CHAPTER 1

Oxford Then and Now

A Critical Review of Oxford Regional Centre's Client Services 1980-1986

This chapter chronicles persistent major concerns of both ORC's own staff and parent groups as well as individuals working with developmentally handicapped individuals in the field of services not formally associated with ORC. It does not consider the question of why these concerns have remained for so long, nor how it is that they can be perceived as major concerns by direct-care workers without similar degrees of concern emanating from the management structure of ORC and the Ministry of Community and Social Services.

Concerns at the Initial Point of Referral for Service

Conflict may develop when ORC's community service workers disagree with the intentions of an agency or worker to apply for admission to ORC. Frequently the disagreement centres around the degree of committment shown by the agency to working with an individual with persistent, obnoxious disturbing behaviour, non-compliance, or a variety of mildly threatening aggression such as slapping, hitting or kicking others. Further conflict may develop when the Area Office arm of the Ministry does not support the aim of keeping the individual in the area and assists the agency, politically, to admit the individual to ORC. There is a perceived lack of accountability to the individual in current Ministry practice. As a result, over the last six years at least, ORC has been the accommodation of choice for individuals coming from certain areas where committment to gaining special tolerance and behaviour management techniques has been weak or non-existent, resulting in low placement activity (discharge from ORC to the area) and high admission activity. The impact on ORC has been to increase its population rather than decrease it, or to demand disproportionate amounts of time at community crisis intervention, admission planning and service time, or discharge planning and support, for what amounts to a negligible decrease in ORC's population. On the positive side, however, there are some areas which show excellent client service committment, with a corresponding significant net decrease in the population of ORC for relatively small amounts of service time from ORC. Evidence of this disparity in community support to ORC population reduction is provided in Table 1.

Since ORC established a "72-hour" emergency placement service in 1983-1984, the communities of ORC's "catchment area" have been almost unanimous in their declaration that this is a needed and worthwhile service. In practice, however, there have been concerns raised by the service itself, and by consumers of the service as well. Too many times, individuals have been left in this "72-hour" accommodation for indefinite periods (one in particular has been at ORC for ten months). ORC has been partly responsible for not ensuring accountability of the community services to the individual before admitting, and in some cases the Ministry's Area Offices have intervened in the process, advocating against the individual returning to the community service. It is obvious that the goal to see that every individual is given full opportunity to succeed in community placement, without being placed at risk, before being admitted to ORC, is not held uniformly across areas and individuals.

For those individuals whose "emergency admission" turns <u>legitimately</u> to a longer-term stay, arguments surface that the process of gaining appropriate accommodation and services takes too long, and leads to lengthy periods within which the individual simply languishes at ORC. This concern is also brought forward in the discussion of ORC's general internal service planning and delivery system, and will be dealt with at greater length in that section following.

One further concern, from the community side, has centred around the vagueness with which access to the emergency admission facilities is offered. Mistakes of the recent past indicate that, under pressure of space and resources, individuals have been temporarily turned away from emergency

admission. It seems that ORC was not supporting the emergency settings by taking individuals into other areas when the main admitting sites were being heavily used. Whatever the ultimate cause for the problem, it is certainly a strong consensus of opinion that emergency admitting services must remain open to the possibility of emergency admissions at any time. As yet there exists no clear policy as to the use and control internally at ORC of the emergency admitting services and sites. As a result, there is some fear and uncertainty surrounding the process of accessing these services.

Finally, and perhaps most importantly from the point of view of planning for the future, there is the absence in the past years of any Management Information System for monitoring admissions of any kind at ORC over the years. If one currently exists, it is not easily accessible, and the planning information detailing admission patterns that has been made available in this document, dating back to 1980, has been the product of a special survey of admissions, conducted by the author, which required something in the order of sixteen hours to produce. Being the product of a one-time only survey methodology, this alone will not serve to significantly alter the problem for the next time such information is required.

Individuals are still being referred for admission to ORC. This is an indisputable fact, although a "visionary" future would certainly allow that no developmentally handicapped individual would have to leave his/her community of choice to receive services. The "groups" of individuals who continue to be referred for service, or who might be predicted to apply for services in a world which does not change significantly in the next several years, are detailed as follows:

1. Individuals with chronic, persistent, obnoxious disturbing behaviour. This includes those who have run into trouble with the law over minor offences, or whose behaviour is essentially intolerable in their home communities. Although this group may not carry a psychiatric label and are frequently refused by psychiatric services as "non-psychotic", they may nevertheless be frequently so characterized under the general diagnosis of "character disorder", "personality disorder" or "pervasive developmental disorder", including "borderline personality" diagnoses. Although referrals from the court are relatively few, they would likely increase in arithmetic proportion to the number of positive responses received. This group is highly determined by the amount of committment communities give to working with developmentally handicapped individuals. As a result, one community's "obnoxious" individual may be appropriately placed in some other community with more tolerance or sophistication of program techniques. Admissions, if any, should be made with extreme discretion, and local Ministry of Community and Social Services Program Supervisors must be supportive of the individual's return to the community in order for ORC to treat quickly and discharge such problematic individuals. High degrees of coordination are required from the more central Ministry offices since individuals may come into ORC from one area and be placed in another for legitimate clinical reason. This group is not truly dangerous to the safety of others.
   This group has comprised approximately 60-70% of all admissions over the past 6 years.

2. Individuals with frequent or even occasional serious violence and aggression, including sex offences, which place other individuals or themselves at serious risk for physical harm. This is also a high-discretion group, where there are both minimum levels of tolerance which vary from community to community, and maximum levels of tolerance which affects even ORC's ability to serve. For example, violence and aggression may be partly environmentally induced, and not well controlled by any one agency, depending on its sophistication in behaviour management and on its local community support network. At the minimum, an individual may be admitted from one agency and soon be placed successfully in another. At the maximum, an individual's violence and aggression may be so serious, so frequent or so in need of intensive supervision that correctional or psychiatric-forensic services are required and ORC, as a voluntary and "non-secure" setting, will be unable to serve. This group is potentially dangerous to the safety of others.
   This group has comprised approximately 10-20% of all admissions in the last six years.

3. Individuals with medical or health care/physical-development needs which require degrees of support from health care staff beyond that which community agencies are prepared, funded or willing to offer. This again is a high-discretion group, which is partly defined by the perceived quality and individual appropriateness of the local services. Given the tendency for Homes for Special Care to provide this type of service, and the numerous complaints about the services in some such settings, ORC has been considered a preferred setting by a number of caseworkers in the community. This group is frequently found to be referred from small, rural settings without strong community associations, or from communities with low tolerance for individuals with special needs.

   This group has comprised approximately 5% of all admissions over the past six years, but ORC may experience an emergency surge of referrals at any particular point in time in the future, depending on the management of the Homes for Special Care problem, if only for the purpose of short-term admission pending placement in community services.

4. Individuals experiencing a momentary or periodic, but short-term treatable mental illness requiring a brief period of placement in a highly controlled setting for stabilizing and close supervision. It has usually been determined that they do "need" full psychiatric hospital admission, or such admission is not recommended by the individual's caseworkers or advocates. These individuals may be depressed or have some other highly treatable mental illness.

   This group has comprised approximately 5% of all admissions in the past six years.

5. Individuals reaching the age of termination from Children's Aid Society wardship, who find community services unable or unwilling to accept them into services. This group may range from only mildly handicapped individuals, to very severely multi-handicapped individuals. Institutional placement often appears to depend on the urgency with which impending termination occurs as a function of the waiting list length of community services and the planning abilities of the local CAS.

   This group has comprised less than 5% of all admissions in the past six years. It is not known whether this group is going to require assistance in the near future, or if it is a potential service group within the next five years, although at least some areas outside of ORC's catchment area have registered sincere concern about this group.

6. Placement breakdowns due to any of a wide variety of reasons. This may be a complete failure of an entire agency, or some parts of an agency, or simply a single individual's placement in that agency. The placement itself may have been improper, or circumstances might have changed significantly in the intervening time, which might be a few months or several years.

   Each of the above three examples has occurred in the past six years. This has partly been due to exceptional circumstances, with the closure of two local facilities in the years 1983 and 1984 in the Southwestern Region, coupled with explosive growth of community services in areas which may have temporarily out-stripped local agency expansion capability.

   However, this group has accounted for 10-20% of all admissions in the past six years.

Concerns Regarding Services at Oxford Regional Centre

In addition to the groups described above, who were still being admitted in 1985-1986, ORC has the responsibility of looking after, until appropriate services are made available in the community, the following groups:

1. The aging and elderly, semi-retired and retired group. This group was passed over as community residences and supported living accommodations run by local Associations accepted referrals only if the individual was under 45. Even without such "institutional" restrictions, there was a strong tendency to accept younger individuals into the prevailing

youthful, exuberant groups in these residences. When the Ministry of Community and Social Services put a moratorium on placements into private Rest Homes, Homes for Special Care, and Nursing Homes, ORC was required to provide such programs for its increasingly aging population. To its credit, ORC has provided specialized residential and day program options on each of its units for this group. This has not been without its special problems, as the ORC material environment is not particularly conducive to providing the best possible options for seniors who may have a variety of physical and mobility problems.

The seniors' population at ORC, defined as those over 50 years of age, comprises 40% of the current total population, and, if current depopulation trends continue, will comprise approximately 50% of the population by the end of the current 5 Year Plan (1987). The special problems of planning for this group will be addressed in a separate submission by the Planning for Seniors Subcommittee at ORC.

2. Individuals with very low Life Skill achievement levels, due partly to very low intellectual ability, and partly to very low-intensive training efforts, which may in turn be due to the very large groupings into which these individuals have been placed historically. Only within the last few years have community programs been developed which have focussed on providing services to this group, albeit with a few exceptions. Still, such programs are in the minority, and, furthermore, there are large geographical areas, mostly rural, which do not have any such programs whatsoever. Although some of this group overlap with the "Seniors" classification, it generally comprises approximately 40-50% of the current total population of ORC.

3. Individuals with very unique needs requiring highly specialized programs and services. Some examples of this group include those with communication disorders, blindness, deafness, or specific psychiatric diagnoses such as autism; manic-depressive illness; sexual disorders (such as pedophilia, exhibitionism, fetishism, or aggressive/violent sexual tendencies); severe epileptic disorders; and any number of other specific medical disabilities. Although this group is extremely heterogeneous, its one common feature is the difficulty presented to the community in finding services matched to the individual's unique needs.

This group might comprise approximately 10% of the total population of ORC.

Since ORC's role should be, plainly and simply, to provide residential and program services (including professional clinical services), to all individuals for whom current community program services are not being made available, and **until** such programs are made available elsewhere, there should be a **"dual purpose"** to all its activities:

1. To serve its present and future clientele in the most professionally responsible and efficient way possible, while at the same time
2. To research, develop and encourage community development in, ways to provide these same (or better) quality services in the community in the most responsible and appropriate manner possible.

A number of serious concerns arise in the consideration of the dual purpose role outlined above, at least as it pertains to ORC's performance in the past and present. Most of these concerns can be summarized as follows:

1. ORC does not currently seem to have the ability to describe its population in detail, in practical terms which objectively indicate required services (regardless of location) as well as professionally in terms of treatment issues which would justify the presence of that individual in relatively costly clinical services. This leaves ORC unable to justify the existence of individuals in its services, and unable to direct community services' attention to the provision of these types of services in order to maintain individuals in their home community.

2. Even when such information may be available, the current individual program and service planning process at ORC has the following major flaws: 1) it fails to summarize the salient assessment findings which indicate why the individual must be served in ORC; 2) it fails to appropriately and objectively priorize areas for intervention which would most immediately lead to placement in community programs; 3) it fails to indicate clearly what actions in the sphere of social-environmental change might significantly alter the course of development of the person, or, perhaps more significantly, the quality of life and personal satisfaction experienced by the individual while at ORC (itself a treatment variable); 4) it fails to provide clear, irrefutable guidelines for the provision of services and programs which would, if carried out in another setting (i.e. a community program), most likely result in equivalent success in the appropriate maintenance of that individual; and 5) it fails to provide an appropriate "blueprint" for an appropriate, "better future" for the individual in question. This latter objective, if followed, would provide planning information for management at ORC in order to effect large-scale social change for the benefit of residents.

3. Many professional departments currently seem to be providing services to individuals which may amount to, in large part, stimulation and social-recreational activity. Thus, while receiving speech therapy (or music therapy, occupational therapy, group or individual psychotherapy etc.), an individual may be in fact receiving, from highly trained professionals, a rather disproportionate amount of their "daily dosage" of activation, stimulation, socialization and perhaps recreation. There may be little question as to the benefit and satisfaction that the individual receives from such professional attention. However, it is arguable that more basic social-recreational curriculum activities, (which are available automatically in the community program "package") may be just as influential in the individual's life and development. Thus, the argument that they are "receiving" the above professional services is not equivalent to the argument that they "require" these services. Conservative estimates place the components of such professional services which serve the more basic function of social and recreational activity at approximately 40%. It is impossible to provide more accurate estimates without appropriate individual assessments having been conducted, including environmental analyses contributing to individual problems.

4. There is a large gap between community service philosophy, technology, and ability, and the corresponding qualities of internal services at ORC. In only a few exceptional cases, is there a great degree of understanding of the internal-community "interface". This understanding does not extend upward into ORC management. There is a perception that some community programs and services are developing so rapidly that ORC's current professional community is not capable of understanding them. To these services, ORC's technological base and mode of operating are so "antiquated" that ORC is held almost in contempt. As a result, ORC's professional credibility as a whole (albeit that there are very notable exceptions), is poor, and perhaps can be considered to be failing rapidly. This is primarily an issue of professional/staff development. In particular, there is the impact of various implementation strategies of social role valorization (the current development of the "normalization" principle), emphasizing much more sociological/social-psychological strategies in the development of competencies of developmentally handicapped individuals over the past emphasis on changing individual competencies through behavioural psychology and individualized programming, a highly labour-intensive method. Furthermore, the dual emphasis of social role valorization on "changing the world" as well as "changing the person", is an area of major influence in community services that is almost entirely outside the experience of ORC professionals. In the former strategy, public education, networking, tolerance, and the building of informal social support groups takes a high priority in the delivery of services to developmentally handicapped individuals. Although technically well within the realm of Social Work practice in Community Development and Social Organization, the professional emphasis in clinical social work has been directed toward psychotherapeutic efforts with the individual or the small group, especially at ORC in the past several years.

It is even more important to note that today's climate of fiscal restraint makes such novel efforts all the more attractive, although the effectiveness of such efforts has yet to be objectively shown.

5. There is a perceived inability of ORC management to respond quickly to front-line requests for support for individual residents. This is best illustrated by anecdotal evidence from certain seniors' residences that appropriate shower chairs and toilet chairs are not available for individuals confined temporarily or permanently to wheelchairs. Furthermore, in the same vein, these same residences have no lifts to assist these individuals and others who are mobile into bathtubs which are perhaps 50 years old and are over three feet high on the side. One residence, without having its staff consulted during design stages, has had an elevator installed in its main shower room, leaving a much less appropriate shower room to do "double duty" for 35 male and female residents. Systematically, office space has been allocated in free-standing "cottage" style buildings, in favour of consolidation of residences into "ward" style settings. For the past three years, wholesale resident movement in groups of up to 15 or more people at a time have been done regularly on three of the four administrative units of the Centre. Staff proposals have been systematically ignored. There is certainly widespread belief among front-line staff that resident concerns are the lowest priority of ORC administration. Even among middle management personnel, there would appear to be a sense of helplessness, or a degree of perceived futility or inability to initiate creative action which is designed to provide better resident care, because of institutional "inertia" through the management structure. This is so pervasive that it can be found in every residence and every unit at the Centre. It is possible that this inertia results from the fact that every decision affecting resident care must be acceptable to three levels of supervisory staff for each Residential Unit, and that decisions beyond Unit Level are subject to consideration by three Unit Directors, at least four Department Heads, and two Assistant Administrators. If ORC has prided itself in the past on democratic team decision making, its front-line staff are apparently suggesting that it is like a football team that can't seem to break out of the huddle.

Concerns Regarding Discharges and Depopulation of ORC

ORC has, for the past six years, maintained a relatively strong role in the placement (discharge) of individuals into a variety of programs throughout, but not restricted to, the Southwest Region of Ontario. Its record of placement was particularly strong in the years before the Drea Five Year Plan, where only the Adult Occupational Centre in Edgar was as busy in discharging residents. For the six year period beginning in 1980, the success rate for placements overall has been 96% (defined as individuals placed in any service where the individual had not, as of Dec. 1986, been re-admitted to ORC, even for a short-term stay). Other particulars are shown in Table 2.

Nevertheless, internal placement coordinators who know ORC residents as well as the competency of community programs in many areas, a number of whom have more than fifty placements as a background of experience against which to compare their judgement, and Area Placement Coordinators who are involved within the Area Offices in planning and coordinating placement activities from that perspective, are voicing the following concerns:

1. A large number of agencies are showing low committment to serving the obnoxious, disturbing, non-compliant, occasionally aggressive, emotionally disturbed, elderly or "low functioning" developmentally handicapped individuals who make up the bulk of ORC's current population. This is unevenly distributed in certain Area Office jurisdictions, with a net effect over agencies indicating problems primarily in one area. It is possible that this is due to the overextension of the agencies in this area due to the recent two facility closures. At a minimum, it is not known for sure whether these agencies or their communities have the

required degree of tolerance, or whether they are prepared, clinically (that is, have the client services, staff sophistication, technology for sensitive management of such clients, etc.) for further successful expansion.

2. Agencies by and large are not intending to admit elderly ORC residents to services until they are assured of being able to manage their own aging population. Furthermore, ORC's seniors, having been convinced long ago of the importance of considering ORC their home, are understandably confused by the change in government attitude today and are more resistant to discharge from ORC than any other group. When prepared to risk, ORC's seniors are most likely to specify, indeed insist on placement in the immediate vicinity of Woodstock, this being considered their "home town". Politically, this places undue stress on the London Area Office for planning and funding purposes, especially since many and perhaps most seniors originated from other areas. Under any circumstances, planning for discharge for seniors, restricted to current community services such as Homes for Special Care and Nursing Homes, the availability of age-flexible group home placements in some communities, and the Family Support Home programs in the Southwest Region, is proving much more difficult in practice than the same process for the rest of ORC's population. Nevertheless, ORC's seniors remain the most skilled, capable group, with the least degree of psychopathology or other special needs, and therefore, technically, the group with the least degree of need for the highly controlled institutional environment. The difficulties in placement of this group as illustrated by success rates in placements, is reflected in the data shown in Table 3.

3. Programs offering only the "basic" group home living and ARC Industries (sheltered workshop) day programs are no longer appropriate for most of the individuals seeking discharge from ORC today. More flexible day programs are required by individuals who have not been able to develop strong work skills or work habits. The funding of Community Activity Programs or Life Skills programs has helped in spurring the development of more appropriate day program options, but as with any new concept, some areas are having greater difficulty mounting acceptable quality programs in the short time since they came into existence. As a result, people with quite acceptable daily living skills for residential placement in the community are being delayed from leaving pending the development of appropriate day programs in the community of their choice.

4. Communities are expressing concern over their ability to access professional services for clients with special needs. Facility-based support services are viewed with mixed feelings because of their history of alienation from and lack of accountability to the communities they are supposed to serve. Furthermore, the concerns expressed earlier about the preparedness of professionals in general within ORC to deal with modern concepts of service to the individual with handicaps, leaves occasional doubts as to the competence of such individuals to provide worthwhile, practical recommendations within the context of holistic approaches to service. Having considered this, there remains the lingering problem of having to deal with highly competent generic services unwilling to extend services to individuals with developmental handicaps (still prevalent, but decreasing), and available generic services which are very archaic in their approach to special services, or not well enough trained in the field to modify their generic methods to suit the developmentally handicapped population (very prevalent still, and apparently hardly decreasing). It is still hard to find top-notch professionals who are well-enough versed in special service provisions as required by the developmentally handicapped population, who are willing to provide their services at the level of intensity desired. This is possibly the most significant problem to breach in the long term goal of full community integration.

5. Placement success in some communities and even parts of agencies within those communities is variable and difficult to predict. Reputations for success and strong committment to keeping individuals in the community once discharged, vary tremendously among agencies,

communities, and even whole Area Office jurisdictions. Coordinated planning and efforts by ORC, Area Offices and Community Programs are just beginning, and, especially in some areas, off to a very shaky start. It would appear that some programs are being avoided entirely for any kind of placement, others are informally "on hold" pending a better assessment of their suitability, others are used very selectively for residents with only certain kinds of special need, and others are approached with large numbers of referrals every time there is an advertised vacancy. The most important concern here is that there is no coordination of this activity at the Program Supervisor level (Ministry Area Office), where the highest degree of accountability of agencies, to the Ministry, is found. Some Area Placement Coordinators, a number of ORC Community Service professional staff, and a number of ORC placement officers, have voiced lack of confidence in the ability of some Program Supervisors to address clinical concerns related closely to prevention of admission to ORC. These concerns have not as yet been addressed at the Ministry level.

6. A number of concerns have been voiced by community program staff regarding the poor quality of information with which an individual is discharged to their responsibility from ORC. This may relate to poor assessment practices at ORC at present, as well as a poor case management/IPP system and a generally poor record system at ORC. It may also be a product of a lack of understanding of what might be relevant information for community agencies to have, however. All of these concerns have been voiced for at least the past six years, but there appears to have been little done of note to correct the problems.

7. Planning for expansion or diversion of funds to new styles of community program generally take place in the Area Offices without much coordination with the individuals at ORC most competent to assist. Planning for depopulation of ORC, which should be seen as an integral part of all community program expansion, becomes more important as the residual population of ORC becomes more complex, heterogeneous, and difficult to place or serve. Individuals with direct placement experience and a strong committment to action are rarely, if ever, involved in planning even at the ORC organizational level, notwithstanding the importance of these people's involvement in Area service planning.

The remaining population at ORC, from the preceding six years of discharge activity, has become exceedingly heterogeneous and difficult to categorize in terms of planning for services. Likewise, this "residual population" brings to placement unique problems in matching, preparation, and follow-up. The two biggest "categorical populations" still remaining at ORC, are the "Capable Seniors" and the "Low Life Skills" groups. Both are still prevalent at ORC because they have been passed over for discharge in past years by community services. Of the two groups, the "Low Life Skills" group stands to benefit most from placement, as they are currently being served in large groups and are unable to find intensive attention to their needs in their current settings. The potential benefits from placement far outweigh the potential risks in leaving their current setting. This is not as clear-cut for the "Capable Seniors", who have the ability to exercise choice and are sometimes quite vocal in doing so. For this group, a more cautious approach to development of services, involving the "Capable Senior" him/herself in the planning of any service, is probably warranted. For the residual population of ORC, highly individualized placement planning will be required.

Summary

A new five year plan will not be successful if it considers only a visionary future of ORC as a much smaller residential facility or group of residential services. It must also consider, perhaps first and foremost, (given ORC's track record of the past six years), how such a vision can be achieved from the current state of affairs, and how, in the process, the residual population can be better served while depopulation is occurring. It must also consider corrective measures to be implemented, starting immediately, for dealing with current strategic management problems. It is

assumed that it is because of management problems that the current lingering problems, as exemplified by the many concerns presented in this chapter, have remained so long unresolved. The next section details some objectives which might be considered in beginning to address the problems identified in this paper.

CHAPTER 2

The Future Begins Today

Objectives to Address Concerns at the Initial Point of Referral

Several major task functions seem warranted in order to establish a much clearer and sensitive admissions process at ORC. The main objectives would seem to be:

1. Initiate a much stronger screening process for all admissions. The purpose of this would be to screen out at the community level, all inappropriate referrals for admission prior to their receipt by ORC. This would reduce the amount of decision making required of ORC management.
   Recommended Strategy: All admission requests should come through the Area Placement Coordinator located in the area from which the referral originates. The request should be accompanied by written requests for services from the local case manager serving the individual, as well as recommendations for eventual return to community living from either the case manager or the Area Placement Coordinator. Committment for such a return to the community should perhaps come, in writing, from the local agency, or the Area Office. If Area Offices adopted a strategy similar to the Hard to Serve Process recommended in the Waterloo Area Office's Five Year Plan (Fall 1986 publication), this would probably indicate the future service plan quite well. The request should also include supporting documentation from the local Community Support Team. For all requests from outside the ORC catchment area, ORC should reserve the right to send out a special Community Support Team to evaluate the need for admission and the urgency with which the admission request should be considered. Although this process would be best to remain very flexible in terms of sequence, response time, etc. to provide emergency admissions in crisis situations, the necessary components could still be carried out provided ORC gained support from Regional Office management, in order to hold Area Offices accountable for admissions to ORC.

2. Individuals coming in on short-term admission from "emergency" admission should be kept on the emergency setting only when such a setting is recommended by a comprehensive individual needs assessment. Otherwise, the individual should be placed, within 30 days, on the setting most appropriate to their needs. This will require an ORC management function of "Placement Coordination" with a strong mandate to ensure placement on the recommended setting. The current Admissions Coordinator should serve this function. It will also require an assessment format which is reliable.

3. Problems with emergency admission of an individual at any time should immediately necessitate a case review. The recommendations of the case review should be followed, and the personnel responsible should be held accountable for correction of any such problems.

4. Individuals entering ORC for the "72-hour" emergency relief service should be accompanied by their case manager and the plan for discharge should be agreed upon at admission, before the case manager leaves ORC. The appropriate procedures should be worked out and made available to all admitting residences.

5. A Management Information System should be implemented immediately to monitor admission activity. When a community agency attempts to admit its second client in any two year period, a Clinical Review of the agency's services should be recommended to the Area Office Program Supervisor responsible for the agency.

6. Special task forces should perhaps be struck to look at the problems of:
   1. Providing community living for individuals with chronic, persistent, obnoxious, or disturbing behaviour.
   2. Providing community living for individuals with violent, aggressive, or self-abusive behaviour problems.
   3. Providing community living for individuals with serious health care problems requiring specialized medical attendant care.
   4. Providing community living for individuals with mental illness who are also developmentally handicapped.
   5. Reviewing agency failures or refusals to provide programs for "special-needs" clients of any kind.
   6. Reviewing placement "breakdowns" or failures of any kind.

It should be noted that a Planning for Seniors Committee is already established at ORC, and will be presenting its recommendations within the planning period of 1986-87 fiscal year (to March, 1987).

Objectives to Address Concerns Regarding Services at Oxford Regional Centre

Several objectives relating to the provision of better client services for all individuals while they are residing at ORC seem warranted. The following major task functions would seem to be appropriate:

1. The physical plants and equipment provided currently to the seniors' population at ORC should be reviewed. On the assumption that at least most of the current seniors at ORC will probably remain the primary responsibility of ORC for at least the next five years, it would be appropriate to determine if the current environment is at all capable of serving its population's needs at a minimum level of adequacy. This is not clear at the present time. It would not be appropriate to attempt to serve seniors at ORC if it cannot be done safely or with some degree of quality.

2. Some work needs to be done still in providing smaller settings, especially for individuals with very low Life Skills levels and low intellectual capacity for learning. This group, more than any other group, needs more intensive attention and smaller, more consistently interactive environments in which to develop their competencies. This also relates to the presumed better quality of living in general and more generalizing qualities of smaller settings. This ought to be done, however, in a highly planned manner, without the massive amounts of group movement which has taken place over the last few years. Settings should be designed with future requirements in mind and transfers should be consistent with both individual need and a future plan for the residence as a whole. This is perhaps only possible when the entire population at ORC is identified and planned for. A residential task force might be appropriate for this purpose.

3. Instead of designing accommodation for autistic individuals, sex offenders, individuals with specialized communication needs, individuals with mental illnesses, etc. it would be better advised to design and develop special consultation service units within ORC (or the Community Teams) to provide direct service and mediator-model training services for counsellors, which can attach themselves as required to a variety of settings which provide general care. Individuals living at ORC could then be grouped on more appropriate general characteristics based on lifestyle needs rather than pathology. Thus younger, more active individuals could live together, individuals needing intensive controls could live together, elderly, sedate individuals could live together, but any and all could get highly specialized services without having to move into another (perhaps less generally appropriate) setting. With this, office space requirements on living settings would be

reduced. More services could be delivered to a wider number of individuals, and the problems of negative modelling, pathology-grouping, etc. could be largely eliminated. Perhaps most importantly, gaps in service created by non-relevant variables (space available, criteria for accommodation not related to primary service characteristics etc.) would be minimized.

4. Complete reviewing of the Individual Program Planning system currently in practice seems strongly recommended. The Future Planning format, with inclusion of clinically relevant procedures, would be a good basic model to investigate. The submission of the IPP Revision Subcommittee (1984) should be seriously reviewed as it might relate to current management requirements and modifications to streamline the current planning process would likely be necessary. It should be noted that the Program Standards Committee's role in clinical and service improvement matters should also be reviewed, as it seems this body has been particularly ineffectual over the past six years.

5. When (or if) individual case information from a reliable assessment and IPP can be made available which would allow objective assessment of professional requirements in program or service delivery, a review of professional services and their allocation across the facility should be conducted, with appropriate adjustments made accordingly. It should be noted that, in accordance with such a process, the extension of certain resource services to community programs can be more appropriately planned and delivered. Related to the issue of professional services, more departments should be considering mediator-model service delivery in order to broader client services at ORC (or in the community). Much that is currently done by professionals might be even better (or at least more often and intensively) performed by residential life counsellors with assistance from professional staff. This would, of course, stimulate an argument over the supervision of programs and the accountability of such services to quality control.

6. Review of the current Staff Development operations, the Department's staffing requirements as they relate to the design, implementation and evaluation of a modern curriculum for the future development of a strong, community-living-oriented, clinically adept Residential Life Counsellor and Professional Therapist staff. Particularly important in today's world, to be relevant, would be to develop a strong conceptual base in Social Role Valorization and the application of progressive clinical services within this framework. This would not be to suggest that we neglect the important, ongoing, clinical training that ORC's own professional staff might provide within this overall general framework. However, a number of areas of competence seem to be in need of stronger development: Some examples of such progressive clinical service topic areas might be:
   a. Applied Behaviour Analysis in individual therapy and overall group/program therapies.
   b. Case Management, Client Advocacy, and Service Development.
   c. Neuropsychology, Learning Disabilities and Special Education assessment and applications.
   d. Treatment, Programs and Services for individuals with serious psychopathologies.

   A comprehensive needs analysis with a future, developmental orientation, would be required to round out this general listing. The current "status quo", which seems reactive, rather unimaginative, and alienated from direct services, would seem particularly needful of change.

7. Serious concern must be given to streamlining and making more accountable the decision-making process at ORC at least for matters relating closely to residential care. Developmentally handicapped individuals should not have to wait in an inappropriate setting for the want of a "potty" chair. Decisions should be reviewed as they relate primarily to their impact on individuals least capable of adjusting to or tolerating the conditions created by the changes represented by those decisions. The implementation of a Case Review Committee at management level, to address serious complaints in access to appropriate service, could perhaps be considered. If not this, then the Resident Rights Committee could

be given a higher profile in the management process. From the Organizational Renewal Process (informal reports), it would seem that problems in decision-making may be at least partly the result of too many "middle" managers with poor leadership abilities, such as passivity, submissiveness, or lack of organizational ability (delegating, task-analyzing, priorizing, time management etc.) being more inclined toward avoiding responsibility and conflict, and creating serious "power vacuums" in critical positions where client care is compromised by lack of action rather than imposed action. How this seemed to gradually and systematically pervade ORC's decision-making establishment is not immediately evident, but, if an accurate assessment, would tend to argue for a review of the Personnel Department's strategic hiring and promoting over the past years in order to, first, solve the current problem, and second, avoid this type of problem again in the future. Managerial competencies can perhaps be addressed then, by re-allocation of staff or a strong leadership training campaign.

Objectives to Address Concerns Regarding Discharges and Depopulation of ORC

Some recommendations presented in the first section of this chapter detail some ways in which concerns over depopulation can be addressed (i.e. preventing needless admissions, relieving agencies occasionally in order to prevent "Front-Line Collapse", and creating task forces to study how "Hard-to-Serve" individuals can be accommodated in the community, etc.).

However, the following suggest some further recommendations which might help over time to better achieve the goal of community living for all:

1. More interactive planning with the Area Offices and agencies serving the areas designated for current ORC residents. This should, wherever possible, involve direct-services placement coordinators rather than management staff at ORC, in order that planning be better "client-driven".

2. Service Planning for Seniors should be given high profile as a planning priority for the Ministry of Community and Social Services.

3. More flexible, "special service options" should be planned for community living accommodation and day program services. Cluster apartments designs, flexible staff allocation, Community Support Service delivery systems, and funding based on individuals rather than buildings ought to be given particularly strong consideration at high Ministry levels.

4. Community Support Service teams at ORC should add professional (staff) development competencies to their in-service training programs and expend considerable effort toward the provision of public education activities for the professional "generic" service community in the areas within their purview. In the absence of advocacy authority, these groups should work towards the filling of gaps in service, while simultaneously working to find or develop community resources ("generic" in particular) to provide such services.

5. Better communications with Area Office Program Supervisors, from Management and Professional staff at ORC and Community Support Service teams in the community, to assure continued development of quality programs in the community for "special needs" clients. Reviews of placement breakdowns, admission requests, etc. would help Program Supervisors to identify communities and agencies with particular need for further development of tolerance or competency. This would also enable them to work more closely with planners, boards, administrators and budgets, to make a significant impact on the development of better services in all areas.

6. Better information on discharge of an individual from ORC would follow from a better assessment and IPP system as recommended earlier. Certainly, it would underline the recommendation for a complete review of Client Information Services at ORC.

7. Program designs capable of managing, tolerating, and/or providing high quality services to individuals with very low Life Skills/intellectual capacity for learning, should be be given funding priority for expansion in the next Five Year Plan. Agencies currently providing services to less needy clients can be enriched and the current clients of those services can be advanced, as needs might indicate, to less intensive programs. Generally speaking, there is good evidence that the Low Life Skills group stands to benefit most dramatically from community living of all the current groups at ORC. As such, they should be the primary focus of new Ministry depopulation initiatives.

8. With regard to placement, further research ought to be undertaken to more clearly define the factors which influence successful adjustment to new styles of living. This would seem to be a special function ideally suited to liaison efforts between Social Work at ORC and Community Support Service teams. With this information, further major initiatives can be more sensitively designed and "client-driven" than the past 5-Year Plan, and hopefully result in lower (or at least less traumatic) failure rates.

Summary

A new Five-Year Plan for ORC, no matter how "visionary" it might be, will be particularly successful (and induce no additional cost or, potentially, result in substantial cost savings from currently "wasted" staff time) if it accomplishes little else but the tasks outlined in this paper. This is because there is a workable system somewhere within the morass of bureaucratic bungling and confusion of the last several years. This is not, of course, restricted only to ORC. The Area Offices were sorely tested by the last 5-Year-Plan, and are only now perhaps beginning to recover significantly from the traumatic events surrounding that Plan. If the significant objectives mentioned in this paper are taken on with some degree of coordination and task orientation, the system can indeed reduce ORC's population successfully, probably to a number about one-half or less than the current population of about 500. With exceptional effort by Area Offices, Community Support Service Teams, Internal Social Workers, assuming the problems that were identified here have been addressed, ORC's population can be further reduced. It is possible to envision a facility with less than 200 people, and a regular flow of admissions and discharges of individuals with truly "exceptional" needs through the treatment system that could be operating at a high degree of efficiency by 1990, serving a community which itself is developing to a point where, someday, only correctional services and intensive psychiatric services will require institutional facilities for the accommodation of developmentally handicapped people.