Study of Housing and Support Service Needs of Minnesotans with Severe and Persistent Mental Illness

The State of Minnesota Department of Human Services

February 1988

Ernst & Whinney

Ernst & Whinney

1400 Pillsbury Center
Minneapolis, Minnesota 55402
612/339-0771

February 5, 1988

Ms. Mary Jo Verschay
Minnesota Department of Human Services
Mental Health Division
Human Services Building
444 Lafayette Road, Third Floor
St. Paul, Minnesota 55155-3828

Dear Ms. Verschay:

We are pleased to present our Final Report on the Study of Housing and Support Services Needs for Minnesotans with Severe and Persistent Mental Illness. In October, 1987, Ernst & Whinney was engaged to study the housing and support service needs of persons with severe and persistent mental illness in the State of Minnesota. The engagement consisted of surveying clients and providers, reviewing current literature and developing a conceptual plan for an array of housing and support services within the State of Minnesota.

A representative sample of clients with severe and persistent mental illness served by the mental health system was surveyed to determine their likes, dislikes, desires and needs for housing and support services. A separate survey was developed for providers of mental health and social services, housing and finance authorities, and family members/advocates of persons with mental illness. Results of these surveys, and concepts reported in current professional literature serve as the base for designing a model for housing and support services for persons with severe and persistent mental illness in the State of Minnesota.

Our report details the completed engagement and presents Ernst & Whinney's recommendations for implementation of an array of housing and support services for persons with mental illness in the State of Minnesota.

Ms. Mary Jo Verschay

February 5, 1988

It has been our pleasure to serve the Department of Human Services in addressing this critical issue of providing housing and support services for persons with mental illness in the State of Minnesota. If you have questions or comments about the report, please contact Barbara Kind or Jon Thompson at (612) 339-0771. We look forward to opportunities to serve the State of Minnesota, Department of Human Services in the future.

Very truly yours,

Ernst & Whinney

TABLE OF CONTENTS

EXECUTIVE SUMMARY

During the 1987 Minnesota Legislative session, concern about the need for housing and support services for Minnesotans with severe and persistent mental illness was raised. Historically, non-institutional based treatment and housing programs for persons with mental illness have been funded almost exclusively through state and local monies. For this reason, the development of programs and services for the mentally ill on a community basis has been driven by the Minnesota Legislature's desire for such programs. The 1987 passage of Chapter 197, the Comprehensive Mental Health Act, was in response to the legislative mandate to the Commissioner of Human Services to create and ensure a unified, accountable, comprehensive system of mental health services by 1990.

Chapter 197 contains the requirement that housing and support services for Minnesotans with severe and persistent mental illness be studied. The firm of Ernst & Whinney was engaged by the Department of Human Services to conduct the required study.

It was agreed that the best approach to studying what clients with mental illness needed for housing and residential support services was to ask them. In order to ensure that persons surveyed met the definition of having "severe and persistent mental illness," the client population currently served by the mental health system was sampled. A representative sample of clients of Rule 36 programs, Rule 29 programs, and county social services/adult protection programs was surveyed.

It is recognized that this selection process, while it ensured a valid population, was limited in the sense that it did not represent persons with severe and persistent mental illness who are not accessing the mental health system. Although a survey of persons not using the mental health service system is outside the scope of this engagement, the need to study this population is recognized. Of particular interest are those persons with mental illness who make up a part of the homeless population since it is commonly thought that a high percentage of the homeless are persons with mental illness who have been "deinstitutionalized."

This engagement focused on:

- Describing the housing and support services needs of Minnesotans with severe and persistent mental illness. Accordingly, surveys obtained information from clients currently in the system, mental health and social service providers, housing and finance authorities, and family members and advocates of persons with mental illness.

- Developing an array of housing and support service options based on the results of the survey and a review of current literature.

- Preparing a plan for implementation of housing and support service options.

- Assembling a data base of survey data which will be used as needed by the Department of Human Services.

In summary, the survey findings indicate the current mental health system is meeting some of the needs of persons with mental illness. Client satisfaction with the system is relatively high. The clients' basic needs of food, clothing, medical care and shelter are being met. Although basic needs are often met for those who are part of the system, choices are not abundant. Additional units of all types of housing, particularly affordable, independent, semi-independent, and supported living situations, need to be made available.

Key results of the survey which was undertaken include:

- Over 75 percent of clients were satisfied with their neighborhood, the type of building they lived in, support services available in their home and town, and their access to public transportation. Between 60 and 75 percent were satisfied with the amount of privacy they had, the people that they live with, the amount of living space they have to themselves and their cost of living.

- When asked to think abut the overall quality of life, over 85 percent indicated they 'feel safe and secure', 'have enough warm clothes to wear', 'have enough to eat each day', 'have at least one friend to trust', 'have a chance to do things for fun', 'have enough medical support available', 'have enough mental health support available', 'feel that my life is worthwhile', 'have medications that help me', and 'get along ok with my neighbors'.

- Almost half (47%) indicated they had less than $50 left after paying for monthly housing. Another 17 percent had $50 to $100 left after paying for housing.

- Within the last month, over half 'met with a psychiatrist' (69%), 'met with a social worker or caseworker' (64%), 'met with a medical doctor' (56%).

- In the last month, over half reported they received help 'managing my medication' (62%), 'cooking, shopping or budgeting' (50%), 'participated in social or fun activities' (79%).

- Over one-third thought the 'best living situation' for them currently was 'on my own'; 10 percent with no support services, 13 percent with support services at home, and 15 percent with support services outside their home. One-fifth (20%) thought a residential treatment facility was the best living situation for them now. The others were divided among other responses.

- 'Having the freedom to do what I pleased' and having 'the help I need' were the two most frequently indicated reasons for wanting to live where they chose.

- The percentage of persons who indicated they were living where they wanted to be was highest for those living on their own (72%). Of those living in residential treatment facilities, 30% indicated they were where they wanted to be. Most frequently checked reasons for not living where they wanted (for those in residential treatment facilities) included:

  - My illness prevents me (21%)
  - I do not have enough money (16%)
  - There is a waiting list ahead of me (13%)

- Clients asked to check areas for needing help if they were living where they wanted. Clients wanted help 'in a crisis' (79%), 'with my mental illness' (75%), 'from a medical doctor' (67%), 'from a case worker' (66%), 'with legal questions' (62%), and 'with finding a job' (60%).

- One-third (34%) indicated they would rather live with people who 'need the same level of services', 22 percent said those who 'are not in need of services at all'; and 30 percent said 'it does not matter'.

- Most (59%) indicated they were not working while only (10%) said they were working full-time.

- Over half (54%) indicated they earned less than $200 per month. One in five (20%) indicated their income was more than $500 per month.

- Providers articulated a need for additional housing and support services. The greatest need seemed to be for affordable, supervised housing in semi-structured or independent settings.

- Clients and providers clearly desire a spectrum of housing alternatives to meet the diversity of needs and desires of the mentally ill population. A system to support their needs requires adaptability and response at an individual level.

The following recommendations were made in response to the findings of the survey and a review of current literature:

- Increase the number of low income residential units available.

- Educate the general public to combat the stigma associated with mental illness.

- Develop supportive employment opportunities or other means of contributing economically to the community.

- Replace residential time constraints and sequential processing through the system with individualized movement.

- Strengthen the case management outreach programs to enable continued access to support services regardless of place of residence.

- Establish the authority and commitment of the state in responding to the need for additional housing and residential support services for the mentally ill.

- Design a dynamic system which incorporates an array of housing alternatives and array of residential support services that are administered according to individual needs.

Most importantly, configurations in housing and service options should be viewed as dynamic, client centered, and flexible. This means that the individual needs dictate the levels of funding by the need for housing and support services.

Secondly, support services and housing options are to be related, but not mutually dependent. This means that a person is not required to change housing as functional needs change. In some cases, however, consumers might change housing as service option needs change.

Finally, to adequately assess needs in a timely fashion, planning for housing and support services originates at the local level. Through standardized planning applications, appropriations can subsequently be determined by county at the state level.

The need exists for multiple types of residential options, including residential treatment facilities currently in place. It is important to recognize that some aspects of the existing system are doing an acceptable job and should be continued. Additional low-income housing alternatives also need to be created to complement existing components. Implementation of the system needs to occur at a local level and progress from there in a structured manner, to the state level.

OVERVIEW OF NEEDS AND SERVICES FOR PERSONS WITH MENTAL ILLNESS

HISTORICAL PERSPECTIVE

"Many mentally ill persons are socially isolated, unemployed, living in inadequate and substandard housing, and lacking in medical and mental health care. Homeless persons who are mentally ill are a visible and much publicized consequence of the lack of comprehensive community support services for the mentally disabled."[1]

Historically, people with mental illness have been vulnerable to neglect and abuse. The state mental hospital system did not provide an acceptable long-term approach to the treatment of individuals with mental illness because they were overcrowded, and tended to be restrictive, dehumanizing places where quality care and treatment were not provided. In the 1950s and 1960s, there were two events which prompted the discharge of thousands of patients from state mental hospitals. Psychotropic medications which were able to control many of the symptoms of mental illness became available, making it possible for patients to function outside of a hospital environment, and the community mental health movement--the concept of providing mental health care to all citizens within their own communities--gained acceptance. The Community Mental Health Centers act in 1963 was based on the principle which created a system of community mental health centers throughout the nation.[2]

The development of psychotropic new drugs and the community mental health movement led to a policy of deinstitutionalization of persons disabled by mental illness. Patients were released from mental institutions in large numbers. During the past 20 years continuing declines in the population of mental hospitals have occurred as courts supported an individual's right to freedom and to treatment in the least restrictive setting. The number of residents in public mental hospitals declined from 559,000 in 1955 to 216,000 in 1974 to approximately 150,000 today.[3]

Deinstitutionalization caused problems because communities were not prepared to meet the needs of the returning mental patients. Basic human needs for shelter, food, clothing, income, and medical care were unmet and supportive and rehabilitative services were unavailable in many areas, leaving discharged patients with little or no follow-up care.

A policy of 'noninstitutionalization' came along with the policy of deinstitutionalization. This policy is reflected in directing efforts at keeping clients out of the hospital if at all possible, and referring them for community care. This has resulted in younger people with severe, on-going mental/emotional disorders being present in communities. Many of these persons are unemployed and financially dependent; many living in housing which is grossly inadequate; many do not receive

supervision and medical care; and many are almost completely without socialization and recreation. In addition, according to Stroul, homelessness has been one of several forces pushing toward 'reinstitutionalization' of mentally disabled persons; reopening state hospitals to provide total care and 'asylum' to the persons who have been receiving inadequate services in the community.[4]

NEEDS OF PERSONS WITH MENTAL ILLNESS

Stroul has stated that, "Institutional care, despite its many negative aspects, provided for all aspects of mentally disabled person's life. Shelter, food, clothing, structured activities, medical care, therapy and rehabilitation were all (theoretically) part of the services of an institution. These same types of services are needed for persons with long-term mental illness to function within the community. There is widespread agreement in the field that an array of services and supports is needed for persons with mental disabilities to live in the community. According to Talbott, adequate care for persons with chronic mental illness must include:[5]

- Rehabilitative and supportive services (such as housing, socialization, social rehabilitation)
- Vocational rehabilitation
- Employment opportunities
- Educational services
- Income maintenance
- Social services
- Medical and nursing care
- Transportation
- Homemaking services

Anthony and Stroul have defined the needs of persons with long-term mental illness more simply:

- "As people, they need and want what most other persons do, a suitable place to live, a job they like and friends."

Throughout the nation, numerous independent individuals developed programs which they believed answered the needs of mentally ill persons within the context of the community support services concept. Stroul later examined common themes or elements among these programs. This examination led to Stroul's identification of five major program types. Brief descriptions of the essential components of the community support services concept and the five program types follow.

According to Stroul, the community support services concept recognizes that traditional mental health services are not enough. The concept includes the entire array of services supports and opportunities needed by persons in order to function within the community including services to address basic human needs and rehabilitative services. The community support services concept delineates 10 essential components that are needed to provide adequate opportunities and services for persons with long-term mental illness:[6]

- Reach out to clients to inform them of available services
- Help clients meet basic human needs of food, clothing, shelter, personal safety, general medical and dental care, and assist them to apply for benefits
- Provide adequate mental health care
- Provide 24-hour, quick response crisis assistance
- Provide comprehensive services to help clients develop social, vocational and community living skills
- Provide rehabilitative and supportive housing options for persons who need that type of environment
- Provide back-up support, assistance, consultation and education to families and others who come in frequent contact with clients
- Recognize and involve natural support systems such as neighborhood networks, churches, family self-help groups, commerce and industry
- Establish grievance procedures and mechanisms to protect clients' rights
- Provide case management to help client make informed choices about opportunities

The community support services concept submits that services should respect the dignity and individual needs of each persons, and that clients should develop their potentials for growth, improvement and movement toward independence, rather than live dependently in chronic 'patienthood'. Community support service emphasizes:[7]

- Client self-determination
- Individualization of services
- Normalizing services and service settings
- Services in the least restrictive setting
- Promoting mutual and self-help

Five models of Community Support Programs which fall within the community support service concept are described by Stroul[8]:

- Psychosocial rehabilitation model:

  The overall goal is to improve the quality of life of persons with long-term severe psychiatric disabilities by assisting them to assume responsibility over their own lives, and to function as actively and independently in society as possible. It is directed at helping clients to successfully maintain a place to live, friends, and productive work. The model is usually organized as a clubhouse, or a center.

- Fairweather Lodge model:

  The Fairweather Lodge model consist of two components: A hospital-based transitional unit designed to prepare clients for community living and a community-based lodge which provides a structured setting for living, employment, and peer support. The lodge offers a supportive group living situation which emphasizes autonomy and self-government, and operates its own business.

- Training in community living model:

  The training in community living model is based on the premise that the primary site of treatment for persons with long-term mental illness must be in the community. This model involves teaching clients the basic coping skills necessary to live as autonomously as possible in the community, and teaches these skills in the client's natural environment.

- Consumer run alternative model:

  The consumer run alternative model consists of services that are planned, administered, delivered and evaluated by consumers (current or former recipients of public or private mental health services). Consumer run service alternatives are an outgrowth of the self-help movement.

- Community worker model:

  The community worker model relies on lay citizens to provide community support as paid workers or on a volunteer basis. The workers generally do not have professional training in any of the mental health-related disciplines, and their livelihood is not connected with mental health services. They function as a complement to professional mental health services and self-help.

Jobs and vocational rehabilitation needs are also an important aspect of each of the community support services program models. Training or employment goals were identified, and there seemed to be a correlation between positive vocational rehabilitation experience and decrease of recidivism. The ongoing stability and integration of persons with mental illness within the community requires addressing their employment and vocational needs.

Historically, mental health legislation and services paid little attention to vocational needs. No direct reference to rehabilitation was included in either the original Community Mental Health Center legislation of 1963 or in the Community Mental Health Center Amendments of 1975. Persons with mental illness were eligible under the law for vocational rehabilitation services since 1943, but people with severe psychiatric disabilities were not well served.[9]

During the 1960s and 1970s, successful independent transitional work programs for the mentally ill were developed based on psychosocial rehabilitation, Fairweather Lodge, and other community support service models. In 1978 the Rehabilitation Services Administration and the National Institute of Mental Health signed a collaborative agreement which led to the funding of two rehabilitation research and training centers focused on psychiatric disabilities. Amendments to the Rehabilitation Act of 1973 were passed in 1986 which:

- Strengthens the definition of 'severely handicapped'
- Specifically includes people with severe psychiatric disabilities

- Redefines 'employability' to include part-time work
- Makes changes intended to improve the rehabilitation and vocational services available to people with psychiatric disabilities

For most people, work provides psychosocial benefits and economic opportunities. It can be a source of social contacts, self esteem, a place to spend one's time, a way to stay involved and active, participate in society and feel included. For psychiatrically disabled persons, work can have the effect of ameliorating psychiatric symptoms. Typically, vocational outcomes for people who are psychiatrically disabled are poor. The data from studies of the competitive employment rate of persons hospitalized for psychiatric illness have been fairly consistent, suggesting a full-time competitive employment rate of 20 to 25 percent. If just severely psychiatrically disabled persons are studied, the full and part-time competitive employment figure drops to 15 percent and below.

A new concept of supported employment contrasts earlier approaches to vocational rehabilitation needs of persons with mental illness.[10] Earlier approaches to vocational rehabilitation assumed that there were two kinds of employment, normal (competitive) employment and sheltered (supported) employment. The severity of their handicaps prevented some percentage of people from working in competitive settings. Interventions which focused narrowly on work related issues were thought to enable successful vocational outcomes for the disabled.

The supported employment approach is different from earlier approaches because the assumption is made that all people, regardless of the severity of their disability, can do meaningful productive work in normal settings if that is what they choose to do and if they are given necessary supports. The supported employment approach reflects an increased awareness that successful employment experiences can not be isolated from the rest of an individual's life, and so provisions are made to intervene on non-work related issues.[11]

A fairly consistent conceptual model of supported employment has emerged. The model is characterized by:

- A goal of paid employment for all disabled people
- Integrated work settings
- On-going support, including supervision, training or transportation

According to Wehman and Kregel, four basic parts make up supported employment programs:

- Job placement
- Job site training
- Ongoing monitoring
- Follow-up

Supported employment is defined as a way for people with psychiatric disabilities to choose, get, and keep paid jobs in integrated employment settings by providing the needed job development, placement, training and support for them to receive the economic and psychological benefits of working.[12]

Ten points are identified by Anthony and Blanch to make certain that supported employment can be successfully implemented with persons with psychiatric disability:[13]

- There must be extensive involvement of the trainees in the identification of supported work slots to match their interest and abilities.
- The supported employment assessment process must have a strong focus on the identification of the employment goals and vocational interest of the person, as well as their skills.
- In order to achieve involvement in the process and to ensure that a person's career goals and interests are addressed, there may need to be a longer pre-employment phase prior to the actual job placement.
- The range of supported work slots must include skilled jobs and entry level jobs with the possibility of advancement.
- Stigma against persons with mental illness is greater than for any other disability group, so extra time and effort is required to educate employers.
- Many persons with psychiatric disabilities prefer not to be identified as a disabled person in the employment setting.
- Many persons with psychiatric disabilities wish to possess skills in resume writing, filling out applications and job interviewing.
- Parental support is desired, but parental consent is not a necessary part of the supported employment process.
- Emphasis must be given to those interventions which focus on applying appropriate job behaviors.
- Coordination of services and provision of support during non-work hours are critical.

Many times, persons with psychiatric disabilities fail at jobs because of the job's stressfulness, not because of its difficulty. Even very complex and technical jobs can be low-stress situations, if such factors as setting, supervision and scheduling are structured appropriately. One problem in the psychiatric vocational rehabilitation field has been the scarcity of job opportunities for persons whose career aspirations, intelligence, educational achievement and interests make an unskilled, entry level position a poor job match (Unger and Anthony, 1984).[14]

HOUSING AND SUPPORT SERVICES

HOUSING NEEDS AND AVAILABLE OPTIONS

According to Carling and Ridgway[15], many developments in the mental health profession have attempted to address the housing needs of people with psychiatric disabilities. The 'halfway house' concept was designed in the early 1960s to facilitate moving from hospital to community living. Providers then realized that there was a need for a range of living environments which would match functional levels of individuals, and created the 'residential continuum model'. Within the residential continuum model, an array of housing options are available, organized according to the functional level of clients. Some examples of the types of housing options include:

- Quarterway houses--often in a facility on hospital grounds, offering preparation for community living.
- Halfway house--with an emphasis on skills development and group environment.
- Three-quarterway houses--with less intensive staffing than halfway houses.
- Family foster care--where families are used as a transitional support as people leave the hospital, or for longer term housing.
- Crisis alternative models--including family-care, crisis residences, special apartment settings, or any intensive on-site outreach to where a person in crisis resides.
- Group homes--congregate living settings that range from custodial boarding home settings to intensive treatment oriented transitional residences.
- Fairweather Lodges--for a small group of patients to move out of a hospital together and live and work together on a long-term basis.
- Apartment programs--which can involve staff living with residents, living nearby or visiting, supervised, semi-supervised or cluster apartments, cooperative, semi-independent, or independent living arrangements.
- Boarding homes--in which ex-patients receive a room, single room occupancy (SRO), rooming houses or room plus meals, and/or services, supervised board and care, or residential care facilities.
- Nursing homes--primarily nusing care centers to which large numbers of patients were transferred and remain.

- Shelters for homeless persons--which provide overnight lodging for individuals and some families.

- Services related to natural families--which assist families in coping with relatives with mental illness.

- Mental health housing partnerships--which are collaborative attempts between public housing and mental health agencies.

Carling and Ridgway[16] explained that use of the 'continuum' concept involved problems such as:

- Rigid implementation with inflexible time limits.

- Clients adjusted to pre-determined programs rather than received individualized services.

- Continued change in residences as clients progress.

- Ultimate return to family, boarding house, hospital or homelessness because of lack of assistance in securing permanent community housing.

- Heavy emphasis was placed on programs in separate residential facilities.

Problems in the concept of 'transition' include:[17]

- The transition process is often squeezed into unrealistic time frames.

- Assumption is made that growth in functioning should be associated with a physical move.

- Emphasis is on skills that apply to a group living environment or which cannot be easily transferred to another setting.

Based on experiences in these historical program efforts, there has emerged a popular emphasis on concepts of normalization, community support services, and psychiatric rehabilitation. Key issues of this emerging thought are:[18]

- Normal housing plus services versus residential treatment.

- Internal transition in lieu of changing one's residence.

- Role of consumer choice in housing and support service arrangement.

- Supports and services available flexibly to all housing arrangements.

- Supports on a transitional basis versus required or on an indefinite basis.

The Community Residential Rehabilitation approach to housing emphasizes:[19]

- Transitions occur within the person.
- That housing should be provided as a basic support distinct from service programs.
- Stability in housing over time is desirable.

Principles supporting the Community Residential Rehabilitation approach include:[20]

- Access and choice
- Consumer involvement and control
- Involvement of family members
- Use of normal environments and roles
- Skills related to specific housing
- Settings in which the consumer resides
- Availability and responsiveness of supports

Ridgway explains that an emerging model in Residential Rehabilitation is that of 'Supported Housing', a program which is intended to assist persons with psychiatric disabilities to select, secure, and successfully remain in community housing. The model addresses the variety of individual, programmatic, and societal barriers faced by people with psychiatric disabilities in their effort to acquire stable, affordable housing. Objectives of Supported Housing include:

- Ensuring access, as soon as possible, to typical integrated community living situations that provide long-term stable housing.
- Concentration on aiding the client to develop the skills needed for the client to be successful in the particular environment that he/she has chosen.
- Provision of a wide variety of supports of varying intensity for as long as necessary.

CURRENT RESPONSES BY STATES TO NEEDS OF PERSONS WITH MENTAL ILLNESS

In many states, the lack of housing and support services for persons with severe and persistent mental illness has reached crisis proportions. In response to these needs, many state mental health authorities are developing residential program alternatives. Mental health authorities are responding to the housing needs of persons with psychiatric disabilities in a number of different ways. The problem of housing for the psychiatrically disabled has several underlying causes:[21]

- Without active rehabilitation many people with serious psychiatric disabilities lack the skills and supports they need to live successfully in the community.
- Most psychiatrically disabled persons are unemployed and rely on income maintenance programs that provide a life well below the poverty level.

- The poverty of most clients leaves them with few alternatives in a shrinking housing market.

- Housing discrimination based on stigma makes it difficult for psychiatrically disabled persons to secure stable community living situations.

The disability of people with prolonged mental illness, their poverty, the lack of affordable housing, active discrimination and the lack of effective service system responses have resulted in serious consequences:[22]

- Inpatient hospital care
- Inappropriate transfer to institutional or custodial settings
- Lack of community integration
- Inappropriate use of families as primary care providers
- Homelessness
- Revolving door hospital re-admissions
- Ineffective mental health intervention
- Community opposition to residential programs
- Consumer dissatisfaction

Events which have heightened the need to respond to housing issues for persons with severe and persistent mental illness include:[23]

- Federal support for low-income housing has dramatically decreased in recent years
- Many state mental health system budgets have insufficient funds to pay for support services necessary for housing success
- There has been little professional agreement about the types of housing and support services needed
- A growing consumer oriented movement stresses the importance of consumer desires in housing options
- The number of affordable housing units has decreased
- Rents have increased, so that gaps between the cost of providing housing and consumers' ability to pay have increased
- There is competition among disabled, elderly, and other low-income populations for the available units.

Nationally, there is a trend away from custodial or psychotherapeutic options and toward a rehabilitation orientation in programs.[24]

The mission of programs with a residential rehabilitation orientation is:

- To help clients define their own values and set their own long-term goals for their living situation.

- To help them acquire a setting and learn the skills they need to function successfully there.

- To develop comprehensive supports such as mental health treatment, medication, skills training, income assistance, practical help and supportive counseling to meet each person's needs.

- To allow each person to function as independently as possible.
- To provide support services as long as necessary.
- To design supports to be moved into and out of people's lives as their needs change.
- To view a stable home as one important aspect in an overall process of rehabilitation.

The draft position statement of the National Association of State Mental Program Directors on Housing and Support for People with Long-term Mental Illness states: **"All people with psychiatric disabilities should be given the option to live in decent, stable, affordable, and safe housing, in settings that maximize their integration into community activities and their ability to function independently. Housing options should not require time limits for moving to another housing option. People should not be required to change living situations when their service needs change and should not lose their place of residence if they are hospitalized. People should be given the opportunity to actively participate in the selection of their housing arrangements from among those living environments available to the general public. Necessary supports, such as case management, on-site crisis interventions, and rehabilitation services, should be available at appropriate levels and for as long as needed by persons with psychiatric disabilities regardless of their choice of living arrangements.**

Services should be flexible, individual and provided with attention to personal dignity. Advocacy, community education and resource development should be continuous. Although public mental health systems need to exercise leadership in the housing area, addressing housing and support needs is a shared responsibility and requires coordination and negotiation of mutual roles of mental health authorities, public assistance and housing authorities, the private sector, and consumers themselves."[25]

Priorities in residential services are shifting away from transitional halfway house type programs. A recent survey found only five states are now developing such models (Ridgway, 1986) while 17 states are emphasizing housing supports and case management, 13 states are developing semi-independent living settings, and seven states have priority development for respite, crisis and shelter programs. Fifteen states are developing long-term residential options of various types.[26]

Many states are considering housing for persons with severe and persistent mental illness a key concern and have begun to develop strategies to address that concern.

In a report summarizing current state activities Ridgway states: "Because of the dramatic decrease of federal involvement and the decline in low income housing stock, many state governments have increased their interest and involvement in low income housing development issues. Some state mental health agencies have become involved in property ownership and other states have turned to private non-profit mental health agencies

to serve as developers and managers. Some states are considering creating housing technical assistance centers, while others have created a housing authority within the mental health agency or within the umbrella social service or health agency. Some states have decided to work with housing development agencies outside their organizations. Other states are considering developing quasi-independent development agencies. Several states and many local programs have developed housing by working more closely with the private sector. Educating and forming working relationships with private landlords and developers is beginning to pay off. Insuring security deposits, rent, damage repair, and on-site crisis assistance, and taking a business-like approach have been found to improve access to mainstream rental housing in some states. Some states have begun to work more closely with the public housing authorities to ensure that mental health clients receive their share of subsidized housing."[27]

According to leading authorities on the development of housing for persons with long term psychiatric illness, the types of housing which should be developed include:[28]

- **Use of regular housing stock**
- **Small housing environments for fewer individuals**
- **Living environments which are personalized**
- **Individuals having control of their environments**
- **Individuals being assured privacy, respect, and dignity**
- **Services which are flexible and individualized**
- **Social relationships among people with and without disabilities**
- **Individuals having opportunities for community participation**

According to Ridgway "there has been no reliable long-term funding source targeted to housing for people with psychiatric disabilities. Almost all state mental health authorities have one or more mechanisms for funding residential services. Fifty percent of states provide funding as direct grants to agencies, thirty-nine percent use performance contracting, other than unit of service, which is used by another thirty-five percent. Twenty states use fee for service mechanisms. Some states finance a substantial portion of their residential programs through resources provided by the Federal Government such as the HUD Section 8 and Medicaid, as well as client Supplemental Security Income (SSI)."[29]

Housing finance requires a very long-term commitment for debt service, maintenance utilities, and management, and short state budget cycles can make such a commitment difficult. In addition, the available financial incentives are often geared toward the most intensive, most restrictive larger facilities. This may result in funding mechanisms driving the system since programs are often developed to follow the available money.

Mental health authorities are trying to overcome funding problems by diversifying the funding mechanisms used, creating more flexibility of funds, and funding mechanisms, and funding clients' service needs separately from long-term housing supports.

"Managers and consultants are beginning to explore innovative finance mechanisms such as providing incentives to private sector investors and developers through such mechanisms as low interest loans, linkage or developer extraction programs, state tax incentives, and federal tax credits, using or adapting typical finance mechanisms by working with housing finance agencies, or guaranteeing loans to allow developers to secure capital at a low interest rate, and using family and client resources such as family sponsored trusts, family and client cooperatives, and client ownership options. In addition, some areas are attempting to use philanthropy sources such as churches, fraternal organizations, corporations foundations, and wealthy individuals as a source of social capital," continues Ridgway.[30]

Laux describes financing options which ought to be considered in the development of financing options for housing for persons with mental illness:[31]

- Conventional mortgages
- Second mortgages, taken on property already owned
- Secondary mortgage market
- Junior mortgages
- Federal housing administration
- Veterans administration
- Balloon mortgages
- Money market financing
- Construction financing
- Foreclosure sales
- Distress sales

Experts indicate the major funding issues for housing for persons with psychiatric disabilities include:[32]

- Develop new funding strategies and merchandising
- Target new monies to new program models
- Shift some percentage of existing money to create new types of services
- Create a trust fund; capital account. Use transfer tax and escrow monies to build such a fund; float tax exempt bonds
- Use an economic development approach
- Create public/private partnerships; develop ideas from financiers
- Use new tax credit opportunities
- Target money so that it follows the client
- Increase client income supports; create state income supplements
- Create consumer owned options
- Develop funds for security deposits and rent, day-to-day and emergency needs

Potential strategies to develop housing financing for persons with mental illness include:[33]

- State housing finance authorities to allocate some proportion of the tax credits for housing for persons with disabilities.

- Use existing resources that are not traditionally used for housing (state appropriations, municipal bond authority, Medicaid).
- Private, state and national foundations.
- Local funds.
- Community development block grants or trust funds.
- Land trade (e.g., state properties which are no longer in use could be traded to developers in exchange for their developing housing elsewhere in the community).
- Impose requirements on developers to set aside a certain number of low-income housing units.

Agency ownership strategies include:

- Conventional financing
- Federal assistance programs (e.g., HUD 202, Section 8 Rental Assistance, Section 221 (d)(3) and (4), Farmers Home Administration Rural Rental Housing--Section 515)
- State assistance programs (e.g., state housing finance authorities can provide low interest loans, guarantee loans, or provide money to use for leveraging other monies)
- Creative financing strategies (e.g., bargain sales, second positions)
- Social investing (e.g., major foundations)

Individual ownership strategies include:

- Prime candidates for use of publicly supported loans
- Revolving loan funds to help individuals get mortgages
- Department of Mental Health guarantee loans with lenders
- Families of consumers own or co-op the property
- Families set up life trusts to guarantee that support services will be provided
- Tenant owned cooperatives or corporations

Several states are implementing new programs consistent with these trends. In a summary of current state activities, Priscilla Ridgway, Research Associate of the Center for Change Through Housing and Community Support, cites the following examples:[34]

- In Colorado, financing approaches must support client access to housing in the local housing market, rather than being used exclusively to purchase group homes.

- Also in Colorado, homeless persons with mental illness are being moved from shelters and emergency rooms into normal housing which has been leased from private developers, a program supported by the state and Robert Wood Johnson Foundation.

- Connecticut has moved toward a system which supports clients in their housing, using the clients' own goals for where they want to live.

- Michigan has emphasized residential development using the Fairweather Lodge model.

- Ohio created a housing task force which suggested strategies of increasing consumer income, making better use of existing resources, developing new long-range financial support for housing and conducting strategic planning.

- Rhode Island created a team of people who could provide technical assistance and education to aid local providers.

- New York has a State Assistant Attorney General devoted to litigating zoning battles.

CURRENT STATUS

In a study prepared for the Minnesota Department of Human Services in September 1987, by Rama S. Pandey, Ph.D., Professor of the School of Social Work at the University of Minnesota, and Soonhae Kang, Research Assistant and doctoral student at the University of Minnesota, estimates of the prevalence of mental disorders for Minnesota counties were made, based on 1985 population estimates. Rates were computed on the basis of six-month prevalence rates of psychiatric disorders for estimated number and percent of United States citizen population. By applying the United States prevalence rates to Minnesota county populations, prevalence estimates for the counties in the state were determined. Accordingly, the study estimates that between 22,368 and 29,824 adults in the State of Minnesota have a long-term mental illness.[35]

Estimates are that 80 percent of people with severe and persistent mental illness at some point are treated for their disease. Most of these people who receive treatment are treated through the state hospital system, community residential treatment programs, community support services, and resident services grants. A report prepared by the Mental Health Division of the Minnesota Department of Human Service to the Legislature summarizes community support services, residential services grants, and community residential treatment programs, commonly known as Rule 36 Facilities. Licensed Rule 36 facilities, located in 29 counties throughout the state, provide 1,818 beds. During fiscal year 1986, over 3,788 clients were served statewide, totaling 586,167 client days of service. Forty-six counties participate in non-residential community support services (Rule 14 programs) designed to help people with severe and persistent mental illness remain and function in their own communities. Rule 14 programs served 3,689 clients, over 1,798 of whom were new to the program.[36]

Those persons in Minnesota with severe and persistent mental illness who are able to live in less restrictive settings than state hospitals or community residential treatment facilities, compete with other low income populations, the elderly, and physically disabled for available subsidized housing units. The Metropolitan Council's 1986 Subsidized Housing Report describes a dramatic decrease in the number of new subsidized units during the past six years, from 2,195 new units in 1980 to 1,422 new units in 1981, to 135 new units in the three years from 1983 to 1986. In addition, the number of subsidized units could decrease significantly in the 1990s when contracts for buildings reach their 20 year expiration date. In 1991, 20 such contracts will expire, and the owners may, without government approval, repay the mortgages and dispose of the property as they wish. Those 20 contracts represent 1,864 units.[37]

The potential loss of low and moderate income housing also includes some units with rent subsidies. Subsidies are renewable every five years up to 15 years, and are scheduled to expire before the year 2000. Landlords have the option of not renewing at the end of each five-year period, displacing tenants who cannot afford unsubsidized rent.[38] Additionally,

in recent years, the number of rooms available in residential hotels and rooming houses in Minneapolis and St. Paul has decreased because of significant redevelopment activities in the center city areas. Out-state areas also face shortages of low income housing and long waiting lists for subsidized housing.

Other factors influencing Minnesota's ability to provide subsidized housing include:[39]

- Housing and Urban Development's (HUD) budget has dropped 60 percent since 1980, from $35.7 billion to $14.2 billion.

- HUD's focus has shifted from new subsidized housing construction to providing those in need of housing assistance with housing vouchers.

- The Metropolitan Council forecasts a need for approximately 121,000 additional units by 1995.

- Housing costs have increased 47 percent over the past decade in the metropolitan area (constant dollars).

The Minnesota Department of Human Services Division of Mental Health has developed a mission statement to address the housing needs of persons with mental illness:

- "All people with mental illness should live in decent, stable, affordable housing, in settings that maximize community integration and opportunities for acceptance. People should actively participate in the selection of their housing from those living environments available to the general public. Necessary support should be available regardless of where people choose to live."

- Success in accomplishing this mission will occur "when Minnesota has a variety of housing and support options for persons with mental illness that are affordable and that can be accessed through generic means". The state goes on to identify, "Housing options would include low-income houses and apartments for individuals and no families, long term supportive care, foster care, semi-independent living situations and whatever else would meet the individual's needs and choices."

- "In moving toward that mission, legislation for a comprehensive system of mental health services requires each county's community service program to develop an individual client housing plan, to aid in accessing an appropriate living situation, and to provide outreach and support to those living independently."[40]

In 1987, the State of Minnesota passed the Comprehensive Mental Health Act Legislation in response to the 1986 Legislative Mandate to the Commissioner of Human Services to create and ensure a unified, accountable, comprehensive, system of mental health services by 1990. Within this legislation:[41]

- An array of services to be provided or made available by each county to meet the range of needs of adults and children with mental illness in a coordinated manner is described.

- Case management and screening activities to assure cost effective and efficient utilization of services are established.

- Quality standards of care consistent with contemporary standards in the field of mental health are established.

- Roles and responsibilities of both the state and counties are described.

- Rule 12 and Rule 14 grants are expanded to improve existing programs, add three new Rule 36 facilities, and develop community support services statewide.

- Assures that new funds are targeted to mental health needs.

- Continues Community Support Services, Title XX, General Assistance and Minnesota Supplemental Aid funding and responsibility for mental health.

- General Assistance Medical Care is expanded to include outpatient mental health services.

- Monitoring and enforcement to achieve a comprehensive mental health system by 1990 is provided.

One component of the Comprehensive Mental Health Act calls for a statewide study of housing needs for persons with severe and persistent mental illness. Objectives of this study are to develop the concept for an array of services needed for persons with severe and persistent mental illness, and map out a plan for implementing this array. The array will adhere to the principles of normalization and least restrictive environment. Also, the array must be developed based on information provided by potential users of the services, sources of referral, and housing and service providers. The firm of Ernst & Whinney Management Consulting Services was engaged to assist the Department of Human Services Mental Health Division in the endeavor.

In response to the legislation, Ernst & Whinney developed, with the assistance of the Department of Human Services Mental Health Division, two surveys addressing housing and residential services for persons with severe and persisent mental illness. One survey was given to mental health, social service, housing, finance and family members. The other survey was given to clients who are currently in the system. Through the survey process, the general indication was that the current mental health system is meeting some of the needs of persons with mental illness; there is a fairly high client satisfaction level in the system, and clients' basic needs of food, shelter and clothing are being met. Although basic needs are often met for those who are part of the system, choices are not abundant.

Additional units of all types of housing, particularly affordable, independent, semi-independent and supported living situations, need to be made available. Based on the response received from these consumers, the thoughts of providers of mental health and social service programs for the persons with mental illness, the experiences of family members and advocates in obtaining services for those in need of mental health treatment for severe and persistent mental illness, and literature reviewed, a conceptual model to meet the needs of the State of Minnesota was created.

CONCEPTUAL MODEL OF HOUSING/SUPPORT SERVICES

In developing the conceptual model, it was recognized that providing available, affordable, accessible and adequate housing and residential support services for the persons with severe and persistent mental illness in the State of Minnesota is not a simple problem, and simple solutions are not appropriate. A model for providing housing/residential support services for persons with mental illness in the State of Minnesota needs to contain many different configurations of housing and support options to reflect the spectrum of needs and desires expressed by consumers and those intimately involved in the current housing/residential treatment system. There is a need for residential treatment facilities options for those who prefer and need the type of structure found in that setting. There is also a need for supervised living situations, semi-independent living situations, and independent living situations with varying degrees of support services. The housing spectrum should include:

- Residential treatment facilities
- Boarding facilities
- Single room occupancy units
- Single bedroom units
- Multiple bedroom units
- Small, multiple adult group homes
- Family living arrangements
- Foster family living arrangements

The model must also include availability and access to a spectrum of support services within each county, independent of the housing alternatives. The types of support services to be available within each county are consistent with those listed in the 1987 Mental Health Act. They include:

- Education and prevention services
- Emergency services--24 hours per day
- Outpatient mental health services
- Residential treatment services
- Acute-care hospital inpatient treatment services
- Client outreach
- Medication management
- Assistance in daily living skills
- Development of employability and supportive work opportunities
- Psycho-social rehabilitation
- Help in applying for government benefits
- Development, identification and monitoring of living arrangements
- Day treatment

As indicated by the literature, the development of employability and supportive work opportunities is important in development of self-esteem, economic opportunities, and in reduction of recidivism. Because of its importance, an array of options within the employability support service was identified. This employability spectrum consists of:

- Competitive Employment
- Supportive Employment
- Fair Weather Lodge Model
- Vocational Training
- Vocational Assessment
- Other Community Service Provision

Most importantly, configurations in housing and service options should be viewed as dynamic, client centered, and flexible. This means that the individual needs dictate the levels of funding by the need for housing and support services.

Secondly, support services and housing options are to be related, but not mutually dependent. This means that a person is not required to change housing as functional needs change. In some cases, however, consumers might change housing as service option needs change.

Finally, to adequately assess needs in a timely fashion, planning for housing and support services originates at the local level. Through standardized planning applications, appropriations can subsequently be determined by county at the state level.

More detailed recommendations concerning the conceptual model are discussed as the implementation of the array of housing and support services is explained.

RECOMMENDATIONS FOR IMPLEMENTING THE ARRAY OF HOUSING AND RESIDENTIAL SUPPORT SERVICES IN THE STATE OF MINNESOTA

This section will address recommendations for implementing the array of housing and residential treatment services in the State of Minnesota. Several important concepts gained through the survey process are necessary to understand the reasoning behind the recommendations. These concepts include:

- Clients who are part of the system are generally satisfied with their lifestyles--while some expressed interest in living in other places; almost half are living in what they say is the "best" place for them. "Lack of financial" means and restrictions caused by their illness were the reasons most often given which prevented them from living where they wanted.

- Most in the system found their basic human needs of food, shelter, clothing and medical care were met satisfactorily; other needs such as privacy and control over their environment were less likely to be met. Most were not working and were supported by government aid. As a result, income levels were very low. Needs for support services which provided help in a crisis, and help with mental health care were most important. Help in finding a job was most difficult to obtain.

- Providers articulated a need for additional housing alternatives for persons with severe and persistent mental illness, as well as additional support services. The greatest need seemed to be for affordable, supervised housing in semi-structured or independent settings. As one provider stated, "Agencies and managers want assurances that the mentally ill will have appropriate access to available medical care and flexible, responsive back-up for the expectable problems of serious mental illness."

- What's clearly desired by both providers and clients is a spectrum of housing alternatives to meet the spectrum of needs and desires of those with severe and persistent mental illness. The nature of the population is one of fluctuations and changes in needs and desires; dynamics similar in nature to those of any living population. The difference of the mentally ill population involves their vulnerability as much as their variability. Assistance in dealing with their illness can enable them to coexist and participate in the community environment in which they live. Designing a system to accommodate housing and residential support services demands adaptability and fluidity of components; to best accomplish this requires controls be built as close to the individual level as possible.

Recommendations in the development of this system of housing and residential support services include:

- Increase the number of low income residential units available.

- Establish the authority and commitment of the state in responding to the need for additional housing and residential support services for the mentally ill.

- Design a dynamic system which incorporates an array of housing alternatives and array of residential support services, and that is administered according to individual needs.

- Educate the general public to combat the stigma associated with mental illness.

- Develop supported employment opportunities or other means of contributing economically to the community.

- Replace residential time constraints and sequential processing through the system. Instead create individualized movement through the system.

- Strengthen the case management/outreach programs to enable continued access to support services regardless of place of residence.

While it is important to improve aspects of the current system, it is also important not to discredit those aspects which are currently acceptable. As demonstrated by the survey responses, the need exists for multiple types of residential options and multiple levels of accompanying support services. To discontinue the acceptable system components would be a step backwards by the state.

Implementation of the system plan should begin with a local assessment of current needs, and progress from there in a structured manner, to the state picture.

AREAS FOR FURTHER STUDY

A number of areas merit further study in the actual implementation of an array of housing and residential treatment services for the persons with severe and persistent mental illness in the state of Minnesota.

Among those are:

- Financing and incentive plans to develop additional low income residential units need to be assessed to determine costs and benefits of different methods.

- The homeless component of the population needs to be assessed and integrated into the overall plan.

- Employment opportunities and other means of providing economic/social contribution from this population need to be evaluated further.

EXHIBIT A
STATE OF MINNESOTA
ARRAY OF HOUSING AND SUPPORT SERVICE OPTIONS

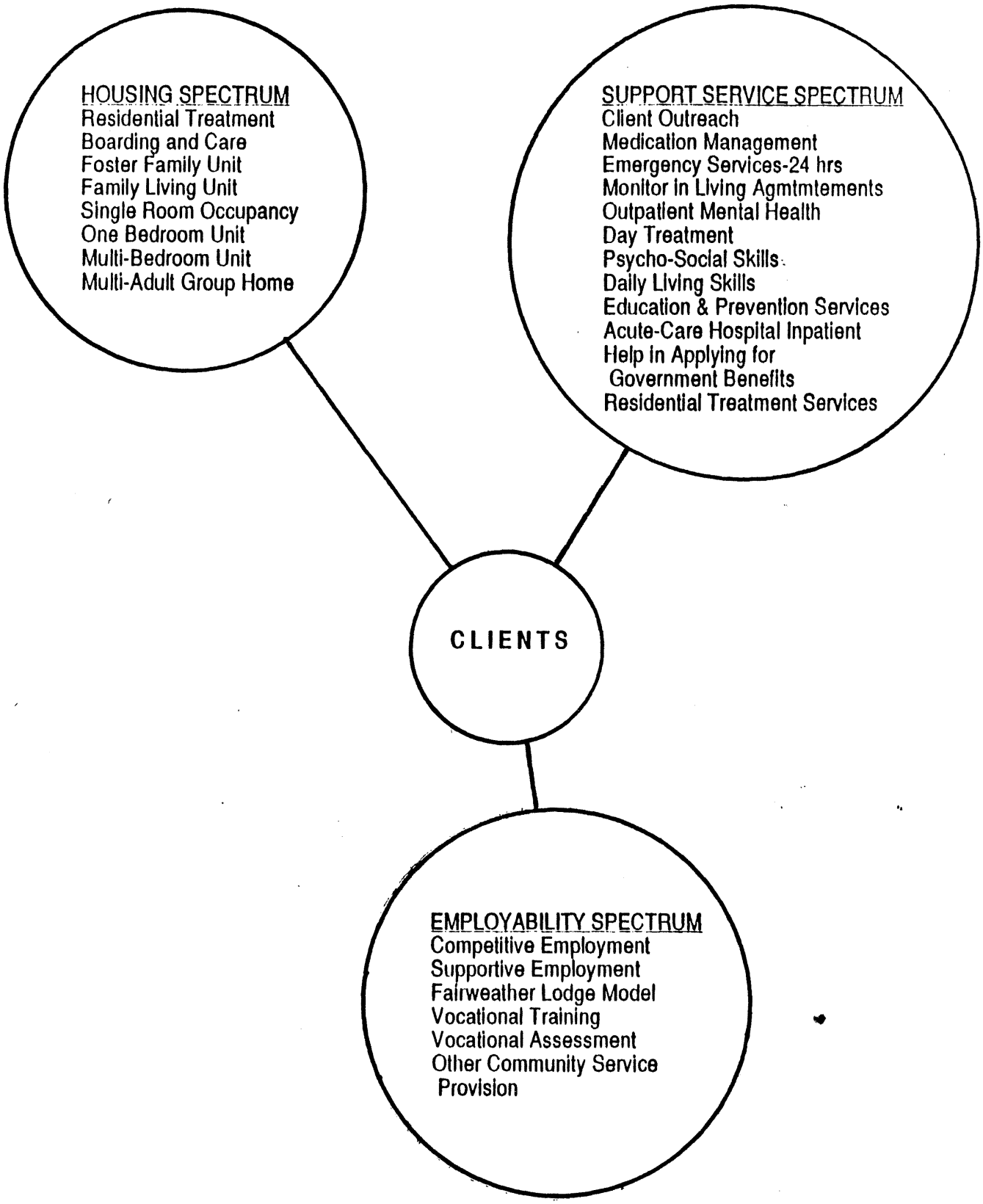
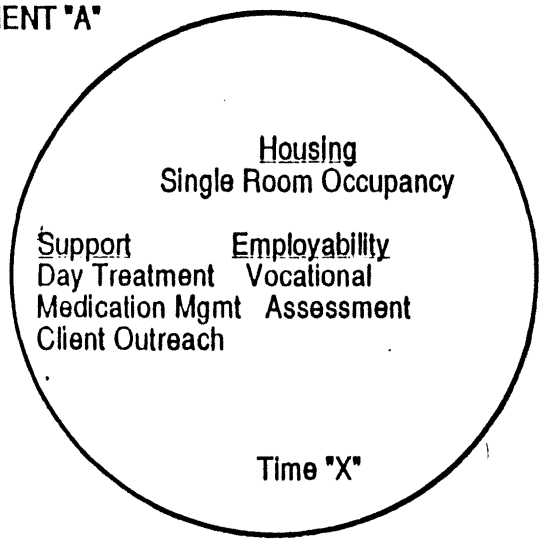


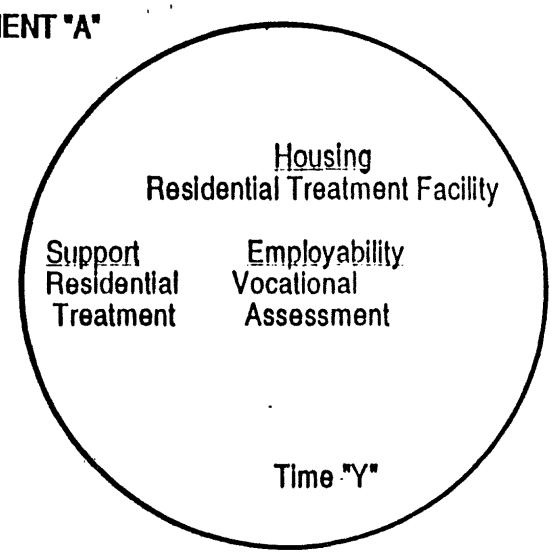
EXHIBIT B

EXAMPLES OF INDIVIDUAL CLIENT CONFIGURATIONS OF SERVICES

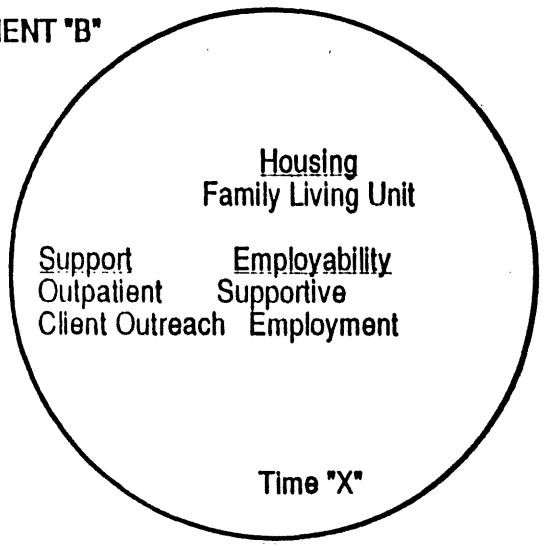
CLIENT "A"



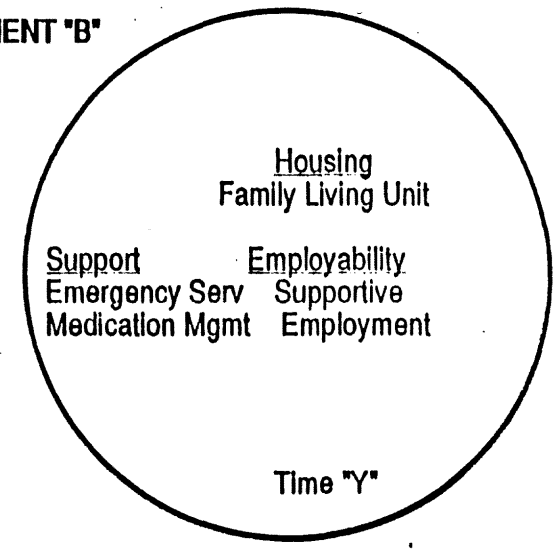
CLIENT "A"



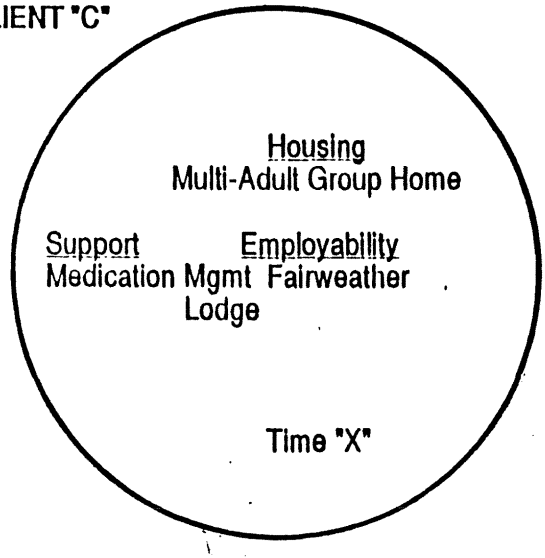
CLIENT "B"



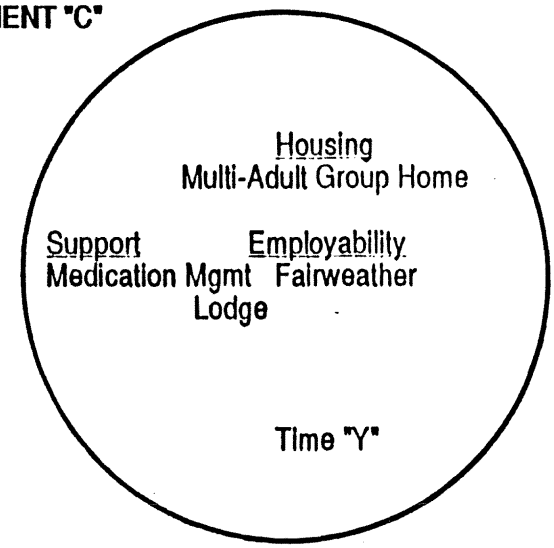
CLIENT "B"



CLIENT "C"



CLIENT "C"



SURVEY OF HOUSING NEEDS

OBJECTIVES

The objectives of the Department of Human Services, Division of Mental Health in conducting this study of housing needs for person with severe and persistent mental illness (target population) were to:

- Develop the concept for an array of housing programs and residential treatment services for persons with severe and persistent mental illness which offers such individuals housing which adheres to the principles of normalization and least restrictive environment.

- Assemble this array based on a survey of the needs of this population of individuals as expressed by potential direct users for the continuum, referral and housing provider sources.

- Map out a plan for implementation of the array based on the results of the study.

- Satisfy the requirements of Minnesota Chapter 197 legislation passed during the summer of 1987.

SURVEY APPROACH

The pilot study was approached in a manner which would address answers to questions of housing and residential service needs and preferences of persons with serious and persistent mental illness in the State of Minnesota.

- A 'client' survey was designed to address the following questions:

  - What are the housing needs identified by clients?
  - What housing options would clients prefer?
  - What residential treatment options would clients prefer?
  - What problems have clients had obtaining residential treatment?
  - What problems have clients had obtaining housing?
  - What types of support services would be needed for clients to live in the situation clients state best meet their need?
  - What problems have clients had in their housing?

- A 'provider' survey was designed to obtain input from mental health, social service, housing, finance, and advocates addressing the following questions:

  - What existing housing options are there for persons with severe and persistent mental illness?
  - What housing needs exist for persons with mental illness?

- What support services are needed to enable clients to live in the least restrictive setting?
- How appropriate are various housing alternatives?
- How adequate are various housing alternatives?
- How available are various housing alternatives?
- How affordable are various housing alternatives?
- How appropriate are various residential treatment alternatives?
- How adequate are various residential treatment alternatives
- How available are various residential treatment alternatives?
- How affordable are various residential treatment alternatives?

Definition

A definition of "severe and persistent mental illness" consistent with that identified in the Mental Health Act was used. This definition states that a person with severe and persistent mental illness is a person who has mental illness and meets at least one of the following criteria:

- The person has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months.

- The person has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months duration with the preceding 12 months.

- The person has had a history of recurring inpatient or residential treatment episodes of a frequency described in the above clauses, but not within the preceding 24 months. There must also be a written opinion of a mental health professional stating that the person is reasonably likely to have future episodes requiring inpatient or residential treatment unless an ongoing community support services program is provided.

Focus Groups

To begin the survey process, two focus group sessions were held, one within housing/mental health providers, and one with clients. Questions addressed during these focus groups included:

- Clients

  - What types of residences do you live in now?
  - What do you like about where you live?
  - What do you dislike about where you live?
  - What type of living arrangement would you like to be in one year from now?
  - What type of job do you work at now?
  - What types of services need to be available?
  - What questions should providers be asked?

- Providers

  - What are residence options available to your clients?
  - How adequate are current housing options in terms of pricing, availability, and meeting client needs?
  - What kinds of housing options should be available to this population?
  - What overall housing options do we think clients would prefer?
  - What other types of services need to be available in order to live independently?
  - What questions should we ask client?

Comments received from the focus groups were reviewed with the Division and used to better design the surveys distributed to clients and providers.

A number of drafts of the survey were designed and reviewed with the Mental Health Division, and various providers to arrive at an appropriate survey to capture responses to the questions identified in the objectives. The survey was then pretested before distribution.

Distribution Methodology

In determining a distribution methodology, methods were selected to attempt to minimize the potential for response bias. It was decided that the best access to persons who met the criteria of serious and persistent mental illness described above was through providers of residential treatment facilities and community support programs. These would also be the persons best able to describe their own preferences. The assistance of providers was sought in randomly selecting these persons so that a sample that was truly representative of the target population was obtained. At one point the possibility of including persons using emergency shelters who were thought to have severe and persistent mental illness was discussed. Since those people were not in the system, it was thought they would provide a different perspective. After carefully considering this as part of the methodology, it was decided that, within the scope of this project, those persons using the shelters who met the criteria for serious and persistent mental illness could not reasonably be determined. For that reason, the focus was only on those clients who had some contact with the mental health system. The Catchment areas defined for the Minnesota Regional Treatment Centers were used to group the samples. (See attached map)

To determine the samples for clients, the following process was followed:

- The prevalence of serious and persistent mental illness was identified for each Mental Health Catchment area (Catchments 2 and 3 were combined to more evenly subdivide the State by population) from the University of Minnesota study.

- The number of Rule 36 beds were calculated for each Catchment area from the mailing list provided by the Division.

- The number of Rule 14 clients from the last available full census year was calculated from the January 1987 report to the legislature provided by the State.

- A sample of approximately 10 percent, with a minimum number of 30, was taken from each Catchment area. Instructions were provided to randomly distribute the surveys to clients.

- Numbers were randomly assigned from a random number table to determine which clients within a facility or caseload were to receive a survey.

- Providers were asked to 'sign-off' on a tally sheet indicating the number of clients who completed a survey as well as those who were not capable of completing the questionnaire.

- A total of 830 client surveys were distributed to Rule 36, Rule 14 and Rule 29 providers to give to their clients.

CLIENT RESPONSE

A total of 207 completed client surveys were received by Ernst & Whinney. Additionally, 83 surveys were returned unanswered. Of these, 53 were marked 'unable to complete' or 'unwilling to complete' and 30 were not marked. This represents a total response rate of 35 percent (290/830) and a completed responded rate of 25 percent (207/830). The target response rate was 30 percent.

In reviewing the responses to determine the representativeness of the sample received, we found that:

- Respondents were quite evenly distributed by Catchment areas, with Catchment 1 accounting for 17 percent of respondents, Catchment 2-3 accounting for 13 percent, Catchment 4 accounting for 17 percent, Catchment 5 accounting for 18 percent and Catchment 6 accounting for 36 percent of the respondents. This distribution seems to match the population distribution across the state, and provides feedback from both metro and non-metro areas of the state.

- There was an equal representation of respondents by sex, with 51 percent male and 49 percent female respondents.

- There was a good representation of ages of respondents, with 18-24 year olds accounting for 12 percent, 25-44 year olds accounting for 58 percent, 45-64 year olds accounting for 25 percent and the over 65 year population accounting for 5 percent of the total respondents. This distribution appears to form a bell-shaped distribution curve.

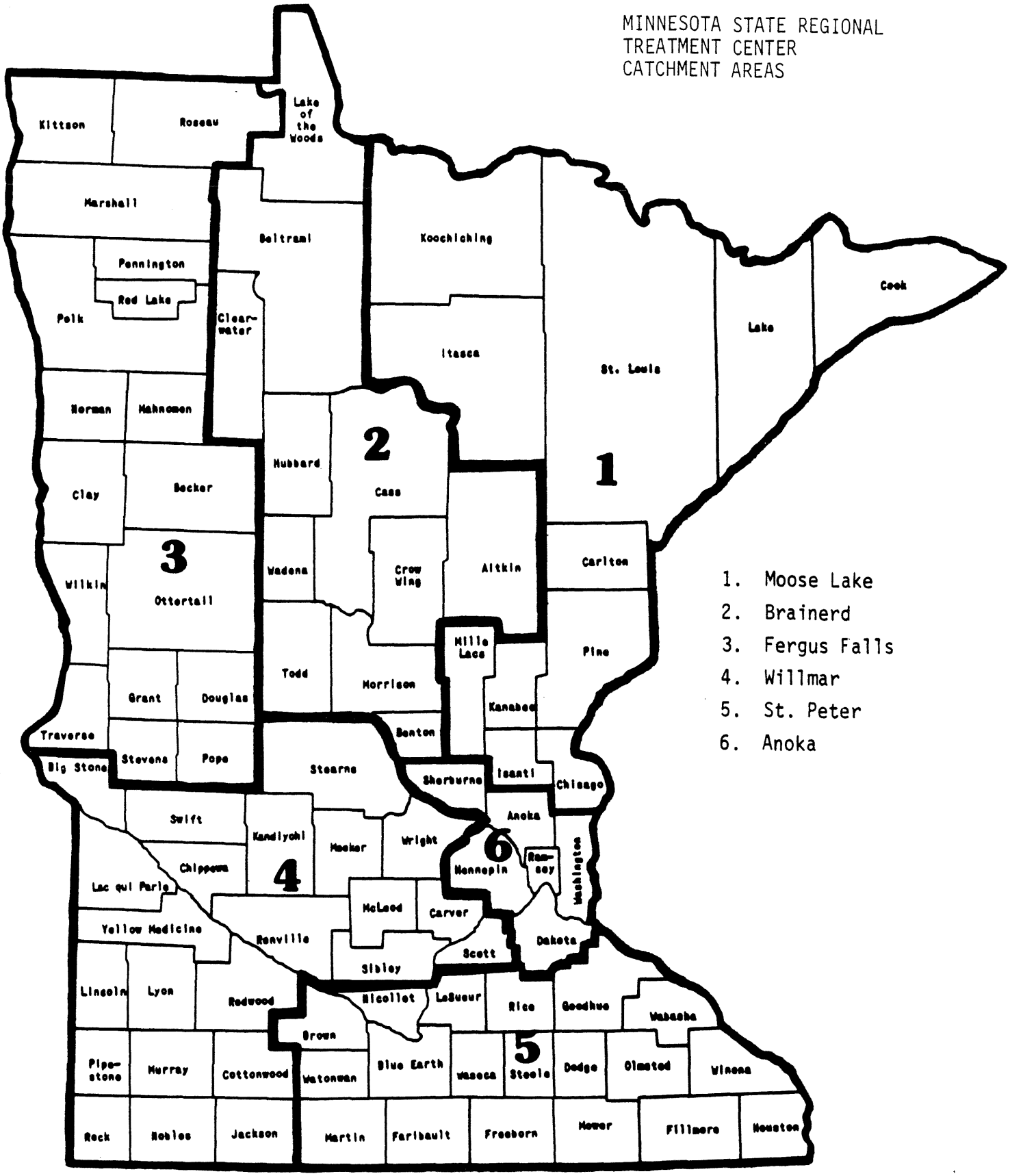
- No significant difference in overall satisfaction was found when tested by Catchment area or by current living arrangement. This suggests that the respondents were not indicative of a negative or positive bias.

- Overall satisfaction levels were distributed across all categories, with 28 percent of respondents indicating they were 'very satisfied', 32 percent indicating they were 'satisfied', 25 percent indicating they were 'somewhat satisfied', and 15 percent 'not satisfied'.

- Respondents represented different current living arrangements, with 55 percent indicating they lived in a residential treatment facility, 16 percent 'on my own', 11 percent with family or relatives, 5 percent in an apartment with support services and 11 percent in a 'boarding house' with either meals or services provided.

Based on these observations, we determined that the sample received was a good representation of the population that we set out to study, and that the answers obtained in the analysis of the data were as valid as could be expected.

Our approach to analyzing the data included three different types of analysis: descriptive, inferential, and qualitative. Each of these approaches will be addressed separately, before collectively focusing on the original questions the survey was designed to address.


MINNESOTA STATE REGIONAL
TREATMENT CENTER
CATCHMENT AREAS
1. Moose Lake
2. Brainerd
3. Fergus Falls
4. Willmar
5. St. Peter
6. Anoka
Kittson
Roseau
Lake of the Woods
Marshall
Beltrami
Koochiching
Cook
Lake
Pennington
Red Lake
Polk
Clear-water
Itasca
St. Louis
Norman
Mahnomen
Hubbard
2
Cass
1
Clay
Becker
Wadena
Crow Wing
Aitkin
Carlton
Wilkin
3
Ottertail
Todd
Morrison
Mille Lacs
Pine
Grant
Douglas
Kanabec
Traverse
Stevens
Pope
Benton
Big Stone
Stearns
Sherburne
Isanti
Chisago
Swift
Kandiyohi
Hooker
Wright
Anoka
Chippewa
4
6
Hennepin
Ram-sey
Washington
Lac qui Parle
McLeod
Carver
Yellow Medicine
Renville
Scott
Dakota
Sibley
Lincoln
Lyon
Redwood
Nicollet
LeSueur
Rice
Goodhue
Wabasha
Brown
Pipe-stone
Murray
Cottonwood
Watonwan
Blue Earth
Waseca
5
Steele
Dodge
Olmsted
Winona
Rock
Nobles
Jackson
Martin
Faribault
Freeborn
Mower
Fillmore
Houston

Descriptive Analysis

Highlights of the descriptive analysis of the client survey show that: (Responses represent the majority of clients, complete results are found in Appendix I)

- Over 75 percent of clients were satisfied with their neighborhood, the type of building they lived in, support services available in their home and town and their access to public transportation. Between 60 and 75 percent were satisfied with the amount of privacy they had, the people that they live with, the amount of living space they have to themselves and their cost of living.

- When asked to think about their overall quality of life, over 85 percent indicated they

  - 'feel safe and secure',
  - 'have enough warm clothes to wear',
  - 'have enough to eat each day',
  - 'have at least one friend to trust',
  - 'have a chance to do things for fun',
  - 'have enough medical support available',
  - 'have enough mental health support available',
  - 'feel that my life is worthwhile',
  - 'have medications that help me', and
  - 'get along ok with my neighbors'.

- Almost half (47%) indicated they had less than $50 left after paying for housing. Another 17% had $50 to $100 left after paying for housing.

- Close to three-fourths (74%) indicated they get 'aid from the government'.

- Within the last month, over half 'met with a psychiatrist' (69%), 'met with a social worker or caseworker' (64%), 'met with a medical doctor' (56%).

- In the last month, over half reported they received help 'managing my medication' (62%), 'cooking, shopping or budgeting' (50%), 'participated in social or fun activities' (79%).

- In the last month, 10 percent indicated they were hospitalized for mental illness reasons, and 12 percent indicated they were hospitalized for physical/medical illness.

- Over one-third thought the 'best living situation for you now' was 'on my own'; 10 percent wanted no support services, 13 percent wanted support services at home, and 15 percent wanted support services outside their home. One-fifth (20%) thought a residential treatment facility was the best living situation for them now. The others were divided among other responses.

- Having 'the freedom to do what I please' and having 'the help I need' were the two most frequently indicated reasons for wanting to live where they chose.

- The reasons given most frequently for not living where they wanted to be were: 'I do not have enough money to live there' (15%) and 'my illness prevents me from living there' (13%). Almost half (45%) indicated they <u>were</u> living where they want to be.

- The percentage of persons who indicated they were living where they wanted to be was highest for those living on their own (72%). Of those living in residential treatment facilities, 30% indicated they were where they wanted to be. Most frequently checked reasons for <u>not</u> living where they wanted (for those in residential treatment facilities) included:

  - My illness prevents me (21%)
  - I do not have enough money (16%)
  - There is a waiting list ahead of me (13%)

- Clients were asked to check areas for needing help if they were living where they wanted. Clients wanted:

  - help 'in a crisis' (79%),
  - help 'with my mental illness' (75%),
  - help 'from a medical doctor' (67%),
  - help 'from a case worker' (66%),
  - help 'with legal questions' (62%),
  - help 'with finding a job' (60%).

- Most (35%) would prefer to live alone, or with one or a group of other adults (30%).

- Most (52%) said they would prefer to live with people their own age, or that it did not matter (27%).

- One-third (34%) indicated they would rather live with people who 'need the same level of services', 22 percent said those who 'are not in need of services at all'; and 30 percent said 'it does not matter'.

- Most (59%) indicated they were not working, while only (10%) said they were working full-time.

- Over half (54%) indicated they earned <u>less</u> than $200 per month. One in five (20%) indicated their income was more than $500 per month.

<u>Inferential Analysis</u>

Several types of analysis were used to draw inferences about the data, including multivariate regression, analysis of variance and goodness of fit testing. Important findings of these analyses are highlighted below.

Analysis was done to determine what factors most influenced clients' general satisfaction. In looking at 17 different variables describing clients' living situations, these five were found to be most important:

- Privacy
- Living space to myself
- Cost of living
- Feeling safe and secure
- Having enough to eat

In looking at whether or not clients were satisfied with their privacy, there was a significant difference in how people responded to that question according to their current living arrangement.

In evaluating the level of difficulty people expressed with obtaining different types of services, 'help finding a job' was the most difficult service to obtain.

The same six services ranked highest: 'help in a crisis, help with my mental illness, help from a medical doctor, help from a caseworker, help with legal questions, and help in finding a job', for clients, regardless of where they were currently living, or whether they were living where they wanted to be.

There was no significant difference in reporting 'personal control over my life' compared among current housing arrangements.

There was no significant difference in reporting 'feeling safe and secure' when compared among current housing arrangements.

A significant difference in incomes was found according to where people stated they currently lived. Seventy three percent of clients living in residential treatment facilities reported incomes of less than $200 per month. Twenty five percent of clients living on their own reported incomes of less than $200 per month.

There was a significant difference in what clients thought the best living situation for them was, according to where they were currently living.

The difficulty clients reported in obtaining services was not significantly different by age, sex, current living situation or catchment area.

There was no significant difference in clients reporting they worried about where they were going to live next, according to their current living arrangement.

Qualitative Analysis

Several open ended questions were included in the survey for clients to elaborate on their answers in order to obtain a better understanding of why clients responded the way they did. In particular, the questions

which asked: 'what do you like best about where you live?', 'what do you like least about where you live?' and, following the question which asks about overall level of satisfaction, 'the main reason for your last answer is....' were found to be helpful in interpreting client responses.

For the question, 'what do you like most about where you live?' clients responded most frequently with:

- Location--convenience to shopping, bus, or other place
- People I live with--residents, friends, family or companionship
- Freedom--independence, privacy, or responsibility for myself
- Staff--some staff, staff who give individual attention
- Food--meals
- Support--treatment or individual treatment
- Activities--social events, things to do
- My room
- Work--job
- Peaceful--quiet
- In the country
- Atmosphere--comfortable, warm

Over 20 clients responded to each of the first three responses above, 10 to 20 responded to each of the second three listed, and 3 to 10 responded to the others. There were a number of other single responses which included answers like: "T.V., plug in for car, easy upkeep, it's off the streets, it's home, can have a pet, can snack between meals, it's a nice place".

In answer to the question 'what do you like least about where you live?' people responded with a variety of answers. Several indicated a need for more money, to pay for personal things or doctor bills, or simply that it was too expensive. Several others responded with comments concerning lack of privacy, wanting to be on their own, or not wanting the constant supervision or interference by staff. Other individual responses included:

- Need to find a permanent home
- Would like more things to occupy my time
- Would rather live with my mother
- Would like an office job
- Not much more support than the last place
- My life type is not satisfying, but it is as good as can be expected
- Need more and better activities
- Feel suspicious of people who work here
- No spiritual help
- I live with all old people
- I don't need to be here
- I'm still upset with my illness
- I'm lonely and depressed
- No guests come to visit me here
- I had no choice in where I got to live
- I don't like living alone all the time
- Bad neighborhood, and tension with my roommate.

Reasons given for responding to the question of overall satisfaction were divided according to how satisfied the person indicated he/she was. For those who indicated they were not satisfied (15% of respondents), the reasons given included:

- No freedom
- Had to live alone
- I am just not
- I resent staff supervision
- I think I'm ready to live on my own
- Life style is not satisfying
- I'm better off than the people who live here
- No choice in deciding
- Bad neighborhood and tension with roommate
- Not enough money
- I don't like staff or types of patients
- Not happy here
- Too many men and not enough privacy
- That's the way I feel
- They are not doing anything to help me
- Need a bigger apartment
- I don't like staff or types of patients
- I don't get enough personal needs money
- Because I'm going to have to move

Those who indicated they were somewhat satisfied (25%) responded:

- I would rather live with family
- I don't need the constant supervision
- Too expensive
- Trouble budgeting money
- The people are very old
- I need more help with transportation
- No guests come to visit me
- Need to find permanent housing arrangement
- I would rather be on my own
- I feel a need to be on my own
- Lonely and depressed
- Not enough money to pay bills
- I haven't gotten much support here
- Stress
- I am limited because of mental illness
- Family problems
- There are some things that I like and some that I don't
- I'm still upset with my illness

People who responded that they were satisfied (32%) indicated:

- People that I live with
- I am happy because Christmas is coming
- Living with family
- I'd rather be here than in my own apartment
- Everyone attempts to live together

- It's by a shopping center and bus line
- I'm content here
- Very clean and private
- It's clean, well kept, well painted
- The way I feel right now
- I have shelter
- I live with all old people
- I have a lot of friends around me
- Much better than other places I've been
- Housing situation is good
- I'm happy here
- Staff provides a clean, liveable treatment facility
- Can't complain
- It is a good atmosphere
- The counselors do not question the irresponsible behaviors of residents
- Things are going good
- People have been nice to me
- Happy with the setting
- I don't have another place to live
- Cheap
- Have my own room, privacy
- It's safe, meals are good, support staff
- It's affordable with the assistance I receive
- Freedom to live the way I choose
- A good day today
- People I live with and staff

Those who responded that they were very satisfied (28%) indicated:

- A bed like I have at home, that's nice
- Variety of things to do
- Come and go as I want
- Like living in Northern Minnesota
- Nice place to be
- Have my own place, furniture, and belongings
- Happy where I'm living now
- I am near friends
- Because I can eat, sleep and have friends
- I like being on my own, and would like my children to join me
- I have freedom, adequate child support services
- Good services
- The staff
- I feel comfortable and relaxed
- Everything is taken care of for me
- Comfortable, pleasant situation
- I have my own apartment
- Like the people here, get the help I need
- I feel I am learning to support myself
- Privacy, I can do as I please
- I enjoy the lake and my own room
- I enjoy being independent and living alone
- Privacy, I can do as I please
- It seems to fit my needs

Answers to Questions Listed in Objectives

This section returns to the original questions asked during the design phase of the survey. Answers to the questions are formulated from the descriptive, inferential and qualitative analysis above.

QUESTION: What are the housing needs identified by clients?
What problems have clients had in their housing?

To answer that question, the responses to several questions were considered, as well as the inferential analysis. Question #3 asked, 'in thinking about where you live now, are you satisfied with...' of the nine items listed, the highest percentages of clients were satisfied with the 'type of building lived in', 'the neighborhood', and 'the support services available' in town. A higher percentage of those who lived on their own or with families reported satisfaction with the neighborhood than those living in residential treatment facilities or apartments with support services. Compared by age group, those in the youngest category (18-24) were less satisfied than older persons. Those over 65 years were the most satisfied. Those in Catchment area 6, which includes the metropolitan area, also reported less satisfaction with neighborhood. None of the differences among groups were statistically significant. There was also no statistically significant difference in satisfaction with building type or support service in town among the groups studied.

When asked, 'in thinking about your overall quality of life right now', clients responded most with 'get along ok with my neighbors, have enough food to eat, and have medications that help me, have enough mental health and medical support available...'. The lowest percentage of respondents indicated they 'have a job I like, have a church where I feel welcome, or have personal control over my life'. There was not a statistically significant difference among groups for any of these responses. There was, however, a significant difference among how people responded to the amount of privacy that they have, according to where they were currently living. Those living on their own, with family, or in apartments with support services reported higher percentages of satisfaction with privacy than those living in residential treatment and boarding facilities.

The factors from questions #3 and #7 which most influenced clients' overall level of satisfaction were: 'amount of privacy', 'living space to self', 'cost of living', 'feel safe and secure' and 'have enough to eat'.

QUESTION: What housing options would clients prefer?

Clients were asked to indicate what the best living situation was for them now. The largest percentage (38%) indicated 'on my own', with 15 percent wanting support services outside the home, 13 percent wanting support services in the home and 10 percent not wanting support services. Approximately another fifth (20%) marked 'in a residential treatment facility', another 11 percent each indicated 'with my family or relatives' or 'in a boarding house' with either meals or staff support available, and 6 percent checked 'in a small group with support services

available'*. When asked why they were not living where they want to be, 'I do not have enough money (15%)' and 'my illness prevents me from living there (13%)' were the most frequent responses. Almost half (45%) indicated they were living where they wanted to be. The reasons clients most frequently gave for choosing the best living situation were 'I would have the most freedom to do what I please (31%) and 'I would have the help I need (25%), and 'I would be able to support myself (18%).

When asked what age they would prefer to live with, approximately one-half (52%) said their own age, and another 27 percent said it did not matter. Approximately one-third of the clients (34%) preferred to live with people who need the same level of service as they do, another 30 percent said it doesn't matter. Approximately one-fifth (22%) preferred to live with people who needed no services at all.

When asked, 'in what part of the state would you live if you could get the housing and services you need?' 39 percent indicated a preference for Minneapolis/St. Paul or a suburb of Minneapolis or St. Paul, another 36 percent preferred a 'smaller town or rural area', 5 percent preferred Duluth, and 7 percent preferred a 'larger city like St. Cloud, Rochester or Mankato'.

* Responses do not add up to 100 percent because only the top responses are listed in this summary. A complete listing of all responses is contained in the Appendix.

QUESTION: What residential treatment options would clients prefer? What types of support services would be needed for clients to live in the situation which clients state best meets their needs?

Regardless of where clients were currently living, or if they were living in the place which they preferred, the same six services were most often mentioned as ones where they would want help. These six services were:

- Help in a crisis situation
- Help with my mental illness
- Help from a medical doctor
- Help from a case worker
- Help with legal questions
- Help in finding a job

Those services which were least requested were:

- Child care services
- Finding classes to take
- Cooking, shopping or cleaning
- Food service
- Staff to talk to at night

QUESTION: What problems have clients had obtaining residential treatment?

The question was asked, 'in thinking back over the past year, how hard was it to get these services?' accompanied by a list of 16 different services.

The most frequently mentioned 'somewhat hard' or 'very hard' to get service was 'help in finding a job', followed by 'help with legal questions', 'help in a crisis situation' and 'public transportation'. Clients indicated a variety of problems in getting services, including: 'I could not get in right away when I needed to' (30%), 'I could not afford to pay for the service' (27%), 'the service was not available nearby' (23%), and 'the service was there, but it did not meet my needs' (22%).

PROVIDER RESPONSE

A total of 776 'Provider Surveys' were sent out to Mental Health, Social Service, Housing, Finance, and Family/Advocates familiar with the needs of persons with long-term mental illness. The distribution of surveys sent out was as follows:

- Rule 36 Providers - 76
- Rule 14 Providers - 40
- Rule 29 Providers - 91
- County Mental Health Contact Persons - 87
- County Adult Protection Workers - 63
- Emergency Shelter Providers - 6
- Boarding Care Homes Providers - 20
- Board and Lodging Providers - 34
- Multi-Housing Association Members - 100
- Minnesota Housing and Redevelopment Authorities - 86
- HUD Approved Housing Counseling Agencies - 7
- Minnesota Community Housing Resource Board - 6
- Minnesota Housing Task Force - 10
- Minnesota Mental Health Association Reach Members - 90
- Alliance For The Mentally Ill Members - 60

It was recognized that some overlap in members on the mailing lists occurred, so providers were asked to only fill out one survey if they received more than one. This overlap was minimal.

A total of 199 useable responses were returned from providers, Another 32 surveys were received which did not get included in the tabulation because respondents indicated they did not have sufficient knowledge of the subject, the surveys were incomplete, or they were returned after tabulation had been completed. It was primarily Housing/Finance providers who indicated they did not have sufficient knowledge of the availability of housing and support services of persons with mental illness to complete the survey. The response represents a 26% return of useable responses (199/776) and a total of 30% (231/776) responses.

Of the 199 responses used, 21% were from family members/advocates, 40% were from mental health providers, 25% were from social service providers, 9% were from housing/finance persons, and 6% marked 'other'. This is approximately a distribution which matches the distribution of surveys sent to each of the constituency groups. A distribution of responses was also received from each of the Catchment areas. Of the total, 15% were from Catchment 1, 17% were from Catchments 2-3, 13% were from Catchment 4, 29% were from Catchment 5, and 28% were from Catchment 6. This distribution is a bit heavier in Catchment 5, and a bit lighter in Catchment 6 than an ideal distribution. However, it does represent a sample which includes 25 or more respondents from each of the Catchment areas (except Catchment 4, where 24 persons responded). It also represents a desired distribution of providers from rural, suburban, and urban areas of the state.

Descriptive Analysis

Providers were asked to indicate whether certain housing options were available, affordable, accessible, and adequate in their community for persons with serious and persistent mental illness. This is in response to the questions identified in the objectives. The only housing option where over 50% of the 199 respondents indicated the criteria was met was one-bedroom unsupervised apartments, which 108 providers indicated were available. (Caution must be used in interpreting those categories left unchecked since that could mean that the person did not choose to respond. As such, this was a poorly worded question.) Since most of the people responding to the survey could be assumed to have a much greater working knowledge of the types of housing alternatives for persons with mental illness, the lack of affirmative check marks indicates much room for improvement in all areas of availability, affordability, accessibility, and adequacy of housing for the mentally ill.

A subsequent question asked: "What additional housing options are needed for persons with serious and persistent mental illness in your community?" Over 50% of the respondents indicated that each of the following housing options was needed (in order of the greatest need):

- Supervised one-bedroom apartments (N=153)
- Supervised single room occupancy/effective apartments (N=142)
- Adult foster care (N=129)
- Long-term residential facilities with no time limit (N=118)
- Supervised two-bedroom apartments (N=110)
- Supervised board and lodging (N=105)

The least need was mentioned for the following:

- Nursing home (N=27)
- Multiple family dwellings unsupervised (N=37)
- Unsupervised board and lodging (N=48)
- Boarding care (N=55)

Approximately 50% of respondents said Residential Treatment facilities (Rule 36, group home, halfway house) options were available (N=94), affordable (N=97), accessible (N=92), and adequate (N=91). The next closest "affordable" option was adult foster care and one-bedroom unsupervised apartments where approximately 30% responded affirmatively. The next closest "accessible" option was one-bedroom unsupervised apartments where approximately 35% responded affirmatively. The next closest "adequate" option was also one-bedroom unsupervised apartments where approximately 30% responded affirmatively.

Over 50% of respondents indicated the following additional support service options were needed in their communities (in order of greatest need):

- Housing that allows people to return from longer-term hospitalizations (N=149)
- Development of employability and supportive work opportunities (N=146)
- Development, identification, and monitoring of living arrangements (N=137)
- Assistance in daily living skills (N=132)
- Medication management (N=117)
- Psycho-social rehabilitation (N=113)
- Educational and prevention services (N=109)
- Client outreach (N-107)
- Emergency services - 24 hour coverage (N=105)
- Community support services (N=104)

The least need was identified for additional acute-care hospital inpatient treatment services (N=72).

Respondents indicated that the most significant barriers to the development of housing alternatives for persons with serious and persistent mental illness were:

- Lack of incentives for landlords to rent to persons with mental illness
- Lack of guaranteed lease payments to subsidize persons with mental illness when they are hospitalized
- Stigma associated with mental illness
- Lack of dollars allocated to new construction
- Neighborhood resistance to persons with mental illness moving into the area

Most of the residential facilities said that clients stayed about the right length of time. Ninety-two percent said less than one-fourth stayed longer than necessary. Most frequent reasons for clients staying longer than necessary were:

- No residential place to go
- Client did not want to leave
- No support service

A smaller percentage (58%) said less than one-fourth didn't stay long enough. The most common reason for clients leaving was that they "left against staff advice." When asked, "What percent of those persons with serious and persistent mental illness living in residential facilities would be capable of living in a less restrictive setting if appropriate support services where available in the community," 51% said 0 to one-fourth, 32% said one-fourth to one-half, 13% said one-half to three fourths, and 4% said over three-fourths.

Providers were asked to indicate the three most appropriate types of ownership options in providing residential housing for persons with mental illness. The options which ranked the highest include:

- Investor/agency partnerships
- Private investor owned
- Human service agency owned
- Housing cooperatives

In the question which asked to identify how significant the barriers were to the development of housing alternatives for persons with severe and persistent mental illness, these barriers were found to be significantly different among Catchments:

- Complexity of meeting government agency regulations
- Zoning ordinances which prohibit multiple unrelated adults from sharing a single family home
- Coordination between service organizations
- Neighborhood resistance to persons with mental illness moving into the area
- Lack of dollars to maintain existing properties

With the exception of the last item where Catchments 2 and 4 reported the greatest degree of significance, Catchment 6 was found to have reported the greatest degree of significance of the barriers.

In the question which asked whether support service options were available, affordable, accessible, or adequate in the provider's community, a significant difference among Catchment areas was found for the following service options:

- Adequate day treatment services
- Accessible day treatment services
- Affordable day treatment services
- Monitoring of living arrangements accessible
- Help in applying for government benefits adequate
- Help in applying for government benefits accessible
- Help in applying for government benefits available
- Psycho-social rehabilitation adequate
- Psycho-social rehabilitation affordable
- Psycho-social rehabilitation available
- Employability and supportive work opportunities adequate
- Employability and supportive work opportunities accessible
- Assistance in daily living skills adequate

- Assistance in daily living skills affordable
- Medication management accessible
- Medication management affordable
- Client outreach adequate
- Client outreach accessible
- Client outreach affordable
- Client outreach available
- Acute care hospital inpatient services adequate
- Acute care hospital inpatient services affordable
- Residential treatment adequate
- Residential treatment accessible
- Outpatient mental health services adequate
- Outpatient mental health services affordable
- Outpatient mental health services accessible
- Emergency services accessible
- Education and prevention adequate
- Education and prevention accessible
- Education and prevention available

In most cases, a higher percentage of providers from Catchment 6 found the availability, affordability, accessibility, and adequacy of services to be unacceptable. This might be due to the greater complexity service provision within the metro area, as well as the greater population base to cover.

Responses were also reviewed to see if there was a significant difference among provider types in their answers to questions.

For the questions which asked how significant the barriers were, the following barriers were found to have differences among provider types:

- Zoning ordinances which prohibit multiple unrelated adults from sharing a single family house
- Stigma associated with mental illness
- Coordination between service organizations

Family members/advocates reported the highest level of significance associated with the stigma and coordination barriers. Social service providers found the zoning barriers less significant than other provider groups.

For the question which asked about the availability, affordability, accessibility, and adequacy of support services, the following were found to be significant among provider types:

- Help in applying for government benefits adequate
- Medication management accessible
- Medication management available
- Client outreach available
- Acute care inpatient services available
- Emergency services adequate
- Emergency services affordable
- Education and prevention accessible

In general, family members/advocates reported lower percentages of acceptability in their responses. Social service respondents indicated a higher percentage of acceptability of client outreach availability than the other groups. Mental health and social service providers reported higher percentages of acceptable accessibility of education and prevention services than the other groups.

Qualitative Analysis

A number of open ended questions were included in the survey to allow respondents a better opportunity to clarify and explain their thoughts. Emergency shelter and adult protection workers were asked to write what types of services were needed for persons with serious and persistent mental illness. Responses included:

- Follow-up hygiene and medical care, information on medication and housing rights, various agencies which offer help
- More attempts to integrate, not segregate
- Restoration to competency to independent living
- More staff time
- Adequate funding for counties
- Only one crisis bed at the hospital in this county
- We offer enough
- We refer/coordinate with other agencies
- Ours has no services for mentally ill and they would probably not live here
- More MI beds and crisis receiving unit

The same question was asked for outside their facility. Responses included:

- Follow-up hygiene and medical care, information on medication and housing rights, various agencies which offer help
- Increased case management and outreach
- Community psychiatry - increase hours of consultation
- Supervised environment with properly trained staff
- Case management
- Vocational housing programs
- Supportive services
- More employment
- Adequate funding for counties
- There's an 800 number to a Rule 36 facility in another county - otherwise law enforcement and county social services
- Affordable short-term inpatient services
- Economic opportunity and ability
- Follow-up services; outreach workers
- Drop in center for mentally ill to socialize in an affordable manner
- Available, friendly treatment that worked and is not shoved down their throats; SILS programs

Providers were asked to comment on what they thought were the three top priorities for the state of Minnesota in the development of least restrictive housing alternatives and residential treatment alternatives for people with serious and persistent mental illness. These comments are summarized below: (A complete listing of provider priorities by Catchment area is contained in Appendix 3)

- Additional housing was mentioned by many providers as a priority. Some of the housing types mentioned by significant numbers of respondents were: supervised and unsupervised apartments, adult foster care, board and lodging and group homes, halfway homes, three quarter way homes and crisis homes. Supervised apartments were the most frequently mentioned response.

- Respondents usually commented positively about existing Rule 36 facilities and suggested that additional facilities be made available.

- When commenting on housing, providers frequently mentioned having more long-term options available. Several respondents commented on the need for transitional housing which will allow clients to make gradual steps towards independence.

- No significant differences are evident among comments from each of the Catchment areas.

- Creating incentives for landlords to rent to persons with mental illness was mentioned by several respondents.

- Working on developing incentives for private investors (both proprietary and nonproprietary) to develop new housing was mentioned by several respondents.

- Many respondents mentioned the stigma associated with mental illness and suggested that a priority for the state should be to undertake public education to reduce this stigma.

- Funding for housing and new services was mentioned as a priority by a significant number of respondents.

- Several respondents suggested that laws be changed in an effort to prohibit discrimination against persons with mental illness and where they can live.

- Several respondents mentioned that more services need to be made available in rural areas so that clients can access them in their home towns.

- Many respondents suggested that the state concentrate on developing new employment opportunities for persons with mental illness. Vocational training was also a frequently mentioned response.

- Independent living skills training and community living skills training are services that were mentioned by several respondents.

- Additional services mentioned by more than one respondent were: centralized system for listing available housing; respite care; client owned and run cooperatives; case management; transportation and 24 hour emergency lines.

SPECIFIC RESPONSES TO QUESTIONS DIRECTED ONLY TO FAMILY MEMBERS

Family members were asked to write about the housing options they would prefer for their relative, problems they have experienced in trying to obtain housing for their relative, and problems they have experienced in trying to obtain support services. Their responses are summarized on the following pages:

WHAT HOUSING OPTION(S) WOULD YOU PREFER FOR YOUR RELATIVE WITH A MENTAL ILLNESS?

- Family type home
- Affordable supervised or unsupervised apartment
- Well kept living arrangement
- Supervised housing
- Group home (supervised)
- Single room housing (supervised)
- Clean/neat housing
- Apartment, room and board
- Room and board with supervision (limited occupancy)
- Apartment, low income, supervised
- Foster care
- Independent living, social rehabilitation programs, some case management assistance
- Subsidized public housing
- Supervised living, multi-unrelated adults
- Cleaner, up-to-date building
- Home
- Apartment, supervised, medical management and outreach provided
- Long-term housing
- Home type surrounding
- Long-term housing with structured, semi-structured and independent living arrangements
- Roommate (without losing aid)
- Apartment, unsupervised
- Apartment, supervised, roommate, medication management
- Apartment, unsupervised
- Apartment or dwelling, unsupervised
- Half-way house
- Residential facility, long-term
- Residential treatment facility
- Independent supervised
- Apartment, supervised
- Independent living, supervised
- A rule 36 facility
- Apartment/Home with roommate
- Half-way house, supervised

WHAT HOUSING OPTION(S) WOULD YOU PREFER FOR YOUR RELATIVE WITH A MENTAL ILLNESS?--Continued

- Apartment, supervised
- State hospital
- Housing facility, supervised
- Board and lodging, supervised
- Home, supervised
- Home, small, some supervision
- Group home, supervised
- Good location of group home
- Apartment, supervised, medication management
- Housing development, unsupervised
- Rule 36 facility
- Apartment, efficiency, unsupervised
- Board and lodging that is affordable

WHAT PROBLEMS HAVE YOU EXPERIENCED IN TRYING TO OBTAIN HOUSING FOR YOUR RELATIVE?

- Dirty living accommodations, board and care changed to board and lodging, not safe on the streets
- Long waiting periods for programs, not enough subsidized housing
- Rent not low enough to afford, landlords attach stigma to mental health patients
- No one located residences for me
- Not able to hold a job, cannot afford housing
- Single room housing available only in elderly retirement-type housing, no supervision
- Social Services not locating adequate housing, i.e., run-down
- Long waiting periods to get low income housing
- Programs not meeting the needs of the people in them, location far from family, large capacity board and room
- Rent too high, not enough money to live on after rent
- Lack of quality, high cost of rent, no assistance from social workers in paying bills
- Small space
- Long waiting periods for group homes
- Long waiting periods and red tape
- He can't take care of things
- Limited subsidized highrise apartments available, unsupervised single apartments are not
- High cost of expenses
- Lack of facilities available
- Cost and supervision immediately following treatment are not available
- Lack of facilities available
- Fight red tape, only one facility in county

WHAT PROBLEMS HAVE YOU EXPERIENCED IN TRYING TO OBTAIN HOUSING FOR YOUR RELATIVE?--Continued

- Bias toward mental illness
- Lack of housing
- Long waiting periods, too expensive, isolated
- Lack of half-way homes near home
- Long waiting lists for housing
- Lack of money for rent
- Finding least restrictive alternatives
- Residential treatment facility, thankful everything has gone well
- Removed from home because of time limit program, not good for family member
- No ongoing supervision/education, lack of understanding
- Long waiting lists, too expensive, not able to fill out necessary forms
- "NO" to MI
- Expectations too high, standards too rigid
- Too expensive
- No experience in this area
- None at this time
- Couldn't find adequate facilities for proper care when needed
- High expense, little money remaining for personal needs
- Not knowing if they will be accepted at apartment house, difficulty on own without supervision
- High cost, leases are prohibitive, owners say NO
- Shortage of group homes
- No problems, Hennepin County does good job
- High cost
- Fire hazards in low-income housing
- None
- Too expensive, county offers no subsidy
- Long wait and high cost

WHAT PROBLEMS HAVE YOU EXPERIENCED IN TRYING TO OBTAIN SUPPORT SERVICES FOR YOUR RELATIVE?

- Support comes only in a crisis or acute illness, inability to assist in the treatment decisions
- Long distance to day treatment
- Transportation to support services is limited; support system outside social services works best, more accessible and effective
- None financially, support in understanding the disease and support for family members has been hard to come by
- Not knowing who or what agency to contact or what programs are available, programs lacking for younger (to age 25) persons
- Personnel afraid of MI, no set-up for MI ages 20-50 for recreation, social adjustment unless just out of a mental hospital, no long-term program

WHAT PROBLEMS HAVE YOU EXPERIENCED IN TRYING TO OBTAIN SUPPORT SERVICES FOR YOUR RELATIVE?--Continued

- Help is available but very cheap, money big concern with county/city agencies
- None really
- Problem getting qualified staff in group home; staff, like family, not knowing what to do
- Our area has had adequate counseling
- Lack of support systems and cooperation from support services
- Misinformation, no assessment/review to determine next step
- Space limitations
- Lack of communication
- Financial, medications (generic vs. regular), social activities for older adults
- Services not attractive to MI clients, services developed for state and mental health centers, not persons who have MI
- None
- Red tape, lack of understanding for MI patients
- No programs for children/teens
- Need to be educated to find services
- Not being able to find programs/facilities in immediate living area
- Need education on how to get services and what to do
- Paperwork, need assistance to complete forms; untrained county social service workers
- None
- Finding employment other than with the MR
- Difficulty in finding low income housing
- Availability near home; after discharge from hospital you're on your own
- Lack of assistance in finding employment, no self esteem programs
- None recently
- Dependence on family to pay for housing
- None (feel fortunate)
- Location near home, not being able to get support because of IQ criteria, lack of a definite diagnosis for years, not being informed of diagnosis, not being informed of health status due to age
- Not finding services that are challenging or age-appropriate
- Long waiting lists, paperwork, lack of coordination, lack of consultation, no follow-up
- Distance, not enough services available
- None
- No consultation due to age, SSI does not cover expenses, commitment process is too hard to get assistance, more education on the subject
- Understaffed, time for only the most serious problems, no early intervention
- none
- Lack of proper supervision, inadequate facilities, untrained and uncaring staff
- Treatment services not encouraged due to slow insurance payments, transportation assistance, services that are not available to all, lack of funding for services

WHAT PROBLEMS HAVE YOU EXPERIENCED IN TRYING TO OBTAIN SUPPORT SERVICES FOR YOUR RELATIVE?--Continued

- Travel long distance for emergency services
- Distance, apathy, no decent part-time jobs, lease problems due to hospitalization
- Trouble maintaining medical assistance
- None, but would like to see programs started, i.e. board and care facilities and jobs
- Problem due to commitment law, not able to get proper treatment
- None, services are available
- None
- Lack social worker assistance, lack of medication supervision, problems in obtaining and maintaining employment
- No answers to questions, lack of interest

NOTES

1. Stroul, "Models of Community Support Services"
2. ibid
3. ibid
4. ibid
5. ibid
6. ibid
7. ibid
8. ibid
9. Anthony & Blance, "Supported Employment for Persons who are Psychiatrically Disabled
10. ibid
11. ibid
12. ibid
13. ibid
14. ibid
15. Carling & Ridgway, "A Psychiatric Rehabilitation Approach to Housing"
16. ibid
17. ibid
18. ibid
19. ibid
20. ibid
21. Toff & Merritt, "State Health Reports: Mental Health, Alcoholism and Drug Abuse"
22. ibid
23. Randolph "Strategies for Developing Integrated Housing"
24. Toff & Merritt, "State Health Reports"
25. Draft Position Statement NASMH Program Director
26. Toff & Merritt, "State Health Reports"
27. ibid
28. Randolph "Strategies for Developing Integrated Housing"
29. ibid
30. ibid
31. Laux, "Community Integration Through Creative Financing"
32. Randolph, "Strategies for Developing Integrated Housing"
33. ibid
34. Toff & Merritt, "State Health Reports"
35. Pandey & Kang "Prevalence & Estimates of Mental Disorders for MN Counties"
36. Report to Legislative Rules 14, 12, and 36
37. Metropolitan Council Housing
38. Development Document
39. Vail & Zimbro, "1986 Subsidized Housing Report
40. Mission Statement
41. Comprehensive Mental Health Act, May 19, 1987

BIBLIOGRAPHY

"Mental Health Sections of 1987 - Health and Human Services Omnibus Bill"
Laws of 1987, Chapter 403, Article 2

Directory of Materials for Mental Health Sessions (see attached)

"1986 Subsidized Housing in the Twin Cities Metropolitan Area"
By Joan Vail and Roseann Zimbro, Metropolitan Council of the Twin Cities Area, 300 Metro Square Building, 7th and Robert Streets, St. Paul

"Report to the Legislature, Rules 14, 12, and 36 for Adult Persons with Mental Illness"
Prepared by the Mental Health Division, Minnesota Department of Human Services, January 1987.

Draft position statement of the National Association of State Mental Health Program Directors on housing and support for people with long term mental illness

"Project Update - Community Residential Rehabilitation"
By Paul J. Carling, PH.D. Project Director. Community Resident Rehabilitation Project, Center for Psychiatric Rehabilitation, Boston University, Boston, Massachusetts

"The Role of Expatients and Consumers in Human Resource Development for the 1990's"
West Massachusetts Training Consortium, Inc. July, 1987

"Meeting the Supported Housing and Residential Services Needs of Americans with Psychiatric Disabilities: A State by State Review"
By Priscilla Ridgway, MSW Community Residential Rehabilitation Project, Center for Psychiatric Rehabilitation, Boston University, Boston, Massachusetts, August 1986.

"State Health Reports: Mental Health, Alcoholism, and Drug Abuse"
Gail Toff, Editor, and Dick Merritt, Editorial Director, Intergovernmental Health Policy Project, George Washington University, No. 35, Nov/Dec 1987

"Supported Employment for Persons who are Psychiatrically Disabled: An Historical and Conceptual Perspective"
By William A. Anthony, Ph.D. and Andrea Blanch, Ph.D. (Paper presented at State of the Art Conference on Supported Employment for Cronically Mentally Ill Individuals. March 1987; Washington, D.C.)

"Models of Community Support Services: Approaches to Helping Persons with Long-Term Illness"
By Beth A. Stroul M.ED., National Institute of Mental Health Community Support Program. August 1986.

"A Psychiatric Rehabilitation Approach to Housing"
By Paul J. Carling, Ph.D., Boston University Center for Psychiatric Rehabilitation and University of Vermont, and Priscilla Ridgway, Boston University Center for Psychiatric Rehabilitation adapted from a chapter in Anthony, W. and Farkas, M. (EDS) Psychiatric Rehabilitation: Programs and Practices. Baltimore, MD: Johns Hopkins University Press (in press)

"CRR Project Update: Center for Psychiatric Rehabilitation, Boston University"
November 15, 1986, Cherise A. Rowan, Editor

"Housing and Psychiatric Disability: Barriers and Needs of the Field"
Notes from Community Support Program State Project Director's Meeting, Philadelphia, Pennsylvania, November 5-7, 1986. Prepared by Priscilla Ridgway, Assistant Project Director, Community Residential Rehabilitation Project Center for Psychiatric Rehabilitation, Boston University

"The Bright Promise of Community Rehabilitation for the Psychiatrically Disabled: A Response to a Call for Asylums."
By Anthony M. Zipple, SC.D. Center for Psychiatric Rehabilitation, Boston University, and Paul J. Carling, Ph.D. Center for Psychiatric Rehabilitation, Boston University, and Department Psychology, University of Vermont, and James McDonald, President, Central Massachusetts Alliance for the Mentally Ill, Executive Board Member, Massachusetts Alliance for the Mentally Ill, February 1, 1987

"Community Integration Through Creative Financing: A Summary of Robert Laux's Presentation at the Iowa Association of Rehabilitation and Residential Facilities Annual Meeting"
Prepared for: Minnesota Department of Human Services Division of Mental Retardation by Thomas Fields, June 1986

"Proposal to Meet the Housing Needs of Low-Income, Non-Elderly, Childless Persons"
Executive summary from Sheldon Schneider

"Final Report: HUD/HHS Demonstration for Deinstitutionalization of the Chronically Mentally Ill"
Approved sites under Section 1115 Waiver only grant The Highline Independent Apartment Living Project (HIALF). Washington State Department of Social and Health Services Division of Mental Health, HCFA Grant #11-P198200/01 to 04, January, 1987

"The Impact of Environmental Factors On Outcome in Residential Programs"
By Francine Cournos, M.D., Hospital and Community Psychiatry, August, 1987, Vol. 38, No. 3, Page 848-852

"Minnesota's Planning Document on Housing"

Directory of Materials for Mental Health Sessions

Minnesota Comprehensive Mental Health Act

Instructional Bulletin #87-53B--New Mental Health Legislation Adopted

Instructional Bulletin #87-53D--County Mental Health Plan Format

Community Support Programs

Community Support Program--Background

Models of Community Support Services: Approaches to Helping Persons with Long-Term Mental Illness

National CSP Minority Planning Committee Symposium: Developing a Minority Plan for Implementation Within the CSP Strategy

A Manual on Coalition--Building at the State and Local Levels on Mental Health Issues--NIMH

Housing Programs

A Psychiatric Rehabilitation Approach to Housing

Strategies for Developing Integrated Housing for People with Psychiatric Disabilities

HUD Approved Housing Counseling Agencies in Minnesota

Minnesota Community Housing Resource Boards

Supported Employment

Support Employment for Persons who are Psychiatrically Disabled: An Historical and Conceptual Perspective

Special Populations

Fact Sheet--Refugee Mental Health

Special Populations: Older Adults

Fact Sheet: The Mental Health Dimension of the Farm Crisis

National Action Commission on Mental Health of Rural America

Regional Service Centers for Hearing Impaired People

Coping with AIDS

Special Populations--Continued

Special Populations: Persons with HIV Infection

Traumatic Brain Injury--A Special Needs Population

General Mental Health

Books and Pamphlets on Mental Health--National Alliance for the Mentally Ill

Directory of Mental Health Programs Licensed by the Department of Human Services

Rule 5 Facilities

Rule 36 Facilities

Rule 29 Clinics

Rule 14 List

Fiscal Information Reporting

Current Funding System Chart

Rule 12 Grants

Rule 14 Grants

Medical Assistance for Case Management

Client Data Elements

Maintenance of Effort Bulletin

Planning Data

Prevalence Estimates Statewide and by County

Informational Bulletin #87-53G including county specific utilization data for MA/GAMC, Rule 36 and Regional Treatment Centers

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES
NOVEMBER 24, 1987

Your thoughts and feelings about where and how you live are important to us as we think about community programs to assist persons with mental illness. You can help us by answering each of these questions and returning the answers to us. If you do not understand a question, ask for help. Thank you for your assistance.

1. AT THIS TIME I LIVE....(PLEASE CHECK ONLY ONE ANSWER)*

N	%	
32	16	ON MY OWN
22	11	WITH FRIENDS
10	5	WITH MY FAMILY OR RELATIVES
112	55	WITH A FOSTER FAMILY
14	7	IN AN APARTMENT WITH SUPPORT SERVICES
9	4	IN A RESIDENTIAL TREATMENT FACILITY (RULE 36/GROUP HOME/HALF-WAY HOUSE)
6	3	IN A BOARDING HOUSE WITH MEALS PROVIDED
		IN A BOARDING HOUSE WITH SERVICES
		OTHER: (WHERE?)_____

2. THE BUILDING THAT I LIVE IN IS...(PLEASE CHECK ONLY ONE)*

N	%	
31	13	A SINGLE FAMILY HOUSE
17	7	A DUPLEX FOR TWO FAMILIES
15	6	AN APARTMENT WITH FEWER THAN EIGHT (8) UNITS
31	13	AN APARTMENT WITH EIGHT (8) OR MORE UNITS
136	55	A GROUP FACILITY
8	3	A NURSING HOME
		A SHELTER
		I DON'T HAVE ANY PLACE TO LIVE
9	4	OTHER: _____

* Total percentages not equal to 100 due to rounding.

3. IN THINKING ABOUT WHERE YOU LIVE NOW, ARE YOU SATISFIED WITH..... (PLEASE CHECK 'YES' OR 'NO') FOR EACH QUESTION

%	YES	NO
THE AMOUNT OF PRIVACY THAT YOU HAVE?	69	31
THE NEIGHBORHOOD?	82	18
THE TYPE OF BUILDING YOU LIVE IN?	85	15
THE PEOPLE THAT YOU LIVE WITH?	73	27
THE SUPPORT SERVICES THAT ARE AVAILABLE IN YOUR HOME?	79	21
THE SUPPORT SERVICES IN YOUR TOWN?	80	20
THE AMOUNT OF LIVING SPACE YOU HAVE TO YOURSELF?	73	27
YOUR COST OF LIVING?	61	39
YOUR ACCESS TO PUBLIC TRANSPORTATION?	75	25

5. WHAT DO YOU LIKE MOST ABOUT WHERE YOU LIVE?

6. WHAT DO YOU LIKE LEAST ABOUT WHERE YOU LIVE?

7. IN THINKING ABOUT YOUR OVERALL QUALITY OF LIFE RIGHT NOW, I.... (CHECK TRUE) IF YOU AGREE AND 'NOT TRUE' IF YOU DISAGREE WITH EACH COMMENT.

%	TRUE	NOT TRUE
FEEL SAFE AND SECURE	83	17
HAVE ENOUGH WARM CLOTHES TO WEAR	89	11
HAVE ENOUGH FOOD TO EAT EACH DAY	90	10
HAVE PERSONAL CONTROL OVER MY LIFE	69	31
HAVE A GOOD RELATIONSHIP WITH MY FAMILY	77	23
HAVE AT LEAST ONE FRIEND THAT I CAN TRUST	80	20
FEEL GOOD ABOUT MYSELF	71	29
HAVE CHANCE TO DO THINGS FOR FUN	84	16
HAVE A JOB I LIKE	44	56
HAVE A CHURCH WHERE I FEEL WELCOME	54	46
FEEL THAT I AM NEEDED BY OTHERS	70	30
HAVE ENOUGH MEDICAL SUPPORT AVAILABLE	89	11
HAVE MENTAL HEALTH SUPPORT AVAILABLE	88	12
FEEL THAT MY LIFE IS WORTHWHILE	78	22
HAVE A SOCIAL WORKER WHO HELPS ME	75	25
HAVE MEDICATIONS THAT HELP ME	89	11
GET ALONG OK WITH MY NEIGHBORS	91	9

8. HOW MUCH MONEY DO YOU HAVE LEFT AFTER PAYING FOR HOUSING?*

N	%	
110	47	LESS THAN $50
41	17	$50 TO $100
47	20	OVER $100
35	15	I DON'T PAY FOR HOUSING

9. HOW DO YOU GET MONEY TO PAY FOR YOUR HOUSING EACH MONTH?*

N	%	
29	12	I EARN THE MONEY TO PAY FOR MY RENT AT MY JOB
182	74	I GET AID FROM THE GOVERNMENT
1	<1	MY FAMILY GIVES ME MONEY FOR RENT
9	4	I DO NOT PAY TO LIVE WHERE I LIVE NOW
2	1	I HAVE NO MONEY
23	9	OTHER? _____

10. IF YOU WERE HOSPITALIZED, HOW LIKELY IS IT THAT YOU WOULD NEED ADDITIONAL FINANCIAL ASSISTANCE TO PAY FOR YOUR RENT WHILE YOU WERE IN THE HOSPITAL?

N	%	
84	35	VERY LIKELY
40	17	SOMEWHAT LIKELY
115	48	NOT LIKELY

11. IN THINKING ABOUT THE PAST MONTH, PLEASE LOOK AT THE FOLLOWING LIST OF SERVICES AND CHECK WHETHER YOU HAVE USED EACH SERVICE. (PLEASE CHECK 'YES' OR 'NO' FOR EACH STATEMENT).

IN THE LAST MONTH, I.....(CHECK YES OR NO FOR EACH STATEMENT)

	% YES	NO
MET WITH A PSYCHIATRIST	69	31
MET WITH A PSYCHOLOGIST	33	67
MET WITH A SOCIAL WORKER OR CASEWORKER	64	36
MET WITH A MEDICAL DOCTOR	56	44
MET WITH A DENTIST	30	70
MET WITH A COURT SERVICES OR LAW OFFICIAL	13	87
MET WITH A MINISTER OR SPIRITUAL ADVISOR	27	73

IN THE LAST MONTH, I.....(CHECK YES OR NO FOR EACH STATEMENT)

	% YES	NO
RECEIVED HELP MANAGING MY MEDICATIONS	62	38
RECEIVED HELP COOKING, SHOPPING, OR BUDGETING	50	50
RECEIVED HELP FINDING A PLACE TO LIVE	21	79
RECEIVED HELP FINDING A JOB OR VOLUNTEER WORK	26	74
RECEIVED HELP IN A CRISIS SITUATION	35	65
PARTICIPATED IN SOCIAL OR FUN ACTIVITIES	79	21
RECEIVED HELP APPLYING FOR GOVERNMENT BENEFITS	30	70

IN THE LAST MONTH I.....(CHECK YES OR NO FOR EACH STATEMENT)

	% YES	NO
WAS HOSPITALIZED FOR PHYSICIAL/MEDICAL ILLNESS	12	88
WAS HOSPITALIZED FOR MENTAL ILLNESS REASONS	10	90
USED OUTPATIENT DAY TREATMENT MENTAL HEALTH THERAPY SERVICES	46	54
LIVED IN A RESIDENTIAL TREATMENT FACILITY (RULE 36/GROUP HOME/HALFWAY HOUSE)	54	46
OBTAINED FINANCIAL ASSISTANCE FROM THE GOVERNMENT	77	23
RECEIVED OTHER TYPES OF FINANCIAL ASSISTANCE	36	64

12. WHAT DO YOU THINK IS THE BEST LIVING SITUATION FOR YOU NOW? (PLEASE CHECK ONLY ONE ANSWER)

N	%	
23	10	ON MY OWN (WITH NO SUPPORT SERVICES AVAILABLE)
30	13	ON MY OWN (WITH SUPPORT SERVICES IN MY HOME)
37	15	ON MY OWN (WITH SUPPORT SERVICES AVAILABLE OUTSIDE MY HOME)
13	5	LIVING WITH FRIENDS
27	11	WITH MY FAMILY OR RELATIVES
4	2	WITH A FOSTER FAMILY
		IN A SMALL GROUP (WITH NO SUPPORT SERVICES AVAILABLE)
10	4	IN A SMALL GROUP (WITH SUPPORT SERVICES AVAILABLE)
4	2	IN A SMALL GROUP SETTING (WITH TREATMENT SERVICES--STAFF LEAVE AT NIGHT)
49	20	IN A RESIDENTIAL TREATMENT FACILITY (RULE 36)
13	5	IN A BOARDING HOUSE WITH MEALS
14	6	IN BOARDING HOUSE WITH STAFF AVAILABLE 24 HOURS PER DAY
16	7	OTHER: (DESCRIBE)_____

13. IN THINKING ABOUT YOUR ANSWER TO THE LAST QUESTION, WHY WOULD YOU CHOOSE THAT TYPE OF LIVING SITUATION? (PLEASE CHECK THE TWO MOST IMPORTANT REASONS)*

I WOULD CHOOSE THAT TYPE OF LIVING ARRANGEMENT BECAUSE.....

N	%	
65	18	I WOULD BE ABLE TO SUPPORT MYSELF
112	31	I WOULD HAVE THE MOST FREEDOM TO DO WHAT I PLEASE
90	25	I WOULD HAVE THE HELP I NEED
13	4	I WOULD BE ABLE TO LIVE WITH MY FRIENDS
38	11	I WOULD BE ABLE TO LIVE WITH MY FAMILY
12	3	I WOULD BE ABLE TO LIVE NEAR MY FAMILY
8	2	FINANCIAL REASONS
21	6	OTHER: (WHAT?) _____

14. WHY AREN'T YOU LIVING WHERE YOU WANT TO BE? (PLEASE SELECT ONE MOST IMPORTANT REASON).

I AM NOT LIVING THERE BECAUSE.....

N	%	
19	8	THIS CHOICE IS NOT AVAILABLE NEARBY
34	15	I DO NOT HAVE ENOUGH MONEY TO LIVE THERE
20	9	THERE IS A WAITING LIST OF PEOPLE AHEAD OF ME
5	2	THERE ARE NOT SUPPORT SERVICES AVAILABLE
29	13	MY ILLNESS PREVENTS ME FROM LIVING THERE
5	2	I WAS TURNED DOWN
1	<1	NO PUBLIC TRANSPORTATION IS AVIALABLE THERE
14	6	OTHER? _____
105	45	I AM LIVING WHERE I WANT TO BE

15. IF YOU WERE LIVING WHERE YOU WANT TO BE, IN WHICH AREAS WOULD YOU WANT HELP? (PLEASE CHECK 'YES' OR 'NO' AND IF YOU WOULD PREFER THE HELP BE IN YOUR HOME)

I WOULD WANT HELP.....

	% YES	NO	IN MY HOME?
WITH MY MEDICATION	37	46	17
IF I GET IN A CRISIS SITUATION	57	21	21
FROM A MEDICAL DOCTOR	52	33	15
FROM A CASE WORKER	48	34	18
WITH MY MENTAL ILLNESS	58	25	16
WITH LEGAL QUESTIONS	49	38	13
WITH FINDING A JOB	46	40	14
FINDING PUBLIC TRANSPORTATION	38	50	11
MANAGING MY MONEY	40	49	11
FOOD SERVICE	38	50	13
COOKING, SHOPPING, CLEANING	32	55	13
FINDING CLASSES TO TAKE	35	57	8
STAFF TO TALK TO AT NIGHT	37	50	13
CHILD CARE SERVICES	21	76	3
OTHER: (WHAT?)_____	21	64	15

16. HOW LONG HAVE YOU LIVED WHERE YOU LIVE NOW?*

N	%	
60	25	LESS THAN SIX (6) MONTHS
40	17	SIX (6) MONTHS TO A YEAR
44	18	ONE TO TWO YEARS
94	39	OVER TWO YEARS

17. HOW MANY PLACES HAVE YOU LIVED IN THE LAST TWO YEARS? (DO NOT COUNT "HOSPITAL" OR REGIONAL TREATMENT CENTER AS A PLACE)

N	%	
119	51	ONE
65	28	TWO
27	12	THREE
10	4	FOUR
5	2	FIVE
8	3	MORE THAN FIVE

18. IN THINKING AHEAD TO YOUR FUTURE, HOW LONG DO YOU PLAN TO LIVE IN YOUR CURRENT LIVING SITUATION? (PLEASE CHECK ONE ANSWER)

I PLAN TO CONTINUE LIVING WHERE I LIVE NOW.....

N	%	
75	31	LESS THAN ONE YEAR
28	12	ONE TO TWO YEARS
19	8	THREE TO FIVE YEARS
52	21	PERMANENTLY (OVER 5 YEARS)
61	25	I DON'T KNOW
7	3	OTHER _____

19. IF YOU COULD NOT STAY WHERE YOU ARE, WHERE WOULD YOU GO?*

N	%	
28	12	TO RESIDENTIAL TREATMENT FACILITY
14	6	TO THE HOSPITAL
9	4	TO A SHELTER
42	18	TO MY FAMILY
11	5	TO FRIENDS HOUSE
92	39	I DON'T KNOW
14	6	TO ANOTHER CITY OR STATE
28	12	OTHER _____

20. DO YOU FEEL LIKE YOU WILL HAVE TO MOVE SOON?

N	%	
57	24	YES
180	76	NO

21. DO YOU WORRY ABOUT WHERE YOU ARE GOING TO LIVE NEXT?

N	%	
81	34	YES
158	66	NO

22. IF YOU WERE HOSPITALIZED, HOW LIKELY IS IT THAT YOU WOULD BE ABLE TO COME BACK TO WHERE YOU ARE NOW LIVING?*

N	%	
109	45	VERY LIKELY
56	23	LIKELY
30	12	NOT LIKELY
46	19	DON'T KNOW

23. THE LAST TIME YOU HAD TO MOVE, DID THE STRESS CONNECTED WITH MOVING CAUSE YOU TO.....

N	%	
32	14	GET SICK
16	7	GET HOSPITALIZED
15	6	GO HOME TO YOUR FAMILY
6	3	QUIT TAKING MEDICATIONS
5	2	END UP ON THE STREETS
124	54	MANAGE OK
33	14	OTHER _____

24. IN THINKING BACK OVER THE PAST YEAR, HOW HARD WAS IT TO GET THESE SERVICES? (PLEASE CHECK THE BEST ANSWER FOR EACH SERVICES).*

%	NOT HARD	SOMEWHAT HARD	VERY HARD	I DIDN'T WANT THIS
HELP WITH MY MEDICATION	79	8	3	9
HELP IN A CRISIS SITUATION	65	13	8	14
HELP FROM A MEDICAL DOCTOR	73	12	6	9
HELP FROM A CASE WORKER	73	14	6	7
HELP WITH MY MENTAL ILLNESS	68	12	7	13
HELP WITH LEGAL QUESTIONS	49	12	9	29
HELP WITH FINDING A JOB	40	13	16	31
HELP FINDING PUBLIC TRANSPORTATION	60	13	8	20
HELP MANAGING MY MONEY	57	15	4	24
HELP WITH FOOD SERVICES	64	10	5	21
HELP WITH COOKING, SHOPPING, CLEANING	58	9	8	26
HELP FINDING CLASSES TO TAKE	38	12	7	43
STAFF TO TALK TO AT NIGHT	51	10	8	31
CHILD CARE SERVICES	28	5	3	63
SUPERVISED HOUSING	48	8	3	41
HOUSING WITH STAFF	47	6	5	42
OTHER: (WHAT?) _____	36	16	7	42

25. WHAT TYPES OF PROBLEMS HAVE YOU HAD GETTING THESE SERVICES? (PLEASE CHECK ALL THAT APPLY).

YES	NO	
23	77	THE SERVICE WAS NOT AVAILABLE NEARBY
30	70	I COULD NOT GET IN RIGHT AWAY WHEN I NEEDED TO
27	73	I COULD NOT AFFORD TO PAY FOR THE SERVICE
22	78	THE SERVICE WAS THERE, BUT IT DID NOT MEET MY NEEDS
16	84	I WAS NOT ACCEPTED
28	72	OTHER: (WHAT?) _____

26. IF YOU COULD GET THE HOUSING AND SERVICES YOU NEED, IN WHAT PART OF THE STATE WOULD YOU LIKE TO LIVE? (PLEASE CHECK ONE ANSWER)*

I WOULD LIKE TO LIVE....

N	%	
68	29	IN MINNEAPOLIS OR ST. PAUL
23	10	IN A SUBURB OF MINNEAPOLIS OR ST. PAUL
12	5	IN DULUTH
17	7	IN A LARGER CITY LIKE ST. CLOUD, ROCHESTER OR MANKATO
84	36	IN A SMALLER TOWN OR RURAL AREA
29	12	OTHER _____

27. WOULD YOU PREFER TO LIVE.....(PLEASE CHECK ONE ANSWER)*

N	%	
83	35	ALONE
46	19	WITH YOUR FAMILY
6	3	WITH ANOTHER FAMILY
41	17	WITH ONE OTHER ADULT (FRIEND)
31	13	WITH A GROUP OF ADULTS (FRIENDS)
17	7	IT DOESN'T MATTER
12	5	OTHER _____

28. WHAT AGE OF PERSONS WOULD YOU PREFER TO LIVE WITH? (PLEASE CHECK ONE ANSWER).*

N	%	
116	52	YOUR OWN AGE
35	16	OLDER
13	6	YOUNGER
61	27	DOESN'T MATTER

29. WOULD YOU RATHER LIVE.....

N	%	
77	34	WHO NEED THE SAME LEVEL OF SERVICE AS I DO
8	4	WHO ARE IN NEED OF MORE SERVICES
23	10	WHO ARE IN NEED OF LESS SERVICES
50	22	WHO ARE NOT IN NEED OF SERVICES AT ALL
67	30	DOESN'T MATTER

30. HOW LONG HAVE YOU RECEIVED MENTAL HEALTH SERVICES?

N	%	
24	11	LESS THAN A YEAR
34	15	ONE TO TWO YEARS
37	16	TWO TO FIVE YEARS
32	14	FIVE TO TEN YEARS
100	44	OVER TEN YEARS

31. HOW ARE YOU FEELING RIGHT NOW IN YOUR LIFE?

N	%	
104	44	GOOD
82	35	OK
48	21	NOT SO HOT

32. ALL THINGS CONSIDERED, HOW SATISFIED ARE YOU WITH YOUR CURRENT LIVING SITUATION? (PLEASE CHECK ONE)

N	%	
66	28	VERY SATISFIED
75	32	SATISFIED
58	25	SOMEWHAT SATISFIED
36	15	NOT SATISFIED

THE MAIN REASON FOR YOUR LAST ANSWER IS:

IDENTIFICATION INFORMATION:

THE NEXT SECTION ASKS GENERAL BACKGROUND INFORMATION THAT WOULD BE HELPFUL TO US AS WE THINK ABOUT HOUSING AND RESIDENTIAL SERVICES. WE APPRECIATE YOUR TAKING THE TIME TO COMPLETE EACH ANSWER.

AGE

N	%	
29	12	18-24
137	58	25-44
58	25	45-64
11	5	65+

SEX

N	%	
120	51	MALE
116	49	FEMALE

	N	%
MARRIED	24	10
SINGLE	159	68
DIVORCED OR SEPARATED	51	22

ANY CHILDREN?

	N	%
YES	79	34
NO	154	66

AGE(S) _____

RESIDENCE: (WRITE IN)

CITY _____
COUNTY _____

EMPLOYMENT: (CHECK ALL THAT APPLY)

	N
COMPETITIVE	15
FULL-TIME	24
PART-TIME	51
VOLUNTEER	26
NOT WORKING	137

HOW LONG AT CURRENT JOB? (CHECK ONE)

N	%	
57	47	LESS THAN 6 MONTHS
24	20	6 MONTHS TO ONE YEAR
41	34	OVER ONE YEAR

HOURS PER WEEK WORKED? (CHECK ONE)

N	%	
59	44	LESS THAN 10 HOURS PER WEEK
36	27	TEN TO TWENTY HOURS PER WEEK
40	30	OVER 20 HOURS PER WEEK

INCOME:

N	%	
92	54	LESS THAN $200 PER MONTH
44	26	$200 TO $500 PER MONTH
33	20	MORE THAN $500 PER MONTH

LAST HOSPITALIZATION:

MONTH_____
YEAR_____
NONE _____

	1987	1986	1985	1984	1983	Before 1983
N	66	41	35	7	10	46
%	32	20	17	3	5	22

FAMILY IN AREA:

	N	%
YES	158	70
NO	69	30

IF YES, WHEN DID YOU LAST SEE THEM? MONTH_____ YEAR_____

	3 mos	3-6	6-9	9-12	>12 mos
N	149	10	4		11
%	86	6	2		6

SELF ASSESSMENT: EXPLAIN IN YOUR OWN WORDS WHAT YOUR PROBLEM IS.

ANY OTHER MEDICAL PROBLEMS?

CATCHMENT

	N	%
1	36	17
2-3	28	13
4	37	17
5	38	18
6	77	36

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES
NOVEMBER 24, 1987

Your experience and perspective is important as we consider development of an array of housing options for persons with severe and persistent mental illness. You can help us by answering each of the following questions and returning the survey to us. Thank you for your time and assistance.

Please check the most appropriate identification category.

N	%	
41	21	FAMILY MEMBER
80	40	MENTAL HEALTH PROVIDER
49	25	SOCIAL SERVICE PROVIDER
18	9	HOUSING/FINANCE
11	6	OTHER _____

CITY _____

COUNTY _____

CATCHMENT

1	28	15
2-3	32	17
4	24	13
5	55	29
6	53	28

1. PLEASE INDICATE WHETHER THE FOLLOWING HOUSING AND COMMUNITY SERVICE OPTIONS CURRENTLY FOUND IN YOUR COMMUNITY FOR PERSONS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS MEET THESE CRITERIA.

   AVAILABLE: THE QUANTITY AT HAND IS SUFFICIENT TO MEET DEMAND

   AFFORDABLE: PRICING IS WITHIN THE FINANCIAL MEANS OF THE MENTALLY ILL POPULATION

   ACCESSIBLE: EASY FOR PEOPLE TO OBTAIN

   ADEQUATE: SATISFY THE NEEDS OF THE MENTALLY ILL POPULATION

FOR EACH OPTION, PLACE AN 'X' IN THE APPROPRIATE COLUMN IF IT MEETS THE CRITERIA, AND LEAVE THE COLUMN BLANK IF IT DOES NOT MEET THE CRITERIA.

N=	AVAILABLE	AFFORDABLE	ACCESSIBLE	ADEQUATE
HOUSING OPTIONS				
SINGLE ROOM OCCUPANCY/ EFFICIENCY APARTMENTS (UNSUPERVISED)	83	58	53	44
SINGLE ROOM OCCUPANCY/ EFFICIENCY APARTMENTS (SUPERVISED)	20	23	16	20
ONE-BEDROOM APARTMENTS (UNSUPERVISED)	108	55	68	59
ONE-BEDROOM APARTMENTS (SUPERVISED)	19	17	12	22
TWO-BEDROOM APARTMENTS (UNSUPERVISED)	99	41	56	52
TWO-BEDROOM APARTMENTS (SUPERVISED)	18	15	12	19
SINGLE FAMILY DWELLINGS/ DUPLEX/TOWNHOUSE (UNSUPERVISED)	87	24	39	43
SINGLE FAMILY DWELLINGS/ DUPLEX/TOWNHOUSE (SUPERVISED)	10	4	8	8
MULTIPLE FAMILY DWELLINGS/ DUPLEX/TOWNHOUSE (UNSUPERVISED)	67	22	31	30
MULTIPLE FAMILY DWELLINGS/ DUPLEX/TOWNHOUSE (SUPERVISED)	11	4	6	4
ADULT FOSTER CARE	47	57	29	32
BOARDING CARE HOME	40	42	31	24
BOARD AND LODGING (UNSUPERVISED)	44	39	38	23
BOARD AND LODGING (SUPERVISED)	58	53	48	36
RESIDENTIAL TREATMENT FACILITIES (RULE 36/GROUP HOME/HALFWAY HOUSE)	94	97	92	91
NURSING HOME	93	50	56	53

SUPPORT SERVICE OPTIONS N=	AVAILABLE		AFFORDABLE		ACCESSIBLE		ADEQUATE	
	YES	NO	YES	NO	YES	NO	YES	NO
EDUCATION AND PREVENTION SERVICES*	126	56	119	33	102	53	61	91
EMERGENCY SERVICES--24 HOUR COVERAGE	147	39	133	25	122	41	95	63
OUTPATIENT MENTAL HEALTH SERVICES	158	27	135	28	136	38	99	64
RESIDENTIAL TREATMENT SERVICES	113	52	100	40	106	43	85	61
ACUTE-CARE HOSPITAL INPATIENT TREATMENT SERVICES	123	53	68	69	98	53	86	61
COMMUNITY SUPPORT SERVICES								
CLIENT OUTREACH	115	57	109	31	86	58	63	79
MEDICATION MANAGEMENT	122	50	109	35	98	52	71	71
ASSISTANCE IN DAILY LIVING SKILLS	122	54	112	37	92	61	70	80
DEVELOPMENT OF EMPLOYABILITY AND SUPPORTIVE WORK OPPORTUNITIES	104	71	101	44	79	71	45	103
PSYCHO-SOCIAL REHABILITATION	103	60	95	42	79	64	57	87
HELP IN APPLYING FOR GOVERNMENT BENEFITS	135	37	129	16	107	47	92	61
DEVELOPMENT, IDENTIFICATION, AND MONITORING OF LIVING ARRANGEMENTS	79	87	82	52	65	76	48	94
DAY TREATMENT SERVICES	126	48	111	40	101	53	79	75

* (definition: educate general public about mental illness, increase understanding and acceptance of problems associated with mental illness, increase awareness, an availability of resources, and increase people's ability to deal with situations known to affect mental health)

2. WHAT ADDITIONAL HOUSING OPTIONS ARE NEEDED FOR PERSONS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS IN YOUR COMMUNITY? (PLEASE CHECK ALL THAT APPLY)

N=

79	SINGLE ROOM OCCUPANCY/EFFICIENCY APARTMENTS (UNSUPERVISED)
142	SINGLE ROOM OCCUPANCY/EFFICIENCY APARTMENTS (SUPERVISED)
73	ONE-BEDROOM APARTMENTS (UNSUPERVISED)
153	ONE-BEDROOM APARTMENTS (SUPERVISED)
50	TWO-BEDROOM APARTMENTS (UNSUPERVISED)
110	TWO BEDROOM APARTMENTS (SUPERVISED)
105	SINGLE FAMILY DWELLINGS FOR MULTIPLE UNRELATED ADULTS (SUPERVISED)
37	MULTIPLE FAMILY DWELLINGS/DUPLEX/TOWNHOUSE (UNSUPERVISED)
82	MULTIPLE FAMILY DWELLINGS/DUPLEX/TOWNHOUSE (SUPERVISED)
129	ADULT FOSTER CARE
55	BOARDING CARE
48	BOARD AND LODGING (UNSUPERVISED)
105	BOARD AND LODGING (SUPERVISED)
81	RESIDENTIAL TREATMENT FACILITIES (RULE 36/GROUP HOME/HALFWAY HOUSE)
118	LONG-TERM RESIDENTIAL FACILITIES (NO TIME LIMIT)
27	NURSING HOME
12	OTHER _____

3. WHICH OF THE FOLLOWING ARE THE THREE MOST APPROPRIATE TYPES OF OWNERSHIP OPTIONS IN PROVIDING RESIDENTIAL HOUSING FOR THE MENTALLY ILL? (PLEASE RANK ONE THROUGH THREE)

1st	2nd	3rd	
33	16	25	HUMAN SERVICE AGENCY OWNED
13	41	31	HOUSING COOPERATIVES
18	9	12	CLIENT OWNED
16	14	20	STATE OWNED
38	30	16	PRIVATE INVESTOR OWNED
32	35	29	INVESTOR/AGENCY PARTNERSHIPS
1	0	0	OTHER _____

COMMENTS:

4. WHAT ADDITIONAL SERVICE OPTIONS ARE NEEDED TO ENABLE PERSONS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS TO LIVE IN THE LEAST RESTRICTIVE SETTING IN YOUR COMMUNITY? (PLEASE CHECK ALL THAT APPLY).

N=

109	EDUCATIONAL AND PREVENTION SERVICES
105	EMERGENCY SERVICES--24 HOUR COVERAGE
149	HOUSING THAT ALLOWS PEOPLE TO RETURN FROM LONGER-TERM HOSPITALIZATIONS
84	OUTPATIENT MENTAL HEALTH SERVICES
82	RESIDENTIAL TREATMENT SERVICES
72	ACUTE-CARE HOSPITAL INPATIENT TREATMENT SERVICES
104	COMMUNITY SUPPORT SERVICES
107	CLIENT OUTREACH
117	MEDICATION MANAGEMENT
132	ASSISTANCE IN DAILY LIVING SKILLS
146	DEVELOPMENT OF EMPLOYABILITY AND SUPPORTIVE WORK OPPORTUNITIES
113	PSYCHO-SOCIAL REHABILITATION
90	HELP IN APPLYING FOR GOVERNMENT BENEFITS
137	DEVELOPMENT, IDENTIFICATION, AND MONITORING OF LIVING ARRANGEMENTS
90	DAY TREATMENT SERVICES
25	OTHER:_____

5. ON A SCALE OF ONE TO FIVE, HOW SIGNIFICANT ARE THE BARRIERS POSED BY EACH OF THE FOLLOWING ITEMS ON THE DEVELOPMENT OF HOUSING ALTERNATIVES FOR THE SERIOUS AND PERSISTENTLY MENTALLY ILL?

%	NOT SIGNIFICANT 1	2	3	4	VERY SIGNIFICANT 5
LACK OF DOLLARS ALLOCATED TO NEW CONSTRUCTION	8	11	19	20	42
LACK OF DOLLARS ALLOCATED TO MAINTAINING EXISTING PROPERTIES	7	14	28	26	25
LACK OF INCENTIVES (TAX & OTHER) FOR DEVELOPER AND OWNERS	4	6	23	30	38
LACK OF INCENTIVES FOR LANDLORDS TO RENT TO MENTALLY ILL	3	5	15	31	46
LACK OF GUARANTEED LEASE PAYMENTS TO SUBSIDIZE MENTALLY ILL PERSONS WHEN THEY ARE HOSPITALIZED	4	5	13	33	44
LACK OF COORDINATION BETWEEN FUNDING SOURCES	6	7	30	26	32
NEIGHBORHOOD RESISTANCE TO MENTALLY ILL PERSONS MOVING INTO THE AREA	4	12	24	21	39
LACK OF COORDINATION BETWEEN SERVICE ORGANIZATIONS	11	19	31	22	18
STIGMA ASSOCIATED WITH MENTAL ILLNESS	1	6	24	25	45
ZONING ORDINANCES WHICH PROHIBIT MULTIPLE UNRELATED ADULTS FROM SHARING A SINGLE FAMILY HOUSE	11	24	28	16	21
COMPLEXITY OF MEETING REGULATIONS GOVERNMENT AGENCY	3	11	27	28	30
OTHER:			6	13	81

COMMENTS:

6. WHAT DO YOU THINK ARE THE THREE TOP PRIORITIES FOR THE STATE OF MINNESOTA IN THE DEVELOPMENT OF LEAST RESTRICTIVE HOUSING ALTERNATIVES FOR PERSONS WITH SERIOUS AND PERSISTENT MEDICAL ILLNESS? (RANK 1, 2, 3)

1.
2.
3.

7. WHAT DO YOU THINK ARE THE THREE TOP PRIORITIES FOR THE STATE OF MINNESOTA IN THE DEVELOPMENT OF RESIDENTIAL TREATMENT ALTERNATIVES FOR PERSONS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS? (RANK 1, 2, 3)

1.
2.
3.

ONLY RULE 36 PROVIDERS RESPOND TO QUESTIONS 8-14

8. IN GENERAL, IS THE LENGTH OF STAY FOR CLIENTS IN YOUR RESIDENTIAL FACILITY....

N	%	
9	17	TOO LONG
11	21	TOO SHORT
32	62	JUST RIGHT

9. LOOKING BACK OVER THE PAST YEAR, WHAT PORTION OF CLIENTS STAYED LONGER THAN NECESSARY IN YOUR RESIDENTIAL TREATMENT FACILITY?

N	%	
48	92	LESS THAN 1/4
3	6	1/4 TO 1/2
1	2	GREATER THAN 1/2

10. WHAT WAS THE REASON(S) THAT CLIENTS STAYED LONGER THAN NECESSARY? (CHECK ALL THAT APPLY).

N=

30	NO OTHER RESIDENTIAL PLACE TO GO
24	CLIENT DID NOT WANT TO LEAVE
15	CLIENT COULD NOT AFFORD OTHER HOUSING
24	NO SUPPORT SERVICES AVAILABLE
7	OTHER: _____

11. LOOKING BACK OVER THE PAST YEAR, WHAT PORTION OF CLIENTS DIDN'T STAY LONG ENOUGH?

N	%	
31	58	LESS AND 1/4
18	34	1/4 TO 1/2
4	8	GREATER THAN 1/2

12. WHAT WAS THE REASON(S) THAT CLIENTS DIDN'T STAY LONG ENOUGH?

N	%	
45	87	LEFT AGAINST STAFF ADVICE
4	8	FUNDING RAN OUT
		PRESSURED BY OTHERS WAITING TO GET IN
3	6	OTHER

13. WHAT PERCENT OF YOUR CLIENTS GO TO EACH OF THE FOLLOWING AFTER LEAVING YOUR RESIDENTIAL TREATMENT FACILITY? (TOTAL SHOULD EQUAL 100)

AVERAGE WEIGHTED VALUE

3.4	SINGLE ROOM OCCUPANCY UNIT
10.5	ONE-BEDROOM APARTMENT
3.3	TWO-BEDROOM APARTMENT
3	SINGLE FAMILY DWELLING (HOUSE)
1.9	MULTIPLE FAMILY DWELLING (DUPLEX, TOWNHOUSE)
4.8	BOARD AND LODGING
2.8	DON'T KNOW
8.8	HOSPITAL
7.1	OTHER RESIDENTIAL TREATMENT
	OTHER: _____

14. WHAT PERCENT OF THOSE PERSONS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS LIVING IN RESIDENTIAL FACILITIES WOULD BE CAPABLE OF LIVING IN A LESS RESTRICTIVE SETTING IF APPROPRIATE SUPPORT SERVICES WERE AVAILABLE IN THE COMMUNITY.

N	%	
27	51	0 TO 25%
17	32	26 TO 50%
7	13	51 TO 75%
2	4	75 TO 100%

ONLY EMERGENCY SHELTER/ADULT PROTECTION WORKERS RESPOND TO QUESTIONS 15-17

15. IN YOUR OPINION, ARE THE CLIENTS WHO USE YOUR FACILITIES THERE BECAUSE....

4	THEY COULD NOT GET TREATMENT
7	THEY DID NOT WANT TREATMENT
3	OTHER

16. WHAT TYPE OF SERVICES ARE NEEDED FOR SERIOUS AND PERSISTENTLY MENTALLY ILL CLIENTS WITHIN YOUR FACILITY?

17. OUTSIDE YOUR FACILITY?

ONLY FAMILY MEMBERS RESPOND TO QUESTIONS 18, 19 AND 20

18. WHAT HOUSING OPTIONS(S) WOULD YOU PREFER FOR YOUR MENTALLY ILL RELATIVE?

19. WHAT PROBLEMS HAVE YOU EXPERIENCED IN TRYING TO OBTAIN HOUSING FOR YOUR RELATIVE?

20. WHAT PROBLEMS HAVE YOU EXPERIENCED IN TRYING TO OBTAIN SUPPORT SERVICES FOR YOUR RELATIVE?

STATE OF MINNESOTA
ACTION PLANS

The following action plans are designed as general guidelines for the implementation of the recommendations contained in the Report on Housing and Residential Support Service Needs for Persons with Serious and Persistent Mental Illness in the State of Minnesota. This report details the results of surveying mental health, social service, housing, finance, family members and clients currently in the system. Through the survey process, the general indication was that the current mental health system is meeting some of the needs of persons with mental illness; there is a fairly high client satisfaction level in the system, and clients' basic needs of food, clothing, medical care and shelter are being met. Although basic needs are often met for those who are part of the system, choices are not abundant. Additional units of all types of housing, particularly affordable, independent, semi-dependent and supported living situations, need to be made available.

MOST IMPORTANTLY, CONFIGURATIONS IN HOUSING AND SERVICE OPTIONS SHOULD BE VIEWED AS DYNAMIC, CLIENT CENTERED, AND FLEXIBLE. THIS MEANS THAT THE INDIVIDUAL NEEDS DICTATE THE LEVELS OF FUNDING BY THE NEED FOR HOUSING AND SUPPORT SERVICES.

SECONDLY, SUPPORT SERVICES AND HOUSING OPTIONS ARE TO BE RELATED, BUT NOT MUTUALLY DEPENDENT. THIS MEANS THAT A PERSON IS NOT REQUIRED TO CHANGE HOUSING AS FUNCTIONAL NEEDS CHANGE. IN SOME CASES, HOWEVER, CONSUMERS MIGHT CHANGE HOUSING AS SERVICE OPTION NEEDS CHANGE.

FINALLY, TO ADEQUATELY ASSESS NEEDS IN A TIMELY FASHION, PLANNING FOR HOUSING AND SUPPORT SERVICES ORIGINATES AT THE LOCAL LEVEL. THROUGH STANDARDIZED PLANNING APPLICATIONS, APPROPRIATIONS CAN SUBSEQUENTLY BE DETERMINED BY COUNTY AT THE STATE LEVEL.

Each action plan contains an objective, steps and positions responsible for carrying out that action plan. Because of the importance of obtaining sanction from the Governor's office and/or Legislature to proceed with these action plans and the steps involved, a separate plan has been included specifically for that purpose. In all cases, ongoing communication with appropriate government resources is essential. For further detail regarding the reasoning or construction of these action steps, the original report should be consulted.

STATE OF MINNESOTA ACTION PLANS

SUBJECT: Commitment and Authority of Governor's Office/Legislature

OBJECTIVES:

Establish the authority and commitment of the state government in responding to the need for additional housing and residential support services for the persons with severe and persistent mental illness.

ACTION STEPS:

1. Develop support for the action plans throughout the legislature and the Governor's office, building from the support gained through the 1987 legislative session.

2. Gain the authority of the state to continue to proceed in the implementation of the plan to provide for housing and residential support services for the severe and persistent mentally ill.

3. Assign a Housing Task Force responsible to the Department of Human Services Mental Health Division. One member of the task force should be a representative of the Mental Health State Advisory Council. The charge of this Task Force would be to address each of the action plans, and present specific recommendations to the state.

4. Dedicate the resources to pursue the housing issue by hiring one or more full time positions to effectively implement these plans.

RESPONSIBLE:

Department of Human Services
Department of Health
Division of Mental Health
Minnesota Housing Finance authorities
HUD and Federal Housing Programs
Financial Institutions--Banks, bond brokers, savings and loans
Minnesota Tax Department
Private Foundations (i.e., McKnight, Robert Wood Johnson, etc.)
Legislators
Governor's Office
Provider Representatives
Consumers
County Designees
Property Managers
Outside Negotiators
Advocates

STATE OF MINNESOTA ACTION PLANS

SUBJECT: Dynamic Array of Housing and Support Service Options

OBJECTIVES:

Design a dynamic system which incorporates an array of housing and residential support services alternatives, and that is administered according to individual needs.

ACTION STEPS:

1. Designate positions responsible within the Department of Human Services to translate implementation action plans into a responsive, dynamic system to meet the needs identified. Outline the structure for this system to serve as a framework for local assessment.

2. Study in greater depth, the hypotheses contained in this survey report in order to identify the scope and configuration of the array of housing and support services to best meet the needs of Minnesotans with severe and persistent mental illness.

3. Further develop the role of the case managers (part of the 1987 Mental Health Act) responsible for assessing housing and support service needs for persons with severe and persistent mental illness locally within the Department of Human Services guidelines.

4. Utilize county mental health advisory councils to estimate program costs associated with development of housing and support service needs at local and state levels.

5. Develop a system of checks and balances which enables individualized housing and program planning to occur locally, and to evolve into state-wide allocation of resources to match the local planning.

6. Establish a system to monitor results, and to periodically evaluate the state-wide system capacity to meet the designated objectives.

RESPONSIBLE:

Department of Human Services
Department of Health
Division of Mental Health
Minnesota Housing Finance Authorities
HUD and Federal Housing Programs
Financial Institutions--Banks, bond brokers, savings and loans
Minnesota Tax Department
Private Foundations (i.e., McKnight, Robert Wood Johnson, etc.)
Legislators
Governor's Office
Provider Representatives
Consumers
County Designees
Property Managers
Outside Negotiators
Advocates

STATE OF MINNESOTA ACTION PLANS

SUBJECT: Need for Flexible Case Management

OBJECTIVES:

In support of the Comprehensive Mental Health Act case management system, reinforce the case management system to respond to housing and support service needs to persons with severe and persistent mental illness in the state of Minnesota.

ACTION STEPS:

1. Continue to assess the need locally for flexible case management outreach and the community support services.

2. Develop programs and budgets to meet local needs for individualized case management.

RESPONSIBLE:

Department of Human Services
Department of Health
Division of Mental Health
Private Foundations (i.e., McKnight, Robert Wood Johnson, etc.)
Provider Representatives
Consumers
Advocates
Case Managers

STATE OF MINNESOTA ACTION PLANS

SUBJECT: Low Income Housing Units

OBJECTIVES:

Assess the need for low-income housing units and develop financing strategies to enable this need to be met locally throughout the state.

ACTION STEPS:

1. Define the population of persons with severe and persistent mental illness who are potential candidates for low income housing.

2. Determine the current supply of low income housing units available.

3. Clarify qualifications for access to low income housing and rent subsidies and estimate required levels of rent subsidy for persons participating in the program.

4. Assess the desire of existing landlords to continue low income contracts after the initial expiration, and develop incentives to continue, if necessary.

5. Project the number and type of low income housing units needed, keeping in mind that other populations such as elderly, homeless, physically disabled, and immigrants compete for available low income units.

6. Determine costs/benefits associated with different financing and ownership options based on projected needs.

7. Establish a residential financial support system that considers hospitalization interruptions of lease cycles and other illness-related needs.

8. Develop incentives to encourage use of existing housing stock and development of new housing stock for low income mentally ill persons.

9. Involve housing developers, financial resources and mental health division staff in the creation of mutually beneficial financing and ownership options.

10. Create a financing implementation plan.

11. Communicate financing implementation plan to appropriate resources to generate interest and commitment to meeting the identified need.

SUBJECT: Low Income Housing Units--Continued

RESPONSIBLE:

Department of Human Services
Department of Health
Division of Mental Health
Minnesota Housing Finance Authorities
HUD and Federal Housing Programs
Financial Institutions--Banks, bond brokers, savings and loans
Minnesota Tax Department
Private Foundations (i.e., McKnight, Robert Wood Johnson, etc.)
Legislators
Governor's Office
Provider Representatives
Consumers
County Designees
Property Managers
Outside Negotiators
Advocates

STATE OF MINNESOTA ACTION PLANS

SUBJECT: Public Education Program

OBJECTIVES:

Significantly reduce public misperceptions about the nature of mental illness.

ACTION STEPS:

1. Develop a public education campaign to increase understanding about mental illness. Target schools, landlords and employers in educating about the nature and treatment of the disease.

2. Involve non-mental health related professionals in a one-to-one type of association with persons with mental illness to facilitate community integration.

3. Enforce existing and establish new anti-discriminatory rights protection for persons with mental illness within the community.

RESPONSIBLE:

Department of Human Services
Department of Health
Division of Mental Health
Minnesota Housing Finance authorities
HUD and Federal Housing Programs
Private Foundations (i.e., McKnight, Robert Wood Johnson, etc.)
Legislators
Governor's Office
Provider Representatives
Consumers
County Designees
Property Managers
Outside Negotiators
Department of Education
Vocational Rehabilitation
Advocates

STATE OF MINNESOTA ACTION PLANS

SUBJECT: Employment and Vocational Rehabilitation Opportunities

OBJECTIVES:

Create employment and supportive work opportunities or other alternatives for those persons with serious and persistent mental illness.

ACTION STEPS:

1. Develop a positive campaign program for encouraging employment opportunities for the persons with serious and persistent mental illness.

2. Develop the necessary assessment and support skills to assist persons with severe and persistent mental illness in work opportunities.

3. Research federal funding of programs for vocational opportunities for persons with severe and persistent mental illness. Support the Department of Human Services, and the Department of Rehabilitative Services joint application for employment related funding programs for those with severe and persistent mental illnes.

4. Work with sheltered workshops and vocational training programs to develop specific programs for those persons with severe and persistent mental illness.

5. Explore and encourage private competitive employment programs similar to the Fairweather Lodge and other models.

RESPONSIBLE:

Department of Human Services
Department of Health
Division of Mental Health
Minnesota Housing Finance authorities
HUD and Federal Housing Programs
Private Foundations (i.e., McKnight, Robert Wood Johnson, etc.)
Legislators
Governor's Office
Provider Representatives
Consumers
County Designees
Property Managers
Outside Negotiators
Department of Education
Vocational Rehabilitation
Advocates

STATE OF MINNESOTA ACTION PLANS

SUBJECT: Medication Management

OBJECTIVES:

Provide access to medication management assistance to persons with severe and persistent mental illness, regardless of their place of residence.

ACTION STEPS:

1. Identify those persons locally whose service needs include the on-going administration and management of psychotropic medications.

2. Working through the country outreach/case management system, provide for administration, follow-up and management of medications for those persons requiring this service.

RESPONSIBLE:

Department of Human Services
Department of Health
Division of Mental Health
Consumers
County Case Managers
Advocates
Public Health Nurses