A LOOK AT SUPPORTIVE HOUSING FOR MENTAL HEALTH CONSUMERS IN FOUR OREGON COUNTIES

Final Report of Phase I of the
Oregon Supportive Housing Evaluation Project

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Executive Summary

This report summarizes the findings of Phase I of the Oregon Supportive Housing Evaluation Project. OSHEP-Phase I consisted of a process evaluation that compared and contrasted three approaches to providing housing and support services to persons with serious mental illness through the systematic collection of descriptive data.

The three housing approaches studied are collectively called "supportive housing". They include Integrated Supported Housing (ISH), Site-specific Supported Housing (SSH) and Supportive Communities (SC). All approaches provide mental health consumers with assistance in obtaining and maintaining decent and affordable housing in community settings. These programs all offer a high degree of independence and privacy and are considered less restrictive than traditional residential programs which include group homes and foster care. The approaches differ primarily by type of housing, level of staffing and degree to which services are blended with the housing:

> The *ISH approach* assists consumers with acquiring housing from private community landlords and provides outreach-oriented support services.
>
> The *SSH approach* offers housing at designated sites where all or most units are for persons with mental illness; services are provided both on site and at other community locations.
>
> The *SC approach* offers housing and services at designated sites with larger numbers of units; the services offered on site tend to be more comprehensive than in the other approaches.

OSHEP-Phase I was implemented with funding from the federal Center for Mental Health Services (CMHS) as one of ten sites nationwide evaluating housing approaches for persons with serious mental illness. OSHEP was carried out locally through a partnership involving the state Mental Health and Developmental Disability Services Division, the Regional Research Institute of Portland State University, a Local Research Advisory Council and ten service providers in Clackamas, Lane, Multnomah and Washington counties.

The process evaluation methodology included document reviews, site visits and surveys. Site visits were made to each participating agency and included interviews, tours, and focus groups. Surveys were completed by service providers on clients currently receiving supportive housing services, clients newly enrolled over a six-month period, and the costs associated with providing each of the three housing approaches. Data collected was used to assess comparability of approaches across providers through a fidelity analysis and to identify key characteristics of housing programs, their staff and residents.

The major findings can be summarized as follows:

- Oregon's emphasis since the late 1970s on assertive, outreach-oriented community support services contributed to the current availability of supportive, independent living opportunities for persons with serious mental illness.

- The extremely low incomes of persons with serious mental illness, combined with limited affordable housing opportunities in Oregon's tight housing market, have made access to decent housing a continuous challenge and have led mental health service providers to become direct developers of housing and partners with housing agencies.

- When analyzing the three supportive housing approaches, it was found that

  - All three approaches offer consumers affordable accommodations and individualized services.

  - The ISH and SSH approaches were similar in many ways — emphasizing consumer choice of services and housing, providing rights of tenancy to residents, and utilizing permanent, independent and private housing settings.

  - The ISH and SSH approaches differed in that housing and services were more functionally bundled in the SSH approach; consumers in the ISH approach experienced more integration with other community members in their housing settings; and some socialization opportunities were tied to the SSH housing sites.

  - The SC approach differed from the other two approaches with respect to its higher degree of structure, the increased level of socialization activities, the 24-hour availability of staff and services on site, and the most blending of housing and service functions.

- The consumers living in all supportive housing approaches tend to be single and middle-aged. They are slightly more likely to be male. Their ethnicity tends to reflect the ethnicity within the larger mental health services population and Oregon general population. They generally have major mental illnesses such as schizophrenia, bi-polar disorders and depression; are considered at risk of psychiatric hospitalization; and are assessed, on average, to have a moderate level of disability.

- On average, consumers in the three supportive housing approaches use crisis services 7-12 times per year. About one in five have needed brief out-of-home residential treatment (crisis-respite services) since entering their supportive housing program.

- A significant level of criminal justice system involvement (31% to 63%, depending upon housing approach) was reported for individuals prior to their entering the housing program. Criminal justice involvement was reported to decrease significantly (to 4% to 11%, depending upon housing approach) after consumers entered the supportive housing.

- While the majority of current consumers in all three supportive housing approaches enjoy considerable residential stability and collectively average three years in their current housing, more recent entrants report multiple prior moves and a higher degree of recent homelessness.

- Costs for supportive housing services ranged from $332 per consumer per month for the least expensive ISH services for general client populations to $2,227 per consumer per month for highly specialized SC services for clients with significant histories of

homelessness and psychiatric hospitalization. ISH and SSH programs were generally less costly than SC programs. Costs appeared to increase in accordance with the level of staffing, inclusiveness of services provided, and the degree to which housing costs were included in the program budget. The highest cost services tend to serve consumers with the lowest functioning levels.

- The study provided an opportunity to explore changes in supportive housing services under a managed care system as mental health services for Medicaid eligible persons became integrated into the Oregon Health Plan. Agencies in two of the counties under study transitioned to managed care about two years prior to the study while agencies in the other two counties were just beginning to provide services under contract with managed care organizations. While results are preliminary, the transition to managed care seemed to result in lower funding levels, some staff lay-offs, more paperwork, less individual contact with clients, increased accountability for services and the potential for more flexible service delivery.

- When queried about likes and dislikes, residents in all three housing approaches identified characteristics of their housing or its location as the most liked or disliked aspects. Consumers in the ISH approach identified independence and choice of living situation as aspects they liked more frequently than consumers in the SSH and SC approaches. The SSH and SC consumers were more likely to indicate that they liked the availability of support from other consumers and staff in their buildings.

- Consumers appeared satisfied with their housing and services in general. However, when asked about desired changes some areas were more frequently mentioned. With respect to desired changes in the housing, residents and staff for all housing approaches identified better housing amenities and improved maintenance as desirable. With respect to desired changes in services, more social activities and increased staff contact were most frequently requested.

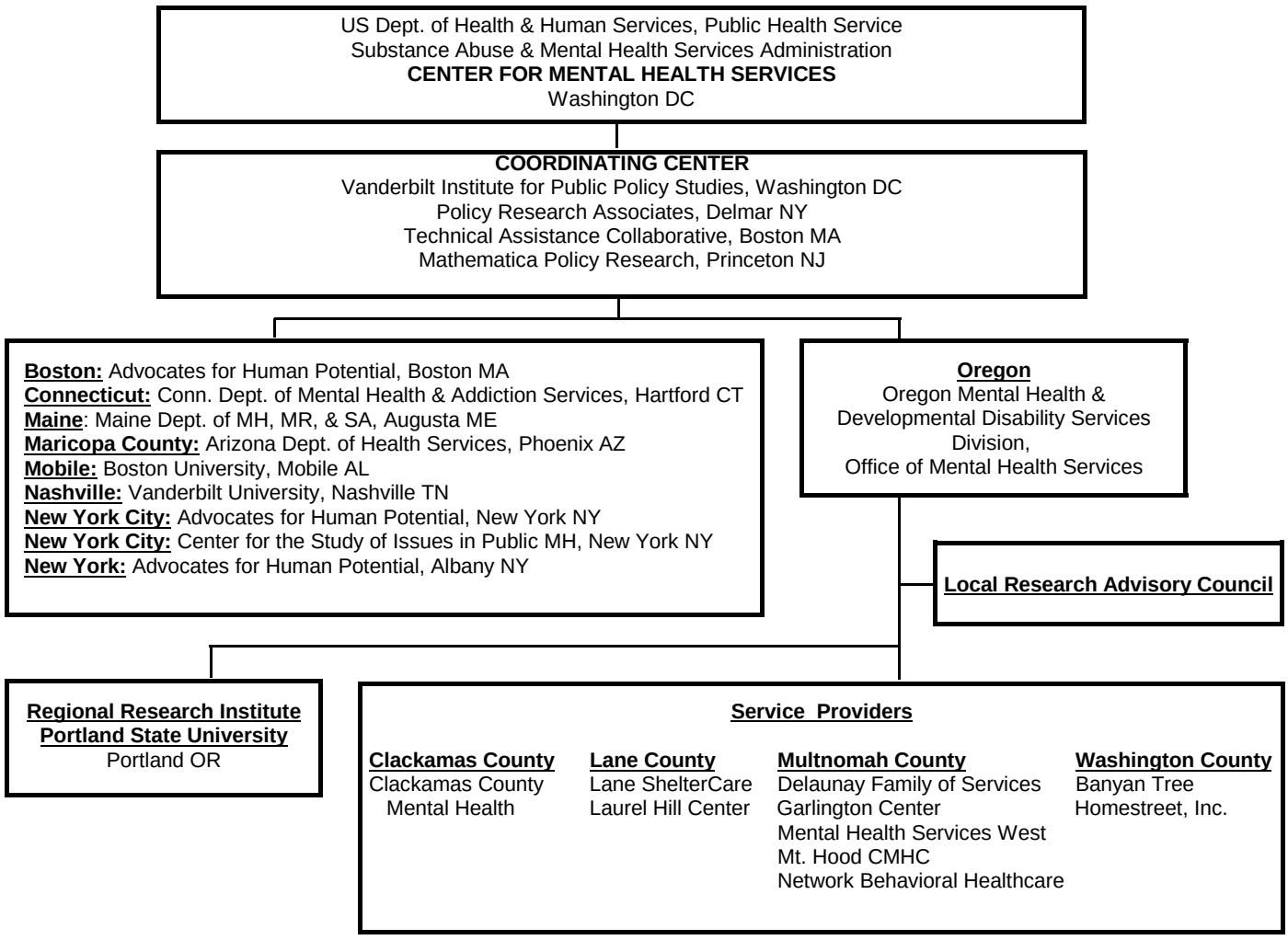
The process evaluation conducted through OSHEP-Phase I produced a wealth of descriptive data that contributes to a better understanding of three approaches to providing supportive housing services. Phase II of the project includes an outcome evaluation to be conducted over a two year period. OSHEP will continue in Phase II as one of seven CMHS-funded sites across the nation. Results from OSHEP-Phase II will further increase understanding of supportive housing through the assessment of newly entering consumers as they progress in the ISH and SSH approaches.

Introduction

The Mental Health and Developmental Disability Services Division (MHDDSD) of the Oregon Department of Human Resources and the Regional Research Institute (RRI) for Human Services of Portland State University collaborated to implement a comprehensive process evaluation of various supportive housing options in four Oregon counties. This report presents the findings of this effort known as Phase I of the **Oregon Supportive Housing Evaluation Project (OSHEP)**.

OSHEP-Phase I was made possible through a grant from the federal Center for Mental Health Services. OSHEP was granted funds along with a coordinating center and nine other projects throughout the country to study a defined "Supported Housing" model along with various comparison models through which housing and support services are made available to persons with psychiatric disabilities. The organizational chart provided as Figure A illustrates the organizational structure of the overall evaluation.

Figure A: Organizational Context of Oregon Supportive Housing Evaluation Project



While OSHEP-Phase I was part of a broader national evaluation effort, this report will focus on findings of the Oregon study. Participating in the national research provided a national context for understanding the supportive housing services available in Oregon. It is expected that results from the national study will soon be published.

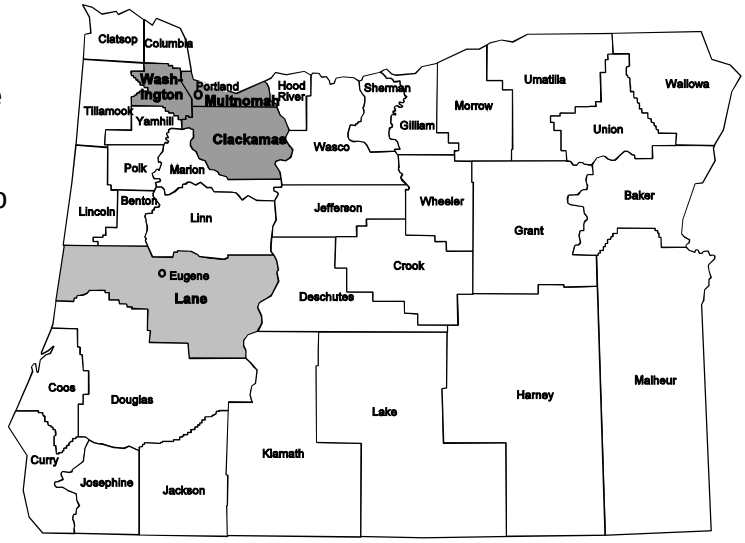
Table 1: Participating Service Providers and Housing Approaches

County	Service Provider	Approaches
Clackamas	Clackamas County Mental Health	ISH and SSH
Lane	Lane ShelterCare	SSH only
Lane	Laurel Hill Center	ISH only
Multnomah	Delaunay/Garlington/MH Services West	ISH, SSH and SC
Multnomah	Mt. Hood Communtiy Mental Health Center	SSH only
Multnomah	Network Behavioral HealthCare	SSH only
Washington	Banyan Tree	ISH and SSH
Washington	Homestreet	ISH and SSH

The process evaluation was completed through the participation of ten service providers located in four counties (Clackamas, Lane, Multnomah and Washington). These service providers, based in the Metropolitan areas of Portland and Eugene, were selected due their large numbers of consumers receiving supportive housing services in a concentrated geographic area. Three housing types were studied during Phase I: Integrated Supported Housing (ISH), Site-specific Supported Housing (SSH) and Supportive Communities (SC)[1]. The participating service providers and housing approaches studied are presented in Table 1. A brief description of each agency is provided in Appendix A. The geographical location of the four counties is displayed in Figure B.

A Local Research Advisory Council (see Appendix B) provided oversight and advice to the implementation of OSHEP-Phase I. Its members include service provider representatives, consumers, family members and professionals with expertise relevant to the project. The Council met five times during Phase I.

Figure B: Counties Participating in OSHEP



[1]The terminology used for housing types in this report differs slightly from terminology used in the national study in order to make the discussion more consistent with its Oregon context. The housing type referred to as "Integrated Supported Housing" herein was labeled "Supported Housing" in the national study; "Site-Specific Supported Housing" herein was referred to as "Supervised Apartments" in the national study; and "Supportive Community" is the term used herein and in the national study.

Background

Description of Study Housing. The purpose of OSHEP is to evaluate "supportive housing". In contrast to the structured settings provided in residential treatment facilities and adult foster care homes, "supportive housing" offers consumers more independence and privacy. It includes housing selected by consumers from among units available in the open housing market and housing made available through a mental health provider at a designated site. As mentioned above, three categories of supportive housing were analyzed through the OSHEP process evaluation: (1) Integrated Supported Housing (ISH), (2) Site-specific Supported Housing (SSH) and (3) Supportive Community (SC). These models can be summarized as follows:

The purpose of OSHEP is to evaluate "supportive housing". . . . three categories of supportive housing were analyzed . . . .

Integrated Supported Housing is an approach through which consumers receive assertive, community-based and outreach-oriented case management services directed at assisting them to find, get and keep housing of their choice. The housing used in this approach is integrated throughout the community and consists of housing stock that all community members have access to. Consumers generally lease the housing directly from private landlords.

Site-specific Supported Housing, as used in this proposal, refers to a complementary approach where the service provider makes designated, decent and affordable housing available to consumers. Services are provided in accordance with individual resident needs, and while all residents in this approach are offered case management, it may or may not be considered a direct part of the housing program. The housing has either been developed by the service provider or is leased from a housing authority, nonprofit housing agency or private landlord. Consumers enjoy well-maintained housing with a minimal level of staff support on site. All housing in this approach is comprised of units which are either 100%, or primarily, reserved for persons with a serious mental illness.

Supportive Community refers to a housing approach that provides a higher level of programmatic structure in accommodations that afford a maximum level of independence, safety and privacy to residents. These settings tend to serve mental health consumers who were recently homeless or discharged from psychiatric hospital settings. They all have staff available on site on a 24-hour basis. While some residents reside in supportive communities on a long-term basis, this type of housing is generally viewed as transitional. Residents are provided or assisted with obtaining one or more meals each day. Recreational activities, therapeutic groups and case management are offered on site.

While consumers enjoy a degree of independence and permanence in all three approaches, they differ in significant ways.

While consumers enjoy a degree of independence and permanence in all three approaches, they differ in significant ways. In the ISH model, a greater value is placed upon social integration, a consumer's need for privacy and anonymity, and the use of existing community housing stock.

In the SSH model, more emphasis is placed on peer support, quality of living environments, and the value of permanent, decent, affordable housing stock that is reserved for persons who are not good competitors for scarce affordable units in the private housing market. In the SC model, on site staffing is provided on a 24-hour basis and more structure is available to residents. Many basic values are shared by all approaches. For example, all approaches endorse consumer choice, individualization of services and a community-based orientation.

Historical Context. The supportive housing models developed in Oregon parallel those found elsewhere across the country. Some Oregon programs emphasize "social integration" (Carling, 1993; Carling, 1995; Curtis, 1994) and focus on the use of existing community housing. Others emphasize "community support" (Mandiberg and Telles, 1991) and actively address the lack of decent, affordable housing (Cohen, M.D., 1992; McCabe et. al., 1991) by developing new units or negotiating for clusters of units in larger complexes.

Oregon has an extensive history of promoting a variety of approaches to serving persons with serious mental illness in affordable community-based housing.

Oregon has an extensive history of promoting a variety of approaches to serving persons with serious mental illness in affordable community-based housing. As a state awarded Community Support Project (CSP) funding from the National Institute of Mental Health beginning in 1978, Oregon re-structured its service system to be more responsive to persons with severe and persistent mental illnesses (Cutler et. al., 1984; Field and Yegge, 1982; Hammaker, 1983). Oregon's CSP was highly influenced by the Wisconsin PACT program and other similar CSP models emphasizing assertive community treatment. Rather than promoting the development of "halfway houses" or group homes, an emphasis was placed on serving persons in their own, independent settings through the delivery of flexible services and supports. Because affordability of decent housing has always been an issue, local community mental health programs were encouraged to work with local public housing authorities and other nonprofit housing agencies.

Non-profit low rent housing: ISH site

Throughout the 1980s, Oregon was fortunate to receive consultation and technical assistance from many experts. Representatives from the Center for Community Change through Housing and Support, Boston University's Psychiatric Rehabilitation program and the State of Colorado were among those who visited and advised. In 1988, Oregon was one of five states awarded funding from the National Institute of Mental Health to promote supported housing at the state level and develop local demonstration projects (Livingston and Srebnick, 1991; Livingston et. al., 1992). As reported in the literature, Oregon took several steps to promote supporting individuals in independent housing settings, developing affordable housing opportunities and re-structuring service delivery to be outreach-oriented and focus on the supports needed by consumers to experience successful community living. The Laurel Hill Center in Eugene was Oregon's local demonstration site. An evaluation of two groups of persons enrolled in Laurel Hill's supported housing program, one consisting of consumers voluntarily seeking assistance and the other consisting of individuals assigned to the program due to their high risk of rehospitalization, indicated that the supported housing approach worked well with both groups, but the "high risk" consumers had a greater need for services and

supports (Brown et. al. 1991).

Environmental Context. While serving persons with serious mental illness in existing community housing has been promoted, the economic environment in Oregon has made doing so increasingly difficult. While Oregon's general population decreased during the recessionary 1970s, the economy turned around in the 1980s, and the general population has been increasing at about twice the national rate in recent years. The demand for affordable housing sky-rocketed. As decent and affordable housing became more difficult to access for mental health consumers, due to long waiting lists for an insufficient supply of public housing units and rent subsidies, local mental health agencies began developing affordable housing.

> ***As decent and affordable housing became more difficult to access . . ., mental health agencies began developing affordable housing.***

Because of this housing crisis, the Oregon MHDDSD began awarding funds to local agencies in 1989 to assist the development and renovation of affordable housing for persons with psychiatric disabilities. To date, about $2.4 million has been awarded to 96 housing projects in 24 counties to create and preserve housing for over 1,000 consumers. These small grants, combined with the technical assistance available at the state level, have contributed to much success in competitions for federal and state housing funds. For example, there are 22 HUD Section 202 or 811 Independent Living Complexes in Oregon, representing a total of 314 multi-family units. Sixteen of these, representing 250 apartments, are operated for mental health consumers served by the participating service providers.

Table 2: Economic and Housing Market Context for OSHEP

Select Demographics	State of Oregon	Clackamas County	Lane County	Multnomah County	Washington County
Population:					
1997 General Population	3,217,000	317,700	308,500	639,000	385,000
% Change '90-'97	13.2%	13.9%	9.0%	9.4%	23.6%
Income/Employment					
Median Household Income (MHI)	$37,200	$42,300	$34,800	$39,100	$42,300
% of State MHI		114%	93.5%	105%	113.7%
Unemployment	4.7%	3.4%	4.7%	3.4%	3.4%
SSI Annual Income (1997)	$5,808	$5,808	$5,808	$5,808	$5,808
SSI as % of Median Income	15.6%	13.7%	16.7%	14.9%	13.7%
Federal Poverty Level	$7,896	$7,896	$7,896	$7,896	$7,896
Housing Statistics:					
Median Value of Home in 1990		$85,200	$65,500	$61,100	$85,100
Average 1996 Housing Value		$132,577	$138,100	$130,400	$130,000
in Following City		Oregon City	Eugene	Portland	Hillsboro
# of Housing Units - 1980		84,424	102,424	231,870	89,348
# of Housing Units - 1990		109,003	116,676	255,751	124,716
Net Gain/Loss		24,579	14,252	23,881	35,368
Fair Market Rents (1997):					
Studio		$398	$324	$398	$398
1-Bedroom		$490	$444	$490	$490
% SSI Needed for 1B FMR:		101%	92%	101%	101%

Exterior of 30-unit SSH site

The Oregon MHDDSD convened a Residential Services Work Group in 1992 to recommend ways to improve housing and related support services for persons with psychiatric disabilities who were not succeeding in traditional residential programs (Skryha and Kast, 1993). The findings of the work group led to the promotion of various supportive housing approaches (including the ISH, SSH and SC models) to serve persons discharged or diverted from the state psychiatric hospital system as inpatient capacity was reduced.

Some socio-economic indicators paint a picture of the current environmental context for housing in the four counties whose geographic areas are served by agencies participating in the study. These indicators are summarized in Table 2.

The socio-economic data provided in Table 2 illustrate the following characteristic that impact housing options:

- Consistent with nationwide trends shifting population from northern and eastern states to western and southern states, Oregon has experienced a population boom. While the four counties involved in this study have all experienced population growth, the suburban, Portland-area counties (Clackamas and Washington) have grown most dramatically.

- Median household incomes in the Portland area are higher than the state average, while median household incomes in Lane County are lower than the state average. SSI incomes (most common income source for persons with serious mental illness served by the public mental health system) in all areas range from 13.7% to 16.7% of median income, placing them well below HUD's "extremely low income" cut-off (30% of median income) and below the federal poverty level.

- Housing values have increased dramatically. Due to population pressures, the supply of housing has also increased, but newer housing units tend to be more expensive.

- Fair market rents (based on 1997 HUD data) indicate that mental health consumers who receive SSI would have to use all, or nearly all, of their income to pay rent for a one-bedroom apartment on the open market.

Interior of typical SSH unit

Methodology

Throughout OSHEP-Phase I, data was collected using mailed surveys, site visits to each housing program and document reviews. A thorough description of the methodology employed to conduct the process evaluation is provided in Appendix C. In summary, the methodology employed the following:

- Mailed Surveys. Participating service providers were asked to complete three surveys: one on "current clients", a second on "new clients" and a third on housing program costs. In the "current clients" survey, demographic and other descriptive information was collected on all clients enrolled in the supportive housing programs as of December 1, 1997. This data provided a snapshot description of the consumers served by the different housing approaches. Through the "new clients" survey, comparable information was obtained on clients enrolled in supportive housing programs over a six month period (October 1, 1997 through March 31, 1998). This second survey also provided an indication of the admission rates to the various approaches. In the cost survey, information was collected on housing and service costs for the fiscal year ending June 30, 1997. Copies of the survey instruments are included in Appendix D.

- Site Visits. Site visits to each of the ten service provider agencies took place from late January through early April 1998. Prior to each site visit, descriptive information was collected for each housing program. Site visits were conducted by a team which included the project director, principal investigator, project manager, graduate research assistant, and one or both consumer research assistants. Each site visit began with an overview of the project and site visit agenda. This introduction was followed by half-day data collection segments for each housing approach provided at a given agency. For each housing approach, data was collected through administrator interviews, staff and consumer focus groups, staff and consumer questionnaires, program documents, and housing tours. Copies of interview and focus group questions and questionnaires are included in Appendix D. All interviews and focus groups were tape recorded. The tapes were transcribed, qualitatively analyzed, and included in the fidelity analysis (see Appendix C). Similarly, questionnaire data was analyzed and used to assess the approaches.

- Document Reviews. Any written materials relevant to the supportive housing programs were collected from service providers. These materials included descriptive narrative, application materials, activity schedules, program policies, etc. These materials were assembled into notebooks and reviewed as part of the fidelity analysis.

Through these methods, the research team was able to collect informative qualitative and quantitative data about supportive housing approaches and the consumers served in them, and to evaluate the approaches for consistency across service providers. The consistency analysis, referred to as the "fidelity assessment", was an important preparatory step completed in anticipation of

5-unit "Quint": SSH site

the outcome evaluation (OSHEP-Phase II).

Findings

The Housing Approaches Studied.

The characteristics of the three housing approaches were documented through tours, photographs, and staff and consumer reports. Results of the analysis of the these sources can be summarized as follows:

- *Integrated Supported Housing*. The housing used in the ISH approach consisted of housing available to the general community or to low income members of the community in the case of subsidized housing. The housing ranged from single family homes owned by a few consumers to a variety of apartment units, duplexes, shared homes and some single room occupancy housing in downtown areas. Research team members observed that housing units shown as examples were always integrated into their surrounding neighborhoods and were comparable in size and structure to other housing in the immediate neighborhood. Additional descriptive data came from ISH consumers who participated in focus groups. A questionnaire item asked consumers to rate the degree to which their housing is "integrated into a residential neighborhood" (1-5 point scale with "5" indicating "very integrated"), the mean score across 39 consumers was 4.16, indicating a general belief that ISH housing was well situated in residential neighborhoods.

Suburban duplex: ISH site

- *Site-specific Supported Housing*. The housing used in the SSH approach was also observed to be comparable to surrounding housing in size and structure. While the housing was occupied solely by mental health consumers, it was not identified or "labeled" in any way that would indicate to a passer-by that it was "special housing". This housing included apartment complexes with 4 to 35 units, shared homes, "quints" and "quads", and some single room occupancy housing. The "quints" and "quads" consisted of attractive, well-designed buildings on single family lots that appeared to be large single family homes or townhouses from the exterior. They provide residents with locked single room units including private bathrooms; private, locked food storage areas; and living room and kitchen/dining areas for common use. The quints and quads are types of housing that may be unique to Oregon. When SSH consumers responded to the questionnaire item rating integration, the mean score across 67 consumers was 4.17, indicating a general belief, almost identical to ISH focus group participants, that SSH housing was also well placed in residential neighborhoods.

HUD 811 Complex: SSH site

- *Supportive Communities*. Three buildings operated by two service providers comprised the sites for SCs. These buildings contained single room or efficiency apartment units for residents. All offer some degree of community space and shared cooking facilities. Two of the sites that were located in the downtown Portland area blended well with adjacent architecture. Similarly, the third site was well designed and blended into its mixed commercial and residential area. Like the other two approaches, residents were provided with personal keys for their individual, locked residential units. Bathroom facilities were shared in two buildings but private in the third. When SC consumers responded to the questionnaire item rating integration, the mean score across 11 consumers was 3.50, indicating that SC housing was viewed as less integrated into residential neighborhoods.

HUD McKinney Project: SC site

To insure comparability of housing and services available within each housing approach, a comprehensive effort was made to conduct a fidelity assessment. The purpose of the fidelity assessment was to determine and confirm that all of the housing sites assigned to a given approach were comparable on the 15 key housing dimensions developed for the national evaluation effort. A description of the methodology used for the fidelity assessment and the definitions of the housing dimensions are provided in Appendix C. Ratings assigned to housing types through the fidelity assessment are summarized in Table 3.

Table 3: Fidelity Scores on Housing Dimensions across Housing Approaches*

DIMENSION	Integrated Supported Housing	Site-Specific Supported Housing	Supportive Communities
Supported Housing Criteria:			
1. Housing Choice	4.8	4.2	2.5
2. Functional Separation	5	2.5	1
3. Housing Affordability	4.8	4.9	5
4. Integration	5	1.4	1.5
5. Rights of Tenure	4.9	4.4	1.5
6. Service Choice	4.7	4.2	3.5
7. Service Individualization	4.8	4.6	4.5
8. Service Availability	5	3.4	1.5
Other Housing Criteria:			
9. Permanence	5	4.6	3.5
10. Independence	4.8	4.1	3
11. Safety	3.4	3.7	3
12. Socialization	2.5	4	4
13. Structure	1	2.6	4
14. Privacy	5	4.3	3
15. Shared Living	1.7	2	3

**Key: 5 = High congruence with criteria; 1 = Low congruence with criteria. See Table C-2 in Appendix C for criteria definitions. A score of 4.0 to 5.0 indicated that the housing approach met the criteria (see shaded cells).*

Findings that compare and contrast the approaches according to each identified dimension can be summarized below. Data from questionnaires completed by staff and consumers participating in focus groups during site visits provided a source of quantitative data for the fidelity analysis. Table E-1 in Appendix E summarizes relevant findings.

1. Housing Choice. Through focus group discussions, all ISH and SSH service providers were found to explore preferences with consumers and accommodate consumer choice to the extent feasible within real world constraints. There was significantly less housing choice experienced in the SC approach; this can probably be explained by the limited availability of SC sites and their tendency to serve recently homeless or hospitalized persons. Consumers sometimes expressed in focus groups that their choice was limited due to the tight housing market or the limited availability of desirable SSH units.

2. Functional Separation of Housing from Service Provision. This dimension clearly differentiated ISH from SSH and SC housing. Based on tours and focus group discussions, the ISH programs were found to provide services to consumers who are living in housing integrated throughout the community; these residents have leases with private landlords. There were a couple of exceptions where an agency co-signs or subleases housing to particular consumers who had problematic rental histories and would otherwise not have had access to the housing. For the SSH and SC programs, on the other hand, the service provider has an identified role through which it controls access to the housing. In some cases, different departments within agencies were responsible for the "property management" and "service" functions, but it was still clear that the housing is identified as the service providers' housing. Housing and services are the most functionally blended in the SC programs.

3. Housing Affordability. The Oregon MHDDSD has a state-level "Housing Policy for Mental Health Consumers" which participating service providers follow in implementing their housing services. This policy states, "Housing used by or made available to persons with mental illness must be safe, affordable and decent". Based on focus group questionnaire data, consumers in all three approaches considered their housing to be affordable (see item 10, Table E-1). The SSH programs are all subsidized, either through development grants or attached rental subsidies, and rents are all well below market levels. SC programs offer "below market" rents to consumers or use "Shelter Plus Care" and other subsidies to insure affordability. SC programs also offer affordable meal options to residents which help stretch meager budgets in addition to providing nutritional advantages. In ISH programs, consumers are assisted with finding affordable (sometimes subsidized) units, getting on waiting lists for Section 8 vouchers/certificates, and accessing short term rental subsidies (as available). In some cases, ISH service providers use discretionary funds to subsidize rents until a housing authority subsidy becomes available. Because of long waiting lists for Section 8 rent subsidies, some ISH residents may experience higher levels of rent payment initially (upon obtaining housing) than residents at SSH housing sites. All case managers work to get ISH consumers signed up for rent subsidies as a matter of course. In addition, all service providers enjoy good relationships with local housing authorities.

4. Integration. All housing used for the ISH approach is scattered site; in cases where more than one consumer lives in a multi-unit apartment complex, the mental health consumers comprise well below 50% of total tenants. In contrast, housing used in the SSH and SC models tend to be 100% occupied by persons with serious mental illness

or, in one case, concentrated in a couple of multi-unit buildings within a very large complex. Based on focus group questionnaire data, consumers tended to view ISH and SSH housing as integrated into residential neighborhoods (see item 11, Table E-1).

5. Rights of Tenure. In the ISH approach, consumers have leases with private landlords, housing authorities or nonprofit housing agencies, and are accorded full rights of tenure. The only exceptions are rare situations where a service provider co-signs or subleases a unit due to a particular consumer's bad rental history; in this case, the intent is to "pass through" full rights of tenancy to the consumers. In the SSH approach, consumers typically have leases or rental agreements identical (or at least, comparable) to those in the ISH approach. However, in some cases, there tends to be subtle differences, such as house rules outlining expectations that alcohol not be used on the premises, that differentiates the approaches to a minimal degree. In the SC approach, residents also have individual leases, but house rules are more clearly an addendum to these rental agreements and expectations for some level of program participation are apparent. Based on focus group questionnaire data, it is apparent that consumers may view their "rights of tenure" differently than the more objective analysis suggests (see items 23-31, Table E-1).

Private market ISH site

6. Service Choice. The process evaluation found that consumers are offered choice and the opportunity to refuse or modify services across all service providers in all approaches. Because of their programmatic structure, service choices tended to be more constricted in the SC settings (see items 19 and 20, Table E-1).

7. Service Individualization. The findings of the process evaluation indicate that services were highly individualized for consumers across all three housing approaches and all service providers.

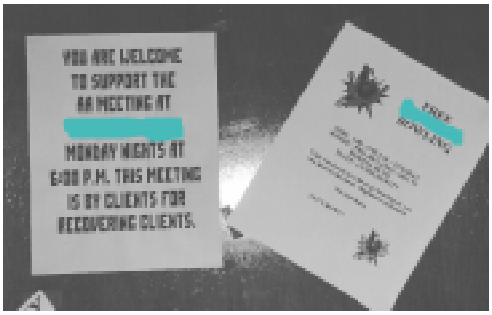
8. Service Availability. The national study defines service availability as the residents and housing program relying exclusively on community-based (i.e. off-site) service availability, which includes a comprehensive range of mental health and support services. The ISH approach was found to definitely be consistent with this definition. The SSH approach, due to having on-site or site-assigned staff associated with the housing, was found to be more reliant on some level of site-specific support for residents. In the SSH approach, this site-specific support was found to include skill development activities and informal counseling provided by paraprofessional staff; residents received case management, mental health treatment and psychiatry services off-site. In the SC approach, residents tend to receive the majority of their services, including case management and mental health treatment, from staff based at the housing site.

9. Independence. Consumers in both the ISH and SSH approaches were found to experience a high level of independence as defined by the amount of control the consumer exerts over his/her living environment. There were subtle, minimal differences at some SSH sites due to the availability of services offered on site and/or the general identification of the housing as "for mental health consumers only". Most SC

consumers reported experiencing a similar level of independence; however, due to the amount of on site support and meal availability, the level of independence was assessed to be less.

10. Permanence. Throughout the ISH approach, it was clear that a consumer's housing is permanently available for as long as the consumer wishes to reside in it and complies with the lease. While there are no actual limits on housing tenure in the vast majority of SSH sites, there was a perception, in some cases, that the SSH housing was either contingent on continuing with mental health services or a "stepping stone" to a more desirable housing option. While no maximum lengths of stay were specified, SC housing is considered "transitional" and consumers tend to live there for briefer durations. However, at each SC site, there were residents who had resided there since the housing became available. Consumers in all approaches tended to believe they could stay in their housing for as long as they wanted (see item 28, Table E-1). Consumer responses with respect to permanency of housing tend to be confusing at times. For example, consumers tended to report that they would lose their housing if they discontinued services or medications much more frequently than staff reported that housing would be lost for these reasons (see items 29 and 30, Table E-1). Since several consumers had experienced housing instability in the past, they often believed a relapse of their mental illness, that might occur if medications or service participation were discontinued, could lead to behaviors resulting in a loss of the housing.

11. Socialization. The approaches varied in the extent to which social activities were integrated into the housing program (see item 27, Table E-1). Throughout the ISH approach, case managers work with consumers on an individualized basis to address socialization needs, but scheduled or facilitated socialization activities are not an active component of the overall housing approach. In contrast, the SSH approach tends to have some level of regularly scheduled, generally "low key", social activities associated with the housing program. These typically include barbeques, potlucks, holiday gatherings, etc. held in a common area or on the grounds of the housing program. SC programs tend to have regularly scheduled social or recreational activities; however, attendance at these is voluntary. Housing for all approaches was similar in the extent to which it was located near places for recreation and socialization (see item 9, Table E-1).



Postings in community area of SSH site

12. Safety. The safety of housing was perceived to be moderate to high across all approaches, with SC sites being seen as least safe (see items 3-6, Table E-1). While consumers in focus groups occasionally complained about needed repairs or maintenance, the housing viewed during tours all appeared to meet basic health and sanitation standards. With respect to crime and victimization, there was some variation based upon the location of the housing. Whereas buildings were generally believed to be safe, surrounding neighborhoods in downtown and other higher crime areas were perceived to be less safe for all approaches. SC sites tended to be located in these less

safe areas.

13. Structure. The level of structure among approaches varied in accordance with the expected pattern (see item 27, Table E-1). All ISH programs were rated as having the lowest level of structure. SSH programs were relatively unstructured but tended to include some level of social activities and "community meetings". While these were not mandatory for residents, attendance was generally encouraged. SC programs tended to have the highest degree of structure, but like SSH sites, attendance at structured activities was encouraged but not mandatory. The amount of programming on site at SC programs was greater than at SSH programs and tended to include more "therapeutic" offerings (in addition to social and recreational activities).

14. Privacy. Consumers in all approaches report that they enjoy privacy in their housing (see items 14 and 17, Table E-1). All ISH programs were consistently rated as affording the highest level of privacy to consumers. While consumers in SSH housing tended to report similarly high levels of privacy, SSH programs were rated as slightly less private due to on site staff presence and the nature of buildings where 100% of tenants are mental health consumers (i.e. everyone knows everyone else has a mental illness). Similarly, consumers in SC programs tended to report high levels of privacy, but these locations were rated to be the least private due to on site staff presence and the concentration of mental health consumers as tenants.

15. Shared Living. Shared living was uncommon across all housing sites. Some roommate situations existed in ISH programs and generally consisted of a mutually acceptable shared apartment or rental home through which a higher quality of housing was affordably obtained. To some degree, shared housing existed in the SSH approach as well. These tended to be situations where the consumer had a locked single-room-with-private-bath unit in a house with shared common areas. In SC programs, each consumer or couple had a private room; however, it was more common for bathroom and kitchen facilities to be shared.

Overall, the housing in all three approaches was found to be decent, safe and affordable. Services were individualized and provided with various degrees of structure.

Overall, the housing in all three approaches was found to be decent, safe and affordable. Services were individualized and provided with various degrees of structures. Privacy and independence were experienced by residents in all approaches.

The Consumers Living in Supportive Housing.

Descriptive information about consumers in the three housing approaches was obtained in three ways: (1) through rosters completed by service providers on all consumers in the housing as of December 1, 1997 ("current clients") , (2) through similar rosters on all consumers entering the housing between October 1, 1997 and March 31, 1998 ("new clients"), and (3) from consumer focus group participants during site visits. Because data from the current client rosters is most comprehensive, this section focuses primarily on those findings. Data tables on "new clients" and on consumers who participated in focus groups is provided in Appendix F.

Current Clients. Table 4 summarizes data on all consumers served in each of the three approaches as of December 1, 1997. On this date, six agencies were providing ISH services to a total of 406 consumers, eight agencies were providing SSH services to a total of 436 consumers, and two agencies were providing SC services to a total of 119 consumers. Thus, this data represents characteristics of 961 consumers. These consumers comprise the majority of persons with serious mental illness who receive supportive housing services in the four-county study area.

Table 4: Characteristics of Consumers Living in Housing as of December 1, 1997

Consumer Characteristic	ISH	SSH	SC	TOTAL
Average Age	41.2 years *(n=406)*	41.9 years *(n=436)*	43.3 years *(n=119)*	41.81 years *(n=961)*
Gender				
Male	53.6% *(n=187)*	57.7% *(n=206)*	56.3% *(n=49)*	55.7% *(n=442)*
Female	46.4% *(n=162)*	42.3% *(n=151)*	43.7% *(n=38)*	44.3% *(n=351)*
Marital Status***				
Never Married	55.3% *(n=193)*	67.3% *(n=241)*	58.6% *(n=51)*	61.1% *(n=485)*
Married or Living As Married	8.3% *(n=29)*	4.5% *(n=16)*	3.4% *(n=3)*	6.0% *(n=48)*
Divorced, Widowed or Separated	23.8% *(n=83)*	20.9% *(n=75)*	10.3% *(n=9)*	21.0% *(n=167)*
Unknown	12.6% *(n=44)*	7.3% *(n=26)*	27.6% *(n=24)*	11.8% *(n=94)*
Ethnicity				
White	83.5% *(n=284)*	87.5% *(n=308)*	75.3% *(n=61)*	84.5% *(n=653)*
African-American	9.4% *(n=32)*	6.3% *(n=22)*	14.8% *(n=12)*	8.5% *(n=66)*
Native American	1.8% *(n=6)*	1.4% *(n=5)*	3.7% *(n=3)*	1.8% *(n=14)*
Asian, SE Asian, Pacific Islander	2.1% *(n=7)*	2.0% *(n=7)*	2.5% *(n=2)*	2.1% *(n=16)*
Hispanic (Mexican, Cuban, Other)	3.2% *(n=11)*	2.8% *(n=10)*	3.7% *(n=3)*	3.1% *(n=24)*
Priority One Clients[1]	95.3% (*n=324)*	97.5% (*n=349)*	97.7% (*n=85)*	96.6% *(n=758)*
Multnomah County Ability Scale				
(average scores)	*(n=203)*	*(n=294)*	*(n=43)*	*(n=540)*
Interference with Functioning***	16.77	17.60	15.11	17.09
Adjustment to Living***	10.73	11.24	7.95	10.79
Social Competence***	14.57	15.35	12.91	14.86
Behavioral Problems***	15.81	17.03	14.09	16.34
TOTAL[2,]***	57.89	61.21	50.07	59.08
Average Length of Stay	3.04 years *(n=400)*	3.5 yrs. *(n=439)*	1.62 yrs. *(n=110)*	3.09 yrs. *(n=949)*
Range	4 days - 15.29 years	14 days-16.31 yrs.	6 days-7.26 yrs.	4 days-16.31 yrs.
Average Use of Crisis Services***				
(1=rarely, 5=A Lot)	2.08 *(n=346)*	1.87 *(n=429)*	3.25 *(n=120)*	2.14 *(n=895)*
Post[3] Crisis Respite Use	20.9% *(n=72)*	17.3% *(n=74)*	20.3% *(n=25)*	19.1% *(n=171)*
Prior[3] Criminal Justice Involvement***	31.6% *(n=103)*	33.1% *(n=120)*	63.2% *(n=67)*	36.5% *(n=290)*
Post[3] Criminal Justice Involvement*	5.5% *(n=20)*	4.1% *(n=18)*	10.8% *(n=13)*	5.6% *(n=51)*

[1]Priority One = At risk of hospitalization or poses hazard to health/safety of self/others.
[2]Levels of Ability: 17-47=severe disability, 48-62=medium disability, 63-85=little disability.
[3]Relative to entry into housing program.
* $p < .05$
** $p < .01$
*** $p < .001$

For all approaches, the average age of consumers was low forties. Slightly more males than females were served in all approaches. In terms of marital status, the vast majority of residents in all approaches are single; marital status is unknown, however, for a significant portion of residents at SC sites. Ethnicity varied to some degree among approaches with residents at SC

sites comprised of the most non-Whites (24.7%), followed by ISH (16.5%) and SSH (12.5%). All approaches served primarily "Priority One" clients who were assessed to be at risk of psychiatric hospitalization. While individual diagnostic data was not analyzed, service providers report that residents generally have major mental illnesses such as schizophrenia, bi-polar disorders and depression.

For portions of the current clients in each approach, level of functioning data (Multnomah Community Ability Scale[2] scores) were available in the State's data system. Overall, consumers' average scores are indicative of moderate disability. These scores indicate that SC residents tend to have lower levels of functioning overall.

Residential stability was analyzed by computing "average length of stay" for consumers in their current housing. Residential stability was highest in the SSH and ISH approaches where residents averaged 3.5 and 3.04 years in their housing respectively. In the SC approach, residents average 1.62 years in their housing. Across all approaches, longevity in housing ranged from 4 days to over 16 years and averaged about 3 years.

The current client surveys requested data on each resident's use of crisis services, use of crisis-respite once in the housing approach and criminal justice system involvement prior to and after entering the housing approach (see copy of survey form in Appendix D). With respect to use of crisis services, service providers were asked "How often does this individual use crisis services, including hot lines, on-call staff intervention, emergency room visits?". They estimated frequency of use on a scale ranging from "never" to "a lot" (more than once a week). These responses were converted to numerical ratings ranging from 0 to 5 and averaged as indicated in Table 4. Overall, average use of crisis services was moderate to minimal. SC residents used crisis services most frequently, averaging 7-12 times per year.

Crisis-respite use means that a resident left their housing to stay in a more structured residential environment on a temporary basis for some period of time since entering the housing approach. Overall, about one out of five consumers utilized crisis-respite services. This rate of use was fairly consistent across approaches.

With respect to criminal justice system involvement, about one-third of ISH and SSH residents and close to two thirds of SC residents were reported to have had involvement with the criminal justice system prior to entering housing. For all approaches, criminal justice involvement was dramatically reduced after entering the housing. Only 5.5% of ISH residents, 4.1% of SSH residents and 10.8% of SC residents were indicated to have criminal justice involvement after entering the housing program.

New Clients. Data on clients entering the programs over a recent six-month period is presented in Table F-1 (see Appendix F). Data on these new clients was obtained primarily to document the rate of client entry into the housing approaches in preparation for the Phase II

[2]The Multnomah Community Ability Scale is a 17-item instrument used throughout Oregon to functionally assess community mental health program clients who are seriously mentally ill. The instrument was developed by community mental health staff following standard instrument development methodology. It was normed on samples of males and females aged 18 to 91 years, living in both urban and rural areas, who suffered from a major mental illness, had been recently hospitalized or were at risk of hospitalization and suffered from social role impairment in several areas. Test-retest and inter-rater reliability analysis revealed more than sufficient correlation of the total scores (Barker et. al., 1994). Scores of 63-85 indicate mild disability; scores of 48-62 indicate moderate disability; and scores of 0-48 indicate severe disability.

outcome study. However, this data was also compared to "current client" data in order to analyze any differences that might exist between the newer and the more long term residents of the supportive housing approaches. These data are derived from 41 consumers entering ISH approaches, 67 entering SSH approaches, and 44 entering SC approaches.

The new supportive housing clients were slightly younger overall than existing residents. Gender, marital status and ethnicity distributions were very similar for new and current clients. Level of functioning scores were slightly lower for new clients. The new and current clients seemed comparable on other characteristics.

Focus Group Participants. Data on consumer focus group participants by housing type are presented in Table F-2 (see Appendix F). Because consumer focus group participants were selected on a non-random basis by service providers, data was collected to enable a comparison between this select group and the larger universe of all "current clients". Based on available demographic data, the two groups appear comparable. Mean ages (by approach) of focus group and "current client" groups were early to mid-forties with focus group participants slightly older overall (mean difference of four years or less). Gender trends were similar with males slightly more dominant overall, except in the SC focus group where females slightly outnumbered males in a very small sample. Ethnicity distributions were comparable overall, but included slightly more non-Whites among SSH and SC focus group participants than among the more comprehensive "current client" samples in these approaches.

Through consumer focus group questionnaires, additional data related to residential stability was collected. Depending upon the approach represented, 50% to 74% of these consumers had not moved in the past year. However, because others had higher incidences of moves (residential instability), the average number of moves for all approaches ranged from 0.6 to 1.0 in the past year. Focus group participants representing the SSH approach were least likely to have moved in the last year. Focus group participants were also asked to indicate whether they had been homeless in the past five years. Significant numbers answered affirmatively. Specifically, 25.6% of ISH participants, 30.2% of SSH participants and 45.5% of SC participants indicated that they had experienced homelessness in the recent past.

Ethnicity Analysis. In order to interpret ethnicity data, the larger contexts of the entire service population and the general population must be considered. Table 5 summarizes this data for the four counties included in OSHEP. Ethnicity within the general population of the four counties is predominantly White (89.4%), followed in declining order by Asian (3.6%), Hispanic (3.3%), African American (2.8%) and Native American (1.0%).

With respect to the ethnicity distribution among persons receiving mental health services, a greater proportion of non-Whites is represented. This is especially true for persons of African American and Asian ethnicity and may be explained by the existence of specialized services for these groups within the four county area. Hispanics comprised the only group under-represented in the service population. This under-representation may be explained by a larger proportion of Hispanic children in the general population (whereas service population data includes adults only) and the expanding nature of the Hispanic population in recent years (service enrollment may be lagging behind this population trend).

Considering this ethnicity context, the percentages of Whites served in the three approaches vary but tend to be less than the percentage of Whites in the general population. While ethnicity varies by housing approach, African Americans tend to be represented in housing

approaches to a greater extent than would be predicted by the general population or service population data. Asians and Hispanics tend to be under-represented while Native Americans are served in the housing programs to about the same extent as they are served in the larger mental health service system.

Table 5: Ethnicity within General Population and among Adult Mental Health Service Recipients

	White		African American		Native American		Asian		Hispanic	
	#	%	#	%	#	%	#	%	#	%
Clackamas County										
General Pop.	261,350	94.6%	1,134	0.4%	1,971	0.7%	4,827	1.7%	7,129	2.6%
MH Services	1,396	93.0%	20	1.3%	21	1.4%	23	1,5%	41	2.7%
Lane County										
General Pop.	262,946	93.7%	2,107	0.8%	3,207	1.1%	5,557	2.0%	6,852	2.4%
MH Services	1,312	91.8%	32	2.2%	46	3.2%	17	1.2%	22	1.5%
Multnomah County										
General Pop.	489,500	84.8%	35,135	6.1%	6,734	1.2%	27,326	4.7%	18,390	3.2%
MH Services	3,915	73.1%	564	10.5%	83	1.5%	680	12.7%	114	2.1%
Washington County										
General Pop.	272,058	89.6%	2,058	0.7%	1,779	0.6%	13,424	4.4%	14,401	4.7%
MH Services	1,201	89.0%	51	3.8%	18	1.3%	27	2.0%	52	3.9%
4 County Totals										
General Pop.	**1,285,85**	**89.4%**	**40,434**	**2.8%**	**13,691**	**1.0%**	**51,134**	**3.6%**	**46,772**	**3.3%**
MH Services	**7,824**	**81.2%**	**667**	**6.9%**	**168**	**1.7%**	**747**	**7.8%**	**229**	**2.4%**
Study Housing										
ISH	284	83.5%	32	9.4%	6	1.8%	7	2.1%	11	3.2%
SSH	308	87.5%	22	6.3%	5	1.4%	7	2.0%	10	2.8%
SC	61	75.3%	12	14.8%	3	3.7%	2	2.5%	3	3.7%
Total	**653**	**84.5%**	**66**	**8.5%**	**14**	**1.8%**	**16**	**2.1%**	**24**	**3.1%**

The Staff of Supportive Housing Programs.

Information about staff was obtained from document reviews and site visits. Staff configurations varied for each of the three housing approaches. In the ISH approach, there were no staff based at housing sites. ISH staff consisted of case managers, skills trainers, nurses and other adjunct positions. Their offices were based at mental health clinics or other primary service locations but contact with clients frequently took place on an outreach basis at various community locations. In the SSH approach, there was typically much fluidity in the staffing associated with SSH sites. At larger apartment complexes, there was usually a resident manager on site whose responsibilities primarily included property management tasks, but who tended to be viewed by consumers as the first person to talk to if any kind of problem arose. In some cases, additional staff were present but on less than a 24-hour basis. The smaller SSH sites (quints, quads, shared homes) had no resident or on-site staff, but housing program staff were assigned to these sites. Staffing levels tended to be adjusted in accordance with resident needs. There were examples of SSH

Staff configurations varied for each of the three housing approaches.

housing where initially one or more full-time program staff were available on site but, over time, this was reduced to a resident manager (who was often a consumer) with only property management duties on his/her official job description. In the SC programs, staff were available on site 24 hours per day. Staff positions ranged from case mangers and nurses, who tended to be scheduled during the daytime shifts, to paraprofessionals who staffed "front desks" or provided nonclinical direct services to residents.

Quantitative data collected on staff came from questionnaires completed by staff participating in focus groups. These staff who completed questionnaires included 23 ISH staff of six service provider agencies; 31 SSH staff of eight service provider agencies; and 10 SC staff of two service provider agencies. In some agencies, the same team of staff were responsible for providing most or all of the support services to both persons living at SSH sites and persons living in private market, scattered site housing (ISH approach). In all approaches, residents had a case manager or service coordinator who was their primary mental health treatment contact. Case managers tended to be persons with graduate level degrees. Paraprofessional staff, and sometimes consumers who were trained peer counselors, provided additional support services such as skill development.

Table 6: Characteristics of Staff Focus Group Participants

Staff Characteristic	ISH	SSH	SC	TOTAL
Average Age	36.9 years *(n=23)*	37.6 years *(n=30)*	37.6 years *(n=9)*	38.1 *(n=62)*
Gender:				
Male	34.8 % *(n=8)*	29.0% *(n=9)*	70.0% *(n=7)*	37.5% *(n=24)*
Female	65.2 % *(n=15)*	71.0 % *(n=22)*	30.0% *(n=3)*	62.5% *(n=40)*
Ethnicity:				
White	91.3% *(n=21)*	90.3% *(n=28)*	70.0% *(n=7)*	87.5% *(n=56)*
African /American	4.3% *(n=1)*	6.5% *(n=2)*	10.0% *(n=1)*	6.3% *(n=4)*
Native American	—	—	10.0% *(n=1)*	1.6% *(n=1)*
Asian, SE Asian, Pacific Islander	—	3.2% *(n=1)*	—	1.6% *(n=1)*
Hispanic (Mexican, Cuban, Other)	4.3% *(n=1)*	—	10.0% *(n=1)*	3.1% *(n=2)*
Highest Education Level:				
HS Diploma/GED	4.3% *(n=1)*	3.2% *(n=1)*	—	3.1% *(n=2)*
Some College	17.4% *(n=4)*	12.9% *(n=4)*	30.0% *(n=3)*	17.2% *(n=11)*
AA Degree	4.3% *(n=1)*	9.7% *(n=3)*	—	6.3% *(n=4)*
BA/BS	34.8% *(n=8)*	58.1% *(n=18)*	40.0% *(n=4)*	46.9% *(n=30)*
MA/MS/MSW	34.8% *(n=8)*	16.1% *(n=5)*	20.0% *(n=2)*	23.4% *(n=15)*
PhD/PsyD/MD/JD	4.3% *(n=1)*	----	10.0% *(n=1)*	3.1% *(n=2)*
Years With Program:				
<1 year	21.7% *(n=5)*	16.1% *(n=5)*	30.0% *(n=3)*	20.3% *(n=13)*
1-2 years	17.4% *(n=4)*	22.6% *(n=7)*	30.0% *(n=3)*	21.9% *(n=14)*
2-4 years	21.7% *(n=5*	29.0% *(n=9)*	30.0% *(n=3)*	26.6% *(n=17)*
4-7 years	17.4% *(n=4)*	12.9% *(n=4)*	—	12.5% *(n=8)*
>7 years	21.7% *(n=5)*	19.4% *(n=6)*	10.0% *(n=1)*	18.8% *(n=12)*
Average Years with Program	4.3 years *(n=23)*	3.8 years *(n=31)*	2.3 years *(n=10)*	3.7 *(n=64)*
No. Clients on Caseload				
<10	26.1% *(n=6)*	22.6% *(n=7)*	20.0% *(n=2)*	23.4% *(n=15)*
10-19	21.7% *(n=5)*	29.0% *(n=9)*	20.0% *(n=2)*	25.0% *(n=16)*
20-29	39.2% *(n=9)*	29.0% *(n=9)*	10.0% *(n=1)*	29.7% *(n=19)*
30+	13.0% *(n=3)*	19.4% *(n=6)*	50.0% *(n=5)*	21.9% *(n=14)*
Average Number of Clients on Caseload	20.3 clients *(n=23)*	19.0 clients *(n=31)*	32.6 clients *(n=10)*	21.6% *(n=64)*

Table 6 displays characteristics of staff for each of the three housing approaches as derived

from focus group questionnaire data. ISH and SSH staff groups are predominantly female and White. The SC staff sample consisted primarily of males and was 70% White. All staff groups appeared comparable in terms of age. Longevity with the housing program was greatest among staff of ISH programs (average of 4.3 years); next greatest for SSH staff (average of 3.8 years); and least among SC staff (average of 2.3 years). Two of the SC programs were relatively new which may explain the shorter duration of staff with that approach. ISH programs tended to have the highest concentration of staff with graduate degrees (39.1% compared with 16.1% of SSH staff and 30% of SC staff).

With respect to caseload size, there was not much difference between the ISH and SSH approaches. The average number of clients reported on caseloads of ISH staff was 20.26. The average number of clients reported on SSH staff caseloads was 19.0. In contrast, SC programs had a mean caseload size of 32.6 clients. It should be noted that not all staff had designated "caseloads". For the ISH and SSH approaches, Table 6 data typically referred to the number of clients per case manager. Additional staff (generally paraprofessionals and resident managers) are not reflected in these numbers. The case load sizes of service providers newly impacted by managed care were in the process of increasing to accommodate decreased funding levels available to service providers from managed care organizations.

Cost Analysis

Findings from the cost survey are presented in Table 7. This information pertains to the 1996-97 fiscal year, the most recent, completed fiscal year at the time of the study. Cost data was incomplete for two housing programs at one of the participating service agencies; these were excluded from the analysis. Overall, costs ranged from $322/month for the least expensive ISH program to $2,227/month for the most expensive SC program.

Integrated Supported Housing data was based on six ISH programs of five service providers. One of the programs (the high cost outlier) is a specialized program for persons with histories of high state psychiatric hospital utilization. In the case of larger or more comprehensive service providers, ISH programs were integrated into the agency's case management or community support services program, and therefore, tended to directly include a more comprehensive array of services.

- The ISH programs consistently included case management, social/recreational activities, medication oversight, crisis intervention, support groups, skill development and supportive counseling among the services provided by staff and included in the housing program budget.

- ISH programs served, on average, 46 consumers at a time, and the average number of clients per direct service staff person was 10.5.

- The average expenses in ISH programs per client per year was $7,465 ($622/month). However, if the one high cost, specialized program is removed, the average cost of ISH programs drops to $4,756 per client per year ($396/month). It should be noted that ISH program expenses did not include any housing expenses since housing is a direct client expense in the ISH approach.

- With respect to services and benefits provided outside the housing program, all ISH

programs indicated that some percentage of their clients received vocational or employment services, Section 8 subsidies, Oregon Health Plan coverage and social security benefits. Other services and benefits were accessed to varying degrees outside of the housing program.

Table 7: Summary of Cost Survey Data

Services Offered as Part of Housing Program:	Integrated Supported Housing (6 programs) % with Service Available			Site-Specific Supported Housing (10 programs) % with Service Available			Supportive Communities (3 programs) % with Service Available		
Case Management Services	100%			70%			100%		
Social/Recreational Activities	100%			100%			100%		
Medication Oversight	100%			90%			100%		
Crisis Intervention	100%			100%			100%		
Meals	0%			10%			100%		
Support Groups	100%			80%			100%		
Skill Development	100%			100%			100%		
Nursing Services	17%			10%			100%		
Psychiatry (Medications)	83%			60%			100%		
Vocational/Employment	17%			10%			33%		
Supportive Counseling/Therapy	100%			90%			100%		
Clients Served and Staffing	**Average**	**Range**		**Average**	**Range**		**Average**	**Range**	
# Served at one time:	46.3	18 to 64		37.3	16 to 67		44.7	22 to 62	
Clients per direct service FTE	10.5	3 to 17		20.3	10 to 37		2.4	1.5 to 3.5	
Annual Expenses:	**Average**	**Range**		**Average**	**Range**		**Average**	**Range**	
Expenses per client/yr	$7,465	$3,985 to $18,133		$6,034	$4,093 to $9,718		$16,603	$8,523 to $26,721	
Other Services and Benefits:									
MH Services Outside Hsg Prog:	**# of Prog's (of 6)**	**Low**	**High**	**# of Prog's (of 10)**	**Low**	**High**	**# of Prog's (of 3)**	**Low**	**High**
Case Management	1*	76-100%	76-100%	6	76-100%	76-100%	0		
Medication Management	2	0-25%	76-100%	6	26-50%	76-100%	0		
Day Treatment	3	0-25%	76-100%	9	0-25%	76-100%	2	0-25%	26-50%
Drop-in Center	4	26-50%	76-100%	9	0-25%	76-100%	1	0-25%	0-25%
Voc/Empl Services	6	0-25%	51-75%	10	0-25%	76-100%	2	0-25%	0-25%
Support Groups	2	0-25%	26-75%	8	0-25%	76-100%	0		
Individual Therapy	4	0-25%	26-50%	6	0-25%	76-100%	0		
Group Therapy	0			7	0-25%	76-100%	0		
Rent Subsidies:									
Section 8/Vouchers	6	0-25%	76-100%	7	0-25%	76-100%	0		
Shelter Plus Care	1	0-25%	0-25%	2	0-25%	26-50%	2	0-25%	76-100%
Other: Low Income Hsng.	2	0-25%	26-50%	4	0-25%	26-50%	2		
Other Benefits:									
Oregon Health Plan	6	51-75%	76-100%	10	51-75%	76-100%	3	76-100%	76-100%
Other Health Plan	5	0-25%	0-25%	7	0-25%	26-50%	3	0-25%	0-25%
Transportation subsidies	4	26-50%	76-100%	7	26-50%	76-100%	1	76-100%	76-100%
SSI/SSDI	6	51-75%	76-100%	10	51-75%	76-100%	3	26-50%	76-100%
Welfare (GA, TANF)	5	0-25%	0-25%	5	0-25%	0-25%	3	0-25%	26-50%
Food Pantry/Food Bank	4	0-25%	51-75%	7	0-25%	26-50%	1	26-50%	26-50%
Energy Assistance (eg LIEP)	5	0-25%	76-100%	9	0-25%	51-75%	3	0-25%	0-25%

* Refers to county case managers who monitor services.

Site-specific Supported Housing data was based on ten SSH programs of seven service providers. In the case of larger or more comprehensive service providers, SSH programs were likely to be one component of an array of services received from the agency through a more

centralized case management system. The following are findings relevant to SSH program costs:

- The SSH programs consistently included social/recreational activities, crisis intervention, and skill development among the services provided by staff and included in the housing program budget.

- SSH programs served, on average, 37 consumers at a time, and the number of clients per direct service staff person was 20.3.

- The average expenses in SSH programs per client per year was $6,034 ($503/month). This average expense amount for SSH programs includes housing costs. Housing costs averaged $152/client/month for SSH programs. These costs were offset by rental income collected from residents.

- With respect to services and benefits provided outside the housing program, all SSH programs indicated that some percentage of their clients received vocational or employment services, Oregon Health Plan coverage and social security benefits. As in ISH programs, SSH consumers accessed other services and benefits to varying degrees outside of the housing program.

. . . . it appears that costs are related to the level of staffing, the inclusiveness of services provided, and the degree to which housing costs are included in the budget.

Supportive Community data was based on three SC programs of two service providers. These programs tended to operate on a more self-contained basis; in other words, clients at SC sites were less reliant on mental health services provided outside the auspices of the program. The following are findings relevant to SC program costs:

- The SC programs consistently included case management, social/recreational activities, crisis intervention, medication oversight, meals, support groups, skill development, nursing services, psychiatry and supportive counseling among the services provided by staff and included in the housing program budget. Thus, SC programs provide the most comprehensive services.

- SC programs served, on average, 45 consumers at a time, and the average number of clients per direct service staff person was 2.4. Therefore, SC programs have the lowest ratio of clients to staff.

- The average expenses in SC programs per client per year was $16,603 ($1,384/month). This average expense amount for SC programs includes housing costs (averaging $103/client/month) and covers the higher levels of staffing and services provided.

- With respect to services and benefits provided outside the housing program, SC programs indicated that far fewer residents received mental health services off site, and some percentage of SC clients receive vocational or employment services, Oregon Health Plan coverage, social security benefits, welfare benefits and energy assistance.

In interpreting these findings, it appears that costs are related to the level of staffing, the

inclusiveness of services provided, and the degree to which housing costs are included in the budget. The SC services are much more costly than the other two approaches but include a more comprehensive array of services. Economies of scale, especially with respect to more structured programs, appeared to be related to cost; programs serving larger numbers of persons in more structured settings were less costly than those serving fewer persons in a more structured setting.

Other Findings.

In addition to descriptive data on the housing approaches, consumers, staff and costs, the OSHEP-Phase I evaluation collected information on managed care, the aspects of the housing approach liked best and liked least by consumers, and the changes both consumers and staff would like to see in the housing and services. An analysis of focus group questionnaire data was also conducted and identified some interesting trends.

Managed Care. The impact of managed care on supportive housing was of special interest in this study since mental health services were in the process of becoming integrated into the Oregon Health Plan and delivered through contracts with managed care organizations. Agencies in two counties (Clackamas and Washington) were part of a group of counties that transitioned to managed care in 1995. The agencies in the other two counties (Lane and Multnomah) were in the process of entering contracts with managed care organizations and adjusting to a "managed care" way of doing business.

These results should be considered preliminary. Since service delivery experience under a managed care approach is still minimal, it is too early to assess the long term impact of managed mental health care on the supportive housing approaches. It should be noted that the State's contract for managed mental health care under the Oregon Health Plan encourages flexible service delivery, defines "Supported Housing" as a service covered by the capitation payment and allows the use of funds to assist consumers with accessing housing. However, most of the service agencies included in the study reported that funding levels decreased as a result of the conversion to managed care. This reduced level of funding diminished the extent to which service providers could implement the activities encouraged or allowed under the managed care contracts.

During site visits, administrative staff, direct service staff and consumers were all asked to summarize the impact of the shift to managed care on services. The comments noted in administrator interviews and staff and consumer focus groups are presented in Table G-1 (see Appendix G). The following is a summary of findings based on an analysis of these comments:

The impact of managed care on supportive housing was of special interest . . . .

- Except for the one county-operated agency (Clackamas County Mental Health), all service providers experienced budget cuts of at least 25%, upon initially contracting with managed care organizations. These funding cuts resulted in staff lay-offs. The service providers in Washington County, who went through the transition over two years ago, were able to slowly re-build staffing levels, though not to levels existing prior to managed care. The funding cuts and staff reductions in the other two counties were in the

process of occurring as the OSHEP-Phase I site visits were taking place.

- It was consistently reported that case load sizes and paperwork increased while service contacts with consumers decreased. Several providers were increasing services provided in group formats and decreasing the number of individual contacts. Vocational, sheltered employment and socialization programs were diminished for many consumers who complained about the lack of activities and decreased opportunities to earn income.

- Direct service staff uniformly voiced frustration with the transition to managed care. In particular, they expressed concern over decreased funding levels, increased caseload sizes, decreased time with clients, and the uncertainty of the future under managed care.

- Consumers in all but the one county-operated program reported experiencing changes in case managers, psychiatrists and other staff that appeared to be related to the shift to managed care.

- On the positive side, the "managed care" focus has caused service providers to become more accountable and focused in their allocation of services to consumers.

- Some of the service providers commented on increased flexibility in service delivery.

- Credentialing requirements necessitated the provision of services by masters level personnel. While this resulted in more highly trained staff overall, the paraprofessional staff who tend to provide outreach and support in housing programs were diminishing.

- Several service providers voiced that the client population was diversifying to include a broader range of clients. While newly eligible persons (e.g. persons with brain damage, personality disorders, anti-social disorders) were enjoying greater access to supportive housing services, less time was available for services to persons with traditional diagnoses of serious mental illness. The new populations were viewed as more challenging to serve.

Characteristics about the housing itself were most frequently cited as the aspects consumers like best

Additional time and further study will enable a more comprehensive assessment of the impact of managed care on supportive housing services for persons with serious mental illness.

Analysis of What Consumers Like Best and Least. In focus groups and in questionnaires, consumers were asked what they like best and least about their housing. This data was analyzed by sorting responses according to housing approach and categorizing them. Tables summarizing focus group comments are included in Table G-2 of Appendix G. Table G-2 compares responses of ISH focus group participants to combined responses of SSH and SC consumer focus group participants. The reason SSH and SC responses are combined is due to some of the focus groups including participants from both groups early in the process before the housing was well categorized. The discussion will therefore compare ISH housing to the site-based alternative approaches (SSH and SC).

There was a high degree of variability in the responses of consumer focus group participants. It

should be noted that each consumer participant responded based on his or her specific housing situation. The housing aspects cited by some consumers as what they like best were sometimes the very aspects cited by others as what they like least. For example, one consumer liked having a small, "manageable" unit while other consumers complained that their apartment was too small. Nonetheless, some trends emerged:

- Characteristics about the housing itself were most frequently cited as the aspects consumers like best or least in all housing approaches. Therefore, characteristics of the housing, including location, proved to be very important to consumers. The characteristics most frequently mentioned include those relating to the spaciousness of the unit, its state of repair, amenities, landscaping, noise level, and proximity to public transportation and other community amenities.

- Analysis of responses among approaches in the next most frequently mentioned housing aspects revealed interesting differences related to the approaches.

  – With respect to the next most frequently mentioned "like best" responses (listed in descending order), ISH participants valued independence, choice of whom to live with or near, and affordable rent, while SSH/SC participants voiced an affinity for the availability of support, privacy and independence.

  – With respect to the next most frequently mentioned "like least" responses (listed in descending order), ISH participants specified various affordability issues and management issues, while SSH/SC participants named issues with services or staff and interpersonal issues.

- For all approaches, the "like best" responses outnumbered the "like least" responses. This appeared to reflect a general, overall level of satisfaction among all consumer focus group participants in all housing types.

- While a couple of consumers in the SSH and SC approaches identified living in housing with other people who are mentally ill as something they disliked, it was surprising how many voiced the opposite view. Most of the 23 responses in the "like best" category of "availability of support" described positive benefits derived from having neighbors with mental illness and a sense of community within the housing.

. . . better housing amenities and improved maintenance were most frequently mentioned as desirable changes.

Analysis of Desired Changes to Housing and Services. Focus group questions addressed desired changes to the housing and the services. Consumers were asked to list the changes they would most like to see in their housing and their services. Staff were asked what changes they thought consumers in the program would like to see. These responses were sorted and categorized by housing type. Consumer responses were compared to staff responses. Table G-3 in Appendix G summarizes these focus group comments.

The following is a summary of key findings with respect to desired changes to housing:

- For all housing approaches, better housing amenities and improved maintenance were most frequently mentioned as desirable changes. These desired changes ranged from new paint on walls and cable TV hook-ups to air conditioning and better soundproofing

between units.

- Consumer and staff responses seemed to correlate overall. There were some exceptions. ISH staff voiced a need for safer housing options in safer areas more than any other respondent group. Consumer participants were the only ones to note that they'd like relaxed pet policies and the ability to more easily have a pet.

- More housing opportunities and choices overall were seen as universally desirable. This included requests for more flexibility in choices. For example, one consumer whowas an artist would have liked to have a two-bedroom unit so he could use one bedroom for a studio; this was not allowed under the Section 8 rent subsidy program.

The following are key findings with respect to desired changes to services:

- Both ISH consumers and ISH staff most often identified more social and recreational opportunities as desirable. Both ISH staff and consumers mentioned increased staff contact next most frequently.

- While SSH and SC staff also most often mentioned increased social and recreational opportunities as desired changes, the SSH and SC consumers identified personal financial issues and availability of stable staff support as areas needing to change. These consumers almost as often requested more staff contact and increased social and recreational programming.

- More employment opportunities and vocational assistance was requested by a small but vocal subset of consumers and some ISH staff.

- In addition to more social and recreational programming, a wide variety of other services were identified as desirable. These included better transportation options, assistance with housekeeping and meals, and assistance with shopping.

HUD 811 complex: SSH approach

Questionnaire Findings of Interest. Table E-1 (see Appendix E) presents selected findings from questionnaires completed by consumers and staff who participated in focus groups during site visits. These were cited, as applicable, to the housing dimensions analyzed to describe the housing approaches (see pp. 13-16). Most questionnaire items appeared on both staff and consumer questionnaires but were worded slightly differently in order to be applicable to the respondent (i.e. consumers were asked to respond personally; staff were asked to respond based on their clients' situations).

The comment column in Table E-1 summarizes findings relevant to each questionnaire item. In addition to findings noted on pp. 13-16, the following trends are noteworthy:

- Consumers tended to rate their personal housing situations more favorably than staff rated housing situations of clients overall.

- Staff responses tended to differentiate the three approaches more than consumers' responses.

- Consumers tended to perceive more restrictions attached to housing of all types than staff. For example, more consumers than staff felt that residents were not allowed to drink alcoholic beverages, that they would lose their housing if they stopped taking medications and that they would lose their housing it they married. It's possible that consumers responded to these items based upon their personal history or expectation rather than on actual programmatic rules.

Conclusions and Discussion

The array of supportive housing available in the four counties included in OSHEP-Phase I developed within an historical and socio-economic context that parallels experiences of many other states. Oregon's emphasis since the late 1970s on assertive, outreach-oriented community support services contributed to the current availability of supportive services that are critical to successful independent living opportunities for persons with serious mental illness. Accessing decent, affordable housing has been an ongoing challenge. The extremely low incomes of persons with serious mental illness, combined with very limited affordable housing opportunities in Oregon's tight housing market, have led mental health service providers to become direct developers of housing and partners with various community housing agencies.

The major findings are presented and discussed below. They represent the housing programs and related services as experienced by consumers of ten mental health agencies in four Oregon counties. Many of these findings are derived from descriptive inquiries and should be considered preliminary. Findings are presented in **bold** type; discussion follows.

- **When analyzing the three housing approaches, it was found that**
  - **All three approaches offer consumers affordable accommodations and individualized services.**
  - **The ISH and SSH approaches were similar in many ways — emphasizing consumer choice of services and housing, providing rights of tenancy to residents, and utilizing permanent, independent and private housing settings.**
  - **The ISH and SSH approaches differed in that housing and services were more functionally bundled in the SSH approach; consumers in the ISH approach experienced more integration with other community members in their housing settings; and some socialization opportunities were tied to the SSH housing sites.**
  - **The SC approach differed from the other two approaches with respect to its higher degree of structure, the increased level of socialization activities, the 24-hour availability of staff and services on site, and the most blending of housing and service functions.**

As expected, the three approaches were found to be similar in some ways and different in others. There were greater similarities between the ISH and SSH approaches than between these two approaches and the SC approach.

The characteristics of SSH housing in Oregon may differ from site-specific, apartment living programs in other parts of the country. In Oregon, housing programs based at apartment settings that provide accommodations for persons with mental illness are generally seen as permanent housing, afford residents full rights of tenancy, and have staffing patterns that fluctuate according the service needs of the tenants. It appears that some of the site-specific housing in other parts of the country may have more structured staffing patterns and more restrictions attached to the housing.

- **The consumers living in supportive housing tend to be single and middle-aged. They are slightly more likely to be male. Their ethnicity tends to reflect the ethnicity within the larger mental health services population and Oregon general population. They generally have major mental illnesses such as schizophrenia, bi-polar disorders and depression; are considered at risk of psychiatric hospitalization; and are assessed, on average, to have a moderate level of disability.**

Demographically, the consumers served in the supportive housing programs are generally comprised of a cross-section of the persons with serious mental illness who receive state-funded mental health services. These individuals have varied levels of functioning that average in the moderate range. It would be interesting to compare the characteristics of consumers in supportive housing to those in independent, family member, group home and other households.

- **On average, consumers in the three supportive housing approaches use crisis services 7-12 times per year. About one in five have needed brief out-of-home residential treatment (crisis-respite services) since entering their supportive housing program.**

The average use of crisis services for adults in the state's mental health service system is not known. It appears, however, that consumers in supportive housing services may rely on the crisis service system to a greater extent than individuals in other living situations. Availability of a crisis response system may be a critical, and regularly used, element of supportive housing programs. This is not surprising since the consumers receiving these services are generally assessed to need some level of support related to maintaining their housing while the staffing patterns are relatively minimal.

SC site developed to replace state psychiatric hospital capacity.

- **A significant level of criminal justice system involvement (31% to 63%, depending upon housing approach) was reported for individuals prior to their entering the housing program. Criminal justice system involvement was reported to decrease significantly (to 4% to 11%,**

depending upon housing approach) after consumers entered the supportive housing.

It appears that stable housing and the availability of supportive services leads to a significant decrease in the level of criminal justice system involvement for consumers in supportive housing. This finding was obtained from service providers as they supplied rosters of clients currently enrolled in the three housing approaches. Consumers in SC programs, which tend to serve higher proportions of previously homeless and psychiatrically hospitalized individuals, had the highest levels of reported criminal justice system involvement both prior and subsequent to entering the housing programs. However, rates of criminal justice system involvement were reported to dramatically decrease across all housing types after consumers entered the programs.

Because consumers' criminal justice system involvement during a specified period of time directly before entering the housing was not specifically compared to its incidence during the same period of time after entering the housing, the role of housing and support services in decreasing criminal justice system involvement remains speculative. It should be noted, however, that current clients averaged three years in supportive housing with the substantially decreased levels of criminal justice system involvement. Fortunately, Phase II of OSHEP includes an outcome study that will track criminal justice system involvement in a more systematic way.

Downtown low rent housing: ISH site

- **While the majority of current consumers in all supportive housing approaches enjoy residential stability, more recent entrants report multiple prior moves and a higher degree of recent homelessness.**

This finding appears consistent with what is known about housing market conditions and the poverty of mental health consumers. Due to the lack of decent, affordable housing, persons with extremely low incomes can be expected to experience a high level of residential instability and some degree of homelessness. The fact that residential stability is attained by others once they acquire supportive housing may suggest that the residential instability is more related to adverse economic conditions than psychiatric diagnoses.

- **Costs for supportive housing services ranged from $332 per consumer per month for the least expensive ISH services for general client populations to $2,227 per consumer per month for highly specialized SC services for clients with significant histories of homelessness and psychiatric hospitalization. ISH and SSH programs were generally less costly than SC programs. Costs appeared to increase in accordance with the level of staffing, inclusiveness of services provided, and the degree to which housing costs were included in the program budget. The highest cost services tend to serve consumers with the lowest functioning levels.**

The cost analysis findings appeared consistent with expected patterns. Costs associated with

providing supportive housing services appeared to fluctuate with levels of staffing and consumer functioning levels. While some variation in costs existed for each approach across programs, the high cost outliers were specialized programs targeted to serve more challenging consumer subpopulations. Economies of scale also impacted overall cost levels; larger programs tended to experience economies over smaller programs.

An analysis of cost effectiveness and comparisons of the costs of supportive housing programs to costs of other residential service approaches were beyond the scope of OSHEP-Phase I. It is hoped that the cost analysis planned for OSHEP-Phase II will yield additional useful cost information.

- **The study provided an opportunity to explore changes in supportive housing services under a managed care system as mental health services for Medicaid eligible persons became integrated into the Oregon Health Plan. Agencies in two of the counties under study transitioned to managed care about two years prior to the study while agencies in the other two counties were just beginning to provide services under contract with managed care organizations. While results are preliminary, the transition to managed care seemed to result in lower funding levels, some staff lay-offs, more paperwork, less individual contact with clients, increased accountability for services and the potential for more flexible service delivery.**

Service providers were asked questions about their experience with managed care in an effort to assess the degree to which supportive housing services were impacted by the transition to new service funding mechanisms. The phased in nature of integrating mental health services into the Oregon Health Plan provided an opportunity to look at changes taking place at the time of the transition (in two counties) and to observe impacts after two years of service delivery in a managed care system (in the two other counties).

Community room at one SC site

The findings included several adverse impacts of managed care. These findings must be considered preliminary since it is hard to assess the impact of a major system change while the change is in process. The findings are also derived from the experience of a four county area within Oregon and do not represent the experience of all Oregon service providers. Because the capitation payment system utilized under the Oregon Health Plan provides relatively fixed rates in contrast to the former fee-for-service system, the conversion to managed care resulted in reduced funding for counties with aggressive Medicaid billing histories and increased funding for counties with conservative Medicaid billing histories. The various managed care organizations that now provide service funding have different rate schedules and organizational relationships with the providers. All of these factors contribute to the complicated nature of the current mental health system and make it difficult to interpret findings.

While findings are preliminary, it does seem clear that the transition to managed care is having an impact. This impact is generally characterized by less funding available to service providers, increases in caseload sizes, and limits in the amount and type of services available to consumers. Since the supportive housing programs were assessed to meet various housing

dimension criteria, it is clear that these supportive housing services will continue. However, it can be expected that services will be "watered down" and may be re-organized as experience with the managed care system continues. Because service providers with two or more years of experience reported that their funding levels had either not significantly changed or had rebounded somewhat over time, there may be some expectation that service funding for those newer to managed care will have a similar experience.

McKinney PH 4-plex: SSH site

- **When queried about likes and dislikes, residents in all three housing approaches identified characteristics of their housing or its location as the most liked or disliked aspects. Consumers in the ISH approach identified independence and choice of living situation as aspects they liked more frequently than consumers in the SSH and SC approaches. The SSH and SC consumers were more likely to indicate that they liked the availability of support from other consumers and staff in their buildings.**

Privately-owned "quad" rentals: SSH site

It should probably not be surprising that consumers, like the rest of us, can identify many things they either like or dislike about their housing situations. What's more interesting is the degree to which other factors seemed to differentiate housing approaches. Consumers in independent, integrated housing scattered throughout the community (ISH approach) voiced their fondness for independence and choice of living situation to a greater extent than consumers in the SSH and SC approaches who more often viewed availability of support from neighbors and staff as a favorable aspect of their housing. This finding may suggest that consumers may sort themselves into housing types to some degree based upon the extent to which they value privacy and anonymity or an environment which provides accessible social support.

- **Consumers appeared satisfied with their housing and services in general. However, when asked about desired changes some areas were more frequently mentioned. With respect to desired changes in the housing, residents and staff for all housing approaches identified better housing amenities and improved maintenance as desirable. With respect to desired changes in services, more social activities and increased staff contact were most frequently requested.**

Again it is not surprising that consumers would desire improvements to their housing or an improved housing location. Much of the affordable housing that is available has limited amenities. Acquiring amenities such as additional storage space, a spare room, a larger unit or even jacuzzis and swimming pools is often accomplished at greater cost. Similarly, affordable housing is often located in the less desirable neighborhoods. The rents in better neighborhoods are generally higher.

With respect to service changes, there was much mention of increased social activities and staff contact. These responses may be related to recent cut-backs in social programs and staff contact in the new managed care environment. However, they also seemed to reflect the limited opportunities for social activities available to persons with very low incomes. Many of the social and recreational activities available in the community have a cost or require a means of transportation to easily access. The desire for increased staff contact appeared to be related to a desire for increased social support and general complaints about the increasingly prevalent group approach to providing treatment.

Next Steps

The process evaluation conducted through OSHEP-Phase I produced a wealth of descriptive data. This information contributes to a better understanding of three popular approaches to pr oviding supportive housing services in Oregon. Some of the fi ndings would benefit from a more thorough research effort. F ortunately, Phase II of the project includes an outcome ev aluation to be conducted over a two year period. OSHEP has b een funded by the federal Center for Mental health Services to p articipate as one of seven sites across the country that will c ontinue to evaluate the effectiveness of supportive housing a pproaches.

A single room occupancy SC site

HUD 811 complex: SSH site

T he OSHEP-Phase II outcome evaluation will more sy stematically assess residential stability, housing satisfaction, cr itical incidents, level of functioning, costs and other key va riables related to supportive housing programs. The outcome evaluation will assess newly entering consumers as they progress through housing in the ISH and SSH approaches. A corresponding assessment of consumers in a waiting list condition will be conducted. This waiting list group will provide a comparison group that will strengthen the ability to interpret findings. OSHEP-Phase II will also include a further exploration of the impact of managed care on supportive housing services and analyses of family member perspectives, therapeutic relationships, the physical characteristics of housing, landlord perspectives, costs and service utilization. Results from OSHEP-Phase II will contribute to an increased understanding of supportive housing.

A 35-unit Section 8 SSH site

Home owned by an ISH Consumer

References

Barker, S., Barron, N., McFarland, B., & Bigelow, D. (1994, Otober). Multnomah Community Ability Scale: User's Manual. Western Mental Health Research Center, Oregon Health Sciences University, Portland, Oregon.

Brown, M.A., Ridgway, P., Anthony, W.A. and Rogers, E.S. (1991) Comparison of outcomes for clients seeking and assigned to supported housing services. Hospital and Community Psychiatry, 42(11), 1111-1115.

Carling, P.J. (1993) Housing and supports for persons with mental illness: Emerging approaches to research and practice. Hospital and Community Psychiatry, 44(5), 439-449.

Carling, P.J. (1995) Return to community: Building Support Systems for People with Psychiatric Disabilities. New York: Guilford Press, 1995.

Cohen, M.D. (1992). The developmental model of housing. The Housing Center Bulletin, I(1), 3-8.

Curtis, L.C. (1994). Social integration: Inviting, including in community. In Community, 4(1).

Cutler, D.L., Terwilliger, W., Faulkner, L., Field, G. & Bray, D. (1984). Disseminating the principles of a community support program. Hospital and Community Psychiatry, 35(1), 51-55.

Ethnograph v5.0 [computer software]. (1998). Amherst, MA: Qualis Research Associates.

Field, G. & Yegge, L. (1982). A client outcome study of a community support demonstration project. Psychosocial Rehabilitation Journal, 6(2), 15-22.

Hammaker, R. (1983). A client outcome evaluation of the statewide implementation of community support services. Psychosocial Rehabilitation Journal, VII(1), 2-10.

Livingston, J.A. & Srebnick, D. (1991). States' strategies for promoting supported housing for persons with psychiatric disabilities. Hospital and Community Psychiatry, 42(11), 1111-1115.

Livingston, J.A., Srebnik, D., King, D.A. & Gordon, L. (1992). Approaches to providing housing and flexible supports for people with psychiatric disabilities. Psychosocial Rehabilitation Journal, 16(1), 27-43.

Mandiberg, J.M. & Telles, L. (1990). The Santa Clara County clusered apartment project. Psychosocial Rehabilitation Journal, 14(2), 21-28.

McCabe, S.S., Edgar, E.R., King, D.A., Ross, E.C., Mancuso, L.L. & Emery, B.D. (1991). Holes in the housing safety net...Why SSI is not enough: A national comparison study of supplemental security income & HUD fair market rents. Center for Community Change through Housing and Support, Department of Psychology, University of Vermont.

Newman, S.J., Reschovsky, J.D., Kaneda & Hendrick, A.M. (1994). The effects of independent living on persons with chronic mental illness: An assessment of the Section 8 certificate program. The Millbank Quarterly, 72(1), 171-198.

Ogilvie, R.J. (1997). The state of supported housing for mental health consumers A literature review. Psychiatric Rehabilitation Journal, 21(2), 122-131.

Skryha, V. & Kast, B. (1993). Report of the Residential Services Work Group. Salem, Oregon: Mental Health and Developmental Disability Services Division, Department of Human Resources, March 1993.

Appendices

Appendix A – Participating Service Providers

The active involvement of administrators, staff and consumers of the ten participating service providers was essential to the study and much appreciated. Service providers are listed by county below. Names of primary contact person(s) and a brief description of each agency are included.

CLACKAMAS COUNTY

Clackamas County Mental Health Center (CC), Oregon City, Oregon.
Contact(s): Dawn Hanson, Susan Johnson

Clackamas County Mental Health Center is a comprehensive, county-operated mental health program serving the entire Clackamas County area. Services for persons with a serious mental illness include the full range of case management, psychiatry, socialization/day treatment, crisis services, access to residential resources and housing, and vocational services. While some consumers "graduate" to the more independent settings offered through ISH and SSH programs, many are placed directly from the hospital, homeless situation or family home into ISH programs due to the limited capacity of group homes. A special case management team provides flexible, individualized services to the most seriously disabled consumers based upon their needs.

LANE COUNTY

Lane ShelterCare (LS), Eugene, Oregon.
Contact(s): Tom Terrell, Susan Ban

Lane ShelterCare began as an emergency shelter program for homeless families in Eugene in the late 1970s. Because so many homeless persons who used its services had a mental illness, the agency expanded to include specialized emergency housing for persons with psychiatric disabilities and permanent housing for persons with serious mental illness. The LS programs for persons with mental illness promote a sense of community among residents while also respecting residents' independence and privacy. LS housing programs for mental health consumers include three SSH programs, an emergency/transitional housing site and a safe haven. County case managers link consumers to other resources and housing settings as needed.

Laurel Hill Center (LH), Eugene, Oregon.
Contact(s): Mary Alice Brown, Dee Wirak

Laurel Hill Center began as a drop-in socialization center, vocational program and independent living center in the late 1970s. It continues to provide these services in an expanded state-of-

the-art manner. It offers two ISH programs, one for the general population of persons with serious mental illness who need help finding, getting and keeping housing, and one for persons transitioning to the community after long term or repeated psychiatric hospitalizations. County case managers link consumers to other resources and housing settings as needed.

MULTNOMAH COUNTY

Delaunay Family of Services (DE), Portland, Oregon.
Contact(s): Mary Denevan

Delaunay Family of Services is a nonprofit agency based in the North Portland (St. Johns) area. It began as a family counseling and youth services center over 20 years ago, but has grown to include community support services for persons with serious mental illness. These include case management, psychiatry, socialization/day treatment and pre-vocational services. Delaunay operates a group home for its most disabled consumers and provides both ISH and SSH housing on a limited basis. Delaunay recently merged with Mental Health Services West. The new service provider entity is called Unity, Inc.

Garlington Center (GC), Portland, Oregon.
Contact(s): Janette Wilken, Dave Helgeson

Garlington Center was one of four "core service agencies" established by Multnomah County in the early 1980s to provide services for persons with serious mental illness. Its geographic area includes north and northeast Portland and encompasses the area of Portland where a concentration of African Americans live. Garlington Center has operated as a comprehensive community mental health center with an emphasis on providing culturally appropriate services. Its services for adults with serious mental illness include case management, psychiatry, socialization/day treatment and vocational services. Its housing includes the innovative "Garlington Plaza" (a supportive community where residents enjoy the privacy of their own efficiency apartments), several SSH sites, referrals to foster care homes, and support services for consumers living in various housing sites integrated throughout the community (ISH). There are no group homes associated directly with Garlington Center. Garlington Center recently merged with Mental Health Services West and is now part of Unity, Inc.

Mental Health Services West (MW), Portland, Oregon.
Contact(s): Brad Heath

Mental Health Services West was established as a "core service agency" in Multnomah County in the early 1980s and serves Portland's west side, including the downtown area where homeless individuals tend to congregate. MW provides comprehensive mental health services. Its community support services for persons with serious mental illness include case management, psychiatry, socialization/day treatment, dual diagnosis, residential/housing and vocational services. Its housing programs include group homes, two large supportive

communities that provide transitional housing to persons who are homeless or at risk of homelessness, several SSH sites, and support to persons living in housing integrated throughout the community (ISH). Recently merged with two other service providers, Mental Health Services West is now known as Unity, Inc.

Mt. Hood Community Mental Health Center (MH), Gresham, Oregon.
Contact(s): Rose Mary Ojeda

Mt. Hood Community Mental Health Center was established as a "core service agency" in Multnomah County in the early 1980s in order to deliver coordinated, community support services for persons with mental illness in the east Multnomah County (east Portland and Gresham) area. It is a comprehensive mental health agency. Its services for persons with serious mental illness include case management, psychiatry, socialization/day treatment, vocational services, group home referrals, several SSH sites and support to persons living in housing integrated throughout the community (ISH). MH works with several privately operated group homes in the east Multnomah County area. Its own housing programs include several SSH sites, a specialized program for elderly persons with mental health and physical care needs and ISH services provided through its case management program.

Network Behavioral HealthCare (NW), Portland, Oregon.
Contact(s): Doug Stockey, Jim Hlava

Network Behavioral HealthCare began as a socialization drop-in center in the early 1980s and became the "core service agency" in Multnomah County for services to persons with serious mental illness in the southeast Portland area. NW is a comprehensive mental health agency that has recently merged with substance abuse and other community service agencies. Through its collaborative relationship with the Chinese Social Services Center, NW incorporated features into one of its housing sites to accommodate Asian residents (e.g. interior design features, kitchen appliances that accommodate wok cooking). Its services for persons with psychiatric disabilities include case management, psychiatry, socialization/day treatment, vocational services and residential/housing services. NW operates group homes, refers to privately operated group homes and foster care providers, operates an impressive array of SSH housing integrated throughout its service area (including specialized housing for persons with HIV/AIDS and dual diagnoses), and provides ISH services to consumers living in housing integrated throughout the community through its case management services.

WASHINGTON COUNTY

Banyan Tree (BT), Aloha, Oregon.
Contact(s): Christine Fore

Banyan Tree is a nonprofit agency based in Aloha (Washington County). BT began as a group home program, but has grown to provide a broader range of mental health services including case management, psychiatry, socialization/day treatment, supported housing and crisis respite

services. BT's housing programs include the original group home, a crisis respite home, some transitional independent living housing and support services for many consumers who live in housing integrated throughout the community (ISH). BT encourages consumers placed in its group home to achieve their highest level of independence and move to less restrictive environments.

Homestreet (HS), Hillsboro, Oregon.
Contact(s): Bill Faricy

Homestreet was established as a supportive housing agency in the early 1980s by family members who were frustrated by the lack of affordable community housing for their loved ones. The agency initially rented 4-bedroom homes and other shared housing that was subleased to consumers who received community-based support services from Homestreet staff. Homestreet has evolved into a more comprehensive mental health service agency and provides case management, psychiatry, socialization and other individualized services to persons in ISH and SSH housing. Its housing programs include a small group home, transitional housing, two apartment complexes (SSH) and support services for many consumers who live in integrated community housing (ISH).

Appendix B – Local Research Advisory Council Members

Membership:

Project Director:	Vicki Skryha, OMHS/MHDDSD
Research Team:	Robert Paulson, RRI/PSU Nancy Koroloff, RRI/PSU Debi Elliott, RRI/PSU Paul Koren, RRI/PSU Mary Mattis, RRI/PSU
Service Providers:	Janette Wilken, Garlington Center Mary Alice Brown, Laurel Hill Center (Chair) Bill Faricy, Homestreet Christine Fore, Banyan Tree Brad Heath, Mental Health Services West Rose Mary Ojeda, Mt. Hood CMHC Tom Terrell, Lane ShelterCare
Consumers:	Scott Huffman, SAFE, Inc. (Oregon CAP Representative) James McCoy, Mt. Hood CMHC Elaine Myers*, Homestreet Jack Smith, Mt. Hood CMHC (Vice Chair) Steve Williamson*, Oregon Office of Consumer Advocacy
Family Members:	Earl Egan, Washington Co. AMI Rich Dierking, Washington Co. AMI Keith Guinn, Multnomah County AMI and Mt. Hood CMHC Board Carol Laine, Multnomah County NAMI
Consultants/Others:	David Cutler, OHSU Community Psychiatry Program Kyleen Gower, OMHS/MHDDSD Michael Sedlock, Marion Co. Mental Health Kay Mattson, Housing Authority of Portland

Purpose:

To provide advice in the implementation of the Oregon Supportive Housing Evaluation Project.

*Research Assistant for Phase I

Appendix C – Detailed Description of Methodology

This appendix provides a detailed description of the methodology employed to conduct the OSHEP-Phase I process evaluation. The methodology included document reviews, site visits and surveys to obtain data on the population served in supportive housing, the costs of various approaches and the degree to which approaches were consistent with identified housing dimensions across providers.

Surveys to Derive Population Description and Group Comparability. Surveys were mailed to all ten service providers in late December, asking them to document by housing approach both current clients as of December 1, 1997 and new clients enrolled in the housing program between October 1, 1997 and March 31, 1998. Information gathered with those surveys included date of entry into housing, past and current criminal justice involvement, and past and current crisis services usage (see Appendix D). As the project director received the surveys they were reviewed for completeness and then entered into a database. After creating a matching code, additional data on all of the consumers listed on those surveys was collected from two state databases: Client Process Monitoring System (CPMS) and Oregon Psychiatric/Residential Care System (OP/RCS). Data from these systems included additional demographic information, priority status, and scores from the Multnomah Community Ability Scale (MCAS). The data was analyzed (employing frequencies, chi square tests, and analysis of variance) to reveal descriptive information about the consumers living in the different housing approaches and to make group comparisons.

Cost Analysis. To obtain cost data, an instrument was developed based upon a prior survey of residential service costs (Skryha and Kast, 1993). Service providers were asked to use the 1996-97 fiscal year and provide data for each housing program relevant to the study that had its own budget. For each housing program, they were asked to indicate which services were provided as part of the housing program (i.e., included in the housing program budget); the number of staff included in the budget; and the number of consumers served at any one time. They were then directed to list all revenues and expenses for each program and to estimate the percentage (by quartile) of consumers in each housing program who received benefits and services not directly included in the housing program budget. Data was then compiled into a consistent format (summary reports) for all agencies. In order to verify the compiled data, service providers were asked to review and confirm the summary reports on two separate occasions before the data was finalized for presentation.

Fidelity Assessment. Site visits to each of the ten housing provider agencies were conducted by the project director, principal investigator, project manager, graduate research assistant, and one or both consumer research assistants over a 3-1/2 month period in early 1998. Prior to each site visit, the graduate research assistant contacted the housing specialist to request a number of program documents and descriptive information for each housing program. A list of the materials requested are presented in Figure C-1. The materials gathered were compiled in a

Figure C-1: Pre-Site Visit Data Collected

- Program Description
  - Services provided
  - History
  - Brochure/Flyer/Fact Sheets
- Housing Description
  - Housing site name and/or address
  - Type of housing (e.g., studio, 1 br, 2 br)
  - # of units
  - # of consumers served (i.e., capacity)
  - Total # of tenants in building
  - Photograph
- Rental agreement/lease
- House rules
- Grievance procedures
- Housing application form
- Schedule of daily activities
- Other program documents
- Eligibility criteria
- Agency organizational chart
- Diagram of the referral process

notebook for each agency and taken to the site visit for review and completion by the housing specialist and project manager.

Also prior to each site visit, the project director contacted the housing specialist for each agency. The purpose of this initial contact was to begin making arrangements for the site visit, including securing the participants needed to gather the necessary data. The project manager followed up that contact to finalize the agenda for the site visit and to make any final arrangements. This two-tiered approach to preparing for each site visit increased the likelihood that the visit went smoothly and that all of the participants were inconvenienced as minimally as possible.

Before any site visit was conducted, consumer research interviewers were hired and trained. The project director and project manager interviewed 17 qualified consumers for the position of research assistant, narrowing the pool down to two highly-skilled individuals. These research assistants participated in a day-long training that provided them with overviews of the project, the housing context in Oregon for adults with psychiatric disabilities, the process evaluation, and the site visits. In addition, the research assistants were instructed in performing research interviews and general characteristics of unbiased data collection. Finally, the focus group questions and questionnaire items were reviewed individually, making sure that the research assistants were clear about the goals of each question. As mental health consumers, these individuals provided valuable input on the focus group protocol and questionnaire content. Adjustments to the items were made and resulted in improved instruments.

Each site visit was divided into an overview of the purpose of the site visit and the collection of agency level data, followed by half-day data collection segments for each housing approach represented at a given agency. During each site visit, data was derived from seven sources: administrator interviews, staff and consumer focus groups, staff and consumer questionnaires, program documents, and housing tours.

Three groups of individuals provided data during the site visits. The administrator interviews included individuals who were most knowledgeable of the history of housing services within the agency. These individuals included the executive director, housing specialist, clinical director, and/or program manager(s). Most commonly, two to three agency staff participated in the administrator interviews. The direct service staff both participated in focus groups and responded to a brief questionnaire. These individuals included case managers, resident managers, skills trainers and staff in related positions that were directly involved in the provision of housing and/or support services to consumers. The consumer participants were identified as being involved in the housing program(s) under study and able to sit through a 1½-hour group data collection meeting. The direct service staff experienced a similar process, that is, focus group participation and questionnaire completion).

The following is a description of the manner in which the data was collected and analyzed for each type of data source.

- *Interviews and Focus Groups:* One administrator interview was performed for each of the ten agencies. The content of the interview focused on the program's guiding philosophy, history, and environmental context, characteristics of the housing and support services, and the impact of managed care. One staff and one consumer focus group was performed for each housing approach within each agency. In total, six

agencies included the ISH approach, eight agencies included the SSH approach, and two agencies included the SC approach, resulting in 16 pairs of focus groups. The groups ranged in size from 2 to 8 participants for direct service staff, and from 3 to 11 participants for consumers. Similar information was gathered from each group, including characteristics of the housing and support services, procedures for securing and maintaining housing, and the effects of managed care.

Prior to each interview and focus group, participants heard a description of (a) the purpose of the project, (b) the extent of their participation in the project, and (c) their rights as human subjects involved in a research project. They were each given an informed consent form, which they were asked to read and sign if they were willing to participate in the research as described. All individuals agreed to participate.

Each interview and focus group was tape recorded for later transcription. The research team created codes for each of the 15 housing dimensions (see Table C-2), as well as other variables including history, context, referral, philosophy, managed care, and organizational issues. The project manager trained four individuals to code the transcripts. The transcript files were imported into Ethnograph (1998), the codes identified by the coders were added, then individual reports by approach within agency were run for each of the 15 housing dimensions.

- *Questionnaires:* Each staff and consumer focus group participant completed a housing questionnaire that focused on consumers' perceptions of their housing and services. The questionnaires were reviewed by the project manager then sent to a local company for data entry, along with clear record layout guidelines. The data files received were analyzed by item (frequencies, chi square tests, and ANOVA's). Reports were printed by approach within agency.

- *Program Documents:* All documents received from providers were organized into notebooks by site within approach within agency. One of the consumer research assistants, who is intimately familiar with program documents through her who work as a resident manager at one of the supervised apartment complexes involved in the project, was trained to review the documents. After familiarizing herself with the housing dimension indicators the research assistant coded each indicator based on whether or not a document existed that supported or refuted it.

- *Housing Tours:* During each housing tour, pictures were taken of both the exterior and interior of the housing sites. With the permission of the tenants, interior apartment/room photos were also taken. These photos were organized and displayed by site within approach within agency.

Once the data was compiled from *all* of the sources, it was organized into notebooks by approach within agency.

Fidelity Scoring. Taking one notebook at a time, the principal investigator and project manager rated each source for each indicator within a dimension (see Table C-2). Ratings were coded as follows: (a) yes, the indicator is true for that source (yes=5); (b) no, the indicator is not true for that source (no=1); or (c) mixed, the indicator is true for some people or some of the time (mixed=3). Any time the information from a source was unclear or missing, the indicator was

not coded. Intermediate codes were also possible (i.e., 4=mixed but true for the majority, 2=mixed but not true for the majority). The indicator ratings were summed across sources to result in an overall indicator score, ranging from 5 (true for all sources available) to 1 (not true for all sources available). The indicator scores were summed to achieve an overall dimension score, also ranging from 5 to 1. The dimension scores were transferred to a Housing Dimensions Rating Sheet to summarize all of the scores for a housing approach within an agency.

As a means to check the reliability of the fidelity scores, the research team reviewed all of the dimension scores. This process considered the scores in light of the team's general knowledge of the housing programs (especially when documentation and/or data were unavailable) and highlighted areas that needed further review of the data (e.g., outliers, discrepancies). A set of fidelity scores were faxed to providers to review and discuss with the project manager. Feedback from the providers resulted in a few minor adjustments to the scores. The final score means are presented in Table 3. Scores were adjusted when justified, based upon data review and team consensus.

Table C-2: Housing Dimensions and Indicators

Dimension	Indicators
Supported Housing Fidelity Dimensions:	
HOUSING CHOICE: Consumer has right to explore housing preferences/options and make a choice from available options; or, consumer has choice of units; or consumer has choice to go on a waiting list for preferred apartment. Consumer always has right to determine if s/he wants a single unit or to have a roommate, and has final decision in choice of roommate(s).	➛ Policies and procedures to explore options/ preferences *OR* housing search function. ➛ Given housing options *OR* shown multiple units. ➛ Decided whether to have a roommate. ➛ Choose who roommate is. ➛ Change roommates if not working out. ➛ Move to unit without roommate if not working out.
FUNCTIONAL SEPARATION OF HOUSING FROM SERVICE PR0VISION: Housing owned &/or managed by separate or subsidiary agency from one providing services or by private landlord; or housing is owned or leased by primary service provider and staff responsibilities are functionally distinct.	➛ Housing owned/managed by agency separate from service provider. ➛ Functional distinction between housing & service staff. ➛ Housing mgt/operation not responsibility of service agency/staff.
HOUSING AFFORDABILITY: Program has written policy that supports housing affordability and procedures for securing federal/state/county/ local/agency subsidies for consumers; or provider has memo of understanding with public housing agency, agency administering federal/state subsidies, or state/ county/ local housing development agency that will provide subsidies or subsidized housing to consumers in this study. Also, at least 75% of new entries will have access to subsidies/subsidized housing. When unit is beyond consumer's means, s/he may determine that s/he wants roommate(s) to make unit affordable.	➛ 40% of monthly adjusted income, *OR* availability of subsidies, *OR* roommates available, *OR* waiting list.
INTEGRATION: Housing is scattered site or multi-unit with <50% of tenants having serious mental illness throughout building.	➛ Tenant selection policies limit percent of SMI *OR* subsidy type (TRA proxy for scattered site). ➛ Building mixed population. ➛ Size and scale of building consistent with neighborhood.
RIGHTS OF TENURE: Consumer has full rights of tenancy consistent with state/local landlord/tenant law.	➛ Standard lease/sublease occupancy agreement consistent with state tenant/landlord law. ➛ Program/house rules consistent with state tenant/landlord law.

Appendix C (continued)

Dimension	Indicators
SERVICE CHOICE: Consumer has right to choose, refuse, and modify services and supports.	➢ Written grievance process *OR* written human rights or statement of rights policy. ➢ Asked what services needed. ➢ Able to get needed services. ➢ Able to change service plan. ➢ Consumer's wants respected if disagree with staff. ➢ Can refuse services and/or meds.
SERVICE INDIVIDUALIZATION: Service delivery prioritizes efforts to adapt type, location, intensity, frequency of services and supports to consumer's preferences/needs.	➢ Service agency is flexible. ➢ Service agency has capacity to individualize services.
SERVICE AVAILABILITY: Consumers/housing program rely exclusively on community-based service availability, including 24/7 crisis services, treatment (mental health, meds, D/A, medical), case management (life skills, serv. coord., assessment & service planning), respite, & vocational.	➢ 24/7 crisis services available. ➢ Reliance on community-based services. ➢ No barriers to receiving services in the community. ➢ Staff on-site.
Other Housing Dimensions:	
PERMANENCE: No actual or expected limits on housing tenure.	➢ Can live in housing indefinitely. ➢ Lease/occupancy agreement/service contract documents tenure. ➢ Tenant determines when to move out.
INDEPENDENCE: Consumer controls decisions regarding her/his living environment including visitation, unit access/privacy, schedule and use of disposable income.	➢ Not required to accept services. ➢ Rep payee not required. ➢ Can come and go as please. ➢ Have key to building. ➢ Can stay in room all day. ➢ No restrictions on drinking/smoking in apartment. ➢ Visitor restrictions compatible with standard lease.
SAFETY: Location of housing and housing itself are safe.	➢ HSQ or similar report *OR* licensed for health and safety *OR* availability of security. ➢ Building perceived as safe. ➢ Neighborhood perceived as safe.
SOCIALIZATION: Housing program facilitates/encourages regular socialization.	➢ Mechanisms for facilitating social activities *OR* regularly scheduled activities. ➢ Opportunities to meet others and make friends. ➢ Reported feelings of isolation.
STRUCTURE: Housing program creates highly motivational environment encouraging/providing regular daily activity.	➢ Evidence of programming and/or staffing patterns. ➢ Meals scheduled at certain times.
PRIVACY: Housing environment provides maximum privacy. Consumer has exclusive use of bedroom, kitchen and bathroom. Staff cannot enter consumer's apartment without prior written notice and approval by consumer. Consumer holds keys to individual apartment, access doors, and laundry facilities.	➢ Exclusive use of bedroom, bathroom, kitchen. ➢ Reported feelings of privacy. ➢ Service staff do not have keys. ➢ No one can enter without permission. ➢ Can lock own apartment/room. ➢ No more than annual inspection.
SHARED LIVING: Consumer lives with one or more unrelated individuals. Consumer may share common space in a unit and have an individual bedroom, or may share a bedroom.	➢ Evidence of consumers sharing apartments/rooms. ➢ Evidence of relationship of roommates.

Appendix D – Copies of Surveys and Site Visit Forms

This appendix contains copies of forms used for mailed service provider surveys and during site visits.

Mailed Surveys:

Form #1: CURRENT Clients on 12/1/97

Form #2: NEW Clients 10/1/97 - 3/31/98

Site Visit Instruments:

Housing Cost Analysis Form (FY '96 - '97) (7//1/96 – 6/30/97)

Interview with Administrators

Consumer Focus Group Questions

Consumer Housing Questionnaire

Staff Focus Group Questions

Staff Housing Questionnaire

Appendix E – Selected Site Visit Questionnaire Data

Table E-1: Summary of Selected Questionnaire Data by Housing Approach & Respondent Group

#	Questionnaire Item [a]		Mean Rating (1-5 point scale [d]) Consumer [b]	Staff [c]	Comments
1	My housing is attractive/pleasant in appearance.	ISH SSH SC	3.38 4.22 3.80 *(p<.01)*	2.87 4.10 3.50 *(p <.001)*	ISH residents tended to rate housing as more attractive than ISH staff. More variability by approach among staff than consumers.
2	My housing is in good repair and condition.	ISH SSH SC	3.66 4.10 4.20	3.09 4.06 3.72 *(p <.001)*	ISH & SC residents tended to rate housing conditions slightly higher than staff; consumer ratings more favorable overall.
3	My housing is located in a safe building.	ISH SSH SC	4.08 4.44 3.55 *(p <.01)*	3.04 4.32 3.89 *(p <.001)*	ISH residents tended to rate buildings safer than ISH staff; opposite tendency with SC staff. SSH received most favorable ratings overall.
4	My housing is located in a safe neighborhood.	ISH SSH SC	3.86 3.70 2.80	2.91 3.61 2.20 *(p <.001)*	ISH residents tended to rate neighborhoods safer than ISH staff.
5	My housing is in a building that is relatively crime-free.	ISH SSH SC	3.92 4.36 3.60 *(p <.05)*	3.09 4.32 4.30 *(p <.001)*	ISH residents tended to rate buildings more crime-free than staff.
6	My housing is in a neighborhood that is relatively crime-free.	ISH SSH SC	3.54 3.79 2.82	3.00 3.48 2.00 *(p <.001)*	Staff viewed neighborhoods as less safe overall; SC neighborhoods rated as least safe.
7	My housing is located near public transportation.	ISH SSH SC	4.66 4.62 5.00	4.43 4.81 5.00 *(p <.01)*	Housing in all approaches was indicated to be near public transportation.
8	My housing is located near a grocery store and other shopping.	ISH SSH SC	4.32 4.05 4.27	3.96 4.27 3.60	Housing was generally found to be near grocery stores and shopping.
9	My housing is located near places for recreation and socialization.	ISH SSH SC	3.92 3.81 3.91	3.35 3.27 3.10	Consumers ratings more favorable.
10	My housing is affordable.	ISH SSH SC	4.05 4.59 4.27 *(p <.05)*	2.52 4.35 4.30 *(p <.001)*	ISH residents tended to rate housing more affordable than ISH staff; otherwise not much variation.
11	My housing is integrated into a residential neighborhood.	ISH SSH SC	4.16 4.17 3.50	3.22 4.19 2.50 *(p <.001)*	Less variability among residents than staff by approach.
12	I get along with my neighbors	ISH SSH SC	4.05 4.13 4.30	n/a	Not much variation among approaches.
13	I have a good relationship with my landlord.	ISH SSH SC	4.28 4.35 4.09	n/a	Not much variation among approaches.
14	I like the amount of privacy I have.	ISH SSH SC	4.31 4.52 4.45	n/a	Not much variation among approaches.
15	I have enough opportunities to meet people and make friends.	ISH SSH SC	3.72 4.37 3.73 *(p <.01)*	n/a	SSH somewhat higher than both ISH & SC.
16	I feel isolated where I live.	ISH SSH SC	2.47 2.08 2.09	n/a	Minimal degree of isolation in all types; ISH tended to be slightly more isolation.
17	Where I live, staff intrudes upon my privacy.	ISH SSH SC	1.71 1.90 2.64	n/a	ISH and SSH comparable; staff viewed as slightly more intrusive in SC.

Appendix E (continued)

#	Question		Consumer	Staff	Comments
18	Services offered are convenient for me.	ISH SSH SC	3.95 4.41 4.55 *(p <.05)*	n/a	SSH and SC consumers indicate services are somewhat more convenient.
19	The services I receive are based on my individual needs and choices.	ISH SSH SC	4.14 4.05 3.60	4.30 4.58 4.30	Not much variation; SC consumers experience least individualization.
20	Everyone gets the same services whether they need them or not.	ISH SSH SC	2.87 3.18 3.30	1.70 1.81 2.10	Consumers perceive more uniformity in services than staff.
21	I can contact staff for assistance any time.	ISH SSH SC	4.08 4.06 4.36	4.22 4.20 4.90 *(p <.05)*	High degree of agreement; SC staff indicated highest level of availability to consumers.
22	How satisfied are you with where you are living right now?	ISH SSH SC	4.13 4.35 3.82	n/a	ISH & SSH have comparable levels of satisfaction; SC slightly lower.
			Percent (%) Yes		
#	**Question (Yes/No)**		**Consumer**	**Staff**	**Comments**
23	Did someone explain your rights and responsibilities under the lease?	ISH SSH SC	82.1 88.6 83.3	100.0 100.0 100.0	Staff indicate that rights and responsibilities are explained to a higher degree than consumers.
24	Can you come and go as you please?	ISH SSH SC	100.0 98.4 100.0	95.7 100.0 100.0	High level of freedom to come and go expressed among all respondents.
25	Are you allowed to have visitors in your room/housing?	ISH SSH SC	97.4 98.4 100.0	100.0 100.0 100.0	Generally high and positive response.
26	Are you allowed to drink alcoholic beverages in your housing?	ISH SSH SC	43.2 12.7 0 *(p <.001)*	71.4 30.0 0 *(p <.001)*	SSH & SC housing are more likely to be considered alcohol-free. Staff (ISH & SSH) view alcohol consumption as more permissive than consumers.
27	Are there regularly scheduled activities associated with this housing?	ISH SSH SC	17.9 84.1 100.0 *(p <.001)*	27.3 93.5 100.0 *(p <.001)*	SSH & SC housing have higher level of regularly scheduled activities.
28	Can you continue to live in your housing as long as you want to or will you have to move?	ISH SSH SC	91.9 86.7 81.8	90.9 80.6 50.0 *(p <.05)*	Relatively higher degree of perceived permanence by all except SC staff.
29	If, for whatever reason, you stopped receiving mental health services, would you lose your housing?	ISH SSH SC	44.4 59.2 66.7	15.0 46.4 66.7 *(p <.05)*	Consumers tended to have greater fear of losing housing than staff. ISH housing least likely to be lost.
30	If you stopped taking medication, would you lose your housing?	ISH SSH SC	46.7 60.4 62.5	9.5 16.1 20.0	Consumers answered yes much more frequently than staff.
31	If you chose to get married, would you lose your housing?	ISH SSH SC	31.4 36.2 83.3 *(p <.05)*	14.3 13.8 80.0 *(p <.001)*	Consumers answered yes more frequently than staff, especially in ISH & SSH approaches.
32	Would you like to move someplace else?	ISH SSH SC	34.2 34.4 36.4	n/a	Comparable levels of desire to move.
33	Do residents need to be home for your visit or be informed prior to your visit?	ISH SSH SC	n/a	90.0 90.0 90.0	Same percentage of yes answers for all approaches.
34	Do staff conduct housing inspections?	ISH SSH SC	n/a	68.2 100.0 100.0 *(p <.01)*	SSH & SC staff more likely to conduct inspections.

[a] Wording of questions taken from Consumer Questionnaire for the majority of items
[b] Consumer sample sizes: ISH=39, SSH=67, SC=11
[c] Staff sample sizes: ISH=23, SSH=31, SC=10
[d] 5 = strongly agree; 1 = strongly disagree

Appendix F – Data Tables for "New Clients" and Consumer Focus Group Participants

Table F-1: Characteristics of Consumers Entering Housing over Six Months

Consumer Characteristic	ISH	SSH	SC	TOTAL
Average Age	37.6 years *(n=51)*	38.8 years *(n=67)*	41.8 years *(n=44)*	39.3 years *(n=162)*
Gender:				
Male	61.4% *(n=27)*	52.2% *(n=24)*	58.1% *(n=18)*	57.0% *(n=69)*
Female	38.6% *(n=17)*	47.1% *(n=22)*	41.9% *(n=13)*	43.0% *(n=52)*
Marital Status: *				
Never Married	52.3% *(n=23)*	58.7% *(n=27)*	58.1% *(n=18)*	56.2% *(n=68)*
Married or Living As Married	11.4% *(n=5)*	6.5% *(n=3)*	3.2% *(n=1)*	7.4% *(n=9)*
Divorced, Widowed or Separated	18.1% *(n=8)*	28.2% *(n=13)*	3.2% *(n=1)*	18.2% *(n=22)*
Unknown	18.2% *(n=8)*	6.5% *(n=3)*	35.5% *(n=11)*	18.2% *(n=22)*
Ethnicity:				
White	84.1% *(n=37)*	86.4% *(n=38)*	76.7% *(n=23)*	83.1% *(n=98)*
African-American	6.8% *(n=3)*	11.4% *(n=5)*	13.3% *(n=4)*	10.2% *(n=12)*
Native American	2.3% *(n=1)*	2.3% *(n=1)*	0% *(n=0)*	1.2% *(n=2)*
Asian, SE Asian, Pacific Islander	2.3% *(n=1)*	0% *(n=0)*	3.3% *(n=1)*	1.2% *(n=2)*
Hispanic (Mexican, Cuban, Other)	4.6% *(n=2)*	0% *(n=0)*	6.7% *(n=2)*	3.4% *(n=4)*
Priority One Clients[1]	97.7% (*n=38)*	97.8% (*n=44)*	100.0% (*n=31)*	96.6% *(n=113)*
Multnomah County Ability Scale				
(average scores)	*(n=32)*	*(n=42)*	*(n=42)*	*(n=86)*
Interference with Functioning**	17.34	17.79	13.33	17.00
Adjustment to Living	9.88	10.10	8.08	9.73
Social Competence*	14.66	15.19	12.42	14.60
Behavioral Problems*	14.53	16.10	12.67	15.03
TOTAL[2],**	56.41	59.17	46.50	56.37
Average Use of Crisis Services**				
(1=rarely, 5=A Lot)	2.89 *(n=37)*	1.97 *(n=64)*	2.75 *(n=20)*	2.38 *(n=121)*
Post[3] Crisis Respite Use	16.7% *(n=5)*	17.5% *(n=10)*	28.6% *(n=6)*	19.4% *(n=21)*
Prior[3] Criminal Justice Involvement	38.5% *(n=15)*	46.0% *(n=23)*	50.0% *(n=10)*	44.0% *(n=48)*
Post[3] Criminal Justice Involvement	9.5% *(n=4)*	1.8% *(n=1)*	19.0% *(n=4)*	7.5% *(n=9)*

[1]Priority One = At risk of hospitalization or poses hazard to health/safety of self/others.
[2]Levels of Ability: 17-47=severe disability, 48-62=medium disability, 63-85=little disability.
[3]Relative to entry into housing program.
*p<.05
**p<.01

Appendix F (continued)

Table F-2: Characteristics of Consumer Focus Group Participants

Consumer Characteristic	ISH	SSH	SC	TOTAL
Average Age	42.9 years *(n=39)*	42.0 years *(n=63)*	46.64 years *(n=11)*	42.73 *(n=113)*
Gender:				
Male	53.8% *(n=21)*	55.6% *(n=35)*	45.5% *(n=5)*	54.0% *(n=61)*
Female	46.2% *(n=18)*	44.4% *(n=28)*	54.5% *(n=6)*	46.0% *(n=52)*
Ethnicity:				
White	87.2% *(n=34)*	76.2% *(n=48)*	72.7% *(n=8)*	80.4% *(n=90)*
African -American	2.6% *(n=1)*	7.9% *(n=5)*	18.2% *(n=2)*	7.1% *(n=8)*
Native-American	5.1% *(n=2)*	12.7% *(n=8)*	9.1% *(n=1)*	9.8% *(n=11)*
Asian, SE Asian, Pacific Islander	—	—	—	—
Hispanic (Mexican, Cuban, Other)	2.6% *(n=1)*	3.2% *(n=2)*	—	2.7% *(n=3)*
Years in Current Residence:				
<1 year	23.1% *(n=9)*	19.4% *(n=12)*	30.0% *(n=3)*	21.6% *(n=24)*
1-2 years	20.5% *(n=8)*	27.4% *(n=17)*	—	22.5% *(n=25)*
2-4 years	15.4% *(n=6)*	37.1% *(n=23)*	60.0% *(n=6)*	31.5% *(n=35)*
4-7 years	25.6% *(n=10)*	8.0% *(n=5)*	10.0% *(n=1)*	14.4% *(n=16)*
>7 years	15.4% *(n=9)*	8.0% *(n=5)*	—	13.5% *(n=15)*
Average Years in Current Residence	4.2 years *(n=39)*	2.9 years *(n=62)*	2.5 years *(n=10)*	3.4% *(n=111)*
Number Moves in Past Year:				
0 moves	57.9% *(n=22)*	73.8% *(n=45)*	50.0% *(n=4)*	66.4% *(n=71)*
1 move	21.0% *(n=8)*	11.4% *(n=7)*	25.0% *(n=2)*	15.9% *(n=17)*
2-3 moves	16.7% *(n=6)*	11.4% *(n=7)*	12.5% *(n=1)*	13.1% *(n=14)*
7+ moves	5.3% *n=2)*	3.3% *(n=2)*	12.5% *(n=1)*	4.7% *(n=5)*
Average Number of Moves in Past Year	1.0 moves *(n=38)*	.6 moves (*n=61)*	1.0 moves *(n=8)*	.8 moves *(n=107)*
Homeless in Last 5 Years:				
Yes	25.6% *(n=10)*	30.2% *(n=19)*	45.5% *(n=5)*	30.4% *(n=34)*
No	74.4% *(n=29)*	68.3% *(n=43)*	54.5% *(n=6)*	69.6% *(n=78)*

Note: No variables were significantly different across groups.

Appendix G – Data Tables for Other Findings
Table G-1

OSHEP Phase 1 - Managed Care Data Analysis

Administrator Interview: Agencies with 2+ years under managed care (n=3a):

(Listed categorically, based on number of responses (r) per category.)

Table G-1:

Funding/staff levels. (10r,2a)
Capacity to provide services went down
Initially took big funding hit
Initially faced 40% funding cut
Initially had to lay off staff
Have to serve more consumers with fewer staff
Before managed care, 18-20 clients/caseload; now 25-30 but have auxiliary staff
Get same case rate for person in group home and person who is homeless -- funding does not cover cost of extra services that are necessary
Funding level has crept back up
Able to negotiate for higher rates over time
Staffing level beefed back up over time (though not to prior levels

Flexibility. (3r,2a)
Flexibility in service delivery has increased
Improved ability to provide housing due to more flexibility
Can use descretionary funds to make loans or grants to consumers to obtain housing (e.g. for security deposits, etc.)

Credentialing. (3r,2a)
Credentialling requirements necessitate hiring more QMHPs (more expensive)
Only Masters level staff can be hired
Increased professionalism of staff

Accountability. (3r,1a)
Greater accountability
More specific treatment plans
More clinical justification for services

More paperwork. (1r,1a)
Staff spend more time doing paperwork/ less time providing services

Diversified client population. (1r,1a)
Client population has diversified (more personality disorders and organic brain disorders); about 80% are old Priority 1 while 20 % are “new eligibles” -- this has created challenges for staff

Priority of housing. (1r,1a)
Housing not on radar screen of Managed Care Organizations

Appendix G -- Table G-1 (continued)

OSHEP Phase 1 - Managed Care Data Analysis

Administrator Interview: Agencies with <1 year under managed care (n=7a):

(Listed categorically, based on number of responses (r) per category.)

Less funding/staff. (16r,7a)
It's been a struggle to insure we have funding to support services/operations at the housing
Acturarial analysis did not take into account the kind of residential supports needed by clients; may result in removing or reducing a critical layer of services at housing sites (e.g. SC sites)
Need to dilute services overall
Case managers feel very constrained due to limited funding
Caseloads up (went from 20-25 to 40-45 clients/CM)
Much harder to provide support to persons in housing due to decreased funding; hard to decrease services without it affecting clients
Community meetings at housing site have been decreased to ½ hour/week
There's a set amount of funding for each client each month; no longer any grant funding; now completely rely on OHP for funding
Have to get individual service authorizations and provide services within set Medicaid allocation
Had to close vocational setting (clothing resale store)
Outreach focus that enables people to live in scattered, integrated housing may be seen as too expensive and not cost-effective
Caseloads are increasing; CMers have less time to visit consumers at housing sites
There's fewer staff to provide services (30% staff reduction)
Providing more groups, less individual treatment
Dual diagnosis housing must now operate with less staff available than originally envisioned
Program used to be based on what consumers wanted and was very successful; now have to cut back "non-medical" support (e.g. going out for a cup of coffee with a consumer)

Increased paperwork. (4r,3a)
Paperwork increased
Paperwork has quadrupled
Each individual's plan of care is approved by MCO; lots of paper and meetings
Went from electronic billing to paper billing resulting in huge increase in time demand

Authorization systems impede flexibility. (3r,3a)
MCO allocates service hours/client; impedes flexibility in service delivery
Now have to work with three different payment systems (one that is discounted fee-for-service, one that is case rate and one that is open card fee-for-service)
Need pre-authorization for every 15 minutes of service

Flexibility. (3r,3a)
Hoping to eventually see more flexibility
Increased flexibility to move dollars within budgets
Traditional outpatient clients (who used to receive 50-min hour therapy) now can access case management and this level of support works better for housing sites

Increased roles for consumers. (3r,1a)
Now have more consumer volunteers
More couples and marriages (may not be related to managed care!)
There's support for consumer drop-in centers

Less service duplication. (1r,1a)
Seems to be resulting in less service duplication in area of case management (CM used to be provided by both County and provider; now may be provider only)

Stable funding. (1r,1a)
Not out dollars due to ice storm days

Maintenance of housing. (1r,1a)
Have maintained housing and continue to develop more

Decision-making. (1r,1a)
Policy decision-making not as inclusive

Diversified service population. (1r,1a)
More diverse service population -- more addictions, anti-social, sociopathic and multiple problem individuals

Increased need for transitional housing. (1r,1a)
See an increased need for transitional housing due to managed care time pressures (less emphasis on permanent)

Appendix G -- Table G-1 (continued)

OSHEP Phase 1 - Managed Care Data Analysis

Consumer Focus Groups:: Agencies with 2+ years under managed care (n=3a):

(For each approach, listed categorically, based on number of responses (r) per category.)

INTEGRATED SUPPORTED HOUSING:

Limited choice. (5r,2a)
Ability to change doctor/dentist is cut back
Can no longer receive services from more than one provider
Can no longer earn income by working in a vocational program; this affects my mental status
If you are on SSD/Medicare, you have very limited benefits
Doctors are less accessible and you can't change them once assigned

Decrease in services/expenses. (2r,1a)
Under managed care, they are cutting down on expenses, services
Staff used to do home visits, take you shopping, take you to Dr. appts., but not anymore

General negative sentiment. (1r,1a)
We're trying to fight HMOs coming in and taking over; strong feelings expressed by several that HMO would have negative impact

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SITE-SPECIFIC SUPPORTED HOUSING:

No change experienced. (2r,2a)
Experienced no change in services since managed care
Some experienced no change

Decrease in services. (2r,1a)
Had to begin paying for my medicine; some medicines no longer covered
Food stamps cut back

More diversity of clientele. (1r,1a)
More people are now coming to the center

SUPPORTIVE COMMUNITY

Not included in this group.

Appendix G -- Table G-1 (continued)

OSHEP Phase 1 - Managed Care Data Analysis

Consumer Focus Groups: Agencies with <1 year under managed care (n=7a):

(For each approach, listed categorically, based on number of responses (r) per category.)

INTEGRATED SUPPORTED HOUSING:

Same or better services. (3r,2a)
Got better access to health care and food stamps
My service provider has always been good to excellent
Things are the same or getting better

Service cuts. (2r,1a)
Cut some services
Entire dual diagnosis program cut back

SITE-SPECIFIC SUPPORTED HOUSING:

Fewer services available. (14r,4a)
Staff cuts are resulting in fewer services
Hard to get access to dental and vision care
Some services are being cut for others but not affecting him directly yet
Vocational program eliminated; now I can't earn money; used to have a car but had to let insurance lapse
Hours cut back at socialization program and I now have nothing to do
Staff are being laid off
Can't go on picnics anymore
Vans no longer available
Has affected me severely -- (my Dr. got laid off; services reduced from 9 to 4 hrs/wk; used to see CMer twice a month and now will only see once/month
Used to have services available at housing site -- there's been a steady attenuation of mental health services available
Staff are getting laid off (even people who have worked here for years) and there are less services overall
It's hard when you've put your trust in staff and they leave; these changes stress us out
Very hard to find a dentist
No changes experienced

Limited choice. (1r,1a)
You have to go to certain place (no choice)

Must rely on peers. (1r,1a)
More reliance on peers

Confusion. (1r,1a)
Managed care can be confusing

SUPPORTIVE COMMUNITY:

Now don't have to pay. (1r,1a)
It's nice not to have to pay for medical services

Appendix G -- Table G-1 **(continued)**

OSHEP Phase 1 - Managed Care Data Analysis

Staff Focus Groups: Agencies with 2+ years under managed care (n=3a):

(For each approach, listed categorically, based on number of responses (r) per category.)

INTEGRATED SUPPORTED HOUSING:

Decreased services. (4r,3a)
Clients still want skills training and more direct staff contact
More groups rather than individual contact
Caseloads have gotten larger (15-25)
Initially, there was a 40% funding cut and half of the staff got laid off

Increased paperwork. (3r,2a)
There's more paperwork; files have gotten bigger (BT)
More financial paperwork (have to track pots of money) (BT)
More paperwork (HS)

Clients have to be more independent. (3r,1a)
Focus is on self-sufficiency of client; clients have to be more responsible for themselves
Clients now more involved with community
Involves more brainstorming/problem-solving for the clients

Flexibility. (2r,1a)
More flexibility due to case rates
Over time, more money became available and more flexibility

Special services. (1r,1a)
Exceptional Needs Care Coordinators help with streamlining special services

Impact on housing. (1r,1a)
Philosophical dilemma: Housing is not managed care; will result in possible loss of housing for clients

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SITE-SPECIFIC SUPPORTED HOUSING:

Decreased service availability. (2r,1a)
Consumers now have less time with service coordinators (i.e. fewer hours with case managers)
Resident managers (who are primarily responsible for "landlord" functions) have picked up some of the load

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SUPPORTIVE COMMUNITY

Not included in this group.

Appendix G -- Table G-1 (continued)

OSHEP Phase 1 - Managed Care Data Analysis

Staff Focus Groups: Agencies with <1 year under managed care (n=7a):

(For each approach, listed categorically, based on number of responses (r) per category.)

SUPPORTED HOUSING:

Services limited. (6r,3a)
Limited resources
Limited funds
Lost three staff
Billing limits reduced
Billing ceiling too low
More groups rather than 1:1

More paperwork. (3r,2a)
Paperwork increased
More paperwork
Have to write to request exceptions

Flexibility. (2r,1a)
Flexible wrap-around services
Think outside of the box

PASSAGES not impacted. (1r,1a)
PASSAGES SH program not impacted

Less duplication of effort. (1r,1a)
SH staff now acknowledged for doing case management rather than county

Effort to minimize client impact. (1r,1a)
Changes mostly affect our boss; clients should not feel the impact

Less individualization. (1r,1a)
Went from very individualized services to a package of services

Confusion. (1r,1a)
Changes are very confusing to staff and clients

Low morale. (1r,1a)
Feel very unappreciated

SUPERVISED APARTMENTS:

Less services. (14r,7a)
A lot less resources available to provide services
Staff are being laid off
Decrease in services to clients
Went from 1:1 to group treatment
Reduction in services
Less programming
Caseloads went from 20-40 to 25-50
It's a nightmare -- can't offer the services we used to
Still try to deliver services, just don't get paid
Less time to get work done
Less time for individual clients
Not enough funding, not paid enough
I feel bad because I have to be less available to clients
Now the lump sum dollars are spread among different providers

Clients unstable. (6r,3a)
Clients more unstable, have increased symptoms
Increase in family problems and interactions
Clients are being relocated; consumers are being shifted to cheaper services
More crisis intervention needed
No hospital beds available
Crisis treatment not available

May increase consumer independence. (2r,2a)
Lack of services may help consumers to gain independence due to necessity
Clients may become stronger and more independent

Confusion and anxiety. (2r,2a)
Much confusion among staff and consumers -- leads to increased anxiety
I feel more anxious

Increased paperwork. (2r,1a)
Need pre-authorizations now
Paperwork has tripled

Communication. (1r,1a)
More communication between psychiatrist and primary care physician

Better clinical information. (1r,1a)
Potential positive: you might get a history and treatment plan

Supervisors stretched thin. (1r,1a)
Flying managers

SUPPORTIVE COMMUNITY:

Decreased services/funding. (3r,3a)
Ties up a lot of staff time, especially CMers

Appendix G -- Table G-1 (continued)

Decreased time for client services and therefore decreased quality of client services
Fee for service worked for this population (homeless); managed care probably won't

Increased paperwork. (2r,1a)
Increased paperwork
Increased need to prove necessity of services

Morale. (1r,1a)
Morale down; fatigue up

PASSAGES not impacted. (1r,1a)
PASSAGES funding -- program not affected by managed care

Appendix G – Table G-2

OSHEP Phase 1 - "Like Best/Like Least" Data Analysis

INTEGRATED SUPPORTED HOUSING

Consumer Focus Group (39 participants from 6 agencies):

(Listed in order of # of responses (r)/from # of agencies (a).)

Like Best (45r):

Apartment/Location Characteristics (14r/4a)
My apartment -- it's quite large, large bedroom, lots of closets
It's a quiet complex with a pool, well-maintained courtyard
There's room for my daughter; nice yard and garden
Well-kept grounds
Provider helped us (couple) find a nicer place after living in a "hairy" place and being homeless
Like the way apartment is set up; close to bus lines and stores
It's quiet
Good location, it's safe
It stays warm without using heat
Design of apartment; good use of space
Like my apartment
The amount of space I have in my 2BR apt with utility room and garage
Buses are nearby
Having my own washing machine

Independence (8r/6a)
First place of my own; like independence; not in constant conflict with another; have time alone
Like the independence -- getting up and going to bed when I want; no one telling me what to do; being alone or visiting with my roommate; watching videos when I want to
Like having own space; feel self-conscious in group
Like having my own space where I can do what I want
Independence
Freedom to do what I want
Being independent
Like independence of living in my own house

Choice of Whom to Live With/Near (7r/3a)
No longer have lawless neighbors
Used to be forced roommate situation; now having a choice is much better
Having choice of either roommate or living alone
Able to choose amount and with whom to be social
Some nights staff stay over night with me - like that
Like ability to live together (husband and wife)
Living near friends (others in building are consumers)

Like Least (36r):

Apartment/Location Characteristics (12r/4a)

Had to spray for bugs even though building is new
Would like rugs and curtains cleaned at least once/year
How hot it gets
No water faucet outside for watering my plants
Can't regulate my own heat
Would like more room for studio (artist)
Walls are thin; can hear neighbors
How old my housing is (out-of-date heating, etc.)
Location is not optimal
Old electrical outlets may not be safe
Cockroaches
Noisy

Affordability Issues (9r/4a)
Level of rent is too high
Rents are too high
Hard to find apartments within HUD rent limits and on low income
Waiting list for low income housing are up to 6 months long
PGE bills (electricity) expensive -- over $100/month recently
It's hard to find a landlord who will take Section 8 in area I'd like to live
Would like passive solar to save on heat bills
If you want to move, it takes an extremely long time (due to local housing market)
High rent ($435 for 2 people on Social Security); not much money left for living expenses

Management Issues (4r/2a)
Owner will not give 24-hour notice; just stops in
Property managers infringe on my time/privacy
Manager is unorganized, takes bribes, is unresponsive
Coffee hour and occasional meals are unorganized

Services/Supports (3r/2a)
Would like to manage my own money; pay my own bills
Housekeeping - would like to have housekeeper
Gets boring sitting around; would like to work

Safety Issues (2r/1a)
Police often come to building
Many people take drugs; it's hard to trust anyone

Appendix G – Table G-2 **(continued)**

Like best (cont'd):

Affordable Rent (6r/5a)
Inexpensive
Got pushed up on waiting list for rent subsidy (provider has local preference with PHA)
Voucher through housing authority
Section 8 -- saves me $300/month
Saving money
Pay only $350/month with utilities included (couple)

Privacy (6r/4a)
Neighbors mind their own business
Privacy
Like privacy
Privacy
Privacy and quiet (compared to homeless mission and last apartment)
Not living with staff

Apartment Managers (3r/1a)
Nice managers; not noisy
Nice managers
Nice managers

Idiosyncratic

Have a roof over my head

Like Least (cont'd):

Idiosyncratic

Not enough independent, affordable housing for the disabled *period*!

Would like to be able to live in normal housing (rather than low income or SRO-type of housing)

Will have to move in May unless County buys building due to development of farmworker housing across the street (??)

Sometimes I feel isolated; it's embarrassing to friek out around neighbors

My roomates (share house with 3 others)

Having to take medications

Appendix G – Table G-2 (continued)

OSHEP Phase 1 - "Like Best/Like Least" Data Analysis

SITE-SPECIFIC SUPPORTED HOUSING and SUPPORTIVE COMMUNITIES
Consumer Focus Group (74 participants from 8 agencies):

(Listed in order of # of responses (r)/from # of agencies (a).)

Like Best (90r):

Apartment/Location Characteristics (26r/6a)
Convenient location
Small, compact apartment - easy to care for
Roomy and spacious apartment
Like living close to stores
As decent a place as I've ever lived
Building is only 2 yrs old; feel brand new
No rats or cockroaches
Feels home-y
You can decorate as you please
Like yard and garden
Buses run close by
Safeway and Fred Meyer are accessible
Close to bus lines; can get out to different places
Nice place to live; close to transportation
Close to service provider
Like living on second floor
More room
Shopping is close by
Locked exterior doors, security
Things get fixed if anything goes wrong
Close to MAX (lightrail) and buses
No roaches
Could plant some plants outside my window
I can have my dog
Being on first floor (wheelchair access)
Apartments are kept clean

Availability of Support (23r/7a)
Having a support system like a family
I was scared living alone before; I like having others around
Lobby area is nice for socializing
A lot of people provide support
We all have same illness; no secrets
Living with other people; not by self
Very nice group here now
Good friends here
Like communication
Not isolated; connected to MH programs that go with housing
Like having resident manager on site
It's like a family
I feel secure (there's someone to call if someone's outside my window)
In regular apartments, people are into themselves, it's different here (more supportive)

Like Least (51r):

Apartment/Location Characteristics (19r/6a)
Patio door needs to be replaced
Bare floors; my dad had to put down carpet
Cockroaches, ants
Closets are too small
No separate dining room
Would like a bigger living room
Kitchens too small
No where to store food (not enough space?)
Bathroom too small
Takes a long time to get things fixed -- many examples of plumbing problems given
Not enough storage space in kitchen, in general
Apartments are small
Rooms are small
No bathtubs (only showers)
Some clients talk early in morning; would like soundproof rooms
Toilet leaks and light goes out a lot
Repairs; sometimes they don't have the money
Didn't paint my apartment before I moved in
All my family can't come over (unit too small)

Services/Staff Issues (13r/3a)
Sometimes when rules are broken, it takes a while for action to be taken; makes me scared
Sometimes feel like they treat us like kids
Asked for basketball hoop, but not provided
Not enough outings
Don't get to go on outings anymore
Medicine checks make me feel like a kid
Staff need to be more available
Disappointed not to have staff on site around the clock (several agreed with this)
When staff swear
One staff person shuts the door and gives resident a hard time
Need to screen people better who move in
Food (in cooking program) -- have same thing over and over; want more variety
Lack of structure; need more things for tenants to do during the day

Appendix G – Table G-2 (continued)

Like Best (cont'd):

Like it because it's all people with disabilities -- very supportive
Can have friends over
Friendly people
It's friendly, like one big family
Having someone I can relate to nearby
Your neighbors understand when you've had a bad day
Everyone knows everyone
Barbeques
Support group with other residents

Privacy/ Own Space (12r/6a)
Can be alone (have privacy) or can socialize
Having no roommates
Being away from parents
Better than prior roommate situation where I couldn't play my radio in the afternoons
Having privacy; glad to have my own little place
Privacy
Better than previous experience where roommate situation didn't work out well
Have my own program; don't have to worry about others who may be abusing alcohol and drugs
Like the peace and quiet
Privacy
Setting is quiet and serene
Privacy

Independence (10r/4a)
I like being able to take my own medications
Having my own record/CD player
It gives me self-confidence to live more independently
It was hard to get used to the idea of cooking, but now I like the freedom
Independence
Buying and cooking my own food
Coming and going as I please
Independence (taking med's on own, own shower, own fridge, etc.)
You are not babied; you are free to come and go
You can have guests to your apt.

Services/Supports (7r/3a)
Groups offered help to occupy the time
Like groups: walking group, art group, library group, cooking group, parties
Skill trainer is helpful
Staff are very positive and happy
Staff are there when you need them
Like to be independent, but go to staff as needed
Taking trips (to state fair, movies, aquarium)

Affordability (6r/6a)
Low rent; have money left to go to the movies (like Titanic)
Doesn't cost much
Affordable for low income
Inexpensive rent
Suits my income
It isn't a group home and it's much cheaper

Interpersonal Issues (8r/6a)
Doing more than my share of chores (shared house)
Can have problems because I speak another language
One guest who started living there created hard feelings
There can be gossip in a small community
People pound on my door sometimes when I'm trying to sleep
Dealing with others who are mentally ill
People bumming off of you
Living with roommate hassles

Safety (4r/2a)
Lots of crime in area, bad neighborhood, got harassed by neighbors, have heard gun fire
Scary at night; can't walk in neighborhood after dark
Have been hassled by gangs; bullet came through window; not good to walk streets at night
Security issue: someone let a person in the bldg. who caused problems

Affordability (2r/2a)
Can't get a Section 8 without moving into duplex and waiting a year
Paying for washing/drying is expensive ($1.00/load)

Idiosyncratic

Sometimes don't like living in a place that's "for the mentally ill"

Would like to live nearer to the woods

Wish more was available for other clients

People don't take care of their animals

"No pets" policy (would like a bird) -- lots of discussion/agreement

Like Least (cont'd):

Appendix G – Table G-3

OSHEP Phase 1 - "Would Like to Change...Housing" Data Analysis

INTEGRATED SUPPORTED HOUSING
Consumer and Staff Focus Groups

(Listed in order of # of responses (r)/from # of agencies (a).)

Consumers:

Better Housing Amenities/Maintenance (10r;3a):
Would like air conditioning (but not paying bill)
Would like my own thermostat
Would like a heated pool
Free cable TV
Paint, cracks fixed
New windows
Parking for car
Cameras/intercoms in hallway
Cable TV
More real Lysol

Bigger/Better Housing (7r;4a):
To have my own apartment--no roomate
To have a bigger place; option to pay a little more to obtain bigger/better place
Change rule that single person is limited to 1BR apt. (artist would like to use extra room for studio)
To be able to live in nice, new places that don't accept Section 8 now
Would like to have my own home (a house) and be able to grow plants outside
Would like 1BR apt.
I'd like to move but housing downtown is at a premium

Rules/Regulations (4r;2a)
To be able to have a cat or other pet
Pleased with my housing but want 24-hour notice from landlord before entering my unit
Change the rules regarding notice for evictions
Make it easier to have a roomate (can only do if Dr. signs a note in Section 8)

Management Issues (2r;1a):
Better manager
More supportive manager (toilet clogged for whole month)

Idiosyncratic:

Cheaper rent

Housing should have all services incorporated

Staff:

Better Housing Amenities/Maintenance (11r; 4a):
Better plumbing in available apartments
Cable TV
Fresh paint
New appliances
Good carpet
No cockroaches
Bigger windows
Landscaped yard
Swimming pool
Bigger rooms
Garden space

More Housing Availability/Choice (10r;5a):
Better location
More conveniently located to shopping, business
More choice and selection of units
Other kinds of housing (more variety of options)
Want "normal" housing
Availability of smaller complexes
More individual units
Individual apartments/no roomates
Better apartments
Bigger/more space

Safety/Security (7r;5a):
More safety/security
Safe, quiet buildings/neighborhoods
Drug free area
Increased safety (less crime)
Safer areas
Safety
Increased safety

Affordability (5r;4a):
More lower cost housing
Affordable housing for individuals (no roomates)
Cheaper
Cheaper rent
Cheaper housing

Idiosyncratic:

To be able to have pets/dog

Fewer people living nearby

Not by day care center

Managers who will listen to their concerns

Appendix G – Table G-3

OSHEP Phase 1 - "Would Like to Change...Housing" Data Analysis

SITE-SPECIFIC SUPPORTED HOUSING and SUPPORTIVE COMMUNITIES
Consumer and Staff Focus Groups

(Listed in order of # of responses (r)/from # of agencies (a).)

Consumers:

Better Housing Amenities (34r;8a):
Dishwaher and disposal
Satellite dish
More roomy refrigerator
Basketball court
Pool table or foosball
Linoleum that doesn't crack
Soundproof walls
More pots and pans and cleaning supplies supplied
Screen doors for the summertime
Swimming pool
Dishwasher
More storage space
Expanded laundry room hours or more machines
Patio/deck
Air conditioning in summer
More phone outlets
New carpet
New paint
Would like colored walls
Stereo TV
"Jacuzzi in front yard" (kidding); very satisfied
More storage space
Better heating system; more heat in winter
More cabinet space
More storage/closet space
Better linoleum in kitchen and bathroom
New carpeting
Better burners for stove--can't clean under burners
Need a bigger table for people in meal program
Would like swimming pool and community TV
Better noise barrier between units (can hear noise from above)
Would like to have a jacuzzi in the back
Would like alarms to not go off all the time (too sensitive)
Need wider doorways and hallways

Improved Maintenance (12r;5a):
Things fixed more timely
Get toilet fixed more thoroughly and timely (not just plunger)
Better maintenance (e.g. unplug bathroom drain in timely manner)
Faster maintenance
Get rid of ant problem
Fix exterior door so it doesn't slam
Window washer
New sinks/appliances (existing getting old)
Repairs can take a while

Staff:

Better Housing Amenities/Maintenance (23r;4a):
Better plumbing
Cement redone
Dishwashers
More garden space
Jacuzzi/pool
New furniture
Windows, open space
More powerful fans in the bathrooms
Smoking areas
Padding under carpeting (less industrial0
Stronger linoleum (tile instead)
Pool
Better ability to regulate heat
More light
Air conditioning
Better landscaping
More phone jacks
Larger socialization area
Rec room
Better maintenance
Air conditioners
Hot tub
Pool

More Housing Availability/Choice (9r;4a):
More single units for residents
Would like 1BR apartments rather than "quads"
Private kitchen/private bath (in situation where it is shared)
More apartments like these
More larger 1BRs
Private unit (1BR)
Some multiple bedroom units to accommodate families
Want accommodations with own bathroom, bigger room, own kitchen
Choice of being downtown or not downtown

Less rules (3r;2a):
Less rules in housing
Less rules (inspections, re: A&D)
To be able to smoke in rooms (SC approach)

Idiosyncratic:
Chickens and goats (petting zoo)

Cheaper

Use of public kitchen space

Appendix G – Table G-3 **(continued)**

Consumers (cont'd):

Faucets need to be replaced; they get fixed then start leaking again
Furniture needs to be replaced in lounge area; it smells and is stained
Would like new carpeting/paint

Bigger/Better Housing (7r;4a):
Bigger rooms, bigger house
Closer store to buy milk and fresh meat (walking distance)
Would like an apartment (with larger room, etc.)
New apartment or house so I could settle down and get married (in quad, it's a violation to take girlfriend to my room)
Chores done more equally by all (in shared living situation
Have everyone pick up after themselves
Everyone needs to do chores daily to keep place nice (e.g. dust hallways or dump ashtrays)

Pet Policy (3r;2a):
Ability to get dog (have to pay deposit)
Like to be able to have animals
Would like to have a pet without paying $300 pet deposit

Idiosyncratic:

Neighbors that don't bother you--almost afraid of them

Would like to have 2 to a room like a collage dorm

To live with other females, rather than three males in current housemate situation

More tenants attending weekly tenant meetings

Complaint box

More immediate intervention by manager when situations arise

Food needs to be improved (for those on meal plan)

Would like guest policy changes so guests can stay overnight more frequently

People should quit stealing my checks, food, etc. (appeared delusional)

Get rid of bullies; people should share their true feelings from the heart

Appendix G – Table G-3 (continued)

OSHEP Phase 1 - "Would Like to Change...Services" Data Analysis

INTEGRATED SUPPORTED HOUSING
Consumer and Staff Focus Groups

(Listed in order of # of responses (r)/from # of agencies (a).)

Consumers:

More Social/Recreational Programming (8r;4a):
New recreational therapy program
Wednesday night shared summer program
More activities at the Center, e.g. table games
Better computer & computer games or video games
Would like to be able to watch TV in clinic day room (can't anymore)
To have access to activity center again
More organized outings ("Wandering Wednesdays")
More ways to meet other people in program

More Staff Contact/Availability (5r;4a):
More contact with staff
Would like service coordinators and doctors to be more accessible
To see my service coordinator more
Would like case manager to come out and see you more
You're classified so you get barely any treatment or lots of treatment; when you're transferred to less treatment, it's too dramatic a change
Services should be incorporated into housing
More stability in staff/services; with budget cuts, staff got laid off

Work Opportunities (2r;2a):
More supported work opportunities
Would like Social Security regulations to change so it would be easier to work

Other:
"They treat us pretty good really"

Would like someplace to discharge violence (e.g. take a baseball bat to a car)

Need spiritual focus to change violent attitude to love

More professional staff; they should wear uniforms

More knowledgeable service coordinator

Would like handbook describing all of the services and housing available

Like opportunity to decline activities

Staff:

More Social/Recreational Programming (8r;4a)
More social activities
More transportation to and from social activities
Outings
Recreation
Staff directed social activities
Group activities
To go to festivals, social programs
Assistance with housing maintenance

More Staff Contact/Availability (8r;4a):
More individual skills training
More 1:1 attention
Want staff to do things for them (e.g. banking)
More time
"I want you to tell me what to do -- and not what to do"
More time for staff to talk over coffee
Really want to see staff more
More staff time

Work Opportunities (2r;2a):
Some want jobs
More vocational services

Transportation (2r;2a):
More transportation
Better transportation

Other:

More family support

More access to computers

Want day structure

Free meals

To not have to stop using drugs and alcohol

Would like to be able to borrow money to buy fast food

Sometimes less staff attention

Rental assistance (more money)

Appendix G – Table G-3 (continued)

OSHEP Phase 1 - "Would Like to Change...Services" Data Analysis

SITE-SPECIFIC SUPPORTED HOUSING and SUPPORTIVE COMMUNITIES
Consumer and Staff Focus Groups

(Listed in order of # of responses (r)/from # of agencies (a).)

Consumers:

Financial Issues/Stability Concerns (11r;7a):
Would like pills paid for
More money; knowing where money is going
More personal funds; not enough income to get by; after rent & food, only $2/wk left for spending
Can be difficult getting on disability
Don't let manager go; give him more money so he will stay
Staff may not be getting paid enough; they get burnt out and then aren't as sociable with people; it's hard with staff are short-tempered
Don't know what they can do because the more we want the more it costs
I used to not pay for services/med's; now I have to
Staff turnover can be difficult
Would like to have permanent doctor; too many changes over the years (several agreed with this point)
Want things stabilized -- same doctor and same case manager; hard to keep re-adjusting

More Staff Contact/Availability (10r;4a):
More responsive services (more contact from CMer)
Back to round-the-clock staffing (now leave at 10pm)
Should be able to get hold of staff at night
Instead of seeing doctor 1:1, I'm going to have to go to a med group; want 1:1 time with doctor
Want to be able to talk to doctor 1:1
Wish we had more people to go to
I'd like to talk with someone on a regular basis, not just when I have an awful problem
I'd like the therapist to visit (not always go to the clinic)
Would like more services
Would like to see doctor more often

More Social/Recreational Programming (9r;5a):
Activities scheduled on weekends and evenings
More funds for parties
Tickets to basketball games and concerts
More social time with staff to hang out
More interaction with roommates -- would like more companions
More potlucks, social activities
More funding for drop-in/activities; need ways to get out and socialize
More activities/trips for recreation
Would like to see more joint activities among apartment complex residents

Staff:

More Social/Recreational Programming (10r;4a):
To be able to arrange more fun things for consumers to do
More organized activities
Admission to Wild Life Safari
More outings
More staff-accompanied outings (movies, etc.)
More recreational outings, especially big ones -- like trip to coast
Camping trips paid for
More money
Going places they can't access like the coast
More nighttime or weekend activities

Other Services Requested (7r;5a):
Help with cleaning (housekeeping)
Better transportation
Assistance with grocery shopping
Help with shopping
More latitude with money management; some want access to money more often
Some consumers want meals cooked for them

More Staff Contact/Availability (5r;4a):
More or less time with service coordinator
More staff support for med's
Want doctor and nurse to come to them
More staff accompaniment out in world (escorting)
More staff to help; looking at training other residents to help

Other:

More involvement from neighbors in buildings (community involvement)

Don't like group work; would like more 1:1 contact

More empowered consumers to do more for themselves since staff is busy

To have no staff around

Some don't like all the socializing they're forced to do

Appendix G – Table G-3 (continued)

Consumers (cont'd):

Other Service Requests (6r;4a):
Would like skills trainers to be available to help with shopping, cleaning, cooking
Would like visiting animals--need the unconditional love
Would like more shopping trips to different stores
Would like to ride in staff cars
Need more help with transportation
More assistance with gardening project/greenhouse

Employment/Vocational (3r;3a):
Would like to have work 20 hrs/week...
Would like help getting a job (training)
More job opportunities (I used to work, not available anymore)

Other:

"Very satisfied"
"None" (would change nothing)
"We get good services"

Not having to talk to service coordinator for one month (a month off)

Would like to sort out business v. friendship relationship with service coordinator

Staff should not play games and ignore tenants' needs

Wish there could be more of this type of housing in other places

Computer use is a problem

"Like living with others but being alone"

To not have to have a label to get services

Pets; more equitable enforcement of pet policy