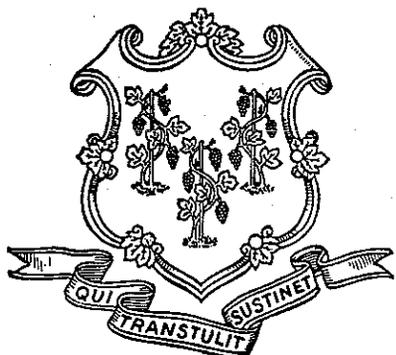


**FAMILY CARE HOMES
FOR THE MENTALLY ILL**

**Connecticut
General Assembly**



**LEGISLATIVE
PROGRAM REVIEW
AND
INVESTIGATIONS
COMMITTEE**

JANUARY 1992

**CONNECTICUT GENERAL ASSEMBLY
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE**

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and during the 1977 session added responsibility for "sunset" (automatic program termination) performance reviews. The committee was given authority to raise and report bills in 1985.

The program review committee is composed of 12 members. The president pro tempore of the senate, the senate minority leader, the speaker of the house, and the house minority leader each appoint three members.

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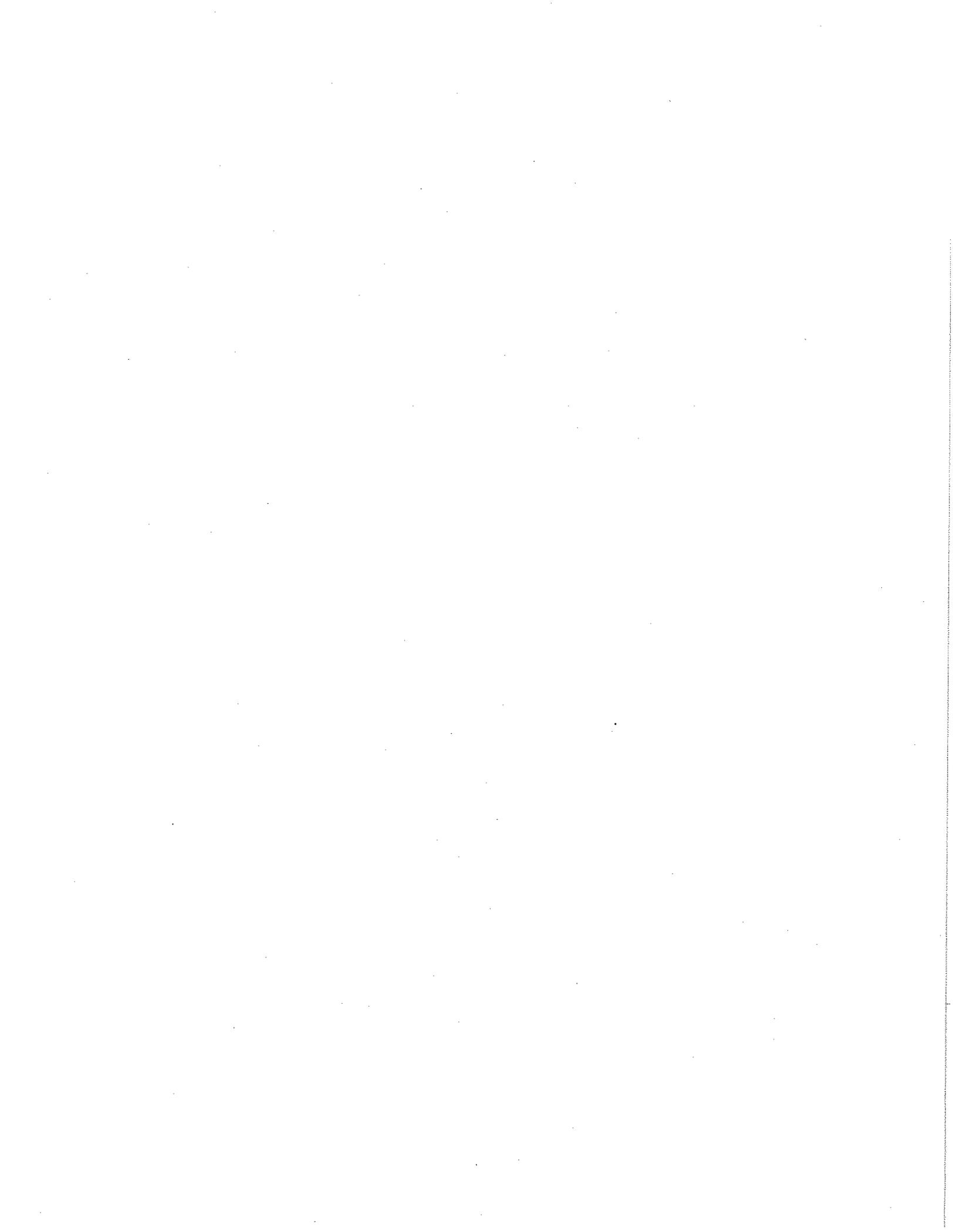


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EXECUTIVE SUMMARY

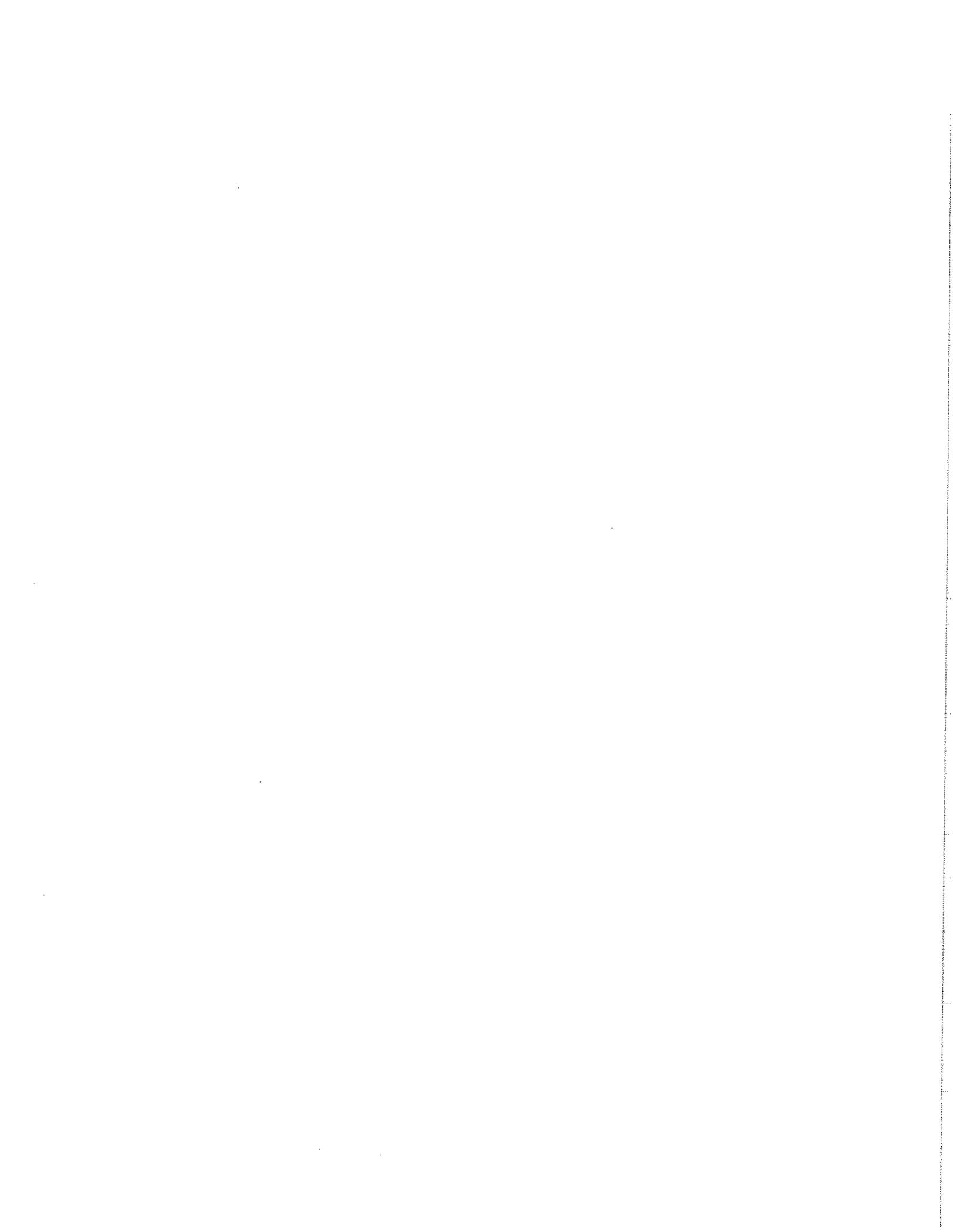
In January 1991, the Legislative Program Review and Investigations Committee authorized a review of the family care homes for the mentally ill. The focus of the study was to evaluate the overall management of the family care home program. In particular, the study examined the program's structure, administration, and policies.

Overall, the program review committee found that the current family care home program is not functioning as originally intended nor in a way that emulates other foster care systems. Connecticut's family care home system has gradually become more of a boarding home operation. The program lacks an integrated administrative structure and comprehensive quality assurance process.

The program review committee found that, in order for Connecticut's family care home program to operate as an efficient and effective foster care model, significant time and resources on the part of the state agencies involved in the administration of the program would be required. Based on its findings and the current economic climate, the program review committee concluded that efforts to re-establish and re-invest resources in this program would be inappropriate. In response to the evaluation of the family care home program, the Legislative Program Review and Investigations Committee adopted the following recommendations in December 1991.

RECOMMENDATIONS

1. **As of October 1, 1993, family care homes shall no longer be licensed as mental health facilities.**
2. **The Department of Mental Health shall assist family care home residents find alternative housing.**



INTRODUCTION

The goal of family care homes is to provide a domestic setting for the mentally ill while giving the individual the independence needed to make the transition to community life. In Connecticut, the family care home model was designed to achieve this goal while increasing the availability of affordable community housing.

This report contains findings and recommendations resulting from the Legislative Program Review and Investigations Committee's study of Connecticut's family care homes for the mentally ill. The study evaluated the state's management structure and operating procedures related to family care homes. The study also concentrated on current state policies and procedures and reviewed the responsibilities of and relationship among the governmental entities that have a role in the administration of the family care home program.

Methodology

A variety of sources and research methods were used in conducting the study of family care homes. Committee staff compiled and analyzed data from the Department of Health Services (DOHS) licensure and inspection files. Structured interviews were held with agency personnel from the departments of health services, mental health, and income maintenance. In addition, committee staff met with family care providers, case workers, and residents. A public hearing held in August 1991 also provided the committee with input concerning family care home operations.

State statutes, regulations, agency reports and documents, and relevant literature were reviewed. Other states were contacted for detailed information on their foster care programs for the mentally ill. In addition, the committee compared the family care home program to the foster care program of the Department of Children and Youth Services (DCYS) and the community training program in the Department of Mental Retardation (DMR) to understand how other state agencies operate this type of residential option. Although these foster care systems target different client populations, the programs are basically the same whereby a small number of special need clients are placed in a private home on a temporary basis. Finally, committee staff accompanied the family care home coordinator and health inspector on visits to family care homes.

Organization

The report is organized into four chapters. The first contains an overview of the responsibilities of the departments of health services, mental health, and income maintenance in the management of the family care home program. In addition to background information, Chapter I summarizes the current legislative mandates governing the administration of family care homes as well as reviews the available

residential alternatives. Chapter II provides analysis of data compiled from the Department of Health Services inspection and licensing files and examination of the complaints and investigation process associated with family care homes. Chapter II also describes the role of the Department of Mental Health (DMH). Chapter III provides a comparison to other foster care models. The committee's recommendation to address the status of family care homes as licensed mental health facilities is presented in Chapter IV.

It is the policy of the Legislative Program Review and Investigations Committee to provide state agencies subject to a study with the opportunity to review and comment on recommendations prior to publication of the final report. Responses from the departments of health services, income maintenance, and mental health are contained in Appendix E.

CHAPTER I

OVERVIEW

One of the most critical components of community-based care for people with disabilities is housing. For most persons with mental illnesses who live outside hospitals, housing is scarce. According to mental health advocates, the housing shortage contributes to homelessness or increased reliance on hospital care. As a result, some individuals with mental illness remain in state hospitals or other restrictive settings because there is no appropriate place for them to live in the community.

For the mentally ill in Connecticut, an assortment of housing programs involving varying degrees of supervision and structure that encourage the individual to achieve his or her greatest possible level of functioning, exists. The goal of these programs is to monitor an individual's mental illness while fostering self-sufficiency. One of the community based residential alternatives is family care homes, which are privately owned homes that provide a family-like residential alternative for mentally ill persons. The homes, which are licensed by the Department of Health Services (DOHS) are intended to provide supervised living arrangements for up to six residents.

History

Little information regarding the origin of family care homes in Connecticut is available. Various agencies have tried to research their development without much success, but certain facts have led to a sketchy history. Family care homes emerged during the 1970's in response to the de-institutionalization of clients from the state's psychiatric hospitals. The homes were originally designed to provide a family-like setting for the mentally ill while giving clients the independence needed to make the transition to community life.

In 1977, the Department of Mental Health, assisted by the federal government's Comprehensive Employment and Training Act (CETA) funding, developed a family care model designed to provide placement of certain mentally ill persons in selected and supervised private homes. The CETA workers, through various community agencies and resources, distributed literature describing the family care program and encouraged people interested in becoming family care home providers to contact the worker. Once developed, the CETA workers maintained contact with clients in the family care homes and fostered supportive relationships with the providers. In August 1978, CETA funds were eliminated for this activity and supervisory functions for family care homes were transferred to DMH.

During 1979, the Connecticut General Assembly implemented a major re-organization of state agencies and operations. One change that affected family care

homes was the transfer of responsibility for licensing mental health facilities from the mental health department to the health services department.

Administration

Currently, three state agencies are involved in the administration of family care homes. The Department of Health Services (DOHS) licenses and inspects the homes. The Department of Mental Health (DMH) refers clients to the homes. The Department of Income Maintenance (DIM) provides payments to clients who reside in these homes.

Department of Health Services. The Department of Health Services is the lead agency for protecting and promoting the health of Connecticut residents. The Bureau of Health System Regulation within the department is responsible for licensing, inspecting, and overall quality assurance of health professionals and institutions.

The Hospital and Medical Care Division within the bureau inspects, licenses, and certifies health care institutions providing various levels of care. Family care homes are among the facilities licensed by the division. According to administrative reports, a total of 885 health care facilities, 23 of which were family care homes, were licensed during FY 1990.

The role of the department in the administration of family care homes is to process applications for an operating license, conduct pre-licensing and biennial inspections, and issue licenses to approved homes. The department also investigates allegations of regulatory violations and enforces compliance. In Chapter II, DOHS administration of family care homes is discussed in more detail.

Department of Mental Health. The Department of Mental Health is responsible for the planning and delivery of services for adults affected by mental illness. These services are provided within department-operated facilities, community mental health centers, and through a network of community-based services funded by the department and operated by other non-profit agencies.

The goal of the department is to develop a wide range of services to meet the needs of people in the most appropriate and least restrictive environment possible. The department's mental health service system also includes programs to provide housing, case management services, social skill rehabilitation programs, vocational training, and other support services.

As Figure I-1 illustrates, the department has divided the state into five mental health regions. Each region has a regional director responsible for the development and direction of all mental health services within that region. Regional directors

supervise the state facilities in their region and work closely with other mental health providers.

As Table I-1 shows, the majority of family care homes are located within Region I. Region I consists of 14 cities and towns in southwestern Connecticut. The department's connection to the administration of family care homes is the referral it makes to its clients. Referrals are made by case managers from DMH facilities or mental health agencies which receive DMH grants. Further discussion on DMH case management and referrals is described in Chapter II.

In 1990, the Legislature's Public Health Committee requested DMH to review the family care home program and prepare a report. A summary of this report is provided in Appendix A.

Table I-1. Locations of Family Care Homes (1991).		
DMH REGION	TOWN	NUMBER OF HOMES
1	<i>Bridgeport</i>	11
1	<i>Stratford</i>	2
3	<i>Norwich</i>	2
3	<i>New London</i>	1
5	<i>South Kent</i>	1
5	<i>New Milford</i>	1
5	<i>New Fairfield</i>	1
5	<i>Bethel</i>	2
TOTAL		21
Source: LPR&IC Staff Analysis of DMH and DOHS documents 07/91		

Department of Income Maintenance. The role of the Department of Income Maintenance with respect to family care homes is limited. In the event that a resident is also a DIM client, DIM will provide financial assistance for housing costs to that individual. This is the extent of DIM's responsibilities with regard to the operation of Connecticut's family care home system.

Through various entitlement programs, the department provides financial support and assistance to low income individuals and families in obtaining basic necessities such as food, health care, shelter, clothing, and heat. In general, the department calculates benefits based on the client's need. For example, if a client requires special housing DIM will calculate benefits based on the rates or limits the department has set for that particular type of housing. DIM policy classifies housing into two basic categories: rated and non-rated. Rated housing is defined by DIM as facilities licensed by another state agency. Non-rated housing is any facility that is not licensed by a state agency.

Based on this definition, licensed family care homes are classified as rated or licensed facilities. The department sets a per diem reimbursement rate for each rated facility. The current per diem rate for family care homes is \$22.43. The department could not document the reasons why this rate is used, but the rate is the same as that set for homes for the aged. Current agency administrators believe that the department originally equated the levels of service at family care homes with homes for the aged.

Current Regulations

By regulation, a family care home is defined as a home that provides complete living arrangements in a supervised, family-like situation for up to six residents (Regs., Conn. State Agencies Sec. 17-227-51). The regulations further define a householder as the individual in charge of the family care home, and responsible for supervision of the residents. Residents are defined as mentally ill adults, or adults suffering from other abnormal mental or nervous conditions, who do not need active psychiatric in-patient treatment and reside in a family care home.

Physical Requirements. The regulations also specify physical requirements for family care homes. Each home must provide a minimum amount of space per resident for living, dining, and activity areas. In particular, each home must provide:

- multiple bed sleeping rooms or single bedrooms which are appropriately furnished;
- at least one general use room which can comfortably accommodate the residents simultaneously;
- one easily accessible and adequately equipped bathroom per six residents;
- an outdoor recreation area;

- adequate and secure storage area and designated smoking areas;
and
- access to laundry facilities.

In addition, each home must be maintained at adequate levels of repair, cleanliness, lighting, ventilation, and temperature. Furthermore, homes must make sanitary food service available to residents.

Licensee Responsibilities. By regulation, the householder must reside in home where the residents are boarded. The householder must also maintain receipts for valuables or monies the residents may choose to place in safe keeping. Each licensee must ensure that medical and psychiatric supervision is available for each resident. Licensees must also arrange for medical and psychiatric pre-screening if the referring agency has not done so. In addition, any changes in or deterioration of a resident's mental or physical health must be reported to the resident's psychiatric or medical provider.

Residents must be allowed reasonable visiting and guest privileges. Physical restraints are not allowed unless an emergency necessitates their use. Licensees must maintain up-to-date written records of the resident's next of kin and the person or facility responsible for psychiatric and medical supervision. The licensee must report to the next of kin and the supervising facility if any resident is missing or leaves for more than 24 hours from the home without permission or informing the householder.

Regulatory Authority

Regulations regarding family care homes have remained the same since they were adopted in 1978 despite subsequent statutory changes. As noted earlier, the responsibility for licensing mental health facilities was transferred from DMH to DOHS in 1979. All DMH licensing regulations concerning mental health facilities existing at that time would remain in effect until repealed or amended by DOHS with the advice of DMH. Furthermore, annual licensing or certification inspections and all interim inspections of mental health facilities would be conducted by DOHS with one representative from DMH.

In 1982, the legislature eliminated the requirement that a DMH representative conduct joint annual inspections for licensure with DOHS. However, DMH could, at the request of DOHS, enter any mental health facility to evaluate any program conducted therein. A copy of the written report of the findings must be forwarded to DOHS and be maintained as part of the mental health facility's licensure file. In 1989 another change was made to the statutes regarding mental health facilities. The

annual inspections of mental health facilities were eliminated and replaced by biennial inspections.

Family Care Home Client Profile

As part of the family care home study, the profile of DMH clients currently residing in family care homes was examined. According to the mental health agencies that refer clients to family care homes, individuals considered for placement in a family care home usually have had a history of hospitalization and are currently using psychiatric services in the community. They do not need medical care requiring intensive supervision and vary by the level of independent functioning. They also do not exhibit violent or suicidal behavior. However, placement of the individual in more independent living situation, such as a supervised apartment or more structured living arrangement, such as a group home, may be inappropriate. These individuals deal better with little structure but require some supervision.

Tables I-2 and I-3 summarize information about current DMH clients residing in family care homes. Table I-2 shows the age range of the family care home residents. Table I-3 shows the number of years these individuals have resided in a family care home.

Table I-2. Family Care Home Client Profile	
Age	# of Clients
Less than 30	2
30 - 39	11
40 - 49	11
50 - 59	6
60 - 69	9
70 or more	3
TOTAL	42

Source: LPR&IC Staff Analysis of DMH documents

Table 1-3. Resident Time in Home	
Time in Home	# of Clients
Less than a year	4
1 to 3 years	20
4 to 6 years	5
7 to 9 years	9
More than 9 years	4
TOTAL	42
Source: LPR&IC Staff Analysis of DMH documents	

Alternative Forms of Care

Family care homes are only one of a variety of housing options provided to mentally ill individuals by the Department of Mental Health (DMH). DMH has established a number of residential settings to meet the needs of a broad range of clients with varying functioning levels. Settings range from independent living (the least restrictive) to supervised apartments, group homes, and nursing facilities (the most restrictive). This continuum of care provides community alternatives to state hospital treatment and care. DMH's main objective is to provide their each client with the most appropriate setting available.

Unlike other mental health facilities, family care homes are not considered a treatment facility. They are not required to have a professional staff (e.g. nurses, psychologists, therapists), and do not offer nursing, medical or habilitative services. Rather, they are expected to provide room and board, limited personal care, and supervision and/or assistance to residents in attending to their own needs. The following is a brief description of other residential options currently available to DMH clients.

Supported Independent Living. Independent living is the least restrictive setting for the mentally ill. Here the individual resides in the community with little or no active psychiatric treatment. Unlike other residential models, there is no live-in staff and the individual is responsible for day-to-day activities. However, support services are available through a case manager when needed. This residential model is designed for individuals who can function well independently without supervision.

Supervised Apartment Program. Another important community-based housing alternative is the supervised apartment program. The goal of the supervised apartment program is to provide an unstructured, minimally supervised setting where the resident can achieve an autonomous and self-reliant level of functioning.

Supervised apartments generally operate under the sponsorship of a community agency that offers support services and consultation to the individuals on an on-going basis. Individuals in supervised apartments require little or no supervision in their day to day activities. However, professional staff is available on-site.

Group Homes. Group homes are highly structured licensed facilities with 24-hour professional staff on site. Residents in group homes generally need an intensive level of supervision. The homes provide a highly supervised and structured group living experience where residents can develop basic living skills. They also offer rehabilitation and other support services so that hospitalization or re-hospitalization can be prevented. Usually, 10 to 15 residents live together in a family-like atmosphere with supervision provided by house-parents, managers, and/or social workers. Group homes are usually operated by non-profit agencies that contract with DMH.

Nursing Facilities. Nursing facilities are the most restrictive setting except for institutionalization. Residents of nursing facilities require 24-hour medical services that cannot be handled in any less restrictive setting.

Comparison of Program Use and Costs

In analyzing these available options, it is important to note that the mentally ill individual's level of functioning may vary. As a result the level of care and supervision needed will differ. Table I-4 shows the number of residential programs and beds available statewide by each service type. In addition, the table also indicates the number of clients who received these services in 1990.

As Table I-4 illustrates, the number of clients participating in the family care home program is extremely small when compared to the number of clients using other alternatives. According to DMH, other alternatives provide the type of living environments that are in greatest demand. They also provide supervision by professionally trained staff in contrast to family care homes, where the providers are not required to have any experience in caring for the mentally ill.

Table I-4. DMH Residential Program Options.			
Service Type	Programs	Beds	Clients
<i>Supported Apartment*</i>	26	497	619
<i>Supervised Apartment**</i>	55	759	977
<i>Group Homes**</i>	27	270	334
<i>Family Care Homes</i>	-	67	42
TOTAL	108	1593	1972

* Clients live independently in community but periodically receive support services from case managers.
 ** Generally operated under sponsorship of community agency that provides professional staff on-site.
 Source: LPR&IC Staff Analysis of DMH documents

As Table I-5 reveals, the difference in cost among the various service types is substantial. As shown in the table, the per diem cost for living in a family care home is \$22.43. This cost is considerably lower than the costs associated with any other available option. Differences are due to the level and type of services provided. Typically, group homes provide the most services and therefore are the most expensive. The location of a facility also contributes to differences in cost. This is a result of the fact that the acquisition and operation of facilities often varies by region in the state.

Table I-5. Alternative Program Costs.	
Service Type	Per Diem Rate
<i>Supported Apartments</i>	\$42.68 - \$82.61
<i>Supervised Apartments</i>	\$33.64 - \$84.17
<i>Group Homes</i>	\$44.16 - \$106.26
<i>Family Care Homes</i>	\$22.43

Source: LPR&IC Staff Analysis of DMH documents

CHAPTER II

ADMINISTRATION

Department of Health Services

The Department of Health Services (DOHS) oversees all licensing requirements for family care homes. The department's licensure and inspection process for family care homes is described below. In addition, analysis on data compiled from the DOHS inspection files is provided.

Inspections. Currently, the department employs one person who is responsible for the overall inspection process for all mental health and substance abuse programs. This inspector performs pre-licensing and biennial inspections as well as complaint investigations and follow-up visits for family care homes. The purpose of the inspections is to assure that conditions at the facilities are safe and sanitary. According to department policy, all inspections are unannounced. Once the physical inspection is completed, the inspector will interview the householder and residents if possible. Following an inspection, a report containing observations and recommendations is filed. After acting on the report, DOHS formally notifies several state agencies that the home has or has not obtained licensure. Appendix B is an example of the format used by DOHS to notify state agencies of a particular homes license status.

The program review committee examined DOHS inspection records from 1984 to 1991 for all currently licensed homes. Figure II-1 compares the number of inspections conducted and the number of violations issued. The table shows that 47% of the inspections resulted in a violation.

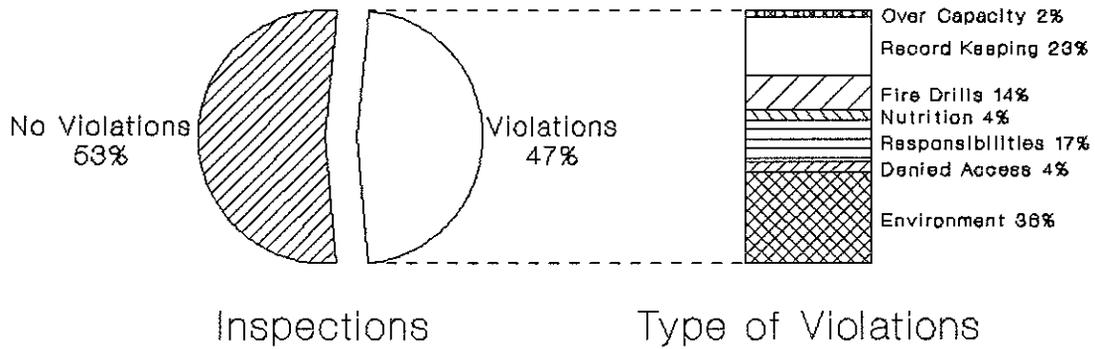
More important than the number of violations is the nature of the violations found. Obviously, some violations may be more serious than others and could have an immediate impact on the home's safe operation. A detailed discussion of the nature of the violations follows.

Violations. As Figure II-1 indicates, the majority of violations examined by program review committee involved the physical environment, record keeping, provider responsibilities and fire drills. Generally, noncompliance with physical environment regulations involved violations, such as water temperature or location of a fire extinguisher. Another area of noncompliance involved the operator's responsibilities, such as the failure to provide toiletries, house keys, or 24-hour supervision.

If a violation is found by the inspector, a notice of violation is issued. This notice informs the provider in writing that he or she is not in compliance with a

specific section of the regulations. The notice also directs the provider to submit a plan of correction including the maximum amount of time needed to remedy each violation. In addition to the written notice, most providers are informed of the violation during the inspection to allow for an immediate remedy. Every six to eight weeks DOHS provides DMH a list of all notices of violations issued to mental health facilities.

Figure II-1. Violations to Inspections



Source of Data: DOHS inspection files

Enforcement. For any mental health facility found in violation of statutes and/or regulations, DOHS is legally authorized to take the following enforcement actions:

- revoke the license;
- suspend the license;
- censure the licensee;
- issue a letter of reprimand to the licensee;
- place the licensee on probationary status and order him or her to report regularly to the department on the matters that are the basis of the probation;
- prohibit the acquisition of other facilities for a period of time set by the commissioner; or
- issue an order compelling compliance with applicable statutes or regulations of the department.

A review of the family care home inspection files revealed the enforcement tool most commonly used is a notice of violation. If the provider corrects the violation within the allotted time, another inspection is conducted to verify compliance. If in compliance, the facility's license is renewed.

If a notice of violation fails to bring compliance or the provider indicates he or she cannot comply within the time given, the inspection files indicate that the next enforcement tool most commonly used is to require the provider to attend an office conference to discuss the problem and possible remedy. At the conference, the provider and the department meet to discuss a new compliance timetable.

The committee's review of the inspection files shows that 10 of the current 21 homes (48 percent) have had at least one office conference to discuss violations and compliance timetables. For the most part, it appears providers were cooperative, but a few were reluctant to attend and many attempts had to be made for rescheduling violation-related office meetings. Over the course of the program's existence, only five homes have had their licenses revoked.

Complaints. Data on complaints filed against family care homes were also analyzed as part of the committee's review. There have been relatively few complaints over the course of the program's existence. Since the program's inception in 1978, only 10 formal complaints have been filed with DOHS. Table II-1 presents the number of complaints filed each year from 1986 through 1991.

Table II-1. Number of Complaints.	
Year	Number of Complaints
1991	1
1990	2
1989	1
1988	3
1987	1
1986	2
TOTAL	10
Source: LPR&IC Staff Analysis of DOHS files	

All complaints concerning family care homes are handled by DOHS. When a complaint is received, it is recorded and assigned to an inspector. The inspector may attempt to contact the complainant to obtain additional information. Table II-2 shows the sources of the 10 family care home complaints.

Table II-2. Complainant Profile.	
Complainant	Number of Complaints
Relative	4
Case Worker	3
State Agency	2
Anonymous	1
TOTAL	10
Source: LPR&IC Staff Analysis of DOHS files	

As part of the complaint investigation, the inspector will visit the home, meet with the householder, interview individuals who may have knowledge of the allegations, and prepare a written report. Notice of the investigation outcome is provided to the complainant.

Table II-3 documents the investigation outcome for the ten complaints. As the table shows, three complaints resulted in notices of violation that were eventually corrected and another three eventually led to the closing of the home involved. Three investigations did not result in any violations and one complaint is still pending.

Table II-3. Complaint Outcomes.	
Investigation Outcome	Number of Complaints
<i>Notice of Violation issued - Corrected</i>	3
<i>Notice of Violation issued - Home Closed</i>	3
<i>Notice of Violation not issued</i>	3
<i>Investigation Pending</i>	1
TOTAL	10
Source: LPR&IC Staff Analysis of DOHS files	

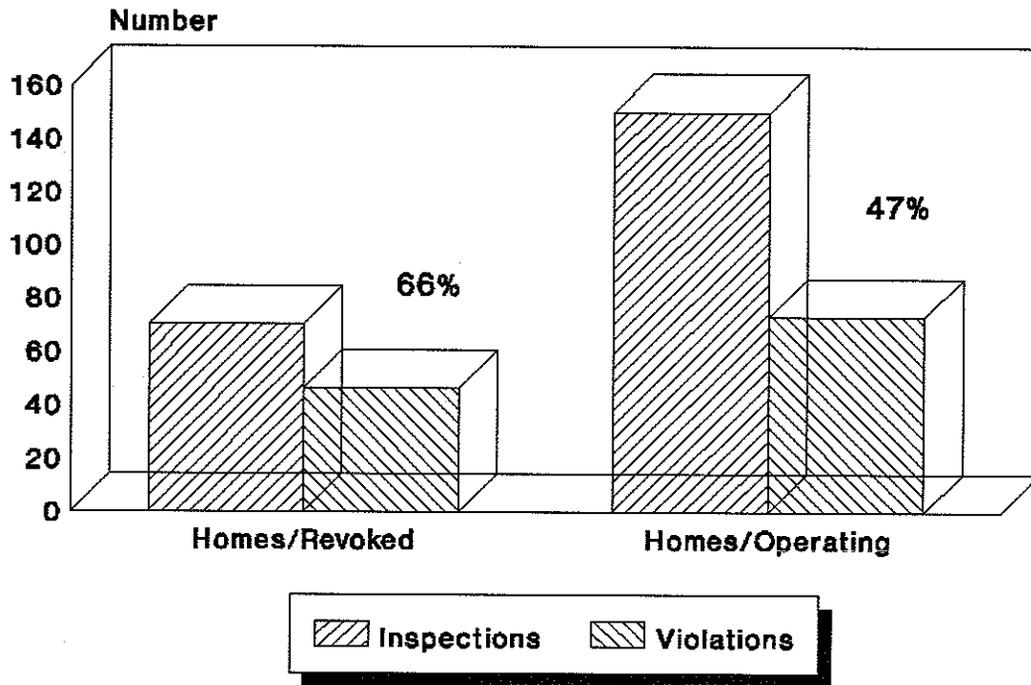
Revocations. In addition to the files of currently licensed homes, the files of the family care homes which have had their licenses revoked were also examined. To date, five homes have had their licenses revoked by the department. Of these five homes, three had been licensed for more than ten years and two had been licensed for six to ten years.

As Figure II-2 shows, the percentage of inspections resulting in a notice of violation for these homes was extremely high. Review of their inspection files, revealed that these homes were cited for repeated violations and subject-of-complaint investigations. Three of the homes were closed as a result of the complaint investigations mentioned above.

It should be noted that in a few instances the revocation of license has not precluded providers from housing DMH clients. This is possible because a provider may still operate as a regular boarding house after its family care home license has been revoked. Since referrals are voluntary placements, clients may decide to live in the home even though it is no longer a family care home but rather a boarding house.

According to DMH, one reason clients may choose to stay is that they have been living there for many years and are reluctant to leave.

**Figure II-2. Violations to Inspections
Comparison of Former and Current Homes**



Source of Data: DOHS inspection files

Table II-4 illustrates the difference in DIM benefits paid between a family care home (licensed) and a boarding home (unlicensed). As discussed in the previous chapter, the current family care home per diem rate is \$22.43 or \$682.24 a month. This rate is only used for residents of *licensed* facilities. Assistance for clients residing in non-rated room and board facilities or any other unlicensed facility is limited to \$400. In addition to cash assistance for housing, DIM also provides clients with a personal allowance. The monthly personal allowance for individuals residing in licensed facilities is \$28.90 and \$164.10 for residents of a unlicensed facility.

Table II-4. Comparison of DIM Benefits.		
	FAMILY CARE HOME	BOARDING HOME
<i>Status</i>	Licensed	Unlicensed
<i>Monthly Rate</i>	\$ 682.24	\$ 400.00
<i>Personal Allowance</i>	\$ 28.90	\$ 164.10
TOTAL ASSISTANCE*	\$ 711.14	\$ 564.10

* This amount does not include assistance a client may receive from other sources such as Medicare, Social Security Disability or Supplemental Security Income.

Source: LPR&IC Staff Analysis of DIM documents

As Table II-4 shows, there is approximately a \$147 difference between the total DIM assistance for residents of a licensed family care home and an unlicensed boarding home. This difference is due to the fact that family care homes, as licensed facilities, are required to provide services beyond basic shelter such as food, laundry, and minimal supervision.

Department of Mental Health

The Department of Mental Health's goal is to develop a wide range of services to meet the needs of clients in the most appropriate and least restrictive environments available. The department's case managers are charged with the responsibility of implementing this goal. The case manager's objective is to ensure that the services provided clients are necessary, adequate, appropriate, and economical. Referrals for residential placement in family care homes or other settings are usually made by case managers from the DMH regions offices.

As noted in Chapter I, although DMH has five mental health regions family care homes are located in only Regions I, III, and V. The management and utilization of the family care program differs among the DMH regions. A brief description of the DMH regional administration of family care homes follows.

DMH Region I. There are two sources of referrals for family care homes in Region I: Greater Bridgeport Community Mental Health Center (GBCMHC) and Family Services - Woodfield. GBCMHC, a DMH facility, is the main source of referrals for placement in family care homes. Family Services - Woodfield, a non-profit agency, also refers clients to family care homes in Region I. Both agencies provide case management services to clients.

When referring a client for residential placement, a case manager identifies and assesses the needs of the client. Based on the client's resources, level of functioning, and preference, the case manager will propose to the client the housing option which is most suitable. It is important to note that this recommendation is simply a referral and the final decision remains with the client.

Once a client has opted for residence in a family care home, the case manager usually accompanies the client to the home for a brief initial meeting with the provider. This is the extent of Region I case managers' role in the administration of family care homes.

DMH Region V. In Region V, Fairfield Hills Hospital (FHH) may refer discharged patients to family care homes. Unlike the referring agencies in Region I, FHH does not provide case management services. However, the hospital does employ a psychiatric social worker who acts as a family care home coordinator on a part-time basis.

The family care home coordinator at Fairfield Hills Hospital plays a more substantial role in the administration of the family care homes. All referrals for placement in a family care home are screened and approved through the coordinator. The coordinator uses a list of criteria, presented in Appendix C, to determine whether a client is appropriate for a family care home placement. The coordinator visits the homes at least once every two weeks. When necessary, frequent telephone contacts and immediate home visits are arranged. If a problem arises, the coordinator is available to assist as mediator between the resident and provider.

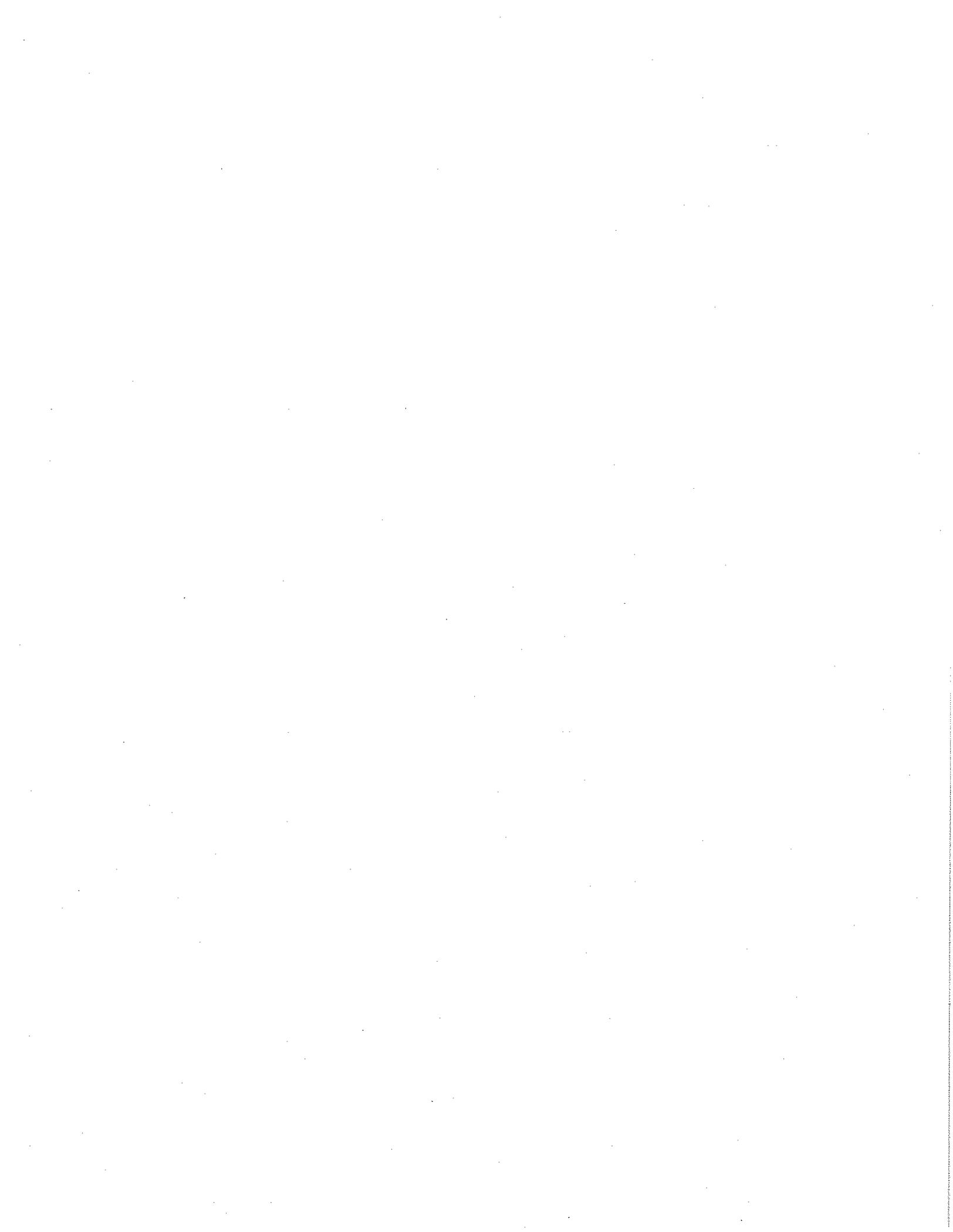
Although training is not mandated for family care home providers, the coordinator in Region V conducts monthly meetings for all family care home operators. These sessions provide on-going technical training and allow general problem discussions. In addition, the coordinator also initiates the only family care home recruitment efforts in the state.

DMH Region III. There are three family care homes in Region III, although one of the homes does not have any clients at present. According to the DMH regional office, a referral has not been made to a family care home in four years. For the most part, the family care residents in Region III have been "adopted" by their provider families and have been integrated into the community although they may still be receiving mental health services.

Early in the development of the family care home program, Region III did attempt to recruit more homes but found no interest. Additionally, Region III reported that, over the years, their clients preferred other types of residential options like supported apartments.

The program review committee found the management approach of the family care home program differs among the DMH regions. These differences are due to the level of involvement on the part of the referring agencies and client needs. The committee also found that aside from the referral process, DMH case managers do not participate in any of the traditional quality assurance components associated with other residential options, such as recruitment, training, inspection, licensing, or investigation of complaints.

Because the case managers are not involved in quality assurance, the only quality control available to them is not to refer or use homes they feel are inadequate. However, according to DMH this mechanism for quality control is not always a viable option for case managers. Due to the scarcity of housing options, especially in Region I, a referral may be made to a home that has passed the regulatory physical inspection but is unacceptable to a case manager.



CHAPTER III

FOSTER CARE MODELS

It is generally recognized that in order to operate an efficient and effective foster care system, the following characteristics are practical necessities: a strong administrative structure; intensive provider screening and training; caseworker involvement; and quality assurance inspections. This chapter discusses the management structure of Connecticut's family care home program and compares it to similar programs in other states and to the administrative structures of foster care programs in the Department of Children and Youth Services (DCYS) and the Department of Mental Retardation (DMR).

Connecticut's Management Structure

By legislative mandate, DOHS is responsible for program oversight of family care homes through its licensing and inspection process. The purpose of licensing and inspection is to ensure the program is following both state law, and department policies and regulations. The DOHS inspection process provides the only quality assurance element to the family care home program.

DOHS routinely notifies DMH of inspections of all mental health facilities. Also throughout its inspection process, DOHS notifies both the departments of mental health and income maintenance of the licensure status of family care homes. After an inspection, DOHS formally notifies DMH and DIM that the home has or has not obtained licensure. In addition, DOHS periodically provides DMH a listing of mental health facilities, including family care homes, that have been issued notices of violation as a result of an inspection.

DMH and DIM then, in turn, may use this information to carry out their responsibilities. For example, DIM uses the information provided by DOHS to establish benefit payments to its clients. Likewise, DMH may use the information provided by DOHS in deciding whether to refer clients to a family care home. However, in practice, the program review committee found there is very little administrative interaction among the three agencies.

Comparison to Other States

Although there are differences among state foster care programs for the mentally ill, the fundamental components underlying the programs remain similar. In all of the state programs reviewed by committee staff, three components were repeatedly emphasized: 1) screening and training of providers; 2) maintenance of

supportive home environments and positive relationships; and 3) development of client independence and personal growth. Table III-1 compares the foster care systems of Arkansas, Georgia, Indiana, New Jersey, New York, and Washington, DC.

Table III-1. Foster Care Systems In Connecticut and Selected Other States.							
	CT	AR	GA	IN	NJ	NY	DC
<i>Mandated Training</i>	NO	YES	YES	YES	YES	YES	YES
<i>Intensive Application Requirements</i>	NO	YES	YES	YES	YES	YES	YES
<i>Administrative Agency</i>	DMH DIM DOHS	VA Hosp	DMH	DMH	DMH	DMH	DMH
<i>Caseworker Involvement in Quality Assurance</i>	NO	YES	YES	YES	YES	YES	YES
<i>Physical Inspection</i>	2yr	1yr	6mo	1yr	1yr	6mo	1yr
<i>Quality of Care Inspections</i>	NONE	1mo	1mo	1mo	1yr	1yr	1yr
<i>Percent Increase in Number of Homes*</i>	-30%	0%	-92%	N/A	56%	30%	0%
* Growth over five years Source: LPR&IC Staff Analysis							

As Table III-1 indicates, Connecticut's program differs dramatically from other states in many areas. Unlike other programs, provider training is not mandated and the application requirements are minimal. In addition, Connecticut has three administrative agencies that establish and regulate the homes whereas other states' programs rely on a single department as the primary administrative agency. Unlike Connecticut, the other programs conduct physical or environmental inspections annually; some inspect the homes every six months. Additionally, the other states incorporate mental health case workers in a regular and frequent quality-of-care inspection.

Overall, many of the basic elements common to foster care programs are not integrated into Connecticut's program. The program review committee found that Connecticut's family care home system for the mentally ill, and its administrative structure, is in many ways less intensive than programs in other states. Appendix D provides a synopsis of foster care systems in the other states reviewed by the committee.

Comparison to Other Connecticut Programs

As part of the evaluation, the program review committee compared the administrative structure of the family care home system with the foster care programs in the Department of Children and Youth Services and the Department of Mental Retardation. Overall, the program review committee found that the current application and licensing process for family care homes is minimally selective. This is especially evident when compared to the stringent application and licensing requirements of the foster care programs in DCYS and DMR.

Application and Licensing Process. To receive a license to operate a family care home, an individual must apply to the Department of Health Services which oversees all licensing requirements for mental health facilities. The single-page application requires the inclusion of three references, a fire marshal's certificate of inspection, and verification of local building code compliance. Upon satisfactory completion of the application, the home receives an initial inspection to verify compliance with state laws and regulations. If found in compliance, DOHS issues a license which is renewed biennially.

In contrast, the application process for DCYS foster homes is approximately 4 to 8 months long and requires submission of detailed personal and historical information. Applications to become foster parents must include references, medical and financial information, and documented family history.

DCYS handles all of its licensing requirements itself through its Homefinders Unit. This process includes a series of three home visits which involve extensive interviews with all of the family members. Finally, the DCYS homefinder worker presents a home study report to the Quality Assurance Unit within the DCYS central office for final review and verification.

The Department of Mental Retardation's application and licensing process is similar to the DCYS process. An interested individual must first submit an application to the corresponding DMR regional office along with letters of reference, a certificate of good health from a physician, and undergo a police background check. Applicants are interviewed by DMR regional office staff and a complete home study, which includes interviews with family members, an initial inspection of the home environment, and a thorough explanation of the program, is done. If no problems are identified, the applicant is referred to the DMR agency's central office for final verification. DMR central office then conducts another inspection and if the home is in compliance with department regulations, a license is issued.

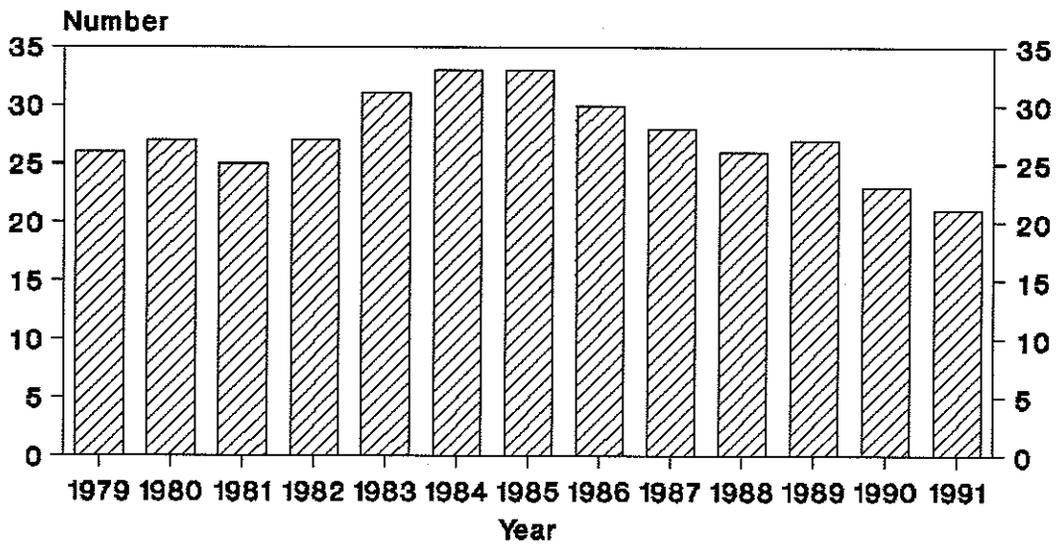
Training. As mentioned earlier, training for DMH family care home operators is not mandatory. According to DOHS, department structured training or orientation is not offered, however, consultation is provided if requested. One DMH region does offer on-going technical training sessions for home operators.

In contrast, training is an important element in the DCYS and DMR programs, especially in the early stages. The DCYS foster care applicant must attend eight orientation sessions that provide information on foster parenting. First aid and CPR preparation, evacuation procedures, and information on mental retardation are included in the required DMR training. These sessions are on-going throughout a home operator's participation in the program.

Recruitment. In DCYS, recruiting foster families is a continuing effort. The Homefinders unit within each DCYS region locates temporary foster homes for children pending permanent placement or reunification with families. Recruitment in the DMR foster care program is also on-going and includes efforts to interest persons in using their own homes to provide a family setting for up to three clients. Those individuals expressing an interest are provided additional information about the program.

In the DMH family care home program, there is virtually no recruitment of new homes. DOHS accepts and processes licensure applications, but, the department does not conduct recruitment activities. Although three of the five DMH regions use family care homes, only one initiates efforts to recruit new homes. The absence of active recruitment efforts is reflected in Figure III-1, which shows the number of family care homes during 1979 through 1991. As the figure indicates, for a period of time the number of family care homes remained fairly constant, but there has been a decrease in the last few years.

**Figure III-1. Number of Homes
1979-91**



 Number of FCHs

Source of Data: DOHS

CHAPTER IV

FINDINGS AND RECOMMENDATIONS

At present, family care homes are licensed as a "mental health facilities." Connecticut General Statutes (C.G.S.) § 19a-490(h) defines a "mental health facility" as "any facility for the care or treatment of mentally ill or emotionally disturbed adults." The statutes require all mental health facilities to obtain a license from DOHS. In addition, DOHS must conduct biennial licensure inspections of all mental health facilities as well as conduct interim inspections as necessary.

Although the Department of Mental Health is not mandated to accompany health services staff on inspections, the agency is authorized to enter any mental health facility for the purpose of program evaluation [C.G.S. § 19a-498(c)]. DOHS notifies DMH of all mental health facilities inspections approximately 45 days before the inspections actually occur. A review of DOHS files and interviews with the various DMH regional directors indicated that DMH is regularly notified and invited to participate in inspections of family care homes, but rarely, if ever, attend.

The program review committee found that the mental health department interprets this statutory language as allowing it to enter a mental health facility for the purpose of evaluating any program provided in the facility. Because DMH does not view family care homes as a "treatment program" they do not believe they have the authority to enter the homes. Thus, the program review committee found that while DOHS licenses family care homes as "mental health facilities", DMH does not view the homes as a mental health "program". This finding raises questions over whether this residential alternative should be licensed as a mental health facility.

Despite major changes in law which have given DOHS the statutory authority to enforce, amend, and adopt regulations concerning mental health facilities, family care home regulations have not been updated since their adoption in 1978. For example, regulations still state that DMH is responsible for licensing facilities when, in fact, the health services department was given authority for licensure in 1979. In addition, regulations indicate that homes operating without a license are subject to monetary penalty, when the corresponding statutory authority has been repealed.

Originally, family care homes were designed to operate as a foster care model. However, the program review committee found that the homes, as presently administered, operate as boarding houses. This is particularly evident when the current family care model is compared with other foster care models, such as those presented in Chapter III.

Various problems have arisen as a result of the structure of the operation. For example, although information regarding family care homes is distributed from DOHS to the other administrative agencies, the departments of mental health and income maintenance have limited administrative roles and are not required to collect or provide any information regarding family care homes to DOHS. Also, despite the fact that their clients are the consumers, neither agency is required to participate in the quality assurance process. As a result, the management structure for family care homes is disjointed and administrative components are not integrated.

The committee found that each agency handles its administrative role relatively independent of the administrative functions of the other agencies involved. Thus, there are three agencies in charge of specific administrative functions, all of which interrelate but are not necessarily interdependent. The program review committee found that each agency is adequately performing their particular mandates, however, given the current disjointed management structure, comprehensive responsibility for the family care home program as a whole is lacking.

As discussed in Chapter II, the committee found that the program lacks a comprehensive quality assurance component. The existing quality assurance element only provides for physical or environmental inspections. The application and licensing requirements are rudimentary and minimally selective. Orientation or training for providers is not required for licensure and recruitment of new homes is non-existent.

In addition, given the trends of essentially no recruitment, the program review committee concludes that the number of homes will most likely continue to decline. Also, the committee has found that caseworker involvement in the family care home program is insufficient as compared to other similar operations. Aside from the initial referral, DMH case managers do not play an active role in the administration or quality assurance components of family care homes.

Only three of the five DMH regions utilize the family care home model. The administration and level of DMH involvement with family care homes varies among the DMH regions. Subsequently, the family care home experience is different in each region. The region with the majority of homes is only minimally involved in the program's administration. Region III has not referred a client in four years. Region V, which has a part-time coordinator, provides structured training, and initiates some recruitment, but it only has five homes.

There are several differences regarding the operation of family care homes in the various regions, but regardless of the region these homes still remain the least expensive option. Despite the low cost associated with family care homes, this alternative remains the least in demand and the least utilized of all other options. While family care homes are inexpensive as compared to other alternatives, the cost reflects the level of service and care provided.

The program review committee believes that in order for the family care home program to operate comparably to a foster care model, the following steps would be necessary:

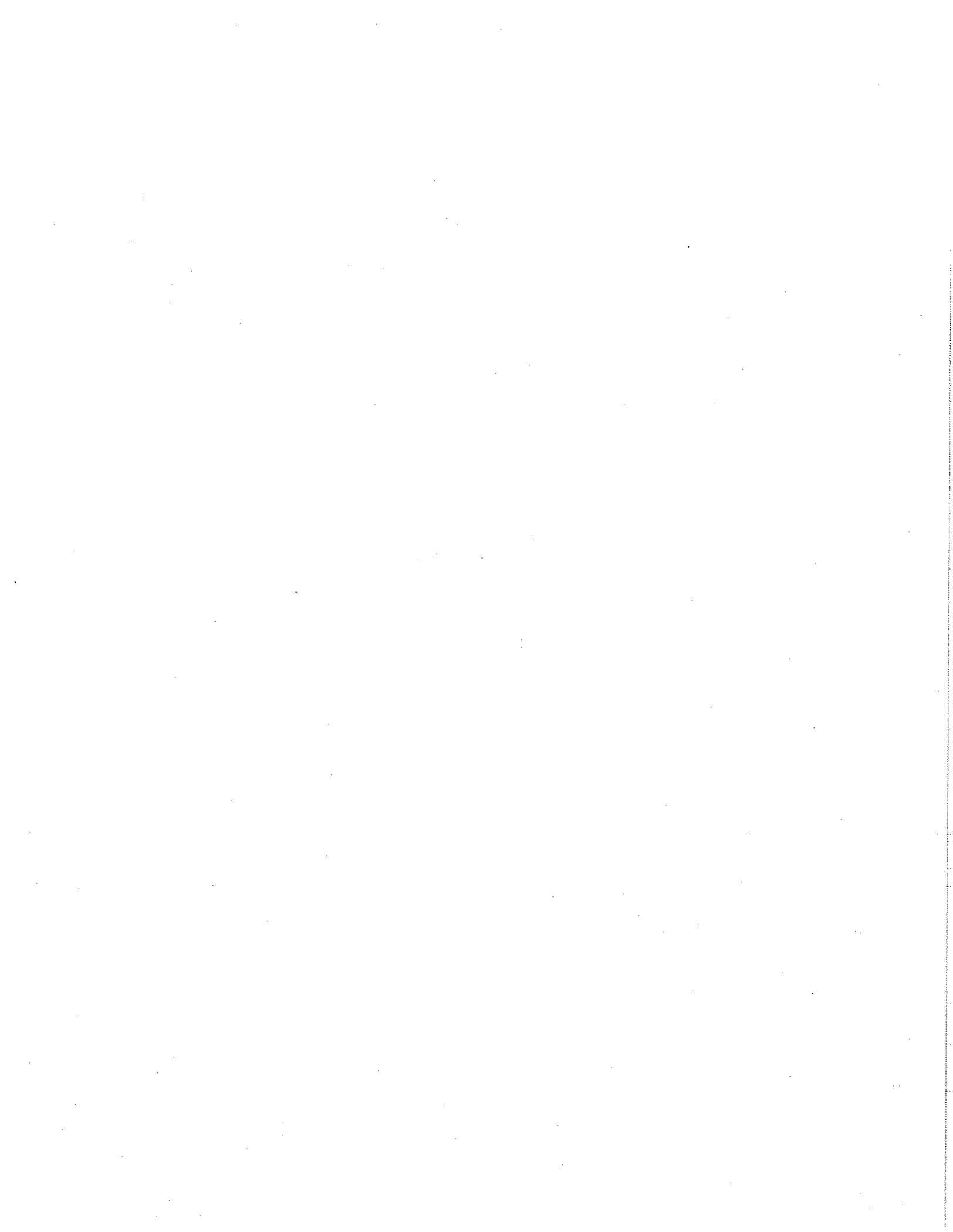
- DMH must examine the viability of utilizing family care homes statewide;
- the administration components must be strengthened and integrated;
- recruitment, application, and licensing requirements must be intensified;
- corresponding regulations must be revised and updated;
- orientation and training must be mandatory;
- DMH policy must be established to ensure that family care homes are administered uniformly throughout the DMH regions; and
- case managers should play a more active role in the administration and oversight of the homes.

The program review committee found that implementation of these steps would entail significant time and resources on the part of the agencies involved. Given the current economic climate, the program review committee believes re-vamping and re-investing resources in a program which services a limited number of clients would not be prudent. **Therefore, the Legislative Program Review and Investigations Committee recommends that as of October 1, 1993, family care homes no longer be licensed as mental health facilities.**

As noted earlier, without a state license these homes would be reclassified as regular boarding homes. Because residents of family care homes are on voluntary placement, it would be the client's option to remain or leave. As evidenced by the experience at homes which have had their license revoked, clients may by choice decide to remain in an unlicensed home. For those individuals having to relocate, **the Legislative Program Review and Investigations Committee recommends that the Department of Mental Health assist family care home residents find alternative housing.**



APPENDICES



APPENDIX A DMH STUDY OF FAMILY CARE HOMES

In December 1990, the Department of Mental Health, in conjunction with Greater Bridgeport Community Mental Health Center and Family Services - Woodfield, undertook a study of family care homes (FCH) at the request of the legislature's public health committee. The Greater Bridgeport Community Mental Health Center is a DMH facility that provides case management services, community-based crisis intervention, assessment and triage, day hospital treatment, and acute inpatient treatment to individuals with prolonged mental illness. Family Services - Woodfield is a DMH grantee agency that mostly provides case management services. The study consisted of:

- clinical assessments of FCH residents;
- a consumer survey of residents to gauge their residential preference and satisfaction;
- a poll of FCH providers regarding issues and problems with FCH program; and
- recommendations regarding the housing needs of this population and the FCH program.

In general, the study suggested that regulatory changes were necessary. It found that FCH providers have received very little orientation regarding licensure standards, and little or no training. It also cited a lack of systematic oversight for FCHs. To address these issues, the department recommended that:

- FCH regulations should be changed;
- Timely sharing of information between DMH and DOHS should be improved;
- Training be mandated for all FCHs;
- DMH be empowered to offer consultation, training, and assistance to providers;
- DMH and DOHS should jointly investigate problems regarding FCHs;

- an incentive program (not necessarily financial) should be established for FCHs treating clients well;
- a statewide ombudsman program be created to respond to complaints; and
- the number of FCHs increase to address the needs of DMH clients.



STATE OF CONNECTICUT
DEPARTMENT OF HEALTH SERVICES

TO: Comm. on Hosp. & Health Care
Dept. on Aging
Dept. of Income Maintenance (4)
Health Statistics
Dept. of Mental Health
Comm. on Long Term Care
SNC (Certification) H&MCD
Health Fac. Const. Section - H&MCD
Conn. Alcohol and Drug Abuse Commission

Office of Fiscal Analysis
Consultant Section - H&MCD
Facility File
Licensure Supervisor - H&MCD
SNC - (Licensure) H&MCD
DHS - MQA - Nurse Aide
Training

FROM: Hospital and Medical Care Division
Licensure Section

DATE: _____

Please adjust your records accordingly.

- General Hospital
- Chronic & Conv. Nursing Home (SNF)
- Home for the Aged
- Mental Health Facility Category:

- Chronic Disease Hospital
- Rest Home with Nursing Superv. (ICF)
- Clinic
- Amb. Surgical Center
- Other

SUBJECT: New Facility Facility Closed Other _____
Administrator _____

The _____ License # _____ located at _____ has _____

- Increased licensed beds from _____ to _____, effective _____.
- Decreased licensed beds from _____ to _____, effective _____.
- Opened on _____ with _____ licensed beds.
- Closed on _____ with _____ licensed beds.

For Health statistics only

licensee ownership status:

- proprietorship
- partnership
- profit corp.

- non-profit corp.
- municipality
- trust

Sincerely,

Donna K. Burke
Health Facilities Licensure Supervisor
Hospital and Medical Care Division



APPENDIX C

FAMILY CARE HOMES CRITERIA FOR PLACEMENT

The Family Care Home by design is a non-professional family dwelling unit. There are no special facilities for handling violent or suicidal behavior. Neither is it a medical institution capable of caring for medical needs. The following criteria for placement of patients/clients takes into account these limitations:

GENERAL CRITERIA

1. Patient/client has a history of hospitalization and current needs for psychiatric services in the community.
2. Patient/client is inappropriate for independent or $\frac{1}{2}$ way house living situation at this time.
3. Patient/client is in need of non-professional supervision and support in addition to room and board.

SPECIFIC CRITERIA

1. Patient must be ambulatory, including ability to navigate stairs and exit in case of emergency.
2. Patient must be continent - bladder and bowel.
3. Patient must be orientated to person and place - use buses for local travel - not get lost easily.
4. Patient must express personal needs and be readily understood.
5. Patient must have activities of daily living skills, dress, bath, feed self.
6. Patient must be willing to cooperate in FCH program. He/she is willing to take medication (with supervision), attend clinic, group or workshop program when appropriate.

The following behaviors are inappropriate for Family Care Home placement since they are disruptive to others. Persons with a repeated history of such behavior will not be considered.

1. Assaultive, physical or actively verbal.
2. Violent
3. Suicidal - verbal as well as physical
4. Sexual acting out.
5. Fire setting - very bad smoking habits.
6. Drug/alcohol abuse.
7. Severe medical problems - if illness is management problem.
8. Rebelliousness - refusal to follow rules, arguing with operators/staff,
etc.

APPENDIX D MENTAL HEALTH FOSTER CARE SYSTEMS IN OTHER STATES

As part of the committee's study of family care homes, programs in selected other states were reviewed. The following is a synopsis of foster care programs in New York, New Jersey, Georgia, Arkansas, and Washington, DC.

New York

Since 1937, the Pilgrim Psychiatric Hospital (PPH) has conducted a family care home system. The purpose of this program has been to provide a network of family living settings for the residents of the center who no longer need institutionalization. Today, there are approximately 135 homes with about 435 residents.

One interesting aspect of the program is the "Family Care Team". As members of the team, caseworkers play a crucial role in directly carrying out the treatment plans, as well as periodically evaluating both client and provider progress. Caseworker visits to family care homes are very frequent during the early stages of a placement and gradually taper off as the resident becomes more acclimated.

To be a provider, an individual must fulfill a series of requirements involving both personal qualifications and home environmental standards. Once an application receives a favorable recommendation, the applicant must take part in several training sessions. Finally, providers must maintain compliance with established program standards, which are evaluated by several methods- an annual unannounced inspection; environmental inspections every six months; and a number of informal caseworker visits per year.

New Jersey

In New Jersey, where the number of homes and the number of residents has doubled in just the last six years, only one or two mentally ill clients at most are permitted to reside in a single care home. This was instituted to promote the establishment of an actual family-type environment.

The New Jersey system places great emphasis on the training of providers, who receive a minimum of 40 hours of training. In addition, the homes must enter a contract and agreement that indicates the services to be provided for the client. Homes are inspected by case workers informally once a month and formally by the state on an annual basis.

Georgia

The family care home program in Fulton County, Georgia (Atlanta), which served 130 clients in 1984, is currently serving only 10. The program is being phased-out for various reasons. First, the already difficult problems associated with caring for mentally ill individuals has been largely compounded by the increase of drug and alcohol abuse. The Georgia Department of Mental Health believes that these problems can not be properly treated by untrained individuals. The Department also witnessed the increase in demand for housing options other than family care homes.

Despite Georgia's experience with this type of program, it is still worth pointing out one of the interesting aspects of their system. The county is divided into five catchments and one caseworker is assigned to each catchment. That caseworker is responsible for developing homes, recruiting home care operators, and providing supervision. These duties are very similar to those carried out by the family care coordinator in Region V of Connecticut.

Washington, D.C.

The foster care system in Washington, D.C., is maintained by St. Elizabeth's Hospital for the Mentally Ill. The uniqueness of this program lies in the existence of an Office of Outplacement Services (OOS), which handles all administrative and management details associated with family care homes.

OOS was established in 1980. By 1984, there were 525 outpatients living in 150 foster care homes. This number has remained stable. The program involves three individual units - operational, homefinding, and monitoring. The operational unit has several functions, such as maintaining transitional services (social/vocational), crisis intervention projects for residents, and providing training for home operators. The homefinding unit is responsible for screening patients and evaluating foster homes after the formal licensing by the State. Finally, the monitoring unit conducts ongoing evaluations of homes and clients concerning both environmental issues and quality-of-care issues.

Arkansas

The Arkansas family care home program was established in 1953 to make room in the hospitals for more acutely ill psychiatric patients, create a more normal environment for improved patients, and form a transitional living arrangement for rehabilitative purposes. In this program, a "community residential care team" is directed by a program coordinator who is responsible for making the final approvals or disapprovals of both clients and residents.

The initial screening is done by a residential care social worker using established criteria. The final screening is done by the program coordinator who, using similar criteria, produces a psychosocial assessment, rationale for placement, and a statement of needed care. In order to become a provider, an individual must submit an application which is then reviewed by the coordinator and given to a community social worker who then schedules a site visit. The social worker visits the home and submits his or her evaluations and recommendations to the coordinator. Following confirmation of a home, the provider must take part in mandatory training.

The social worker or residential care worker makes regular visits to residences, approximately two per month. In addition, homes are formally inspected on an annual basis for health and safety compliance.

APPENDIX E
AGENCY RESPONSE



STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH

February 5, 1992

Michael Nauer, Ph.D.
Director
Legislative Program Review and
Investigations Committee
Room 506
State Capitol
Capital Avenue
Hartford, CT 06106

Dear Dr. Nauer:

The Department of Mental Health appreciates the opportunity to comment on the final report of the Program Review and Investigations Committee on Family Care Homes.

The Department appreciates the work of the committee and staff in studying this complex issue. We have concerns, however, about the implementation process between now and October 1, 1993.

It would be helpful if several issues as related to implementation were clarified in the final report:

1. A decision needs to be made when referrals to these family care homes must be stopped. Who will be responsible for making that decision?
2. Who will be responsible for the overall phase down process?
3. Who is responsible for notifying the family care home operators that the programs will not be licensed after October 1, 1993 and offering alternatives to the operators, i.e. licensing as a boarding home through local municipalities.
4. Who will be responsible for notifying the clients in the family care homes of the upcoming changes?
5. Is consideration being given to rent subsidies for those clients who choose to leave family care homes but will be unable to pay market rents.

The Department of Mental Health is ready to assist wherever feasible in order to make this transition as easy as possible for the clients involved. It seems appropriate, however, to have the Department of Health Services be the

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lead agency for the phase-out process since, currently they have the licensing responsibilities. The need for authority within the Department of Health Services to begin issuing directives and proceeding with phase-out of the family care programs should be clarified.

Sincerely,

A handwritten signature in cursive script that reads "Albert J. Solnit M.D." with a stylized flourish at the end.

Albert J. Solnit, M.D.
Commissioner

AJS:gro