situational support. The professional literature reviewed to date points to the following areas of consideration: (1) There is a serious shortage of facilities nationally to deal with the need for housing coupled with a program to improve coping abilities. (2) Federal and State laws mandate care for this population, but a gap in the system is residential living with supervision present to assist in individuals being discharged from a hospital without adequate situational support, and preventing hospitalization when needs can be addressed in the community with adequate resources. (3) Linking people, programs, and organizations is crucial for effective treatment and is consistent with the continuity of care concept which underlies the NIMH commitment to community support. (4) Need for meaningful evaluation criteria to assure quality community service. (5) Need for a coordinating body with clear lines of communication and minimal administrative detail. (6) Need for exclusion of individuals with active primary problems of substance abuse. (7) Needs assessment conducted by the Municipal Health Commission, by the University of Alaska, and by the Department of Health and Social Services indicate that there is a serious gap in this type of living facility to serve the Anchorage catchment area.

Adequate housing for the emotionally unstable is a national problem dating back for generations. The advent of psychotropic drugs in the 1950's and the process for deinstituionalization and acceleration of the community psychiatry movement in the 1960's appear to be major factors affecting the declining acceptance of state mental hospitals as a means for dealing with consumers' lack of support systems in the community. Many of the needs of the acute and chronic "mental patient" are absorbed by the core of the community--family, friends, schools, clergy, community services, professional boarding homes, foster care, independently operated

hotels, apartments and the hospitals. This core has varying levels of commitment, skill, and understanding to assist the individuals with transitional coping needs. Even on the professional end of the spectrum, there is a limited milieu for observation of structured living and monitored progress outside of the hospital. Consequently, the hospital, primarily A.P.I., is inundated with people needing situational support, not necessarily inpatient psychiatric care.

The following is a perception of factors affecting the potential resident population we are addressing: Dysfunctional precursors such as distorted perception of events; inadequate situational and emotional support; inadequate coping abilities and symptoms of mental illness lead to a stressed, potential resident. This potential resident then exhibits such things as dysfunctional attempts at stabilization, loss of motivation, crisis to crisis lifestyle, substance abuse, legal encounters, marginal existent transient lifestyle, agency bouncing, community bouncing, exhaustion of community resources, stressed family, friends and community, and in general, needs not being met. This inability to cope with and relate to the community leads to request for hospitalization and regression to institutionalization.

Stress is an inherent factor of life. The population that is being spoken of does not exhibit the wherewithall of adequate stress management. The theoretical causes or enhancers of this inability to cope are numerous and will not be explored here. Rather, we will look at the interventions and education which can be utilized to assist people with coping needs. The need for, and at times the number of, support systems that this population utilizes to compensate for this inability to cope, is at times a stress source in and of itself defining an imperative need for coordination. The individual's ability to coordinate and to cope with living at the highest potential is the goal. A transitional residence program would provide a base where staff with adequate theoretical knowledge and experience could assist a resident in assessing what coping skills they are lacking to achieve and maintain maximum functioning in the community.

At present there are few statistics available to document the need for this facility in Anchorage. In consultation with planning agencies, and in a review of the various documents and assessments that have variously been done, the need seems evident. The consensus of professionals in the area is that such a facility is desperately needed.

The residential transitional home that we are addressing here is thought to be a short-term facility. Short-term is defined as a maximum single stay of up to a 90-day period of time. This seems like a reasonable period in which an assessement of the individual needs and linkages in the community could be achieved. In some cases, an additional 90-day stay could be recommended. The acceptance criteria for such a facility would be as follows: (1) Age 19 or over. (2) Primary problem of

emotional instability and not other related issues. (3) Inadequate or no support system. (4) Inability to cope with stressful events. (5) Needing coordination of services. (6) Capable of functioning without constant direct supervision. (7) Accepting of and willing to participate in the contract agreed upon with screening person and staff as well as residents. (8) Not imminently dangerous to self or others. (9) Engaged in a therapeutic relationship or willing and able to engage in such. (10) As an alternative to 24-hour inpatient hospital care.

During the resident's stay, growth will be facilitated by: (1) Community meetings, peer supported feedback, decision-making and problem-solving. Here plans for residence managing will occur, including disciplinary actions, allocation of chores for housekeeping, maintaining, purchasing, group therapy, etc. (2) The therapeutic community environment milieu will focus on interaction between members, not intrapsychic content of individual. (3) Group therapy, emotional interdependence, nature of living situation, and review of individual's plan, action, support and confrontation. (4) Individual or conjoint sessions with significant others as necessary. Program framework would undoubtedly have included a preventative approach to self-care, educational resources, community classes, stress management, recreation and physical fitness, nutrition--whatever else is possible or necessary. Complete details of the program will be addressed in the policy and procedures manual.

This facility would receive residents from numerous community areas. The channels that would be utilized to determine acceptance would be as follows: (1) Potential residents would demonstrate need for situational support and express a desire to explore the options and initiate change. (2) Referee consults with staff as part of pre-discharge planning, identifies status as medically and psychiatrically cleared for discharge without adequate situation support; (3) Potential resident is then interviewed by the staff; (4) Following the interview and screening, if the facility is suitable for the potential resident's needs, expectations and responsibilities of potential resident and the facility will be discussed, and if agreed upon, a treatment plan will be initiated.

Linkages within the community for a resident of this facility is imperative. Therefore, due to the nature of the environment of this facility and the individual housed therein, the communication between the facility, the resident and the following community resources must be open, collaborative and responsive: (1) Community consumers; (2) Division of Vocational Rehabilitation; (3) A.P.I., Community Hospital, Community Services; (4) Adult Basic Education; (5) Work and recreational resources; (6) Social Security, Alaska State Housing Authority, Food Stamps, and other supportive services; (7) Police and legal department systems; (8) Substance abuse programs; (9) Emergency services; (10) Community professionals.

In looking at quality assurance for such a facility, it appears that formal evaluation criteria is one of the major areas lacking in documentation of published literature. Due consideration in this area will need to be given. At present, it seems reasonable to measure the following areas:

(1) The resident

(a) Initial resident's assessment of needs and goals

(b) Monthly formal monitoring evaluation

(c) Termination evaluation with report regarding status of goal attainment. Appropriateness of services, follow-up availability.

(2) Staff

(a) Regular supervision and evaluation program

(b) Six-month review of overall operation of program

(c) Yearly evaluation with input from referral sources; follow-up on prior residents and staff recommendations

(d) Two-year evaluation of needs for program changes, funding, referral criteria and other major overall program changes.

It appears that a transitional facility of this nature would be far less expensive than a hospital stay, and a much more favorable and healthier choice for the individual in terms of residing in the community. Hopefully, in the future some arrangements in terms of assisting residents in moving toward semi-independent or apartment living would be the next feasible step for those on the higher end of dysfunctioning continuum. Utilizing data from the ongoing assessment of the resident while in the facility, appropriate referrals to family, friends, boarding home, etc., within the community could be made with the clear understanding of the individual's needs and growth potential.

The emphasis should be on incorporating the facility into an already existing neighborhood. This facility would involve the necessity of meeting the existing codes required by the Municipality of Anchorage, as well as the State of Alaska, in addition to any Federal NIMH or JCHA standards which are warranted. The facility itself would be adequate in terms of square footage to meet zoning requirements per individual, as well as adequate fire, health and other code and zoning requirements. We visualize this facility as housing a maximum of twelve clients with a hoped for average of about eight. This would involve sleeping and cooking facilities adequate to cover the maximum number of clients in the program, as well as leisure and recreation areas such as a TV and recreational room.

Other budgetary items necessary would be to support the program involving money for equipment and supplies of an ongoing nature. This would include funds for capital improvement and upkeep; funds for acquisition; funds for fixed costs such as electricity, gas, telephone and salaries of staff and purchase of equipment which would be necessary for the proper operation of the program. A vehicle should be provided which can be used by the staff to provide transportation for clients, either on a full or part time basis, or in a shared arrangement with another part of the program.

Staffing pattern would include: (a) One full time resident manager who would be required to be on the premises 24 hours a day, five days a week; (b) A part-time cook who would also serve as dietician in arranging for and supervising preparation of at least two meals per day; (c) A part-time or backup manager who will work on weekends and serve as backup to the resident manager; (d) A professional staff person who would do most of the screening, provide the group therapy; provide the liaison with a variety of community agencies; maintain the records; and provide the follow-up.

In 1955, well over half a million people resided in state and county hospitals. The latest data shows that this population has now been reduced by more than half or about 200,000 people. This decrease has been accompanied by a rise to over a million people who now reside in a community nursing homes which have grown in number and now house a large proportion of these former patients. There are many residents currently in nursing homes, however, who are not in need of this type of expensive care, yet inadequate boarding homes or slum hotels offer no solution either. In reviewing the literature concerning those best equipped to initiate a transitional living program, there seems to be general agreement that this type of living should be an extension of the community mental health service.

Research also seems to point to a special need and special attention must be given to the type of community which is to be home to the residents of this facility. This is particularly true in regard to community mores and sociocultural variables.

residents of this home should not be an instrument of social reform, but rather should be a part of an existing community which is most nearly representative of the clients who will be living in the facility.

A second factor that becomes increasingly apparent is that this facility must not be seen as simply a convenient place to house a patient when the emergency or chronic wards are overcrowded in the institution. We will use special care that this facility not become a dumping ground for all those who have no other place.

The third major pitfall to avoid is in reference once again to the host agency. Several instances have shown that the likelihood of success is considerably less where private agencies try to develop programs by themselves without entire community support. Of vital necessity is the support of other service providers. If agencies operate in an isolated fashion, very likely there will be a narrow concentration of similar clients when a mix of clients is much more desirable.

In conclusion, it must become apparent to all that a major value underlying all programs is that those who are suffering from mental disabilities have the same right as anyone else to live in a type of environment which affords a quality of life conducive to self-realization and growth. Since a transitional facility offers relative anonymity to the residents and presents less cause for community fears, they have many advantages not often realized by other residential modalities such as boarding homes. Chief among such advantages is the avoidance of stigma-prone situations brought about in conspicuous community living arrangements, such as large residential care facilities or large hotels. The whole concept of normalization seems to become increasingly apparent in this endeavor.

TRANSITIONAL LIVING FACILITY

PROPOSED BUDGET

Facility Acquisition	$300,000	
Equipment and furniture	40,000	
Transportation	10,000	
Food and consumable supplies	21,000	
Utilities	2,000	
Insurance	2,000	
		$375,000
Staff:		
Resident manager - Salary and fringes	$ 20,000	
Asst. and backup manager - sal. & fringes	12,000	
Cook and aide	12,000	
Professional staff - screening, therapy, etc.	29,000	
		$ 73,000
		$448,000
Miscellaneous		2,000
Estimated Total		$450,000