FAMILY CARE FOR THE MENTALLY ILL: THE UNFULFILLED PROMISE

A Report by the New York State Commission on Quality of Care for the Mentally Disabled

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

The family care program administered by the Office of Mental Health is a significant part of its efforts to place psychiatric patients in a less restrictive environment than provided by the psychiatric hospital.*

A public hearing conducted by the Commission in Buffalo last October elicited community concern about the family care program operated by Buffalo Psychiatric Center, the largest such program run by a psychiatric center in the State.** This hearing and others held by the Commission resulted in family care being targeted as one of the 12 areas for particular attention.

In January 1979, the family care program was the subject of a series of local newspaper articles in Buffalo. In response, Commissioner James Prevost requested the Commission to examine the management and operation of the family care program run by Buffalo Psychiatric Center.

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*Over 3,000 persons reside in OMH licensed family care homes while just over 1,300 persons are served in OMH licensed community residences. New York State Office of Mental Health, Annual Report on Community Residents 5 (March 1, 1979).

**Buffalo Psychiatric Center has over 460 family care residents, and St. Lawrence Psychiatric Center serves over 430 family care clients. There are only four other psychiatric centers with a family care population of 200-300 persons, while five facilities serve between 100-199 family care residents. Twenty-five psychiatric centers have less than 100 persons in family care. Letter from Angela Zeppetello, Federal Program Coordinator of the Bureau of Patient Resources of the Office of Mental Health to Walter Saurack of the New York State Commission on Quality of Care for the Mentally Disabled (February 22, 1979).

The Commission agreed to do so as part of a larger Commission effort to examine the family care program statewide. This report represents an assessment of the family care program at Buffalo Psychiatric Center as it existed during the period of January through March, 1979.

As an evaluative effort designed to assist the Office of Mental Health and Buffalo Psychiatric Center improve the family care program, this report, of necessity, emphasizes the deficiencies in the program. However, as we attempt to point out in the body of the report, we witnessed several individual homes that epitomize the highest expectations of the program.

In conducting this study, Commission staff selected 25 homes at random for the review. Commission staff performed a comprehensive review of the Buffalo Psychiatric Center records on the selected homes and examined records of a total of 47 clients prior to site visits and interviews. Day programs in which clients participated were visited and the clients and program staff were interviewed. In addition, staff from the Buffalo Psychiatric Center and the Office of Mental Health Regional Office responsible for the administration of the family care program and for ensuring the continuity and adequacy of care for the clients were interviewed. The Commission spent approximately 75 staff days in the field conducting this study.

Findings

FIRST, THE REALITY OF FAMILY CARE DIFFERS SIGNIFICANTLY FROM THE CONCEPT PROPOUNDED BY THE OFFICE OF MENTAL HEALTH OF A TRANSITIONAL STEP IN THE CONTINUUM FROM INSTITUTION TO INDEPENDENT LIVING. THE PROGRAM IS NOT TRANSITIONAL BUT A DEAD END FOR THE MAJORITY OF PATIENTS PLACED IN FAMILY CARE (Report, pp. 4-6).

A. The family care program at Buffalo Psychiatric Center serves primarily elderly patients with a long history of psychiatric hospitalization. Both as a result of the type of patients predominantly placed in family care and because of the lack of other community placement alternatives in the Buffalo Psychiatric Center catchment area, the family care program is the first and final stop for many deinstitutionalized patients.

B. The family care providers do not perceive their role as preparing the client for more independent living even where this is a realistic possibility. Indeed, they resent and resist removal, from the home, of a patient whose level of functioning indicates a readiness for a less restrictive environment. The discharge of such a patient is often viewed as punishment for having succeeded in enabling the client to progress.

SECOND, WITH OCCASIONAL EXCEPTIONS, THE FAMILY CARE HOMES DO NOT PROVIDE THE THERAPEUTIC/REHABILITATIVE ENVIRONMENT ENVISIONED BY THE OFFICE OF MENTAL HEALTH (Report, pp. 51-61).

A. Clients are often physically and socially isolated in the household and live in worse conditions than the rest of the provider's family. Separate but unequal is all too true and common in family care (Report, pp. 51-55).

B. Medication storage and dispensing practices are dangerously out of compliance with OMH standards (Report, pp. 58-61).

C. Although 18 of the 25 homes in the sample were in reasonable compliance with fire safety standards, there were deficiencies. Fire drills were rare and in some homes fire extinguishers, required by regulations to be on the premises, were either not readily accessible or providers did not know how to use them (Report, pp. 56-58).

D. Physical and sanitary conditions of several of the homes need major improvements (Report, pp. 54-55).

E. There was no pattern of abuse and mistreatment found in the sample of homes reviewed, although the residents in one home were assigned tasks not shared by other family members (Report, p. 46).

F. In a few homes, the clients and providers had managed to build up close, supportive, family-type relationships (Report, p. 54).

THIRD, THERE ARE MAJOR DEFICIENCIES IN THE ADMINISTRATION AND PROVISION OF MEDICAL CARE AND SERVICES TO CLIENTS IN FAMILY CARE RESULTING IN INADEQUATE, IMPROPER AND FRAGMENTED CARE.

A. Most of the family care providers were inadequately trained in medication storage and dispensing and in monitoring the effects of the medications (Report, pp. 60-61).

B. This deficiency is compounded by OMH policy, which does not require physicians to review periodically the medications the client is receiving or the progress being made by the client under medication. In addition, physicians at Buffalo Psychiatric Center showed minimal involvement with their patients (Report, pp. 25-27). Indeed, we discovered that at Buffalo Psychiatric Center, non-physicans had signed monthly medication orders for the clients (Report, p. 27).

C. Annual mental status examinations are required for all patients by OMH policy. However, we found that in 1978 for 35 out of 47 clients in our sample, there were only cursory notes by the psychiatrists, and the remainder lacked psychiatric notes of any kind (Report, pp. 28-29).

D. Where physical examinations of clients were performed annually as required, the results were not communicated to BPC. Thus, BPC staff remained ignorant of changes in the clients' physical condition which often resulted in residents not obtaining necessary follow-up medical care (Report, p. 28).

FOURTH, IT WAS EVIDENT THAT BUFFALO PSYCHIATRIC CENTER STAFF DID NOT PLAY AN ACTIVE ROLE IN THE TREATMENT OF CLIENTS IN FAMILY CARE EVEN THOUGH THE CLIENTS CONTINUED TO REMAIN ON THE PATIENT ROLL OF THE CENTER.

A. The lack of treatment to family care clients was made apparent to Commission staff members through their interviews with patients, family care providers, family care teams and staff in day programs. This lack of treatment was reflected in the client records. There were gross deficiencies in the use of the form called the Individual Service Plan which made it clear that this document, intended as a blueprint for services to be rendered, was instead being perceived as a paper requirement. As a result there was insufficient thought given to each patient's needs (Report, pp. 8-10).

B. There was no evidence of any intention to implement such individual service plans (Report, pp. 10-12).

FIFTH, THE FAMILY CARE PROGRAM IS POORLY ADMINISTERED AND THERE ARE SHORTAGES IN CLINICAL STAFF.

A. There is excessive reliance upon family care as an alternative to the institution. This is partly due to the lack of other forms of community placement which deprives the facility of other options and makes it impossible to routinely match clients and providers. Instead, BPC is forced to consider where vacant "beds" are available, with the clients' needs of secondary importance (Report, p. 10).

B. The administration of family care was decentralized and there were wide variations in performance among the geographic units. This, along with inadequate central

management by the facility, resulted in a lack of cohesiveness in the program. For example, some units were in complete compliance with the required monthly visits and other units were not. In some units staff members would make special efforts to settle a patient in a new home while others did not visit the home at all during the first few weeks (Report, pp. 17-20).

C. We found no systematic effort to evaluate the quality or effectiveness of the family care homes. There were few unannounced visits to family care homes by BPC staff, and such visits as were made did not result in deficiencies in the homes either being noted or corrected. Even when visits were made, the reports were cursory and uninformative (Report, pp. 20-24).

D. The Regional Office played an insignificant role in monitoring both the family care homes and BPC. The Regional Office delegated most of its oversight functions to the psychiatric center itself. In effect, this resulted in the staff responsible for providing services to the family care homes monitoring their own performance (Report, pp. 78-81).

E. We found that BPC relied excessively on mental hygiene therapy aides to perform diverse clinical and administrative functions. The responsibilities assumed by these persons conflict with the job classification standards for such positions as established by the Department of Civil Service (Report, pp. 32-33).

SIXTH, THERE IS AN OVERALL LACK OF COMMUNICATION AND COORDINATION AMONG BUFFALO PSYCHIATRIC CENTER STAFF, FAMILY CARE PROVIDERS, COMMUNITY AGENCIES PROVIDING PROGRAMS FOR THE CLIENTS AND THE CLIENTS THEMSELVES. SERVICES ARE PROVIDED IN PIECEMEAL FASHION AND THERE IS NO CONTINUITY OF CARE FOR THE PATIENT (Report, pp. 12-14).

Conclusions and Recommendations

Family care is an important part of the State mental health system. Family care providers serve as a valuable resource in providing economical lodging and boarding in a less restrictive environment than a State institution. However, many of the State's expectations of this program appear to us to be either unduly optimistic or unrealistic.

First, and fundamentally, it is unrealistic in most cases to expect that the delicate and personal relationships within a family will adapt to the addition of new and unfamiliar members, especially persons who are mentally disabled. This is particularly the case given the limited ability of the family care programs at BPC to match clients and providers. That so many of the clients in our sample were segregated from the family is not so much a reflection upon those who provide the care as upon the concept. Part of the reason for the failure of the concept of this simulated family is that there are no readily apparent traditional family roles for an adult mental patient in a family.

Elderly clients may be integrated into a family in the role of a grandparent, but the general tendency is to treat adult clients, who require more attention and supervision than non-clients, as children, creating an environment which differs significantly from normal family life.

Second, just as it is unrealistic to expect integration of most clients into a family, so too it is unrealistic to expect family care providers to act as staff to the psychiatric center and provide skilled care to the clients. This is not intended as a condemnation of the providers, many of whom have both the desire and the ability, if properly trained and supervised, to perform these functions.

Third, it is apparent to us that this program will be unsuccessful in serving its purpose in providing a transition for clients from the hospital to more autonomous living unless there are community placement alternatives offering more independence.

Fourth, even assuming the creation of an integrated network of community placement alternatives that form a continuum of care from the institution to independent living in the community, where appropriate, it seems to us essential to establish incentives for family care providers to help clients reach their full potential, even where it means leaving the home. Such a discharge must be viewed as a success, and rewarded as such, rather than being perceived as a failure for which the provider is penalized either by

the loss of income or by the burden of integrating a new person into the home. Clearly, such a system of incentives will need close monitoring of the quality of proposed discharges to prevent dumping of clients from family care homes. We therefore recommend:

(1) THAT THE OFFICE OF MENTAL HEALTH REASSESS ITS EXPECTATIONS OF FAMILY CARE, PARTICULARLY THE ROLE OF THE PROVIDER IN PROVIDING SKILLED CARE TO THE CLIENTS.

(2) THAT PRIORITY BE GIVEN AT BUFFALO PSYCHIATRIC CENTER TO EXPANDING THE RANGE OF COMMUNITY PLACEMENT ALTERNATIVES.

(3) THAT THE OFFICE OF MENTAL HEALTH EXAMINE THE FEASIBILITY, PERHAPS ON A DEMONSTRATION BASIS, OF CREATING A SYSTEM OF INCENTIVES FOR FAMILY CARE PROVIDERS FOR PREPARING CLIENTS FOR MORE INDEPENDENT LIVING WHERE THAT IS DEEMED APPROPRIATE.

* * *

The quality of the family care program can best be described as neglectful. To avoid warehousing clients in family care, it is essential that they be given more active treatment. The psychiatric center staff should play a leadership role in ensuring that each client gets needed clinical attention. The Individual Service Plan, if properly utilized, is the key to this process.

Family care teams should have additional professional staff instead of relying on therapy aides to perform administrative and clinical functions. Closer coordination of staff efforts and stronger administration of this program are essential to ensuring that available treatment resources are fully utilized. We therefore recommend:

(1) THAT THE INDIVIDUAL SERVICE PLANS BE USED AS A REAL PLANNING TOOL AND IMPLEMENTED AS SUCH.

(2) THAT THE FAMILY CARE TEAMS BE AUGMENTED BY THE ADDITION OF PROFESSIONAL STAFF TO PROVIDE SERVICES TO CLIENTS IN FAMILY CARE.

(3) THAT THE ADMINISTRATION OF THE FAMILY CARE PROGRAM BE STRENGTHENED TO COORDINATE THE USE OF ALL TREATMENT RESOURCES AVAILABLE WITHIN THE BPC CATCHMENT AREA.

* * *

There is a critical need for much more vigilant regulation of the family care homes than we witnessed during our study. Although the Regional Office is conceptually responsible for regulating the homes, in practice both regulatory and clinical functions are assigned to the treatment units at BPC. This requires the family care teams, in part, to monitor their own performance, resulting in a lack of independent monitoring which permits the conditions we have described to flourish in some homes.

In the course of our investigation, we found no reluctance on the part of providers to comply with regulations when appropriately instructed. It seems clear that the providers would welcome clear guidance on what is expected of their homes. Particular attention is needed in the areas of fire safety and medication storage and dispensing. The Board of Visitors, an independent citizen watchdog body, has no oversight jurisdiction over family care homes. With increasing emphasis on community alternatives to institutions, including community residences and family care homes, it is time to broaden the role of the Board of Visitors.

The Commission recommends:

(1) THAT THE REGIONAL OFFICE SHOULD PLAY A LARGER ROLE IN THE INSPECTION AND REGULATION OF FAMILY CARE HOMES. IT SHOULD PERIODICALLY ASSESS THE EFFECTIVENESS OF THE PSYCHIATRIC CENTER'S MANAGEMENT AND OPERATION OF THE FAMILY CARE PROGRAM; AND

(2) THAT LEGISLATION PROPOSED BY GOVERNOR CAREY (S. 6299-A SENATOR PADAVAN; A.8190-A ASSEMBLYWOMAN CONNELLY) TO PROVIDE A MECHANISM TO PERMIT BOARDS OF VISITORS TO VISIT AND INSPECT FAMILY CARE HOMES AND COMMUNITY RESIDENCES BE ENACTED.

As part of the process of strengthening the administration of the family care program, clear responsibility should be placed on medical professionals for overseeing all medical services required by or provided to clients in family care. It is critical that periodic reviews by physicians of patients' medication regimens be instituted to properly monitor the drugs being administered to family care clients. It is essential that the practice of non-physicians signing monthly medication orders cease immediately. There ought to be consistent efforts to obtain from providers their observations on the effect of medication being given to clients. This would be an important factor for the physician to consider before continuing or changing medications. Family care providers will require training to recognize the intended and unintended effects of medications. Beyond training, providers should be given specific information regarding the intended and possible side effects of medications being prescribed for each client.

Responsibility for good medical care should be assumed by the medical and nursing staff of the family care teams. Complete medical information should be available to the physicians prescribing psychotropic medications for their clients. Although outside health services are used by the clients, it is essential for BPC nursing staff to direct, coordinate and monitor the use of these services.

The Commission recommends:

THAT THE RESPONSIBILITIES OF THE MEDICAL AND NURSING STAFF AT BPC SHOULD BE REDEFINED. IT SHOULD BE THE PRIMARY RESPONSIBILITY OF THE NURSING STAFF TO MONITOR AND COORDINATE ALL ASPECTS OF MEDICAL SERVICES TO FAMILY CARE CLIENTS. THE NURSING STAFF SHOULD ALSO BE RESPONSIBLE FOR MAKING THIS INFORMATION AVAILABLE TO THE PHYSICIANS.

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THE COMMISSION, IN CONCLUSION, RECOMMENDS THAT THE OFFICE OF MENTAL HEALTH USE THE FINDINGS AND RECOMMENDATIONS OF THIS REPORT AS A FIRST STEP IN A COMPREHENSIVE STATEWIDE EVALUATION OF FAMILY CARE.

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Many of the observations contained in this summary have been communicated to the administrators at Buffalo Psychiatric Center and to the Commissioner in the course of conducting this investigative review. Some of the deficiencies we have cited have been corrected as indicated in the correspondence appended to this report.

Commissioner Prevost's response to a draft of this report indicates that "we have made some major management changes in our family care and other alternative living programs which have already produced a majority of the changes which both of our staff agree were necessary" (See Appendix A for this response).

The Commission is aware of the effect upon employee morale of a report of the Erie County Grand Jury which studied some aspects of the operation of Buffalo Psychiatric Center. The Commission report is not intended to further demoralize the administration and employees at Buffalo Psychiatric Center, but to serve as a guide to improving the quality of life for patients in family care.

The Commission wishes to acknowledge the cooperation it has received from Commissioner Prevost and from Dr. Ralph Michener, Director of Buffalo Psychiatric Center, and other employees of the facility, in the course of this investigation. We have also enjoyed the advice and assistance of the Board of Visitors of Buffalo Psychiatric Center.

Clarence J. Sundram
Chairman

Mildred B. Shapiro
Commissioner

I. Joseph Harris
Commissioner

INTRODUCTION

This investigative review of the family care program operated by Buffalo Psychiatric Center was undertaken by the Commission upon the request of James A. Prevost, M.D., Commissioner of the State Office of Mental Health. This request followed a series of articles in the Buffalo Evening News which cited serious shortcomings in the family care program.

Commission staff members spent over 75 days in Buffalo in the middle of winter visiting and inspecting family care homes and day programs, and reviewing patient records. They also interviewed patients, BPC staff, Regional Office staff and personnel from the Erie County Department of Mental Health.

The six clinical staff assigned to the study had a total of 64 years experience in working with the institutionalized and deinstitutionalized mentally disabled as psychiatric social workers, rehabilitation counselors, psychiatric nurses and in other clinical or treatment capacities. They were thus uniquely qualified to examine all facets of the operation and management of this program.

AN OVERVIEW OF FAMILY CARE AT BPC

The family care program is designed to provide residential care for persons no longer required to be hospitalized. Individuals in this program receive care and treatment for their particular needs to enhance their ability to function adequately in their own homes or in other community living arrangements. The treatment network for the OMH family care program is composed of three basic units: the family care home, the psychiatric center, and day treatment generally provided by a community-based agency.

1. Family Care Population: A 1979 OMH report on family care and community residences stated that "Family Care has increasingly moved in the direction of providing long-term care for elderly chronic patients."[1] This assessment is supported by the characteristics of the BPC sample population. Although the mean age for residents in the sample was 62 years, nearly one-third of the residents were in their 70's or 80's. In contrast, three persons were in the 35-50 year age range and only one resident was in the 20-35 year category. Most of the clients had been in the family care program for about six years, and had lived generally in one or two family care homes during this period.

The psychiatric histories of the clients in the sample also show that most have been hospitalized for extended

periods of time and suffer from serious mental disorders. Seventy percent of the residents in the sample (33 of 47) have a diagnosis of schizophrenia, while eight other residents have a primary diagnosis of other psychoses, with two diagnosed as being mentally retarded and one of the two also having epilepsy. Of the five clients in the sample with a diagnosis of organic brain syndrome (OBS), two were diagnosed as OBS with psychosis, one as OBS with psychosis and alcoholism, and another as OBS with paranoid ideation. One person in the sample was diagnosed as being in "involutional paranoid state."

Most of the sample population have had psychiatric problems for over 25 years and typically were hospitalized for the first time in their young adulthood (age 30). Of the 47 clients sampled, only one resident had a psychiatric history of less than seven years.

Almost every resident was receiving some form of medication. Forty-three of the forty-seven residents were taking medicine for psychiatric and/or seizure disorders, while 37 clients were prescribed neuroleptics or antipsychotic medications. Seven of these persons took at least one of the neuroleptics by injection. Over half of those persons receiving medications (23 persons) were taking two or more medications, with 17 on an antiparkinsonian drug for the side effects of the neuroleptic medicines.

2. Residential Opportunities: The residents in the family care program at BPC suffer from serious and chronic disabilities which necessitate long-term supervision. The residential services for the mentally disabled available in the Buffalo area are limited essentially to two programs: family care and Transitional Services, Inc. (TSI).

The Transitional Services program provides different levels of care which range from closely supervised living to independent living. All clients in this program are expected to move through these different levels of care in accordance with specific time frames. Clients are not permitted to live in a supervised setting in the program for an indefinite period of time. BPC staff responsible for the placement of clients generally view this program as inappropriate for the vast majority of clients being placed in the community. During the course of interviews, BPC staff cited cases where clients, required to live on their own, stopped taking their medicine and became acutely ill. Within the sample, three family care residents had been in the TSI program and another client had been rejected. All three failed in the program, one due to behavioral problems and a second had become "reclusive and withdrawn" while living alone. The third person who failed in TSI had stayed for five months, but no reason for leaving was found in the client's records. The one person rejected by TSI needed greater supervision than could be provided by the program.

In assessing the appropriateness of placement in family care, the Commission's clinical staff made evaluations on the basis of client interviews, reports of current behaviors and abilities by care providers, a review of clients' history of adjustment in community placements other than family care, the rate of recent rehospitalization, and the age of the clients. Based on these factors and the OMH descriptions of levels of care for different populations (See Appendix B), it was determined that all clients were in need of long-term supervised care and treatment. Independent living, without supportive services, did not seem to be a viable living alternative for these family care residents. Although family care is the only available long-term alternative living arrangement, approximately 19 of the 47 persons in the sample could live in a more independent living situation. Partially supervised living arrangements such as cooperative apartments would be appropriate for these clients to further their growth and development. Considering the chronic nature of the disabilities of the sample population, this type of living arrangement must be accompanied with active and periodic supervision if it is to be a viable community placement option. Without the development of such alternatives, it is doubtful that family care will evolve towards a transitional living arrangement as envisioned

by OMH, but will remain a long-term community residential setting for the chronically mentally ill in the BPC catchment area.

3. BPC Services: The clinical services of Buffalo Psychiatric Center are provided by units organized on a geographical basis which provide psychiatric services to the residents of its catchment area. In addition, there are specialized units for geriatric and adolescent patients. The other distinct services provided by BPC include medical and ancillary services. Family care is considered a clinical service of BPC, and primary responsibility for supervising the homes and clients is assigned to a family care team in the geographic and special care units with family care residents. The family care program also is coordinated and monitored by a facility-wide Family Care Coordinator appointed by the Facility Director.

4. Day Programs: The day program component to family care should provide residents with opportunities to further develop their talents and learn new skills which will help them achieve their potential and enhance the quality of their daily lives.

The majority of clients in the sample, 35 out of 47, were participating in day activites. There was only one unit, Niagara, in which none of the clients in the sample

were attending a day program. After reviewing the records of other family care residents in this unit who were not part of the sample, it was found that they too were not engaged in day programs to the same extent as clients on other units. The major difficulty cited by staff was inadequate transportation services in that rural area. However, other BPC units responsible for similar areas had overcome this barrier.

Recommendation

FAMILY CARE HAS BEEN THE ONLY COMMUNITY-BASED SYSTEM OF CARE FOR MENTALLY ILL PERSONS IN NEED OF LONG-TERM CARE AND TREATMENT IN THE BPC CATCHMENT AREA. THE LACK OF OTHER ALTERNATIVE RESIDENTIAL PROGRAMS NOT ONLY EFFECTIVELY IMPEDES THE PLACEMENT OF RESIDENTS IN LESS RESTRICTIVE LIVING ENVIRONMENTS, BUT ALSO RESULTS IN PLACING PATIENTS ON THE BASIS OF AVAILABLE BEDS RATHER THAN ON THEIR INDIVIDUAL NEEDS. OMH AND BPC SHOULD ASSIGN PRIORITY TO THE DEVELOPMENT OF ALTERNATIVE RESIDENTIAL SETTINGS IN ORDER TO EXPAND THE RANGE OF COMMUNITY PLACEMENT OPTIONS.

CHAPTER I

BPC TREATMENT FUNCTIONS

Buffalo Psychiatric Center plays an integral role in the quality of treatment for residents in family care homes. The staff of the facility are responsible for services such as treatment planning, psychiatric evaluations, home visits, referral to day programs, and training of care providers. BPC staff also must ensure that each resident has an annual medical, dental and mental status examnation.

1. Individual Service Plan: Prior to the placement of a patient in a family care home, a written plan is to be developed by BPC staff.[2] This plan, referred to as an Individualized Service Plan (ISP), requires the staff to identify the needs of each client and the services to be provided, as may be appropriate, in such areas as housing, medical care, psychiatric care, alcoholism treatment, finance, vocational/training services, education, self-care and transportation. As part of this planning effort, each patient also is to receive a medical examination, including a dental evaluation, which is used to assess the client's health care needs in the Individual Service Plan.[3] An evaluation of the ability of the client to self-administer medication also is to be contained in this medical report.

In reviewing the medical records, the required documentation on preplacement medical and dental examinations was most often not included in the patient's records. The physicians' recommendations regarding placement in a family care home as well as the medical factor affecting any placement were not available. Even though the physician is required to make recommendations as to the client's ability to self-administer medications, there was no item on the medical review form related to this evaluation.

Based on the review of treatment plans for the sample, a typical ISP could be described as follows. There is no provision for educational and vocational/training programs. The single nearest day treatment service provider is named in the social needs section regardless of the applicability of its activities to the client's needs. Although the next of kin is listed under "family and other support," discussions with care providers and clients indicate that no real efforts are made to contact family members or persons who frequently visited the client. Under "Self Care" there is no comprehensive assessment of client needs and strengths. BPC is listed as the only provider of mental health, mental retardation and alcoholism services, with no mention of other community services or even the identification of specific units at BPC responsible for providing care.

Although the purpose of the ISP is to encourage comprehensive service planning at BPC, it is clearly just another form to fill out. As such, it actually reflects the inadequate service planning which it was designed to correct.

Commenting on placement in family care homes, several BPC employees noted that very little is done to match a client with an appropriate family care provider. All too often this process consists only of finding an available bed and referring the client to that home. However, as noted by a supervisor, the placement process also can become one in which clients are placed according to the needs of care providers. In such cases staff, who have developed a protective relationship with the care provider, will place "good patients" (those with no behavioral problems and who require little supervision) in the homes of these providers.

The poor placement of clients was apparent to Commission staff on their numerous visits to family care homes. Some of the most regressed clients had been placed in homes which had what amounted to be a separate apartment, while higher functioning clients, who might have benefited from such independence, were living together with the care provider's family and were not given opportunities to engage in daily living activities such as housekeeping, necessary for independent living.

The failure in treatment planning was found in several of the cases reviewed by Commission staff. In one case,

Mr. W. was being considered for placement in a family care home. The client already had been placed unsuccessfully in two other homes and complained that he would rather stay at Buffalo Psychiatric Center than go back into another family care home. Nonetheless, the staff recommended that he be placed "into another family care home as soon as possible." The records did not indicate any effort by BPC staff to ascertain the reasons for the previous failures and to identify the type of home in which he could possibly succeed.

Another example can be seen in the case of Mr. G. This 59-year old man had successfully participated in the Psychiatric Center's hospital industries program in the 1960's and was described in a ward progress note as a person who "likes to keep busy running errands and doing chores around the ward." Contrary to his experiences at BPC, the ISP prepared for Mr. G. prior to placement indicated that vocational planning was not appropriate. In an interview, Mr. G. stated that he was a gardener by trade and enjoyed doing outdoor work in his current family care home. This satisfactory experience for the client developed by accident, and was not planned for by BPC staff in the ISP process.

The case of Mr. J. further demonstrates a disregard for a client's skills and experiences. Although he had been a cook on the railroads, his ISP did not indicate that this

skill could be further developed either in the family care home or in a vocational training program. There was no indication that staff even considered the ability of the client to apply for competitive employment.

However, there were some cases which showed placement was indeed based on the clients' needs. In one example, a Polish client was moved from one home to another home where the care provider not only spoke Polish but also prepared Polish meals. In another case, a Jewish woman had been placed in a Jewish home so that the client could observe her religious traditions.

2. Day Programming: Day programs are a critical component of a family care resident's treatment program. The Office of Mental Health requires the staff of its facilities to work with family care providers in developing "arrangements with local communities to provide residents in Family Care with programs and services."[5] This collaboration also is specified by OMH in the procedures for preparing the Individual Service Plan which stipulate that community providers of services are to participate in the design and implementation of the treatment plan.[6]

As previously noted, most of the clients in the sample (35 of 47) were in day programs. The effectiveness of these