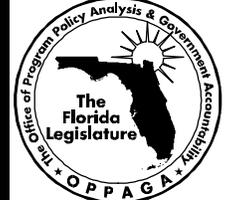




Office of Program Policy Analysis And Government Accountability



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Review of Assisted Living Facilities Serving Residents With Severe Mental Illnesses

Report Abstract

- We estimate that between 170 and 300 assisted living facilities serve between 2,000 and 3,600 residents with severe mental illnesses.
- Mentally ill residents of assisted living facilities receive personal services from the facilities and may also receive mental health services from community mental health centers.
- The Agency for Health Care Administration cites most assisted living facilities for deficiencies. Facilities with poor compliance records may not be inspected often enough.
- The new licensing requirement may result in modest service improvements in assisted living facilities that serve mentally ill residents but could result in the displacement of over 550 residents. The loss of placement options could increase costs to state and local governments if individuals with mental illness become homeless, incarcerated, or institutionalized.

Purpose of Review

This review was requested by the Joint Legislative Auditing Committee in response to a request from the Senate Health and Rehabilitative Services Committee. Our objectives were to address the following questions regarding assisted living facilities.

- How many assisted living facilities have residents with severe mental illnesses?

- What types of services do assisted living facility residents with severe mental illnesses receive?
- To what extent do assisted living facilities comply with license standards developed by the Agency for Health Care Administration?
- What is the potential impact of the state's limited mental health license on assisted living facilities serving residents with severe mental illnesses?

Background

Assisted living facilities (ALFs) provide housing, meals and personal assistance to frail elders and persons with physical and mental disabilities who need support to live in the community but do not require institutionalization. In November 1996, Florida had 1,914 licensed ALFs, with capacities ranging from a single bed to several hundred. These facilities were licensed for a total of 62,202 beds. Most of these facilities are relatively small with 16 or fewer beds. Assisted living facilities are located throughout the state, and many are in single family houses in residential neighborhoods.

Two state agencies oversee ALFs, while a third provides services to mentally ill residents. The Agency for Health Care Administration licenses and regulates facilities, investigates complaints, and imposes sanctions when required. The Department of Elder Affairs develops licensing rules and trains facility staff. The Department of Children and Families provides services to mentally ill residents of ALFs through several of its program offices.¹

¹ Effective January 1, 1997, the Department of Health and Rehabilitative Services was reorganized to create two departments: the Department of Children and Families and the Department of Health.

The Alcohol, Drug Abuse, and Mental Health Program Office oversees the mental health system and contracts with local community mental health centers to provide services to individuals with mental illnesses, including those residing in ALFs. The Economic Services Program Office, through its Adult Payments Unit, establishes fiscal eligibility for Optional State Supplementation (OSS) clients. OSS is a state-funded program intended to prevent institutionalization by providing supplemental income to low-income individuals who are aged or disabled, including those disabled because of mental illnesses. The OSS payment enables these individuals to pay for care in ALFs.

Most ALFs are able to deal with the challenges of serving mentally ill residents. Many ALFs screen prospective residents and will not accept individuals who are likely to engage in problematic behavior. As a result, these facilities pose few problems for their residents and neighborhoods. However, some facilities accept residents who are subject to frequent changes in mental health status or who may engage in unpredictable or socially unacceptable behaviors such as public drunkenness, drug abuse, and panhandling. When such behavior appears to be a threat to other ALF or community residents, law enforcement may be called to intervene. Community mental health center staff consider the facilities that accept such residents to be an important community-based placement resource. However, some of these facilities have become a source of community concern.

In 1995, to address these concerns, the Legislature enacted a law requiring ALFs that serve mental health residents to obtain a limited mental health license in addition to the standard license required of all ALFs. Under the implementing rules for the new law, facilities were to apply for a license by October 2, 1996. However, due to concerns about the potential impact of the new law, and in accordance with the provisions of s. 400.451, F.S., the Secretary of the Department of Elder Affairs postponed the license application deadline until April 2, 1997, to allow the Legislature time to address those concerns.²

² Section 400.451, F.S., provides that existing facilities may be given a reasonable time, not to exceed six months, within which to comply with new rules and standards.

Findings

Question 1

How many assisted living facilities serve residents with severe mental illnesses?

We estimate that between 170 and 300 ALFs serve residents with severe mental illnesses.³ There are no statewide data on the number of such facilities or the number of mentally ill residents they serve. To estimate these data, we surveyed the owners and administrators of the 482 ALFs that the Department of Children and Families, Department of Elder Affairs, and state mental institutions identified as serving individuals with severe mental illnesses. Of the 266 facilities that responded to our survey, 165 facilities (62% of respondents) reported they serve mentally ill residents. However, some facilities that did not respond to our survey also serve such clients. For example, we visited five ALFs that serve residents with severe mental illnesses but did not respond to our survey. If a similar percentage of the non-responding ALFs serve mentally ill residents, we estimate that 300 ALFs would serve residents with severe mental illnesses statewide.

We estimate that ALFs serve between 2,000 and 3,600 persons with severe mental illnesses.⁴ The 165 ALFs that responded to our survey reported serving 1,988 such persons. Based upon these responses, we project that there could be about 3,600 such residents statewide.

Question 2

What types of services do assisted living facility residents with severe mental illnesses receive?

Mentally ill residents of ALFs receive personal services from the facilities and may also receive mental health services from community mental health centers. ALFs provide housing, meals and personal assistance to all of their residents. Facility staff supervise residents, providing oversight of their diet, activities, and general whereabouts, and encourage residents to participate in social, recreational, vocational, treatment services, and

³ One of the factors compounding efforts to identify the number of facilities that serve individuals with severe mental illnesses is that there is no good definition of what constitutes severe mental illness. ALF operators expressed uncertainty about how to classify their residents. In our survey, we used federal guidelines to define adults with a serious mental illness.

⁴ This estimate may be low. In its 1989 study, the Department of Health and Rehabilitative Services (DHRS) estimated that there were at least 5,600 residents with mental illnesses in assisted living facilities. By 1994, in its Agency Strategic Plan, DHRS estimated the number at 7,000 residents.

other activities within the community and the facility. ALFs maintain records pertaining to residents' care and note deviations from a resident's normal appearance, health, or well-being. They are responsible to contact a resident's family, case manager, health care provider, or other appropriate person in the event of an emergency or significant change in health. ALFs are also responsible for supervising activities of daily living, providing opportunities for social and leisure activities, and overseeing residents' health care needs, including managing and (if appropriate) storing residents' medications.

Some ALF residents may also receive mental health services from the community mental health system. These services typically include case management, psychotropic medication, and day treatment. Community mental health center case managers assess the needs of their clients and assist them in gaining access to needed medical, social, housing, educational, or other services. Center physicians prescribe psychotropic medications for these residents to help control the symptoms of their mental illnesses. Community mental health center staff also supervise day treatment services, which are activities conducted away from the clients' residence for part of the day to help teach behavioral skills.

However, community mental health center staff we interviewed generally indicated that their services to ALF residents are limited. Case managers said they do not always visit their clients at least once a month, which is the case management standard. They indicated that better coordination of information about clients' psychotropic medications is needed. Center staff noted that the availability of day treatment was limited by Medicaid restrictions on the number of treatment hours for which it will provide reimbursement. Due to these limitations, the responsibility for mentally ill residents of ALFs falls primarily on the facilities.

While most ALF residents with severe mental illnesses do well in the ALF setting, others do not and may cause problems for the communities where they reside. ALF operators cited weaknesses in mental health services as affecting their clients' ability to function in the community. For example, of the ALF survey respondents who serve mentally ill residents, 19% indicated that case management services seldom or never meet their residents' needs. ALF operators also responded that case management services could be improved if case managers had more direct client contact and knowledge of clients' needs. ALF operators also told us that case managers can be difficult to locate when crises occur, requiring the facilities to call on law enforcement for help.⁵ ALF operators also reported that

⁵ OPPAGA staff met with eight owners or operators of ALFs in Pinellas and Pasco counties who serve residents with mental illness.

because of poor communication with mental health center staff, facility staff may not know what medications their residents should be receiving. Finally, ALF operators noted that mental health center day treatment programs are not always helpful because they are typically half-day programs, and the centers do not provide structured activities for ALF residents for the remainder of the day. Some mentally ill residents are not interested in attending these day treatment programs. Facility operators who responded to our survey reported that less than half of their residents with mental illnesses went to day treatment.

Question 3

To what extent do assisted living facilities comply with license standards developed by the Agency for Health Care Administration?

AHCA typically cites most assisted living facilities for at least some license deficiencies. AHCA conducts a comprehensive inspection of ALFs every two years in conjunction with renewal of the facility's license. During these inspections, staff review facilities' records to verify that employees meet background and training requirements and evaluate the facilities' adherence to approved procedures for administering medication. Field inspectors also interview residents about the appropriateness of services the facilities provide. Inspectors cite assisted living facilities for any deficiencies found during the inspection, establish a plan of correction, and verify the facilities' compliance with the plan. AHCA also inspects assisted living facilities to investigate complaints against the facilities made by consumers, their families, and others.

AHCA program managers said most inspections find one or more deficiencies, such as poor facility maintenance and housekeeping, problems with medication management, and poor record-keeping. Typically, AHCA establishes a corrective action plan and conducts a follow-up inspection to ensure that deficiencies are corrected; some deficiencies may result in fines. AHCA may impose heavier sanctions on ALFs that have more serious deficiencies or repeated violations by denying, suspending, or revoking the facilities' license or by placing a moratorium on new admissions. AHCA licensure files show that during the two-year period July 1994 through June 1996, many of the ALFs we surveyed were cited for deficiencies and many of these resulted in fines. During the two-year period, AHCA sanctioned 11% of these ALFs (18 of 65) for violations that would affect their ability to continue to serve residents with mental illnesses.

AHCA staff and an industry association assert that ALFs with poor compliance records may not be inspected often enough. When assisted living facilities defer maintenance or otherwise fail to meet state standards, the licensing process is intended to bring them into compliance and

thereby help ensure residents' health, safety and welfare. Because of the two-year inspection cycle, it is possible for facilities to operate in violation of licensing standards for several years before the Agency imposes a sanction.

Question 4

What is the potential impact of the state's limited mental health license on assisted living facilities serving residents with severe mental illnesses?

The limited mental health license established by the 1995 Legislature has not been implemented, but it could adversely affect placement options if implemented as currently designed. In 1989, the Legislature first established an optional license for ALFs that serve mental health residents. This optional license was intended to develop facilities with an enhanced capability of serving mentally ill residents by improving the knowledge and skills of facility staff and administrators. However, only two ALFs ever applied for licenses. In 1995, the Legislature repealed the optional license and enacted another law requiring all ALFs that serve residents with mental illnesses to acquire a limited mental health license in addition to the standard license required of all facilities.

Potential Benefits of Limited Mental Health Licenses. The new license requirement has the potential to improve ALFs that serve residents with severe mental illnesses. Facility staff must have two to eight hours of training on mental health concepts such as major mental health diagnoses and behavior management techniques. The implementing rules also require facilities to provide structured leisure activities every day. Further, the new law requires that facilities have a cooperative agreement with a mental health provider and a mental health service plan for each mental health resident.

Potential Problems of Limited Mental Health Licenses. The limited mental health license law could result in the loss of placement options for individuals with severe mental illnesses. As shown in Exhibit 1, about one-fourth of the ALFs now serving residents with mental illnesses either will not qualify for the special license because they have been sanctioned by AHCA in the past, or they have decided not to apply for a limited mental health license. If these facilities could not or did not obtain this license, more than 550 mentally ill residents would be displaced. Another one-fourth of the ALFs now serving residents with mental illnesses indicated uncertainty as to whether they would apply for a limited mental health license or did not answer our survey question. These facilities now serve another 405 residents with mental illnesses.

**Exhibit 1
Survey Responses From ALF Operators
Indicate Licensing Requirements Could Displace
Many Mentally Ill Residents**

Facilities That Serve Mentally Ill Residents	Facilities		Residents	
	Number	Percent	Number	Percent
Will not qualify for licenses ¹	18	11%	334	17%
Decided not to apply for licenses	24	14%	224	11%
Total Placements At Risk	42	25%	558	28%
Did not respond or did not know whether would apply	43	26%	405	20%
Eligible facilities planning to apply for licenses	80	49%	1,025	52%
Total	165	100%	1,988	100%

¹OPPGA determined that 18 ALFs will not qualify for the limited mental health license because of a history of sanctions.

Source: Office of Program Policy Analysis and Government Accountability survey of ALF operators who serve residents with mental illnesses.

If these ALFs are no longer available to provide community-based housing for individuals with mental illnesses, it will make the process of finding suitable placements for such individuals more difficult, and state and local governments may incur additional costs. The result will be that many mentally ill individuals will need to be placed in new settings, such as other ALFs. Clients who are now accommodated in ALFs may become homeless, incarcerated, or institutionalized, which may create additional costs for state and local governments. For example, state support for a mentally ill individual residing in an ALF totals about \$538 per month for both housing and community mental health services.⁶ This figure is well below a typical county's cost of maintaining an inmate in jail at about \$1,750 per month, or the state's cost of maintaining an individual in a state mental institution at about \$5,364 per month. Some survey respondents indicated they were concerned that the new licensing requirements would increase their costs. Department of Elder Affairs staff said they tried to minimize the cost impact of the new license by developing rule requirements that differed only marginally from the rules governing all ALFs. Nonetheless, some ALF operators perceive that the new licensing requirement will increase their costs and make it uneconomical to serve

⁶ This amount (\$538) is the sum of the state's maximum share of the monthly OSS payment (\$128) plus the monthly cost of providing community mental health services (\$410).

mentally ill residents. For example, these operators indicated concerns regarding additional training, paperwork, and licensing fees associated with the mental health license. Subsequent to our survey, AHCA decided not to charge the limited mental health license fee because it concluded the fee was never intended to be included in the new law.⁷

The licensing requirements also will probably not fully resolve the problem of mental health services for ALF residents. The law requires ALFs to work with mental health professionals to develop service plans for their residents. However, mental health center services are limited and facilities cannot force clients to attend day treatment.

Another problem with the new licensing requirement is that current Department of Elder Affairs' rules do not effectively target those mentally ill individuals who are most likely to need an increased level of care. Current rules specify that ALFs must obtain licenses if they serve persons who have a history of admission to state mental institutions or residential treatment facilities. However, some of these individuals have lived outside of state mental health institutions or residential treatment facilities for years without exhibiting problematic behavior. These more stable individuals may not need to stay in facilities with limited mental health licenses. Conversely, the rules do not require ALFs to obtain licenses if they serve other mentally ill residents, such as those with recent histories of multiple admissions to crisis stabilization units, who may need the more extensive care. As a result, the licensing requirements may not target the clients that most need services or the facilities that need to be licensed in order to serve difficult residents.

Conclusions and Options for Legislative Action

There are no reliable data about the number of assisted living facilities serving persons with severe mental illnesses, but we estimate that there are between 170

⁷ The biennial fee for the limited mental health license is \$200 per facility plus \$10 per resident, based on the capacity of the facility for limited mental health services. This fee is in addition to the standard license fee, which is \$240 per license with an additional \$30 per non-OSS resident based on the total licensed resident capacity. In October 1996, AHCA decided not to charge the limited mental health license fee because it concluded the Legislature had not intended to charge a fee for the license. Legislative staff confirmed that the license fee was never intended to be included in the new law.

and 300 facilities serving from 2,000 to 3,600 such residents. Individuals at assisted living facilities receive housing, meals, and personal assistance to live in the community, and may also receive mental health services from community mental health centers. However, for a variety of reasons, problems have developed at some assisted living facilities. In 1995, in an effort to deal with some of these problems, the Legislature enacted a limited mental health license law. However, without further legislative action, the limited mental health license law could result in the loss of some placement options for individuals with severe mental illnesses.

We identified three options the Legislature may wish to consider to address the issues related to the limited mental health license. These include leaving the current law intact, repealing the license law, and modifying the law or implementing rules.

Take No Action. Under this option, the current law would be retained and implemented. This would likely result in improved services by those ALFs that obtain licenses, as staff would receive additional training, facilities would offer expanded times for recreational and social activities, and coordination between ALFs and mental health providers could be improved. However, this option would not address the likely loss of placement options for persons with severe mental illnesses.

Repeal the Law. The second option is to repeal the limited mental health license law. This would avoid the loss of some placement options that would likely result if the law were implemented. However, repealing the law will not address the problems the Legislature intended to solve by enacting the law. For example, without the law, facility staff may not be trained to meet the special needs that some residents with severe mental illnesses may have, or provide sufficient supervision and recreational activities to such residents. Repealing the law also would result in no improvement in the coordination and delivery of mental health services. As a result, some ALFs that serve severely mentally ill persons would likely continue to pose community and law enforcement problems.

Keep But Modify the Law or Implementing Rules. The third option is to retain the licensing requirements but modify it to make it more effective. We identified the following potential changes the Legislature may wish to consider:

- **Better define in Department of Elder Affairs' rules the types of persons who are considered to have severe mental illnesses that require**

placement in a specially licensed ALF. The definition should be limited to those persons who, due to a history of placements and/or recent crises, are considered to require a high degree of supervision and support.

- **Reduce regulatory costs for ALFs.** This could be done by eliminating the statutory authorization for AHCA to assess a fee for the new license. The Legislature could also exempt small facilities, such as those serving less than five mental health residents, from license requirements. Due to the small number of persons these facilities serve, they may be better able to supervise mentally ill residents, but compliance costs may be most burdensome to these facilities. Many of the ALFs who reported to us that they may not apply for licenses were relatively small. These facilities served an average of less than ten residents with severe mental illnesses.
- **Require community mental health centers to place a higher priority on providing services to their clients who reside in ALFs.** This could be accomplished by directing the Department of Children and Families to incorporate specific requirements for serving this population in its contractual arrangements with community mental health centers.
- **Require ALFs that serve residents with severe mental illnesses and have poor records of compliance with licensing standards to be inspected more frequently.** Requiring annual, rather than biennial, inspections for ALFs with serious or repeated violations would help ensure that corrective measures are more timely. This requirement should specifically authorize AHCA to impose additional inspection fees as an incentive for ALFs to maintain adequate compliance with state standards.
- **Phase in eligibility requirements based on past sanctions.** The Legislature could phase in the new eligibility requirements that exclude some facilities from qualifying for the license. This would give those facilities serving mentally ill residents time to correct any deficiencies before placement options are lost.
- **Provide additional financial support for ALFs that serve individuals with severe mental illnesses.** For example, this could be accomplished by providing a special supplemental payment to facilities that serve OSS recipients with severe mental illnesses. This supplemental funding could be channeled through the community mental health

system to strengthen the relationship between community mental health centers and the ALFs in which their clients reside. This is consistent with the way the community mental health system now provides support for their clients who reside in adult family care homes. Economic Services staff in the Department of Children and Families estimate that between 1,300 and 2,900 ALF residents receive OSS payments because of mental illness. Thus, for example, providing a \$100 monthly supplement would require between \$1.6 million and \$3.5 million in additional funding annually. This may not be feasible given current state funding.

Agency Responses

Agency for Health Care Administration

The Director of the Agency for Health Care Administration provided the following written response to our review.

In reviewing page 3, paragraph 3, right hand column, regarding administrative sanctions, the Agency for Health Care Administration considers fines and moratoriums administrative sanctions. It should be noted that when a facility fails to correct a deficiency, or has a repeat deficiency, a conditional license may be issued and fines may also be imposed. Depending on the seriousness of the deficiency, a moratorium can also be placed on the facility until all deficiencies are corrected.

On page 5, paragraph 3, left hand column, you refer to LMH facilities as those serving persons who have "...a history of admission to state mental institutions or residential treatment facilities." The administrative Rule 58A-5.029(4)(a) also includes those persons eligible for case management services under Rule 10E-15.031(1)(a-c)(e)(g). This is a partial definition of the "specified population" currently in law. The law refers to 394.75(4), F.S. which contains a number of other categories as well.

The following comments are offered about the recommendations on page 6.

- **Definition.** We agree that a clearer and perhaps more narrow definition would be very helpful in targeting a specific mental health population. The definition may need to include provisions for persons who require ongoing treatment to prevent decompensation

and possible hospitalization. This could be handled in the rule depending on how the law is written.

- **Regulatory Costs.** The Agency can agree that fees for a limited mental health license should be waived for facilities with a specified number, possibly three or fewer, mental health residents as long as they maintain that number. We believe a \$200 application fee for facilities with four or more mental health residents is appropriate in that it helps to offset the additional expenses of processing the application and conducting the survey. Consistent with standard ALF fee structure, there should be no bed fee for Optional State Supplementation (OSS) residents, which constitutes the majority of the ALF mental health residents. This is not a large sum of money for a two-year license and is actually less than other specialty ALF licenses. As you know, the revenue currently generated through ALF license application and bed fees does not support the cost of administering the program. Therefore, any further reduction in fees without a corresponding reduction in regulation would require funding from an additional source.
- **Annual vs Biennial Surveys.** The Agency is supportive of this concept but must point out that the current number of staff in the area and central office are having difficulty maintaining the current workload. The ALF caseload has increased from 1704 facilities in 1994 to 1914 in 1996 with no additional staff. In addition, complaint investigations of ALFs increased from 771 in 1994 to 938 in 1996. Additional staff would be needed to assume the additional workload.

Thank you for the opportunity to respond to this report. The Agency is committed to ensuring the success of the ALF limited mental health license program. We will continue to work closely with the Departments of Elder Affairs and Children and Families to promote the quality of care needed for this population. Each agency has a strong and supportive relationship that we believe will ensure the success of this program. Our goal is to make sure the program meets the intent of the Legislature and the needs of mental health and all other residents of ALFs.

Department of Children and Families

The Secretary of the Department of Children and Families provided the following written response to our review.

The current law attempts to improve assisted living facilities (ALFs) serving people with mental illness by placing a higher standard on them, but without additional resources. Although not mentioned in the draft report, residents with mental illness require more supports and services than other people in general. Imposing increased requirements on these facilities without additional resources may result in some finding it impractical to continue serving these individuals, resulting in fewer housing opportunities for them.

The study found that 558 people who have a serious mental illness are at risk of being displaced under the current law. Alternative housing opportunities for these individuals are extremely limited. As pointed out in the study, most of these people would require significantly more expensive and restrictive placements. An appropriation of \$3.5 million to provide additional financial support to ALFs would result in a major cost savings compared to the expense of other placements currently available to these individuals.

In our view, it is essential to channel any additional funds through the community mental health system to develop partnerships between the facilities and the community mental health providers.

The two aspects of the law intended to improve facilities with a limited mental health license are likely to have minimal or negative effects on residents with mental illness. First, the law requires that the facilities' staff must receive two to eight hours of training on mental health concepts. However, the additional training required of the facilities' staff cannot be enforced.

Also, the law does not designate a specific curriculum or qualifications for trainers. In addition, it doesn't require trainees to demonstrate proficiency in the training information. Consequently, a person may attend a training session conducted by an unqualified person using a curriculum that would not improve his or her knowledge about working with people who have a mental illness, but would meet the statutory requirement for training.

Furthermore, the law requires facilities to enter into a cooperative agreement with a community mental health provider or a licensed mental health professional "designated by the Department of Health and

Rehabilitative Services.” However, the current law does not provide authority to establish designation criteria. Therefore, any licensed mental health professional can enter into a cooperative agreement with an assisted living facility with a limited mental health license, regardless of the professional’s past performance or intent.

This factor, combined with the current law requirements for securing a Medicare provider number, creates the potential and incentive for facilities to operate as a center for mental health treatment without standards, separate from the state-funded community mental health system.

Department of Elder Affairs

The Secretary of the Department of Elder Affairs provided the following written response to our review.

Targeting

The report indicates that Department of Elder Affairs rules do not effectively target the intended residents. If this is the case, the problem stems from the definition of “mental health resident” in the Adult Living Facility law [s. 400.402(15), F.S.], which references portions of Chapter 394, the mental health statute and which has been subject to varying interpretations. The language in the rule was recommended by Department of Children and Families Mental Health program office staff to clarify the meaning of the statutory definition in a way that would be clear to those who must abide by or enforce this provision. The Department believes that amendment of the statutory definition is necessary to correct this situation.

The Department has a bill to amend the limited mental health statutory requirements, including the definition of mental health resident. In drafting this bill we considered a number of variations of functional

definitions such as that suggested in the report, but found it difficult to frame a workable definition. Definitions based on the resident’s history pre-suppose that facilities and surveyors have access to information that may not be available due to lack of a paper trail or lack of access because of confidentiality of records. Accordingly, the Department’s bill recommends basing this determination on eligibility for Social Security Income or Social Security Disability Income due to a psychiatric disability, information that we believe is easily understood and readily documented, although admittedly somewhat narrow in scope.

Delay in Implementation

The report indicates that the Department’s Secretary delayed the implementation of the limited mental health requirements. Although the document was issued by the Department’s Secretary, it was prepared with the knowledge and concurrence of Agency for Health Care Administration, which has enforcement authority.

Numbers of Facilities and Residents

The number of facilities reported as serving mental health residents probably includes most of the facilities that have a high proportion of mental health residents. However, data from a statewide survey by the Florida Policy Exchange Center on Aging and Department’s telephone survey of half the assisted living facilities that have Optional State Supplementation residents strongly suggests that many more facilities have a small number of such residents, so that the actual number of facilities affected by the limited mental health law is much higher. It should be noted that the law currently applies even if a facility has only one mental health resident. In addition, a recent data analysis by the Department of Children and Families which cross-matched clients of the mental health system with Optional State Supplementation recipients showed about 3000-4000 such individuals.

Again, the Department supports the findings and recommendations included within the report and believes the final report should have a positive impact on Legislative review of the issues related to the limited mental health license.

This project was conducted in accordance with applicable evaluation standards. Copies of this report may be obtained by telephone (904/488-1023 or 800/531-2477), by FAX (904/487-3804), in person (Claude Pepper Building, Room 312, 111 W. Madison St.), or by mail (OPPAGA Report Production, P.O. Box 1735, Tallahassee, FL 32302).

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