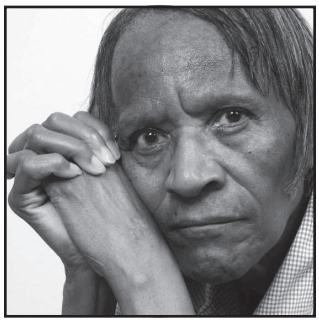
# Introduction

# Chapter 1



In North Carolina, more than 28,000 people live in adult or family care homes (ACH). The purpose of ACHs is to provide the frail elderly and people who have a temporary or chronic physical condition or mental disability with a place to live, supervision, and assistance with personal care needs.[a] ACHs do not provide *treatment* for mental illness or alcohol and drug abuse, and regulations specify that individuals who pose a *direct* threat to the health and safety of others should not to be admitted as residents of ACHs.[b] Data collected by the Division of Health Services Regulation suggest that more than 60% of all residents in ACHs had a primary diagnosis of mental illness, intellectual and developmental disabilities, or Alzheimer disease/dementia in 2009.[1] The placement of individuals with mental illness, substance abuse problems, intellectual and developmental disabilities, and other disabilities[c] that may result in serious behavioral problems can pose a threat to the health and safety of other residents, especially the frail elderly, and the staff of ACHs. Problems may include physical harm, sexual assault, and verbal and psychological abuse.

The precursors to ACHs—boarding homes, rest homes, and convalescent homes—formally began caring for "aged or mentally or physically infirm" in 1945.[d] The primary purpose of these residences was to provide personal care and not "medical care or diagnostic treatment."[2] The population of individuals with disabilities has increased during the past 60 years as the care of these individuals has shifted from large state hospitals to the local community. Since this practice began, the approach to housing and providing services for individuals with disabilities has evolved. Today, best practice research in this field has demonstrated that living in one's home community in affordable, supportive housing and receiving community-based support services is the best option for most individuals with disabilities.[3]

Although ACHs may be suitable residences for the frail elderly, they may be insufficient to meet the needs of other individuals with disabilities that may result in behavioral problems. Because of a shortage of more appropriate community alternatives for these individuals and because of financial incentives embedded in the system, these individuals continue to be placed in ACHs even when their wishes or needs could be better supported in their community. Without substantial increases in community alternatives for individuals with disabilities, this population will continue to constitute a large portion of the ACH population. In addition to the concerns raised by housing these individuals in homes that may not be designed to care for their needs, the co-location of older individuals who have personal care needs with individuals who may have behavioral problems poses a safety risk to staff and residents.[4]

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a G. S. 131D-10.10, 10 NCAC 13F.0701, and 10NCAC 13G.0701
b 10 NCAC 13F.0701 and 10 NCAC 13G.0701
c Individuals with mental illness, substance abuse problems, intellectual and developmental disabilities, and other disabilities are referred to collectively as individuals with disabilities throughout this report.
d G.S. 108-3 (1945)

In 2009, the North Carolina General Assembly asked the North Carolina Institute of Medicine (NCIOM) to convene a Task Force to study the co-location in ACHs of the frail elderly with individuals with disabilities who may have behavioral problems. The Task Force on the Co-Location of Different Populations in Adult Care Homes was chaired by Maria Spaulding, Deputy Secretary for Long-Term Care and Family Services, North Carolina Department of Health and Human Services; Representative Jean Farmer-Butterfield, North Carolina General Assembly; and Senator John Snow, North Carolina General Assembly. There were 41 additional Task Force and Steering Committee members. The Task Force on the Co-Location of Different Populations in Adult Care Homes was supported by funding from the North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities, and Substance Abuse Services through the North Carolina Substance Abuse Prevention and Treatment Block Grant from the Substance Abuse & Mental Health Services Administration.

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In examining the co-location of different populations in ACHs, the NCIOM was asked to consider:

1. The problems created by the co-location of different populations in ACHs.
2. Ways to appropriately identify/screen people for behavioral health problems.
3. The training of ACH staff.
4. Other options to ensure that people with mental illness, those with behavioral health problems, the frail elderly, and others with disabilities are receiving appropriate care.

The Task Force initially focused on people with mental illness, substance abuse problems, or intellectual and developmental disabilities who also display behavioral problems (including physical, verbal, or sexual behaviors that can cause harm to themselves or others). The Task Force recognized that not every person with disabilities acts in ways that can create a threat to themselves, other residents, or staff. The primary charge to the Task Force was to examine the problems that can be created by the co-location of people with behavioral problems—whatever the underlying cause—with the frail elderly or other people with disabilities. However, in exploring this issue, the Task Force necessarily was faced with the larger question of how to best provide services to all individuals with disabilities who currently reside in ACHs. In their work, the Task Force focused on system issues, such as housing options that are available to individuals with disabilities, placement and care coordination, staff training, system functionality, and financing. The Task Force did not focus on the infrastructure of ACHs (e.g., buildings, room size, or number of individuals per room) or on the internal workings of ACHs (e.g., the way that meals are provided, residents' ability to structure their own days, or transportation options).

The Task Force was asked specifically to focus on the issue of co-location, which led to a major examination of whether ACHs meet the needs of individuals with disabilities. Although the discussion often addressed ACHs, such homes are part of a larger system that has failed to provide adequate options and supports for individuals with disabilities. For many decades, ACHs have stepped in to provide housing and basic support services for individuals with disabilities who have no other housing and support options. The Task Force does not wish to diminish in any way the valuable role that ACHs have played for individuals with disabilities. However, best practices for providing supports and services for individuals with disabilities have evolved, and North Carolina's system for individuals with disabilities needs to evolve to reflect best practices.

It will take time to provide individuals with disabilities real choices about where they live and the types of supports they can access. Therefore, the Task Force's recommendations had two goals: in the short term, to improve the ability of ACHs to appropriately serve these co-located populations; and in the long term, to provide more viable options to live in their home communities for people with disabilities whose needs are not met by ACHs, thus preventing co-location. The Task Force developed nine recommendations, with two designated as priorities: improving and strengthening ACHs, and expanding options for affordable housing and ways and places to access services and supports for individuals with disabilities.

**The Task Force's recommendations had two goals: to improve the ability of ACHs to appropriately serve these co-located populations and, in the long term, to expand the array of housing and support services for people with disablities.**

## References

1. Adult Care Licensure Section, Division of Health Service Regulation. Diagnosis Data by Age Groups 2009, 2010 License Renewal Application. North Carolina Department of Health and Human Services.

2. North Carolina State Board of Public Welfare. Rules and Regulations Governing Licensing of Boarding Homes, Rest Homes, and Convalescent Homes for Older Persons. 1950; G.S. 108-3 (15).

3. Substance Abuse and Mental Health Services Administration. Mental health: a report of the Surgeon General. US Public Health Service; 1999. http://www.surgeongeneral.gov/library/mentalhealth/home.html. Accessed September 22, 2010.

4. North Carolina Study Commission on Aging. Study of Issues Related to Persons with Mental Illness in Long-Term Care Facilities. North Carolina Department of Health and Human Services; 2005.