

**AmericanWork, Inc. Supportive Living Program:
A Program Evaluation**

by

Shelley Willetts Reed

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Approved by

Jamie Carney, Chair, Professor of Counselor Education and Supervision
Chippewa Thomas, Associate Professor of Counselor Education and Supervision
Melanie Iarussi, Assistant Professor of Counselor Education and Supervision

Abstract

The AmericanWork, Inc. Supportive Living Program is a residential program for the severe and persistent mentally ill. This program evaluation sought to determine the variables which impact the consumer transitioning out of the program into independent community living among participants both currently living at and graduating from the program since its inception and ending November 30, 2011 (n=129). The goals of the program are to reduce need of inpatient psychiatric hospitalization and increase independent living within the community. A logistic regression is utilized for data analysis. Pre-admission, Secondary and Program-specific variables were evaluated with program-specific variables being found to have a significant impact on the outcome of the consumer in transitioning into community living. More specifically, identified discharge barriers were found to negatively impact successful transition of the participants. By determining those variables which impact transition of participants into community living, program improvements can be suggested to address these variables (i.e., natural supports) with individualized treatment planning to improve success of consumer's with severe and persistent mental illness in obtaining and maintaining independent living within the community.

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CHAPTER I

INTRODUCTION

AmericanWork, Inc. is driven by the organization's Mission of providing services to maximize the ability of those receiving treatment services to live and thrive independently within the community (AmericanWork, Inc., 2011). The mission of the AmericanWork, Inc. program continues to state that as a consumer-owned and operated program, and the goals run parallel with the recovery and resiliency model that the state of Georgia has adopted. (AmericanWork, Inc., 2011). AmericanWork, Inc. as an organization, is aware of the "importance of exploring the consumer's perspective and the key roles of instilling hope, promoting self-help, spirituality, education, meaningful employment, the importance of medications and illness management, and the need to build supports for each consumer as a 'whole person' who is seeking a self-directed life." (AmericanWork, Inc., 2011, Home, para. 1). AmericanWork, Inc. was started in 1999 by Ken Whiddon as an agency to provide individualized care to consumers within the community to meet the consumer where they are at. AmericanWork, Inc. has grown over the years and has expanded to have facilities throughout the state of Georgia. Services provided include outpatient care (e.g., doctor services, case management services, groups, individual counseling), peer support centers, supportive employment, psycho-social rehabilitation day services, group homes and supervised apartment living. The Columbus, Ga. AmericanWork, Inc. program began in July 2006 with the community based supportive living program opening in May 2007 (AmericanWork, Inc., 2011).

The Columbus AmericanWork, Inc. supportive living program was developed and initiated in May 2007 for community-based supportive housing supports. The facility is funded via a state contract for treatment under the Department of Behavioral Health and Developmental Disabilities of Georgia (DBHDD). DBHDD's mission is to "provide and promote local accessibility and choice of services and programs for individuals, families and communities through partnerships, in order to create a sustainable, self-sufficient and resilient life in the community" (Adults, 2011, About DBHDD, para. 4). Consumer choice is an important aspect of treatment that is embraced and fostered within treatment providers (Adults, 2011). Supportive living within the AmericanWork, Inc. agency is designed to assist consumers with developing daily living skills, interpersonal skills, and behavior management skills "to enable the person to manage symptoms and regain lost functioning due to mental illness, substance abuse, and/or co-occurring disorders" (AmericanWork, Inc., 2011, Home, Para. 1). Consumers sign a lease to rent their individual apartments with the landlord. The state contract funds a total of 50 long-term or multiple admission consumers (35 civil and 15 forensic consumers). However, AmericanWork, Inc. currently have the staff and facilities to over serve their contract numbers by serving total of 60 consumers (40 civil and 20 forensic consumers). The average amount of consumers at the supportive living program is 58. Forensic consumers have various court mandates in place for treatment. These differing types of legal involvement will be discussed later in this introduction. This facility is supervised 24 hours per day 7 days per week 365 days per year. Staff is onsite to provide for supervision, ensure safety, and provide skill building for independent living. The various services provided at the site will be discussed later in this introduction as will the criteria for admission and discharge into this program. AmericanWork, Inc. is supportive housing with structure to allow for independent living and consumer

preferences, which has been an increased topic in related literature, but also with support and structure of treatment team within the community. There were numerous ways that consumers can transition into the supportive living program.

The AmericanWork, Inc. supportive living program utilizes the transition planning process by maintaining a collaborative relationship with the area's psychiatric hospital. Majority of referrals to the program were from this hospital; however, the program does receive referrals from all state hospitals throughout the state of Georgia. The referral process is initiated by the hospital that the consumer is currently residing. The criteria that has to be met in order for the referral to be initiated include either (a) the consumer is currently residing in the hospital and the consumer has four or more admits to the psychiatric hospital within the last 12 months (30 day readmits were also looked at) or (b) the consumer has been hospitalized for longer than 30 days within the last 12 months. The consumer must have a primary diagnosis of a psychiatric disorder; however, a secondary diagnosis of substance use is acceptable. Therefore, the primary problem cannot be substance abuse however, co-occurring disorders were acceptable. These criteria have been determined by the state of Georgia for which the contract for supportive living originated. This contract is developed at the state level and the individual treatment providers agrees to the provisions, policies and procedures of the contract for providing treatment services in conjunction with receiving payment for the services provided. Upon hospital staff determining that the consumer at hand meets the criteria for the supportive living program, the referral is made to the program. There is a referral packet that is completed. The community liaison for AmericanWork, Inc. attends and is present daily for various transition and admission meetings at the hospital is then given the packet. The liaison reviews the packet and presents it to the director of the supportive living program, as well as the Columbus area director of

AmericanWork, Inc. The consumer's history, psychiatric diagnosis, co-occurring disorders (if applicable), legal concerns, and other extenuating factors to determine acceptance into the program were reviewed. The supportive living program is considered a voluntary placement option and must be agreed upon by all agencies as well as the consumer themselves.

Upon the acceptance of the consumer to the supportive living placement, the consumer will transition from the hospital to the apartment setting. The apartment setting consists of individual apartments or apartments with one roommate. Aspects of the program, including the services and treatment regimen, will be discussed in additional detail later within this manuscript. The consumer themselves also must be in agreement to not only live in the placement but comply and cooperate with the implemented individualized treatment plan that is developed with the consumer present. The living atmosphere is considered to be independent living however there were rules and expectations of the consumers. The handbook for the program is reviewed and signed by the liaison and consumer. The liaison maintains this relationship throughout the hospitalization and transition process. This allows for the consumer to build rapport with someone within the placement program to reduce any fear and uncertainty related to transitioning to a new place. The liaison is critical in this process to ensure an efficient transition into community services.

Often times consumers were nervous or intimidated when moving into a new placement, particularly when the consumer has spent a long period of time inside an institution such as the psychiatric hospital. The AmericanWork, Inc. program attempts to address this concern by providing various social activities, encourage socialization and supports amongst the consumers and the other residents as well as staff supports. Staff is not only there for treatment and psychosocial learning/teaching, but they are also there to provide support, encouragement, and

empowerment during this placement and process of independent living. The individualized treatment plan developed for the consumer most often addresses socialization and isolation concerns. Due to loneliness often resulting in increased symptomology and higher possibility of decompensating and readmission to the hospital, this aspect of the treatment plan is imperative. Therefore, this is a critical issue addressed by the treatment team and housing staff to ensure that all efforts and support were put into place for each consumer during the transition and ongoing treatment process.

AmericanWork, Inc. supportive living differs from independent housing, group homes, personal care homes, and other types of supportive housing as it is independent apartment living with staff on site. The apartment complex is located in a residential neighborhood within the community. The apartments are owned by a landlord and the lease is signed between the consumer and the landlord. However, AmericanWork, Inc. provides the staff and there are offices and other community rooms (e.g., televisions, laundry, etc.) within the complex. The handbook, as mentioned above, is completed by all consumers with staff present for review of the handbook and explanation of its contents. An overview of the program and a welcome statement are included within this handbook. Program description and the goals for the program were overviewed as well. Following is an example of this as stated in the handbook:

Acquiring skills and resources needed in order to obtain and maintain permanent housing.

This is the very goal and direction in which AmericanWork, Inc.'s program was developed. For those residents who have experienced instability because of mental health and/or addiction issues, along this part of your journey you will be given the tools to learn how to live and thrive in the community. For others who are confronting different issues, new tools and directions will be offered in place of the old ones with which you

have been surviving. Part of this journey will be the process of becoming more self-sufficiency you move along. The self-sufficiency may involve finding and keeping a steady job and income. Others may become involved with education or vocational training. All residents use their time in the supportive living program to learn different skills, depending upon their individual needs and goals for their journey. You will be required to pay fees and follow certain rules. Everything here has been put in place in order to Help you obtain your goals and move successfully along your own paths (AmericanWork, Inc., 2011, p. 1).

The individual consumer's case worker is listed as well as additional orientation issues including discussion of medications, meetings, day treatment program, apartment inspections, visitor rules, telephone rules, fire safety, budgeting concerns, sick, and gift policies. Responsibilities and rules of the residents were also listed and discussed as well as signed by both the consumer and the case worker. Human rights and consent for treatment along with a confidentiality agreement (including limitations to confidentiality) were reviewed and signed.

Physician services were provided weekly to all consumers. AmericanWork, Inc. has a resident Psychiatrist (Medical Doctor) who provides these services including psychiatric assessments, ongoing evaluation, and prescribing medications as needed. The psychiatrist assesses the person's symptoms, level of risk for harm to self or others, functional ability, history of consumer's concerns, family history, and medical history which allows the psychiatrist to diagnose and order services by determining appropriate level of care. Nursing care involves monitoring self-administration of medications, providing medication injections (if prescribed), as well as educating consumers on their medications (e.g., risks/benefits, side effects) and ensuring/encouraging compliance. Nursing services were provided daily with on-site nursing

staff. The program director is also on-site daily to ensure the supervision and maintenance of the program. There is clerical staff that assists with the administration aspect of the program.

Case management, also referred to as community support (CS) services; provide skill building to the consumers. There were numerous aspects to this service. This is a community based services to increase the consumer's independence within the community through gaining and adequately using learned skills to increase quality of life and decrease dependence on the mental health treatment system. Case management services were provided within the community to focus on restoration of consumers to their highest possible functioning level while reducing psychiatric symptoms. By identifying barriers that impede development of skills necessary for independent functioning within the community, CS can assist with improvement in skills for increased independence within the community (AmericanWork, Inc., 2011). It is important for the case workers not to enable the consumers as this will increase their dependence on the treatment system rather than decrease their dependence. The purpose of this service according to AmericanWork, Inc guidelines is as follows:

This service is provided in order to promote stability and build towards functioning in their daily environment. Stability is measured by a decreased number of hospitalizations, by decreased frequency and duration of crisis episodes and by increased and/or stable participation in community/work activities. Supports based on the person's needs are used to promote recovery while understanding the effects of the mental illness and/or substance use/abuse and to promote functioning. The Community Support staff will serve as the primary coordinator of behavioral health services and will provide linkage to community; general entitlements; and psychiatric, substance use/abuse, medical services,

crisis prevention and intervention services (AmericanWork, Inc., 2011. Services Provided, para. 11).

CS workers teach and demonstrate rehabilitative skills, daily living skills, independent living skills as well as links the consumer with resources within the community for basic needs and supports. This increases the consumer's ability to utilize skills and access these resources independently without prompts and assistance to improve their ability at maintaining independent living. CS is provided to all residents of the supportive living program to increase skills and encourage independence within the community. Important aspects of CS include empowerment, respect and a clear emphasis on meeting basic needs of the consumers including homes, jobs, and friends (Carling, 1990). With additional skills and increased ability to maintain their independence within the community it allows for consumers to feel increasingly self-sufficient and ability to maintain own living placement with reduced likelihood of losing adequate housing and readmissions to hospitals. The goal is to increase their skills to adequate levels to eventually transition out of supportive living into complete independent living with ability and skills to maintain this living arrangement.

In addition to CS services, housing staff at supportive living provide for leisure activities and additional supports within the living environment. There were extra activities (e.g., going shopping, going to the movies, exercising, going to community activities such as the local fair, etc.). CS and residential staff work together to provide added support, encouragement and skill building for wrap around supports and services. Psychosocial Rehabilitation (PSR) is an additional aspect of the supportive living program. Each resident is required and strongly encouraged to participate in this day treatment program. This is a 5 day a week program that is from 9:00 am – 2:30 p.m. Transportation is provided as it is located at a different

AmericanWork, Inc. facility. According the Georgia FY2012 Provider manual (2011) PSR is “a therapeutic, rehabilitative, skill building and recovery promoting service for individuals to gain the skills necessary to allow them to remain in or return to naturally occurring community settings and activities” (p. 265). Individual counseling and groups were facilitated for skill building activities to improve consumer’s skills in living, learning, social and working environments (Georgia Department of Behavioral Health and Developmental Disabilities, 2011). Psychoeducational and therapy groups consist of building social skills, problem solving, coping skills, illness, and medication self-management, vocational skills, recreational and leisure skills to promote self-esteem and independence.

PSR is a day program that addresses the areas as mentioned in primary group settings. This service is provided for individuals to increase and maintain competence in normal life activities and gain the skills necessary to allow them to remain in or return to naturally occurring community environment (AmericanWork, Inc., 2011). As the consumers go through the program there are updates and revisions made to their treatment plan to ensure that the plan meets the consumer’s needs where they are at the time. As a consumer progresses less intensive treatment services may be required and they can be stepped down to lower level of care. An example of PSR and step down could be reducing days of participation at the day program to two or three instead of five days a week. Reducing the intensity of treatment services allows the consumer to have other responsibilities such as community involvement, volunteer activities, employment, and additional socialization and supports. These goals were identified in their transition plan on their treatment plan at beginning/admission to treatment. As the treatment plan is reviewed and revised at the longest every 6 months. The transition plan is also revised to allow for what goals need to be met to step down to lower level of care.

Group counseling is provided for those diagnosed with co-occurring disorders. Groups were facilitated to enhance the consumer's ability to function more independently by increasing the consumer's ability to manage triggers of substance use for obtaining and maintaining sobriety within the community. Individual counseling is another service that is available for consumers of the supportive living program. Various therapeutic interventions were utilized to restore, enhance, and/or maintain the consumer's level of functioning (AmericanWork, Inc., 2011). Additional services that can be included within the individualized treatment plan comprise of the legal skills group for those deemed incompetent to stand trial for the goal of gaining competency to stand trial. Legal aspects of treatment will be discussed in more detail at a later time. Medication administration can also be administered if a medication is ordered by the psychiatrist on staff. A combination of these services can also be provided amongst the consumers.

As mentioned, transition planning is included on the individualized treatment plan for each consumer. The level of care currently needed as well as demographics and history were included on this plan as well. Treatment goals were identified and individualized for this plan and these goals were required to be SMART (specific, measureable, achievable, realistic, and time-limited). Treatment plans were required to include individualized and specific goals as related to the individual. The importance of treatment goals is to clarify an objective for the consumer to obtain as well as identify ways to measure progress made. These goals also were addressed during the review of the treatment plan at least every six months, at times sooner, to determine if adjustments need to be made, new goals need to be added or to determine if goals have been met at which time these goals were removed from the treatment plan. Ongoing review and assessment of treatment plan and goals were important aspects of the treatment process. This

entire process is completed by the treatment team which includes the physician, counselor, case manager, PSR staff, and the consumer. It is important to remember that the combination of both medications and counseling with therapeutic and psychosocial aspects is fundamental in achieving desired treatment goals. There is extensive research literature showing that psychosocial treatments were an essential component along with medications for persons with severe mental illness (SMI) (Anderson, Lyons, and West, 2001). The Surgeon General's report related to mental health, documents the crucial role that mental health services play in assistance of persons with schizophrenia to maximize functioning and recovery (as cited in Anderson et al., 2001). An important aspect included within both the literature and the supportive living program is socialization and the emphasis on adequate social supports that can ultimately reduce feelings of loneliness and increase quality of life within integration into the community.

Social supports can have a great influence on level of participation in the community activities for individuals with mental illness residing in residential settings (Gulcur et. al., 2007). The support from friends and staff can be beneficial for the consumer to motivate and encourage participation in social and leisure activities within the community. This is where CS steps in and can provide for teaching of skills as well as accompaniment and encouragement for use of skills in community settings. These skills can be taught individually or in groups with multiple consumers to allow for social supports amongst each other in the community social atmosphere. According to Granerud and Severinsson (2006), it is suggested that there is a link between social support and psychological well-being. The connection between social contact and well-being is too critical to ignore. The connection to psychosocial well-being and symptomology proves that social supports should be an essential component of any treatment plan with those diagnosed with a mental illness not excluding those in supportive living programs. This includes

AmericanWork, Inc. consumers within the program at hand. Positive social interactions and a strong support network have been found to have positive impact on illness resulting in relieving psychiatric symptoms, and positively influencing outcomes and recovery (Weiner et al., 2010).

AmericanWork, Inc. supportive living program is a voluntary program, as consumer choice is required when developing transition plan into the program and ongoing treatment planning throughout the program. Consumer choice is emphasized within the AmericanWork, Inc. mission as well as the individual apartment program's mission. The consumer works with the treatment team to determine treatment transition between levels of care as well as the ongoing goals within the program. The individuals vary in what is important to them in the treatment process. This occurs in all treatment settings and does not exclude the supportive living program. It is important to remember that not all consumers have the same goals and not all have the goal of private independent living. Examples of varying goals were that some consumers may have legal involvement and a history of criminal behaviors that would be addressed in the treatment plan.

There were differing aspects of legal involvement for consumers including being under various types of court orders. Drake, Morrissey, and Mueser (2006) point out that the mentally ill population involved in the criminal justice system has become an increasing dilemma for treatment of both community mental health and local jails. Jails can often become a revolving door for those with mental illnesses resulting in numerous arrests and incarcerations. Within the supportive living program there were a number of consumers with legal involvement such as outpatient commitments, not guilty by reason of insanity status (NGRI), and incompetent to stand trial status (IST). Outpatient commitment is initiated by community mental health agencies for those consumers who were continually going in and out of the hospital with a history of

noncompliance resulting in unstabilized mental illness and concerns with safety of the consumer and others. The consumer is then mandated by the court to attend treatment with conditions individualized to the consumer including medication compliance as well as compliance with the treatment plan.

NGRI is initiated by the courts after the consumer is charged with a crime. The public defender and prosecutor both agree on a plea of NGRI with conditions of their release. The conditions of the persons release varies by individual, however, it most always consist of a supportive living program and adequate treatment for mental health and substance abuse if applicable. When a person with a mental illness is arrested and charged with a crime there is often a competency evaluation ordered at their first court appearance. The competency evaluation is to determine if the person is competent to stand trial. This consists of if the person is knowledgeable and has an adequate understanding of the court proceedings and court personnel. This is important as the consumer must be able to assist with his or her own defense during their court proceedings. The competency evaluation can take as much as 12 months or more to obtain. If the person is determined competent then the court proceedings continue as normal. However, if the person is considered incompetent then competency restoration is ordered. Competency restoration also includes a significant wait that the person must serve in the Muscogee County Jail. Once the person begins their restoration, they were then moved to the psychiatric hospital forensic unit. AmericanWork, Inc. supportive living program participates in a new program that has recently begun in the state of Georgia. This allows for those found IST to be obtain competency restoration within the community in a supervised program rather than the forensic hospital. This allows the wait time for beginning the process of competency restoration to decrease. Competency restoration is continued with group, individual counseling, day

treatment programs, psychiatric care and medications. The consumer periodically returns and gets reevaluation for competency. Once becoming competent, the person returns to court.

However, if the person is deemed unable to restore to competency due to severity of psychiatric illness then the court can decide to go a different route with the criminal charges including an NGRI option.

An additional component of legal involvement within the supportive living program is Mental Health Court (MHC). MHC is a concept of treatment rather than jail time. Due to the lengthy amounts of time and increased expenses that SMI population incur while incarcerated, the goal of the MHC program is based on the idea that someone with a SMI would benefit far greater from treatment than from being in jail. Not only does this benefit the consumer, but also society as a whole by promoting stability of the consumer, reducing the risk of further crime, as well as financial savings for the department of corrections.

All of these various types of legal involvement within the SMI population are a concern with any community mental health treatment agency, including the supportive living program. Each of these types of legal involvement has been and/or is currently represented in the supportive living program. Each of these has to be addressed throughout the consumer's treatment, included on their treatment plan as well as court hearings to be attended. This is an additional aspect of treatment for SMI in the community on top of the numerous other factors associated with treatment and housing of this population. These factors also impact the goal of transitioning from the supportive housing program into independent housing as often times the courts have to approve these transitions.

Transition from supportive living program to independent housing in the community is a goal that is addressed based on each individual's goals and treatment plan. Once goals of treatment were met, the person can transition to the community. This could mean the consumer is transitioned to living with friends or family or living in their own apartment or house. The consumer, upon meeting treatment goals, may then begin the transition process. With supportive living the first goal is to determine what type of living arrangements the consumer will transition to. Once this is determined the transition plan is put into place. The consumer often continues to attend the day treatment program, typically in a reduced capacity (e.g., three days a week instead of five), once moved into independent living to continue with a supportive environment. Outpatient case management services were also put into place and the consumer is visited within their home by a community support worker approximately three times a week or as needed with frequency of visits decreasing over time. The consumer also continues to see the psychiatrist and receive medication monitoring. The goal is to ensure support and encouragement during this transition stage. The level of care continues to be reduced as the consumer continually decreases dependence and need of the community mental health treatment agency. Although this is important to a number of consumers within supportive living, all consumers may not desire or have the functioning level to live completely independent within the community. Varying levels of care and services were needed for varying consumers depending on functioning level, severity of illness, and coping ability.

Although, one of the goals of the AmericanWork, Inc. supportive living program is to increase skills to maintain independence within the community, this may not include complete independent living for all individuals. Some individuals may require ongoing supervised living arrangements and may prefer these arrangements above other options. This should be taken into

consideration when planning transitions, discharges and ongoing treatment goals for all consumers being admitted and ongoing clientele within the supervised living program. Majority of clients prefer their own apartment, however it is also important to keep in mind that as consumers progress through treatment their preferences on living arrangements may change. Consumers have identified their goal of some form of independent housing in the future or independently with a family member (Tsai, Bond, Salyers, Godfrey, and Davis, 2010).

There is an assumption that all consumers want independent housing, however Tsai, et. al. (2010) found that even though the majority of consumers preferred independent housing, up to 41% were interested in alternative forms of housing as well. It is important to remember that despite literature, mental health incentives, and states emphasizing independent living, this may be unrealistic or unadvisable for all consumers. Supervised independent living settings may be as independent as some consumers were able to adequately function in, due to the severity of the illness and varying other factors. Consumers may need ongoing consistent supports within their living environment due to their illness.

Purpose

Despite a significant decrease in number of consumers in mental health hospitals every year since 1955 (due to the deinstitutionalization movement), there has been a concern regarding increased number of readmissions to mental health hospitals (Test and Stein, 2000). There is an ongoing and increasing need for improved effective community resources for treatment of those with mental health and substance use concerns. Only by having adequate community resources the need for psychiatric hospitals will be reduced with the severely mentally ill population. There continues to be an increased rotating door of psychiatric hospitals with shorter stays, however

often more readmits. The average stay in a psychiatric hospital is often not effective in building skills for the consumer to maintain stability of illness and prevent future hospitalizations. An alternative to hospitals when there is not sufficient community supports is the jail or prison system. There is an increasing number of mentally ill people incarcerated within jails as they can be viewed as a safe place which particularly occurs when community-based treatment services were inadequate or unavailable (Severson, 2000). Downsizing of psychiatric hospitals continued into the 1990's. However, this continues to this day in the state of Georgia. Georgia continues to push community treatment; however there is an ever decreasing budget for outpatient care which impedes the assurance that consumers, including SMI population, will have adequate care within the community. Lack of adequate community services has resulted in an increase in homelessness and severe stress on families (Friedrick, Hollinsworth, Hradek, Friedrich, and Culp, 1999).

There has been recent developments within the Georgia mental health system and state psychiatric hospitals that affect closings of these hospitals and a need for increased community based services such as the AmericanWork, Inc. supportive living program. Georgia has recently reached a settlement agreement relating to the American with Disabilities Act (ADA) after investigations found inadequate care at state hospitals resulting in this settlement pushing for increased community services. On October 19, 2010, the settlement was put into place with the Federal Government and State of Georgia as related to the American with Disabilities Act due to a lawsuit against the mental health treatment system in the state of Georgia. This settlement focuses on a lawsuit emphasizing moving SMI consumers out of the state psychiatric hospitals and into community based treatments. The settlement resulted from a federal investigation that began in 2007 after articles in the Atlanta Journal-Constitution reported more than 100

consumers from the state hospitals died under suspicious circumstances since 2002 (Judd, 2009). The settlement puts in place types of services as well as the way these services are implemented within the community throughout Georgia. The ADA settlement covers both developmental disabilities as well as mental health disabilities. The following services have been increased and closely monitored as a result of the settlement for those with SMI: Assertive Community Treatment Teams (ACT), Community Support Teams (CSTs), Intensive Case Management, Crisis Service Centers, Crisis Stabilization Programs, Mobile Crisis Services, Supported Housing, Supported Employment, and Peer Support Services (United States v. The State of Georgia, et al., 2010). The settlement further explains what services are required as well as other considerations such as transition planning. This change is and will impact all aspects of community mental health treatment within Georgia including the AmericanWork, Inc. supportive living program.

This program evaluation for the AmericanWork, Inc. supportive living program considered all aspects of the consumer's current treatment plan, housing arrangements, functioning level, diagnosis, history of treatment and hospitalizations, legal concerns, and other variables that may have an impact on treatment of those with SMI. This evaluation attempted to determine the effectiveness of this type of supportive living for those with SMI diagnosis within the community. Are hospitalizations (amounts and frequencies) decreased? Is legal involvement decreased? Are the consumer's better able to manage their illness and symptoms on their own? Has community integration been addressed and sought (e.g., looking at socialization, consumer preference, leisure activities, immersion into the community)? Determining the answers to these questions and how differing variables impact successful transition to community independent living were crucial for this evaluation to allow for improvement of supportive living programs

and ongoing operation and effectiveness of this program. With the increased need for community based services as a result of the reduction in hospital settings and the implementation of the ADA settlement, adequate community based services are needed. To determine adequacy and effectiveness of these programs, evaluations such as this need to be conducted for improvement within these programs as well as development of more of these programs throughout the state.

Significance of Study

AmericanWork, Inc. supportive living continues to operate with an ever increasing need for community based living for the SMI. There is a need, however to determine and ensure that the services provided within this program are adequate for ongoing stability and increased independent living within the community. The goal is to ultimately result in community integration with independent housing and the least amount of dependence on treatment resources that is within the capability of the individual consumers. Carlin (1990) points out that without adequate treatment services individuals lack the skills and supports that are needed for living within the community as well as a negative impact on independent housing as a result of reoccurring readmissions to psychiatric hospitals. The lack of adequate community services has resulted in an increase in homelessness, jailed mentally ill persons and severe stress on families of the mentally ill (Friedrick et al., 1999). There are numerous areas of a mentally ill person's life that are impacted with the lack of adequate treatment resources within the community. The ever increasing number of severe and persistent mentally ill consumers incarcerated in the local jails and prisons is often attributed to the idea that these are safe places for these consumers as a result of inadequate and/or unavailable community resources (Severson, 2000).

Although the supportive living program may not be impacted as a result of changing in need of community based services, it will be needed to continue its operation within the community for those consumers being released from state hospitals under the ADA settlement agreement. The decreased need for state psychiatric hospital admits will allow for improved services for those with mental illnesses as the resources will be adequate and not reduced due to overpopulation of admissions. The ADA settlement has been designed to ensure that the state of Georgia provides adequate community based resources with increased support for the mentally ill. However, the Mental Health and Substance Abuse treatment budget has not increased despite this expansion of services. With the budget continuing to be strained, the mandate for increased community resources/treatment, and a decrease in hospital beds, the need for adequate community based treatment has never been greater.

The AmericanWork, Inc. supportive living program is a program that has been in operation for over four years, and due to current situations in the psychiatric treatment area of the state of Georgia, there is an ever growing need for programs such as these. However, there is also a need to determine the effectiveness of programs such as these. The need for these programs are evident, however the success of these programs and how to implement programs such as these in other places is in need of being determined. This evaluation will attempt to utilize information and to provide ideas for program improvement and program deficiencies along with program successes to ensure effectiveness and provide for ideas of implementation of these types of programs elsewhere in the state of Georgia. All of this will ultimately allow for the consumer to receive the most sufficient care and treatment to allow for the quality of life that is deserved.

Research Questions

The research questions for this program evaluation and study are:

1. What is the level of effectiveness of the supportive living program at increasing transition to community living among severe and persistent mentally ill consumers?
2. What pre-admission, program-specific and secondary variables are related to the outcome of the supportive living program?

Definition of Terms

Supportive Housing Program: In this study the term supportive housing will be in reference to the AmericanWork, Inc. supportive living program. Supportive living and supportive housing are used interchangeably. This is in reference to an apartment complex within the community that is leased from a landlord and onsite 24-hour supervision is provided by the AmericanWork, Inc. treatment facility. Treatment staff includes houseparents, case workers, and nurses. A variety of treatment services are provided including medication monitoring, leisure activities, social supports and skill building. Psychiatric treatment services are provided along with crisis intervention services.

Community Living: For the purposes of this study community living and integration is in reference to living independently within the community without in house or on-site support services. Although treatment services and case management will be available and actively involved with the consumer, the consumer will live in an independent housing setting. This could be on their own or with family or other supports such as friends. The consumer will be responsible for maintaining this living via housekeeping as well as paying their own rent, bills,

etc. The consumer will have access to support services, treatment service, crisis intervention services and other community resources for assistance with their independent living however.

Severe mental illness (SMI): In the case of this study is defined using three criteria: diagnosis, disability and duration. Diagnoses related to SMI consist of common disorders that are severe including: schizophrenia spectrum disorders, Bipolar Disorders, and Major Depression. Disability consists of impairments in functioning areas (e.g., social, relationships, work, leisure, self-care) and duration which is when the consumer has received intense psychiatric treatment for significant length of time such as multiple hospital admits, long hospital stays, and intensive outpatient treatment (Bond et al., 2000). Duration is looked at mostly within the AmericanWork, Inc. supportive living program as the qualification for admission to the program include multiple hospitalizations (four or more during a 12 month period), long hospital stays (more than 30 days) and 30 days readmissions to the state hospital after discharge.

Transitional Consumers: In reference to this study transitional consumers are used to identify those consumers that have completed the supportive housing program and have transitioned into independent living within the community.

Non-transitional Consumers: For the purpose of this study non-transitional consumers are determined to be those consumers who have been discharged from the supportive living program but not into community living as well as those that have remained within the supportive living program for a determined amount of time without being transitioned out into community living.

CHAPTER II

REVIEW OF THE LITERATURE

AmericanWork, Inc. Supportive Living Program's main goal is to prevent ongoing hospitalizations and readmissions of those diagnosed with SMI along with increasing independent living skills within the community to increase their independence and decrease their dependence on the treatment system. The high percentages of the SMI population going in and out of the hospitals, jails, and inpatient treatment settings is a growing concern and the emphasis on adequate community based supports continues to rise in many states, including Georgia. The unproductive cycle of admits and readmits to psychiatric hospitals negatively impacts both the quality of life for the person, but also raises budget concerns for the public (Benefits of Residential Treatment, 2011). However, there is also a declining budget and to continue to provide this adequate community supports new innovations and programs need to be developed. Supportive Living programs are an aspect of this community support and to ensure they are meeting their desired goals ongoing evaluations are needed for program improvement as well as program development of programs such as these throughout the state. Too often once a person is released from the hospital setting they do not receive follow up outpatient care and return to isolation and without the needed treatment the person's functioning level deteriorates, medication noncompliance occurs and often times rehospitalization occurs (Benefits of residential treatment, 2011). This cycle needs to be stopped, and with adequate treatment and community based treatment services, a positive impact can be made for the consumer themselves and the treatment system as a whole.

Supportive Living Programs

Supportive living programs can be defined in various ways and structured in a number of ways. AmericanWork, Inc.'s program is an apartment setting where the entire apartment complex is operated by AmericanWork, Inc. There are single and double occupancy apartments with staff rooms and offices as well as community and laundry rooms. There are various studies within the literature that discusses the most beneficial ways of setting up and structuring this type of program. Mares, Young, McGuire and Rosenheck (2002) maintain that larger homes provide for greater opportunity for development of friendships and socialization activities outside of their own apartment. It is also pointed out by these authors that facilities in lower income neighborhoods may experience less stigma from the neighborhood as opposed to neighbors of higher income neighborhoods which allows for the consumers to feel more comfortable in establishing social relationships within the community outside of their home setting. This has also been found on other studies including Yanos, Barrow, and Tsemberis (2004) who found that programs set within diverse working-class neighborhood as well as non-traditional neighborhoods are welcoming possibly due to differing types of people as well as provide for an atmosphere for tolerance of difference. The idea of supportive living programs increasing a consumer's integration within the community and increasing their socialization within their own community can be increased by the idea of having larger living programs in a lower income based neighborhood for increased acceptance. Mares et. al. (2002) found that those living in larger homes as well as low-income neighborhoods reported an increased amount in contacts with friends and significant others than those living in smaller residences. However, Mares et. al. (2002) also points out that it has been found that residents of smaller care homes reports a family-like setting which improves the mentally ill person's functioning level. Quality

of life and increased integration the residential setting and living environment is crucial. Mares et.al. (2002) found that there positive social climates are positively associated with both subjective quality of life measures utilized in this study. To develop a supportive living program, research is important to review to determine what the desirable environment setting is for the consumers and how to achieve this to reach goals of increased quality of life.

An important aspect of the living environment is resident satisfaction as this will make a difference in the compliance and progress of the consumer. Picardi et.al. (2006) found that limits to residents' privacy are associated with lower satisfaction as related to the privacy experienced within their own living quarters. Yanos et. al. (2004) also discussed privacy in relation to resident's feeling of privacy within supportive housing programs. Challenges with privacy include frustrations with limitations of privacy as well as independence often related to strictness of rules which can be disadvantageous to integration within the community (Yanos, et. al., 2004). These concerns and frustrations may often result in the consumer leaving the program without completion and risking readmission to psychiatric hospital and decreased integration and quality of life. Living with a roommate with separate rooms seems to maintain this residents privacy. However, several consumers in one room correlated with residents' withdrawal which is ultimately related to facility size (Picardi et.al., 2006). Therefore a larger facility may have more opportunity to allow for a lower number of consumers in a single apartment, larger privacy measures, and increased resident's satisfaction. Emphasis on independent housing with increased physical amenities is found within the literature base (Picardi et.al., 2006;Weiner et.al., 2010). Picardi et.al. (2006) discussed how programs "with more physical amenities had patients who were more involved in self-initiated and community activities and were more likely to successfully complete the program and be discharged to independent living situations and paid

jobs” (p. 273). By maintaining comfortable adequate living settings the length of time maintaining compliance with the program increases ultimately increasing the treatment effectiveness due to the prolonged stay at the program. This allows additional skills to be developed and greater success in other areas of life including independent living, vocation, and socialization realms. The goal of the living atmosphere of the supportive housing program is to allow for higher levels of independence which is most beneficial for psychological and developmental impacts on its residents (Chen, 2010).

There is an ample amount of studies within the literature related to the various types of housing within the community for the SMI population. Studies tend to separate group homes, personal care homes, independent living with treatment staff visits, and own housing. Residential arrangements which are more independent and more “normalized” simulates the general population’s idea of “normal housing” improve community integration among the SMI population (Gulcur, Tsemberis, Stefancic, and Greenwood, 2007). Community integration is a widespread topic among the current literature related to community living among the mentally ill population. Yanos, Barrow and Tsemberis (2004) note that services within the community should facilitate SMI consumer’s integration within the community allowing them to participate in the whole community including the same activities and opportunities as the general population. For example, the AmericanWork, Inc. supportive housing program attempts to incorporate this idea by allowing for a number of activities and encouraging these activities for increased participation within the community. Activities such as church or other religious activities, volunteer opportunities, employment, social/leisure activities, and family events are all encouraged. These are not only encouraged and allowed but are also included in the treatment plan of the individual based on their individualized goals and readiness related to these areas.

There may often be initial goals within the treatment plan that are later changed and/or adjusted to fit the needs and goals at the time for the individual.

Test and Stein (2000) found in a study that consumers in the apartment condition showed a significant greater performance behavior than individuals in boarding situations. Weinman, Kleiner, Yu, and Tillson found that individuals placed in settings in the community that require some form of independence will manifest more appropriate instrumental functioning than those who are in total care facilities and this was empirically validated (as cited in Test and Stein, 2000, p. 52). The importance of a consumer's feeling of independence is evident in the literature. The value of feeling independent and part of the community is critical for treatment and ongoing stabilization of mental illness. The more independence a consumer has the more progress towards complete integration can be made. Existing research on homelessness and mental illness has shown evidence of a number of beneficial effects of supportive independent housing including reduced homelessness, increased residential stability, reduced hospitalization, and fewer service gaps, resulting in reduced symptoms, improved social and personal functioning, improved quality of life and increased satisfaction with housing (Wong and Solomon, 2002).

Staffing requirements and skills are also discussed within the literature as discussed in the impact on successful supportive living programs. Working with those who are seriously mentally ill requires many skills to adequately treat the consumer but also remembering self-care as burnout within this field can be common due to the high pressure of the job. As Picardi et. al. (2006, p. 275) conclude "Working with the most severely disturbed residents in residential facilities requires high skills in psychological and social treatment strategies, and this can only be achieved with comprehensive and ongoing training."

Training of staff is imperative and utilized often within the AmericanWork, Inc. supportive living program. Training requirements come from various oversight agencies that audit and monitor AmericanWork, Inc. but also from their own policies as well. Training requirements such as CPR/First Aid, crisis intervention, suicidal education and prevention, mental health 101, dual diagnosis, self-administration of medications, and numerous other topics are required typically on a yearly basis of all staff of the supportive living program. “Poor training, lack of emotional support and supervision to the staff were found to be associated with high expressed emotion attitudes by staff members towards residents and with residents’ refusal to be involved in rehabilitation activities” (Picardi et.al., 2006, p.275). The staff’s training, attitudes, and skill all impact the consumers on a daily basis in relation to their satisfaction with treatment and also their compliance and participation in treatment for ongoing progress. Therefore without the most effective staff within the facility, the progress the consumer makes is negatively impacted resulting in lack of success of the program and poor consumer care. “For many of them, these settings may represent ‘homes for life,’ adequate quality as well as quantity of staffing is equally crucial to maximize the likelihood of good outcomes” (Picardi et. al., 2006, p. 276).

Supportive Living Staff

Program Staff

Within the AmericanWork, Inc. supportive living program there is a total of 47 employees. Amongst this staff there is one Residential Manager who is licensed as a Practical Nurse (LPN) as well as a Certified Addiction Counselor (CACII), one full time LPN, one part time Licensed Professional Counselor (LPC) and one part time Licensed Associate Professional Counselor (LAPC). The program maintains twenty-four hour on-site supervision with three

shifts of case managers. On shift one there are 9 case managers, with shift 2 eight case managers are employed and shift 3 who employs 6 case managers. There are three shift supervisors for these case managers. A Community Support Individual (CSI) Supervisor provides oversight of 15 CSI workers. There is also a secretary on site for the program as a whole. Case managers provide watchful oversight of the consumers as well as monitor self-administration of medications. Requirement is a high school diploma with a preference for some college and experience. CSI workers provide psychoeducation and teaching of skills for a variety of treatment goals. Requirements include minimal of a high school diploma with a preference for a bachelor's degree and experience. Majority of CSI workers currently have a bachelors and many are working towards their master's degree in a related field.

Day Treatment (Psychosocial Rehabilitation) Staff

All consumers of the supportive living program are also required to attend the day program (PSR) where psychoeducational groups are facilitated as well as other services including individual counseling for specific consumers. A total of nine staff work with PSR including a Director, 5 case managers who facilitate the groups, one Certified Peer Specialist (CPS), one Food Service Technician and one Administrative Assistant. Case Managers conduct psychoeducational groups throughout the day while the consumers attend the day program along with the Peer Specialist. At the PSR program it is a requirement to have a CPS on staff. Also the PSR Director must also be a certified psychiatric rehabilitation practitioner and have a bachelor's degree. The director is required to be on site at least 80% of the time and is required to have ongoing training in addiction. It is a preference for the director to also be a licensed counselor.

Other Related Staff

Indirect staff that also have direct contact with the consumers of this program include a Medical Doctor who specializes in psychiatry, a Registered Nurse as well as the Area Director who supervises the entire program and is also an LPC.

Staff Training

All staff are required to be at least 23 years of age, have a clean criminal background, and clean driving record. All of these paraprofessionals are required to have a total of 46 hours of training within 90 days of date of hire. This training includes corporate compliance, cultural competence, documentation, first aid/CPR, mental illness/addictive diseases, pharmacology and medication self-admin, professional relationships, recovery principles, safety/crisis de-escalation, explanation of services, service coordination, and suicide risk assessment. Most of these are required yearly or bi-yearly for each employee. This is in accordance with the state of Georgia and the contract that is agreed upon by the state and AmericanWork, Inc. These are requirements similar to other mental health and substance abuse treatment programs throughout the state that also receive contracts through the state of Georgia.

Consumer Preference

Granerud and Severinsson (2006) emphasized the importance of encouragement and empowerment among persons with mental health concerns to achieve independence through making their own decisions regarding their own lives. Empowerment and choice is crucial when working with mental health consumers as this allows them to own their treatment. Consumers who feel they have a say so in their treatment and feel that it is their recovery as opposed to the

staff indicating every aspect of treatment will have increased motivation and care as to where there recovery goes. Mental health consumers typically have the same goals as the general population such as having satisfactory employment, adequate independent housing, friendships, health, financial stability, and a high quality of life (Bond, Salyers, Rollings, Rapp, and Zipple, 2004). Consumers who have these goals as well as an individualized treatment plan that they participated in developing have increase motivation for treatment and increased likelihood of maintaining stability of illness while living within the community. Tsai, Bond, Salyers, Godfrey, and Davis (2000) conducted a study on housing preferences for those with dual diagnosis and found that “nearly all consumers wanted independent housing in the future, many described needing supervised housing at some point in their recovery. Many consumers talked about how supervised housing provided structure and support that were helpful in their recovery” (p. 386). Shared decision making is found to be crucial in increasing treatment compliance and progress allowing for consumers to be held with the responsibility of their own treatment outcomes which makes it ever more important to allow the decision making to be incorporated in housing placement (Tsai et.al., 2000). The importance of allowing consumers preference into their housing placement is critical as it allows the consumer to be empowered and held responsible for their decisions which will impact their participation and compliance with the treatment regimen.

Friedrich, Hollingsworth, Hradek, Friedrich, and Culp (1999) conducted a study on consumers who lived in group settings and found that these consumers were significantly more likely to be older, less educated, unemployed, and diagnosed with schizophrenia as compared to consumers in other settings. It was also found that consumers who were living in housing with twenty-four hour supervision preferred this type of residence and often reported less social isolation with those living in own homes without staff support preferred this option (Friedrich

et.al., 1999). This may be a good sign as this could indicate that consumers are more than not having an option to live in a residence of their preference. However it is also noted in the literature that there are negative impacts of supervised living environments. Chen (2010) noted that residents who live in supported housing with twenty-four hour on-site staff have often reported feelings of loneliness and isolation. There seems to be inconsistency in this area as there are some studies indicating more isolation and others indicating less isolation. This could impact the consumers within these programs and their treatment plans. More emphasis on improved socialization within the treatment environment, despite what kind it is, should be a crucial focus of their treatment plans. Often times consumers may not feel as they “fit in” within the housing setting or within the community (Yanos et. al., 2004). It was also found that consumers were in residences that their families preferred although it was also indicated that families often preferred higher level of care than the consumer themselves preferred (Friedrich et. al., 1999). It is something that all programs such as supportive living must keep in mind and that is consumer preference. This may make a difference in the consumer’s successful completion of the program or not as they may be more likely to stay in the program if they feel like it is their preferred choice.

Supportive independent housing which Wong and Solomon (2002) identified as “independent community living arrangements coupled with the provision of community support services that has been considered a housing mode most conducive to the goal of integration” (p. 13) into the community. Maintaining community living within a supportive environment is imperative to maintain living within the community along with maintenance of mental health. The supportive living environment provides the consumer with skills needed to maintain independent living as well as the support system to allow for prevention of hospitalizations. This

is an important step to living independently within the community with the least restrictive means necessary to maintain this stabilization. Larivière, Gèlinas, Mazer, Tallant, and Paquette (2006) assert that inadequate placement and care within the community often resulting from a lack of variety of services which possibly leads to deterioration in health status and functioning level resulting in increased rates of admissions to hospital increasing the costs to the healthcare system and society. The crisis of consumers with severe and persistent mental illness rotating and in and out of the hospital is not only a concern for human beings but also to the costs of healthcare and society as a whole.

In the United States the cost of mental health treatment in 2001 went up to \$104 billion (Cawthorpe, 2011). The cost of treatment for both mental health and substance use continues to rise including all levels of care within the treatment system. This can include residential costs, hospitalization costs, mental health treatment within the judicial system, outpatient treatment, emergency room costs, medication costs, and all areas that impact the rise of costs related to mental health/substance abuse treatment. When healthcare costs increase, the priority of policy-makers becomes these costs and how best to allocate the available resources within the budget towards the mental health treatment system (Cawthorpe, 2011). There a variety of reports both federally and on the state level that discusses the cost of mental health treatment as well as some that discuss the role supportive housing plays on these cost. Supportive housing for homeless people with serious mental illness has been shown to reduce costs on publicly funded programs resulting in reduction of shelter use, hospitalizations (both psychiatric and physical health admits) and involvement within the judicial system (National Alliance on Mental Illness, 2007). As a result of supportive housing the reduction of burden on these programs as a result of this type of housing ultimately reduces the cost of publicly funded program for the mentally ill.

There is a large amount of inmates within the judicial system who have diagnosed mental illnesses which increases the cost within the system (National Alliance on Mental Illness, 2007). The judicial system is not the only system whom has an increased cost because of the treatment of mental illness. The emergency rooms at local hospitals also have a burden of increased costs related to treating the mentally ill population. Between 2000 and 2003, emergency room visits of those with primary diagnosis of psychiatric disorders had increased at four times the rate of other emergency room visits (Mental Illness, 2007). With adequate treatment however, these costs and burdens have been shown to decrease as there is a lack of need for these programs as a result of adequate treatment services for ongoing stabilization and management of mental health disorders. It is estimated that the annual economic cost of mental illness is \$79 billion, however with psychiatric rehabilitation models it has been shown that effective results for consumers show an average reduction of more than 50 percent in costs of care directly as a result of reduced hospitalizations (National Alliance on Mental Illness, 2007).

There is a large amount of literature focusing on the reduction of costs as related to adequate treatment. The Georgia Rehabilitation Outreach program began a program and provided an evaluation of this program to show the reduction of costs in treatment. The program, Forensic Assertive Community Treatment, and focused on the forensic population due to history of being released from jail/prisons and being underserved resulting in a cycle of homelessness and recidivism (Georgia Rehabilitation Outreach, 2004-2005). The program hopes to provide support and recovery based services for treatment to increase stability and stop the perpetual cycle. Within this program, the first year in review showed that they were successful in decreasing number of jail days resulting in a savings of \$400,600 to the criminal justice system as well as reduction of hospital admissions resulting in a \$1,245,012 savings to the state hospital

system (Georgia Rehabilitation Outreach, 2004-2005). Due to adequate treatments within the community the costs of treatment, hospitalizations, and incarcerations for the mentally ill decrease, specifically with the forensic homeless population. Savings from reduction of emergency room visits, inpatient medical hospitalizations, crisis interventions, use of shelters and these costs, law enforcement, and other interventions were not included in this report. Therefore, the cost savings would substantially increase if taken in these variables (Georgia Rehabilitation Outreach, 2004-2005). A different study focused on some of the same variables in this one was conducted by Basu, Kee, Buchanan, and Sadowski (2012) that looked at housing and case management intervention and how its savings could impact the homeless with diagnosed mental health disorders. The findings from the cost analysis determined that an estimated \$6,307 per homeless adult was saved with adequate housing and case management services (Basu, et.al., 2012). Those who experienced chronic homelessness had the highest savings at \$9,809 per year per person with the estimation of these authors of saving \$5.5 billion over the next 10 years (Basu, et.al., 2012). The possibilities of savings with the adequate treatment interventions is astounding. This particular study excluded the costs of emergency room visits and psychiatric hospitalization admits which would impact the savings amounts due to the large use of hospitalizations as a result of lack of adequate community services for treatment as well as the vicious cycle of going in and out of hospital settings within the mentally ill population. To consider the tremendous costs of psychiatric hospitalizations and emergency room visits would be beneficial in determining the cost savings with adequate community services and programs such as supportive housing.

Hospital Admissions

Since the late 1950's the emphasis on deinstitutionalization resulted in a vast reduction of psychiatric hospitals and an increased urgency on expansion of community based services. Downsizing of psychiatric hospitals continued into the 1990s nationally, however in the state of Georgia the closing of these hospitals continue to this day. In Georgia, there is currently an upcoming closing of one of the seven state psychiatric hospitals. The continued closing of these hospitals has put the emphasis on community based services. However, the question is has the state mental health system learned from lessons of the past. Are there adequate community resources to serve the mental health population with limited hospital resources? The other question remains: are there adequate funds to support these resources that are so desperately needed? In the state of Georgia there is a continued reduction in budget, as in most areas, due to recent economic crisis. The continued cut of budgets for outpatient treatment community care is impeding the assurance of continuity of care for SMI consumers. This reduction in community based services also impacts the number of readmissions to psychiatric hospitals. There has been a renewed effort on increasing community services as is related to the closing of the state psychiatric hospitals.

Readmissions to psychiatric hospitals have become a growing challenge that has been mentioned within the literature as well as one that is seen on a daily basis when working with mentally ill consumers. Boydell et al. (2004) points out that 28% of patients discharged from psychiatric hospitals were re-admitted within three months of that discharge (as cited in Reynolds et al., 2004, p. 83). Only cardiovascular illness exceeds mental illness in acute hospital care costs (Reynolds et al., 2004). This is a relevant and continually increasing area of concern in the community mental health treatment community. The idea is to provide adequate treatment

resources within the community as a goal to reduce these admissions to state hospitals. However, on the opposing side, there is also a need for crisis stabilization. As with any mental illness, particularly SMI, even despite effective medication and treatment compliance there are times that the mental illness becomes overwhelming and may cycle to the point of being unable to handle amongst the consumers. This is when crisis stabilization is needed to allow for immediate stabilization for the consumer and to prevent harm being done to themselves or others. In the Columbus, GA area hospital emergency rooms are utilized for assessment (by crisis mobile teams) and medical clearance for admission into the area's psychiatric hospital. However, too often these crises could be managed within the community with the adequate resources. If adequate resources were available and effectively utilized than the need for these hospital resources could be reduced. Although, these hospital and assessment resources continue to be an important need, it is and should be used in a manner that is more cost efficient and beneficial for the consumer.

Hospital emergency rooms have become inundated with these crises resulting in overwhelming numbers and resources that are being over-utilized, when there could be alternate forms to prevent this from occurring. Readmissions and utilization of emergency rooms can be reduced in number with the sufficient resources within the community. It is also important to mention that even with adequate resources available within the community there will still be those that do not use available resources when needed and could end up in the emergency room or hospital in cases of extreme need. It is important at these times to have good working relationships amongst the psychiatric hospitals, hospital emergency rooms, and mental health treatment agencies to allow for supports and engagement of these particular consumers to prevent these episodes from continuously reoccurring. Despite the increasing need for

community resources for treatment, there continues to be a need for hospitals possibly in a reduced role. As Test and Stein (2000) note, despite there being a significant decrease in the number of consumers in psychiatric hospitals every year since the deinstitutionalization movement in 1955 there has been a concerning increase in number of readmissions to mental health hospitals. There is ongoing need for sufficient treatment agencies and teams to address this concern at present time and in the future. “It is worthwhile to reduce health care costs by substituting expensive hospital care with appropriate but less costly community services” (Lay et al. 2007) when beneficial for the consumer.

Anderson, Lyons, and West (2001) argue that significant predictors of readmissions to hospitals for persons diagnosed with schizophrenia were persistence of psychiatric symptoms. These symptoms can often be treated adequately within community based services however with their ongoing reduction of these services these symptoms are not treated effectively resulting in increasing hospital admissions. An increase in psychiatric symptoms and substance use often results in medication noncompliance which increases risks of hospitalization (Anderson et. al., 2001). This emphasizes the idea that medication treatment as well as additional therapy and other psychoeducational services would positively impact the consumer’s life as well as reduce the risk of hospitalization. Within the supportive living program at AmericanWork, Inc. a readmit to the hospital after 30 days or less of being within the community is considered a requirement for admission to the program initially. Multiple hospitalizations (four or more within the last 12 months prior to referral) or multiple readmissions (within 30 days of discharge into community) are criteria for admission to the program. This is also included in the goals and purpose of the program to prevent these reoccurrences by providing adequate community based services.

Community based services can be effective at improving functioning level and quality of life for those diagnosed with SMI according to Lariviere, Gelinias, Tallant and Paquette (2006) as they performed a study on elderly population who have been within the community various lengths of time for up to 2 years after discharge from psychiatric hospital. These authors found that there was a strong preference by this population to live within a community facility and found that they “did not show a significant deterioration in symptoms or in cognitive and activities of daily living functioning and expressed a positive view of own quality of life” (p. 194). There were fewer rehospitalization and the admits that did occur were generally shorter in duration and followed by return to community residence (Lariviere et. al., 2006). In summary these authors found that there were no negative impacts on well-being, functioning level, or life satisfaction initially or over time and it appeared that these citizens were happier in their community setting (2006). This is an example of how with community resources available and properly structured and funded that there can be a greater benefit on SMI population within the community versus ongoing hospitalizations.

Transition Planning

In an attempt to reduce the readmissions rates from the beginning is the transition planning. This is a plan that is put in place at the time of the initial admit to the psychiatric hospital. It is important to transition consumers from the hospital to residential placement maintaining a good relationship with hospital staff. Upon admission to the state hospital, the staff needs to begin addressing the transition and discharge plan. In the case that the consumer could benefit from supportive housing upon release the referral could be made at that time. This referral will allow for the supportive housing staff to begin building a relationship with the consumer prior to the transition even occurring. Reynolds et al. (2004) emphasizes the

importance of this connection as it can reduce the consumer's fears and worries once the transition occurs, ultimately reducing the chance of a readmit within thirty days of discharge. Thirty day readmits are a concern of residential treatments as this is an increasing problem. With adequate transition and relationship amongst the program and consumer, the probability of readmits within the first month could be reduced. Transition implies that all treatment providers will collaborate even when specifics of consumer's treatment plan changes or as consumer transitions from one level of care to another (Sowers and Rohland, 2004). The cooperation between staff at the referring facility, staff at the treatment facility being referred to as well as the consumer themselves is imperative to ensure smooth transition which will impact the remainder of their stay at the residential placement. "The ongoing and mutual responsibility of transition partners in transition planning which is required for a successful progression throughout the service continuum" (Sowers and Rohland, 2004).

AmericanWork Inc.'s supportive living program attempts to take consumer preference into consideration as transitioning to the program from the hospital is completely voluntary. Although, the consumer may be under various court orders or mandates this does not indicate that consumer is required to move to only the AmericanWork, Inc. program as there are several options and being able to make the decisions themselves to come to the program is important in their transition planning. Sowers and Rohland (2004) give a guideline for mental health consumers moving in and out of various levels of care with each plan being individualized. This plan of facilitating transitions includes 13 steps of developing and facilitating a transition plan. Following these steps provided allows for a solid transition plan. AmericanWork, Inc. appears to follow these program as the transition planning begins immediately upon acceptance into the program. Discharge barriers, family supports and previous placements are identified to

determine future transition plans upon completion of the program. Along with the discharge plan there is also services and treatment planning that is involved immediately upon acceptance to the program to allow them to meet the transition plan goals. This also includes planning for prevention of crisis and readmissions to hospital as well as future integration into their community with independent living with an adequate treatment plan for ongoing treatment needs.

Treatment Services

Larivière et al. (2006) show that counseling, onsite rehabilitation, medical and nursing treatment along with recreational activities fulfills the needs of consumers in a supportive housing living environment. The AmericanWork, Inc. apartment program provides these services and more to all residents/consumers, as mentioned in the initial introduction. Along with psychiatric treatment from a medical doctor, all consumers also receive nursing care with onsite 24-hour nursing staff as well as case management services. Day treatment programs are utilized as are medication management and monitoring services. Bond, Salyers, Rollins, Rapp and Zipple (2004) identified and discussed eight services that are important to be included within treatment of those diagnosed with SMI. Supportive Housing is discussed along with supportive employment, assertive community treatment teams, illness management and recovery, family psychoeducation, integrated dual diagnosis treatment, medication management and supported education. Within the AmericanWork, Inc. program, aspects of these are included within the treatment plan. Treatment plans are developed along with transition plans initially upon admission. Treatment plans are specific and individualized for each consumer and it is required to be developed with the consumer and clinician present and involved. The treatment plan includes discharge planning, goals as quoted by the consumer, and specific, measureable,

attainable, time-limited, and realistic goals, objectives and interventions. Every six months the consumer and clinician revisit the treatment plan and complete a re-authorization of this plan to update, identify progress towards goals, identify goals that have been met, and determine new goals. Discharge planning is also developed at this point based on the consumer's progress and transition planning. Day treatment programs are provided five days a week to conduct psychosocial rehabilitation. This includes psychoeducational groups, individual therapy, medication education, vocational training, illness management, and skill building, and increased skill building of daily living and independent living skills. Supports within the supportive living site provide various services as well including co-occurring groups, individual counseling, skill building services with case management, resource linkage, educational linkage for furthering education, volunteer activities, employment opportunities, socialization and leisure activities. These are available as the consumer progresses through treatment and these services are provided based on the consumer's needs, skill level, functioning level and progress that have been made within the program. The idea to include all these types of services within the community is repeated frequently within the literature (Bond et. al., 2004; Anderson, Lyons, and West, 2001; Test and Stein, 2000; Peebles et. al., 2009). Peebles et. al. (2009) assert that emphasis of recovery-based services should include broad treatment goals far beyond symptom reduction including a genuine collaborative relationship between the consumer and treatment provides as well as a treatment team which includes not only the consumer but also family members and other consumer advocates. There are various methods utilized to include all aspects of adequate community treatment into services for the SMI population. Test and Stein (2000) give guidelines for treatment of SMI to maximize effectiveness of treatment to increase community living, elevate autonomy and ensure satisfactory quality of life. These are guidelines

that could be utilized within outpatient community setting to increase independence within the community as well as within a supportive living program to increase in obtaining and maintaining living within the community with lowest amounts of supports possible to ensure stabilization. These guidelines are as follows:

1. Focus on Treatment: basic coping skills; typically consumers who present with SMI for treatment have severe psychiatric symptomatology and have limited abilities to problem-solve behaviors and meet demands of life; inadequate social and vocational skills are available; lack of leisure, social and interpersonal skills; these skill impairments will impact institutionalization and lengths of stay, indicating and increased need for these factors to be focused on within community treatment.
2. Site of Treatment: treatment for SMI population is most effective if it takes place within the natural environment of the consumer, with this a concern of not allowing the services to occur within the walls of the living placement allows for more therapeutic environment and reduced thoughts of hospitalization without actually being hospitalized.
3. Methods of Treatment: directive and assertive approach by treatment staff, not waiting on the consumer to be motivated for treatment, provide encouragement, behavioral approaches and social learning techniques, support and reinforcement, and allowing the consumers to maintain personal responsibility. (p. 49-54).

These guidelines seem to align with AmericanWork, Inc. treatment planning. However, as there are always ways for improvement farther assessment of how this can be utilized and how it impacts the consumer is continuously needed. Treatment planning with skill building aspects in a variety of areas depending on the consumer's needs is provided within the area of Focus of

Treatment. Test and Stein (2000) discuss how allowing for the site of treatment to be away from the home of the consumer stating that the less services provided within the home the less it will feel like a hospital setting without it being one which is reason for their argument that limiting number of services provided within the facility will increase the feelings of being institutionalized. Conversely, their main concern of feeling institutionalized is related to the fact that the consumer will not have to meet their own needs as the staff will be prepared to do these tasks for him preventing them from skill building and developing their own abilities. However, within the supportive living program of AmericanWork, Inc. the goal is to teach the consumers how to perform these skills themselves, not to do it for them. This teaching and skill building occurs with demonstration, prompting, redirecting, encouragement and monitoring from staff members. These guidelines appear to relate to the provided services of the supportive living program and appears to be effective treatment guidelines based on the literature. Treatment planning begins at time of admit all the way through until discharge from the program, nonetheless it does not end there as transition and follow up treatment is still recommended and facilitated.

Factors Influencing Community Placement

Community Integration

Integration within the community is imperative for ongoing supports, socialization and to increase sense of belonging which will ultimately increase mood and increase management of symptomology when it does occur. Yanos, Barrow, and Tsemberis (2004) conducted a study to explore the response to housing and experience of community integration of formerly homeless persons with diagnosis of SMI whom had been recently housed in residential settings. This study

found that individuals who moved into housing felt an improvement in sense of safety, in self-esteem and increased feelings of being part of the whole community (Yanos et. al., 2004). However, it was also found that some residents in an independence apartment setting may adjust into comfortable social routines and a sense of belonging into the community, but others will begin isolating themselves and have a difficult time adjusting and will not feel a part of the neighborhood or community (Yanos et. al., 2004). The reasons for these feelings of not belonging are not discussed or expanded on. However, the importance of feeling integrated within the community is evident as the importance of feeling as one belongs within their own neighborhood allows for increased feelings of support and increase purpose in feeling as they also can contribute something to society. Often times those diagnosed with SMI present with low self-esteem and low self-worth which impacts their feelings of belonging and often feel as they cannot contribute to society. Yanos et. al. (2004) found that there is a “significant positive relationship between negative interactions and a measure of community integrations which suggests that negative relationships are associated with diminished subjective quality of life among persons diagnosed with SMI” (p. 407). Negative interactions amongst the consumer’s neighbors and community can distance the consumer from their community farther resulting in isolation and lack of integration, which will ultimately lead to farther complications and psychiatric difficulties for the consumer. “When compared with hospital care or highly structured residential care, supported housing seems to improve functioning, permit higher autonomy and economic viability, facilitate social/community integration and gain higher residential satisfaction” (Chen, 2010, p. 378). Supportive living environments have the opportunity to increase consumer’s feelings of integration within the community increasing their feelings of independence and participation in community activities. Evidenced based practices

are often emphasized as they go beyond maintaining the clients within the community but also endeavors toward entirely integrating them into all of the spheres of the society (Bond et. al., 2004).

An example of these types of activities within the supportive housing program that encourages community integration includes allowing consumers within this setting to vote in the last presidential election. Representatives from the local arena who were running for various positions were invited and agreed to visit the apartment site and speak with the consumers to give their stances on various issues. This allowed the consumer to have knowledge and insight into what they were voting for. This allowed them to feel a part of the community and have a say so in the politics and future of the city that they are a part of. Most of these consumers grew up in the area their entire life and never once had the knowledge or the chance to vote in an election. Allowing this sense of being a part of the community and the city allowed for increased empowerment, informed decision making process, and future knowledge for ongoing support of the community in which they live.

Poverty

There are numerous negative impacts one with a mental illness may experience in their lifetime and there is a high likelihood that more than one of these impacts will be experienced. Most people with mental health disabilities are living in poverty which ultimately contributes to homelessness and multiple admissions to psychiatric hospitals (Carling, 1990). Homelessness is a real concern that the SMI populations have to face. Not only does increasing chance of poverty impact the risks of homelessness, the conflictual relationships they often have with friends and family as well as the lack of social supports may contribute to this issue as well. The likelihood

of substance abuse co-occurring with mental health issues may also contribute. Co-occurring disorders will be discussed later within this review as this is a concern often associated with treatment of the SMI population. “In addition to the challenges posed by mental illness itself, consumers encounter structural barriers including poverty, social, stigma and lack of affordable accommodations and limited employment opportunities” (Wilton, 2003). Consumers with mental health disorders often are faced with a multitude of challenges that the general population does not face on a regular basis. On a daily basis a SMI consumer can face problems meeting their basic needs (e.g., food, shelter), accessing adequate treatment resources, experience social and family conflict, experience social isolation due to stigma or due to their own mental health symptoms, as well as the mental health symptoms themselves that impact adequate ability to cope with these challenges. These challenges themselves in turn make it difficult to find placement within the community as there is a stigma with mental illness and landlords and staff of available boarding or group homes are cautious when renting to someone who has a mental illness. Many consumers diagnosed with schizophrenia have particular behavioral problems which may make it even more difficult to place and maintain this placement within the community (Lay, Nordt, and Rössler, 2007).

Poverty, as mentioned, is often times a major challenge for someone diagnosed with a serious mental illness. Although, many may have certain state benefits such as social security income or social security disability income this is often minimal income and additional benefits and resources are needed. Others, may have no benefits, and many lack additional supports from family and friends. These factors increase poverty and reduce access to services that are available for treatment as well as adequate housing options. In turn, this may intensify the stigma of the person suffering from SMI. Wilson’s study (2003) offered that perceptions of

bizarre actions and inadequate socialization skills may be exaggerated by poverty where the lack of resources results in the consumer wearing old and unmatched clothing, lacking personal care items, which may exacerbate the stigma of mental illness despite the cause of this condition may actually be poverty. These effects of poverty on dress, hygiene, grooming and lack of resources will ultimately increase the stigma as related to mental illness and bizarre behaviors that people identify with mental illness. The lack of material resources also negatively impacts the consumer's empowerment and sense of being a part of the community (Wilton, 2003). Wilton (2003) also found that the extent to which people are unable to meet their basic needs was a predictor of overall quality of life and people with the lowest incomes were less likely to report high levels of quality of life along with a low support system. The lack of income and access to resources and supports will not only increase stigma but also the support system, housing opportunities and social opportunities for improved community integration, social integration and increased independence. Lack of income and poverty can impact people's ability to find decent housing in safe neighborhoods (Wilton, 2003).

Poverty may also impact family ties as it is common for consumer's to feel burden to those supporting them such as parents, siblings, and adult children (Wilton, 2003). The strain on the family relationships as well as the feelings of being a burden on others impacts negatively on the consumer's feelings of self-worth and independence which will ultimately impact psychiatric symptoms and progress within treatment. This impact is also felt on the consumer's socialization interactions and leisure activities. "Financial hardship experienced by respondents worked directly against their participation in meaningful activities, their ability to build and sustain social relationships, and opportunities to enhance self-esteem and reduce social stigma" (Wilton, 2003, p. 152). Not only does lack of resources and finances impact relationships,

housing and adequate resources, the lack of finances also impacts the opportunities that the consumer has for participation in social/leisure activities and other activities to feel a part of the community. Consumers often have problems in participating in meaningful activities on a limited budget resulting in increased time within their supportive living program. “An absence of meaningful activities may make social integration for people with mental illness more difficult and it has particular implications for people in congregate living facilities. Many respondents felt they spent too much time at their facilities” (Wilton, 2003, p. 147). This could result in increased isolation of the consumer as well as less integration within their own community and having reduced opportunities for increased social supports, particularly for those who are being discharged into the community. Having this additional social support already accessed in the community will make the transition that much easier. However, this researcher would also like to point out that within supportive living programs a sense of community is built amongst the consumer and staff at the program and they build their own support systems amongst each other within the program as well as upon release. Consumers continue to maintain their friendships and supports of each other even after the transition into independent living occurs which offers additional supports to each other allowing for a more effective transition and support of maintenance of treatment compliance. “Relationships with other people and meaningful activities on a routine basis provide a solid foundation and enable the participants to feel whole and equal” (Granerud and Severinsson, 2006, p. 291).

Socialization

Individuals who have mental health concerns often struggle with social integration in the community. One explanation the authors Granerud and Severinsson (2006) offer are the reported experience of living with shame and loneliness. Often times those with SMI live with shame as a

result of the stigma directed towards the SMI population resulting in social isolation and feelings of loneliness. Another explanation may be that the symptoms related to various mental illnesses such as depressive mood from major depression or bipolar diagnosis could result in social withdrawal. Paranoia related to schizophrenia diagnosis could also result in a consumer withdrawing oneself due to lack of trust in others. These actions result in feeling lonely which are often linked to low self-esteem, anxiety, and depression (Granerud and Severinsson, 2006). Persons who exhibit more psychiatric symptoms experience more negative reactions from others as well as fewer supportive interaction which in turn makes social integration that much more difficult (Granerud and Severinsson, 2006). Therefore, an adequate day program or support organization (e.g., national alliance for mental illness) or even satisfactory employment may reduce the stigma and ultimately reducing the feeling of alienation (Granerud and Severinsson, 2006). Granerud and Severinsson (2006) found that approximately half the respondents diagnosed with SMI reported conflicts among their family relationships which they believed had these conflicts were felt to have a bearing on the ability of the participants to lead a meaningful life. Family conflict and social isolation results in increasing feelings of loneliness, inadequacy related to the stigma, and feeling alone in day to day lives due to lack of support not only financially but also emotionally. “The quality of a person’s social relations and the way they are experienced affect one’s sense of loneliness; Loneliness is often associated with psychological and somatic ailments, lower level of satisfaction in life, alcoholism, suicide and physical illness” (Weiner et al., 2010). As Weiner et al. (2010) pointed out often times these feelings can trigger increase in other mental health symptoms such as increasing depressive mood or suicidal ideations. Physical ailments such as stomach aches or headaches can occur as a result. As related to feelings of loneliness one may begin to feel helpless and hopeless, may feel there are not

adequate resources for help and may often become uncooperative or unmotivated in improving mood.

The impact on the psychiatric symptoms from negative relationships with others will in turn affect the relationships among others. Within the process of integrating in the community consumers often seek supports and relationships with family, friends and other health services (Granerud and Severinsson, 2006). The added supports and relationships are beneficial for the consumer, not only for their own emotional well-being but also for their continued independent living, compliance with treatment, and ongoing psychiatric stabilization. Social support and relationships can play essential roles in improving the lives of those with SMI (Yanos et. al., 2001). The importance of positive social interactions and supports is evident throughout the literature and is evident when working in the treatment field. This is an important aspect of treatment, in outpatient settings or supportive living settings, and it is important to include these on treatment plans and within all treatment modalities and settings. Those persons who have a positive social support system recover quicker from serious mental illness than those who do not have as strong of a support system (Granerud and Severinsson, 2006).

Social relationships among those diagnosed with SMI impact all aspects of their lives this includes quality of life. Yanos et. al. (2001) within their study of this topic found that negative interactions socially may have a causal role in determining the quality of life and that this effect can not be explained only on the basis of mental health symptoms, such as paranoia or depression, causing the person to interpret social interactions in a negative light. This suggests that the impact that social relationships have on mentally ill persons is significant and cannot be explained away by the impacts that psychiatric symptoms may have on their quality of life. Typically the treatment of persons with a mental illness takes place within the community and

social integration is imperative to this treatment to improve mental health and symptomatology (Granerud and Severinsson, 2006). However, this type of treatment and the importance of social integration should also be included within treatment of mentally ill consumers in all treatment settings including supportive living environments. Chen (2010) maintains that highly structured residential settings including supportive housing improves functioning, permits for higher autonomy and economic viability, facilitates social and community integration and gains higher resident satisfaction.

“In conjunction with skill trainings, practitioners need to assist consumers in adjusting family relationships and developing new social connections in order to make independent living a positive attribute of consumer’s psychological well-being” (Chen, 2010, p. 378). Family relationships and social relationships are once again emphasized to maintain and stabilize psychiatric symptoms and well-being of SMI consumers. Programs were encouraged by this as supportive living programs can foster social interactions and increase feelings of acceptance and integration within a social setting. There is a need to increase social supports within the SMI population. Those working within the community mental health are encouraged to ensure people with mental illness experience a sense of belonging within the community enabling them to develop a positive social network, learn adequate social skills and ultimately achieve social integration (Granerud and Severinsson, 2006). These ideas have great implications amongst supportive living programs. This is imperative for housing programs to foster these relationships and teach adequate skills for this population. Increase in socialization is not only important for those within these settings but also to prepare them with skills once they transition to their own independent living environment (Tsai et. al., 2000).

Quality of Life

Quality of life is another topic that often shows up in the literature related to residential and supportive housing treatment modalities. Due to deinstitutionalization there is a concern in quality of life amongst the SMI population. Test and Stein (2000) indicate that it is often considered “patients have simply been moved from the ‘back wards’ of the hospital to the ‘back alleys’ of the community.” The quality of life for individuals diagnosed with SMI has drastically reduced. Adequate skills are not developed and adequate resources are not available. Quality of life impacts a variety of life domains including social and family supports, independent living, employment, symptomology and other areas of functioning. As mentioned when social supports are affected this also results in a diminished functioning capacity. Yanos, Rosenfield, and Horwitz (2001) found that the degree in which basic needs are not met with those diagnosed with SMI is an important negative indicator of overall quality of life. Factors associated with living situation, poverty, physical health limitations as well as poor management of symptoms and lack of social supports will negatively impact quality of life. Poverty is a variable that is often overlooked as a variable that has an effect on quality of life as well as low social status of the SMI population (Yanos et. al., 2001). There is a large need for transitional programs and housing programs for the SMI population, specifically in Georgia where deinstitutionalization continues to occur. Therefore, it is important to recognize how various types of housing programs can impact quality of life of those transitioning into these types of housing. Specifically when looking at a supportive housing program. Weiner et. al. (2010) completed a study for a preliminary investigation of how the type of housing, levels of loneliness and social supports impacts quality of life. Two different types of housing were looked at including group homes and supportive community housing (Weinder et. al., 2010). These authors found that

“social loneliness impacted the quality of life of only those consumers living in the group homes” (p. 395). The authors of this study (Weinder et. al., 2010) offered an explanation of this: “the more normative supportive housing communities create opportunities for more independence and autonomy, which in turn, help them become less vulnerable to a reduced quality of life” (p. 395). This is important when looking at supportive living programs as this should be a positive environment for improved integration and social supports within the community. This allows for skill building and support system development which will continue when integration within the community occurs. These issues should continue to be addressed in all treatment settings and within the support living program as a large part of the housing setting.

However, it should always be kept in mind that all treatment capacities and goals including improved quality of life and socialization is ultimately the consumer’s choice. Gulcur et al. (2007) emphasizes that consumer choice has been associated with positive outcomes related to community integration such as increase in residential stability and a decrease in psychiatric symptoms. This finding is closely related to the AmericanWork, Inc. supportive housing program as consumer choice is required when developing transition plan into the program and ongoing treatment planning throughout the program. Tsai, Bond, Salyers, Godfrey and Davis (2010) point out that there is an assumption that all consumers want independent housing, however it was found within this study that although the majority of consumers preferred independent housing, as many as 41% are interested in alternate forms of housing as well which includes supportive housing options. Therefore, it is important in developing transition plan at beginning of treatment as well as treatment goals throughout treatment to not allow assumptions to get in the way of identifying the individualized treatment goals. The individual needs to identify what is important to them and the treatment team should recognize

this and not jump to conclusions that all consumers want the same, in this case individual independent housing.

Other Treatment Considerations

Co-Occurring Disorders

Thus far mental health diagnoses have been mostly discussed. However, there is another aspect to those receiving mental health treatments and that is co-occurring disorders. Wilton (2003) found that along with cigarettes those diagnosed with a SMI are at a greater risk for substance use and problems than the population as a whole. Co-Occurring disorders are identified as having both a mental health disorder and a substance use diagnosis. Although, diagnoses of both disorders are common with SMI, co-occurring disorders bring a new set of challenges in treatment. Both need to be addressed but which way is most effective? It was previously debated which disorder should be treated first. Should the mental health concerns be addressed prior to substance abuse problems or should the substance abuse be addressed to ensure sobriety before mental health could be assessed and treated? However, the most recent research has indicated that treatment of both mental health and substance abuse should be treated at the same time. People with co-occurring disorders should receive co-occurring treatment. On top of treatment for both disorders there are numerous other concerns related to those having substance abuse and mental health disorders. Substance abuse is associated with a number of social and financial costs for those also with a SMI diagnosis including homelessness, incarcerations, limited supports, and psychiatric relapse (Wilton, 2003). Therefore, the need for supportive living housing as well as transition plans for those hospitalized does not lie only with the SMI population but also the co-occurring population. Tsai et al. (2000) found that consumers

with a co-occurring disorder can benefit from supervised housing and their study found that approximately half of those diagnosed with co-occurring disorders in this study preferred supervised housing at the onset of treatment with future hopes that independent living would be achieved. These participants, although wanting independent housing, were satisfied and preferred supervised housing, particularly at the start of treatment. Co-occurring has typically been connected with numerous other negative outcomes including increase in relapses and hospitalizations, instability of housing often resulting in homelessness, increased incarceration rates, violence and economic burden on others such as family (Bond et al., 2004). It is also thought that consumers diagnosed with co-occurring disorders are responsible for creating a higher demand for treatment services in local jails and may impact the perceived high recidivism rate among the mentally ill (Severson, 2000). This indicates an even greater need for adequate community based services not only to reduce hospitalizations but also to reduce legal involvement among both SMI and co-occurring populations.

Drake, Morrissey and Mueser (2006) suggests that there is a tendency for diagnosis of conduct disorder, antisocial disorder and criminal behaviors of consumers with co-occurring disorders before there is a diagnosis of schizophrenia or co-occurring disorder rather than as a consequence of these disorders. This impacts not only the consumer but how the consumer is clinically treated. There are typically no standard treatment recommendations for dually diagnosed forensic consumers. At the same time that there is an increased incarceration rate of these consumers there is also a decrease in funding for developmental treatment research for the forensic mentally ill which impacts developing adequate treatment recommendations for this population (Drake, Morrissey, and Mueser, 2006). However, these authors also suggested that a specific model of combining the co-occurring treatment with traditional criminal justice system

interventions may be effective when treating this population (2006). This could include cognitive behavioral interventions which is often recommended for antisocial behaviors. A variety of techniques may be useful with the co-occurring forensic population however additional research is needed to determine effectiveness of these treatment interventions. This population presents additional challenges in treatment. Forensic consumers with a co-occurring diagnosis have been found to have less psychosis, more depression and trauma, more childhood conduct disorders, and more adult antisocial personality disorders along with violent behaviors and severe substance abuse than the non-forensic co-occurring study samples (Drake, Morrissey, and Mueser, 2006). These challenges in themselves need to be included in treatment on top of the treatment for SMI and substance abuse. This within a supportive living program can prove to be complex and challenging for staff and the program as a whole. Drake, Morrissey, and Mueser (2006) offer suggestions for treatment of these individuals including “therapeutic use of leverage and criminal justice sanctions (e.g., court stipulations, probation revocations, jail time, emergency detentions), therapeutic communities, medications that may diminish disruptive, violent, and criminal behaviors, or newer interventions to help individuals move towards recovery” (p.430).

Legal Involvement

In 2006, there were at minimum 341,000 incarcerated individuals with diagnosis of SMI in the United States, representing approximately 15% of individuals incarcerated in that same year (Bloom, 2010). “Researchers have found that the percentage of incarcerated persons with mental disorders, is significantly higher than the percentage of persons with mental disorders residing in the general population” (Severson, 2000, p. 574). The increasing incarceration of individuals of the SMI population may be due to a number of reasons; however, it continues to

impact the criminal justice system ultimately affecting the treatment system. Bloom (2010) offers an explanation of the increasing incarceration of mentally ill persons: “mental hospitals now have the lowest number of beds in decades, and over the last decade we have been losing community hospital beds, even as our population continues to increase” (p. 2010) referring to this era the “incarceration revolution” due to the increase of incarceration of the mentally ill. The link between incarceration and hospitalization is evident within the literature. Chaiklin found an association between length of time spent in jail and a history of having been in a mental health hospital (as cited in Severson, 2000, p. 576). This connection has a major impact on the community based mental health services and specifically on those within the supportive housing program. However, this is not the only issues related to forensic involvement within the community mental health treatment environment.

There is a vast amount of literature related to various legal concerns and involvement with the SMI population. This concern also applies to the supportive housing program. Test and Stein (2000) emphasized treating this population the same as the general population allowing for natural consequences; without natural consequences people become irresponsible for their behaviors and reinforces deviant behaviors which ultimately can increase the frequency of these behaviors. This is addressed within the supportive housing program as those consumers who break the law are held responsible for their actions. Although all factors are taken into consideration (e.g., if delusional or psychotic and reacting on these delusions or psychosis an alternative option is hospitalization or crisis programs for stabilization) legal involvement is sought for safety and to ensure that the consumers take responsibility for their behaviors. Consumers who break the law should be arrested, prosecuted, and held accountable for their sentence (e.g., jail, fine, probation) just as any other citizen would (Test and Stein, 2000).

However, clinical judgment is crucial when determining how the consumer's criminal behaviors should be managed.

There are numerous ways that a consumer within the supportive living program of AmericanWork, Inc. can be involved with the legal system as discussed in the introduction. Mental Health Court, Not Guilty by Reason of Insanity status, Incompetent to Stand Trial as well as Incompetent to Stand Trial non-restorable status as well as civil/outpatient commitment status are all ways in which a consumer within the program can have legal involvement. This is on top of probation and parole involvement from previous criminal convictions. Hospitals are increasingly housing consumers with forensic involvement for the state resulting in decreased beds for voluntary admissions or those without court order (Bloom, 2010). This poses an additional problem with ever decreasing crisis stabilization availability as related to the deinstitutionalization in most states. With those consumers found incompetent to stand trial they often wait in jails for a period prior to this status as they await the official evaluation. Then they may wait in jail after the evaluation to gain a bed opening within the hospital to begin the competency restoration process. On top of this the hospital stays may be longer than expected for all those with forensic involvement as placement is more difficult than someone without legal involvement. Often, there are limited options for this clientele. The courts have to approve their release plan and their chosen placement therefore this may limit the opportunities available. Bloom (2010) found in the state of Oregon that SMI individuals were incarcerated in jails for abnormally long periods of time awaiting evaluations and beds in the state psychiatric hospitals. These stays may not always be the best of conditions as jails often are not set up for treatment of the SMI population including adequate medication resources.

“The degree to which forensic outpatients were integrated into the community along psychological social, and physical dimensions was also fairly low” (Gulcer et. al., 2007, p. 226). Supportive Living programs are increasingly needed for placement of SMI population with legal involvement which is an ever expanding population. Bloom (2010) offered that communities need an adequate number of beds within acute care facilities for necessary backup to the criminal justice system and SMI consumers, this includes ongoing transition housing within supportive living programs. Taking legal aspects and the numerous other factors involved in the supportive housing program into consideration as well as treatment for SMI, often times the ultimate goal of the consumer is independent living within the community. Tsai et al. (2000) found that majority of consumers in their study preferred their own apartment as the consumer progressed through treatment. Preference in living arrangements may change as treatment progresses and this is addressed with each consumer within the supportive housing program. There is a need for more structured supportive living arrangements when consumers transition into the community and studies have found that this is often preferred by consumers. However the goals and desired living arrangements may be adjusted as the consumer begins to meet treatment goals and becomes farther stabilized with their mental illness.

Transitioning from supportive living environment to independent living residences is a move that requires careful planning and adequate follow up supports. Yanos, Barrow, and Tsemberis (2004) conducted a study as related to independent living apartments for mentally ill consumers. The authors found that within this population the challenges presented were difficulty coping with loneliness and adjusting to new tasks of living alone. Correlational analysis of these researchers indicated persons discharged from state psychiatric hospitals were particularly likely to face these difficulty immediately prior to being discharged. This is

consistent with previous findings which suggest a prolonged institutionalization actually decreases a consumer's preparation for returning to independent living within the community (as cited in Yanos et. al., 2004). Yanos et. al. (2004) also found in this study that feelings of "culture shock" and grief of leaving previous living arrangement decrease over time however it is important for these issues to be addressed and preparations for managing these concerns need to be included in transition planning. As consumers are preparing to leave a supportive housing program and gaining independent living environments alone or with family/friends it is important to have adequate frequent support systems within the community to prevent feelings of being abandoned and "dumped" by the treatment system. Ongoing follow up of the consumer and encouragement to maintain compliance with mental health treatment with amount of supports diminishing over time will benefit the consumer and allow for increasing chance of success living independently within the community.

Program Evaluation

Need for Evaluation

Within program evaluation of programs like these it is imperative to ensure that the goals of the programs in improving quality of life for the consumer as well as reducing need for hospitalization, however there is a lack of these type of evaluations. The increasing need for supportive living programs in Georgia as a result of the ADA settlement and impending closing of state psychiatric hospitalization is indicative of increasing need for evaluation of effectiveness of programs such as these. Program improvement of existing programs and determining aspects of the programs that are effective for development of additional programs can be gained from program evaluations such as these. Determining variables that allow for successful transition

from supportive living programs to independent living within the community as well as determining variables that negatively impact this successful transition will benefit community based treatments such as these greatly. However, often times program evaluations are not completed on state funded programs or programs not developed from a grant in which an evaluation would be mandatory. Bloom (2006) offered an explanation of reasons for lack of these evaluations: “grossly under-funded by both state and county government and if not extremely well managed, these programs will run into trouble such as lack of knowledge as related to problems of the programs as too little attention is paid to program evaluation and oversight” (p. 731). Although there are numerous agencies providing oversight of state funded programs including state agencies, accreditation agencies and payment sources there is minimal actual formative structured evaluations performed. These types of oversights are typically audits in which there is an evaluation after the service is provided. However, there is no information or evaluation completed to determine what makes this program effective and what doesn’t providing for suggestions of program improvement and suggestions for program development. Kirsh, Krupa, Horgan, and Carr (2005) suggested that such processes are often viewed as a way to meet requirements of accreditation or other funding sources. Yet, the benefits of program evaluation go beyond funding and professional standards and allow for improvement of implementation and ongoing operation of programs for community participation and quality of life for those needing these services.

The determination of shared purposeful goals is difficult among agencies as the goals are often determined not by the agencies but by others sources. This makes program evaluation further challenging. There are additional concerns including funding and political concerns as related to program such as these. Kirsh et. al. (2005) asserted that “the extent to which program

evaluation drives policy and funding decisions influences the ability of community mental health programs to establish their own goals” (p. 240). Evaluation of treatment programs should be done internally as well as externally throughout the development and implementation of the said program. Kirsh et. al. (2005) assert that there is an assumption that community mental health and addiction programs are able to participate in evaluation activities for accountability, public relations and improved service delivery purposes. These can be used internally for informed service delivery and improved treatment services with ongoing program improvement (Kirsh et. al., 2005). The need for ongoing evaluation of programs is needed for farther assessment of what is working and what is not. By determining successful aspects of supportive living programs than these can be implemented within other programs such as these throughout the state. Also, by determining what is negatively impacting the program and goals of the program by an evaluation than changes can be made for the program to become more efficient in meeting their goals, specifically with supportive housing, meeting the goal of community placement.

Evaluations of Community Placement

There have been prior evaluations located within the literature that discusses program evaluation on supportive housing programs as well as community placement programs. Although these types of evaluation are limited, overview of these types of programs are important in developing an evaluation model of a similar program. Lutze, Bouffard, and Falconer (2009) completed a program evaluation on the Washington State’s reentry housing pilot program which took high risk offenders from prison or jail and provided wrap around services, treatment, and affordable/safe housing during reentry into the community. The housing program lasted approximately 12 months with ongoing supports to gain treatment, employment, and self-sustainability (Lutze, Bouffard, and Falconer, 2009). This program was in its infancy at time of

review and despite inability to determine its effects on recidivism, hospitalizations, or other variables, the evaluation determined through the program and literature review that access to stable housing is an important aspect to assist offenders with transition from prison to community (Lutze, Bouffard, and Falconer, 2009). A similar evaluation was conducted by Wilson and Davis (2006) on the Project Greenlight reentry program which was also a prison based reentry program. This evaluation asserted that the program was implemented primarily based on current literature and found that correctly matching offenders with services is just as critical as the services provided (Wilson and Davis, 2006). In other words, not only is important to link these participants with treatment services and community resources, but also to ensure that the offender is linked with these services that match the offender and their needs. This is similar with individualized treatment planning as it is important to match the treatment needs and stated goals/objectives are individualized to the consumer and correctly matches their particular needs. Wilson and Davis (2006) also found that services provided needed to be the highest quality, however even with the quality of services being taken into consideration the consumer needed to be matched carefully with all services being implemented properly. These evaluations determined that the need for adequate treatment services as well as individualized consumer needs including stable and affordable independent housing within the community is of utmost importance.

Within the literature there are also various evaluations as related to placement of homelessness within supportive housing programs. Rickards et.al. (2010) performed an evaluation on the Collaborative Initiative to Help End Chronic Homelessness coordinated by several federal agencies. The program was initiated to provide housing and supportive services for individuals with psychiatric diagnosis, substance use concerns, health and related disabilities

who experienced chronic homelessness (Rickards, et.al., 2010). This evaluation discussed and determined that for those who are homeless to completely engagement in mental health and substance abuse treatment and recovery services, stable and safe housing is a necessity. Immediate access to housing, choice with living arrangements, supports with intensive case management and linking to treatment services is essential for housing stability and participation in treatment according to Rickards et.al. (2010). This particular evaluation is pertinent with the current evaluation as implementation and program improvement based on identified variables that negatively and positively impact the success of community placement from the supportive living program relates to homelessness factors. Within this evaluation challenges of providing housing and services to those with complex issues and needs are discussed in relation to success within the program as well as the multifaceted process of program/services improvement and systems change that are related to homelessness and the mentally ill (Rickards, et al., 2010). The growing body of literature related to supportive housing as well as the increasing utilization of program evaluations within this area will continue to increase the knowledge of implementation and improvement within supportive housing programs.

Conclusion

It is emphasized in the current literature that social integration, autonomy and privacy are preferences of consumers living with SMI within the community (Santone et al., 2005). However, barriers to community integration exist which include stigmatizing attitudes of staff and practitioners, segregated services, fragmentation within services and lack of access to adequate services (Bond et al., 2004). It is important within community treatment services, including supportive housing, that all aspects of services ensure suitability and effectiveness for each individual and that these barriers are addressed and eliminated. Previous research and

literature show that community based treatment is as effective or more effective than hospital based treatment in helping people with psychiatric disabilities to gain employment, acceptance in community, and reduce use of medications and outpatient services – resulting in less dependence on mental health system and more dependence on self (Carling, 1990). The goal of the AmericanWork, Inc. supportive housing program is to meet these requirements of effective treatment to reduce hospitalizations and ultimately improve quality of life. By determining specific variables that both positively and negatively impact the successful transition of consumers into community integration and independent living, only then can program improvement be gained as well as improvement in developing future programs such as these.

There is a lack of utilization of program evaluation within state funded programs for a number of reasons; however, the need for these evaluations for programs such as supportive living facilities continues to rise. With the continued emphasis on community based treatments without the use of psychiatric hospitalizations the need for supportive living programs is increasingly important. However, without program evaluations it remains unknown if these programs are successful in meeting their goals. By completing program evaluations on programs such as these there is the ability to identify variables that positively and negatively impact the outcomes of the program. In this case a program evaluation is needed to determine those variables that positively impact successful transition to community living and those that negatively impact successful transition to community placement. By conducting evaluations further implementation of supportive living programs in other locations have information to draw from in its implementation as well as additional information for program improvements and changes.

CHAPTER III

METHODOLOGY

This chapter will discuss the research methodology and design used by the researcher to evaluate aspects of consumers within the AmericanWork, Inc. Supportive Living Program that allow for successful living within the community after completion of the program. The ultimate goal of the AmericanWork, Inc. supportive living program is to decrease hospital admissions and readmissions by increasing stability with independent living placement within the community.

Research Questions

1. What is the level of effectiveness of the supportive living program at increasing transition to community living among severe and persistent mentally ill consumers?
2. What pre-admission, program-specific and secondary variables are related to the outcome of the supportive living program?

Participants

The participants for this study include consumers from the supportive living program that continue to live at the residence, that have graduated from the program or that have been discharged from the program between the periods of May 2007 thru November 2011.

An exhaustive sample was taken based on the program participants including participants currently enrolled in the program as well as those that have been discharged to the community and other referral placements since the beginning of the program in May 2007. Participant's data

was gathered from existing records maintained by the supportive living program. Weekly reports were maintained of all consumers that have been with the program since its inception. Approval from the area director of Columbus, Ga, Ann Riley and program director, Charlotte Wenzell, were obtained. (See Appendix A). A total of 140 participant data was available through already existing data. This data was maintained by the program and was provided anonymously without identifying information of the consumers. The data was maintained via excel spreadsheet and was updated weekly with changes. This information was given to this researcher via the spreadsheet without the names of the consumers to maintain this confidentiality.

The 140 participants were all adults ages 18 and older, ranging from ages 23-71 with the mean age of 45.61. Ages 30 to 44 are more likely to experience mental illness (55%) with ages 45-59 (46.5%) being at a higher rate of seeking mental health treatment according to the National Institute of Mental Health (2005). The participants were both male (n-96, 68.57%) and female (n-44, 31.43%) and all have primary diagnosis of a mental health disorder as this is the criteria of being in the program. The National Institute of Mental Health (2005), however, reports that women are no more or less likely to experience mental illness in their lifetime as compared to males. Of the sample of consumers 100 (71.43%) identified as African American, 38 (27.14%) identified as Caucasian, and two (1.43%) identified as Asian. It was also reported that African Americans are 30% less likely to experience mental illness than Caucasian, despite the differences within this population (National Institute of Mental Illness, 2005). It is important to note that this population was gained from a program which accepts consumers who have no or low income as well as those with disability benefits from the state. The National Alliance on Mental Illness have found that African Americans are at a disadvantage in accessing mental

health care and it was found in 2001 that 20.2% of African Americans were uninsured.

Therefore, this program along with other community mental health treatment facilities may see a higher rate of minority consumers who are at a disadvantage socioeconomically. There was an average of 7.04 days back into the hospital after admission to the program amongst the 140 participants with a 99.51% rate of community days compared with hospital days since admission to the program. There was a total of 82,705 days within the community and 993 hospital days amongst all 140 participants since the inception of the program in May 2007.

Participants were categorized by their status in the program. Group A includes consumers who have successfully transitioned from the supportive housing program to independent living within the community. Independent living can include own apartment/housing placement as well as living with family or other support system such as a friend. Group B was defined as those consumers who have been discharged from the program. These were defined as those being discharged from the program and no longer living within the residence, other than successfully transitioning to the community. These could include but were not limited to those who have been discharged to higher level of care such as personal care for medical needs, incarcerations, or return to hospital for farther stabilization. Higher level of care was often needed and these consumers returned to the hospital or other placement for the care that was needed. These consumers may have returned to jail due to new charges or violations of previous court orders. No follow up was completed or maintained upon their discharge. This group also included those consumers that continued to live within the supportive living program and have been with the program for greater than or equal to 18 months without discharge into the community.

Other groups included those consumers living within the program for less than 18 months that have not been discharged into the community, those that were discharged out of town

therefore no follow up was available as well as those that are deceased. These groups were not included in the data analysis as the goal of the evaluation was to determine the variables that impact those successfully discharging within the community and maintaining this placement within the community. The evaluation sought to determine which variables positively and negatively impacted those successfully graduating as compared to those that remained in the apartments. The goal of the program was to successfully transition the consumers to independent community living. Determination of which variables play a part in consumers not transitioning out and those who who have transitioned out and were successful at maintaining this community living is imperative for farther success and ongoing operation of the program.

The sample includes majority of participants (n=71) within group B with group A totaling 30 participants. Other groups as mentioned above include those who are deceased (n=5, 3.57%) and those that were discharged without follow up out of town (n=14, 10%). There remain 20 participants (14.29%) that were currently living within the supportive housing program and have been there less than 18 months.

Program Evaluation Model

A Logic Model for program evaluation identifies step-by-step what a program will do and how their goals will be accomplished. This ultimately allows for evaluators to identify goals, theories, population, inputs, strategies, outputs, and outcomes of the program (United Way, 2008). This allowed for the program evaluator to determine the intent of the program and what has been accomplished at adequately implementing these intents and meeting the desired outcomes of the program. Within this researcher's evaluation, the program was already in existence therefore these aspects were reviewed as they were already in place within the

supportive housing program. The outcomes were identified to determine what has been accomplished and the evaluation determined those variables that assisted with meeting these outcomes and those variables that were not a positive impact on meeting these outcomes. As an outcome based model the Logic Model assisted in evaluation of determining how and if the program goals were met and how the program can ultimately improve to meet the desired outcomes. The United Way publishes a Logic Model Handbook (2008) as a guideline in applying for a grant for starting and implementing a program and then completion of a program evaluation. This guideline was how this researcher organized and completed the evaluation of the AmericanWork supportive housing program.

The United Way Handbook (2008) identified several steps in completing an evaluation including determining various aspects of the program: goal, theory, population, inputs, strategies, outputs, outcomes and indicators. The current evaluation was conducted on an already existing program and therefore this researcher gained the cooperation of the Area Director and Program Director and assistance and determined these various aspects as follows.

Goal

The goal of the supportive living program was to reduce hospital admits of those within the program and to ultimately improve their skills to successfully live independently within the community.

Activities

The theory of the program was to provide adequate community mental health treatment services and supports for increase of skills of the consumer to reduce crisis needing hospitalization as well as improved independent living skills and illness management to allow for

the consumer to maintain independent living. By providing the appropriate treatment services and supports the consumer, in theory, will improve management of their illness and learn daily living skills for managing their own independence within the community without having to rely on the hospital system. This program is needed as hospitals and crisis stabilization units continue to decline in numbers. The consumer will need to learn to rely on outpatient treatment services to decrease the dependence and need of these hospital stabilization units.

Population/Inputs

The population of this program included adults age 18 and over that have primary diagnosis of mental illness (excluding developmental disabilities and those with primary diagnosis of substance abuse). The consumer must have had (a) four or more admissions to the state psychiatric hospital within the 12 months prior to their referral to the program (30 day readmits were also looked at), or (b) greater than 30 days in the hospital within the 12 months prior to their referral. Strategies of the program which included inputs as in resources that were needed to operate the program and services that were provided by these resources for treatment of the consumer.

Strategies

Strategies included the psychiatric treatment received (i.e., doctor services with medication management, psychosocial rehabilitation day treatment services, case management services, and nursing management with medication monitoring). The specifics of each of these treatment modalities were also included in the strategies with interventions such as, but not limited to, social skills, vocational skills, independent living skills, and illness management skills.

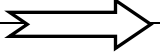
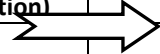
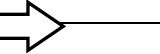
Outputs

The outputs were identified as the direct results of the interventions and what was actually completed and accomplished based on the treatment plan. The overall objective of the program as identified in the strategies with the specific intervention as provided in the outputs.

Outcomes

The last step of the Logic Model was identified by the Logic Model Handbook provided by the United Way of American (2008) is the outcomes. Due to the supportive living program being already in existence the outcomes was what was focused on within this evaluation. Although, the above criteria were gathered to allow for farther understanding of the program to develop the adequate evaluation model and variables for which should be measured, the outcomes were what this researcher focused on. To determine what impacts the successful transition into the community from the program and what negatively impacts those who do not complete the program an outcome based model was utilized. Within the model outcomes included indicators for which the outcomes were measured and how this researcher will know that the goal and proposed outcomes were met. Indicators for this particular evaluation include the variables that were measured. This allowed for measurement of the goals which included reduction in psychiatric hospital admits as well as improved transitioning to independent living. This model was used to organize the evaluation and ensure all information was gathered and measured to determine if the goals of the program were accomplished. Figure 1 illustrates a simple logic model based on this evaluation.

Figure 1: *Program Logic Model*

INPUTS	Program Activities	OUTPUTS (Implementation)	OUTCOMES	IMPACT
Cooperation of the program staff for obtainment of existing data in relation to the participant's data including pre-admission, program-specific and secondary variables.	 Psychiatric treatment services provided and received by each participant, treatment modalities utilized, individualized treatment plans with inclusion of specific identified discharge barriers. Identification of specific goals identified for the consumers for which they receive while in the program.	 Accomplishing these activities based on the individualized treatment plan for each consumer will provide the following outcomes.	 Improved symptom management and stabilization for reduction of need for psychiatric hospital admits as well as improved illness management skills in a variety of areas to improve ability at obtaining and maintaining independent living within the community.	Improvement of quality of life for each of the consumer by allowing for independent living as well as a reduced need for psychiatric services. By obtaining a program evaluation the variables for which have a positive and negative impact on the goals of this program will be identified for additional improvement within the program itself.

Impact

Utilizing this outcome based Logic Model as proposed by United Way (2008) the supportive living program's goal was identified along with each intervention and strategy that was put into place. These include all treatment services provided. Other variables which were described within this method sections were identified as well as the step by step procedures that were completed within this model.

Procedure

After obtaining approval by the Institutional Review Board (Appendix B), the researcher coordinated with the supportive living program director, Charlotte Wenzel, to obtain the data

from the supportive living program. This included weekly reports of those within the housing program as well as additional discharges. Additional information included the supportive living program handbook, policies and procedures, criteria for admissions and the mission/goals of the program set forth by AmericanWork, Inc. were obtained via handbooks as well as interviews with the Area Director, Ann Riley and the program director, Charlotte Wenzell. The reports were condensed into the above mentioned groups as well as additional variables that were analyzed. The reports were obtained via email from AmericanWork, Inc. staff and the data was maintained via Microsoft Excel spreadsheet. The data obtained was existing data and was further analyzed for the needs of the program evaluation.

Data Analysis

Multiple Regression was used with the goal of identifying which variables correlate with success in discharging from the program into community independent living. The variables that correlate with Group A were identified as variables that assist in successful transition within the community. Identifying variables that correlate with Group B also allowed for increased understanding of what variables have negative impact on successful completion of the program. The goal of the analysis was to determine the variables that correlated with those who have successfully completed and have maintained independent living as compared with those variables that correlated with those who have unsuccessfully completed the program. This allowed for improvement and suggestions for changes in the program for a better chance of success within transitioning to community living. The basic idea with using multiple regression was to look at several independent variables to determine predictors of success in the program (Group A). By better understanding predictors of success, program improvements can be made.

Thus by evaluating the program in this way, suggestions of program changes can be made to increase chance of success for each consumer in transitioning into community living placement.

Pre-admission variables were those variables that impacted the consumer prior to admission to the supportive living program. This included length of stay in the hospital prior to admission to the program, prior placement type, prior community placement, and number of admits to hospital prior to the program. Program specific variables which were variables that impacted the consumer while living at the supportive housing program included services received while in the program, identified discharge barriers, length of stay at the program, and number of days readmitted to the psychiatric hospital while in the program. Secondary variables included legal status and diagnosis of the consumer. The dependent variable was identified as the status of discharge from the program. Meaning that those consumers discharged and living within the community and those that have either been discharged without completing the program or those who have yet to complete the program and remains living within the program after a specified period of time (greater than or equal to 18 months).

Summary

The program evaluation was completed on the AmericanWork, Inc. supportive housing program and determined the variables that have impacted those who have successfully transitioned into the community from the program and those that have not transferred to the community for various reasons. By determining which variables were associated with those transitioning within the community and those that were associated with those who have not been transitioned it allowed for recommendations to the program at adjusting variables and increasing success of those participants of the program at successfully transitioning to independent living.

The variables were based off of existing data and these variables were those that were viewed to have the greatest impact on the consumer in successful transition. Variables such as discharge barriers, family supports and diagnosis can positively or negatively impact their transition and by determining which variables have what impact can improve the success of ongoing operation of the supportive living program.

CHAPTER IV

RESULTS

This chapter includes the results of the data analysis for this program evaluation. A brief description of the participants, statistical procedures and the results of the data analysis were discussed. The findings pertaining to each research question will be summarized within this chapter.

Participants

The participants included consumers (n=129) who have been a resident at the AmericanWork, Inc. Supportive Living Program since the start of the program until the last date of data gathering on November 30, 2011. Adult residents, over the age of 18, with primary diagnosis of mental health as well as meet one of the following criteria: four or more admissions to state psychiatric hospital in the prior 12 months, or long period of stay at state psychiatric hospital (more than 30 days). The dependent variable was identified as the status of discharge from the program. Those consumers who have completed the program and have been discharged successfully to independent living in the community were deemed successful and were identified as Group A (n=45, 34.9%). Unsuccessful consumers have not completed the program or have been discharged from the program without successful transition into the community and were identified as Group B (n=84, 65.1%).

Variables

Pre-admission variables included those variables that impacted the consumer prior to admission to the supportive living program and include the following. Length of stay at the hospital referred to the length of time the consumer resided within the state psychiatric hospital prior to being admitted into the program. Prior placement type was where the consumer lived immediately prior to the program where as prior community placement refers to the where the consumer lived within the community prior to the hospitalization. Numbers of admissions to the hospital were noted to identify how many adult admissions the consumer had to a state psychiatric hospital prior to supportive living.

Secondary variables indicated those variables that impacted the consumer outside of the program and treatment systems and included if the consumer was involved in the legal system (i.e., probation/parole, incompetent to stand trial, not guilty by reason of insanity). Primary diagnosis of the consumer was identified as psychotic disorders, mood disorders or other psychiatric diagnosis. Secondary diagnosis was identified for those who have a secondary diagnosis along with their primary psychiatric diagnosis. Co-occurring diagnosis refers to those who have a secondary diagnosis of substance abuse.

Program specific variables, which were variables that impacted the consumer while living at the supportive housing program, were also included within the analysis. These include additional services the consumer received while a resident on top of the basic core services. Additional services could include various types of groups (i.e., substance abuse group, competency restoration groups), individual counseling, and medication administration. Discharge barriers were identified for each consumer by the program staff upon admission and throughout stay at

the program. These were categorized into 13 areas listed within Table 4. Length of stay at the program as well as number of days readmitted to the psychiatric hospital while a resident within the program were analyzed in determining impact on dependent variable.

Frequencies and descriptive statistics were run to gain descriptive statistics including secondary variables which are included within Table 1.

Table 1 *Descriptive/Secondary Variables*

		Group A Successful (n=45)	Group B Unsuccessful (n=84)
Race	Caucasian	12 (26.67%)	25 (29.76%)
	African American	33 (73.33%)	59 (70.24%)
Gender	Male	28 (62.22%)	61 (72.62%)
	Female	17 (37.78%)	23 (27.38%)
Primary Diagnosis	Psychotic Disorder	37 (82.22%)	77 (91.67%)
	Mood Disorder or Other	8 (17.78%)	7 (8.33%)
Secondary Diagnosis	Yes	30 (66.7%)	62 (73.81%)
Co-Occurring	Yes	11 (24.44%)	19 (22.62%)
Legal Involvement	Yes	20 (44.44%)	47 (55.95%)
Age	Mean	46.00	44.82
	SD	10.766	11.042
	Range	23-63	23-71

Frequencies and descriptive statistics were run on each consumer for pre-admission and program specific variables as well. These frequencies are shown in Table 2.

Table 2 *Preadmission and Program Specific Variables*

Pre-Admission Variables		Group A Successful (n=45)	Group B Unsuccessful (n=84)
Prior Placement Type	Psychiatric Hospital	42 (93.33%)	70 (83.33%)
	Other	3 (6.67%)	14 (16.67%)
Prior Community Placement	Independent Living or w/Family	24 (75.56%)	40 (47.62%)
	Other or Unknown	21 (46.67%)	44 (52.38%)
Length of Stay at hospital (days)	Mean	211.18	545.42
	SD	459.58	1065.37
	Range	0-2555	0-5840
Number of Adult Admits to the Hospital	Mean	n=40 10.15	n=72 10.25
	SD	14.18	9.24
	Range	1-73	1-44

Program-Specific Variables		N	Min.	Max.	Mean	Std. Deviation
Length of Stay at program (Months)	Successful/Group A	45	1	48	14.78	12.642
	Unsuccessful/Group B	84	0	51	20.42	16.233
Days Readmitted to Psychiatric Hospital	Successful/Group A	45	0	44	2.29	7.736
	Unsuccessful/Group B	84	0	309	10.18	38.569

Program-Specific Additional Services	Group A Successful (n=45)	Group B Unsuccessful (n=84)
No additional services	20 (44.44%)	41 (48.81%)
Medication Administration	11 (24.44%)	28 (33.33%)
Substance Abuse (SA) Group	4 (8.89%)	4 (4.76%)
Individual Counseling	2 (4.44%)	3 (3.57%)
Individual Counseling & SA Group	1 (2.22%)	2 (2.38%)
Incompetent to Stand Trial (IST) Group	4 (8.89%)	1 (1.19%)
IST Group & Medication Administration	1 (2.22%)	3 (3.57%)
SA Group & Medication Administration	1 (2.22%)	1 (1.19%)

SA Group & IST Group	0 (.0%)	1 (1.19%)
IST Group, Individual Counseling & Medication Administration	1 (2.22%)	0 (.0%)

Data Analysis

A Three backward elimination logistic regressions were performed to identify which pre-admission, program-specific, and secondary variables most accounted for positive and negative program outcome (i.e., transitional consumers) within the supportive living program. The model chi square was used to determine if each of these three models provided a better fit than that the null model. A summary of the three backward elimination logistic regressions is provided in Table 3.

Table 3 *Logistic Regression*

Model	Pre-Admin	Secondary	Program-Specific
Full Model			
# Variables	4	7	5
% Classified Correctly	64%	67.4%	69%
Model Chi-Square (Sig)	6.074 (.194)	6.122 (.526)	16.591 (.005)
Restricted Model			
	N/A	N/A	Discharge Barriers (Yes/No)
% Classified Correctly			65.19%

a. A restricted model containing one variable (program-specific discharge barriers) was retained ($\chi^2=13.063$, $p<.001$).

While the pre-admission and secondary models failed to reach statistical significance the program-specific model was supported ($\chi^2=16.59$, $p = .005$). This model was able to classify

69% of the participant's correctly, an improvement over the 65.1% in the null model. This model was further refined to include just one predictor, whether a person had discharge barriers ($\chi^2=13.06$, $p < .001$). More specifically, of the 62 participants that had some type of discharge barrier, 50 of these participants (80.6%) were not successful in the program.

Discharge Barriers

To further identify which discharge barriers were more likely to impact success in the program, a logistic regression was run using each of the 13 discharge barriers as predictors. The overall discharge barrier model was able to classify 68.2% of the participants correctly and was statistically significant ($\chi^2=27.89$, $p=.009$). After a backward elimination model just one discharge barrier (DC Support) was retained. This restricted model was able to classify 65.1% correctly and was statistically significant ($\chi^2=9.78$, $p=.002$). Those who lacked support (e.g., family) were less likely to be successful in the program. More specifically they had a .129 probability of being successful, compared to a .418 probability of being successful among those who did not have this barrier. From another perspective, those without this discharge barrier were 3.24 times more likely to be successful in the program. This is further illustrated by the program outcome numbers, specifically, of the 31 participants that had lack of support identified as a discharge barrier 27 were unsuccessful, a total of 87.1%.

Table 4 *Discharge Barriers*

Discharge Barrier	Total	Group A Successful n= 45	Group B Unsuccessful n=84
Lacks Independent & Daily Living Skills	36	6 (16.7%)	30 (83.3%)
Lacks Natural Support	31	4 (12.9%)	27 (87.1%)
Psychotic	26	5 (19.2)	21 (80.8%)
Needs Supervision	11	5 (45.4%)	6 (54.6%)
Noncompliance	8	2 (25%)	6 (75%)
Legal Involvement	7	2 (28.6%)	5 (71.4%)
Medical Issues	7	2 (28.6%)	5 (71.4%)
Substance Abuse	7	2 (28.6%)	5 (71.4%)
IST Group	6	0 (0%)	6 (100%)
Depressive Symptoms	5	1 (20%)	4 (80%)
Aggressive Behaviors	4	2 (50%)	2 (50%)
Other identified Barriers	3	0 (0%)	3 (100%)
Failed Prior independent Placement	2	1 (50%)	1 (50%)
Consumers w/Identified Barrier	62	12 (19.4%)	50 (80.6%)
Consumers w/No Identified Barrier	67	33 (49.3%)	34 (50.7%)

Within the participants that have identified discharge barriers (n=62, 48.06%), psychotic symptoms (n=26, 20.16%), lacking independent and daily living skills (n=36, 28.01%), and lack of natural supports (31, 24.03%) showed to be the most common, particularly within the unsuccessful group. Sixty-seven participants (51.94%) did not have identified discharge barriers.

In summary, the transition consumers within the supportive living program that have identified discharge barriers were less likely to successfully complete the program and gain independent living within the community. The most significant discharge barrier identified that negatively impacts successful transition was lack of natural supports. However, psychotic symptoms and lack of independent/daily living skills were also indicated as a high frequency of occurrence for those participants who were unsuccessful at transitioning to community living.

CHAPTER V

DISCUSSION

The AmericanWork, Inc. supportive living program serves those consumers who were the severest of the mentally ill population within their community. These consumers have either had multiple admissions to the state psychiatric hospitals or have been in the hospitals for a long period of time. These were consumers with primary diagnosis of mental illness as well as have severe deficits in skills to live independently within the community. The participants within this evaluation include past and current residents that have successfully completed the program, have been discharged but not successfully transitioned to community living, or remain living within the supportive living program. The goal of the program was to reduce hospitalizations and improve ability among the consumers to live independently within the community with the least amount of supports from and dependence on the treatment system as possible. Programs such as these are rare and program evaluations even less common. Therefore, it was important to see what was effective with this program in meeting its goals to provide for program improvements as well as allow for suggestions for opening other programs such as these. This can provide a foundation for improving this program and give suggestions for potential development of similar programs.

It is important within supportive living programs such as these to focus on transition into community, as successful transition is a primary goal. Integrating within the community in relation to maintaining support system, social interactions and a sense of belonging within their

community was a critical aspect of successful completion of this program. Upon completion, and obtaining independent living, these aspects were an even greater component in maintaining the

consumer's independence within community living. Yanos et al. (2001) found a positive relationship between negative interactions and community integrations, with these negative interactions having a result of decreased quality of life among those with severe and persistent mental illnesses. Community integration and inclusion of these within individualized treatment planning was consistent within this program and gaining positive outcomes. Gaining community integration with natural supports improves quality of life amongst those with mental illnesses resulting in sustained stabilization and independence.

The primary focus of the current study was consideration of the variables and factors that influence or contribute to the success of a program focused on the goal of increasing successful integration of the severely mentally ill into the community. Based on these goals, the primary question of the current study, examined the level of effectiveness of this supportive living program at increasing transition to community living among severe and persistent mentally ill consumers. The findings demonstrated that among participants of this program there were 84 participants who did not successfully complete the program as compared to 45 who successfully transitioned to community living. It is important to note that the history of most of the participants, due to the severity of their illness, often does not include community living. Often times consumers were discharged from psychiatric hospitals and residential settings without the appropriate follow up or available community based services, resulting in inability for consumer to remain stable within community living (Feldman, 2003; Moxham and Pegg, 2000; Hamden, Newton, McCauley-Elsom, and Cross, 2011). Therefore, having a percentage of those consumers who complete this program and become successful at living independently within the community is a positive for this program. The revolving door phenomenon as it is often termed, refers to rapid and repetitive utilization by consumers with mental illness, of emergency room

visits and need for acute inpatient units often resulting in the increasing need and demand for adequate and available mental health care which has occurred at an ever increasing level since the closure of institutions. (Girolama and Cozza, 2000; Dixon and Goldman, 2004; Razali, 2004; Sawyer, 2005; Hamden, et al., 2011). Therefore, having successful outcomes at any rate is indicative that programs can be constructed to successfully meet the goal of transition into community living for consumers with severe mental illness. Although the need for program improvement is evident, ongoing evaluation and determination of how programs can improve are crucial.

When considering pre-admission and secondary variables, it was anticipated that these variables would not have an impact on the program's outcome. Program specific variables include variables that impacted the consumer prior to admission to the supportive living program, including length of stay in hospital prior to admission, prior placement and prior community placement types and adult admissions to psychiatric hospitals. Secondary variables include those variables that impact the consumer including primary diagnosis, secondary diagnosis, co-occurring diagnosis and legal involvement. The supportive living program can have no impact on these variables as they both have an impact on the consumer outside of the program's control. For example, if one of these variables were found to have a negative impact on program outcome, there would be very little the program could change in regards to these variables. The program evaluation looked at each of these variables to not only look at what works and what does not work in terms of successful transition; it also addresses areas in which the program can improve at meeting the program goals. Therefore, if program specific variables are more successful at impacting program outcome, than the program itself can make adjustments and improvements. In many ways it is actually a positive indicator of the program

that these variables, specifically the pre-admission variables did not seem to influence program outcomes.

Coupled with the investigation of these variables it was also essential to examine the impact of program specific variables or factors and their link to successful completion of the program. In regard to this program examined in the current study, program specific variables were found to have an impact on the outcomes. This occurred within the program specifically with the variable discharge barriers. Discharge barriers were divided into several categories: legal involvement, found incompetent to stand trial, unstable psychotic symptoms, excessive depressive symptoms, noncompliance with treatment and medications, medical issues/concerns, in need of supervision for daily living and medication compliance, substance abuse, lacks independent and daily living skills, lack of or unavailable natural and family support, failed attempts at prior discharge and history of aggressive behaviors. Lack of natural supports indicates consumers who lack supports including family supports within the community as well as those consumers whose family is unable or unavailable to provide support for the consumer. Instability with psychotic symptoms include those symptoms which continue to negatively impact the consumer such as delusional behaviors, auditory/visual hallucinations, and paranoia. Lack of independent and daily living skills include those skills that a consumer needs to maintain their independent living such as cooking, cleaning, maintaining hygiene, grooming, budgeting, etc. A consumer with an identified discharge barrier had a least likely chance of successfully transitioning into community living.

It is found within this study, that discharge barriers make the biggest impact on outcome of the program amongst the consumers. This is important and not surprising as an outcome within this study. Discharge barriers in itself were identified as variables that impact the

consumer successfully transitioning and were determined at the beginning as well as throughout the consumer's enrollment within the program. The terms themselves, discharge barriers, encompasses identified obstacles which hinder successful discharge and stabilization of illness and independence. These were variables that can have negative impact on obtaining community living and stabilization of mental illness as well as maintenance of this independent living and stability. By having these identified, it is not surprising that these consumers will have a lower rate of successful completion of transitioning into community living. The discharge barriers were developed to indicate to treatment planning that these were areas that need to be addressed and included within treatment services for the consumers. These barriers can be utilized as a means to ensure that the consumer is receiving the most individualized treatment to focus on these concerns and progress within these matters. By inclusion of these variables within the treatment plan for each consumer individually, the program can improve the treatment services provided to each consumer.

Consumers who have discharge barriers may have a lower rate of successful discharge, however, by identifying these concerns the treatment can focus on the concerns and address these to decrease these barriers and improve ability for consumer to successfully transition out of the program. The barriers identified as having the highest frequency of occurrence within consumers who had identified barriers included psychosis, lack of natural supports and lack of independent/daily living skills. It is suggested by this author, as well as within the literature, that these three barriers were linked to each other amongst mentally ill consumers and it would not be surprising for a consumer to have all of these three variables (Wagner, 2006). A consumer with three discharge barriers identified may have less of a chance of stabilization and successful transition into community living. It has been shown that a positive social relationship and a

strong support network have a potential for decreasing and eliminating psychiatric symptoms resulting in a positive influence on outcomes of treatment and maintaining ongoing recovery of mental illness (Weiner et al., 2010). The connection between support systems and psychiatric symptoms including psychosis is evident. The impact of positive social supports on psychosis is advantageous to the consumers and indicates the importance of supports. Gulcer et al. (2007) suggests that individuals who were severely mentally ill were more likely to need the support of others. Wagner (2006) found that there is a high prevalence of social behaviors related to negative symptoms of mental illness ultimately resulting in a longer length of stay in inpatient programs. The supportive living program may also experience lengthier stays within their program without successful discharge due to these identified barriers. Some studies have suggested that diagnosis is not associated with length of stay, while others have found that psychosis and major depression were correlated with longer length of stay at inpatient and residential placements (Gigantesco, et al., 2009). Treatment programs, particularly those such as these that have goals of improved independence within the community, are in need of improving their emphasis on these factors, not only to meet their own program goals, but to also benefit the consumer of ongoing recovery and stability.

Research amongst the mental health population has shown community living relies heavily on treatment that includes daily living activities as well as social/emotional supports (Mirza et al., 2008). There is a connection of these two discharge barriers, support systems and daily living skills, which is needed to address within treatment programs. Focus on these two barriers will improve treatment planning and progress amongst consumers within programs who are attempting to improve their consumer's independence as well as outpatient treatment programs that are assisting these consumers with maintaining community living. Gill and Hinds

(2003) found within their study that two-thirds of their sample of those with psychosis reported also having difficulty with one or more identified daily living skills. Natural support systems as well as independent/daily living skills both impact and are impacted by severity of symptoms. It is not surprising that psychosis negatively impacts supports as well as daily living skills, however improved support systems and independence can in turn decrease psychiatric symptoms including psychosis. The feeling of empowerment and independence among consumers allow for improved management of these symptoms ultimately reducing their severity. Wagner (2006) proposed that consumers with severe impairments in social skills also have increased deficits in autonomy resulting in a decreased involvement in socially specific activities. Despite the connection between these three variables, the significant barrier for impact on outcome of success within the program is natural support.

Lack of Natural Support

The discharge barrier termed natural support refers to those consumers identified as having a lack of natural/family support, unavailable family support, unstable family support or the family is unable to manage the consumer. Those identified within this discharge barrier, within this study, have been shown to be less likely to discharge successfully from the program into independent living. Evidently, having a natural support system that is able to offer adequate support within the community is vital to successful integration within the community and imperative for maintenance of this independent living. McRea and Spravka (2008) suggest that while medications are often emphasized within the literature, among consumers supportive relationships are a priority over these medications. The consumers indicated within McRea and Spravka's (2008) study that being able to contact staff and having an ongoing support system is crucial to the consumer within their ongoing recovery. Additionally, McRae and Spravka (2008),

argue that case management support systems with frequent contact with the consumers show to be most effective in facilitating and maintaining recovery among mentally ill individuals. It is apparent that providing the consumer's with skills to maintain the support system, which should be developed in the program prior to discharge, is central to the consumer's well-being and ongoing stability of their illness. Not only is independent living within the community important to the consumer but also to the treatment system. The less dependent the consumer is on the treatment system the better for the consumer's quality of life as well as the treatment providers whose resources are already limited. Green et al. suggests that social relationships impact a consumer's sense of loneliness (as cited in Weiner et al., 2010). Loneliness can often be associated with psychological and somatic issues, decreased satisfaction with life, alcoholism, suicide and physical health problems (DiTommaso et al., 2004; Ditommaso and Spinner, 1997). The sense of loneliness impacts various aspects of a consumer's life and with the negative impacts of supports on loneliness, it is evident that support with the severely mentally ill population is crucial in most aspects of their ongoing recovery and stabilization process.

Within program evaluations such as these, length of stay is often evaluated as well as how this impacts the success of the consumer in the program, and it is often assumed that the longer the stay the more successful the program is at treating the consumer and improving their independence. McGuire, Rosenheck, and Kaspro (2011) argue that the length of stay in a residential program is a consistent predictor of improved program outcomes even after 1 year of discharge from the program the benefits maintain. However, a prolonged length of stay at treatment programs and inpatient stays have also been found to be connected to lack of social and natural supports. Gigantesco et.al. (2009) also suggests that a decrease in psychosocial functioning was positively associated with longer stay in the hospital. Conversely, these authors

note that it is difficult to say whether this is due to difficulty with planning discharges and community living concerns or if the longer stays decrease basic living skills and independence; although these authors state it could be a combination of both with these decreased skills this could in turn increase the consumers time within the treatment program. Boettcher and Schie (1975) found that hospitalization may produce a consumer who has become dependent on rules and structures of these programs resulting in poor motivation to leave with little potential for discharge into community living. Routines and adequate social supports are emphasized as this allows the consumer for encouragement and structured transition planning to successfully discharge and maintain independent living within the community. With this noted, the length of stay could be crucial as well in ensuring that the identified barriers are addressed and focused on to improve the consumer's skills and reduce the impact of these barrier in successful transition. Treatment programs including supportive living placements need to address these concerns within their treatment and discharge planning process.

Recommendations

Based on the outcome of this study it is recommended that this program provide individualized treatment planning focusing on each consumer's identified discharge barriers. The finding that discharge barriers may be related to program outcomes provides a foundation for considering how it may influence outcomes or treatment. Specifically, research (Hero and Drury, 2007; Sharfstein, 2009) has demonstrated that it is critical to consider these type of individual differences when developing and implementing treatment options, treatment planning and treatment goals with the severely mentally ill population. Discharge barriers were found in this study to be indicative of less success in the program and therefore should be concentrated on for treatment planning and services throughout the program for each consumer. Inclusion of these

identified discharge barriers among each consumer within their individual treatment plans would improve aspects of treatment for successful transition into community living. An integrative individualized treatment approach is emphasized. Test and Stein (2000) as well as Hero and Drury (2007) both provided guidelines for increased effectiveness of living independently within the community with inclusion of these within the individualized treatment plan. These guidelines focus on skill building, inclusion of an accurate diagnosis,, focus on the site of treatment with inclusion of natural supports, allow for encouragement and support from the staff and the consumer's identified support system, and most importantly focus on the consumer's goals and where they are at within their treatment.

An individualized treatment approach based on the above mentioned guidelines would be beneficial to the program in meeting its identified goals. Focusing on the most frequent discharge barriers, lack of daily living skills, lack of natural support and psychotic symptoms throughout the treatment process could improve the benefits of the program as well as improving program outcome. Sharfstein (2009) suggests that treatment planning should not only include psychopharmacology aspects but also diagnosis and psychosocial components which in turn identifies the appropriate therapeutic intervention and rehabilitations to promote recovery and stabilization. By identifying each consumer's specific needs and individualized treatment goals and objectives a treatment plan can be developed to address each consumer's needs and in this case discharge barriers. Specialty treatment and residential care provides an opportunity to the consumer to focus the treatment on each individual for severe and often difficult-to-treat mental disorders (Sharfstein, 2009). Treatment planning teams should collaborate and consist of not only the treatment provider/staff, but also the consumer themselves along with identified support systems.

Along with the individualized treatment plans, it is also suggested that an improved evaluation could be conducted with additional data. To determine which variables impact successful discharge from the program, all variables that could be an impact need to be included within the available data. Each consumer within the program receive a core set of treatment services, however despite these services being available to the consumers it is not always equal across the clientele. For example, psychosocial rehabilitation day treatment program is a requirement for each consumer who is living at the program. Although this may be a requirement, the consumer does not always comply with this requirement. In other words, a consumer can attend the day program five days a week as required, three days a week or sporadically as they choose. This is a prominent aspect of the treatment services for the consumer in improving their skill set for independent living and attendance at this is presumed to be critical for their progress, however without this data and evaluation of the impact of attendance at the program, this statement cannot be validated. Additional assessment of the varying aspects of this program and other programs such as these will benefit the literature as well as the services that are provided in meeting the treatment goals.

Ongoing assessment of programs such as these with these additional variables will improve the impact that the evaluation findings have on the success of the program. An additional aspect could be to look at the consumer's perceptive of the success of the program at meeting not only the program's goals but also the individualized goals of the consumer. Encouraging individualized treatment planning is important, nonetheless determining the consumer's goals from their perspective is also crucial. The consumer's perceptive of the program, what the program should help them with, when the consumer themselves feel they have

met their goals and are ready for independent living within the community can be beneficial in determining the success of the program at meeting their own identified treatment goals.

The consumer should identify their own treatment goals and determine what they are wanting at this time in relation to treatment and outcomes. However, utilizing the support system (i.e., family) as well as all treatment providers that are working with the consumer is critical to treatment plan development (Sharfstein, 2009). The natural support system is emphasized and important within treatment for the severely mentally ill. As mentioned above, this is most significantly the reason for unsuccessful transition into community living within the evaluated program. However, recognizing this upon admission to the program, allowing the identification and maintenance of a support system throughout the treatment process, and inclusion of this within the treatment plan, is imperative to allow for successful transition into community living.

Limitations

This study included a large sample of participants, however, a significant amount of the participants were unsuccessful in completing the program and meeting the goal of transitioning into independent community living. Due to this it was difficult to determine variables that were effective in successful discharge as there were a low percentage of participants that discharged successfully. There was also large amount of variance within the identified discharge barriers which impacts the identification of the barriers which had an impact on transitioning successfully out of the program. The varying perceptions amongst therapeutic staff related to symptomology may have caused a large amount of variability in the chosen barrier for each consumer or could have impacted if a discharge barrier was identified in the first place. Furthermore, within the

identified discharge barriers there was not a high representation across each individual barrier among the successful and unsuccessful groups. Additionally stated, there were a large variety amongst the barriers there were not equal representation among the successful and unsuccessful groups. This could have impacted the outcome as it was difficult to determine which variables played a part in successful or unsuccessful transition to community living due to the variance in representation. Finally, it is important to emphasize that this evaluation was conducted on one program in one state. The limits of generalizability were apparent. Programs such as the AmericanWork, Inc. supportive living program are uncommon which impacts program evaluations completed on these types of programs. Additional research within supportive living programs of the severe and persistent mentally ill would be beneficial to determine variables that positively and negatively impact successful discharge.

In conclusion, the outcome of the program evaluation has identified the importance of an adequate support system. By identifying the Consumer's discharge barriers at admission and adjusting these throughout the treatment process, the individual treatment planning and care can focus on what is most needed by each individual Consumer. This will in turn allow for positive outcomes within the supportive living program. Assisting the Consumer with developing and maintaining adequate support systems is crucial in ongoing care of the Consumer as well as ongoing stabilization of the consumer within community living. Discharge is often a stressful event for consumers, particularly those who lack supportive relationships to turn to in time of need, therefore ongoing relationships with staff and developed support systems are critical with successful discharge and independence within the community (McCrea and Spravka, 2008).

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APPENDIX A

LETTER OF APPROVAL

AmericanWork, Inc.

Mental Health and Addictive Disease Services

March 25, 2012

To Whom it May Concern:

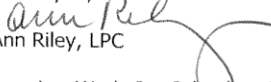
AmericanWork, Inc has approved the program evaluation of the supportive living program by Shelley Reed of Auburn University. This agency collects data as part of internal and external program review. The informed consent by all participants for program review and evaluation is obtained in writing prior to admission to the supportive living program as a part of orientation and overview of the program handbook. This information is obtained weekly on all participants within the program and maintained on an excel spreadsheet which is beneficial for the program itself but also satisfies requirements of the state agencies for which funding is obtained.

Shelley Reed is employed with AmericanWork, Inc outpatient clinic, however she is not connected with the supportive living program. This program is at a different location and Mrs. Reed does not have contact nor provide any type of services to the clients within the supportive living program. During this process she will not have access to any client records that are part of this evaluation and will be blocked from electronic medical records of these participants to eliminate any contact.

The data that is obtained by the program staff will be transferred to Shelley Reed via an excel spreadsheet with no identifying data present. The spreadsheet will only contain the information as requested and will have no identifying data (i.e., names) located within the spreadsheet. Any additional data that is needed will be given to Mrs. Reed verbally or within an email via word document, once again, with no identifying data to ensure confidentiality of all participants.

If you have any additional questions please feel free to contact me at 706-494-7796.

Thank you,


Ann Riley, LPC

AmericanWork, Inc Columbus Area Director

MUSCOGEE COUNTY OFFICE
421 - 12th Street • Columbus, Georgia 31901
Toll Free: 1.866.678.7144 • Phone: 706.494.7796 • Fax: 706.494.7072

APPENDIX B
AUBURN UNIVERSITY INSTITUTIONAL REVIEW BOARD APPROVAL
TO CONDUCT STUDY

**AUBURN UNIVERSITY INSTITUTIONAL REVIEW BOARD for RESEARCH INVOLVING HUMAN SUBJECTS
RESEARCH PROTOCOL REVIEW FORM**

For information or help contact THE OFFICE OF RESEARCH COMPLIANCE, 115 Ramsay Hall, Auburn University
Phone: 334-844-5966 e-mail: hsubjec@auburn.edu Web Address: <https://www.auburn.edu/research/vpr/ohs/>

Revised 03.26.11 - DO NOT STAPLE, CLIP TOGETHER ONLY.

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1. PROPOSED START DATE of STUDY: March 15, 2012

PROPOSED REVIEW CATEGORY (Check one): FULL BOARD EXPEDITED EXEMPT

2. PROJECT TITLE: AmericanWork, Inc Supportive Living Program: A Program Evaluation

3. Shelley W. Reed Mrs. SERC 706-587-8372 swr0004@auburn.edu
PRINCIPAL INVESTIGATOR TITLE DEPT PHONE AU E-MAIL
1113 Steve Mar Drive Columbus, Ga 31904 shelleywreed@gmail.com
MAILING ADDRESS FAX ALTERNATE E-MAIL

4. SOURCE OF FUNDING SUPPORT: Not Applicable Internal External Agency: Pending Received

5. LIST ANY CONTRACTORS, SUB-CONTRACTORS, OTHER ENTITIES OR IRBs ASSOCIATED WITH THIS PROJECT:

6. GENERAL RESEARCH PROJECT CHARACTERISTICS

<p>6A. Mandatory CITI Training</p> <p>Names of key personnel who have completed CITI: Shelley W. Reed <input checked="" type="checkbox"/></p> <p>CITI group completed for this study: <input checked="" type="checkbox"/> Social/Behavioral <input type="checkbox"/> Biomedical</p> <p align="center">PLEASE ATTACH TO HARD COPY ALL CITI CERTIFICATES FOR EACH KEY PERSONNEL</p>		<p>6B. Research Methodology</p> <p>Please check all descriptors that best apply to the research:</p> <p>Data Source(s): New Data <input type="checkbox"/> Existing Data <input checked="" type="checkbox"/></p> <p>Will recorded data directly or indirectly identify participants? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>Data collection will involve the use of:</p> <p>Educational Tests (cognitive diagnostic, aptitude, etc.) Interview / Observation Physical / Physiological Measures or Specimens (see Section 6E) Surveys / Questionnaires Internet / Electronic Audio / Video / Photos Private records or files</p>	
<p>6C. Participant Information</p> <p>Please check all descriptors that apply to the participant population.</p> <p><input checked="" type="checkbox"/> Males <input checked="" type="checkbox"/> Females <input type="checkbox"/> AU students</p> <p>Vulnerable Populations <input type="checkbox"/> Pregnant Women/Fetuses <input type="checkbox"/> Prisoners <input type="checkbox"/> Children and/or Adolescents (under age 19 in AL)</p> <p>Persons with: <input type="checkbox"/> Economic Disadvantages <input type="checkbox"/> Physical Disabilities <input type="checkbox"/> Educational Disadvantages <input type="checkbox"/> Intellectual Disabilities</p> <p>Do you plan to compensate your participants? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>		<p>6D. Risks to Participants</p> <p>Please identify all risks that participants might encounter in this research.</p> <p><input type="checkbox"/> Breach of Confidentiality* <input type="checkbox"/> Coercion <input type="checkbox"/> Deception <input type="checkbox"/> Physical <input type="checkbox"/> Psychological <input type="checkbox"/> Social <input checked="" type="checkbox"/> None <input type="checkbox"/> Other: _____</p> <p align="center">Received APR 16 2012</p> <p><small>*Note that if the investigator is using or accessing research or identifiable data, breach of confidentiality is prohibited.</small></p>	
<p>Do you need IBC Approval for this study? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - BUA # _____ Expiration date _____</p>			

The Auburn University Institutional Review Board has approved this document for use from 5/1/12 to 4/30/13
Protocol # 12-169 EX 1205

FOR OHSR OFFICE USE ONLY

DATE RECEIVED IN OHSR: 4.16.12 by UB
DATE OF IRB REVIEW: 5/1/12 by KJE
DATE OF IRB APPROVAL: _____ by _____
COMMENTS: revisions 5/1/12 -OK

PROTOCOL #: 12-169 EX 1205
APPROVAL CATEGORY: 45CFR 46.101(b)(4)
INTERVAL FOR CONTINUING REVIEW: 1 year

