NOTICE AND AGENDA

SOUTH OGDEN CITY PLANNING COMMISSION MEETING

Thursday, September 8, 2016

Notice is hereby given that the South Ogden City Planning Commission will hold a meeting September 8, 2016, beginning at 6:15 p.m. in the Council Chambers located at 3950 Adams Avenue, South Ogden, Utah.

A briefing session will be held at 5:30 pm in the conference room and is open to the public.

I. CALL TO ORDER AND OVERVIEW OF MEETING PROCEDURES - Chairman Raymond Rounds

II. SPECIAL ITEMS

A. Plat Approval to De-Condominiumize Property Located at 5860 Wasatch Drive

III. OTHER BUSINESS

A. Discussion on Amendments to General Plan

B. Presentation By Dan McDonald and Discussion Concerning Amendments to SOC 10-14-16 Having To Do With Residential Facilities For Disabled Persons

IV. APPROVAL OF MINUTES OF PREVIOUS MEETING

A. Approval of August 11, 2016 Briefing Meeting Minutes

B. Approval of August 11, 2016 Meeting Minutes

V. PUBLIC COMMENTS

VI. ADJOURN

Posted and emailed to the State of Utah Public Notice Website September 2, 2016
The undersigned, duly appointed city recorder, does hereby certify that a copy of the above notice and agenda was posted in three public places with the South Ogden City limits on September 2, 2016. These public places being City Hall (1st and 2nd floors), the city website (www.southogdencity.com), and emailed to the Standard-Examiner. Copies were also mailed to each commissioner.

Leesa Kapetanov, City Recorder

In compliance with the Americans with Disabilities Act, individuals needing special accommodations, including auxiliary communicative aids and services during the meeting should notify Leesa Kapetanov at 801-622-2709 at least 48 hours in advance.

FINAL ACTION MAY BE TAKEN ON ANY ITEM ON THIS AGENDA

Planning Commission Report

Subject: **Plat Amendment**
Author: Leesa Kapetanov
Department: Administration
Date: September 8, 2016

Background
The applicant is requesting that a 4-plex previously platted as condominiums, now be un-condominiumized.

Analysis
Since the applicant owns all 4 units in the building, there are no ownership issues in allowing this action. City Attorney Bradshaw advised that the action was not a subdivision amendment, but simply a plat amendment that needed to be approved by the planning commission.
City Engineer Brad Jensen has the plat for review and will advise the applicant if it meets all requirements.

Recommendation
Staff recommends approval.

planning commission **south ogden city**

~~SUBDIVISION~~ AMENDMENT PETITION

PLAT

Designated Contact Person: Jeff Holden

Phone (801) 540-7614 email jeff.holden123@gmail.com

Address PO Box 150467 S. Ogden State Ut Zip 84403

Subdivision Name: Clinton Village Condo Ph. 1 Approx. Address: 5840 Wasatch Dr

Existing Zone R-3 No. of Acres or Sq. Ft. 0.287 S. Ogden ut. 84403

A petition to amend an existing plat requires the name and address of each owner of record of the land contained in the entire plat, as well as their signatures if they consent to the petition (please see form on next page).

This petition must be accompanied by a pdf file of the proposed amended plat. The pdf file can be sent via email to lkapetanov@southogdencity.com. A paper copy of the proposed plat must also be submitted to Brad Jensen at Wasatch Civil Engineering, 5434 S. Freeway Park Drive, Riverdale UT 84405 (801-775-9191). Other information, as determined by staff, may be required.

All required documents must be submitted and the fee paid at least 20 days before the planning commission meeting at which you would like your item considered. The Planning Commission meets the second Thursday of every month.

Fee – Subdivision Amendment - $75

OFFICE USE

Request for Recommendation sent to the following by copy and return of this form:

City Engineer -	Date_____	Received back - Date _____
Fire Dept. -	_____	_____
Public Works -	_____	_____
Other -	_____	_____

RECOMMENDATION: (INCLUDE ATTACHMENT)

_____

_____

_____

PLANNING COMMISSION ACTION:

APPROVED _____ DENIED _____ Date _____

Applicant notified - Date _____

APPLICANT'S AFFIDAVIT

State of Utah
County of Weber

I (we) Jeffrey S. Holden, being duly sworn, depose and say I (we) am (are) the sole
Property Owner(s) or Agent of Owner
owner(s)/agent of the owner(s), of the property involved in this application, to-wit,
5840 Wasatch Drive Ogden UT 84403 and that the statements and answers contained herein, in
Property Address
the attached plans and other exhibits, thoroughly and to the best of my ability, present the argument in behalf of the application. Also, all statements and information are in all respects true and correct, to the best of my knowledge and belief.

Dated this 02 day of August, 2016.

Signed: _____ _____
Property Owner or Agent — Property Owner or Agent

Subscribed and Sworn before me this 2nd day of August, 2016.

Notary Public: _____

LEESA KAPETANOV
Notary Public • State of Utah
Commission # 672829
COMM. EXP. 12-22-2017
Notary Stamp

AGENT AUTHORIZATION

State of _____
County of _____

I (we) _____, the sole owner(s) of the real property located
Property Owner(s)
at _____, South Ogden, Utah do hereby appoint
Property Address
_____, as my (our) agent to represent me (us) with regard to this application affecting the above described real property, and to appear on my (our) behalf before any city boards considering this application.

Dated this _____ day of _____, _____

Signed: _____ _____
Property Owner — Property Owner

Subscribed and Sworn before me this _____ day of _____, _____.

Notary Public: _____

Notary Stamp

Uintah Village Subdivision - 2nd Amendment

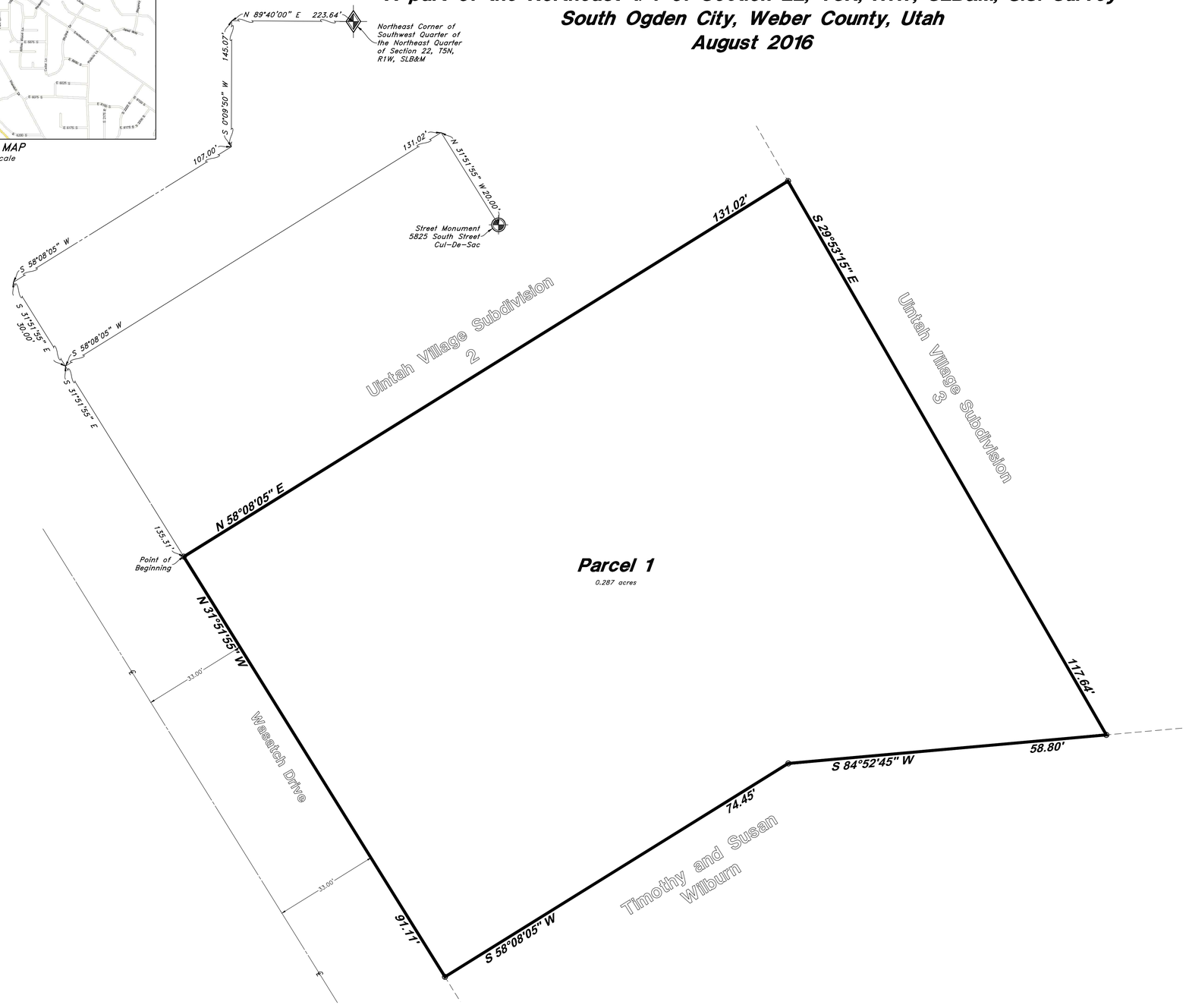
All of Lot 1, Uintah Village Subdivision

A part of the Northeast 1/4 of Section 22, T5N, R1W, SLB&M, U.S. Survey

South Ogden City, Weber County, Utah

August 2016

VICINITY MAP
Not to Scale



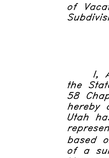
LEGEND

- Set Nail & Washer
- Set Hub & Tack
- Monument to be set
- Existing Fence Line
- Found Rebar & Cap
- (Rad.) Radial Line
- (N/R) Non-Radial Line
- Meas. Measured Distances
- Zone Boundary Line
- Residential Building Set Back
- Flood Zone Area
- Set Rebar & Cap

Scale: 1" = 10'

10 0 5 10 15 20

Graphic Scale



CAP DETAIL

A 5/8"# rebar 24" long with plastic cap (see detail above) was set at all property corners as shown.

DESCRIPTION

All of Lot 1, Uintah Village Subdivision South Ogden City, Weber County, Utah According to the official Plat thereof. Being a part of the Northeast Quarter of Section 22, T5N, R1W, SBL&M, U.S. Survey, South Ogden City, Weber County, Utah.

Beginning at the Southwest corner of Lot 2, said Uintah Village Subdivision being 223.64 feet South 89°40'00" East along the North line of Lot 5 and 6 said Uintah Village Subdivision, 146.07 feet South 0°09'50" West along the West line of said Lot 6 to the North line of 5825 South Street, 107.00 feet South 58°08'05" West along said North line to the Easterly line of Wasatch Drive, and 165.31 feet South 31°51'55" East along said Easterly line, being the Westerly line of said Lot 2, to the Southwest corner thereof, and running thence North 58°08'05" East 131.02 along the Southerly line of said Lot 2 to the Westerly line of Lot 3 said Uintah Village Subdivision; thence South 29°53'15" East 117.64 along said Westerly line; thence South 84°52'45" West 58.80 feet; thence South 58°08'05" West 74.45 feet to said Easterly line of Wasatch Drive; thence North 31°51'55" West 91.11 feet along said Easterly line to the point of beginning.

Contains: 0.287 acres

OWNER'S DEDICATION

We, the undersigned owners of the hereon described tract of land, hereby set apart and subdivide the same into lots and streets as shown on this plat, and name said tract Uintah Village Subdivision-2nd Amendment, and do hereby dedicate, grant and convey to South Ogden City, Weber County, Utah, all those parts or portions of said tract of land designated as streets, the same to be used as public thoroughfares forever, and also dedicate to South Ogden City those certain strips as easements for public utility and drainage purposes as shown hereon, the same to be used for the installation, maintenance and operation of public utility service lines and drainage, as may be authorized by Weber County.

Signed this day of , 2016.

Signature: _____

ACKNOWLEDGMENT

State of Utah
County of } ss

On the day of , 20__, personally appeared before me, the undersigned Notary Public, the signers of the Owner's Dedication, two, in number, who duly acknowledged to me they signed it freely and voluntarily and for the purposes therein mentioned.

Residing At:_____ _____
A Notary Public commissioned in Utah

Commission Expires:_____ _____
Print Name

NARRATIVE

This Subdivision plat was requested by Mr. Jeff Holden, for the purpose of Vacating Uintah Village Condominiums Phase 1 and Amending Uintah Village Subdivision, creating a single Residential Lot.

SURVEYOR'S CERTIFICATE

I, Andy Hubbard, do hereby certify that I am a Professional Land Surveyor in the State of Utah, and that I hold Certificate No. 9239283 in accordance with Title 58 Chapter 22, Professional Engineers and Land Surveyors Licensing Act. I also do hereby certify that Uintah Village Subdivision – 2nd Amendment in Weber County, Utah has been correctly drawn to the designated scale and is a true and correct representation of the following description of lands included in said subdivision, based on data compiled from records in the Morgan County Recorder's Office, and of a survey made on the ground in accordance with Section 17-23-17. Monumented Lot corners have been set as shown on this drawing.

I also certify that all the lots within Winchester Property meet the frontage and area requirements of the Morgan County Zoning Ordinance.

Signed this day of , 2016.

6242920 _____
License No. Andy Hubbard

ENGINEER:
Great Basin Engineering
c/o Jason T. Felt
JasonF@greatbasineng.com
5746 South 1475 East Suite 200
Ogden, Utah 84405
(801) 394-4515

DEVELOPER:
Jeff Holden
P.O. Box, 50467
Ogden, Ut 84415
(801) 540-7614

SOUTH OGDEN CITY ATTORNEY

Waste Disposal System Approval
this day of , 2016.

_____
Signature

CITY ENGINEER

I hereby certify that the requirements of all applicable statues and ordinances prerequisite to City Engineer approval of the foregoing Plat and Dedications have been complied with,
Signed this day of , 2016.

_____
City Engineer

SOUTH OGDEN CITY PLANNING COMMISSION APPROVAL

This is to certify that this Subdivision Plat was duly approved by the South Ogden City Planning Commission on,
this day of , 2016.

_____
Chairman, South Ogden City Planning Commission

SOUTH OGDEN CITY PLANNING COMMISSION APPROVAL

This is to certify that this Subdivision Plat was duly approved by the South Ogden City Planning Commission on,
this day of , 2016.

_____
Chairman, South Ogden City Planning Commission

SOUTH OGDEN CITY COUNCIL APPROVAL

This is to certify that this Subdivision Plat was duly approved by the South Ogden City Council on,
this day of , 2016.

_____
South Ogden City Recorder

_____
South Ogden City Mayor

WEBER COUNTY RECORDER

ENTRY NO._____ FEE PAID___
_____FILED FOR RECORD AND RECORDED_____, AT _____IN BOOK_____ OF OFFICIAL RECORDS, PAGE_____. RECORDED FOR_____

_____
WEBER COUNTY RECORDER

BY:_____
DEPUTY

16N715-Plat

Planning Commission Report

Subject: **Progress Report**
Proposed Amendments to the General Plan
Land Use Chapter and Land Use Map

Author: Mark Vlasic

Department: Planning & Zoning

Date: September 8, 2016

Background

South Ogden adopted a General Plan in 1997, which primarily focused on Land Use/Transportation/Parks and Recreation. Updates to the plan were prepared in 2001 and 2008, which focused primarily on housing, livability, parks and recreation, urban design and the formation of a city center. While each of these updates incorporated substantial land use changes, the Land Use Chapter and Land Use Map were not updated.

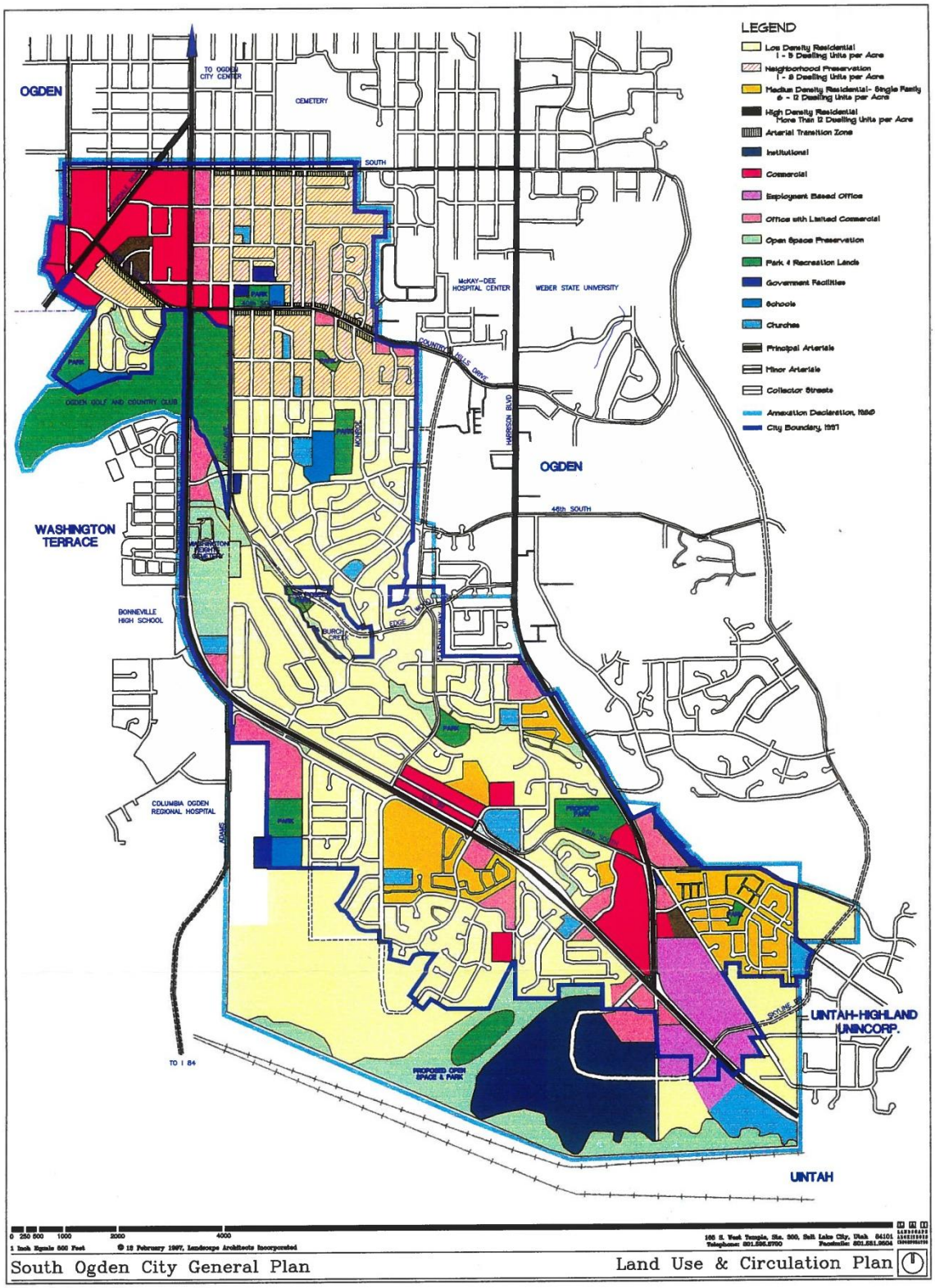
Nearly two decades have passed since the 1997 plan was adopted, and the city is approaching buildout, in large part matching the vision and direction expressed in the 1997 Plan. However, the existing plan and map do not reflect the land use visions expressed in the two updates, resulting in confusion and difficulty in determining which of the three plans should apply.

In order to resolve this confusion and to present a clear message to the public, staff recently began a review of the three plans, with the intent of creating a new Land Use Chapter and Land Use Map that reflects the cumulative land use vision of the three plans. This process focuses on the changes contained in the 2008 update, and assumes that land use ideas reflected in that plan supersede any conflicting direction contained in the 1997 plan and 2001 update. It is also important that the new Land Use Chapter and Land Use Map update specific changes that have been implemented during the last 19 years.

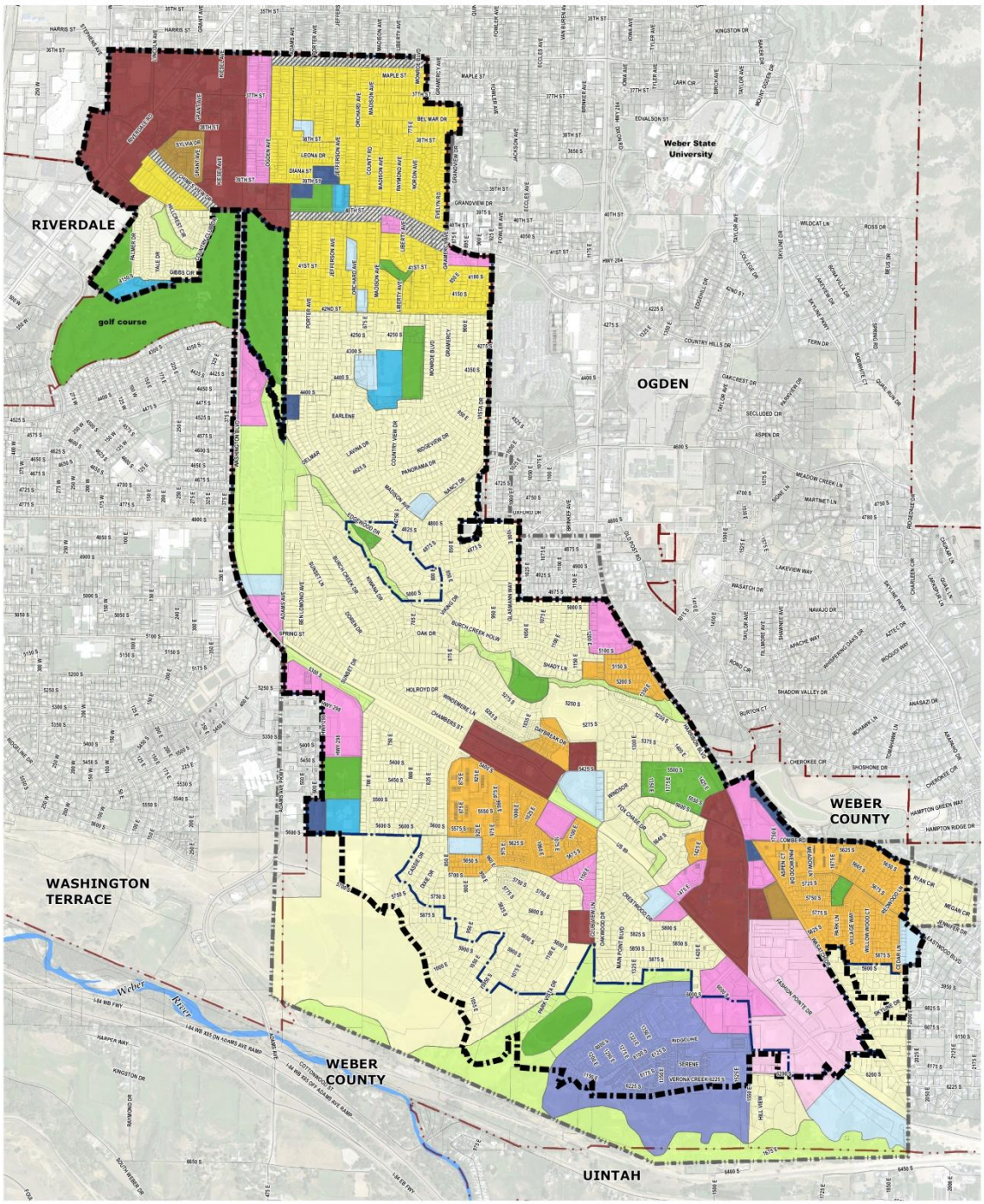
The final deliverable of this process will be a revised Land Use Chapter and Land Use Map, which should adopted as an update to the 1997 Plan Land Use Chapter.

Review and Analysis

The *1997 Land Use and Circulation Plan* is illustrated in Map 1. In order to compare this map with the 2008 update, the original map has been converted into a digital GIS format (see Map 2). Map 3 is the Existing Land Use Map that was contained in the 2008 General Plan, reformatted and updated to reflect existing uses through 2014. Map 2 and Map 3 have been compared and analyzed, with 48 inconsistencies/conflicts indicated, as illustrated in Map 4. Most of the differences are site-specific, reflecting the difference between the vision contained


LEGEND
Low Density Residential
1 - 3 Dwelling Units per Acre
Neighborhood Preservation
1 - 3 Dwelling Units per Acre
Medium Density Residential- Single Family
6 - 12 Dwelling Units per Acre
High Density Residential
More Than 12 Dwelling Units per Acre
Arterial Transition Zone
Institutional
Commercial
Employment Based Office
Office with Limited Commercial
Open Space Preservation
Park & Recreation Lands
Government Facilities
Schools
Churches
Principal Arterials
Minor Arterials
Collector Streets
Annexation Declaration, 1959
City Boundary, 1997
OGDEN
TO OGDEN CITY CENTER
CEMETERY
SOUTH
McKAY-DEE HOSPITAL CENTER
WEBER STATE UNIVERSITY
COUNTRY HILLS DRIVE
HARRISON BLVD
OGDEN GOLF AND COUNTRY CLUB
PARK
WASHINGTON TERRACE
46th SOUTH
BONNEVILLE HIGH SCHOOL
BURCH CREEK
EDGE
COLUMBIA OGDEN REGIONAL HOSPITAL
ADAMS
UINTAH-HIGHLAND UNINCORP.
TO I 84
PROPOSED OPEN SPACE & PARK
UINTAH
0 250 500 1000 2000 4000
1 Inch Equals 500 Feet
© 12 February 1997, Landscape Architects Incorporated
South Ogden City General Plan
Land Use & Circulation Plan

MAP 1



LEGEND

- South Ogden City Boundary
- Annexation Boundary
- 1997 City Boundary
- Municipality Boundary
- Low Density Residential (1- 5 Dwelling Units per Acre)
- Neighborhood Preservation (1- 8 Dwelling Units per Acre)
- Medium Density Residential - Single Family (6-12 Dwelling Units per Acre)
- High Density Residential (More than 12 Dwelling Units per Acre)
- Institutional
- Arterial Transition Zone
- Commercial
- Office with Limited Commercial
- Employment Based Office
- Open Space Preservation
- Park & Recreation Lands
- Government Facilities
- Schools
- Churches

1997 GENERAL PLAN
(Updated GIS Version-2014)

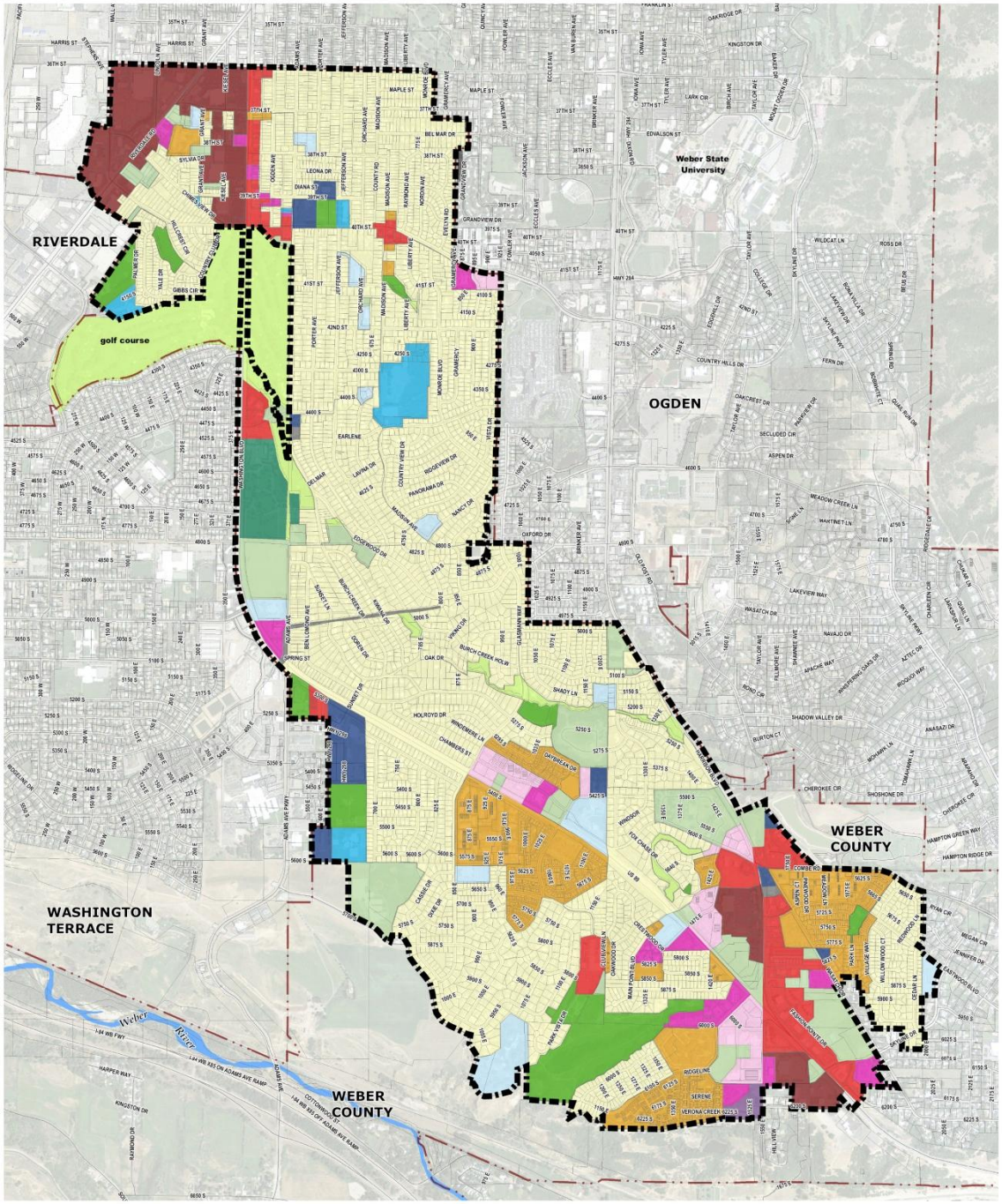
June 2014

South Ogden General Plan Map Analysis

0 0.125 0.25 0.5 Miles

LANDMARK DESIGN

MAP 2



LEGEND

- South Ogden City Boundary
- Single Family Residential
- Multiple Family Residential
- Regional Commercial
- Neighborhood Commercial
- Office
- Medical Office
- Public
- School
- Religious
- Vacant/Private Open Space
- Open Space/Golf Course
- Parks
- Cemetary
- Light Industrial
- Utilities

2008 LAND USE
(Updated GIS Version-2014)

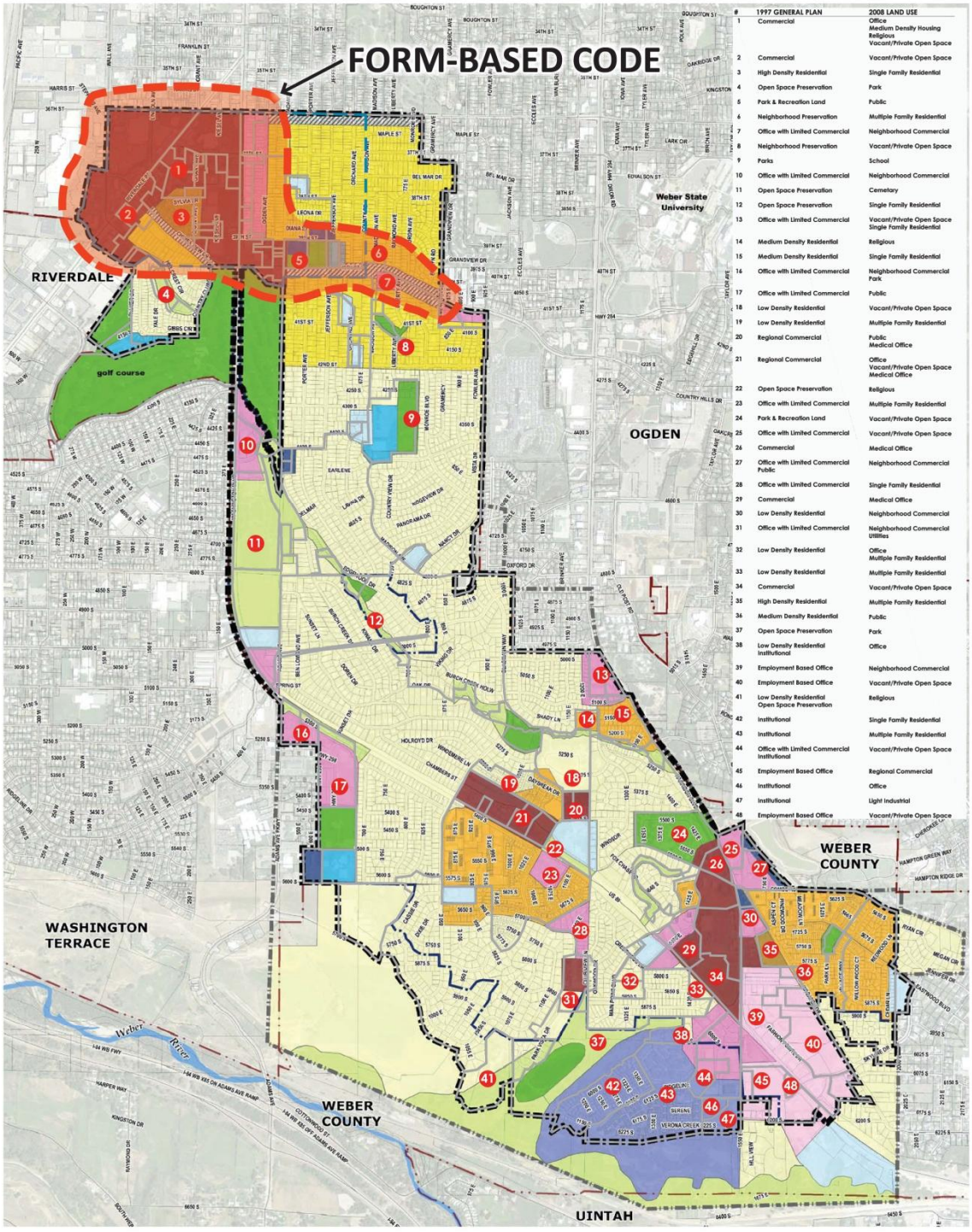
June 2014

South Ogden General Plan
Map Analysis

Miles 0 0.125 0.25 0.5

LANDMARK DESIGN

MAP 3



#	1997 GENERAL PLAN	2008 LAND USE
1	Commercial	Office Medium Density Housing Religious Vacant/Private Open Space
2	Commercial	Vacant/Private Open Space
3	High Density Residential	Single Family Residential
4	Open Space Preservation	Park
5	Park & Recreation Land	Public
6	Neighborhood Preservation	Multiple Family Residential
7	Office with Limited Commercial	Neighborhood Commercial
8	Neighborhood Preservation	Vacant/Private Open Space
9	Parks	School
10	Office with Limited Commercial	Neighborhood Commercial
11	Open Space Preservation	Cemetary
12	Open Space Preservation	Single Family Residential
13	Office with Limited Commercial	Vacant/Private Open Space Single Family Residential
14	Medium Density Residential	Religious
15	Medium Density Residential	Single Family Residential
16	Office with Limited Commercial	Neighborhood Commercial Park
17	Office with Limited Commercial	Public
18	Low Density Residential	Vacant/Private Open Space
19	Low Density Residential	Multiple Family Residential
20	Regional Commercial	Public Medical Office
21	Regional Commercial	Office Vacant/Private Open Space Medical Office
22	Open Space Preservation	Religious
23	Office with Limited Commercial	Multiple Family Residential
24	Park & Recreation Land	Vacant/Private Open Space
25	Office with Limited Commercial	Vacant/Private Open Space
26	Commercial	Medical Office
27	Office with Limited Commercial Public	Neighborhood Commercial
28	Office with Limited Commercial	Single Family Residential
29	Commercial	Medical Office
30	Low Density Residential	Neighborhood Commercial
31	Office with Limited Commercial	Neighborhood Commercial Utilities
32	Low Density Residential	Office Multiple Family Residential
33	Low Density Residential	Multiple Family Residential
34	Commercial	Vacant/Private Open Space
35	High Density Residential	Multiple Family Residential
36	Medium Density Residential	Public
37	Open Space Preservation	Park
38	Low Density Residential Institutional	Office
39	Employment Based Office	Neighborhood Commercial
40	Employment Based Office	Vacant/Private Open Space
41	Low Density Residential Open Space Preservation	Religious
42	Institutional	Single Family Residential
43	Institutional	Multiple Family Residential
44	Office with Limited Commercial Institutional	Vacant/Private Open Space
45	Employment Based Office	Regional Commercial
46	Institutional	Office
47	Institutional	Light Industrial
48	Employment Based Office	Vacant/Private Open Space

LEGEND

- South Ogden City Boundary
- 1997 City Boundary
- 1997 Annexation Boundary
- Municipality Boundary
- 2008 Land Use
- Downtown Redevelopment
- Low Density Residential (1- 5 Dwelling Units per Acre)
- Neighborhood Preservation (1- 8 Dwelling Units per Acre)
- Medium Density Residential (6-12 Dwelling Units per Acre)
- High Density Residential (More than 12 Dwelling Units per Acre)
- Institutional
- Commercial
- Office with Limited Commercial
- Employment Based Office
- Open Space Preservation
- Park & Recreation Lands
- Government Facilities
- Schools
- Churches
- Arterial Transition Zone

June 2014

South Ogden General Plan Map Analysis

0 0.125 0.25 0.5 Miles

LANDMARK DESIGN

MAP 4

in the 1997 General Plan and the reality as developed. Updating the plan and map for these will be relatively straight-forward.

Updated Land Use Map (2016)

The following map represents the draft updated Land Use Map (2016). In addition to updating the map with a new *City Center* and *40th Street* Transition designation, it also includes the following changes:

- Incorporation of the City Center and 40th Street Corridor ideas;
- Elimination of the Arterial Transition Zone;
- Elimination of the Industrial classification; and
- Elimination of the institutional classification;

In addition, the map has been modified to address existing uses that have developed in contrast to the general plan

Draft Land Use Chapter and Map

The following draft text and map were presented to the Planning Commission During the August 2016 regular meeting. The Planning Commission requested that the map and text be modified slightly, to represent more accurately the status of parks and cemeteries in the City. These changes have since been completed.

Staff believes that this update provides a clear and consistent land use vision for the city that incorporates the three general plan documents that have been prepared since 1997. As such, it will be an invaluable tool for city staff and decision makers, citizens, land owners and potential developers/investors.

The following draft text and map are submitted to the Planning Commission for their consideration.

DRAFT LAND USE CHAPTER AND OFFICIAL MAP UPDATE – 2016

The South Ogden City General Plan encompasses approximately 2,500 acres of land. It is bounded on the north and east by Ogden City, on the west by Washington Terrace and on the south by a steep bluff of land located in unincorporated Weber County. The city boundaries include all lands within the city's Annexation Declaration boundary, which are currently under Weber County jurisdiction. Less than 5% of the total land area is vacant or undeveloped.

As a city approaching build-out, future development opportunities are limited to redevelopment and small undeveloped parcels. It is critical that future development should be carefully implemented in order to match the land use vision for the future community.

Land Use Plan and Categories

This Land Use Plan and Map illustrate the type and location of existing development as well as future development and redevelopment envisioned for the future. The purpose of each land use category, as well as the general standards for development are described below. These uses, where possible, reflect the currently established patterns and designations, as well as future changes envisioned as part of long-term redevelopment efforts.

Nine land use categories are indicated, each depicting the specific land use types and patterns that are encouraged in a particular area. Each category describes the allowable uses and densities supported, as follow. In addition, public utilities are also addressed as related to land use needs and implicartions.

<u>Low Density Residential/ Residential Preservation (1-8 units per acre)</u>

This is the primary land use category in the city, reflecting the fact that the city was originally established as a residential community with limited commercial uses. Low Density Residential uses are predominantly single-family detached homes, with limited areas for duplexes. This land use type should also allow necessary public and quasi-public uses such as public schools, places of worship, government uses, parks and open space. However, the main intent for these areas is to preserve the overall residential character of the established neighborhoods.

<u>Medium to High Density Residential (6 to 12 units per acre and higher)</u>

This category supports detached and attached homes and multi-family units, as well as appropriate and necessary public and quasi-public uses such as public schools, religious institutions, government uses, parks and open space. Densities typically range from six to twelve units per acre, although developments up to 50 units per acre as well as low-density offices and similar commercial operations may also be allowed as transitions to adjacent commercial areas.

All higher density uses should be developed in a manner that provide a buffers to adjacent and nearby lower density uses and neighborhoods, and against adjacent and nearby commercial and office uses.

<u>City Center</u>

The majority of future change and development in South Ogden is likely to occur in this area as part of concerted redevelopment efforts. As regional transitions and changes take place and grow pressures

within the City and in adjacent and neighboring municipalities, this area has been identified as the location for mixed-use development profile and the emergence of the South Ogden City Center.

The City Center area has been identified as priority redevelopment area, where a commercial and residential core will be developed over time. In addition to providing a range of residential, commercial and mixed uses, the area should be redeveloped in a manner that ensures residents are proud of their city, and that visitors want to stop and visit this destination as they pass through the community. Accordingly, the east and west sides of Washington Boulevard between 36th and 42nd Streets should be developed into a discernable and attractive downtown for South Ogden, which will also encourage a major transformation of Washington Boulevard into an urban corridor that establishes the sense of downtown to motorists and passersby. As such, the City Center should become a distinct place and the "heart of the community, where residents of South Ogden can gather for community events, and which can be carefully integrated with existing residential neighborhoods.

The City Center should encourage existing residents to remain downtown and new residents to locate in the area as part of new, mixed use development. New uses should be transitional, honoring the scale and feel of the surrounding residential blocks. It should also encourage creative development and mixed-residential development, where people can gather for community events and activities. Finally, the City Center should be unified and consistent, clearly designating and signifying routes which connect residents to other neighborhoods and important places within the city and adjacent to it.

Arterial Transition Corridor

This district allows transition from existing low-to-medium density residential uses along and near 40th Street to appropriately-scaled higher density residential uses, commercial, office and mixed uses which are better aligned for locations along aa major street corridor. The intent is to allow and encourage a range of appropriate uses and to discourage uses and patterns that foster strip development and which rely on high volumes of auto traffic. Ultimately, the corridor should become an extension of the City Center, providing distinct places and activities that are people-oriented.

Commercial Campus

These areas are earmarked for well-designed, master-planned, campus-type commercial developments that will contribute to the establishment of employment in the city. Envisioned uses include research and development, and office parks. Primary uses should be centered in these areas and along primary streets, with transitional office, higher density residential and similar uses located along the edges with residential uses.

Neighborhood Commercial/Office

These areas are primarily intended for general office, medical and similar office-type uses. These uses are intended in part to act as a transition between adjacent residential uses and US-89, and are relatively small in area to prevent commercial sprawl along the primary street corridors.

Public

These areas encompass key public office and similar uses, including City Hall, police and fire operations, public utility sites, military uses, and similar uses comparable uses.

Parks/Open Space

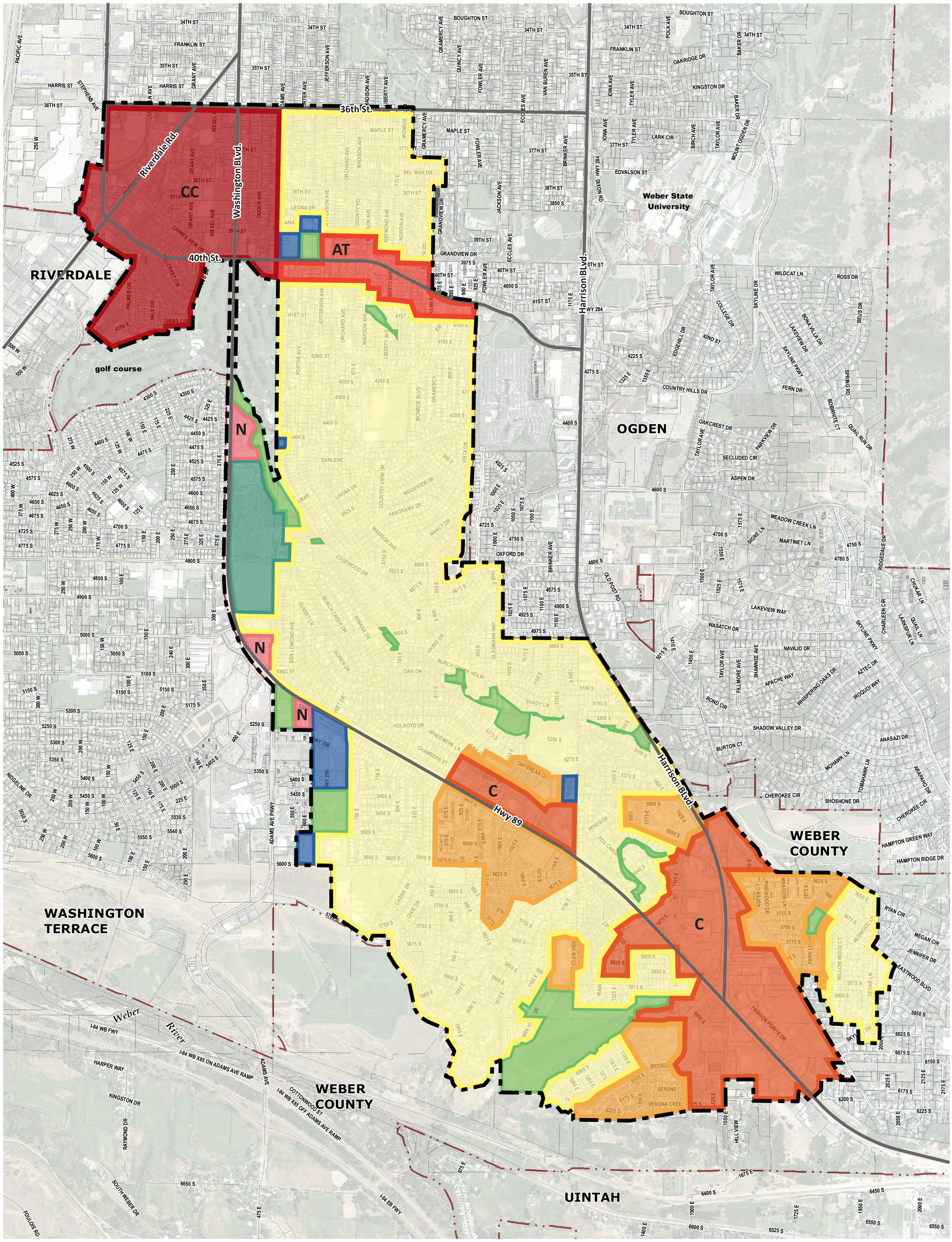
This category includes public parks and open spaces devoted to natural, scenic, wildlife resource and recreational uses. Park land is generally developed and maintained to accommodate sports and similar uses, while open space sites include wetlands, waterways, steep slopes ravines and similar natural features. This category also encompasses the Ogden Golf and Country Club, which is partially located in South Ogden and partially in Weber County.

Cemetery

This category includes a single private cemetery and adjacent vacant land earmarked for future expansion of the cemetery. It is assumed that this use will be maintained in perpetuity.

Utilities

Critical public infrastructure includes public utility substations, water reservoir tanks, canals, overhead power lines and similar uses. Such facilities should be sited where necessary, assuming that special review and effort is undertaken to ensure such uses fit in with the surrounding areas they are located.



LEGEND

- South Ogden City Boundary
- Single Family Residential
- Multiple Family Residential
- CC — City Center
- AT — Arterial Transition Corridor
- C — Commercial Campus
- N — Neighborhood Commercial/ Office
- Public
- Parks/ Open Space
- Cemetery

South Ogden City
REVISED LAND USE

0 0.125 0.25 0.5 Miles

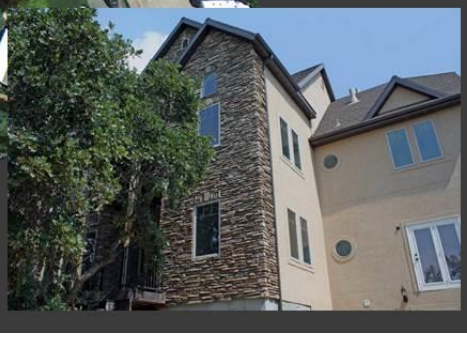
LANDMARK DESIGN

Group Homes & the Fair Housing Act:

POLICY CONSIDERATIONS, OBSERVATIONS AND RECOMMENDATIONS – SOUTH OGDEN CITY

What is happening out there?

(Alpine City – 18 residents requested)

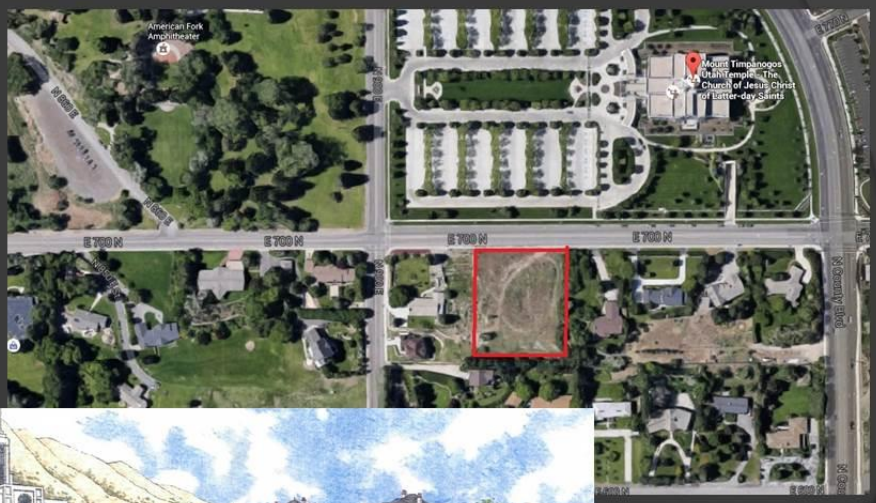


Developers are proposing large group homes and residential treatment facilities ("RTFs") in residential neighborhoods

Using the federal Fair Housing Act ("FHA"), they ask for accommodations from local zoning ordinances

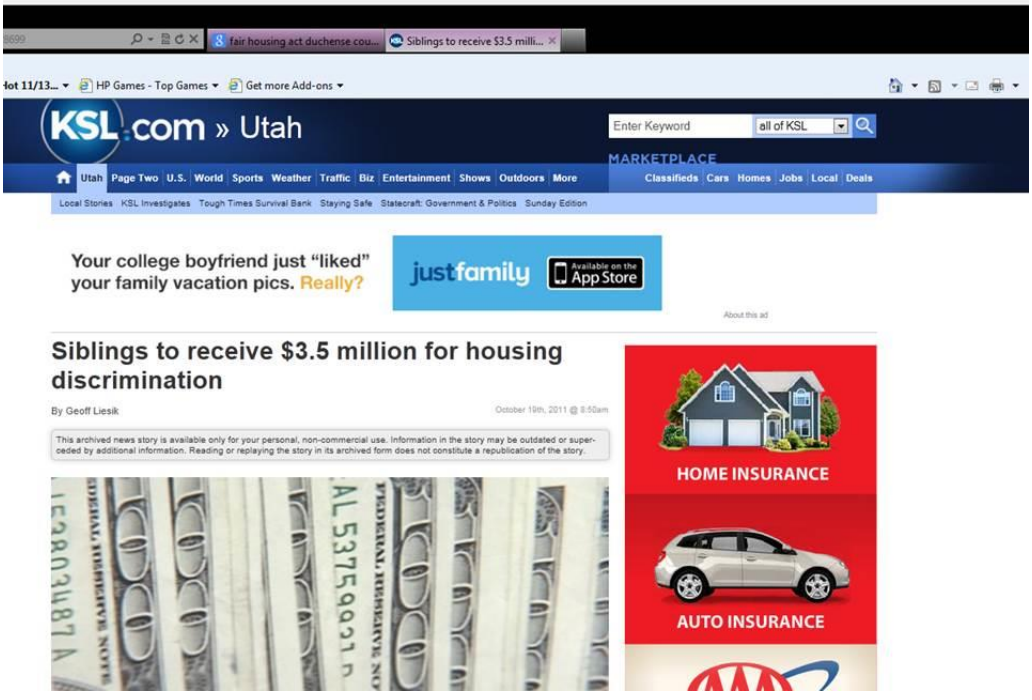
(Mapleton – 16 residents)

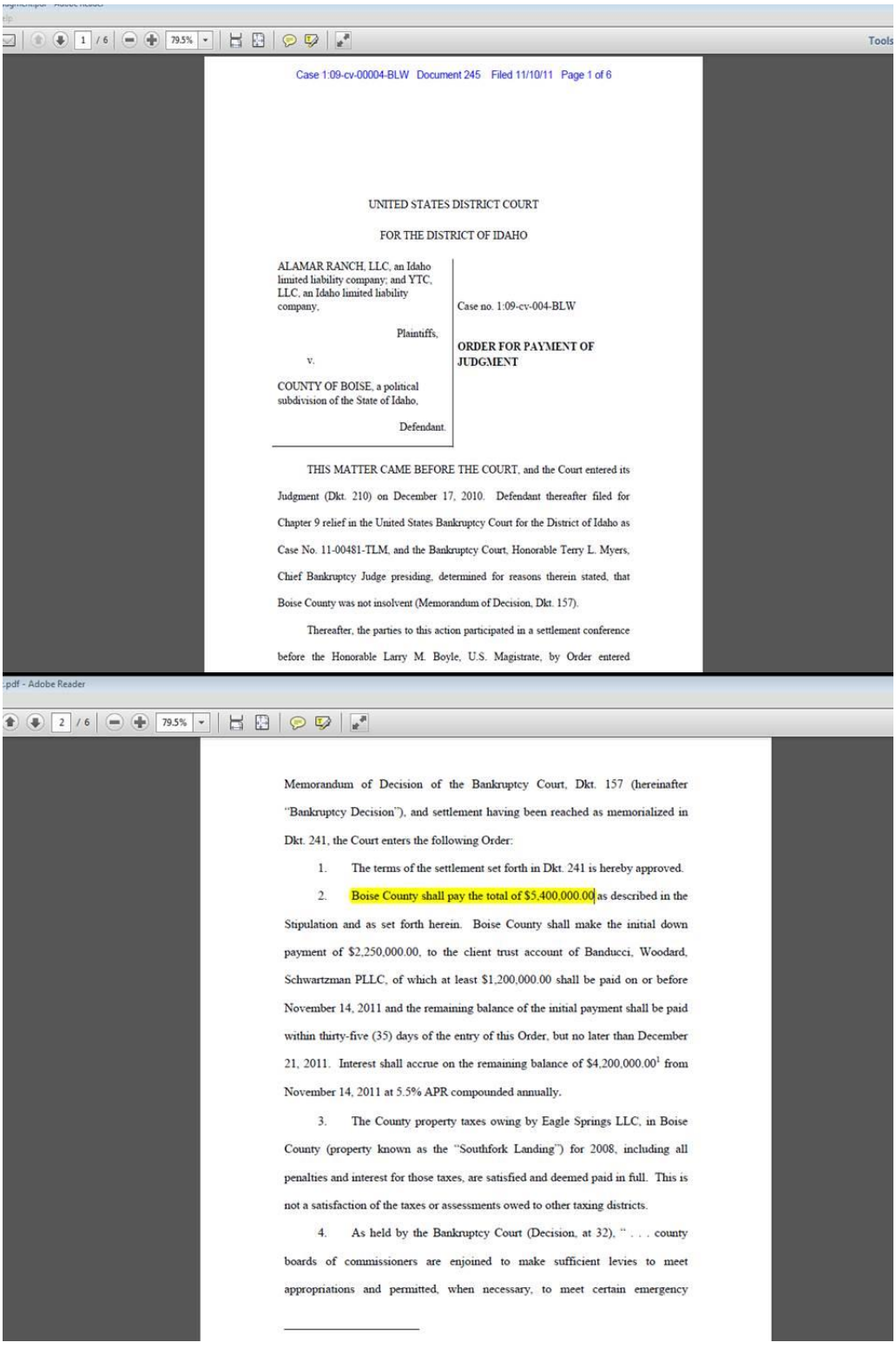
(American Fork – 34+ residents)




What is the typical request for accommodation?
Relief from the definition of "family," which typically limits the number of non-related people that may live together in a single household (usually to 4-8 unrelated residents)
Relief from the 8-person "built-in" accommodation/limitation for RTFs
What motivates group home and RTF operators?
Higher densities mean higher profits
Large damages awards under the FHA

They often sue for damages under the FHA when they don't get their way





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UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ALAMAR RANCH, LLC, an Idaho limited liability company; and YTC, LLC, an Idaho limited liability company,

Plaintiffs,

v.

COUNTY OF BOISE, a political subdivision of the State of Idaho,

Defendant.

Case no. 1:09-cv-004-BLW

ORDER FOR PAYMENT OF JUDGMENT

THIS MATTER CAME BEFORE THE COURT, and the Court entered its Judgment (Dkt. 210) on December 17, 2010. Defendant thereafter filed for Chapter 9 relief in the United States Bankruptcy Court for the District of Idaho as Case No. 11-00481-TLM, and the Bankruptcy Court, Honorable Terry L. Myers, Chief Bankruptcy Judge presiding, determined for reasons therein stated, that Boise County was not insolvent (Memorandum of Decision, Dkt. 157).

Thereafter, the parties to this action participated in a settlement conference before the Honorable Larry M. Boyle, U.S. Magistrate, by Order entered

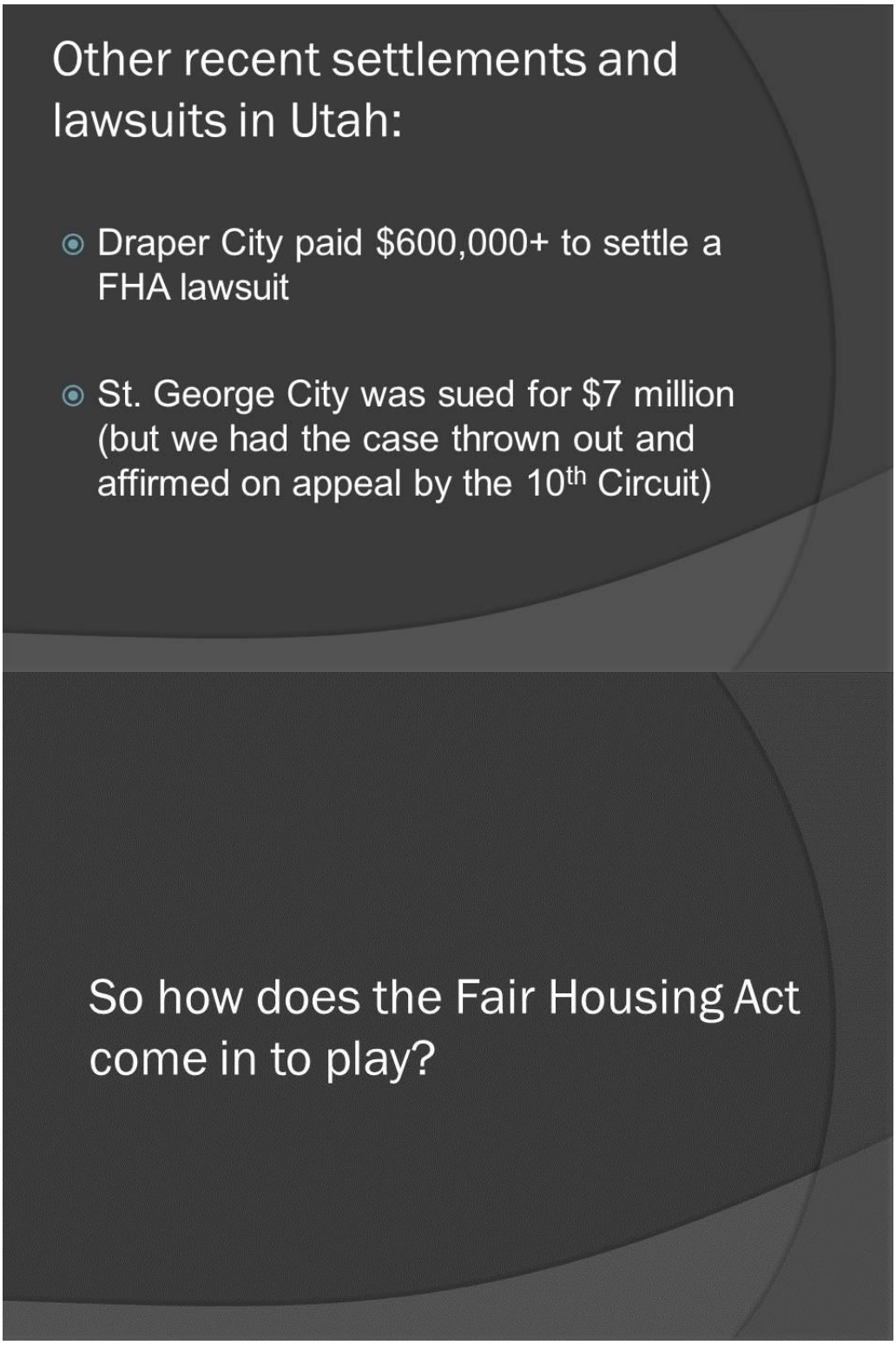
Memorandum of Decision of the Bankruptcy Court, Dkt. 157 (hereinafter "Bankruptcy Decision"), and settlement having been reached as memorialized in Dkt. 241, the Court enters the following Order:

1. The terms of the settlement set forth in Dkt. 241 is hereby approved.

2. Boise County shall pay the total of $5,400,000.00 as described in the Stipulation and as set forth herein. Boise County shall make the initial down payment of $2,250,000.00, to the client trust account of Banducci, Woodard, Schwartzman PLLC, of which at least $1,200,000.00 shall be paid on or before November 14, 2011 and the remaining balance of the initial payment shall be paid within thirty-five (35) days of the entry of this Order, but no later than December 21, 2011. Interest shall accrue on the remaining balance of $4,200,000.00[1] from November 14, 2011 at 5.5% APR compounded annually.

3. The County property taxes owing by Eagle Springs LLC, in Boise County (property known as the "Southfork Landing") for 2008, including all penalties and interest for those taxes, are satisfied and deemed paid in full. This is not a satisfaction of the taxes or assessments owed to other taxing districts.

4. As held by the Bankruptcy Court (Decision, at 32), " . . . county boards of commissioners are enjoined to make sufficient levies to meet appropriations and permitted, when necessary, to meet certain emergency


Other recent settlements and lawsuits in Utah:
Draper City paid $600,000+ to settle a FHA lawsuit
St. George City was sued for $7 million (but we had the case thrown out and affirmed on appeal by the 10th Circuit)
So how does the Fair Housing Act come in to play?

The FHA prohibits discrimination against persons with handicaps and provides that discrimination includes "a refusal to make reasonable accommodations … when such accommodations may be necessary to afford such person equal opportunity to use and enjoy a dwelling."

42 U.S.C.A. § 3604(f)(3)(B)

"[T]he thrust of a reasonable accommodation claim is that a defendant must make an affirmative change in an otherwise valid law or policy."

Bangerter v. Orem City Corp., 46 F.3d 1491, 1501-02 (10th Cir. 1995).

Group Therapy

Group home operators claim that waiver of the restrictions on the number of non-related people that may live together are necessary to facilitate group therapy, which requires groups of no less than 6-8, preferably separated by gender or some other common trait.

Financial Necessity

Group home operators claim that accommodation on the number of non-related people that may live together is necessary to make the group home or RTF financially viable.

When is an accommodation "necessary"?

- When a person is "handicapped" or "disabled," which means they have a "physical or mental impairment which substantially limits one or more of [a] person's major life activities." 42 U.S.C.A. § 3602(h)
- "Handicap," does not include current, illegal use of or addiction to a controlled substance (as defined in section 802 of Title 21). 42 U.S.C.A. § 3602(h)
- "Drug addiction (other than addiction caused by current, illegal use of a controlled substance) and alcoholism" qualify as a "handicap." 24 C.F.R. § 100.201(a)(2)

When is an accommodation "necessary"?

- "[T]he FHA's necessity requirement doesn't appear in a statutory vacuum, but is expressly linked to the goal of "afford[ing] ... ***equal opportunity*** to use and enjoy a dwelling." 42 U.S.C. § 3604(f)(3)(B). And this makes clear that the object of the statute's necessity requirement is a level playing field in housing for the disabled. Put simply, the statute requires accommodations that are necessary (or indispensable or essential) to achieving the objective of equal housing opportunities ***between those with disabilities and those without***."

Cinnamon Hills Youth Crisis Center, Inc. v. Saint George City, 685 F.3d 917, 923 (10th Cir. 2012) (emphasis added)

Cinnamon Hills

"[W]hile the FHA requires accommodations necessary to ensure the disabled receive the *same* housing opportunities as everybody else, it does not require *more* or *better* opportunities."

Id.

The "necessity" analysis:

- Is there a comparable housing opportunity to begin with?
- Does the failure to accommodate the rule in question hurt handicapped people by reason of their handicap, rather than by virtue of what they have in common with other people (i.e., does it have a handicap-isolated impact)?
- Will the requested accommodation ameliorate the effect of the plaintiff's disability so that he or she may compete equally with the non-disabled in the housing market?

What is a "comparable housing opportunity?"

Are group homes/RTFs for the disabled the same as …

… a traditional single family?

What is the appropriate comparison? Do we compare groups homes for the disabled against single family households to make sure we treat them equally?

Are group homes/RTFs for the disabled the same as …

… homes with a traditional single family?

Or do we compare group living for the disabled with group living arrangements ("GLAs") for the non-disabled?

Are group homes/RTFs for the disabled more like…

… other non-related group living arrangements for the non-disabled?

There are two main paradigms out there as to what is the correct legal advice to give on group homes:

(1) The traditional paradigm, which treats group homes like single family residences and advises cities and counties to allow group homes for the disabled wherever single family residences are allowed.

(2) The emerging paradigm, which treats group homes like other forms of group living for the unrelated and non-disabled, such as fraternities, monasteries, boarding houses, etc., and endeavors to treat them equally.

What has the United States Supreme Court said about the ability to regulate GLAs?

The regimes of boarding houses, fraternity houses, and the like present urban problems. More people occupy a given space; more cars rather continuously pass by; more cars are parked; noise travels with crowds.

A quiet place where yards are wide, people few, and motor vehicles restricted are legitimate guidelines in a land use project addressed to family needs. This goal is a permissible one …. The police power is not confined to elimination of filth, stench, and unhealthy places. It is ample to lay out zones where family values, youth values, and the blessings of quiet seclusion and clean air make the area a sanctuary for people.

(*Village of Belle Terre v. Boraas*, 416 U.S. 1, 9, (1974))

What has the 10th Circuit Court of Appeals said about what is the appropriate comparison to draw?

From *Cinnamon Hills:*

"We agree with the district court that Cinnamon Hills has failed to show a similarly situated ***group*** has been granted zoning relief remotely like the requested variance."

685 F.3d at 920

From *Cinnamon Hills*, quoting *Bangerter v. Orem City Corp.,* 46 F.3d 1491, 1502 (10th Cir.1995):

To show intentional discrimination against handicapped residents of group homes, plaintiff was required to show " that group homes for the non-handicapped are permitted" in the city and are not subject to the same onerous requirements.

Id. at 921

"Neither has Cinnamon Hills presented evidence suggesting a reasonable likelihood that the city would grant a ***group*** of non-disabled applicants the relief it denied in this case. . . . In fact, the record reveals that ***the most similarly situated non-disabled comparators*** Cinnamon Hills has identified are also categorically excluded from C-3 commercial zones: ***boarding schools*** and ***housing for colleges and trade schools open to the non-disabled***, no less than residential treatment programs for the disabled, cannot locate there."

685 F.3d at 921

Pros and cons of the traditional paradigm which treats group homes like single family residences and advises cities and counties to allow group homes for the disabled wherever single family residences are allowed:

Pros	Cons
- Perceived lower risk of liability - More in line with the historical paradigm in many court cases - Perceived as a more liberal interpretation in favor of people with disabilities - Easy advice for the attorney … you have to allow them	- Where do you draw the line on numbers and density? - You still get sued when you disagree on what's "reasonable"; enough is never enough for group homes - It's a political nightmare (the NIMBY/public clamor problem) - Damage to the general plan, zoning program and neighborhood integrity - You still have IFC, IBC issues - Facially discriminatory ordinances are inevitable as you try to draw lines

Pros and cons of the emerging paradigm, which treats group homes like other forms of group living for the non-disabled, such as fraternities, monasteries, boarding houses, etc., and endeavors to treat them equally:

Pros	Cons
- Better serves the interests of the general plan, the zoning program and preserves neighborhood integrity (avoids the pig in a parlor problem) - It's rational and achieves the purposes of the FHA by an apple-to-apples comparison - Reduces stress on neighborhoods and, through careful planning, puts group homes and other forms of group living where they are a good fit - Fewer political and administrative issues; fewer decisions to be made by the city (theoretically) - Better shields you from intentional discrimination claims; you can better avoid facially discriminatory ordinances	- It's new; some courts will get stuck in the old paradigm; perceived higher risk of liability - Group homes can *still* ask for accommodations under federal law anyway; they can still ask to be treated like a single family residence

Draper City (traditional paradigm)

- Defines an RTF as a facility limited to 8 occupants, exclusive of staff
- Then provides that RTFs "shall be permitted uses in any zone where a dwelling is allowed either as a permitted or conditional use"
- There is an administrative review process where staff makes sure they are licensed with the state of Utah and will be limited to 8 occupants
- RA requests are administrative. There is no city council input; no planning commission input; purely administrative/staff decision
- Classic example of a "built-in" accommodation
- Facially discriminates *in favor* of group homes for the disabled vs. group living for the non-disabled, which is limited to a maximum of 5 unrelated individuals
- Appeals go to hearing officer

St. George City (traditional paradigm)

- Defines an RTF as a facility limited to 8 occupants
- Provides, "A residential facility for persons with a disability shall be a permitted use in any zoning district where a dwelling is allowed"
- There is no administrative review process … just move right in
- No city council input unless a request for accommodation from the 8-person limitation is requested (which it often is)
- Classic example of a "built-in" accommodation
- Facially discriminates *in favor* of group homes for the disabled vs. group living for the non-disabled, which is limited to a maximum of 5 unrelated individuals or 6 if it's a college dorm
- Appeals on RA decisions go from city council to the board of adjustment

Alpine City (emerging paradigm)

- Taps in to the group-to-group vs. group-to-single family comparison by creating a definition of "Group Living Arrangement" that includes all groups of unrelated people, regardless of disabilities, including group homes
- Policy decision was made as to where an appropriate location for "Group Living Arrangements" is in the overall zoning scheme (B-C Zone was decided but could have included any zone, including high density residential, etc.)
- Nearly all specific reference to RTFs and any facially discriminatory language regarding RTFs was removed from the code since RTFs were now just thrown in with and treated equally to all other forms of group living for the unrelated and non-disabled – however, RTFs are defined as being limited to 8 persons with a disability (a type of "built-in" accommodation)
- Other discriminatory provisions, like spacing requirements, number of occupants, security and supervision provisions, etc. were removed
- A generic reasonable accommodation provision/process was created
- That process is administrative and reviewed by the DRC; does not go to planning commission or city council as it is a technical and complex zoning/legal issue
- Appeals on RA requests go to a hearing officer; appeals are not de novo but record-based
- RA process forces applicants to produce substantial evidence demonstrating necessity

South Ogden City Observations:

- Definition of "Disabled Person" needs to be refined and updated
- Definition of "Family" includes RTFs
- RTFs "shall be a permitted use in any zone where a dwelling is allowed either as a permitted or conditional use" (traditional paradigm)
- Submission requirements are probably discriminatory since single families are not required to do the same
- Limited to 6 occupants (4 disabled and 2 staff) – pushes the limits on therapeutic viability and probably not supported by the scholarly literature on group homes; 6-8, excluding staff, would be a more defensible number
- Can RTFs move right in or is there a review process?
- Group Dwelling Application – is this used for reasonable accommodation requests or all RTFs?
- Planning Commission decides reasonable accommodation requests – consider making this a staff level decision
- Appeals go to a hearing officer
- Where do you really want group living arrangements? What are the appropriate zones?

Where are GLAs allowed now?

Type of GLA (P=permitted C=conditional)	Where allowed
RTF (P)	R-1-6, R-1-8, R-1-10, R2, R3, R3A, R3B, R-4, R-4A, R-5, R-5A, R-5B, R-5C
Nursing home (C)	R3, R3A, R3B, R-4, R-4A, R-5, R-5A, R-5B, R-5C
Boarding and lodging house (P) Boarding housing (C) Lodging house (C)	R-4, R-5, R-5B, R-5C, C3, C3zc(A), CP3, CP3zc(A) C2, CP2 C2, CP2
College or university (dorms) (P)	R-4, R-5, R-5A, R-5C
Assisted living units (C)	R-4, R-4A, R-5, R-5B, R-5C
Clinics, medical or dental (P) Hospital, clinic (C)	C1,C2, C3, C1zc(A), C3zc(A), CP (all) R-4, R-4A, R-5, R-5A, R-5B, R-5C,
Senior housing (C)	R-5A, R-5C

How much power does the FHA give group homes and RTFs? How much does it give you?

"In enacting the FHA, Congress clearly did not contemplate abandoning the deference that courts have traditionally shown to such local zoning codes. And the FHA does not provide a 'blanket waiver of all facially neutral zoning policies and rules, regardless of the facts,' … which would give the disabled 'carte blanche to determine where and how they would live regardless of zoning ordinances to the contrary.'"

Bryant Woods Inn, Inc. v. Howard County, 124 F.3d 597, 603 (4th Cir. 1997)

What group home and RTF operators think …

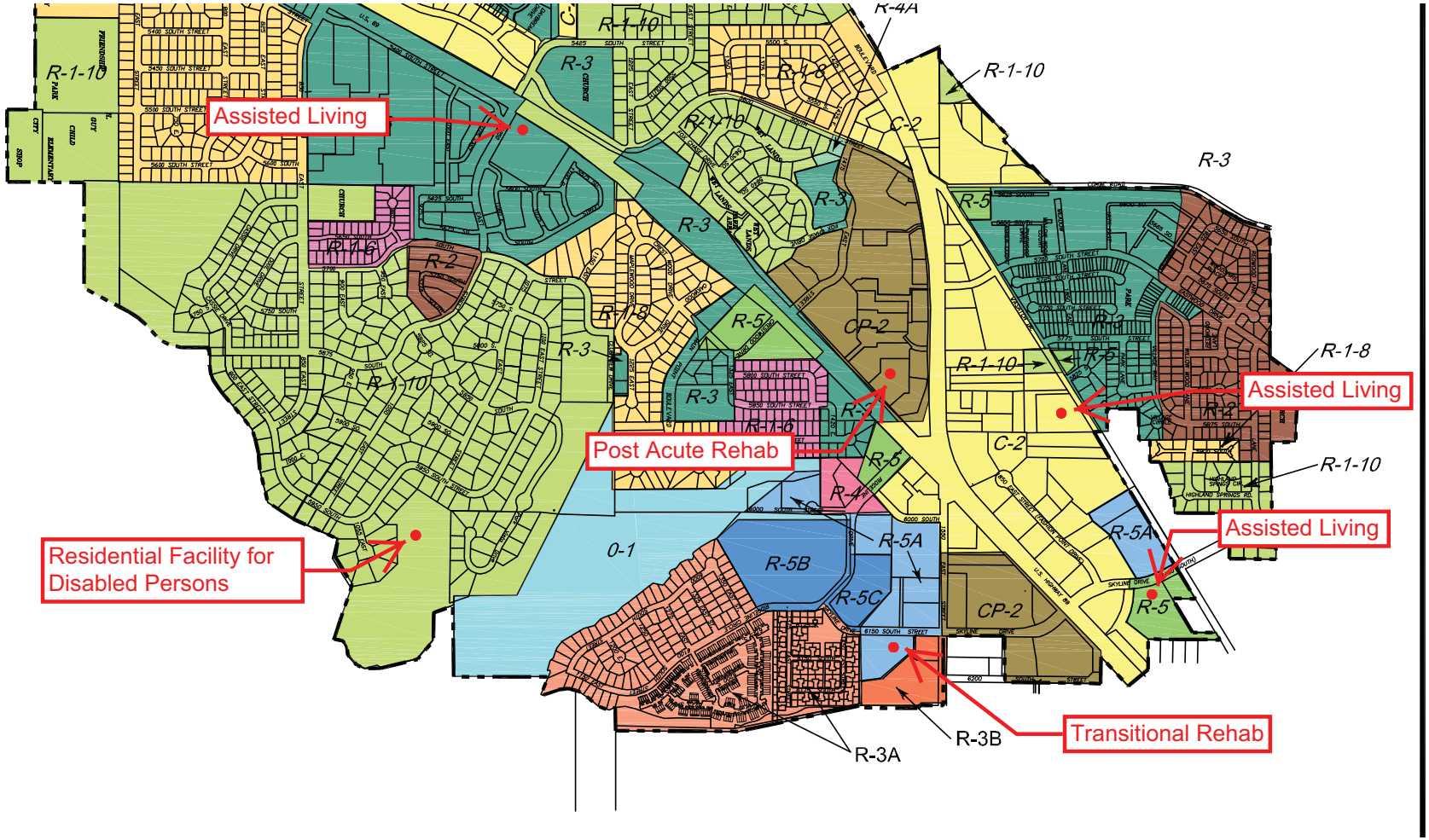
What the courts have said …

Recommendations:

- Revise your ordinance, regardless of the paradigm you choose, to eliminate problems with facial discrimination – my preference is the emerging paradigm
- Create a "built-in" that increases group size from 4 (with 2 staff) to 8 (excluding staff); this is legally defensible according to the most current available therapeutic data
- Make reasonable accommodation requests an administrative/staff decision
- Eliminate de novo review in your appeals process
- Create a new GLA definition and then make a policy decision as to where you want all GLAs, regardless of disability; put them all on equal footing and in the same place
- Create a record for your decision that includes research (I can help you with that)
- Let me circulate a draft ordinance and then come back and explain/answer any questions that you have or receive direction for further revisions

Where are GLAs allowed now?

Type of GLA (P=permitted C=conditional)	Where allowed
RTF (P)	R-1-6, R-1-8, R-1-10, R2, R3, R3A, R3B, R-4, R-4A, R-5, R-5A, R-5B, R-5C
Nursing home (C)	R3, R3A, R3B, R-4, R-4A, R-5, R-5A, R-5B, R-5C
Boarding and lodging house (P) Boarding housing (C) Lodging house (C)	R-4, R-5, R-5B, R-5C, C3, C3zc(A), CP3, CP3zc(A) C2, CP2 C2, CP2
College or university (dorms) (P)	R-4, R-5, R-5A, R-5C
Assisted living units (C)	R-4, R-4A, R-5, R-5B, R-5C
Clinics, medical or dental (P) Hospital, clinic (C)	C1,C2, C3, C1zc(A), C3zc(A), CP (all) R-4, R-4A, R-5, R-5A, R-5B, R-5C,
Senior housing (C)	R-5A, R-5C


Assisted Living
Post Acute Rehab
Residential Facility for Disabled Persons
Assisted Living
Assisted Living
Transitional Rehab
R-1-10
R-3
R-2
R-1-6
R-1-8
R-5
CP-2
C-2
R-4A
R-4
R-5A
R-5B
R-5C
0-1
R-3A
R-3B

Revisions to Definitions and 10-14-16 and addition of 10-14-21 (as of 8.19.2016):

10-2-1: DEFINITIONS:

~~DISABLED PERSON: A person who has a severe, chronic disability attributable to a mental or physical impairment, or to a combination of mental and physical impairments, which is likely to continue indefinitely or which results in a functional limitation in three (3) or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency, and who requires a combination or sequence of special interdisciplinary or generic care or treatment.~~

DISABLED PERSON: A "Disabled Person" is a person with a physical or mental impairment that substantially limits one or more of a person's major life activities, including a person having a record of such an impairment or being regarded as having such an impairment; a person with a "Disability" under Title 57, Chapter 21 of the Utah Code, as amended; a person with a "disability" under 42 U.S.C. § 12102(1), as amended; and a person with a "Handicap" under 42 U.S.C. § 3602(h), as amended. A "Disabled Person" does not include a person engaged in the current illegal use of, or addiction to, any federally-controlled substance, as defined in Section 102 of the Controlled Substances Act, 21 U.S.C. Sec. 802.

FAMILY: Any of the following who occupy a dwelling unit: a) one person living alone; b) two (2) or more persons related by blood, marriage or adoption and foster children living together as a single housekeeping unit; and up to two (2) other persons hired for domestic help residing on the same premises where the housekeeping unit is located; or c) not more than four (4) unrelated persons living together as a single, nonprofit housekeeping unit~~; or d) a group of persons with a disability living in a residential facility for persons with a disability as permitted by section 10-14-~~.

~~16 of this title.~~

GROUP LIVING ARRANGEMENT: A group living or congregate living arrangement where groups of more than four unrelated persons live together in a single dwelling or housekeeping unit, including, but not limited to, Assisted Living Unit, Boarding House, Lodging House, Nursing Home, Senior Housing, assisted living facility, nursing care facility, Residential Facility for Disabled Persons, dormitory, student housing, fraternity, club, institutional group, half-way house, convent, monastery, or other similar group living or congregate living arrangement of unrelated persons. A Group Living Arrangement does not include clinics, medical or dental; hospital(s) or hospital/clinic.

RESIDENTIAL FACILITY FOR DISABLED PERSONS: A residence in which no more than ~~one person with a disability resides~~eight (8) Disabled Persons reside and which is licensed or certified by:

A. The Utah department of human services under title 62A, chapter 2, of the Utah code, licensure of programs and facilities; or

B. The Utah department of health under title 26, chapter 21, of the Utah code, health care facility licensing and inspection act.

SENIOR HOUSING: A building or group of buildings containing residential dwelling units where daily meals shall be offered for the residents in a community dining room and support services such as crafts, exercise, TV, personal care and party rooms may be available on site. One family member of each residential dwelling shall be a minimum of fifty--five (55) years of age at the time of initial occupancy. ~~Also, physically or mentally disabled persons qualify under this definition as though they were fifty five (55) years of age.~~

10-14-16: RESIDENTIAL FACILITIES FOR PERSONS WITH A DISABILITY:

A. Purpose: ~~The purpose~~It is the intent of the City that this ~~chapter is to comply with~~ section ~~10-9a-516 of the~~ shall be interpreted and applied in a manner that is consistent with Title 57, Chapter 21, Utah ~~code and avoid discrimination in housing against persons~~Fair Housing Act, the federal Fair Housing Amendments Act of 1988, 42 U.S.C. Sec. 3601 et seq, Title II of the Americans with ~~disabilities pursuant to the Utah fair housing act~~Disabilities Act and the ~~federal fair housing act as interpreted by courts whose decisions are binding in Utah~~Rehabilitation Act.

B. Scope: If any Group Living Arrangement, facility, residence, congregate living or other housing arrangement meets the definition of a ~~residential facility~~Residential Facility for ~~persons with a disability~~Disabled Persons as ~~set forth~~defined in Section 10-2-1 of this title, the requirements of this chapter shall govern the same notwithstanding any conflicting provision of this title or this code. Except as provided herein, the requirements of this chapter shall not be construed to prohibit or limit other applicable provisions of this title, this code or other laws.

C. Permitted Uses:

1. Notwithstanding any contrary provision of this title, a ~~residential facility~~Residential Facility for ~~persons with a disability~~Disabled Persons shall be a permitted use in any zone where a ~~dwelling~~Group Living Arrangement is allowed either as a permitted or conditional use, subject to the same development standards as are applied to Group Living Arrangements in this title.
~~permitted or conditional use subject to the development standards in this chapter.~~

~~2. In order to evaluate the impact of a proposed facility and its similarity to the impact of a lawfully occupied dwelling located in the same zone where the facility is located, the following information shall be submitted with the application:~~

~~a. Site plan, building plan, and other information necessary to determine compliance with building safety and health regulations applicable to similar residential dwellings permitted in the zone where the residential facility will be located;~~

~~b. Licensing information required by section 62A-2-108.2, Utah code, or its successor;~~

~~and~~

~~c. Number of residents and staff, including staff who will reside on the premises, if any.~~

3. A use permitted by this chapter is nontransferable and shall terminate if:

a. The facility is devoted to a use other than a residential facility for persons with a disability, or

b. Any license or certification issued by the Utah department of health or the department of human services for such facility terminates or is revoked, or

c. The facility fails to comply with requirements set forth in this chapter.

D. Development Standards:

1. The development standards set forth in this section shall apply to any residential facility for persons with a disability.

a. The facility shall comply with building, safety, and health regulations applicable to similar residential structures within the zone in which the facility is located.

b. Each facility shall be subject to the same development standards applicable to similar residential structures located in the same zone in which the facility is located.

2. The facility shall be used as a residential facility without fundamentally altering the structure's residential character or the character of the neighborhood where the facility is located.

3. The facility shall be limited to six (6) occupants, consisting of up to four (4) persons with a disability and two (2) resident staff.

4. No residential facility shall be made available to an individual whose tenancy would:

a. Constitute a direct threat to the health or safety of other individuals, or

b. Result in substantial physical damage to the property of others.

5. Prior to occupancy of any residential facility, the person or entity operating the facility shall:

a. Provide to the city a copy of any license or certification required by the Utah state department of health or the Utah state department of human services, and

b. Certify in a sworn statement that no nonresident staff occupant will reside or remain in the facility whose tenancy would:

(1) Not meet the definition of a person with a disability under the federal fair housing act and Americans with disabilities act,

(2) Constitute a direct threat to the health or safety of other individuals, or

(3) Result in substantial physical damage to the property of others.

E

2. In determining whether a Group Living Arrangement is allowed, only those uses currently and presently allowed by ordinance shall be considered; variances, prior accommodations, pre-existing non-conforming buildings, or pre-existing non-conforming uses shall not be considered.

D. Reasonable Accommodation:

1. None of the requirements of this chapter shall be interpreted to limit any reasonable accommodation necessary to afford a person with a disabilityDisabled Person an equal opportunity to use and enjoy a dwelling as required by the fair housing amendments actFair Housing Amendments Act of 1988, titleTitle II of the Americans with disabilities actDisabilities Act, the Utah fair housing actFair Housing Act, the Rehabilitation Act, and any other federal or state law requiring a reasonable accommodation for a Disabled Person.
law requiring a reasonable accommodation for a person with a disability.

2. Any person or entity wanting a reasonable accommodation shall submit an application to the planning commissionAccommodation Review Committee (ARC) and shall in writing:

a. Provide the address of the property to which the accommodation will be applied;

b. Specify the accommodation requested~~; and~~, including the regulation(s), policy or procedure for which an accommodation is sought;

c. Explain why the accommodation is reasonable and necessary to afford a ~~person with a disability~~Disabled Person an equal opportunity to use and enjoy a dwelling~~.~~; and

d. Provide all information necessary for the findings set forth in Section 10-14-16.D.4.

3. The ~~planning commission~~ARC shall evaluate ~~a~~all reasonable accommodation requests based on the criteria set forth in Section 10-14-16.D.4.

4. Within thirty (30) days after receipt of a complete application, the ARC shall issue a written decision on the requested reasonable accommodation. The ARC may either grant, grant with modifications, or deny a request ~~based on the~~ for reasonable accommodation in accordance with the following factors ~~as permitted by law, including, but not limited to~~:

~~a. Whether the accommodation is reasonable under all current standards in applicable case and statutory law and this chapter;~~

a. ~~b.~~ Whether the housing, which is the subject of the request for reasonable accommodation, will be used by ~~one or more persons with~~ a ~~disability;~~Disabled Person;

b. ~~c.~~ Whether the requested accommodation is ~~reasonable and~~ necessary to afford ~~such persons an~~Disabled Persons equal opportunity to use and enjoy a dwelling~~;~~ when compared to similarly-situated persons or groups without a disability;

Whether the requested

~~d. Whether tenancy of the property proposed to be occupied by such persons would constitute a direct threat to the health or safety of other persons or result in substantial physical damage to the property of others;~~

c. ~~e. Whether the~~ accommodation would impose an undue financial or administrative burden on the ~~city; and~~City;

d. ~~f.~~ Whether the requested accommodation would require a fundamental alteration in the nature of ~~a city program, including~~ the ~~city's~~City's land use ~~and~~, zoning ~~program.~~or building programs;

e. ~~4. Within thirty (30) days after receipt of a complete application the planning commission shall approve a requested reasonable accommodation to the extent necessary to afford a person with a disability an equal opportunity to use and enjoy~~ Whether the requested accommodation is reasonable;

Whether the request for accommodation would result in a dwelling ~~unless evidence of record demonstrates:~~

f. a. Tenancy of the property by that person being made available to an individual whose tenancy would constitute a direct threat to the health or safety of other persons orindividuals or whose tenancy would result in substantial physical damage to the property of others; or; and

b. The accommodation would:

(1) Impose an undue financial or administrative burden on the city; or

(2) Require a fundamental alteration in the nature of a city program, including the city's land use and zoning program.

g. c. If a reasonable accommodation is granted, it shall be documented in writing and shall specify the nature and extent of the reasonable accommodation authorized. Any other relevant considerations under federal or state law.

5. A reasonable accommodation shall not be deemed a variance or to run with the land.

5. 5. If a reasonable accommodation request is denied, the decision may be appealed to the hearing officer in the manner provided for appeals of administrative decisions set forth in chapter4 of this title. (Ord. 15-07, 2-17-2015, eff. 2-17-2015). The review of all such appeals, including any appeals from the hearing officer to the district court, shall be based upon the record presented to the ARC and shall *not* be de novo.

6. A reasonable accommodation shall not be deemed a variance or to run with the land.

7.)If the ARC fails to render a written decision on the request for reasonable accommodation within the thirty (30) day time period allotted by Section 10-14-16.D.4., the request shall be deemed denied based upon the insufficiency of the applicant's information to satisfy the criteria set forth in Section 10-14-16.D.4.

8. While a request for reasonable accommodation is pending, all laws and regulations otherwise applicable to the property that is the subject of the request shall remain in full force and effect.

9. It is the applicant's burden to demonstrate that the accommodation is necessary and reasonable under the standards and definitions set forth in federal and state law, including federal and state case law.

E. Accommodation Review Committee (ARC):

1. The purpose of the ARC is to assure that all reasonable accommodation requests comply with the provisions of this title and that all decisions on reasonable accommodation requests are reviewed and handled in compliance with this title, the Fair Housing Amendments Act of 1988, Title II of the Americans with Disabilities Act, the Utah Fair Housing Act, the Rehabilitation Act, and any other federal or state law requiring a reasonable accommodation for a Disabled Person.

2. The ARC shall consist of five (5) members: The City Manager, the City Planner, the Fire Chief, the Chief Building Official, and the City Attorney or their designee(s). The Police Chief, the City Engineer, the Public Works Director and any other person(s) designated by the ARC shall serve as advisors to the ARC.

3. The City Manager shall serve as the chairperson of the ARC.

4. The ARC may establish procedures for the preparation of its agendas, the scheduling of meetings, and the conduct of meetings and field trips, if any.

5. The ARC may retain the services of any other outside professionals or technical experts to help evaluate any and all requests for accommodation.

10-14-21: GROUP LIVING ARRANGEMENTS:

A. Group Living Arrangements which are not expressly permitted within a zone or by the Zoning Ordinance are expressly prohibited.

B. Group Living Arrangements are a permitted use in only the following zones:

R-4
R-4A
R-5
R-5A
R-5B
R-5C

C. Group Living Arrangements are a conditional use in only the following zones:

C3
C3zc(A)
CP3
CP3 zc(A)
C2
CP2

The following subdistricts of the City Center & 40th Street Corridor Form-Based Code:

City Center "Core"
City Center "General"
Riverdale Road "General"
40th Street "General"
Edge

D. No Group Living Arrangement shall be allowed, established or maintained within the City if it is located or proposed to be located within a 2,640-foot radius of any other Group Living Arrangement, whether located in the City, County, State, or a surrounding municipality.

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Oxford House Recovery Homes: Characteristics and Effectiveness

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Abstract

One of the largest examples of a community-based, mutual-help residential community for high risk substance abuse individuals is *Oxford House*. In the U.S., over 9,800 people live in these self-run dwellings where they obtain jobs, pay utility bills, and learn to be responsible citizens. Beginning with one single rented residence in the mid 1970s, Oxford Houses now number over 1,300. These rented homes are helping to deal with drug addiction and community re-entry by providing stable housing without any limits on length of stay, a network of job opportunities, and support for abstinence. An exploration of the research on these unique settings highlights the strengths of such a community-based approach to addressing addiction. New roles for psychologists in working with these types of support systems are identified.

Keywords

Substance abuse; Recovery homes; Oxford House; ex-offender

After treatment for substance abuse, whether by prison, hospital-based treatment programs, or therapeutic communities, many patients return to former high-risk environments or stressful family situations. Returning to these settings without a network of people to support abstinence increases chances of relapse (Jason, Olson & Foli, 2008). As a consequence, alcohol and substance use recidivism following treatment is high for both men and women (Montgomery et al., 1993). Alternative approaches need to be explored, such as abstinence-specific social support settings (Vaillant, 2003). Self-governed settings may offer several benefits as they require minimal costs because residents pay for their own expenses (including housing and food). Recovering substance abusers living in these types of settings may develop a strong sense of bonding with similar others who share common abstinence goals. Receiving abstinence support, guidance, and information from recovery home members committed to the goal of long-term sobriety and abstinence may reduce the probability of a relapse (Jason, Ferrari, Davis & Olson, 2006). This experience might provide residents with peers who model effective coping skills, be resources for information on how to maintain abstinence, and act as advocates for sobriety.

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Oxford Houses are single-sex adult dwellings, yet some allow residents to live with minor children. Individual members are expected to pay monthly rent and assist with chores. They are one of the largest self-help residential programs in the US. Unlike other aftercare residential programs, such as halfway houses, Oxford House has no prescribed length of stay for residents and there is no professional staff. Each House operates democratically with majority rule regarding most policies, and an 80% majority for accepting membership (Oxford House Manual, 2006). Residents must follow three simple rules: pay rent and contribute to the maintenance of the home, abstain from using alcohol and other drugs, and avoid disruptive behavior. Violation of the above rules results in eviction from the House (Oxford House Manual).

As of 2008, there were 321 women's Oxford Houses with 2,337 women, and 982 men's Oxford Houses with 7,487 men, for a total of 1,303 houses serving 9,824 people (Oxford House, 2008). There were Oxford Houses in 42 states and 383 cities in the US. Of the residents, 18% were veterans, and 91% were working with average monthly earnings of $1,480. Most residents had been addicted to drugs or drugs and alcohol (73%) whereas 27% had been addicted to only alcohol. Regarding race, 54% were White, 42% were Black, and 4% were other. Regarding marital status, 45% had been never married, 18% were separated, 33% were divorced, and only 4% were married. Fifty-three percent of residents reported prior homelessness for an average time of 6 months. In addition, 76% had been in for an average of 13 months. The average length of stay in an Oxford House was 10.1 months. The average cost per person per week was $98.75.

There appear to be considerable standardization of locations of Oxford Houses as well as what occurs in these settings (Ferrari, Groh & Jason, 2009). Ferrari, Jason, Sasser et al. (2006) studied 55 Oxford Houses across three diverse regions of the U.S and found that regardless of geographic location, Oxford Houses were rather similar in size and amenities that were available to residents (e.g. room air-conditioners, a utility room for laundry, a communal lounge for televisions, comfortable furniture in communal living areas. Observers (with high inter-rater reliability) noted that public transportation was available near the houses, and the streets and neighborhoods were clean and well-lit. These results, in fact, were replicated in Australian Oxford Houses (Ferrari, Jason, Blake et al., 2006).

Jason et al. (2003) used interviews and observations to better understand governance issues in the Oxford Houses. They found that residents utilized a number of strategies to confront behavioral issues, including imposing fines for not completing house duties, discussing interpersonal conflicts and behaviors such as isolation at business meetings, and developing behavioral contracts. Houses also implemented rewarding events for achieving goals. The Oxford House model of treatment for substance abuse issues is an intriguing concept based on self-governance and mutual support. The self-governing policies described above help create and nurture abstinence-specific social support networks. In the absence of professional staff, residents are forced to develop rules and policies, learn to self-govern, and assume positions of leadership within their houses. The democratic feature of the Oxford House program differentiates it from other types of residential care settings and recovery homes, where rules and sanctions for infractions may exist, but with less explicit efforts to encourage a supportive milieu

Limited research, however, is available regarding how Oxford House settings compare to other treatments. Using cross sectional data, Ferrari, Jason, Davis, Olson, and Alvarez (2004) compared the operational policies of 55 Oxford Houses to those of 14 Therapeutic Communities (TCs). Neither type of facility permitted self-injurious behaviors (e.g., physical self-harm or misuse of medication) or destructive acts (e.g., destroying site property or others' possessions). Oxford Houses, however, were significantly more liberal in permitting residents personal liberties compared to the TC facilities. For example, Oxford Houses permitted greater

flexibility in terms of residents' smoking in their rooms, sleeping late in the morning or staying out late at night, going away for a weekend, and having "private time" in their locked room with guests. Oxford Houses also were more likely than TCs to allow residents to have personal possessions (e.g., pictures, furniture) within the dwelling (Ferrari, Jason, Sasser et al., 2006).

Unfortunately, there have not been any outcome studies comparing TCs with Oxford Houses, although the first author currently has a NIDA funded study that is exploring this issue. There is considerable evidence for the effectiveness of TCs (DeLeon, & Rosenthal, 1989). Substantial reductions in recidivism rates have been found when in-prison Therapeutic Communities (TCs) are combined with community transition programs (Hiller, Knight, & Simpson, 1999; Wexler et al., 1996). As an example, Inciardi et al. (2004) found that at a five year follow-up, those individuals who participated in a combined TC and work release program had significantly less drug use and were significantly less likely to be re-incarcerated compared to those individuals in just the TC program or a no-treatment control group. Unfortunately, these TC programs often create a financial burden on society, and are not available to all that need them. Also, therapeutic community residents may stay only for a limited time before many return to former high-risk environments or stressful family situations (Goldsmith, 1992).

Limited research is also available comparing Oxford Houses versus more traditional recovery homes, which also tend to have supervising staff and less democratic self-governing principles. Harvey (2009) recently found that Oxford House residents had higher scores on social climate scales Involvement, Support, and Practical Orientation, Spontaneity, Autonomy, Order and Organization, and Program Clarity measures compared to a traditional recovery home. This study did not provide outcome data regarding residents' experiences living in these recovery communities. Few methodologically sound studies have emerged in the area of traditional recovery homes. In one of the few recovery home longitudinal studies, Polcin (2006) found that 51% of recovery home residents were abstinent from drugs and alcohol at a six-month follow-up. Regrettably, there are few studies reporting differential outcome data contrasting recovery home and therapeutic community residential treatments for substance abuse. In part, this is due to the fact that it is hard to provide systemic long-term outcome data on these hard to reach, highly recidivist populations.

The present article addresses the primary outcome studies conducted on one form of recovery home called Oxford House. We also examine whether settings such as Oxford Houses have an impact on their greater community. Finally, the implications for how clinicians might work with these types of community support settings will be reviewed.

Main Outcome Studies

Our NIAAA-Study

In a National Institute of Alcohol Abuse and Alcoholism (NIAAA) supported study, we successfully recruited 150 individuals who completed treatment at alcohol and drug abuse facilities in the Chicago metropolitan area. Over half of the individuals who participated in this study were women. Half the participants were randomly assigned to live in an Oxford House, while the other half received community-based aftercare services (Usual Care). We tracked over 89% of the Oxford House and 86% of the Usual Care participants throughout two years of the study. Results from this randomized study were encouraging, indicating significantly more successful outcomes including reduced recidivism for Oxford House than Usual Care participants 24 months after discharge from residential treatment (see Jason, Olson, Ferrari, & LoSasso, 2006).

Positive outcomes also emerged in terms of substance use (31.3% of participants assigned to the Oxford House condition reported substance use at 24 months compared to 64.8% of Usual

Care participants), employment (76.1% of Oxford House participants versus 48.6% of Usual Care participants reported being employed at the 24 month assessment) and days engaged in illegal activities during the 30 days prior to the final assessment ($M = 0.9$, $SD = 4.43$ for Oxford House; $M = 1.8$, $SD = 6.12$ for Usual Care participants). In this study of 150 participants, 87% of the female participants had children, but 50% of these women reported having lost custody of their children due to their addictions. Two years after entering Oxford House, 30.4% of all the women assigned to the Oxford House condition had regained custody of their children while only 2% (1 woman) had lost custody. On the other hand, in the Usual Care condition, only 12.8% of all the women regained custody of their children, while 4% (2 women) lost custody.

In this same study, we examined the combined effects of 12-step involvement and Oxford House residence on abstinence over a 24-month period (Groh, Jason & Ferrari, 2009). Among individuals with high 12-step involvement, the addition of Oxford House residence significantly increased the rates of abstinence (87.5% vs. 52.9%). Results suggested that the joint effectiveness of these mutual-help programs may promote abstinence and extended our previous research indicating that OH residents frequently engage in 12-step program use (Nealon-Woods, Ferrari, & Jason, 1997).

Economic data also were supportive for participants in the Oxford House condition over the course of the two-year study. Oxford House participants earned roughly $550 more per month than participants in the usual care group. Annualizing this difference for the entire Oxford House sample corresponds to approximately $494,000 in additional benefits to those in the Oxford House condition. The lower rate of incarceration (3% versus 9%) in the study among Oxford House versus usual care participants corresponded to annualized savings for the Oxford House sample of roughly $119,000. Together, the productivity and incarceration benefits yield an estimated $613,000 in savings accruing to the Oxford House participants.

In 2007, the Oxford House organization received about $1.6 million in grants from state and local governments to pay outreach workers to develop and maintain networks of individual Oxford Houses in nine States and the District of Columbia. Only 6% of these costs were for general and administrative costs of Oxford House, Inc. During 2007, the inhabitants of Oxford Houses expended approximately $47,814,156 to pay the operational expenses of the houses. If the Oxford Houses had been traditional, fully staffed halfway houses, the cost to taxpayers would have been $224,388,000 (Oxford House Inc., 2007). In the current cost-conscious environment by local, state, and federal governments, Oxford House represents an important network of recovery homes that promote abstinence for individuals needing ongoing support after an initial episode of substance abuse treatment.

Our NIDA-Study

Our next large scale completed study received funding from the National Institute on Drug Abuse (NIDA). This study examined abstinence-specific social support and successful abstention from substance use in a national sample of over 900 Oxford House residents. Results were quite positive; only 18.5% of the participants who left Oxford House during the course of the one-year study reported any substance use (Jason, Davis, Ferrari, & Anderson, 2007). Additionally, over the course of the study, increases were found in the percentage of their social networks who were abstainers or in recovery. Finally, latent growth curve analyses indicated that less support for substance use by significant others and time in Oxford House predicted change in cumulative abstinence over the course of the study.

Within this large study, we analyzed psychiatric severity data such that we compared residents with high versus low baseline psychiatric severity (Majer, Jason, North, Davis, Olson, Ferrari et al., 2008). No significant differences were found in relation to residents' number of days in

outpatient and residential psychiatric treatment, abstinence rates, and Oxford House residence status. These findings suggest that a high level of psychiatric severity is not an impediment to residing in self-run, self-help settings such as Oxford House among persons with psychiatric co-morbid substance use disorders.

Kim, Davis, Jason, and Ferrari (2006) examined the impact of relationships with parents, significant others, children, friends and co-workers on substance use and recovery among this national sample of Oxford House residents. They found that children provided the only type of relationship that was able to affect both substance use and recovery in a positive direction. D'Arlach, Olson, Jason, and Ferrari (2006) found that the children residents had a positive effect on the women's recovery, and this positive effect was identical for both mothers and non-mothers. It is possible that these positive effects are due to the fact that having children present leads to increased responsibility among all House residents, aiding in recovery. Women also reported that Oxford House residents helped one another with child care. Ortiz, Alvarez, Jason, Ferrari and Groh (2009) found that Houses with men and children had the highest rates of long term recovery, and perhaps men in recovery who take care of their children are in situations more advantageous to sustained recovery and have more resources compared to others.

Within this large national data set, we also examined ethnic differences. Within our sample, 58.4% were Caucasian, 34.0% were African American, 3.5% were Hispanic, and 4% were other. African-Americans were over represented in the sample. Flynn, Alvarez, Jason, Olson, Ferrari, and Davis (2006) found that African Americans in Oxford House maintain ties with family members yet develop supportive relationships by attending 12-step groups and living in Oxford House. These different social networks are able to provide support for abstinence to African Americans.

Less than 4% of our sample with Hispanic, and this led us to examine possible reasons for this under-representation. Alvarez, Jason, Davis, Ferrari, and Olson (2004) interviewed nine Hispanic/Latino men and three Hispanic/Latina women living in Oxford House. Only two individuals were familiar with Oxford House prior to entering residential treatment; the others had never heard about the program. Participants decided to move to an Oxford House based on information they received from counselors and peers indicating that Oxford House would facilitate their recovery. Prior to entering Oxford House, participants were concerned that House policies would be similar to those of half-way houses they had experienced (i.e., too restrictive).

Half the individuals interviewed also had concerns about being the only Hispanic/Latino House member. Despite their initial concerns, participants reported overwhelmingly positive experiences in Oxford House, with the majority of interviewees indicating that they "blended into the house" within their first few weeks. Most participants reported regular contact with extended family members and stated that family members supported their decisions to live in Oxford House. The most commonly endorsed suggestion for increasing Hispanic/Latino representation in Oxford House was to provide more information regarding this innovative mutual-help program. Residents indicated that personal motivation for recovery was a necessary component of their success in Oxford House (Alvarez, Jason, Davis, Ferrari, & Olson, 2007). Additionally, mutual help, social support, a sober living environment, and accountability emerged as strongly-endorsed therapeutic elements of the Oxford House model. Finally, consistent with a broad conceptualization of recovery, residents reported that living in Oxford House helped them remain sober but also facilitated the development of life skills and a new sense of purpose along with increased self-esteem.

There were only seventeen American Indian participants in our national NIDA study (Kidney, Alvarez, Jason, Ferrari, & Minich, 2009). Nevertheless, American Indians were no more likely to report more severe substance use, psychological problems, criminal histories, or lower incomes than other groups. In addition, American Indians were more likely to report being on parole or probation and being referred for aftercare by the legal system. Moreover, American Indians reported greater disharmony within their recovery residences than Caucasians, but there were no significant ethnic differences in length of stay in Oxford House.

Finally, Mortensen, Jason, Aase, Mueller, and Ferrari (2009) studied this national sample of Oxford Houses for six years following the completion of our study in order to investigate factors related to whether the Oxford Houses remained open or closed. Results indicated a high sustainability rate (86.9%) during a six year period of time. Houses that remained open had significantly higher incomes of residents than houses that eventually closed. No other significant differences were found between the two groups of houses, including sense of community among residents, neighborhood or policy characteristics, and house age. It appears that adequate house income seems to be a necessary factor for houses continuing to function over time.

Impacts Beyond Oxford House: Community Perceptions

Because the Oxford House organization was frequently confronted with a variety of community reactions to the presence of an Oxford Houses, our team decided to explore attitudes of neighborhood residents toward Oxford Houses (Jason, Roberts, & Olson, 2005). We found that neighbors who lived next to an Oxford House versus those a block away had significantly more positive attitudes toward a) recovery homes, b) the importance of individuals in recovery to have the ability to live in residential neighborhoods, c) neighbors' roles in providing a supportive environment to those in recovery, and d) a self-run recovery home on their block. Oxford House residents are often considered good neighbors, and when neighbors get to know these residents, they often feel very positive about these homes. Many individuals who lived a block away did not even know that a recovery home existed in their neighborhood, and the attitudes of these individuals who did not know the Oxford House members was less positive in general about these types of recovery homes. In addition, property values for individuals next to recovery homes were not significantly different from those living a block away. These findings suggest that well-managed and well-functioning substance abuse recovery homes elicit constructive and positive attitudes toward these homes and individuals in recovery (Ferrari, Jason, Sasser et al., 2006).

We were also interested in exploring whether rates of crime increased in locations where there were Oxford Houses. We investigated crime rates in areas surrounding 42 Oxford Houses and 42 control houses in a large city (Deaner, Jason, Aase, & Mueller, 2009). A city-run Global Information Systems (GIS) website was used to gather crime data including assault, arson, burglary, larceny, robbery, sexual assault, homicide, and vehicle theft over a calendar year. Findings indicated that there were no significant differences between the crime rates around Oxford Houses and the control houses. These results suggest that well-managed and governed recovery homes pose minimal risks to neighbors in terms of criminal behavior.

We also designed a study to assess the types of contributions that Oxford House residents report making to their neighborhoods and communities. Jason, Schober and Olson (2008) found that Oxford House members reported participating in the community for about 10.6 hours per month. The majority of participants were involved in activities around their recovery. Sixty-three percent were involved in mentoring others in recovery. Forty-four percent of the sample was involved in administering and running support groups. Involvement around recovery also included involvement in large community initiatives, as 39% of participants reported involvement in informing or advising agencies or local leaders and 32% reported involvement

in community anti-drug campaigns. For some, this involvement also included speaking at political events (16%), and attending community meetings (30%), and public hearings and forums (21%). Other general community activities reported by participants included working with youth (32%), fundraising (30%), and volunteering time with community organizations (23%). These findings indicate that Oxford House residents are not only working on their own recovery, but also working to make positive changes in their communities.

Group homes like Oxford House sometimes face significant neighborhood opposition, and municipalities frequently use maximum occupancy laws to close down these homes. Towns pass laws that make it illegal for more than 5 or 6 non-related people to live in a house, and such laws are a threat to Oxford Houses which often have 7–10 house members to make it inexpensive to live in these settings. Jason, Groh, Durocher, Alvarez, Aase, and Ferrari (2008) examined how the number of residents in Oxford House recovery homes impacted residents' outcomes. The Oxford House organization recommends 8–12 individuals residing in each House (Oxford House, 2006). Homes that allow for 8 or more residents may reduce the cost per person and offer more opportunities to exchange positive social support, thus, it was predicted that larger Oxford Houses would exhibit improved outcomes compared to smaller homes. Regression analyses using data from 643 residents from 154 U.S. Oxford Houses indicated that larger House size predicted less criminal and aggressive behavior. These data were used in 5 court cases, which were successful in arguing against closing down Oxford Houses that had more than 5 or 6 non-related residents.

Conclusion

Our overall findings that emerged from two large NIH-funded grants suggest that Oxford House provides an effective and inexpensive alternative for many individuals attempting to recover from addictions to alcohol and other drugs (Jason, Davis et al., 2007; Jason, Olson et al., 2006). Our findings from a number of other studies indicate that Oxford House may be appropriate for a variety of individuals recovering from substance abuse, including those with histories of legal involvement and co-occurring mental health conditions. Oxford House appears to provide a substance-free environment where recovering individuals may live without restrictions on length of stay, and residents report that residential settings devoid of relapse triggers help them remain substance-free (Jason et al., 1997; Alvarez et al., 2007). Given the high costs associated with professional treatment, it is critical to identify more affordable community-based models that might provide long-term support in order to break the cycle of relapse (for more details, see also Jason, Ferrari, et al. 2006; Jason & Ferrari, 2009).

Our research examined the nature and outcomes of the Oxford House model of substance abuse recovery. We worked with the needs of diverse groups, including ex-offenders, minority groups including Native Americans, and women and women with children. Our efforts involved a commitment to collaborative research with a grass-roots organization, assessing change at multiple levels with a multidisciplinary team of economists, biostatisticians, social, developmental, clinical and community psychologists.

For over 18 years, our research team used cross-sectional, operant (Jason, Braciszewski, Olson, & Ferrari, 2005), and longitudinal designs; employed quantitative and qualitative methods, and used self-report, observational (Jason, Ferrari, Freeland, Danielewicz, & Olson, 2005), and organizational data to assess Oxford Houses. We collected data at the individual, house, and state levels, and at times compared data over these different levels of analysis. We believe that selecting multi-level, multi-methods approaches allowed us to better clarify complex phenomena that we were studying.

We also believe that Oxford Houses and other community-based support system provide social scientists with rich opportunities to explore a vast array of psychological and sociological constructs. Because of space constraints, we were not able to review other topics our Oxford House research group has explored, but they include criminal and aggressive behaviors (Aase, Jason, Olson, Majer, Ferrari et al., 2009), anxiety (Aase, Jason, Ferrari, et al., 2006–2007), hope (Mathis, Ferrari, Groh, & Jason, 2009), optimism (Majer, Jason, & Olson, 2004), tolerance (Olson, Jason, Davidson, & Ferrari, 2009), self-regulation (Ferrari, Stevens & Jason, 2009), social climate (Horin, Alvarez, Jason, & Sanchez, 2007), social support (Groh, Jason, Davis, Olson, & Ferrari, 2007), altruism (Viola, Ferrari, Davis, & Jason, 2009), sense of community (Bishop, Jason, Ferrari, & Huang, 1998; Graham, Jason, & Ferrari, 2009), employment issues (Belyaev-Glantsman, Jason, & Ferrari, 2009), and even specialized Oxford Houses for deaf residents (Alvarez, Adebanjo, Davidson, Jason, and Davis (2006). Clearly, psychologists with interests in community based support networks for substance abusers have ample research topics worthy of exploration, and this research may have public policy implications.

We currently have received NIH support to begin researching individuals leaving jail and prison with substance abuse problems. This line of research could be expanded to other levels or target groups, such as men and women with substance abuse returning from foreign wars in Iraqi and Afghanistan. Reports of post-traumatic illnesses and substance abuse among returning veterans suggests that cost effective programs like Oxford House need closer federal attention. Our work with African Americans suggests that the Oxford House model meets cultural needs of this group; but culturally-modified houses might need to develop to meet the needs of Spanish-speaking Latinos due to their lack of representation within Oxford Houses. Our group has recently received a federal grant to explore this new type of culturally modified recovery home.

Clearly, it is important to improve the quality of the data for outcomes research with residential substance abuse treatment. Both NIDA and NIAAA have health services research study sections that are willing to review these types of applications. It is hoped that more researchers will consider developing grant proposals in this area, particularly as research focusing on the solution of applied problems is becoming a larger priority area for the federal government. With adequate funding, large clinical trials can emerge and adequate personnel can be employed for the arduous task of tracking over time these at-risk samples.

Implications for Clinical Practice

Alcoholism and substance abuse affects over 20 million Americans, and thus is the most prevalent mental disorder facing our nation (Jason, Ferrari, Davis, & Olson, 2006). Many psychologists are involved in the delivery of services to those with substance abuse addictions. Each year, 600,000 inmates are released back into communities, and many are released with ongoing drug addictions (substance abuse within correctional facilities ranges from 74 to 82%; Keene, 1997). One of the strongest predictors of criminal recidivism is substance use (Bureau of Justice Statistics, 2005). According to Horgan, Skwara, Strickler, Andersen, and Stein (2001), societal costs attributed to substance abuse in the United States alone is greater that $500 billion, which includes substance abuse treatment and prevention, medical and criminal costs, accidents, and losses of earnings. Of those with substance use addictions/dependence, only about 10% even reach any type of substance abuse treatment. This suggests a large need for creative new types of screening methods to identify patients in need of treatment. Almost all medical problems are first identified by primary care and referred to specialists, but this is not the case with substance abuse disorders, where most individuals first approach specialist substance abuse treatment settings. The Office of National Drug Control Policy is currently considering recommending that primary care settings should identify people with substance

abusers in primary care settings in order to refer more patients to detoxification and treatment. If this occurs, there will emerge unique opportunities for psychologists in both screening and referral.

For many individuals with substance abuse problems, entry into the existing continuum of services begins in a detoxification program. In the optimal case, an individual completes the detoxification process and then moves through a time-limited therapeutic program, but these programs are becoming briefer as federal, state and local sources of funding for these services has decreased (Jason, Olson & Foli, 2008). Detoxification program readmission represents a potential indicator that services received have not facilitated sustained recovery. It has been suggested that for a substantial portion of addicted persons, detoxification does not lead to sustained recovery. Instead, these individuals cycle repetitively through service delivery systems (Richman & Neuman, 1984; Vaillant, 2003). Recidivism rates within one year following treatment are high for men and women, and 52–75% of all alcoholics drop out during treatment (Montgomery et al., 1993). These kinds of programs are also expensive (Schneider & Googins, 1989).

These findings provide a challenge to psychologists working in the addiction field. The missing element for many patients is supportive settings following treatment for substance abuse, and the expansion of these types of settings is an important activity for psychologists. Vaillant (1983) noted that environmental factors may be key contributors to whether or not individuals maintain abstinence, and these factors include the support one receives for abstinence among their support networks. Moos (2006 Moos (2007) pointed to other individual, biological, and socio-environmental factors that predicted abstinence maintenance. Moos (1994) maintained that effective interventions for recovering individuals might be those that engage clients and promote naturally-occurring healing processes, such as self-help based treatments. Abstinence-specific social support may be critical to facilitating abstinence among persons with substance use disorders. Such social support is often acquired and utilized through participation in mutual-help groups (Humphreys, Mankowski, Moos, & Finney, 1999), where individuals are likely to develop peer networks consisting of abstainers and others in recovery. Investment in abstinence-specific social support was reported to be one of the best post-treatment prognostic indicators of recovery (Longabaugh et al., 1995; Zywiak, Longabaugh & Wirtz, 2002).

Oxford Houses represent one type of community support that psychologists could refer patients to, and this can be accomplished by reviewing the website for Oxford House, where all houses and current vacancies are listed (see http://www.oxfordhouse.org/locate_houses.php). Professional-practicing psychologists may make a referral to an Oxford House by asking the patient to call the Oxford House and set up an appointment with the house members for possible entry into that house.

Of course, no one particular type of treatment setting is appropriate for all individuals. Individuals early in their recovery or with particular interpersonal characteristics might need more of a structured and professionally-led milieu in order to maintain abstinence given the freedoms that are provided in Oxford Houses. In our national NIDA data set (Jason et al., 2007), 43% of participants had a history of psychological medications, 30% had attempted suicide, 46% had a history of physical abuse, 35% had a history of sexual abuse, 40% had one or more inpatient psychiatric treatments, and 40% had one or more outpatients treatments. In the past 90 days, the sample had an average of 1 day of residential treatment for psychiatric problems and an average of 3 sessions with a counselor for psychiatric problems. Certainly, it is clear that the sample of Oxford House residents do have significant mental health problems and that they do utilize mental health services outside of their Oxford Houses. Although there are no on-site clinical services, effective outreach can be accomplished by mental health

professionals becoming aware of the existence of these abstinent specific settings, and informing residents that they are willing to provide supportive therapy services to residents.

Given the expanding federal deficit and obligations to fund social security, it is even more important for psychologists to consider inexpensive ways to remediate inequities within our society. The Oxford House model suggests that there are alternative social approaches that can transcend the polarities that threaten our nation (Jason, 1997). We believe that there is much potential in the Oxford House model for showing how intractable problems may be dealt with by actively involving the community.

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Size, Quality, and Cost of Residential Settings:

Policy Analysis of Literature and Large Data Sets

Submitted to:
Michigan Association Of Community Mental Health Boards

- and -

Department of Community Health
Mental Health & Substance Abuse Administration
Bureau of Community Mental Health Services

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Executive Summary

This Policy Report is a summary of scientific evidence bearing on one issue:

What impact does bed size of a group home have on quality of life and cost?

Aspects of quality of life[1] and costs are both considered. We consider several kinds of data, including research literature from several fields and new research. The result of this multi-perspective approach can be considered a form of "meta-analysis" – an attempt to synthesize information from many sources to shed light on a single question.

The issue has risen to prominence many times over the past century, and this time it is primarily because of the poor economy that took hold at the end of the first decade of the 21st century. Policy makers nationwide, and in Michigan, seem to believe that putting people with intellectual and developmental disabilities into larger and larger group homes will save money - with no major decline in quality.

Is this true? The question is explored in this paper, through three general methods:

1. Theoretical review of the concept of "economy of scale" from economics
2. Reviews of related scientific literature from Sociology, Organizational Psychology, Education, and Developmental & Intellectual Disabilities
3. Analyses of some of the largest quality of life and cost databases in the field of developmental and intellectual disabilities.

This is a very important question at this time in our history. The pressures to achieve economies are enormous. The purpose of this Policy Report is to assist policy makers in wrestling with this very difficult issue – knowing that one size can never fit all, that variety and choice of kinds of settings are important, and yet to approach the question from the "meta" perspective – other things being equal, and on the average, is it wise to increase group size in residential settings?

[1] Quality of life is composed of a complex of factors, such as comfort, freedom, good relationships, wealth, and security, that combine together in different ways and different priorties for different people. There is no single definition that satisfies all. Quality of life is best thought of as multiple dimensions of qualities of life. Many dimensions must be measured so that interested parties can draw their own conclusions about which qualities and which tradeoffs are "most important" to them. This is the strategy employed in this and related papers, e.g., *Conroy, J. (1986). Principles of quality assurance: Recommendations for action in Pennsylvania. Philadelphia, PA: Temple University Developmental Disabilities Center/UAP*.

The scientific literature review began with a thorough review of four kinds of scientific literature that was conducted in 1992.[2] These reviews were then updated with more recent quantitative (data-based) studies and findings, bringing the state of knowledge up to the present.

The quantitative analyses were made possible by the fact that the author of this Policy Report has conducted some of the largest and longest lasting studies of quality of life, costs, and outcomes in the field of intellectual and developmental disabilities. Most of these databases had never been specifically analyzed to explore the relationships between the size of community residential settings and their quality. Old analyses from the National Consumer Survey, the Pennhurst Longitudinal Study, and the Connecticut Applied Research Project were reviewed and refined based on the most recent analytical approaches. Then large data sets from California, Indiana, Michigan, Oklahoma were analyzed for size effects for the first time. In addition, recent analysis performed by the National Core Indicators project, now the largest national database on quality in developmental disabilities, is included.

For the purpose of this Executive Summary, here is what we can learn from the sources above in bullet form.

- **Very Large Settings (Institution versus Community)**: This issue is regarded as "settled science." From the 1909 White House Conference on Care of Dependent Children to the deinstitutionalization movement of the latter half of that century, we now know that very large settings, whether they are called orphanages or developmental centers, are not optimal places for people to grow, learn, and socialize. The largest settings are portrayed in the developmental disabilities literature as the least cost-effective, as well. The economy of scale argument is compellingly refuted[3] by the decades of scandals, evidence of poor quality, and the high cost of large institutions.
- **Economy of Scale**: Policy makers have often remembered the economy of scale phenomenon from elementary economics, but have not remembered the 'next page' of the textbooks – which described diseconomy of scale. Organizations that become too large show drop-offs in quality and productivity. This inevitably will happen in human residential groupings as

[2] Conroy, J. (1992). *Size and Quality in Residential Programs for People with Developmental Disabilities*. A Dissertation Submitted to the Temple University Graduate Board in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy. Philadelphia: Temple University.

[3] At least in part – for the comparison of very large to very small – but this Policy Report goes on to analyze outcomes and cost-effectiveness within the small range, usually called "community living" realm.

well. Given the national rejection of the very large scale groupings, i.e. institutions, the question becomes where the diseconomy of scale sets in within the range of 1 to 10 people receiving supports in a home. Literature evidence appears to imply that the turning point is around 4 people – going above 4 is not beneficial, and beyond 6 is sharply negative. New research analyses performed for this Report support this inference rather strongly.

- **Sociology**: Group sizes above roughly 4 to 6 people tend to show losses in individual participation, effort, communication, and satisfaction.
- **Organizational and Industrial Psychology**: The entire notion of Economy of Scale in industrial production is questioned, the application of industrial models to human service processes is challenged, and the evidence in favor of small groups for both productivity and member satisfaction is strong. Studies support the sociological evidence that group sizes are ideally kept small, meaning in the range near 5 people. With more people than that, diminishing returns set in.
- **Education and Classroom Size**: Class size in the range 15 to 40 students has some impact on their achievement, but it is quite small. Size in that range has a much larger impact on qualitative measures like enjoyment and morale. Large effects on student achievement are found only when the instructional group size shrinks to the very small, below 10 students. The truly dramatic benefits are only seen at the level of 1 to 3 students, which is more like tutoring situations, and appears to be explained by the heightened frequency of one to one interactions. This finding from more than 100 years of research, and hundreds of studies, merits very careful consideration for policy concerning residential program size – particularly if learning and behavioral development are desired outcomes of residential programs.
- **Analyses of the Largest Data Sets in the Field of Developmental and Intellectual Disabilities**: By combining old data with newly analyzed recent data, the pattern of declining quality with increasing size of community homes becomes more clear. Increasing the size of group homes is associated with considerable risk of losses in many dimensions of quality. The decline begins at 4 residents and above; beyond 6, the decline is sharper.
- **Money**: By simply looking at the average cost per person of community homes across the large data sets, we find only weak and conflicting evidence that making homes larger results in savings.[4] In the broad view, the conclusion is the exact opposite. The largest settings are, in fact, the most expensive human services in human history. In this Policy Report, we show

[4] This is a question that requires further study, however, because the kind of people assigned to larger and smaller settings tends to vary somewhat. This may complicate the cost findings.

evidence that, even in the range below 10 people in a home, the larger settings do not consistently show cost savings.

For policy makers and advocates in the field of developmental and intellectual disabilities, what is learned from the current state of the literature and most recent science strongly supports a few fairly simple conclusions:

Other things being equal, smaller homes are associated with higher qualities of life and better outcomes.[5]

The evidence that systems can 'save money' by putting people into larger group homes is extremely weak, and the common interpretation of 'economies of scale' has consistently neglected to include consideration of 'diseconomies of scale.' Moreover, careful review of decades of studies on the economy of scale arguments in industry and sociology strongly lead to doubt about the original assumptions of higher productivity in larger organizations.

There is no consensus on what constitutes the optimal number of people in a residence, but across an extraordinary variety of states and systems, qualities of life and outcomes drop measurably when there are 5 residents, and drop sharply when there are more than 6 residents.

[5] Some of the qualities of life and outcomes treated in the present research are individualized treatment, opportunities for control over one's own life (with support as needed), person-centered planning, physical quality of the home, integration, friendships, comfort, lack of loneliness, services delivered for specified needs, achievement of individual goals, and self-reported qualities of life.

The Notion of Economy of Scale

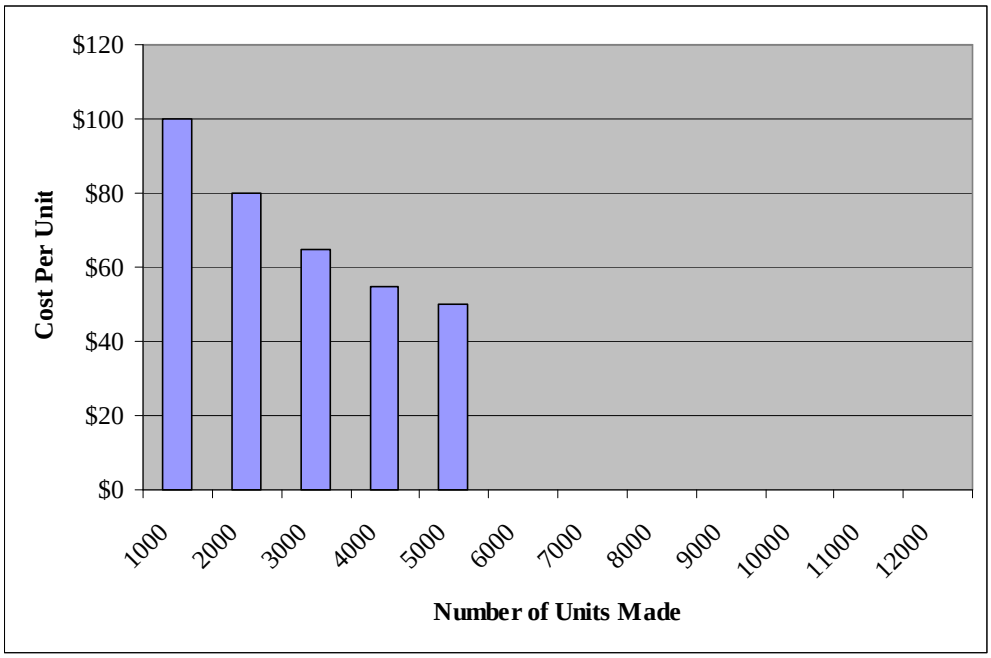
There is a great deal of pressure, during the current hard fiscal times, to move people with intellectual and developmental disabilities into larger and larger homes to save money. A great deal of the pressure to do this arises from the idea that it would be more "efficient." The notion of "Economy of Scale" is at the core of this kind of thinking. This is an idea from economics that is present in every elementary textbook. Unfortunately, the Economy of Scale idea is only half of the true picture – the other half is Diseconomy of Scale, which has usually been forgotten or ignored by proponents of larger settings.

The idea of Economy of Scale comes from the original 'assembly line' innovation of industrial production. The bigger the plant, the greater the 'per-worker' productivity was the belief – because bigger plants could keep all the resources for allied and ancillary needs in one place – instead of having separate administrative units and support operations for many small and separate units.

This kind of thinking helped create America's movement toward large scale institutions. Samuel Gridley Howe, who brought the model of a self-sufficient agrarian community (the original institutional model) to America in 1848, said soon after seeing the fruits of his innovation,

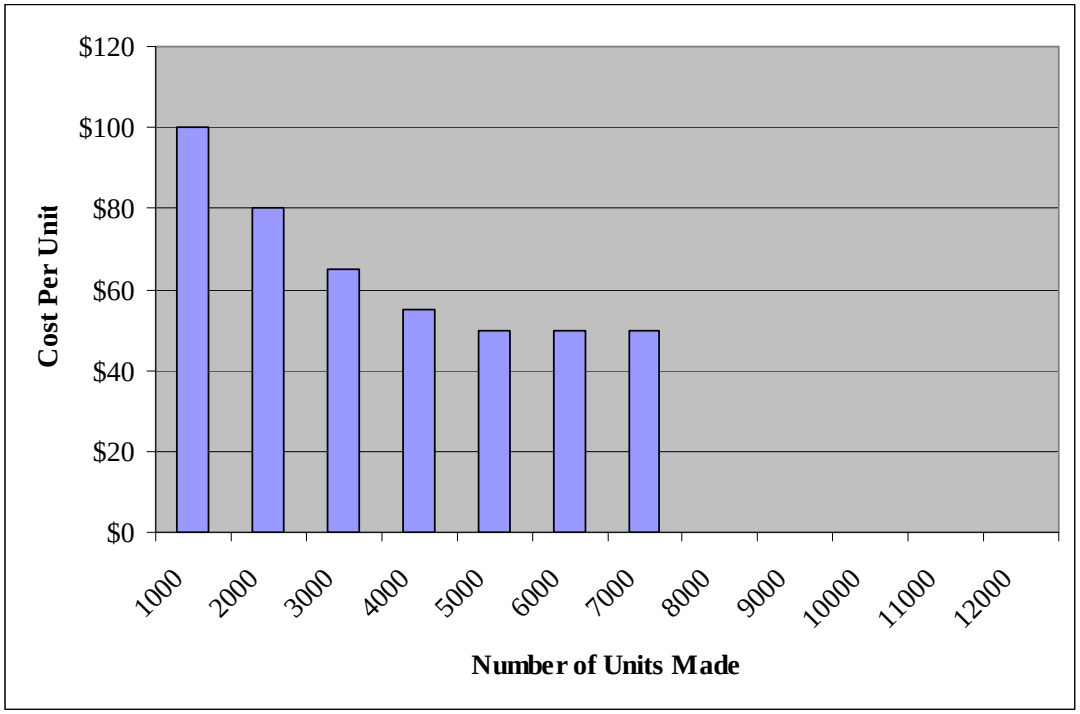
> As much as may be, surround insane and excitable persons with sane people, and ordinary influences; vicious children with virtuous people and virtuous influences; blind children with those who see; mute children with those who speak; and the like.
>
> **People run counter to this principle for the sake of economy**, and of some other good end, which they suppose cannot be had in any other way; as when they congregate the insane in hospitals, vicious children in reformatories, criminals in prisons, paupers in almshouses, orphans in asylums, blind children and mute children in boarding schools. Hence I begin to consider such establishments as evils which must be borne with, for the time, in order to obviate greater evils. I would take heed, however, against multiplying them unnecessarily. I would keep them as **small** as I could. I would take the most stringent measurements for guarding against those undesirable effects which lessen their usefulness; and for dispensing with as many of them as may be possible.

The general theory of Economy of Scale is simple. As the size of an organization increases, the ability to keep administration centralized will cause higher productivity per worker per hour. In graphic form, it looks like this:



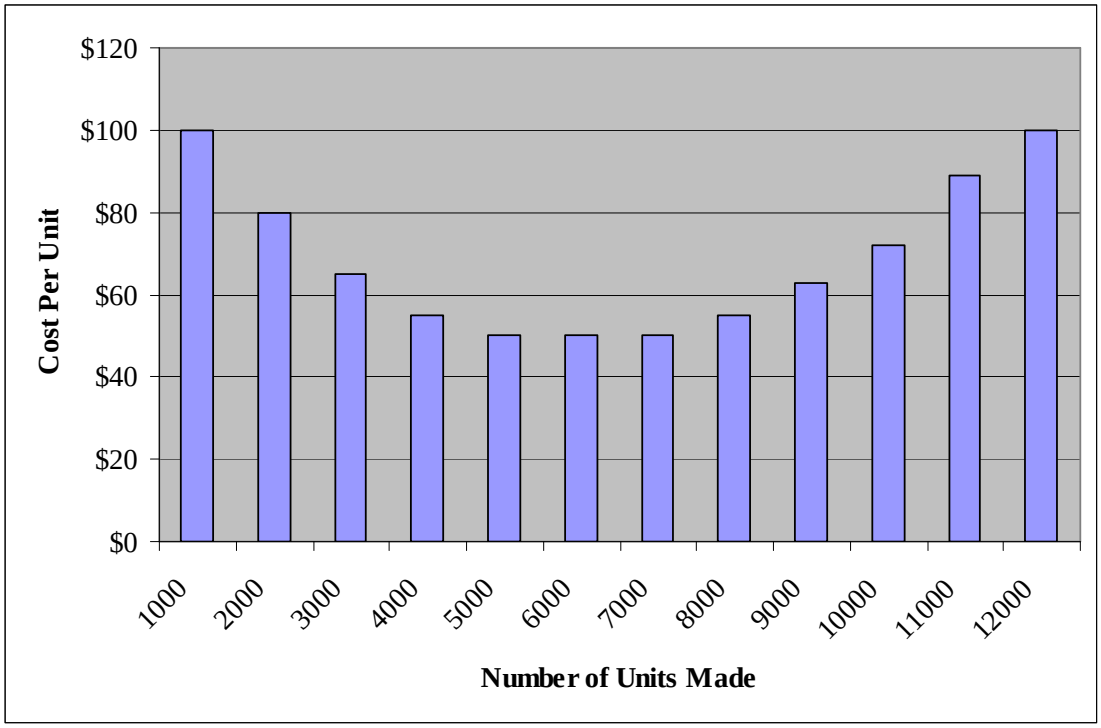
The graph shows the "Cost Per Unit" going down with the size of the operation – the total number of units manufactured. This was part of Henry Ford's greatest innovation with the 'assembly line' concept. Efficiency was the goal.

Of course, there had to be a limit to this gain in efficiency with size. That limit was called "Diminishing Returns" in many textbooks, and it looked like the graph below – as the size of the operation got even bigger, there were no further gains in efficiency.



As the size of the operation increased to higher levels, the Cost Per Unit stayed the same. This 'leveling off' of the theorized gains with size was the point of Diminishing Returns.

What is forgotten by most policy makers in the human services is that the economists long ago realized that there is also "Diseconomy of Scale." When organizations become too large, inefficiencies set in. This phenomenon is the subject of a very large literature in economics, reviewed in Appendix B of this Policy Report, but the salient point is that organizations that become too large not only lose the theorized Economy of Scale – they go the other way – into Diseconomy of Scale. That situation is graphically represented below.



When an organization gets too big, its efficiency suffers. On the right side of the graph, cost per unit goes right back up to where it began, when the organization gets bigger.

According to Shumacher (1973), that is a natural part of the ecology of organizations – and when they reach such counterproductive sizes, they tend to break up into smaller subunits.

Because the current fiscal climate drives policy toward economy, it is essential to know whether larger residential settings will indeed lead to cost savings without major losses in quality of life. The simple pattern of Economy of Scale, followed by Diseconomy when groups become too large, strongly suggests that homes for people with intellectual and developmental disabilities might fall into diseconomy if made too large. The question has become: Where is that point in size, beyond which quality may be impaired and costs may begin to rise back up?

The research literatures from Sociology, Organizational Psychology, and Education all shed considerable light on this issue. From multiple perspectives, the optimal size of human groupings tends to converge in the region below 10 people for most, if not all, important functional tasks. The latest literature in intellectual

and developmental disabilities on the issue of size, plus the new analysis of the largest databases, supports those perspectives.

The Group Size Issue in Sociology

The review of sociological interest and research shows that questions about group size have been a major concern in the development of modern sociology. Beginning with Simmel, continuing right into the content of the most recent introductory textbooks, and covering nearly 100 years, it is clear that group size has been a major concern of sociologists. The scientific evidence about group size and group effectiveness gives a complex picture, probably because of the many and varied approaches to measuring effectiveness. However, a consensus from the sociological literature does seem to emerge: human beings tend to prefer to live, work, and play in small rather than large groups. The preferred group size is clearly below 10 people, but beyond that, the evidence is not yet conclusive.

This sociological tradition and interest in group size is in some ways to be quite relevant to the issue of residential program size. In particular, these findings suggest useful insights into the question of group homes for citizens with disabilities, in that within the small group size range, as size increases,

- People spontaneously interact in very small groups, mostly dyads or one on one (as in the direct observation of natural interactions research of James)
- People spontaneously subdivide their groups, rarely allowing them to exceed 5 or 6 people (as in the party situation studies of Simmel)
- Participation via individual effort tends to decrease in a phenomenon often called 'free riding' (as in the tug of war studies of Kohler)
- Participation via communication tends to decrease and centralize, relying on increased leadership by the few, but allowing anonymity and silence by the many (as found by Bales et al.)
- Authoritarianism increases from group size four to eight, correlating with the emergence of leadership and of members becoming passive followers (in the work of Carter et al.)
- Satisfaction with group process may reach a 'saddle point' around five people (as in the famous and influential work of Slater)
- Satisfaction with group process falls off in groups above five, and keeps falling lower into the teens, where it levels off at a low state
- Increasing size is related to formalization, rulemaking, regimentation, bureaucratization, and decreases in personal relations (discussed by Clegg & Dunkerley)

Applying these sociological findings to the world of residential programs implies that small numbers of residents are beneficial to the quality of life and interactions of individuals However, there is insufficient evidence to draw conclusions about specific sizes of homes that are 'too big.' And, as is obvious from the beginning, there really cannot be an optimum number for all groups and all kinds of people. One size will never fit all. Nevertheless, our effort here is to think in policy terms, covering thousands of people, in thousands of homes, and considering the averages of well being and quality across them. With that perspective, the sociological body of knowledge suggests that there is probably a natural human break point somewhere between four and six people in a home. Group sizes that big can be tolerated, and can sometimes be effective and/or satisfying – but where there are more people than that, the most desirable qualities of intimate and rewarding human interaction are lost.

The Group Size Issue in Organizational and Industrial Psychology

Until the 1980s, the study of size and effectiveness in the organizational research literature was somewhat chaotic, and very difficult to interpret. In 1985, Gooding and Wagner reviewed the relationship between size and performance of organizations and their subunits. Gooding and Wagner screened nearly 200 published studies, and selected 31 that met consistent methodological criteria. From these 31 studies, they attempted to find an interpretable pattern. The remainder of this section is a review of their conclusions.

Gooding and Wagner noted that three kinds of scientists had been at work on the question:

1. Industrial-organizational economists had approached it through examination of organizational economies of scale. Most often, these analysts were searching for the size of organization or unit that would optimize the cost per unit of production. Findings in the literature were inconsistent.
2. Many, but not all, organizational theorists also approached the problem with an inherent belief that organization size would be associated with significant economies of scale. Others emphasized the ability of larger organizations to exert more control over the sources of resources. This and related perspectives predicted that larger organizations would produce more, but not necessarily more per worker.
3. Social psychologists approached the problem largely from the group, rather than organizational, level, and often reported an insignificant relationship between group size and indices of effectiveness, but sometimes reported decreasing effectiveness with increasing size. These analysts frequently hypothesized "free riding" as the culprit (in which group members, relatively anonymous in larger groups, could slack off with no one noticing), and also higher coordination costs with larger groups.

These three kinds of scientists had been approaching the question with different definitions and measurement techniques. Gooding and Wagner suggested that the reason the literature was confusing and often contradictory was that different kinds of scientists had been defining and measuring things differently. Gooding and Wagner specified three dimensions which had varied across studies:

1. The LEVEL OF ANALYSIS. Some studies had examined entire organizations, while others had analyzed subunits within large organizations.
2. The PERFORMANCE MEASURE. Some studies had used key informant ranking, others used organizational records, and others used physical output. Most importantly, some had used absolute output and others had used relative output (i.e., output per unit of size), potentially a very important difference.
3. The SIZE MEASURE. Some investigators had operationalized the size variable as the number of employees, others as the number of beds in a hospital or like facility, others as financial assets, and other as the magnitude of output transactions such as sales or number of clients served.

Gooding and Wagner concluded that these three variations could explain a major proportion of the differences across the studies. Employing a form of meta-analysis, as improved by Hunter, Schmidt, and Jackson (1982), Gooding and Wagner categorized each of the 31 studies according to the level of analysis, the performance measure, and the size measure. Their conclusions were clear:

> 1. Studies that used the organizational LEVEL OF ANALYSIS found that larger organizations were more productive in absolute terms, but not in ratio terms. That is, larger organizations produced more units, but did not produce more per worker. Gooding and Wagner concluded that there was actually no evidence for economies of scale in terms of worker efficiency. This finding was consistent across a variety of SIZE MEASURES.
> 2. Studies that used the subunit LEVEL OF ANALYSIS showed a negative relationship between size and productivity, both for absolute and relative measures of performance. This also held true across studies using a variety of SIZE MEASURES.

The group home size question is at the subunit LEVEL OF ANALYSIS. The typical situation is that a private service provider corporation operates several group homes. Thus each group home is a subunit of the larger organization. The group home PERFORMANCE MEASURES are related to the quality of life of the individuals in the group homes, and are therefore best thought of as efficiency measures. For example, growth in adaptive behavior/independent functioning per unit of staff time or per dollar would be useful measures of performance. The SIZE MEASURE in the group home situation is simple: the number of people living in the home.

According to Gooding and Wagner's meta-analysis, then, we should expect to find smaller group homes producing more positive outcomes.

The organizational literature reviewed here includes more than 100 pieces of primary research. From them, no clear consistent pattern of the organization size and effectiveness relationship emerged, until the meta-analysis of Gooding and Wagner (1985). They showed that prior studies had varied in their levels of analysis (organization or subunit), their performance measures (absolute or relative), and their size measures.

When these were examined via meta-analysis, a clear pattern did emerge. This pattern called the entire notion of Economy of Scale into serious question.

Whether approached from the perspective of the organization or the subunit, when confounding variables were controlled, larger organizations and larger subunits did not produce more per worker.

The contribution of Schumacher, in ***"Small Is Beautiful: Economics as Though People Mattered"*** is considerable in the present context. While Gooding & Wagner's brilliant meta-analysis brought order to the study of organizational size, it also called the traditional Economy of Scale assumptions into very serious question. At the same time, Schumacher was calling for consideration of outcomes other than economic. Our concern in the human services is precisely suited to this refreshing new perspective – and it came along at the same time that even the most rigorous scientists were questioning whether larger plants really produced more widgets per person per hour. Perhaps our assumptions about size and Economy of Scale, so easily imported from industry into the human services, were dangerously misleading.[6]

The organizational goals of group homes for people with intellectual disabilities are fundamentally human, not financial. They are primarily concerned with the quality of life experienced by the people who live in them.[7] Quality is multi-dimensional; it has dozens of aspects. Among them are developmental progress toward increased independence and socially appropriate behavior, integration, relationships, opportunities for choicemaking, satisfaction, individualization, services and supports intensity, attainment of individual goals, normalization, health, safety, and physical comfort. Hence indicators of each of these organizational goals must be explored. If the analyses are done properly, the quality and outcome indicators are likely to turn up to be strongly related to size, if the literature from organizational and industrial psychology is any guide.

For this Policy Report, we performed exactly that kind of analyses, across many states and many thousands of people in various kinds of homes and service milieus.

[7] And the direct support people who work in them – good research must take both into account as a synergistic and mutually reinforcing system.

The Group Size Issue in Education: The Class Size Debate

Just on the topic of academic achievement, illustrating the degree of conflict in 100 years of study of this issue, Slavin (1989) wrote:

> The search for substantial achievement effects of reducing class size is one of the oldest and most frustrating for educational researchers. The search is approaching the end of its first century; eventually, it may rival the search for the Holy Grail in both duration and lack of results. (Page 99.)

The situation had been substantially improved by application of the method called "meta-analysis," which means rigorously pooling the findings from a lot of studies, weighting them by how well they were designed, and coming up with the best summary of all of them put together. Glass and Smith (1978) produced the first such analysis. They performed a meta-analysis on the outcomes of 77 studies that included 725 comparisons of student achievement between smaller and larger class sizes. (Glass was, in fact, in the process of creating the concept of meta-analysis while working on the class size literature.) In sharp contrast to past narrative reviews, which had seen the literature as internally inconsistent and inconclusive, Glass and Smith's meta-analysis came to the relatively clear conclusion that smaller classes were associated with superior achievement outcomes.

Cooper (1989) suggested caution, coupled with a firm conviction that the weight of the evidence was on the side of smaller classes:

> Reviewers of the class size literature disagreed over whether a reduction in instructional group size has its intended effect ... However, some consensus did emerge ... Reduced class size appeared to be most efficacious with low-ability or disadvantaged students when reductions were in the range typically associated with Chapter 1 programs. Such reductions may not only lead to higher achievement but to better student and teacher attitudes and morale and to an enrichment of the core curriculum. (Page 98.)

Slavin (1989) was skeptical, and did the entire meta-analysis over again, calling his new approach "best-evidence synthesis." Using exactly the same studies as Glass and Smith, and even their own tables, Slavin showed that the average effect of the smaller class size on achievement was no more than about 13% of a standard deviation. In statistical terms, that is a very small effect.

Equally interesting, multiyear studies showed that initial gains faded after a year or two, suggesting that smaller class sizes might have, not only small benefits, but temporary benefits as well. The studies in his analysis reduced class sizes from an average of 27 to 16 students. Yet the effects were very small indeed. In trying to

explain why this might be so, Slavin's strongest suggestion was that *"teachers' behaviors do not vary very much with size of classes."* The implication was that behaviors might change slightly, but in the size range of real world classrooms, teachers really did not markedly change how they taught students whether they had 16 or 27 in their class.

Most importantly for our current concerns about residential homes, Slavin also showed that the major educational effects, even in Glass and Smith's own tables, occurred in the very small "classes" of size 1 to 3. From that, Slavin inferred that class size was the wrong focus for those concerned with national policy. For students such as those served by Title 1, what would be most beneficial was not smaller classrooms, but individual or extremely small group tutoring. This may be a key finding for the search for quality in residential settings for people with intellectual and developmental disabilities: we need to aim above all for situations that support frequent one-to-one interactions.

But academic achievement, while it is the primary purpose of schools, is not everything. Slavin made a major concession when he mentioned factors other than achievement:

> Of course, it is important to note that reductions in class size do seem to have significant effects on other variables, such as teacher and student morale (Glass et al., 1982). Reducing class size may be justified on morale and other quality-of-life grounds. However, as a means of increasing student achievement, even substantial reductions in class size have little apparent impact.

It is most intriguing that Slavin, who so strongly believes that the achievement claims are nonsense, is willing to consider the notion that smaller class sizes produce other kinds of significant benefits. He admits that the evidence is fairly clear that people <u>like</u> smaller classes better. They are <u>happier</u> in them. The <u>quality of life</u> may be superior in smaller classes. This may be an important clue for the present effort, which is concerned with quality of life as much as behavioral outcomes.

Moreover, Slavin agrees that the evidence supports a notion that size may become very important when class size drops to three or fewer, a conclusion that may be highly related to group home models. Pennsylvania limited group home size to three people for more than 20 years, but then began to approve larger ones – with quality impacts that have been widely suspected, but not studied with rigor.[8]

[8] Personal communication with leaders of three provider agencies, 2007.

In summary, the classroom size literature achieves consensus about only four findings: (1) smaller classes are usually found to be related to slightly better student achievement, but mostly in the lower grades; (2) smaller classes are consistently found to be "better" in terms of indicators of quality other than student achievement such as satisfaction and morale; (3) large differences in achievement and qualities of schooling are not found until class size drops below 10 students; and (4) dramatic improvements in student achievement are only found in the extremely small "tutoring" situations in which a single teacher is alone with just one or a very few students.

This fourth finding parallels a conclusion from the intellectual disabilities literature, that the best results come from situations in which single support workers are alone with a very small number of people.

The Group Size Issue in Residential Programs for People with Disabilities: Literature Review

This section provides a chronological review of the research concerning the size and quality of residential settings in the field of intellectual and developmental disabilities.

Klaber (1969) was among the first to suggest that setting size might be related to quality. He studied institutional settings in Connecticut, and concluded that living unit size was more influential than overall staff ratios in promoting quality. He suggested that 1 aide for 10 residents would result in much higher quality than 10 aides for 100 residents.

The next explicit treatment of the size issue in the intellectual disabilities field was that of King, Raynes, and Tizard (1971) in England. They developed a scale to measure the degree to which daily life was regimented and institution-oriented, as opposed to individualized and person-oriented, called the Resident Management Practices Inventory.[9] They applied the scale to mental deficiency hospitals (bed sizes from 121 to 1650), voluntary homes (bed sizes from 50 to 93), and group homes (bed sizes from 12 to 41). They found care practices to be more person-oriented in the smaller facilities. However, within any of the three types of facilities, size was not found to be significantly related to the quality indicator.

Their overall conclusion, which probably confused the size issue for years to come, was: *"Our hypothesis that management practices are not effected [sic] by institutional size was confirmed" (p. 184)*. What they meant to say was that the smaller types of facilities were always better than the larger types. Within a type, though, size did not matter; a 121 bed institution was just as regimented as a 1650 bed institution.

Advocates and program designers were already issuing opinions about optimal size. Bedner (1974), writing from the experience of programs in Denmark, Sweden, and Holland, wrote that:

> "The retarded person needs a small number of interpersonal relationships so that those relationships can be accepted as positive stimulation ... The sizes of group homes for children should be from four to six residents ... For adults, the same principles apply. Group homes should be of either three to four or seven to eight persons, but no larger." (p. 33)

[9] Several research groups are still using derivatives of this scale.

In 1974, Harris, Veit, Allen, and Chinsky (1974) performed studies in one large institution, using direct observation of staff-resident interactions. They started out with an interest in the impact of staff ratio on the amount of direct nurturing interaction between staff and residents. Surprisingly, they found essentially no differences across wards with widely varying ratios. Generally, aides did not interact very much at all with the people living on the wards; moreover, ***when the investigators actually added another aide to several wards, the people living there experienced absolutely no increase in interaction. The staff did, however, interact with each other a lot more***.[10]

Harris et al. did find one condition which was consistently associated with higher quantity and quality of interactions: when staff people were alone, working with a small group of consumers. They suggested that large wards should be broken down into smaller units, each staffed by a single aide. They speculated that creating small family-like living units within institutions of whatever size would create higher quality care. Interestingly, this is in effect what happens in small group homes.[11]

Balla (1976) attempted to summarize the state of knowledge about the relationship of institution size to quality of care by reviewing the literature. His review relied heavily on a cross-cultural study (McCormick, Balla, & Zigler, 1975) that used the same measure of quality as King, Raynes, and Tizard (1971), and that obtained similar results. Balla concluded:

> In summary, it seems that from the studies concerned with what may be called the quality of life dimension, care is more adequate in smaller community-based institutions, especially in those under 100 population. However, the number of studies upon which these conclusions are based is small indeed. In addition, the literature reviewed provides almost no indication of an answer to the critical question of whether there are structural aspects of large institutions that tend to coerce practices leading to poor quality of care. The most appropriate conclusion from this literature review would seem to be that the data base if far too scanty at this time to construct a social policy based on empirical evidence.

Balla's work considered <u>only</u> institutions – in no way did it compare quality in institutions versus small community settings. Although Balla found weak evidence that the quality of life in smaller institutions was better than larger

[10] This finding, that adding staff did not add quality interaction with residents, was parallel to Kohler's 1927 findings in the Tug of War experiments – adding pullers to Tug of War teams did not add the full strength of the new person, because the other team members tended to relax slightly when new members joined the team.

[11] This, in turn, relates to the Class Size finding that the large education achievement gains only occur in the smallest groups sizes – 1 to 3 – more in the nature of tutoring, with one to one interaction most prominent.

institutions, his work shed no light at all on the issue of very small or family scale community homes.

O'Connor (1976) took the next step, and did compare smaller homes to the larger institutions. Analyzing data from a national survey of community living situations, O'Connor reported that homes with fewer than 20 residents were more "normalized." In contrast to homes serving more than 20 residents, there were fewer security features, personal effects were more visible in peoples' rooms, and there was greater privacy. "Size" was the only factor that distinguished those group homes which were considered "normalizing."

Heiner and Bock (1978) were the first to attempt to relate setting size to individual behavioral growth and development. Using a large data base on Minnesota's group homes, all certified as ICFs/MR, they tested whether size made any differences in developmental growth, residential stability, and costs. They used data on 163 people from 1975 and 1976. The 250 people were living at 18 group homes, for an average size of 14 people. There were 4 homes of size 6, 8 of size 8, and 5 of size 15.

The behavioral measure was the Minnesota Developmental Programming System (Bock, 1974), a well known scale with inter-rater reliability of .84 and test-retest of .94. The best developmental progress was seen in the 8 bed homes. However, that finding may have been related to the fact that 5 of the 8-bed sites served young children, and their progress was much greater than that seen among the adults in all the other homes.

The authors checked these results against formal reports of functional improvement maintained by the Department of Health. Their data base included 141 people in 5-10 bed homes, 192 people in 11-16 bed homes, and 86 people in 20-26 bed homes. The data showed that people in facilities larger than 20 exhibited less progress than the other two groups. Reported progress in personal hygiene and emotional behavior was slightly higher in 11-16 than in 5-10 bed homes, and progress in communication was highest in the 5-10 bed homes. These differences were small and no tests of statistical significance were reported.

Heiner and Bock detected no variation in residential stability by size. They also performed multiple regression analyses on cost, individual, and programmatic data. They reported that group home costs did not vary systematically by size.

From the various threads of evidence, Heiner and Bock concluded that *"The data support the conclusion that smaller (8 bed) facilities tend to produce positive client changes at a better rate than larger ones; and, do so without significantly higher costs."*

Heiner and Bock also summarized their impressions of the advantages and disadvantages that might go with small and large group homes. Their impressions came from the small group literature, the organizational effectiveness literature, and their direct experience with group homes.

SMALLER GROUPS (2 TO 10 PEOPLE)

ADVANTAGES
1. Greater actual participation for all members
2. Participation is more evenly distributed throughout the group
3. Evaluated more positively by group members
4. Fewer signs of tensions
5. Less strict conformity to group norms
6. Better performance on basic skills (cognitive and sensorimotor) as a result of small group instruction
7. Better performance on conjunctive tasks
8. Higher staff expectations
9. Greater opportunity for people with intellectual disabilities to model normal staff behaviors

DISADVANTAGES
1. Limited human resources
2. May be more expensive in terms of maintenance costs

LARGER GROUPS (10 TO 20 PEOPLE)

ADVANTAGES
1. Greater number of human resources
2. Increased problem solving ability
3. Greater opportunity to meet attractive others
4. Better performance on additive and disjunctive tasks
5. Greater anonymity for shy individuals (this could also be considered a disadvantage)

DISADVANTAGES
1. Organization may be a problem
2. Subgroups are likely to form causing greater potential for conflict
3. Relatively fewer members participate. The group is often dominated by one or a few powerful individuals
4. Strict conformity to normative group pressures is more likely
5. Organizational and interpersonal effects may interfere with the effective use of resources
6. Disciplinary control is exercised more often

Raynes, Pratt, and Roses (1979) reported that the presence of more than one staff person on a residential unit systematically <u>decreased</u> the frequency of

informative remarks to consumers. They suggested either very small settings or settings with very small subdivisions, as did Balla (1976).[12]

Landesman-Dwyer, Sackett, and Kleinman (1980) studied the effects of size in group homes in the state of Washington. Clearly skeptical of the claims that "small is good," Landesman-Dwyer and colleagues conducted direct observation studies of 240 people with intellectual disabilities, and of 75 staff members, in 20 group homes. The people were relatively highly capable, in that only 20% were labeled severely or profoundly retarded. The smallest group home had 6 people, and the largest had 20.

The authors found that staff behavior was much the same across all sizes of home. This was a surprising finding, because the smaller homes had significantly higher staffing ratios. However, their finding corresponds to the earlier Harris et al. (1974) research. Enriching the staff ratio does not seem to lead to more teaching, nurturing, or interaction with the people in the home.

Resident behaviors did vary somewhat with size, but Landesman-Dwyer et al. concluded that most of the differences were either unimportant or explainable from things other than size. One difference they did emphasize was the people in larger group homes engaged in more social behavior by "about 4 to 5 percent" than did those in smaller homes. The people in the large group homes interacted with more peers, were more likely to have a "best friend," and spent more time with their best friends than did people in smaller group homes. These socially oriented findings mirrored their findings reported a year earlier from a different study (Landesman-Dwyer, Berkson, & Kleinman, 1979).

Landesman-Dwyer et al. concluded: *"We did not find evidence of any dramatic effects of group home size in community based facilities that ranged from 6 to 20 residents. Social relationships did appear significantly enhanced as the number of peers increased, suggesting that extremely small group homes may be socially limiting."* This article was then criticized by advocates of smaller settings from a variety of perspectives, primarily that the range of sizes excluded the family-like settings being developed widely in many states – that is, below size 6.

Baroff published a review article in 1980, which examined the same literature reviewed by Balla (1976). Baroff reached conclusions quite different from those of Balla. First examining the class of studies he called "resident-

[12] This finding paralleled findings from the Tug of War and other organizational psychology studies.

oriented versus institution-oriented care practices" studies, he noted that *"What we have then is the curious finding that size* is *and is not important."* He was referring to the fairly consistent finding that size made a difference between types of settings, but not within.

Baroff re-examined the finding of Klaber (1969), that a 1 staff to 10 residents ratio was inherently better than 10 to 100. Baroff suggested that it might be most reasonable to admit outright that this was exactly what small community settings accomplished. Furthermore, he questioned the then-common thinking that the smaller groupings should be achieved simply by subdividing existing institutions. Baroff claimed that this would still keep people isolated from the rest of society, and that would not be in keeping with modern values, particularly integration.

Baroff expressed the opinion that the small residential facilities offer individualization possibilities which are inherently more difficult to realize in larger group care settings. He also suggested an inherent difference in the way caregivers view their roles: *"The institutional attendant is commonly one of a large number of employees. He sees other attendants come and go and this conveys to him his own sense of interchangeability. He does not, in fact, have the same degree of personal responsibility for the residents in his care as the foster or group home parent" (p. 114).*[13]

Baroff's summary of the second type of literature, that which relates size to behavioral growth and development, was simpler than Balla's:

> The current literature consists of eight studies which relate behavior to size. Seven of them show some advantage to the smaller setting and one shows no difference. None show any advantage to the larger ones.

Baroff's overall conclusion was also simpler than Balla's:

> It does seem that size makes some difference. Smaller residential settings, typically serving not more than 10 persons, can necessarily be more responsive to individual needs. Moreover, their location in normal community residential neighborhoods allows for easy access to the range of community experiences that can enhance social, vocational, and recreational skills and can foster greater independence. These same experiences are much more difficult to provide in the more physically isolated and autonomous setting of the large institution.

It is of particular interest that Baroff's review still gave no guidance about the quality of the smaller settings. He urged that size stay below 10, but that was

[13] This is clearly related to the sociological finding of increasing anonymity in larger groups, and the organizational finding of the phenomenon of "free riding."

all. The literature up to this point had nothing to say about quality and size in the range of 1 to 10 beds. No one had compared one versus three, or three versus six, or six versus eight.

However, the earliest suggestions that quality could be enhanced simply by subdividing large institutions into smaller subunits had been strongly questioned. Up to this point, researchers said, there was little support for such a claim – and more importantly, there was a need for more evidence on relative quality within family-scale community homes.

Investigating the quality of staff-consumer[14] interactions in day programs in England, Dalgleish and Matthews (1981) found that engagement was likely to be lower in a large room and when a large number of consumers are present, but this was not related to the staff-consumer ratio. The key variable was size itself, not the ratio. They speculated that when two groups of consumers plus their associated staff are placed together, the staff from the two groups will talk between themselves, at the expense of communication directed toward consumers. This finding was, once again, consistent with the 1969 suggestion of Klaber and the 1974 finding of Harris et al.[15] But Dalgleish and Matthews further pointed out the disturbing fact that, while many people had moved their homes from institution to community, nearly all of them were spending their entire day in a very large room with dozens to hundreds of other people with intellectual disabilities.

There has been a strong and vocal component of the disability field working to defend large settings – even the very large ones. The "Voice of the Retarded" is the most prominent and influential among them.[16] McCann (1984), a policy-oriented ally of that group, wrote an advocacy document entitled "The Sanctity of Size" for circulation in Louisiana. In it, he strongly questioned the size evidence, although not very thoroughly. It was a direct response to a bill introduced by Senator Chaffee of Rhode Island. The bill contained a provision that group homes receiving federal support could not exceed three times the average family size in the area of service. This would limit group home size to between 9 and 12 people. McCann concluded that there was no hard evidence that size made any difference, no good evidence that community placement was associated with any benefits, and

[14] The terminology used in their article is maintained here for clarity. Modern customs utilize different terminology.
[15] This phenomenon has been reported in this and other literatures frequently. This author has satirically called it the "softball team effect" - meaning that as soon as there are enough staff to form a softball team, interactions with the people living in the home will drop precipitously. At some critical mass point, workers will tend to interact with one another rather than with the people served, many of whom do not use verbal forms of communication.
[16] http://www.vor.net/about-vor/general-information/why-we-still-use-mental-retardation

no reason to believe that the quality of care in institutions was anything less than excellent. The document was never published in any book or journal, but it was widely circulated among proponents of institutional care.

Felce, de Kock, and Repp (1986) studied changes in the lives of 12 people in England, 6 of whom moved from institution to small community homes, while the other 6 remained in the institution. The 12 people were the most severely handicapped in the service area. The results included major improvements in the adaptive behavior of the consumers who moved to the community. Results in the community settings also revealed greatly improved staff performance in terms of interacting in positive ways with consumers. The authors wrote,

> Life in the small homes was characterized by a substantially greater opportunity to run one's own life. Increased domestic activity and personal and leisure engagement more than doubled nonsocial participation. Considerable staff effort in delivering antecedents and consequences was directed to eliciting such activity levels, particularly among the most handicapped individuals. As a result, social interactions between clients and staff also showed substantial improvement.

The authors commented directly on the size issue, noting the continuing interest of researchers. They found it particularly significant that the small homes had smaller rooms, and more of them, than the institution. The number of rooms tended to favor creation of the situation described by Harris et al. (1974), in which one staff person was alone with just one or a few consumers. They believed the changes could be attributed to this reallocation of staff resources into very small groups, to the material enrichment of the environment and its free accessibility, and to job specifications and staff training. They concluded by restating the fact that these major benefits had been observed in the most severely handicapped, longest institutionalized, people.

Landesman (1987) studied the movement of 147 people from one kind of institutional environment to another. The old settings were traditional institutional wards of 40 to 60 beds, dormitory style bedrooms, open bathing and toileting areas, large common living rooms, and clearly identified staff offices, coffee rooms, and storage areas. The new living units were 14-bed duplexes constructed on the grounds of the institution.

The duplexes had 6 to 8 people on each side. People had "single or double bedrooms, places for their own clothes and personal possessions, and private bathing and toileting areas. Each side had its own kitchen (although meals were prepared in a centralized kitchen), dining area, and small living room. The furniture was more home-like and colorful. On the outside, the duplexes appeared

to be attractive single-story brick homes, identified by numbers rather than names, and surrounded by sidewalks, streets, and yards."

Landesman's conclusions were not strongly supportive of a size and quality relationship in terms of staff-consumer interactions:

> In the new duplexes where the assigned staff: resident ratios had been enriched considerably, there was no evidence that this led to increased interactions between staff members and residents. In fact, residents actually spent significantly more time totally alone or without any staff person present than they had in the old halls. (p.114)

Other measures, however, more closely paralleled prior research findings:

> Management practices in the new duplexes were rated as significantly more resident-oriented versus institutional. Similarly, the Caldwell HOME scores reflected significant, although quantitatively small, increases in stimulation. Despite these important changes, residents' daily behavior was not affected dramatically.

This article was of particular interest because it was, in essence, a study of the then-current theory that, if small was good, then subdividing a large segregated and isolated institution into smaller subunits should enhance quality of life. These sorts of "make-believe community homes" have been constructed on institutional campuses many times.[17] Landesman's 1987 study is certainly relevant to the size issue, but what it appears to show is that even size cannot make a definitive impact on quality, if the "homes" are still on the grounds of an institution.

This leads to the somewhat more important speculation that size per se really may not be enough to obtain the full benefits seen in studies of community placement. Genuine community placement includes the important dimension of integration, of being in the presence of people who do not have disabilities. Community placement also includes traveling in the real world, as every person in a group home goes away from the home every weekday, as do most Americans.

In the early part of the Pennhurst Longitudinal Study research,[18] it was found that people living at the institution made significantly more behavioral progress if they attended <u>any</u> kind of day program <u>away</u> from the places where they slept (Lemanowicz, Feinstein, Efthimiou, & Conroy, 1980). The difference was attributed to simple daily stimulation via changes of environmental conditions each day. Generally, at the institution, people who were lucky enough to be in a day activity program would simply walk across campus each day, spend a few hours in

[17] There is one such project under way
[18] Directed by the present author.

planned activities, and then walk back to the residential unit. This simple activity was associated with significantly greater developmental progress – people who had a 'day program' gained significantly in self-care and independent functioning abilities, while those with no day program did not make any gains at all.

In community living, however, the daily routine involves more than just a walk across campus. It involves taking a car, van, or bus ride every morning to a day program or employment site. Moreover, the vehicle must travel through the "real world," rather than the institutional campus. People must see and be seen to some degree by non-handicapped members of the general public. They see other peoples' homes and staff as they make their rounds. They tend to spend much more time at the day program than they did at the institution. Perhaps these factors, cumulatively, are having the same effect as the simple day activities did at Pennhurst, but more powerfully. It seems reasonable to believe that this more normalized rhythm and routine of daily life, combined with increased stimulation and integrative opportunities, should be associated with enhanced quality of life. The evidence is consistent with such an interpretation.

If this were true, then once again, size *per se* might not be the most important variable. However, the dispersed nature of the community service system, and its use of regular family-size housing stock, forges an inextricable link with size.

More recent literature, however, has significantly changed the picture.

Lakin, White, Hill, Bruininks, & Wright (1990) noted very large differences among states regarding residence size. They found that, although there was an overall trend toward smaller residence size, there was considerable disagreement about the appropriate size range. They were the first to call for a national policy to make community living in small settings more uniformly available across the states.

Burchard, Hasazi, Gordon, & Yoe (1991) examined lifestyle and adjustment in three community residential alternatives. The study included 133 adults with mild and moderate levels of intellectual disability living in small group homes, supervised apartments, and with their natural families. Results of questionnaires and structured interviews with care providers showed that the residence settings supported quite different lifestyles with respect to independence, lifestyle normalization, and integration. The authors inferred that size of the home was one of the important factors in life quality, engagement, and integration.

Felce & Repp (1992) studied the community home model in England. They compared the small home model to institutional settings and larger community units. The small homes were found to produce beneficial client functioning and high levels of staff/client interaction. The paper concluded that interaction effects were possibly more powerful than single effects, thus illustrating the continuing difficulty of disagreggating the impacts of size, staffing, and individual characteristics.

In 1992, this author completed a doctoral dissertation which included size-related analyses of three large databases: the National Consumer Survey (Conroy, Feinstein, Lemanowicz, Devlin, & Metzler, 1990), the Pennhurst Longitudinal Study (Conroy & Bradley, 1985), and Connecticut's CARC v. Thorne Longitudinal Study (Conroy, Lemanowicz, Feinstein, & Bernotsky, 1990). Those analyses revealed strong evidence of a relationship between size and quality, with qualities of life and service falling off significantly above 4 residents, and sharply above 6 residents. That study did not, however, include consideration of costs of care.

Schalock, Lemanowicz, Conroy, & Feinstein (1994) conducted a multivariate study of quality of life among deinstitutionalized people in Connecticut. They controlled mathematically for individual characteristics and other complicating variables, and found that smaller homes in the community were associated with higher ratings of quality. Later the same year, Schalock (1994) gave more detailed findings from the same database, and reported that size was an important variable but the level of residential supervision was not important beyond the simple factor of the size of the home.

Felce & Perry (1995) explored the complex relationships between staffing levels and size of the home, and were unable to uncouple the two factors. Taken together, smaller homes with richer staffing ratios were naturally superior. They studied 15 housing services in South Wales, and examined complex relationships among ecological variables and resident characteristics. They reported that *"The relative benefits of small, community-based housing services over institutional and larger community settings were confirmed by the Welsh data."*

Tossebro (1995) produced an important study entitled *"Impact of size revisited: Relation of number of residents to self-determination and deprivatization."* Working in three Norwegian countries, he analyzed the impact of number of residents in facilities for people with mental retardation on two quality

of care measures, deprivatization and self-determination. It was hypothesized that the size of the facility would make little or no difference, whereas the size of the living unit will have a significant impact, but only within a narrow size range. *[Subjects]* were 591 residents (aged 18-67 yrs) of 36 facilities in 3 Norwegian counties. Data were based on staff interviews. Results supported the hypotheses: Living unit size had a substantial impact on self-determination and deprivatization in the 1 to 5 bed size range but not among larger units. According to a later review by Stancliffe (1997),

> Tossebro (1995) has helped to clarify this somewhat confusing picture. He found no association between self-determination and ***facility*** size (a number of facilities were made up of multiple living units) but a linear relationship with ***living-unit*** size. There was a strong correlation (r=.48) between self-determination and living unit size for small settings of 1 to 5 individuals but no relation (r=.05) for larger units of between 6 and 16 persons.
>
> Tossebro's (1995) findings are of considerable importance in interpreting research on living-unit size and point to the need to expand the meager research base on size effects in the 1 to 6 person size range that is characteristic of small community settings. The generalizability of Tossebro's findings is limited because all of the living units he examined were classified as institutions. Some very small facilities (4 to 9 persons) were located on an ordinary street, but "the smallest living units were largely located on institution grounds" (J. Tossebro, personal communication, December 4, 1995). One other limitation was that Tossebro assessed self-determination using a single staff rating of each person's freedom of decision. If his findings can be replicated in a community setting, using a more detailed, psychometrically sound measure of choice that does not rely solely on staff perceptions, the generality of his conclusions will be greatly enhanced.

Conroy (1996) used a matched comparison design for 51 pairs of people in community homes in Pennsylvania, and showed that many qualities of life were higher in smaller community homes, other things being equal. Moreover, the total costs of services and support were lower in the smaller homes. The study was complicated by the fact that the settings were associated with different funding streams, and were regulated differently. The larger settings were generally in the ICF/MR,[19] funding stream, and the smaller ones were funded via the Home and Community Based Services Waiver program. Because of the mixture of size and funding variables, the study provided a useful piece of evidence, but could not be definitive.

Perhaps the most significant study of the 1990s was performed by Stancliffe (1997). His article, entitled *"Community living-unit size, staff presence, and residents' choice-making,"* examined the impact of size of residence on residents' opportunities for choice among Australian adults with mental retardation who lived in staff-supported community residences housing one to five residents. Significantly greater choice was exercised by individuals living in smaller settings,

[19] ICF/MR stands for Intermediate Care Facilities for [People With] Mental Retardation.

even when personal characteristics of individual residents were controlled statistically. Staff presence (number of waking hours when staff were present in the home) was confounded with living unit size. Analyses including both staff presence and living-unit size revealed strong effects of staff presence, with more choice displayed in settings with longer periods when no staff members were present. Size effects were less evident once the variability associated with staff presence had been accounted for. Results suggested that both staff presence and living-unit size are important predictors of choice. According to Stancliffe,

> "Together with the results reported by Burchard et al. (1991), Conroy (1992, 1996), Schalock (1994), and Tossebro (1994), the present findings provide a strong case for asserting that, for small community residences, smaller settings (which often have lower levels of staff presence) are associated with substantially better client outcomes, notably choice. Although size was confounded with staff presence and/or residence type (e.g. ICF/MR status) for some of the studies in this list, taken together they offer consistent support for the proposition that size matters in small community residences. Looking at the residence-size literature as a whole, one is struck by the almost complete absence of contrary evidence. Although a number of studies of larger residences have reported no significant size-related effects, almost none have reported better outcomes in larger settings (e.g., Landesman-Dwyer et al., 1980).

Stancliffe, Abery, & Smith (2000) performed a study in which they attempted to go "beyond living-unit size and type"[20] They investigated personal control, an indicator of quality based on self-determination, among 74 adults in Minnesota community homes. They used advanced mathematical techniques to try to tease out the potential effects of individual differences, characteristics and funding streams, and found a clear and rather simple hierarchy. Personal control was highest is semi-independent homes, next highest in Home & Community Based Services Waiver homes, and lowest in community homes funded via the Intermediate Care Facilities for [people with] Mental Retardation (ICF/MR) program. Moreover, the findings held up even within the smallest range of sizes, from 1 to 5 people.

A meta-analysis of behavioral outcomes of deinstitutionalization was reported by Kim, Larson, & Lakin (2001). Their review of more than 30 studies showed that people tend to grow and learn and develop independent functioning skills far more rapidly and effectively in small community homes than in large institutional ones. Their abstract stated:

> A summary of studies conducted between 1980 and 1999 on the changes in adaptive behavior (daily living skills) associated with leaving and staying in institutions. It reviews over 30 studies that followed people from 6 to 72 months after leaving, some

[20] Stancliffe, R.J., Abery, B.H., & Smith, J. (2000). Personal control and the ecology of community living settings: Beyond living-unit size and type. ***Mental Retardation, 105***, 131-154.

> with comparison groups that stayed, some just longitudinal and few that make both comparisons. The consistency of the findings to the benefit of the leavers is extremely impressive.

Cross (2002) reviewed the research on size, and reported to the Australian Capital Territory's Department of Disability, Housing, and Community Service that:

> There has been considerable debate within the literature as to whether 'size' is a key variable in successful and unsuccessful living outcomes. Generally size alone is not considered to be the powerful determinant of outcomes, however there is substantial evidence that size is a factor. Several major studies show that reduction in 'institutional' practices (by staff, and consequently by clients) is most likely to occur when size is small. In some studies this is considered to be 3 or less, in others 4 or less.

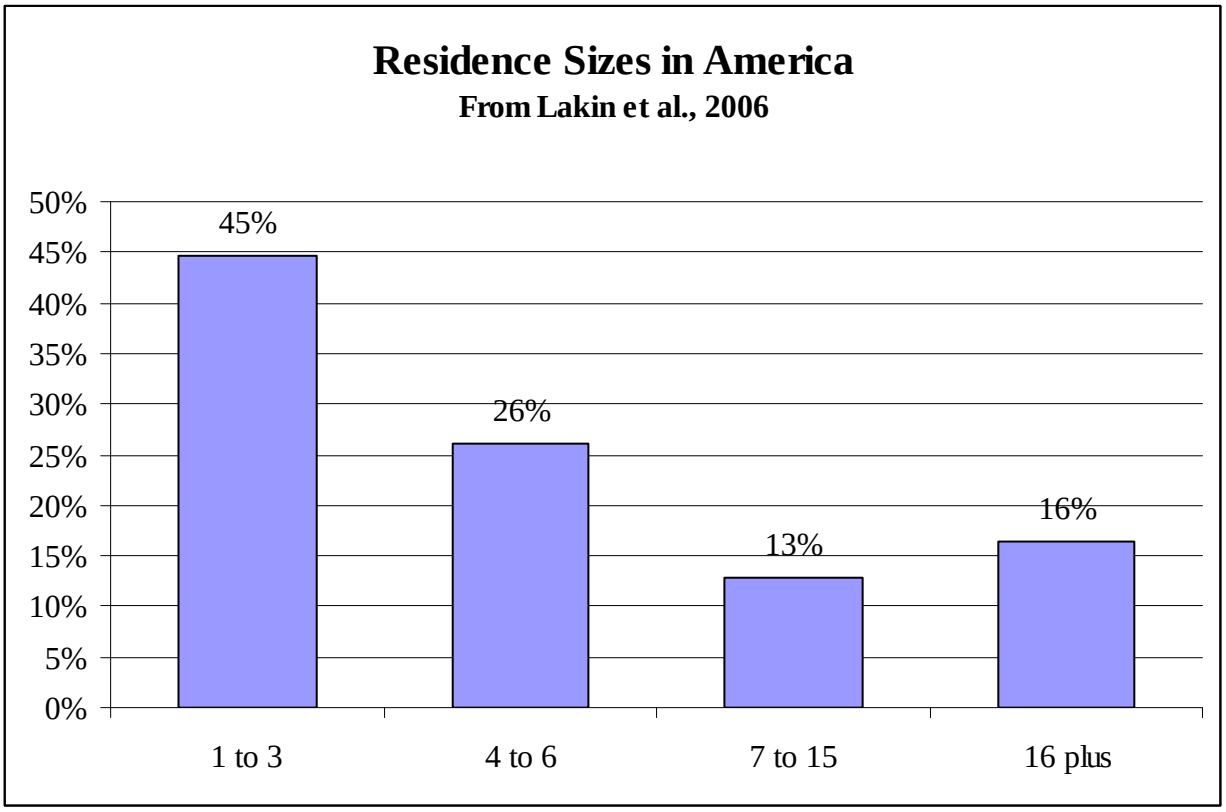
During the past decade, a new resource for databased analysis of the issue of size has been constructed. The National Core Indicator project[21] was designed to collect data on qualities of life and service among people with intellectual and developmental disabilities in residential settings. It gradually grew to include participation of more than 20 states.

Recent analyses, reports, and publications shed light on variations in setting size related to quality indicators including choicemaking, loneliness, and liking one's home. The NCI data have also been used to explore relative cost of two kinds of community funded settings, and this analysis was also related to the size of the home.

Because the NCI data are so new and significant, they are treated in some detail in the *"New Analyses from the National Core Indicators"* section of this report.

[21] See the National Core Indicators website at http://www2.hsri.org/nci/

That summarizes the research literature on the size of group homes in developmental and intellectual disabilities. Since 2000, there have been reports of trends, but we found no further research investigations. Lakin, Prouty, & Coucouvanis (2006) reported on 'changing patterns in size of residential settings,' updating their earlier reports. They had found that in 1977, the average residence for citizens with intellectual & developmental disabilities was 22.5. By 1994, it was 4.9. From the year 2000 to 2005, the preference for small settings continued. In 2000, 39% of people in residential settings were in size 1 to 3 person homes, and in 2005 this figure had increased to 45%. The figure below shows the most recent size distribution of residential settings for people with developmental and intellectual disabilities in America.



In 2005, the total number of people in these residential settings was 411,215. The average cost of the large institutional settings, above 16 people, was more than $200,000 per person per year. The average cost of the small community settings was approximately half of that figure. Clearly, this was an issue with considerable policy import.

The Group Size Issue in Residential Programs for People with Disabilities: New Research

In 1992, we analyzed data from the National Consumer Survey, the Pennhurst Longitudinal Study, and the Connecticut CARC v. Thorne Longitudinal Study with regard to size and quality (Conroy, 1992), and found strong evidence of a direct relationship. That investigation would have benefited from further analysis of small settings, and it did not include costs. Here we have analyzed newer data to explore the size-quality issue, and have included large scale data on costs.

The analyses presented here are primarily offered in graphic format, without complex statistical descriptions, although those are available and all the relationships depicted in the graphics are 'statistically significant' at very high levels. The aim of this presentation is to show whether or not there is a clear, simple, consistent relationship between qualities of life and the size of a group home.

To reveal the answer, we present graphs of quality by the size of the homes across the studies and across many indicators of quality – individualized and person-centered support practices, perceived quality of life, power & control, integration, physical quality of the home, normalization, and individual behavioral progress over time. The number of graphs presented could be overwhelming, but they are all designed to show whether qualities really do vary with size – and are therefore easy to interpret.

The evaluation, research, and quality assurance work we analyze here comes from long term projects in California, Indiana, Oklahoma, Michigan, and the National Core Indicators efforts now under way in more than 20 states.

We tracked the progress of deinstitutionalization in California from 1994 to 2002, and produced more than 30 formal scientific reports on quality. By the end of the 'Coffelt Quality Tracking Project' there were just over 2,400 people being visited annually, face to face, with collection of multiple measures of quality. The studies also included mail surveys of every known family every year, and a quality feedback system to alert local authorities both to situations of concern and situations of unusual merit.

Indiana's progress away from institutional models was tracked from 1997 to 2001, and included direct data collection with more than 600 individuals in their

homes, both before and after movement from institution to community. There were 10 formal research reports issued.

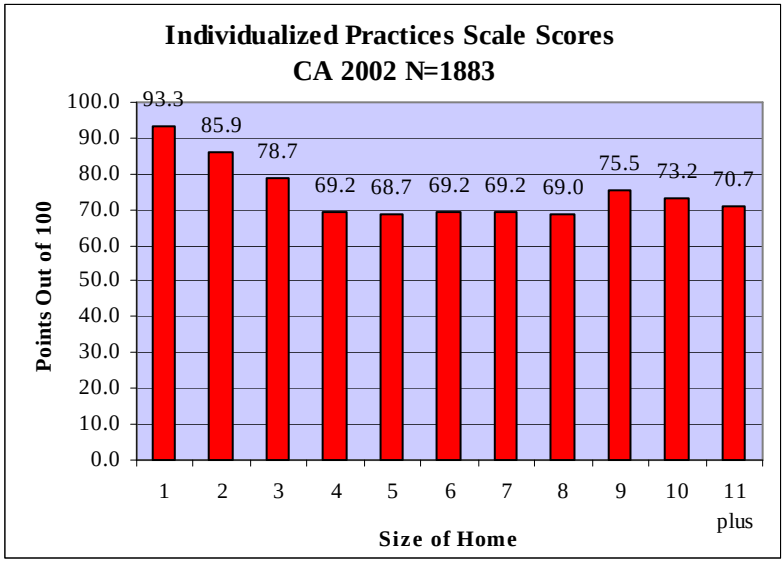
Oklahoma's Quality Assurance Project began in 1992, and continues to the present. It was focused on the approximately 1,000 people who moved out of the Hissom Memorial Center when it closed under court order, but at times included more than 3,500 Oklahoma citizens with disabilities in community settings. There have been more than 30 formal reports arising from this work, which is probably the largest and longest lasting effort to track community quality in the nation.

In Michigan, as part of our research on self-determination for the Robert Wood Johnson Foundation (Conroy et al., 2002), we visited more than 400 potential participants in 1998. Then in 2001 and 2002, we re-visited more than 200 of them, measuring many aspects of quality of life and service.

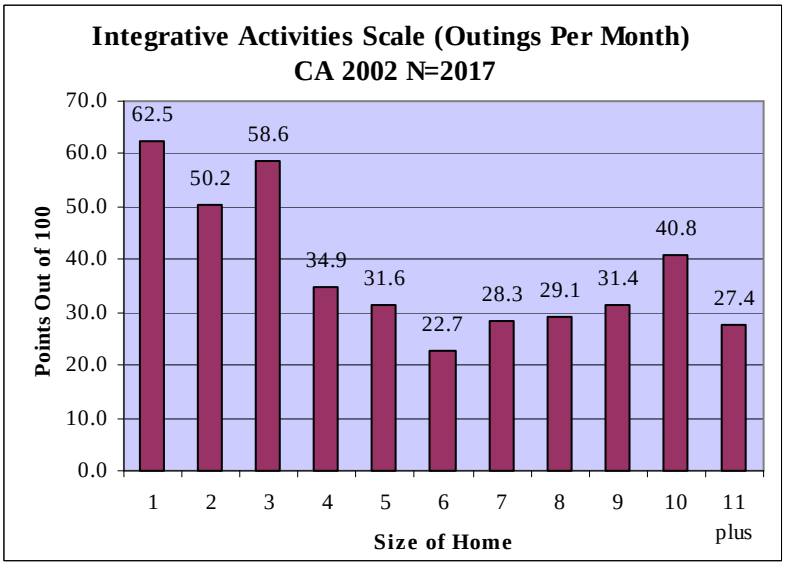
The National Core Indicators project (http://www2.hsri.org/nci/) is an attempt to collect consistent data on community residential settings across state lines. This is the first long lasting undertaking of its kind. It has recently reached the magnitude at which useful analyses of issues like the size of the home can be conducted. We report on the findings of the NCI team with regard to size here.

California's Coffelt Quality Tracking Project

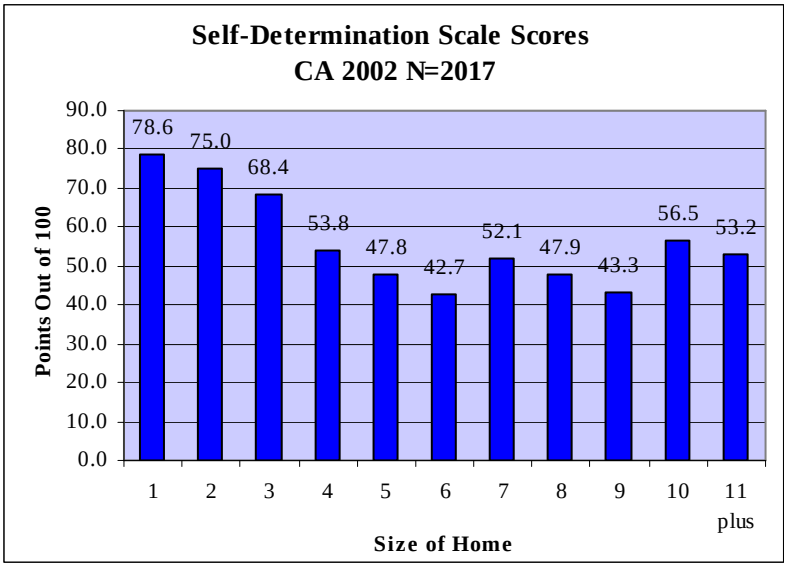
The California measures included a scale of individualized practices in the home. The scores on this scale do vary with size of the home. The data from 2002 show the pattern clearly, with larger homes showing less individualization.



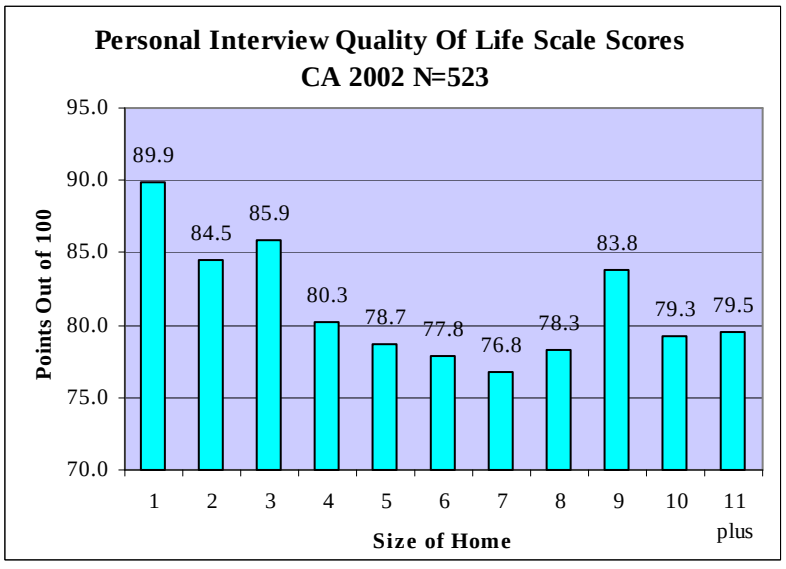
The frequency of integrative activities was measured simply as the number of times per month that each person 'got out' of the home for community outings. The size effect was evident.



A measure of individual power and control, the Decision Control Inventory, was developed for the research on self-determination, and is highly reliable. In California, opportunities to exercise choice were highest in the smallest homes.

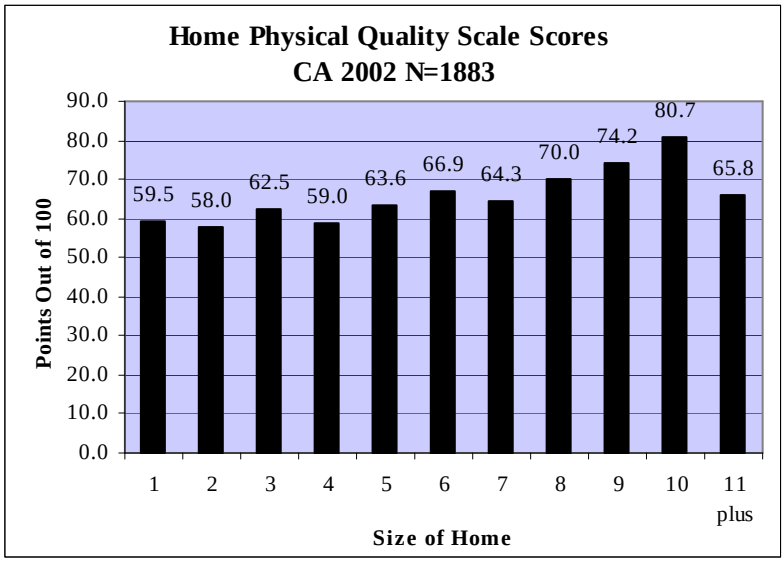


On every visit, an attempt was made by our data collection 'Visitor' to directly interview the focus person. Many people in community residential settings were unable to relate their experiences verbally, but for those who could, the data showed a clear pattern.

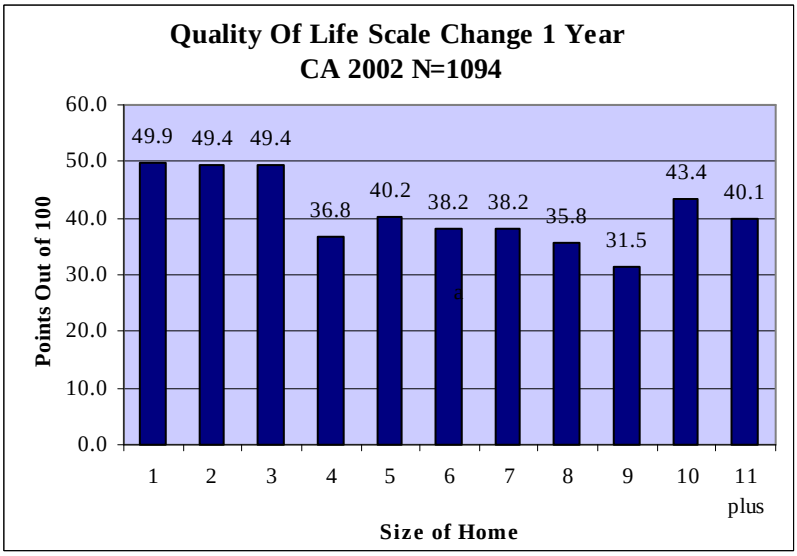


The California battery of instruments included a measure of the physical quality of the home. Here is our first contradictory finding. Our data collection

Visitors found, on the average, that larger settings were somewhat higher in qualities such as orderliness, cleanliness, and spaciousness. Taken all together into a single overall scale, the pattern showed a tendency for larger settings to score slightly higher.

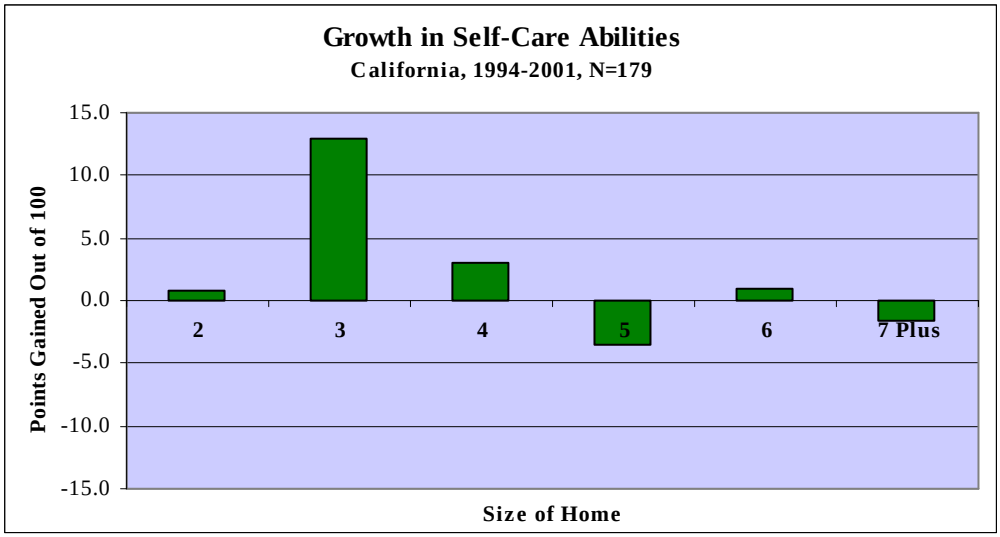


The California work also included our 14 item scale on perceived qualities of life. This simple one page scale asks individuals (and the support workers or family members who know them best) how good or bad their lives are – and also how good or bad their lives were before moving to their current home.



The graph shows perceived change in quality, from "Then" to "Now." The highest positive changes are in the smallest settings.

We also examined the longest possible time span in the California data, from people living in institutions in 1994 to community in 2001. There were 179 people with complete data from that long span of time. One of the classic indicators of quality of service is behavioral growth. In this case, we measured independent functioning (also called self-care or adaptive behavior) over the years. Breaking down growth in self-care abilities by size, we found that size 3 was associated with the largest positive change.



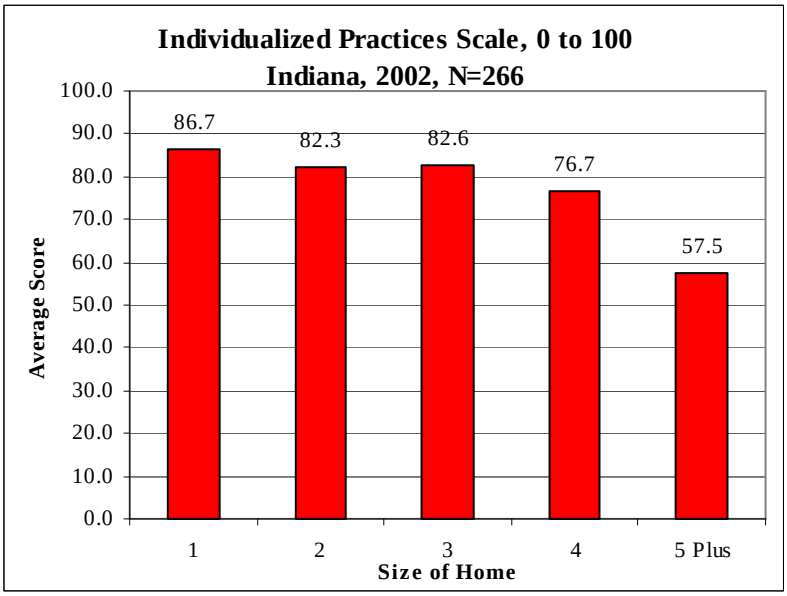
The smaller number of people in this analysis suggests greater caution in interpreting the graph. The suggestion is clear enough, that the smaller settings are associated with greater developmental progress, but the finding cannot be considered conclusive.

Taken as a whole, the California database, here analyzed for the first time about the size issue, leads to the inference that most indicators of quality are higher in smaller community homes.[22]

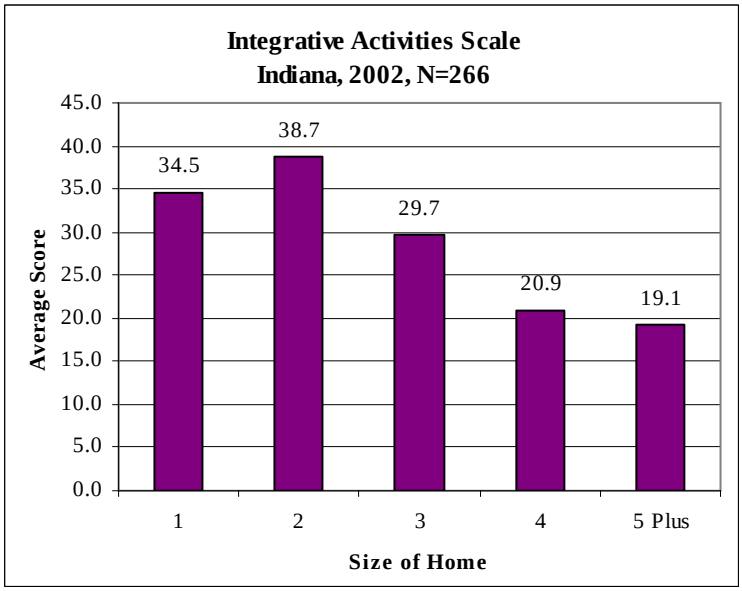
[22] The entire body of work in the Coffelt project also showed conclusively that people were 'better off' by practically every measure in the smaller community homes than they were in the large Developmental Centers.

Indiana's Quality Tracking Project

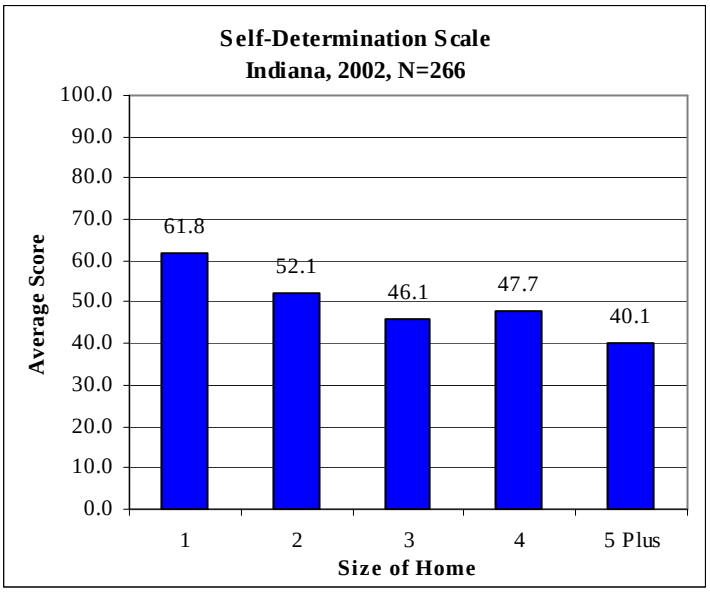
Just as in California, the Indiana work included a scale of individualized practices, and it clearly varied with the size of the home. Indiana was different in that settings above size 5 were almost non-existent, whereas in California, size 6 was commonplace. Hence the Indiana graphs reflect smaller homes.



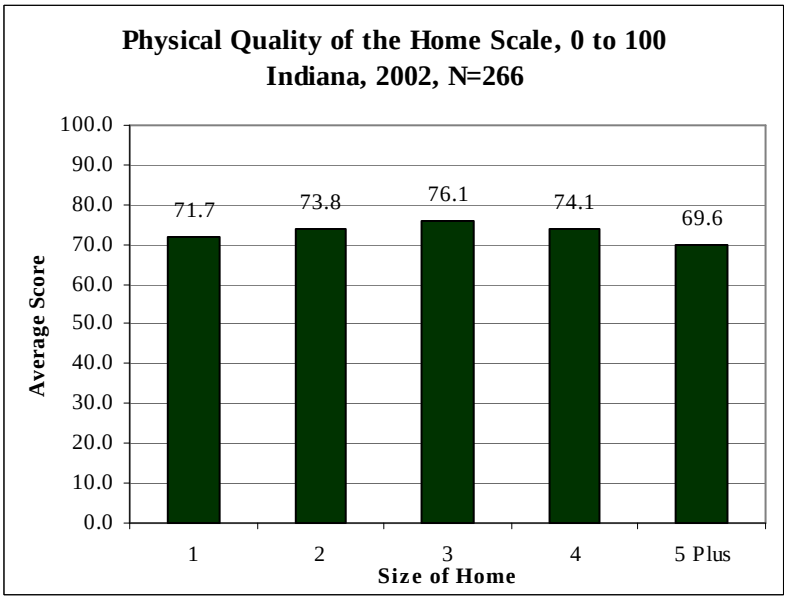
Integrative activities per month were higher in smaller homes:



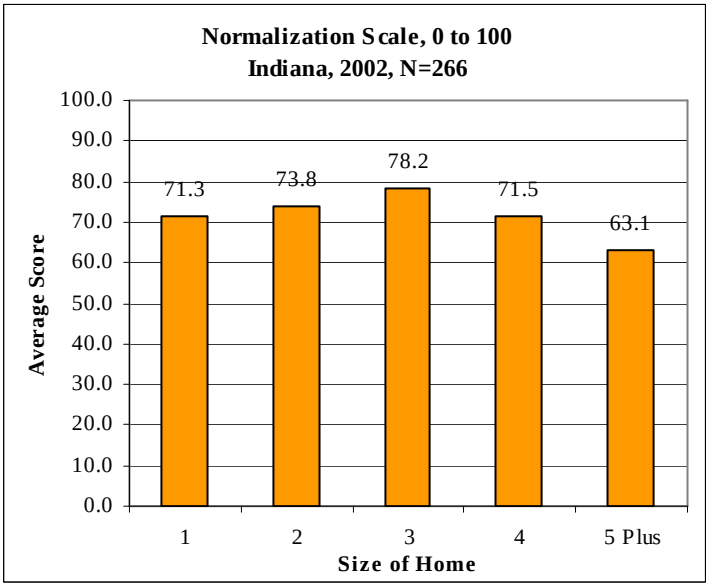
Our reliable scale of individual power and control showed higher scores among people in the smaller settings.



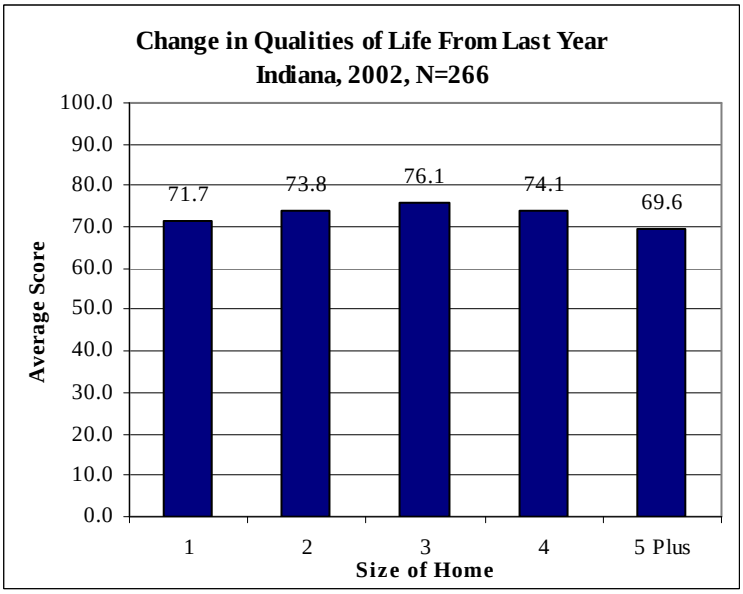
The physical quality of the homes varied slightly by size, but smaller was not consistently 'better,' just as we saw in the California data.



The Indiana work included a classic scale measuring an aspect of quality that was dominant in the field in the 1970s and 1980s, 'normalization.' It showed a pattern of increase up to size 3, and then a decrease as size went up.



Indiana data provided an opportunity to examine the Qualities of Life scale data across one year. Although this measure relied on memory, and was therefore less definitive than true pre-post data, it did show a pattern of highest improvement in the settings of size 3. Life quality improvements were actually lower in both the smaller and the larger settings – a finding much like the Normalization scale.



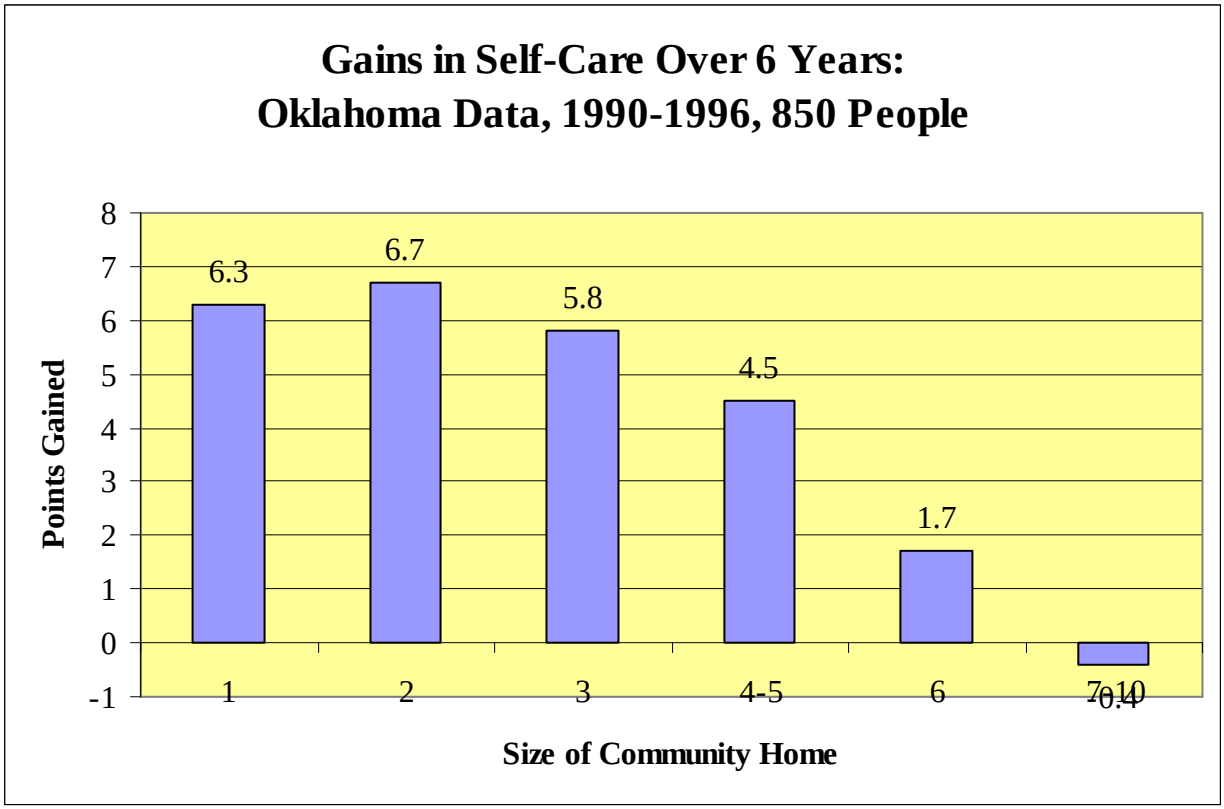
The data from the Indiana work showed a pattern of superior qualities in the smaller settings. Physical quality in terms of order, cleanliness, and roominess were again the exception. Two of the indicators suggested that size 3 was ‘better’ than smaller or larger settings.

This finding is not yet fully understood, but the next data set, from Oklahoma, should shed further light – because the closure of Hissom in Oklahoma was achieved by movement into the smallest settings yet studied. Instead of ‘group homes,’ the Oklahoma community settings were characterized as ‘supported living.’

Oklahoma's Quality Assurance Project

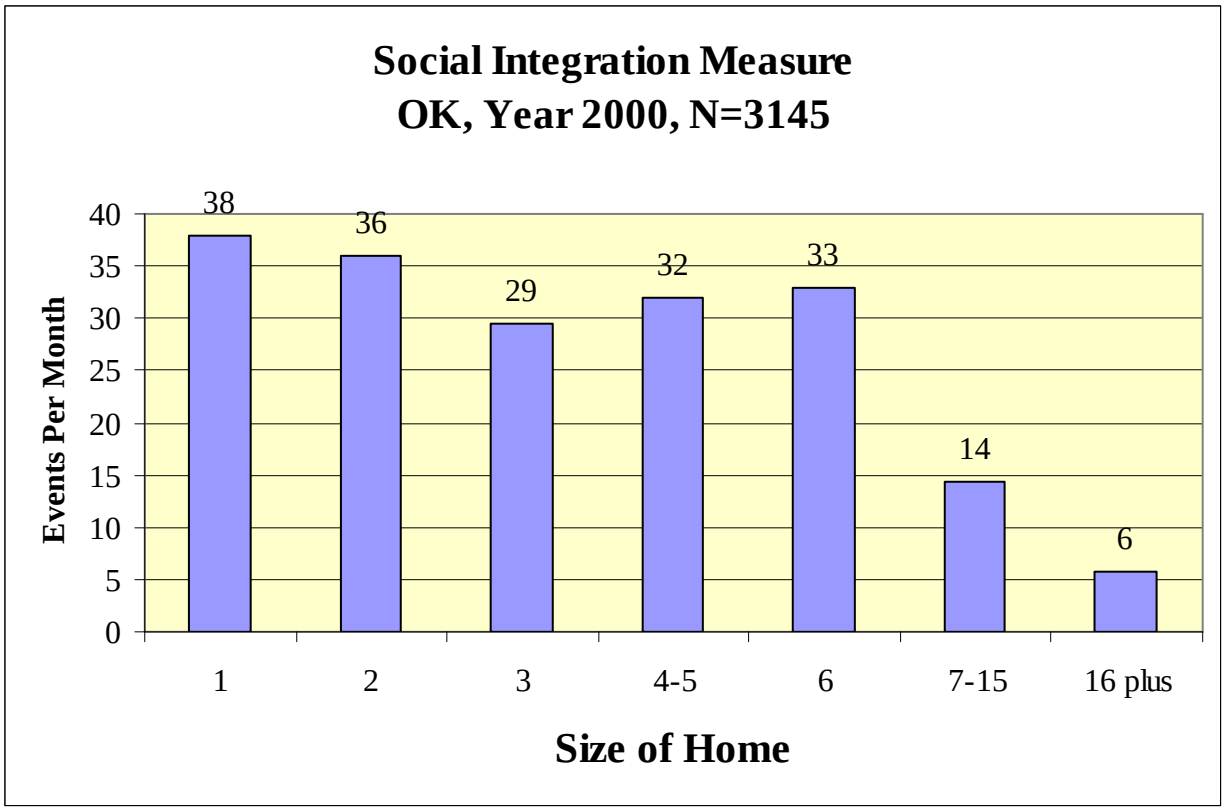
Oklahoma's deinstitutionalization efforts relied on the smallest community settings. This enabled the closest scrutiny yet on the issue of the size range below 6 beds.

In the 1990s, data from Oklahoma were utilized to construct this now fairly well known graph:



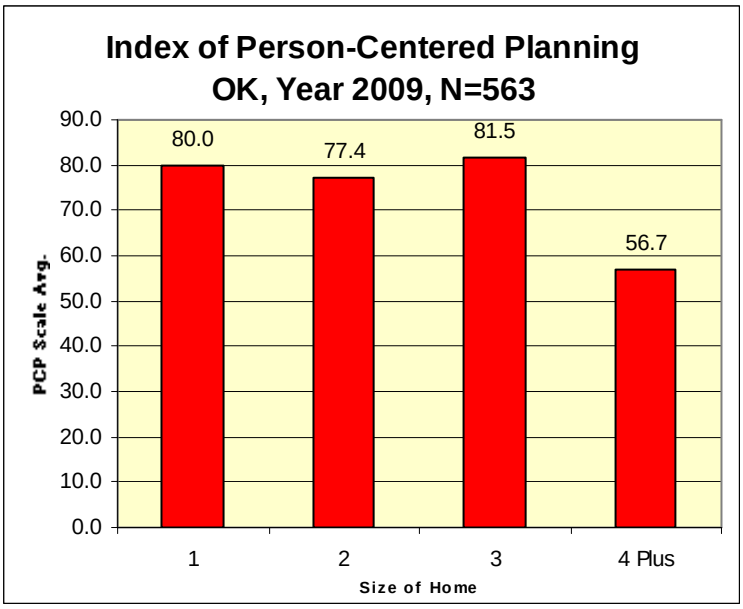
If developmental progress is a desired goal, then the Oklahoma data indicated that people in smaller homes made by far the greatest gains. Above 6 people, gains not only vanished – they tended to move toward losses.

In the year 2000, the Oklahoma data produced insight into the issue of community integration:

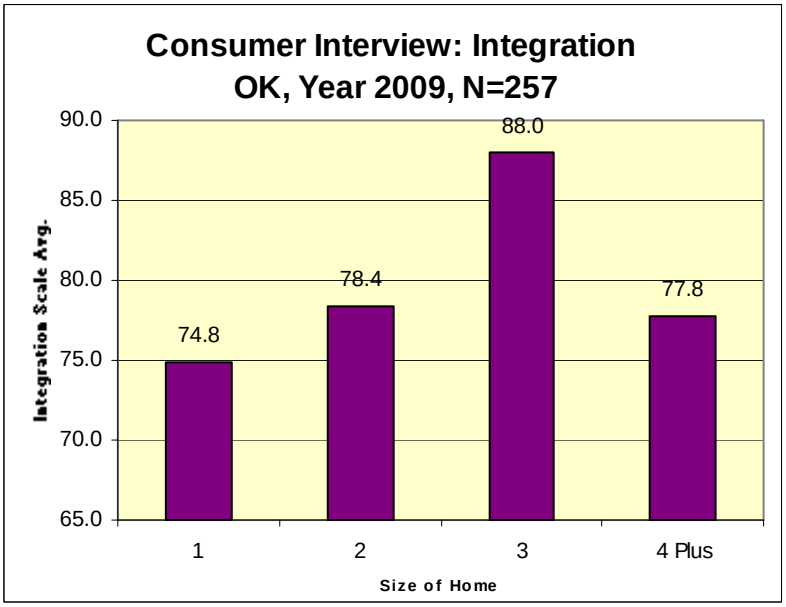


These findings made it very clear that the larger homes tended to cut off community integration.

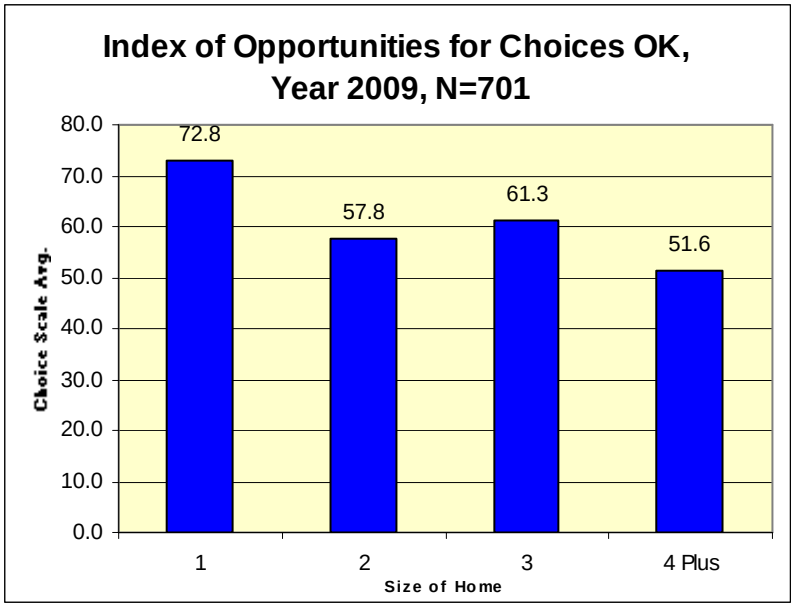
The most recent round of data collection in Oklahoma (2009) yielded equally powerful findings. The measure of the degree to which Person-Centered Planning was implemented, a strong indicator of individualized treatment, showed generally good practice in setting of 3 beds and below, with a sharp drop-off at 4 beds and above.



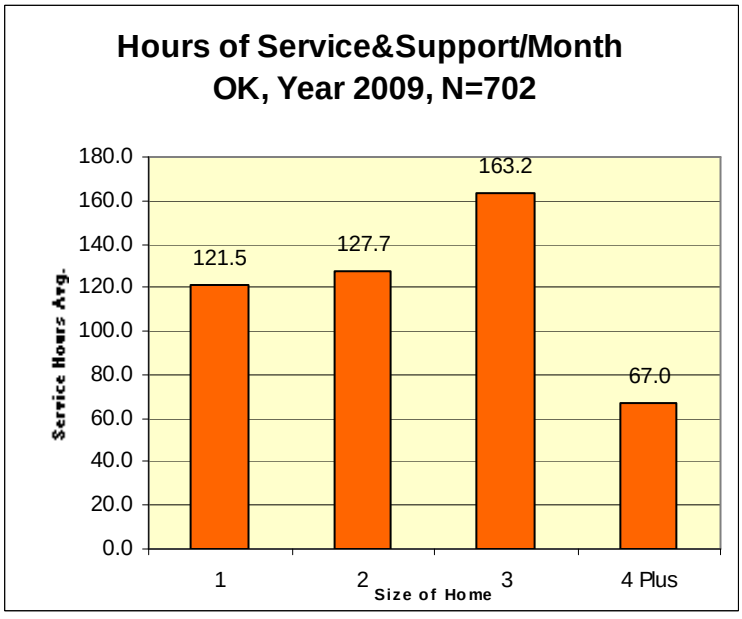
Data on opportunities for integrative activities revealed a peak at size 3, with settings both smaller and larger associated with lower levels of 'getting out and about.'



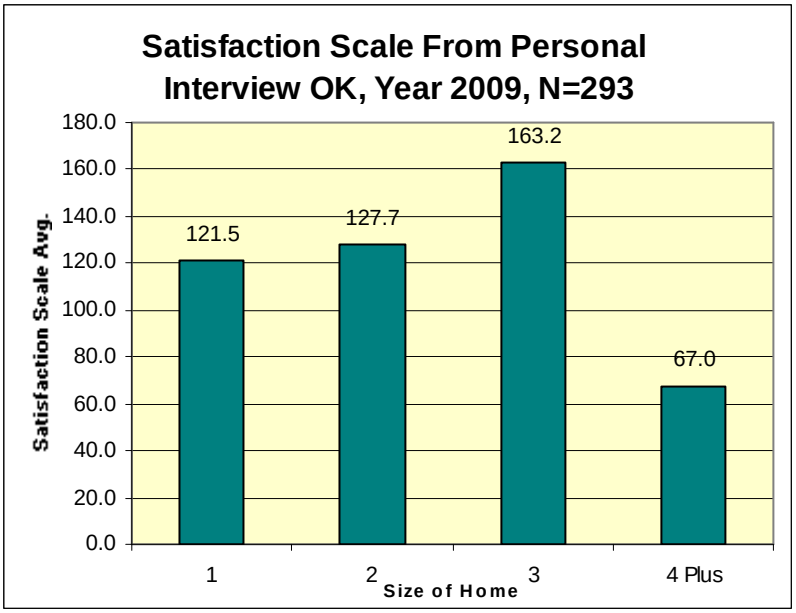
Power and control, or self-determination, was indexed by a shortened form of our Decision Control Inventory, and revealed higher scores in the smaller settings.



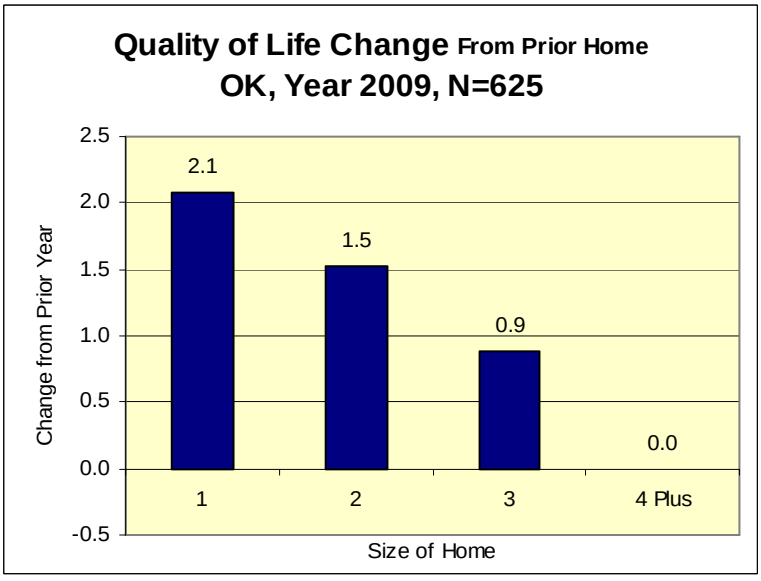
Another index of services was the amount of formally planned and scheduled "services," meaning any staff or professional activity aimed at goals in the person's individual plan. The high point was reached in settings of size 3, again with a sharp drop-off at size 4 and above.



Direct interviews were attempted with every person, on every data collection visit. For the people who were able and willing to respond, the satisfaction with life in the home data showed the highest scores at 3 people, with another sharp drop-off at 4 people and above.



The Oklahoma data included memory. People were asked about the qualities of their lives "Now" and also about quality in their previous homes – for most of the people, this meant the institution. The relation between improvement in life quality and the size of the home was dramatic, and the graph following shows.



The Oklahoma data tended to show a very strong relationship between community home size and quality. Because Oklahoma's deinstitutionalization efforts relied on very small 'supported living' models, this database provided very

important opportunities to examine quality at the smallest setting sizes. The results appeared to be compelling, in the direction of smaller being ‘better’ in every way.

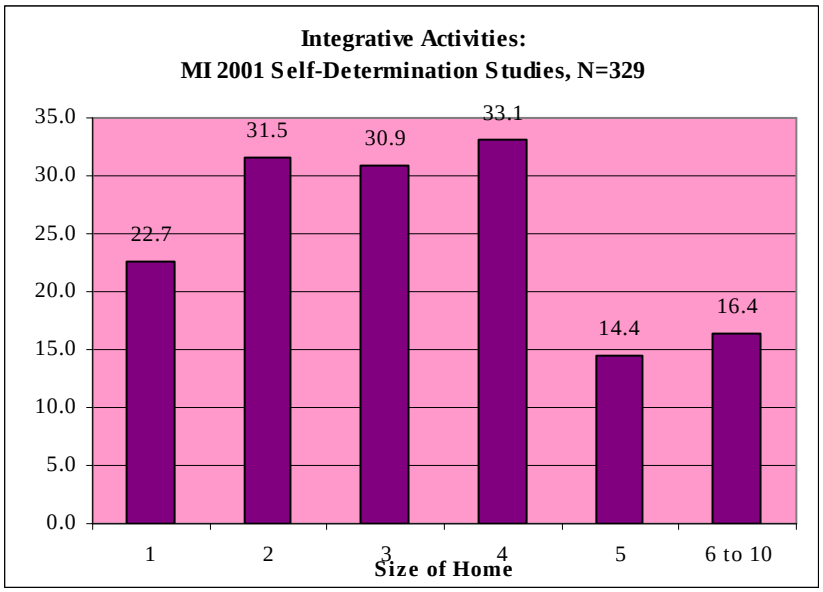
Michigan's Early Self-Determination Research

The original self-determination demonstration was conducted in New Hampshire from 1994 to 1996 (Conroy & Yuskauskas, 1996). The findings were strongly positive, and the question naturally arose: *"Could this model of supports 'work' in another kind of situation, a place larger and more urban?"* The first attempts to test that question were conducted in Michigan, beginning at the then named Wayne Community Living Services agency.

When the Robert Wood Johnson Foundation awarded 17 grants to state agencies to test self-determination, Michigan was one of the first to receive funding. The demonstration involved people at four pilot sites in the state. Our evaluation efforts began in 1998, and involved visiting all the potential participants "pre" self-determination. We collected data on multiple qualities of life before the people began working toward individual budgets, independent case management, and fiscal intermediaries. More than 400 people were included in the 'baseline' data collection.

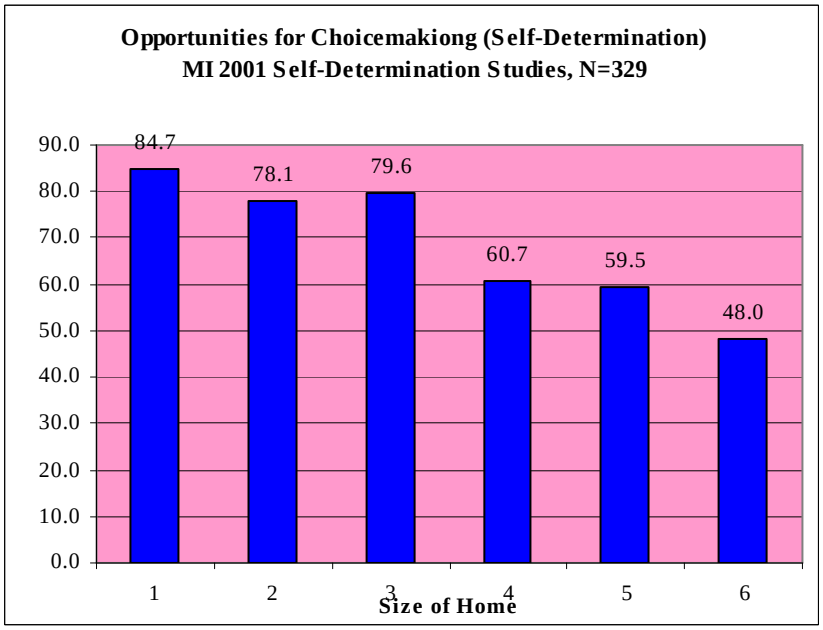
In 2001, most of the potential participants were visited again, and the same quality data were collected. This provided a database on quality for hundreds of people in Michigan – and these data have never before been analyzed with respect to the size of the community residence. What follows is entirely new research on the question of size and quality – and specifically among people in Michigan.

In 2001, we visited 329 people across the four pilot sites in Michigan, and one of the quality indicators was again integrative activities. The following graph shows the results.



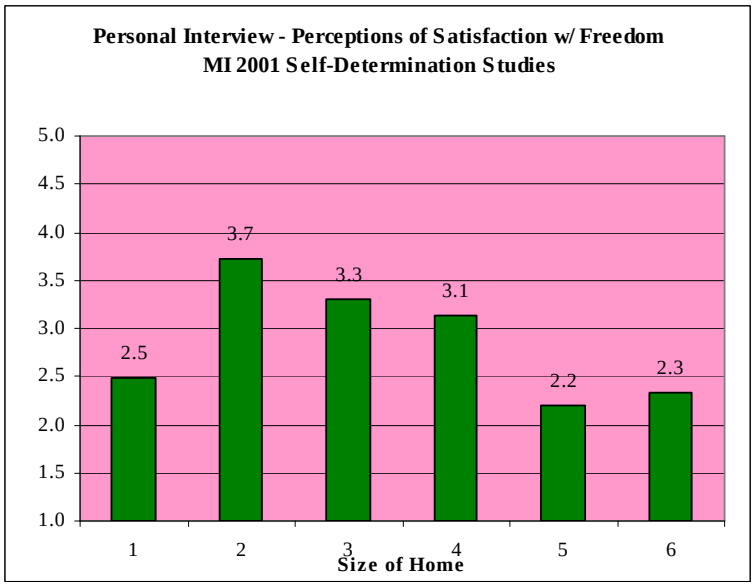
Clearly, the smaller community homes were associated with higher levels of community integration. The drop-off began at 5 people.

Power and control, the classic issues of self-determination, were explored. The next graph makes it obvious that opportunities for choicemaking fell sharply in the larger settings.

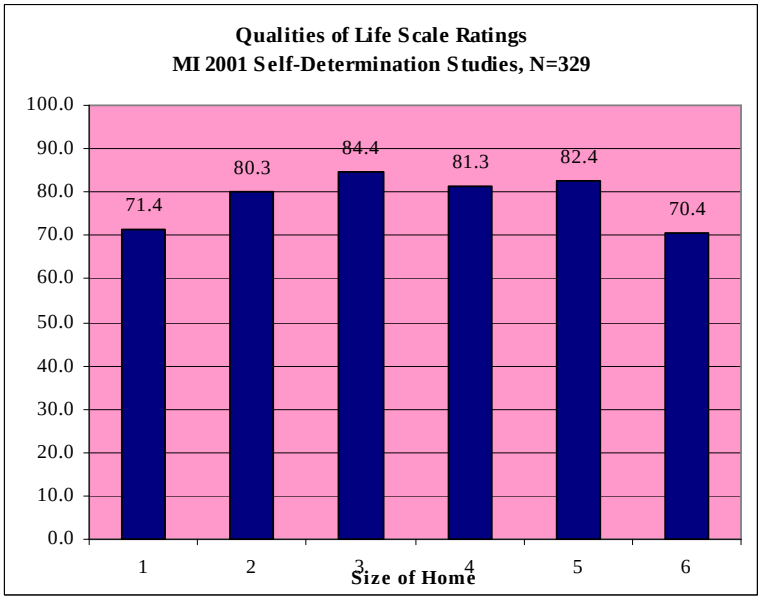


Once again, we attempted to directly interview every person visited. Not everyone was able or willing to respond, but for those who were, we were able to

ask whether they were satisfied with the amount of control and freedom they exercised over their own lives. The data showed superiority in the smaller settings, with a drop-off above 4 people.

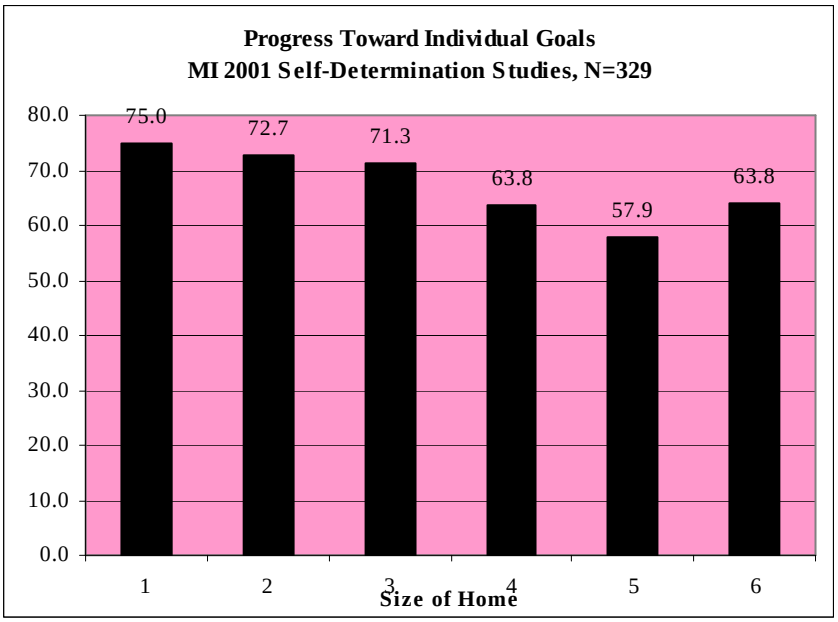


The overall qualities of life scale showed the highest scores in the small settings, with a drop-off above 5 people.



The data included ratings of the degree to which each person was making progress toward his/her individual program goals. The tendency here too was superior outcomes in the smaller settings, with the homes of size 1, 2, and 3 higher

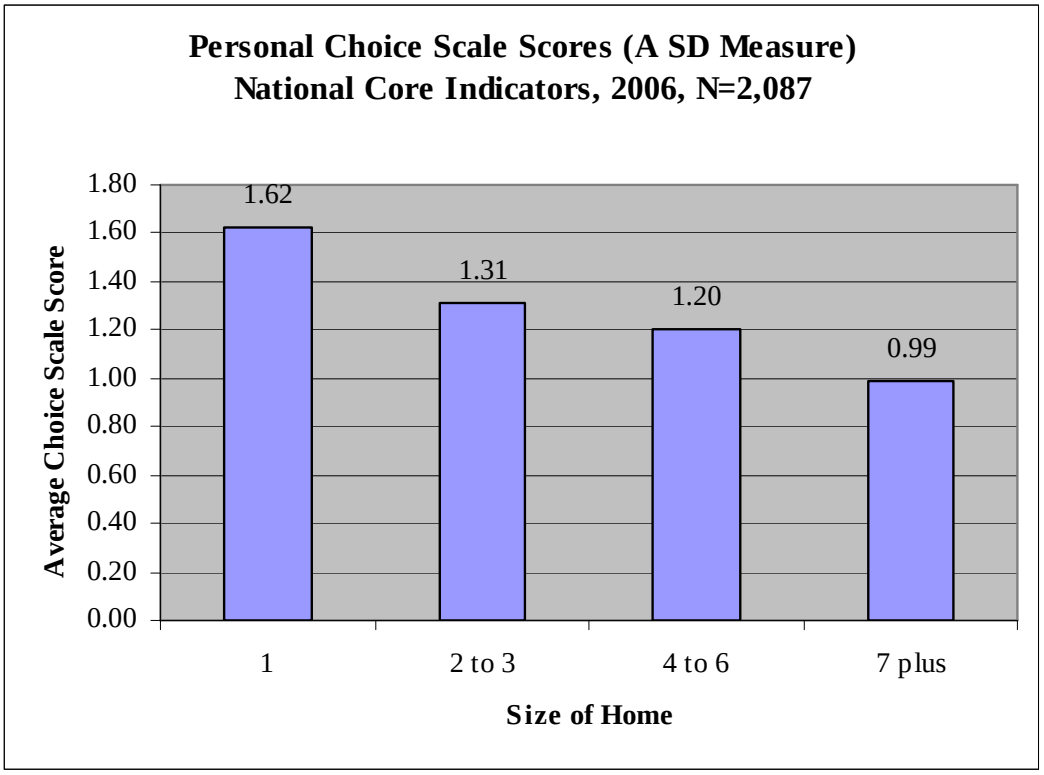
than homes of size 4, 5, or 6. Statistically, these data showed significant difference only between the smaller and the larger homes.



Overall, the data from the Michigan work supported the inference that smaller homes were connected with higher qualities of life and service. Several analyses showed a serious decline in quality when size rose above 4 beds.

New Analyses from the National Core Indicators Project

The NCI (National Core Indictors) project[23] is an attempt to acquire data on qualities of support and life across state lines. Using the most recent data from that project, investigators examined personal choice – an index composed from four simple items on control and power over one's own life. The 2006 data showed a strong pattern of declining choice in larger homes.



These data were explored in Lakin et al. (2008a) in an article entitled "Choice-Making Among Medicaid HCBS and ICF/MR Recipients in Six States."[24] According to the authors,

> Choice in everyday decisions and in support-related decisions was addressed among 2,398 adults with intellectual and developmental disabilities receiving Medicaid Home and Community Based Services (HCBS) and Intermediate Care Facility (ICF/MR) services and living in nonfamily settings in six states. Everyday choice in daily life and in support-related choice was considerably higher on average for HCBS than for ICF/MR

[23] See NCI website at http://www2.hsri.org/nci/ .
[24] This article was based partially on an earlier report submitted by the University of Minnesota to the Centers for Medicare & Medicaid Services: University of Minnesota, 2006.

> recipients, but after controlling for level of intellectual disability, medical care needs, mobility, behavioral and psychiatric conditions, and self-reporting, we found that choice was more strongly associated with living in a congregate setting than whether that setting was HCBS- or ICF/MR-financed.

Thus the data showed that, other things being equal, choice and self-determination were highest in the smallest settings.

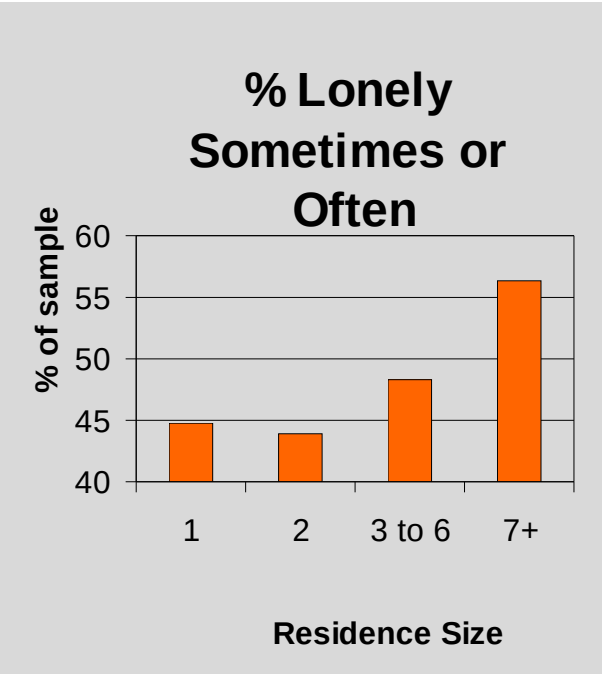
The NCI database also permits analysis of the issue of loneliness. One common question about small settings, naturally, is "Won't people be lonely if they live by themselves or with just one or two others?"

The loneliness issue was explored in some detail, by Stancliffe et al. (2007) in an article entitled "Loneliness and Living Arrangements." The authors found among 1002 people in the NCI database that:

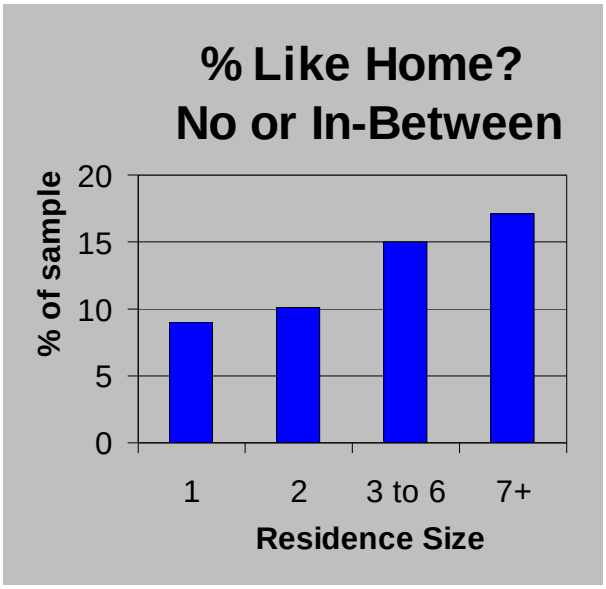
> …loneliness was not more common for people living alone or in very small settings. More loneliness was reported by residents of larger community living settings of 7 to 15 people.

Moreover, higher levels of 'social contact' and 'liking where one lived' were associated with less loneliness.

The most recent data, presented by Moseley, Bradley, & Lakin (2010), showed that loneliness actually increased in the larger settings.



In addition to freedom and loneliness, the NCI data enable some insight into the simple issue of how much people "like" their homes. The following graph was constructed to show how many people Don't Like their homes – and, organized by size, the results are dramatic.



Currently the largest database in the United States on quality of residential settings, the NCI reveals evidence that is entirely one-sided. Larger settings are very much the worse in terms of self-determination, loneliness, and simple satisfaction.

Most human services do not have such national databases with which to examine important issues. The existence of data from the NCI, and our own large studies, are extremely strong advantages in the scientific pursuit of policy. With regard to size and quality, the data overwhelmingly support the notion that small, family-scale settings are far superior to the larger, barracks-like group homes.

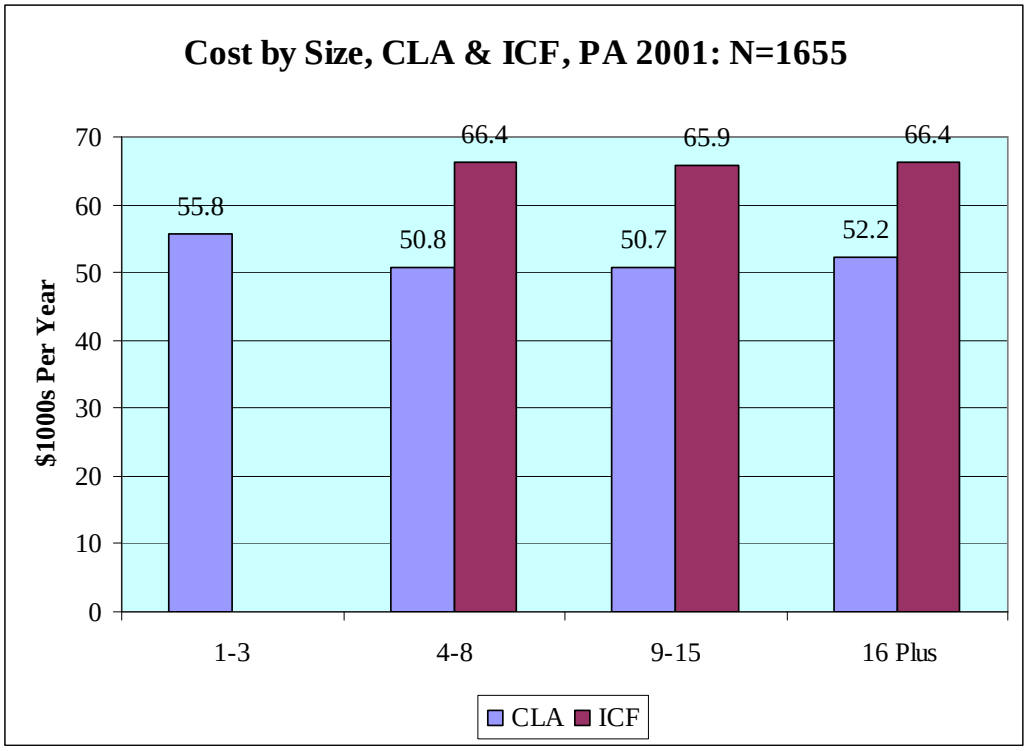
However, money has not yet been considered. The final section of this Policy Report examines what is available in that dimension of public services.

Cost Analyses by Size from Several Databases

The first point to be made about cost, quality, and size of residential settings is that the largest settings are associated with lower quality in the research literature, and yet they continue to be the most costly. The second point is that our usual assumptions about Economy of Scale may be wrong. The third point is that the data available to us right now are not conclusive – but they are consistent in that they tend to question the notion that moving people into larger group homes will "save money."

Before presenting these somewhat old data, it is important to stress that more research is urgently needed. We have not examined the costs of settings by size for nearly a decade.

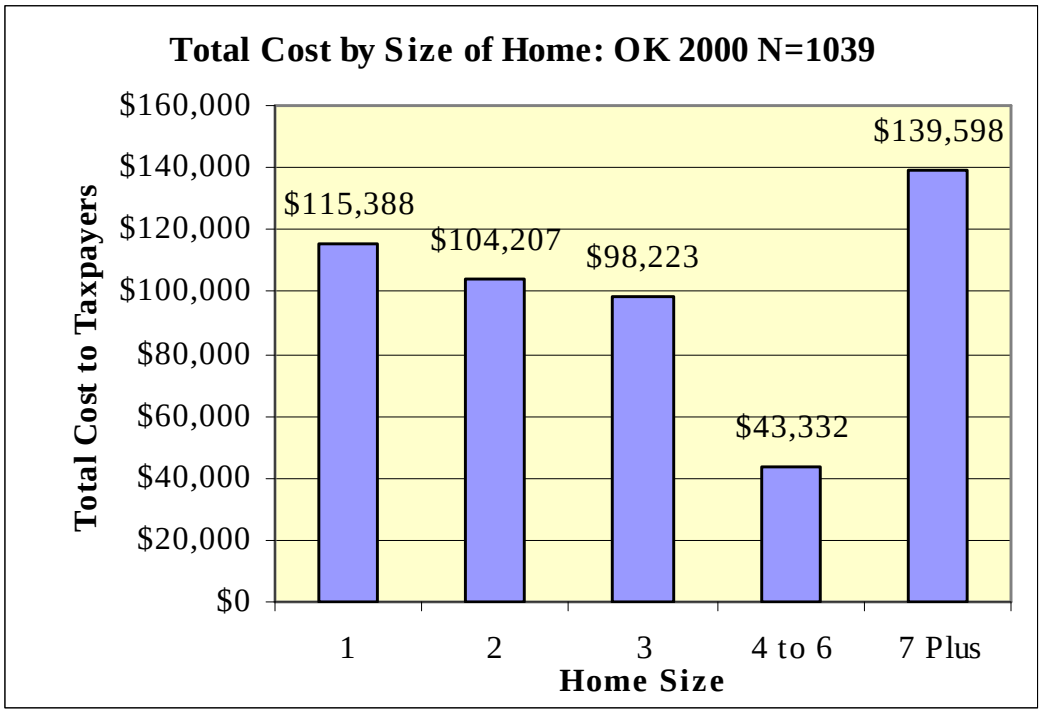
That being said, the first large scale analysis of cost by size is shown in the following graph from Pennsylvania data in 2001.



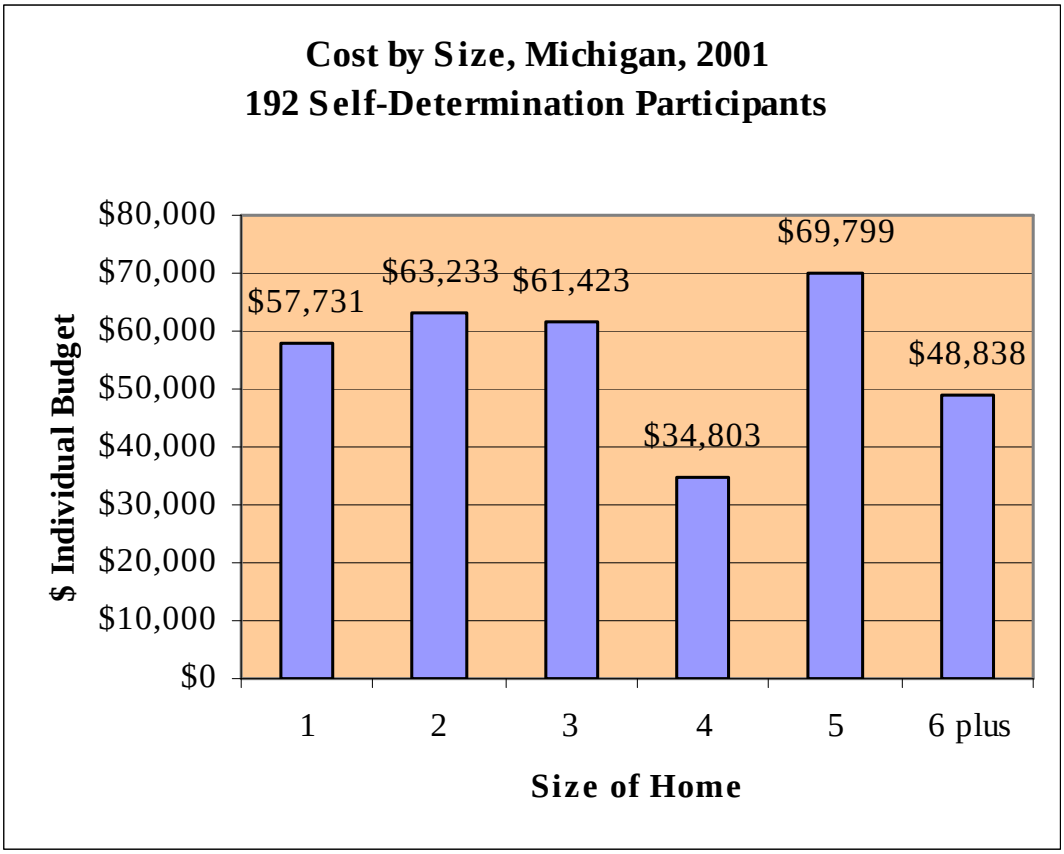
We broke out the data by type of funding stream. CLA stands for Community Living Arrangement, a model that rarely goes above 3 beds. ICF is the Intermediate Care Facilities or ICF/MR funding stream, which was defined in 1981

as “4 to 15 beds.” For the CLAs, costs fell slightly with settings over size 3. For the ICFs/MR, they did not.

In a study published in an academic journal, we investigated costs in Oklahoma in 2000. The graph following shows that the 4 to 6 person homes were less expensive than others, but when programs went above that size, costs escalated sharply.



Finally, in our 2001 studies in Michigan, we found that the amount in a person’s individual budget was inconsistently related to the size of the home.



This data set showed the lowest cost per person for the 4-person homes. The spike at 5-person, and the drop at 6 and more is not yet understood. More study will be necessary to explain these complex findings.

Referring once more to the National Core Indicators database, the most recent cross-state evidence on costs and size of homes is provided in Lakin et al. (2008b). In an article entitled *"Factors Associated With Expenditures for Medicaid Home and Community Based Services (HCBS) and Intermediate Care Facilities for Persons With Mental Retardation (ICF/MR) Services for Persons With Intellectual and Developmental Disabilities,"* these authors explored two kinds of community residential settings and their costs.

The so-called ICF/MR settings are funded via the Intermediate Care Facility/Mental Retardation (ICF/MR) program, which was defined as 4 to 15 beds, and was based firmly on old nursing home models and regulations. The other kind of community funding, the so-called Home and Community Based Services (HCBS) or 'Medicaid Waiver' settings were designed in reaction to the overly medicalized characteristics of the ICF/MR program. Waiver settings are expressly

designed to be smaller and more family-like than 'hospital-like' than the ICF/MR homes.

According to the authors in their Abstract,

> "This article examines expenditures for a random sample of 1,421 adult Home and Community Based Services (HCBS) and Intermediate Care Facility/Mental Retardation (ICF/MR) recipients in 4 states. The article documents variations in expenditures for individuals with different characteristics and service needs and, controlling for individual characteristics, by residential setting type, Medicaid program (ICF/MR or HCBS), and state. Annual average per-person Medicaid expenditures for HCBS recipients were less than those of ICF/MR residents ($61,770 and $128,275, respectively). HCBS recipients had less severe disability (intellectual, physical, health service needs) than ICF/MR residents. Controlling these differences, and for congregate settings, HCBS were less costly than ICFs/MR, but this distinction accounted for only 3.3% of variation in expenditures. Persons living with families receiving HCBS ($25,072) and in host families (including foster, companion, or shared living arrangements; $44,112) had the lowest Medicaid expenditures.

Thus, other things being equal, the smaller, more family-like Waiver or HCBS settings were associated with slightly lower costs than the larger, more institutional, ICF/MR settings.

All in all, the notion that larger settings are less costly is not clear from data in Michigan. We must therefore be cautious and tentative in our conclusions.

However, because the quality data from Michigan and all over the nation are so compelling, we must caution policy makers there is no evidence that moving people into larger group homes will save money, but there is a great deal of evidence that quality would be sacrificed.

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Appendix A: Sociological Literature on Group Size

Literature Review on Group Size from the Sociological Tradition[25]

People have always asked themselves major questions that are related to the issue of group size:

- How many roommates should I have in college?
- Which is better, a small family with one or two children, or a large one with more?
- Should I have a big wedding or a small one?
- Will I be happier working for a large company or a small one?
- How big can a club be before it needs to split up into two chapters?
- What is the best size group of laborers?
- How many soldiers should be in a combat unit?
- What is the best size committee for decision-making?
- What is the best size committee for member satisfaction and enjoyment?
- What really happens as groups get bigger - does specialization increase, and do interpersonal interactions become more formal?

In modern times, people have usually turned to the field of sociology for answers to questions of this kind. Indeed, there are treatments of group size in nearly all of the modern sociology textbooks.

Sociological interest in the question of group size is best traced to the work of German sociologist Georg Simmel (1858-1918). Most of his writings on the sociology of groups were completed around the turn of the century, but the translations of Kurt Wolff (Wolff, 1950) made Simmel's work widely accessible to English speaking sociologists.

The headings within Simmel's seminal essay "Quantitative Aspects of the Group" are illustrative of his interest in the size issue:

I. On the significance of numbers for social life
II. The quantitative determination of group divisions and of certain groups
III. The isolated individual and the dyad
IV. The triad
V. The importance of specific numbers for relations among groups

[25] Adapted and extended from Conroy, J. (1992). *Size and Quality in Residential Programs for People with Developmental Disabilities*. A Dissertation Submitted to the Temple University Graduate Board in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy. Philadelphia: Temple University.

In this essay, Simmel tried to write a "grammar of social life" (Coser, 1965) by considering one of the most abstract characteristics of groups, that is, the mere number of participants. He described the characteristics of dyads and triads, and showed how qualitative differences in interaction patterns inevitably occurred simply as the result of numbers.

Simmel noted that a dyad differs from all other groups in that its members have to interact directly with one another. If one member ceases to pay attention, interaction stops. If either member withdraws from the group, there is no group. The dyad can develop a sense of unity and intimacy not found in larger groups, but the dyad can be fragile, and requires continual efforts by both parties to be maintained.

Addition of another person to form a triad alters the situation significantly. Any one member can ignore the conversation of the others without destroying the group's interaction. The third member can function as a stabilizing and mediating influence for the other two; alternatively, the third member may become an "intruder." Two members can ally against the third, so that feelings of isolation and persecution are possible in a triad. In general, Simmel believed the triad was the most fragile sized group because of the almost inevitable "two against one" situations.

Simmel discussed the properties of interactions within dyads and triads in contexts as diverse as marriages (dyad), mothers-in-law with marriages (triad), neighboring serfdoms in Europe (dyads), and Rome, Sparta, and Athens (a triad in which Rome constantly destabilized the relationship between the two Greek cities.)

After the triad level, Simmel's treatment ceased to discuss specific numbers. He believed that it would be theoretically possible to describe the unique characteristics of each size group, up to the teens at least, but he also believed that the effort required, and the length of the descriptions, would be beyond feasibility. Ultimately, he concluded that group size would be related to group behavior no matter who was in the group or what its purpose was. Thus, for Simmel, size was truly a fundamental property of any group. Much of Simmel's effort on this topic was devoted to understanding why, and by what mechanisms, group size influenced group behavior, but stopped at the triad level.

Although Simmel stopped explicit group size descriptions at size three, it is interesting to note that certain religious writings have gone somewhat further. The Koran contains very specific advice about group size where wives are concerned:

> ...take in marriage of such other women as please you, two, or three, or four, and not more.

Williams (1961), the translator of this edition of the Koran, explained that the law required that a man treat each wife equally. However, the Prophet maintained that with two wives, equal treatment would be very difficult because of competition. In Simmel's terms, the triad would be unstable. With three wives, life would also be difficult because two of the wives would probably unite against the third, in another variation on Simmel's triad theme. With four wives, the odds were even for harmony. Two might side against the other two, but none would be completely isolated in most cases. Interestingly enough, this meant a total group size of five, a number that will appear again later in this section. The Koran analysis stops at total group size five, because more than four wives was simply forbidden as being "unreasonable" for one man. The fact that dogmatic statements about ideal group size were made more than a millennium ago is further evidence of the continuing interest in the size issue.

Although it was not possible for Simmel to demonstrate that each successive addition of a new member would produce a distinct sociological configuration (as he did for the dyad and the triad), he did show that there were crucial differences between small groups and larger ones. He contended that, as more and more members were added, the nature of interactions necessarily continued to change. Many of the changes were related to the phenomenon of division of labor.

Although Durkheim did not mention group size as an explicit consideration in the phenomenon of division of labor (Durkheim, 1933), Simmel did. He believed that division of labor inevitably increased with group size, and that the character of the interactions in the group changed as well. As translated by Wolff,

> It will immediately be conceded on the basis of everyday experiences, that a group upon reaching a certain size must develop forms and organs which serve its maintenance and promotion, but which a smaller group does not need. On the other hand, it will also be admitted that smaller groups have qualities, including types of interaction among their members, which inevitably disappear when the groups grow larger. (Page 87.)

> In the small group, the contribution of each to the whole and the group's reward to him are visible at close range; comparison and compensation are easy. In the large group they are difficult, especially because of the inevitable differentiation of its members, of their functions, and claims. A very large number of people can constitute a unity only if there is a complex division of labor. (Page 88.)

> In a similar manner, the large group gains its unity, which finds expression in the group organs and in political notions and ideals, only at the price of a great distance between all of these structures and the individual. In the social life of the small group, by contrast, the individual's views and needs are directly effective, are objects of immediate consideration. (Page 96-97.)

Simmel clearly perceived tradeoffs inherent in increasing group size. With greater size, he believed, came greater specialization of function, and correspondingly less "wholeness" of personal identities, less equality, and less warmth of interactions.

In small groups, members tend to be able to interact directly with one another. Once the group exceeds a relatively limited size, such interaction must be mediated through formal arrangements. In the words of Coser (1965):

> In order to come to grips with the increasing complexity of relationships among large numbers of individuals, the group must create special organs to help the patterning of interactions among its members. Thus, no large group can function without the invention of offices, the differentiation of status positions, and the delegation of tasks and responsibilities. This is why larger groups must be societies of unequals: in order to maintain themselves, they must be structurally differentiated.

Simmel was also apparently the first to discuss the phenomenon of subgroup formation. As a human group expands, there is a necessity for subgroups to form. Simmel explained this through the example of a "party." As Simmel evidently observed in his own experience, the first few people to arrive at a party tend to interact with each other in a single intimate cluster. But as people continue to arrive, some of the members come to dominate the discussion, and others do not speak at all. This is usually seen when about six to twelve people are present. The members who are not speaking become dissatisfied with their involvement, and strike up side conversations with the people next to them. As the party continues, the original group almost inevitably fragments into smaller groupings, within each of which, each member has a chance to participate verbally.

Although the party may not intuitively seem to be a representative social situation, it has one very crucial aspect: the people are usually there to enjoy themselves. Thus it is one of the best possible situations in which to see what people will do when following their own preferences. It seems clear that most people prefer to be in situations in which they can participate comfortably, and that generally appears to involve small numbers of associates rather than a large "audience."

It is worth noting that sociologists have concluded that the vast majority of our interaction with other human beings occurs in very small groups. Sociologist

John James (1951) and his students observed 7,405 informal interactions of pedestrians, playground users, swimmers, and shoppers, and 1,458 people in a variety of work situations. They found that 71 percent of both the informal and work interactions consisted of two people; 21 percent involved three people; 6 percent included four people; and only 2 percent entailed five or more people.

The crude question "Are small groups or large groups more effective?" can at best yield crude answers. The answer must depend on the type of task, the kinds of members, the time available, and other variables such as the characteristics of the environment in which the group meets. Kohler (1927) reported that in a tug of war, a bigger group can pull harder than a smaller group (not a great shock), but also found that the total team pulling power did not increase in direct proportion to the number of people on the team. As each new person up to 12 was added, each of the members pulled about 10% less energetically.

This simple finding implies that it is necessary to probe deeply into complex patterns of intervening variables to fully understand the why of the relationship between group size and any kind of effectiveness. We need to ask why the addition of another team member might have influenced the motivation of the other members, the group structure and cohesiveness, and/or the leadership of the team. What are the mechanisms through which size can affect other group variables?

This kind of finding is related to Olson's theoretical discussion of the fundamental variable that goes with size of groups, which he said is the visibility of each member's contribution to the common good (Olson, 1965). As he put it,

> ... any group or organization, large or small, works for some collective benefit that by its very nature will benefit all of the members of the group. Though all of the members of the group therefore have a common interest in obtaining this collective benefit, they have no common interest in paying the cost of providing that collective good. Each would prefer that the others pay the entire cost. (Page 21)

Olson then defined three kinds of group in relation to this variable: "privileged," "intermediate," and "latent." These three varied in the amount of incentive for each member to help pay the cost of obtaining the common good. He used these concepts in an analysis that concluded that "small groups are not only quantitatively, but qualitatively, different from large groups" (page 52).

For the current topic, the most germane implication of Olson's analysis was that, in general, the larger the group, the less the incentives for individual members to contribute to the common good. In the very large "latent" group, an individual "cannot make a noticeable contribution to any group effort, and since no one in the

group will react if he makes no contribution, he has no incentive to contribute" (page 50). This could apply to very large group living situations for people with intellectual disabilities. Each individual staff person in an institution would experience a weaker incentive (to work hard for the common good) than in a three person group home.

Simmel suggested that interactions within small groups would prove to be an important subject for future sociological research. This suggestion was neglected until after World War II, when Robert Bales and others initiated a tradition of laboratory studies of small group processes (Bales, 1950; Hare, 1952; Homans, 1950). Although such laboratory studies of primarily white male college students have been criticized for their lack of generalizability to other populations and to "real life," this body of research is still highly influential. Group size, while not a primary research concern in this tradition, was touched upon by nearly every small group researcher.

Bales, Strodtbeck, Mills, and Roseborough (1951) collected data on the distribution of participation among members of one kind of creative group, the discussion group. Their findings suggested that as the size of the group increased, the most frequent contributor assumed a more and more prominent role in the discussion. The bigger the group, the bigger the gap between the most and the least frequent contributors. Communication apparently tends to centralize in one person in larger groups. Moreover, the number of group members who contribute less than their proportionate share goes up as the size of the group increases (at least within the range from two to seven). Anonymity and invisibility become more feasible as group size increases from two to seven.

Gibb (1951) found that the total number of ideas produced by groups engaged in creative tasks increased with size, but not proportionately. Just as in Kohler's tug of war finding, there were diminishing returns from the addition of members. Gibb suggested that the mechanism of action for this phenomenon was the experience of inhibitions related to formalization and structure. As size increased, so did formal rules of participation. Gibb tested this by manipulating the rules of participation himself, and as formalization increased, fewer ideas were generated. The productivity of larger creative groups may suffer because of the shyness, inhibition, and resulting silence of the majority.

Both of these studies suggest that size influences member participation, which in turn influences one kind of effectiveness. Participation, then, is one

intervening variable that must be considered as a possible mechanism for relationships between size and effectiveness.

A second possible mechanism would involve leadership. The processes of leadership emergence and then of leadership style are almost certainly influenced by group size. Carter, Haythorn, Meirowitz, and Lanzetta (1951) found that the correlation between authoritarianism and leadership behavior increased as group size increased from four to eight. Hemphill (1950) compared leader behavior in groups above and below size 30. He found that in the larger groups there were greater demands upon the leaders, and that leader-centered behavior was tolerated by a higher proportion of the members.

Another possible mechanism mediating relationships between size and effectiveness is group cohesiveness and/or satisfaction. Worthy (1950) reported that surveys carried out by Sears, Roebuck and Company showed that both worker satisfaction and operating efficiency tended to decrease in larger administrative units. Seashore (1954) studied the cohesiveness of work groups in a large factory, and found that smaller groups (4 to 22) were more cohesive than larger groups. Mann and Baumgartel (1952) found that absenteeism increased with decreasing group cohesiveness among white collar workers. Hewitt and Parfit (1953) found that absenteeism in groups of 4 was one third of the rate in groups of 36, and one fourth the rate in groups of 128. Miller (1950) found large conference groups to be more disruptive than smaller ones. The feeling of a “sense of belonging” was correlated at -.44 with group size. Lack of opportunity to talk, which was correlated at .80 with group size, was associated with feelings of frustration.

Hare (1952) compared 5 and 12 person groups of Boy Scouts conducting a decision making task during a camping trip. Hare found that the 5 person groups arrived at higher levels of consensus. The larger group was felt to limit participation by leading some members to feel that their individual opinions were not sufficiently important to merit vocalizing.

In what appears to be the study that has been the most influential in the sociological literature on group size, Slater (1958) examined some correlates of group size in a sample of 24 “creative” groups of size four to size seven. After four meetings to discuss specific human relations problems and potential solutions, members were asked whether their group was too small or too large for maximum effectiveness.

Members of the five person groups expressed 100% satisfaction, never once saying their group was too large or too small. Members of larger groups said their groups were disorderly, wasted time, and some members were too aggressive or competitive. Larger group members sometimes called for more structure and central control, and sometimes called for less. Complaints about individuals dominating the entire group were common. In groups smaller than five, the sole complaint was that the group was too small. Direct observation suggested that members were inhibited from completely free expression of ideas because they were afraid of alienating one another and creating an unpleasant atmosphere.

The size issue was prominent in the 1980 examination of organizations by Clegg and Dunkerley (1980). Clegg and Dunkerley reviewed mentions of the size issue by Simmel, Merton, Selznick, Homans, James, and so forth. The flavor of the Clegg and Dunkerley treatment includes the notion of increasing "rulemaking" with increasing size, and regimentation along with that. In some sections of the book they substitute the word "formalization" for this tendency. Decreases in personal relations were also to be expected. They believed that bureaucracy was both more likely to appear and more appropriate for larger organizations. On page 223, they discussed the difficulties with operationalizing size, and noted that researchers had used widely different measures, which made it difficult to compare the results available in the literature. In the review of purely organizational literature of this paper, we will see this comment mirrored in the Gooding and Wagner (1985) meta-analysis of empirical studies.

The sum of these sociological studies seems to be that people tend to be happier in smaller groups. However, for some tasks, groups can be too small, even when satisfaction/happiness is the index of effectiveness.

At the same time that these pioneering post-War sociological studies explored the effects of group size upon a variety of variables related to effectiveness, an organizational literature, more oriented toward business and practical concerns, developed concerning size and "productivity." A full review of the organizational research literature will be presented next, in the literature review labeled Organizational and Industrial Psychology.

The review of sociological interest and research shows that questions about group size have been a major concern in the development of modern sociology. Beginning with Simmel, continuing right into the content of the most recent introductory textbooks, and covering nearly 100 years, it is clear that group size has been a major concern of sociologists. The scientific evidence about group size

and group effectiveness gives a complex picture, probably because of the many and varied approaches to measuring effectiveness. However, a consensus from the sociological literature does seem to emerge: human beings tend to prefer to live, work, and play in small rather than large groups. The preferred group size is clearly below 10, but beyond that, the evidence is not yet conclusive.

This sociological tradition and interest in group size is in some ways to be quite relevant to the issue of residential program size. In particular, these findings suggest useful insights into the question of group homes for citizens with disabilities, in that within the small group size range, as size increases,

- People spontaneously interact in very small groups, mostly dyads or one on one (as in the direct observation of natural interactions research of James)
- People spontaneously subdivide their groups, rarely allowing them to exceed 5 or 6 (as in the party situation studies of Simmel)
- Participation via individual effort tends to decrease in a phenomenon often called 'free riding' (as in the tug of war studies of Kohler)
- Participation via communication tends to decrease and centralize, relying on increased leadership by the few, but allowing anonymity and silence by the many (as found by Bales et al.)
- Authoritarianism increases from group size four to eight, correlating with the emergence of leadership and of members becoming passive followers (in the work of Carter et al.)
- Satisfaction with group process may reach a 'saddle point' around size five (as in the famous and influential work of Slater)
- Satisfaction with group process falls off in groups above five, and keeps falling lower into the teens, where it levels off at a low state
- Increasing size is related to formalization, rulemaking, regimentation, bureaucratization, and decreases in personal relations (discussed by Clegg & Dunkerley)

Applying these sociological findings to the world of residential programs clearly implies that 'small is good.' However, there is insufficient evidence to draw conclusions about specific sizes of homes that are 'too big.' And, as is obvious from the beginning, there really cannot be a magic number for all groups and all kinds of people. One size will never fit all. Nevertheless, our effort here is to think in policy terms, covering thousands of people, in thousands of homes, and considering the averages of well being and quality across them. With that perspective, the sociological body of knowledge suggests that there is probably a

natural human break point somewhere between four and six. Group sizes that big can be tolerated, and can sometimes be effective and/or satisfying – but above that, we tend to lose the most desirable qualities of intimate and rewarding human interaction.

Appendix B: Organizational Psychology Literature on Group Size

Literature Review on Group Size from Organizational and Industrial Psychology[26]

Another area that must be examined for relevant clues is the organizational effectiveness literature. Without doubt, the pyramid builders of ancient Egypt gave serious thought to the relationship between the size of a work group and its productivity. And before there were builders, there were warriors, who were probably even more concerned about how to "split up" to be "most effective."

However, modern management and organizational theory do not extend their bibliographies so far back in history. Here we will trace some of the high points of a huge body of work on organizational size and effectiveness and administrative intensity, which has arisen mainly since 1951. This body of work incorporates a major scientific debate around a concept called the A/P ratio, the relative size of Administrative versus Production personnel within industries. Next we describe the methods and conclusions of what is arguably the "best" summary of the entire body of modern empirical research. In a summary, we interpret the relevance of this body of research for practical interests about the size of community residential programs.

First, a general comment: it seems that any relationship one cares to find, can be found, in the empirical literature. This is probably because of the bewildering variety of measures of size and effectiveness that have been used, and possibly for other reasons, such as varying theoretical frameworks and disciplines of the researchers. Only in the 1980s did significant clarity emerge via the application of meta-analysis (Hunter, Schmidt, & Jackson, 1982).

Melman (1951), interested in the relationship between organization size and "administrative intensity," or the proportion of effort the organization devotes to self-maintenance, reviewed literature as far back as 1934 (Robinson,1934). Melman examined data on American manufacturing industries from 1899 to 1947, and was evidently the first to identify the A-P ratio (the ratio of Administrative to Production personnel) and make the case that larger organizations have a relatively lower proportion of resources devoted to administrative functions than do smaller ones: *"... the largest asset-size firms have a manifest advantage with respect to*

[26] Adapted and extended from Conroy, J. (1992). *Size and Quality in Residential Programs for People with Developmental Disabilities*. A Dissertation Submitted to the Temple University Graduate Board in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy. Philadelphia: Temple University.

lower administrative expenditures per dollar of production expense than was the case for the smaller firms ..." (Page 90).

Soon after that article was published, the A-P ratio became the topic of one of the great debates in organizational theory, spilling over into management science, economics, social psychology, and sociology. According to one of the most recent analyses of the debate, *"The theory of size as a cause of administrative intensity (the A-P ratio) is perhaps the most heavily researched topic in the history of the study of organizations"* (Marsh & Mannari, 1989, page 83). The question of the A-P ratio is closely related to the question of effectiveness, because of the possibility that as administrative intensity increases, it may increase past the point of diminishing returns, and organizations may become "top-heavy" and wasteful rather than "lean" and efficient. It is therefore useful to review the A-P debate, albeit briefly, in responding to the question at hand.

Not long after the Melman article, Terrien and Mills (1955) published evidence that larger organizations had larger proportions devoted to administrative duties. Their conclusion was founded on analysis of 732 school districts in California. It was remarkably weak evidence for such a broad interpretation; but Terrien and Mills themselves never generalized beyond their narrow school district interpretation in the text of their article.

‘; In a review article that attempted to summarize a number of the empirical studies that had been generated in the period after Melman's initial article, Caplow (1957) chose "group size" as a unifying concept. He considered simple mathematical interaction possibilities (combinations and permutations of the number of members of the group), and distinguished small, medium, large, and giant groups. He claimed that each had distinct characteristics. His analysis of the available evidence led him to the conclusion that size was correlated with the A-P ratio, and also with group stability, uniformity of organizational design, and the incidence of communication problems.

Caplow noted that *"There is an almost universal belief that the administrative and overhead components of any organization increase out of proportion to increases in its size" (page 504).* Caplow also made an intriguing observation on the length of the chain of command in large organizations, saying that downward and upward communication becomes awkward when there are "more than six or seven echelons" to be traversed. His choice of "six or seven" was not substantiated in the article, but was interesting in view of later management beliefs about the span of control.

Caplow's specific contribution to the quantitative debate was of limited value. As noted in the closing paragraph: *"We know just enough, in sum, about the effects of size on organizational structure to perceive that size is an important element in determining the way any human organization adapts to its environment and that the whole subject deserves closer study"* (page 505). Nevertheless, in later work, Caplow was almost always cited.

Slater (1958) concerned himself solely with group member satisfaction as his primary measure of group effectiveness. Although it should be considered a tenuous indicator of group effectiveness, for many kinds of tasks, group member feelings are critical for success. His group tasks involved collection and exchange of information about a situation, the coordination, analysis, and evaluation of this information, and a group decision about the best administrative decision in the situation. By interviewing and observing participants, he was able to describe what they felt were the major disadvantages of groups that were too small or too large.

Slater found that groups larger than size four were "never felt to be too small," and groups smaller than six were "never felt to be too large." Slater concluded that group size five was the most effective according to the dual criteria of successful task completion and member satisfaction. Slater's studies are among the most widely cited in the entire size literature. This is remarkable in view of the narrow nature of Slater's measure of group effectiveness, which was member satisfaction, and in view of the very restricted nature of the participants in the studies, i.e., white male college students.

Thomas and Fink (1963) reviewed 31 empirical studies of small groups in which group size was related to group performance, distribution of participation, nature of interaction, group organization, member performance, conformity, consensus, and satisfaction. Unfortunately, the studies were generally of such poor methodological quality, and used such different samples, procedures, and measures, that the conclusions were trivial:

> Many variables were found to be significantly affected by group size, but methodological shortcomings characterizing this group of studies preclude the assertion of broad generalizations. Several dependable and nondependable intervening variables are suggested which may help to account for many of the observed effects. Conclusions are: group size is an important variable which should be taken into account in any theory of group behavior, and future research on group size should proceed more systematically than in the past. (Page 383.)

Or, in idiomatic English: A lot of studies seemed to show that size was related to different kinds of effectiveness, but they were all scientifically mediocre, and better studies are needed.

Steiner (1966) argued that the effects of group size depended on the task. He classified task types in an effort to make predictions about group size and "potential productivity." He conceived of "actual" productivity as potential productivity minus losses due to poor coordination among members. His classification scheme was at least interesting: additive tasks, in which members' abilities add together arithmetically, as in a tug of war; disjunctive tasks, in which the entire enterprise depends on the ability of the most able member; conjunctive tasks, which depend on the least able member; and so on. His analysis rested entirely on reviews of previous studies of group size.

Frank and Anderson (1971) performed an empirical test of Steiner's (1966) notion that the relationship between size and group performance depended on the type of task. Their findings with group sizes of 2, 3, 5, and 8 confirmed the differential effects of size depending on task type, and in the directions predicted by Steiner: increases in group size enhanced performance on disjunctive tasks (where performance depends on the most competent member), and decreased performance on conjunctive tasks (where performance depends on the least competent member). This may have been an obvious and trivial revelation. For a task that depends on the smartest member, larger groups are probabilistically more likely to have one really smart member than smaller groups, so the more the merrier; and vice versa. Nevertheless, later literature referred frequently to this Frank and Anderson study.

Then, in 1970, Blau became interested in the problem, and his influence was strongly felt (Blau, 1970a, 1970b; Blau & Schoenherr, 1971; Blau & Schoenherr, 1973). According to a succinct review of Blau's contributions by Freeman and Hannan (1975), the central point of Blau and colleagues was that larger organizations were more complex, and more complex organizations had more coordination problems, for which the organizations would hire more administrative personnel. However, this did not result in a higher A-P ratio, because larger organizations already had in place a functional and well-understood administrative system. As Blau (1972) put it:

> If the volume of administrative work increases less than proportionately as the volume of operations increases; and if the volume of work governs the number of persons needed to accomplish it, in administration as well as in operations, it follows that the number of persons in administration increases

> less than that in operations; and hence that the proportion of administrative personnel decreases as the total number of employees increases. (Page 18.)

In other words, the position taken by Blau and colleagues was that increases in organization size did lead to more administrators, but not proportional to the size increase. "Economies of scale" more than counteracted the administration increases, via efficient differentiation and assignment of administrators to known and well-defined roles.

In the spirit of a footnote, it was during this historical period that the accomplished and respected economist E. F. Schumacher published a book entitled ***"Small Is Beautiful: Economics As Though People Mattered."*** He emphasized the importance of human feelings within the economic arena (Schumacher, 1973). This intriguing little treatise became a countercultural resource in rapid order. For those who tended toward distrust of the Western establishment, it was easy to jump aboard the simplistic interpretation of Schumacher's work and oppose all "bigness": big government, big industry, big insurance companies, big military-industrial complex, and so on.

However, most interpretations of Schumacher's insightful writing were overly simplistic. His insights, particularly if we extend into the economics of the human services, were quite deep and compelling. Despite the fact that he was not writing for scholars, his work was founded firmly in an understanding of classical and modern economics, and was also blended with a grasp of individual psychology and humanism. Schumacher saw that all of the literature on size, the A-P ratio, and effectiveness had implicitly accepted the notion that the ultimate and only goal of the organization was effectiveness, however measured. Common sense suggested that this was an incomplete view, and one in which humanitarian values might easily become lost. Schumacher traced his economic training as follows:

> I was brought up on an interpretation of history which suggested that in the beginning was the family; then families got together and formed tribes; then a number of tribes formed a nation; then a number of nations formed a "union" or "United States" of this or that; and that, finally, we could look forward to a single World Government. ... Second, I was brought up on the theory that in order to be prosperous a country had to be big - the bigger the better. ... And third, I was brought up on the theory of the "economies of scale" - that with industries and firms, just as with nations, there is an irresistible trend, dictated by modern technology, for units to become ever bigger. ... Even today, we are generally told that gigantic organizations are inescapably necessary; but when we look closely we can notice that as soon as great size has been created there is often a strenuous attempt to attain smallness within bigness. The great achievement of Mr. Sloan of General Motors was to structure this gigantic firm in such a manner that it became, in fact, a federation of fairly reasonably sized firms. (Page 63-64.)

Schumacher's points are still persuasive. Moreover, much of the literature since his book has questioned the old assumptions about economies of scale and the inevitable trend toward huge organizations. He also suggested one thing not seen elsewhere in the literature: the notion that organizations become large for non-rational reasons. Although he did not explicitly state it in anthropological terms, he suggested that the real motivating force behind the creation of vast organizational empires might be, not efficiency or productivity or effectiveness, but simple human territoriality. This drive, which has been clearly documented and studied all the way from insects to humans, aims toward individual "control" of more and more "turf," and "turf" can be spatial or social. Territoriality is a survival trait among species functioning at instinctual levels; whether it is a survival trait for creatures with language and tools and weapons of mass destruction is still an open question.

Schumacher went on to consider human needs on an equal footing with organizational needs. He expressed the opinion that humans needed both freedom, which was strongest in lots of small, autonomous units, and order, which was strongest in larger units with clear rules and predictable actions. In his words:

> What I wish to emphasize is the duality of the human requirement when it comes to the question of size: there is no single answer. For his different purposes man needs many different structures, both small ones and large ones. ... Yet people find it most difficult to keep two seemingly opposite necessities of truth in their minds at the same time. ... For constructive work the principal task is always the restoration of some kind of balance. Today, we suffer from an almost universal idolatry of giantism. It is therefore necessary to insist on the virtues of smallness - where this applies. (If there were a prevailing idolatry of smallness, irrespective of subject or purpose, one would have to try and exercise influence in the opposite direction.) ... For every activity there is a certain appropriate scale, and the more active and intimate the activity, the smaller the number of people that can take part, the greater is the number of such relationship arrangements that need to be established. (Page 65-66.)

Schumacher offered the example of teaching. Some kinds of teaching take place only in small intimate interchanges, while other kinds are best done in mass media or in huge crowds. The first question is always, what are we trying to teach? In the best summary paragraph of his book, he says:

> What scale is appropriate? It depends on what we are trying to do. The question of scale is extremely crucial today, in political, social, and economic affairs just as in almost everything else. What, for instance, is the appropriate size of a city? And also, one might ask, what is the appropriate size of a country? ... We cannot directly calculate what is right; but we jolly well know what is wrong! We can recognize right and wrong at the extremes, although we cannot normally judge them finely enough to say: "This ought to be five per cent more," or "that ought to be five per cent less." (Page 66-67.)

Schumacher forces us to continually wonder, "What are we trying to do?" as we contemplate the size of goal-oriented groups. It seems sensible that goals and

values should shape the desired forms and sizes of organizations, because different goals would be better served by different types of organizations.

Back in the mainstream of the literature, Snyder (1975) performed an experimental study on whether there was an "optimum group size" to accomplish a task and to be most personally satisfying to its members. He used groups of size 4, 5, 6, 7, 8, and 9. His findings indicated that size did make some difference, but relatively little. He concluded that the notion of an optimum group size was not supported by the analysis, although there was a trend for the group sizes 4 and 5 to be considerably more satisfying than sizes 8 and 9. Snyder's finding did not fully confirm that of Slater (1958) that group size 5 was ideal, but they did not reject it either.

In addition to reviewing the literature, Freeman and Hannan (1975) explored the often-raised idea that conclusions drawn from cross-sectional data might be systematically different from those arising from longitudinal data. They pointed out that the bulk of literature on administrative intensity was cross-sectional. They suggested that the relationship between size and administrative intensity might be quite different depending on whether the organization was growing or declining. If so, then cross-sectional analyses would obscure that fact. They developed a conceptual and mathematical model, and tested it with California school districts data, in the tradition established by Terrien and Mills (1955). Their analyses of the data suggested that they were right, and also that the A-P ratios were too complex to be useful in many analyses. They believed that cross-sectional analyses of organizational demography would often be quite misleading.

Freeman and Hannan's major conclusion could be stated as: when an organization is growing, the administrative component is always trying to "catch up" and is disproportionately "lean," but when the organization is declining, the administrative employees tend to be able to hold onto their jobs beyond their usefulness, making the organization look "fat" during decline.

In 1980, Dalton and colleagues published a review of the literature regarding organizational structure and performance (Dalton, Todor, Spendolini, Fielding, & Porter, 1980). The abstract of their article was rather strongly worded:

> Reviewing the research literature available on the relationship between structure and performance in an organization reveals a deficiency of sound research in all areas essential for serious study. Too little research and the inconclusiveness of studies that have been done both demand further research in the area. Distinctions are made between hard and soft performance criteria, the structuring and structural dimensions of structure, and subgroup and organization units of analysis.

Specifically, Dalton et al. reported that most investigators had failed to find a significant size – performance relationship at the organizational level. At the subunit level, they concluded that the majority of studies found that smaller groups were associated with better performance, across a variety of measures; however, a minority found better performance in larger subunit groups.

Despite their failure to substantiate any unambiguous relationship between size and performance, the Dalton et al. analysis was at least useful to the next generation of analysts, in that they suggested that level of analysis might be a very important source of confusion across studies. This led to the notion that one should distinguish studies of organizational size from studies of the size of subunits within an organization.

Until the 1980s, the study of size and effectiveness in the organizational research literature was somewhat chaotic, and very difficult to interpret. In 1985, Gooding and Wagner reviewed the relationship between size and performance of organizations and their subunits. Gooding and Wagner screened nearly 200 published studies, and selected 31 that met consistent methodological criteria. From these 31 studies, they attempted to find an interpretable pattern. The remainder of this section is a review of their conclusions.

Gooding and Wagner noted that three kinds of scientists had been at work on the question:

> 1. Industrial-organizational economists had approached it through examination of organizational economies of scale. Most often, these analysts were searching for the size of organization or unit that would optimize the cost per unit of production. Findings in the literature were inconsistent.
> 2. Many, but not all, organizational theorists also approached the problem with an inherent belief that organization size would be associated with significant economies of scale. Others emphasized the ability of larger organizations to exert more control over the sources of resources. This and related perspectives predicted that larger organizations would produce more, but not necessarily more per worker.
> 3. Social psychologists approached the problem largely from the group, rather than organizational, level, and often reported an insignificant relationship between group size and indices of effectiveness, but sometimes reported decreasing effectiveness with increasing size. These analysts frequently hypothesized "free riding" as the culprit (in which group members, relatively anonymous in larger groups, could slack off with no one noticing), and also higher coordination costs with larger groups.

These three kinds of scientists had been approaching with different definitions and measurement techniques. Gooding and Wagner suggested that the reason the literature was confusing and often contradictory was that different kinds of scientists had been defining and measuring things differently. Gooding and Wagner specified three dimensions which had varied across studies:

1. The LEVEL OF ANALYSIS. Some studies had examined entire organizations, while others had analyzed subunits within large organizations.
2. The PERFORMANCE MEASURE. Some studies had used key informant ranking, others used organizational records, and others used physical output. Most importantly, some had used absolute output and others had used relative output (i.e., output per unit of size), potentially a very important difference.
3. The SIZE MEASURE. Some investigators had operationalized the size variable as the number of employees, others as the number of beds in a hospital or like facility, others as financial assets, and other as the magnitude of output transactions such as sales or number of clients served.

Gooding and Wagner concluded that these three variations could explain a major proportion of the differences across the studies. Employing a form of meta-analysis, as improved by Hunter, Schmidt, and Jackson (1982), Gooding and Wagner categorized each of the 31 studies according to the level of analysis, the performance measure, and the size measure. Their conclusions were clear:

1. Studies that used the organizational LEVEL OF ANALYSIS found that larger organizations were more productive in absolute terms, but not in ratio terms. That is, larger organizations produced more units, but did not produce more per worker. Gooding and Wagner concluded that there was actually no evidence for economies of scale in terms of worker efficiency. This finding was consistent across a variety of SIZE MEASURES.
2. Studies that used the subunit LEVEL OF ANALYSIS showed a negative relationship between size and productivity, both for absolute and relative measures of performance. This also held true across studies using a variety of SIZE MEASURES.

The group home size question is at the subunit LEVEL OF ANALYSIS. The typical situation is that a private service provider corporation operates several group homes. Thus each group home is a subunit of the larger organization. The group home PERFORMANCE MEASURES are related to the quality of life of the individuals in the group homes, and are therefore best thought of as efficiency measures. For example, growth in adaptive behavior/independent functioning per unit of staff time or per dollar would be useful measures of performance. The SIZE MEASURE in the group home situation is simple: the number of people living in the home.

According to Gooding and Wagner's meta-analysis, then, we should expect to find smaller group homes producing more positive outcomes.

The organizational literature reviewed here includes more than 100 pieces of primary research. From them, no clear consistent pattern of the organization size and effectiveness relationship emerged, until the meta-analysis of Gooding and Wagner (1985). They showed that prior studies had varied in their levels of analysis (organization or subunit), their performance measures (absolute or relative), and their size measures.

When these were examined via meta-analysis, a clear pattern did emerge. This pattern called the entire notion of Economy of Scale into serious question. Whether approached from the perspective of the organization or the subunit, when confounding variables were controlled, larger organizations and larger subunits did not produce more per worker.

At the same time that Gooding & Wagner's brilliant meta-analysis called the traditional Economy of Scale assumptions into very serious question, Schumacher's ***"Small Is Beautiful: Economics as Though People Mattered"*** made a compelling case for consideration of outcomes other than economic. Our concern in the human services is precisely suited to this refreshing new perspective – and it came along at the same time that even the most rigorous scientists were questioning whether larger plants really produced more widgets per person per hour. Perhaps our assumptions about size and Economy of Scale, so easily imported from industry into the human services, were dangerously misleading.[27]

The organizational goals of group homes for people with intellectual disabilities are fundamentally human, not financial They are primarily concerned with the quality of life experienced by the people who live in them.[28] Quality is multi-dimensional; it has dozens of aspects. Among them are developmental progress toward increased independence and socially appropriate behavior, integration, relationships, opportunities for choicemaking, satisfaction, individualization, services and supports intensity, attainment of individual goals,

[27] Such mistakes have been made before. One of the worst in history was the importation of biological models into the social realm. The emergence of Social Darwinism in the late 19th century could be argued to have done as much harm as any of the pernicious ideas that have arisen in the modern world. It led to justification of the abandonment, segregation, isolation, underfunding, and forgetting of people with disabilities, both here and abroad – not to mention the rise of the Eugenics Movement, which fostered sterilization and lent support to the National Socialist movement of Germany.

[28] And the direct support people who work in them – good research must take both into account as a synergistic and mutually reinforcing system.

normalization, health, safety, and physical comfort. Hence indicators of each of these organizational goals must be explored. If the analyses are done properly, the quality and outcome indicators are likely to turn up to be strongly related to size, if the literature from organizational and industrial psychology is any guide.

Appendix C: Educational Literature on Group Size (Class Size)

Literature Review on Group Size in Education - i.e., Classroom Size[29]

An issue that may be closely related to the effectiveness and quality of congregate living (group homes) is the effectiveness of instruction in groups of various sizes. Most studies concerned student achievement (academic outcomes, or simply learning). As we will see, however, it is also important to consider other things – such as which situations produce other important things like student happiness, satisfaction, and morale.

Just on the topic of academic achievement, illustrating the degree of conflict in 100 years of study of this issue, Slavin (1989) wrote:

> The search for substantial achievement effects of reducing class size is one of the oldest and most frustrating for educational researchers. The search is approaching the end of its first century; eventually, it may rival the search for the Holy Grail in both duration and lack of results. (Page 99.)

The situation had been substantially improved by application of the method called "meta-analysis," which means rigorously pooling the findings from a lot of studies, weighting them by how well they were designed, and coming up with the best summary of all of them put together. Glass and Smith (1978) produced the first such analysis. They performed a meta-analysis on the outcomes of 77 studies that included 725 comparisons of student achievement between smaller and larger class sizes. (Glass was, in fact, in the process of creating the concept of meta-analysis while working on the class size literature.) In sharp contrast to past narrative reviews, which had seen the literature as internally inconsistent and inconclusive, Glass and Smith's meta-analysis came to the relatively clear conclusion that smaller classes were associated with superior achievement outcomes.

Cooper (1989) suggested caution, coupled with a firm conviction that the weight of the evidence was on the side of smaller classes:

> Reviewers of the class size literature disagreed over whether a reduction in instructional group size has its intended effect ... However, some consensus did emerge ... Reduced class size appeared to be most efficacious with low-ability or disadvantages students when reductions were in the range typically associated with Chapter 1 programs. Such reductions may not only lead to higher achievement but to better student and teacher attitudes and morale and to an enrichment of the core curriculum. (Page 98.)

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[29] Adapted and extended from Conroy, J. (1992). *Size and Quality in Residential Programs for People with Developmental Disabilities*. A Dissertation Submitted to the Temple University Graduate Board in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy. Philadelphia: Temple University.

Slavin (1989) was skeptical, and did the entire meta-analysis over again, calling his new approach "best-evidence synthesis." Using exactly the same studies as Glass and Smith, and even their own tables, Slavin showed that the average effect of the smaller class size on achievement was no more than about 13% of a standard deviation. In statistical terms, that is a very small effect.

Equally interesting, multiyear studies showed that initial gains faded after a year or two, suggesting that smaller class sizes might have, not only small benefits, but temporary benefits as well. The studies in his analysis reduced class sizes from an average of 27 to 16 students. Yet the effects were very small indeed. In trying to explain why this might be so, Slavin's strongest suggestion was that *"teachers' behaviors do not vary very much with size of classes."* The implication was that behaviors might change slightly, but in the size range of real world classrooms, teachers really did not markedly change how they taught students whether they had 16 or 27 in their class.

Most importantly for our current concerns about residential homes, Slavin also showed that the major educational effects, even in Glass and Smith's own tables, occurred in the very small "classes" of size 1 to 3. From that, Slavin inferred that class size was the wrong focus for those concerned with national policy. For students such as those served by educational programs aimed at children in poverty, what would be most beneficial was not smaller classrooms, but individual or extremely small group tutoring. This may be a key finding for the search for quality in residential settings for people with intellectual & developmental disabilities: we need to aim above all for situations that support frequent one to one interactions.

But academic achievement, while it is the primary purpose of schools, is not everything. Slavin made a major concession when he mentioned factors other than achievement:

> Of course, it is important to note that reductions in class size do seem to have significant effects on other variables, such as teacher and student morale (Glass et al., 1982). Reducing class size may be justified on morale and other quality-of-life grounds. However, as a means of increasing student achievement, even substantial reductions in class size have little apparent impact.

It is most intriguing that Slavin, who so strongly believes that the achievement claims are nonsense, is willing to consider the notion that smaller class sizes produce other kinds of significant benefits. basically, even he admits that the evidence is fairly clear that people <u>like</u> smaller classes better. They are

happier in them. The quality of life may be superior in smaller classes. This may be an important clue for the present effort, which is concerned with quality of life as much as behavioral outcomes.

Moreover, Slavin agrees that the evidence supports a notion that size may become very important when class size drops to three or fewer, a conclusion that may be highly related to group home models. Pennsylvania limited group home size to three people for more than 20 years, but then began to approve larger ones – with quality impacts that have been widely suspected, but not studied with rigor.[30]

In summary, the classroom size literature achieves consensus about only four findings: (1) smaller classes are usually found to be related to slightly better student achievement, but mostly in the lower grades; (2) smaller classes are consistently found to be "better" in terms of indicators of quality other than student achievement such as satisfaction and morale; (3) large differences in achievement and qualities of schooling are not found until size drops below 10; and (4) dramatic improvements in student achievement are only found in the extremely small "tutoring" situations in which a single teacher is alone with just one or a very few students.

This fourth finding parallels a conclusion from the intellectual disabilities literature, that the best results come from situations in which single support workers are alone with a very small number of people.

[30] Personal communication with leaders of three provider agencies, 2007.

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What Works in Group Care? – A Structured Review of Treatment Models for Group Homes and Residential Care

Sigrid James

Abstract

This paper presents findings from a structured review of treatment models that are relevant to group care and residential treatment settings for children involved with the child welfare system. Initiated and guided by The California Evidence-Based Clearinghouse for Child Welfare, five treatment models – Positive Peer Culture, Teaching Family Model, Sanctuary Model, Stop-Gap Model, and Re-ED – were reviewed for effectiveness. In this paper, each model s treatment features are described and relevant outcome studies reviewed in terms of their effectiveness as well as relevance for child welfare practice. Findings indicate that four of the models are either supported or promising in terms of evidence for effectiveness. Implications for group care practice and research are discussed.

Introduction

Group care is a very broad term that encompasses many different forms of residentially-based placement and treatment services provided to children and youth with a wide range of needs. It is a placement option or service at the intersect of the three major child serving systems - child welfare, mental health and juvenile justice – describing “a continuum of programs from substance abuse treatment centers to locked units for sexual offenders to family-style residential group homes, and occasionally even residential schools…or therapeutic boarding schools” (Lee, 2008). Clear operational distinctions between different group care settings do not exist in the research literature (Curtis, Alexander, & Lunghofer, 2001; Lee, 2008), leading to the aggregation of diverse programs under one umbrella term as if group care were a monolithic construct. Yet, group care differs along a range of dimensions, including function, target population, length of stay, level of restrictiveness, and treatment approach (Butler & McPherson, 2007; Lee, 2008).

Group care has a long and often debated history in child welfare practice. It is theoretically intended as a placement of last resort, and as a response to characteristics or psychosocial problems that cannot be addressed in less restrictive family-based settings (Barth, 2002). Since the emergence of a growing number of alternative family- and home-based treatment options, group care has increasingly fallen into disrepute. Concerns are manifold. Group care is very costly with limited scientific evidence for its effectiveness. It is also an intervention that ideologically departs from system of care emphasis on community-based care in the least restrictive setting (Stroul & Friedman, 1986). Concerns further revolve around reliance on shift staff with often inadequate training and high turnover rates, issues of safety and potential for abuse as well as negative peer processes (e.g., Burns, Hoagwood

& Mrazek, 1999; Dishion, McCord & Poulin, 1999). Group care treatment cannot be found on any list of evidence-based treatments for youth with serious emotional and behavioral problems (NREPP [SAMHSA], 2009). Instead, it has sometimes been cited as a treatment that may potentially have adverse effects (Barth, 2005; Overcamp-Martini & Nutton, 2009). Nonetheless, placement into group care settings remains a common occurrence for some youth, particularly for youth with extended stays in out-of-home care for whom alternative family- or home-based treatment options are less available (McCurdy & McIntyre, 2004). As such, it remains an integral part of the continuum of services for a sizable proportion of children in out-of-home care (Butler & McPherson, 2007), and questions about the effectiveness and outcomes of services provided through group care settings are highly relevant.

The Effectiveness and Outcomes of Group Care

The outcome literature on group care is scant, and current knowledge about its effect on targeted outcomes is mostly based on studies with small nonrepresentative samples, and weak study designs, lacking control groups and standardized measures (Bean, White & Lake, 2005; Bettmann & Jasperson, 2009; Hair, 2005). Existing studies, relying mostly on pre-experimental designs, have measured outcome in terms of symptom reduction (Lyons, Terry, Martinovich, Peterson & Bouska, 2001; Weis, Wilson & Whitemarsh, 2005), behavioral and socio-emotional functioning (Larzelere et al., 2001; Leichtman, Leichtman, Barber & Neese, 2001; Lyons & Schaefer, 2000; Mann-Feder, 1996; Weis et al., 2005), and academic success (Hooper et al. 2000; Thompson et al., 1996). In general, youths who have less severe dysfunction, greater capacity for interpersonal relationships and acute rather than chronic onset of problems tend to have better outcomes (Landsman, Groza, Tyler & Malone, 2001; Wilmshurst, 2002). Involvement of families in treatment during group care placement, availability of after-care services as well as shorter lengths of stay in group care further mitigate outcome and have been associated with a better prognosis or outcome (Hoagwood & Cunningham, 1993; Larzelere et al., 2001). Predictors of poor outcome include co-morbid substance use disorder, a history of physical or sexual abuse and early onset of persistent conduct problems and delinquency (Peterson & Scanlan, 2002).

While findings from pre-post or nonequivalent comparison group studies point to improvements in functioning following group care placement, a final verdict on the outcomes associated with group care cannot be rendered without carefully selected comparison groups to address threats to internal validity. A handful of studies have compared the outcomes of group care to those associated with home- or community-based interventions (Barth, Greeson, Guo & Green, 2007; Breland-Noble et al., 2004; Breland-Noble et al., 2005; Chamberlain & Reid, 1998; James, Roesch & Zhang, under review; Lee & Thompson, 2008). One of the main challenges is to address the baseline differences that are inherent to the placement of children along the continuum of services and that may not be random. A few studies have addressed this issue via design or through statistical methods. Findings from these studies have been mixed. A few studies found more favorable outcomes for youth receiving community-based treatments (Breland-Noble et al., 2004; 2005). Two studies found no differences in outcome after adjusting for initial baseline differences (Barth et al., 2007; James et al., under review). Contrary to these studies, Lee and Thompson (2008) found that group care youth compared to youth in treatment foster care were more likely to be favorably discharged, more likely to return home, and less likely to experience subsequent placement in the first 6 months following discharge. Authors cautioned not to generalize results to other group care settings given the unique characteristics of the Boys Town residential campus.

A limitation of much of the existing research is the treatment of group care as a uniform construct. With few exceptions (e.g., Lee & Thomas, 2008; Thompson et al., 1996), most studies do not report on specific group care models, and provide limited information on the type of group care received by the study population.

Purpose of Current Review

The current paper responds to this limitation by presenting the findings of a structured review initiated and guided by the California Evidence-Based Clearinghouse for Child Welfare on prevalent group care treatment models relevant to children in the child welfare system. There are several reasons for this particular focus.

First, a considerable proportion of children in group care settings come from the child welfare system. Currently, close to 80,000 children and youth under the supervision of child welfare systems are placed in group care and residential treatment settings (USDHHS, 2008) This represents an estimated 16 percent of the current foster care population. Secondly, despite similar background characteristics among youth from different service systems, children involved with the child welfare system also have unique characteristics and challenges. Children in foster care have high rates of mental health problems stemming from histories of abuse and/or neglect, familial dysfunction, and experiences of separation (e.g., Burns et al., 2004; McMillen et al., 2004). While foster children have been shown to be high users of specialty mental health services (McMillen et al., 2005), family- or home/based treatment alternatives to group care may be less available to them given removal from their biological family. This places them at particularly high risk for group home placement (McCurdy & McIntyre, 2004; McMillen et al., 2004). Thirdly, about 10 to 15 percent of the foster care population experiences considerable placement instability (Wulczyn et al., 2003). Frequent placement moves along with older age and a higher rate of emotional and behavioral problems have been consistently correlated with a greater likelihood of placement into group care (e.g., James et el., 2006). Finally, the field of child welfare has progressed more slowly than either mental health or juvenile justice in building an evidence-based knowledge base; as such it is a stated mandate of the California Evidence-Based Clearinghouse for Child Welfare (CEBC) to advance the knowledge base in child welfare.

Methods

The California Evidence-Based Clearinghouse for Child Welfare

The California Evidence-Based Clearinghouse for Child Welfare (CEBC) was created through a collaborative effort between the California Department of Social Services, Chadwick Center for Children and Families (Rady Children s Hospital, San Diego) and Child and Adolescent Services Research Center. The CEBC is meant as a tool for identifying, selecting and implementing evidence-based child welfare practices in order to improve the safety, permanency and well-being of children and families in the care of the child welfare system. While recognizing a special responsibility to child welfare practice in California, the CEBC provides information that may be useful for any child welfare system (www.cebc4cw.org).

Review Procedures

The CEBC uses a standardized review process, which involves a statewide Advisory Committee, a Scientific Panel consisting of leading national child welfare researchers, and Topic Experts. One of the topics of interest that had been identified involved higher level placement. While higher level placement may also involve settings such as treatment foster care and inpatient psychiatric care, the current review was only focused on group care. The review took place in 2008, and since then has been updated. A team of child welfare experts

identified primary treatment models relevant to residential care. The available published and peer-reviewed literature was searched, using the following databases: Campbell and Cochrane Collaboratives, National Child Welfare Clearinghouse, PubMed, Psych Info, Google, Google Scholar, and NREPP. Next, outcome studies were reviewed by the Topic Expert and rated on an effectiveness scale with five categories ranging from well-supported effective practice to concerning practice. Table 1 specifies both criteria for rating as well as the types of studies considered in the rating process. Dissertations, descriptive articles about a treatment model or program, and reports to funders were not part of the review. Only peer-reviewed literature was included in the final rating process. The classification system uses criteria regarding a practice s clinical and/or empirical support, documentation, acceptance within the field, and potential for harm. A lower score indicates a greater level of support for the practice protocol. In 2008, a not rated category was added for programs that are generally accepted as clinical practice, do not seem to present a substantial risk to those receiving it, but lack literature that would provide evidence of a benefit. Given the focus on child welfare practice, the CEBC further evaluates each model s relevance to child welfare populations and child welfare outcomes in the area of permanency, safety and child/family well-being.

The search process yielded information on five models relevant to group care: Positive Peer Culture, Teaching Family Model, Sanctuary Model, Re-Ed, and the Stop-Gap Model. The features of these models will be briefly summarized and the evidence for the models effectiveness discussed. An overview of each model s features and the relevant outcome literature can be found in Tables 2 and 3, respectively.

Model 1 - Positive Peer Culture

Overview—The Positive Peer Culture (PPC) treatment model was developed by Vorrath and Brendtro (1985) in response to the failure of conventional treatment approaches to effectively deal with negative peer pressure among troubled youth. It is grounded in theories of social psychology and argues that social context is a powerful determinant of thoughts and behaviors. As such, PPC aims to transform a negative peer context into a positive peer culture, in which adult authority is deemphasized. Group norms that reinforce mutual responsibility, prosocial attitudes and social concern are fostered through the development of trust and respect. The model assumes that as youth become more committed to caring for others, hurtful behaviors are replaced by prosocial and responsible behaviors, and self-worth is increased. Some of the behaviors and attitudes that are fostered include:

- A sense of belonging
- A code of conduct that assures a safe environment and promotes pro-social behavior
- Individual members responding positively to the influences of the community
- A sense the each member can make a significant positive contribution to the community
- Positive reinforcement of social responsibility to the community
- Censure of maladaptive and anti-social behavior

Treatment features—PPC has four essential treatment components: (1) *Building Group Responsibility*: group members learn to keep one another out of trouble; (2) The importance of the *Group Meeting*: The group meeting serves as the problem-solving arena in which youth are able to help one of their peers in a safe environment; meetings are structured and involve problem reporting, problem solving, group leader s summary, etc. A distinct

problem list is used in the program to ensure a universal language; (3) *Service Learning*: Youth are engaged in multiple community projects, developed to reinforce the value of helping others; many projects are conducted along side adult service clubs. Youth are taught that community service is an expected part of community living, not a punishment for misbehavior. In the context of a PPC program, service learning is not simply a program component but a life-style of community responsibility and action; (4) *Teamwork Primacy:* a highly successful program management model which assumes that "teamwork" is the highest administrative priority. Staff teams are organized around distinct groups of children.

PPC was designed for group settings, and has been applied in residential settings, outpatient facilities and schools. PPC is generally delivered in groups of 8 to 12 youth in 90-minute structured group meetings, which ideally occur five times per week over a six to nine month period. PPC does not have a parent component. PPC is manualized, and training is available in the form of classroom training and program immersion. It has been acknowledged that the successful implementation of PPC has been a challenge due to a lack of attention given to quality control (Quigley, 2003). Adequate training of staff is an essential component to successfully guide the group process (Moody & Lupton-Smith, 1999; Vorrath & Brendtro, 1985).

Evidence for effectiveness—Evaluative studies of PPC that have appeared in the peer-reviewed published literature are very limited, but include one randomized (Leeman, Gibbs & Fuller, 1993) and one quasi-experimental study (Nas, Brugman & Koops, 2005) within the context of a residential treatment facility. In addition, one quasi-experimental study (Sherer, 1985) evaluated the effectiveness of PPC with "street-corner gangs." It needs to be noted that both the Leeman et al. and Nas et al. studies were conducted on an adaptation of the PPC program, namely the EQUIP program. EQUIP combines elements of PPC, moral discussion groups and social skills training (Gibbs, Potter, Barriga & Liau, 1996). Measured outcomes include moral judgment, cognitive distortions, behavior problems, social skills and self-concept as well as recidivism. All studies were conducted with delinquent youth. Leeman et al. s (1993) experimental study reported significant gains in institutional conduct and social skills in the experimental group relative to the control group; they also reported a 50 percent reduction in recidivism after six months, and a one-third reduction at 1-year follow-up. In the quasi-experimental study by Nas et al. (2005), significant reductions in some cognitive distortions and also in covert antisocial behavior were noted. However, this study did not find significant differences in moral judgment and social skills, overt antisocial behavior or the cognitive distortion of "assuming the worst" between treatment and comparison group. Similarly, the 1985 Sherer study reported improvements on resistance to temptation and moral development in the PPC group, but no differences in other areas (e.g., confession). The limited outcome literature suggests that PPC can be effective with delinquent youth in residential facilities with regard to some outcomes, such as improved self-concept and recidivism. However, there are also concerns about PPC. A case-control study by Ryan (2006) cautioned that PPC may not be the most effective strategy for youth in the juvenile justice system that had experienced maltreatment. Kapp (2000) conducted qualitative interviews with youth who went through PPC programs and were highly critical of the group process. Based on established CEBC criteria, PPC is considered to be "supported by research evidence" (Level 2). With regard to relevance to child welfare practice received a medium (2) rating. Outcomes focused on child and family well-being.

Teaching Family Model

Overview—Of all group home models, the Teaching-Family Model (TFM) is probably the most described and researched model in the literature (Phillips, Phillips, Fixsen & Wolf, 1974). A 2002 annotated bibliography of publications of the TFM (Fixsen & Blasé, 2002)

lists more than 150 titles, addressing a range of topics from research on treatment procedures, practitioner training, program fidelity, administrative support to dissemination/ replication.

The TFM was first implemented in 1967 with the opening of a group home for delinquent youth as the Achievement Place Research Project at Kansas University. The TFM is best known because of its utilization at Boys Town (formerly Father Flanagan s Boys Town). Boys Town uses an advanced and updated adaptation of the TFM that has been described in detail by Daly and Dowd (1992).

Treatment features—TFM is characterized by clearly defined goals, integrated support systems, and a set of core elements, which include:

- Careful selection of prospective Teaching Parents, which are often married couples working as a treatment team
- Comprehensive skill-based training of these treatment providers
- Role of teaching parents as professional practitioners
- 24-hour professional consultation
- The routine use of proactive teaching interactions focused on positive prevention and youth-skill acquisition
- The use of a client peer leadership/self-government system
- Thorough and recurrent professional and community evaluation of the performance of the teaching parents
- Requirement of annual reaccreditation based on these evaluations
- An emphasis on family-style living and learning in a normalizing care environment

Besides residential group care, the TFM has also been applied to home-based services, foster care and treatment foster care, schools and psychiatric institutions. The model uses a married couple or other “teaching parents” to offer a family-like environment in the residence. The teaching parents help with learning living skills and positive interpersonal interaction skills. They are also involved with children s parents, teachers and other support network to help maintain progress.

TFM has been highlighted by the Surgeon General s Report on Mental Health, the American Psychological Association, the Office of Juvenile Justice and Delinquency Prevention, and the Juvenile Forensic Evaluation Resource Center. Inspired by attempts to professionalize and improve care for vulnerable youth, the TFM has been disseminated through the International Teaching Family Association. TFM is manualized and training is provided through regional TFM sponsoring agencies.

Evidence for effectiveness—Our review yielded seven articles, summarizing nine studies that met review criteria. Studied outcomes included behavior problems, symptomatology, family functioning and parental effectiveness, academic outcomes as well as service level outcomes, such as level of restrictiveness, and number of restraints. Studies reviewed included one randomized trial (Lewis, 2005), one quasi-experimental study with an equivalent comparison group (Thompson et al., 1996), four quasi-experimental studies with non-equivalent/non-matched comparison groups (Bedlington, Braukmann, Ramp & Wolf, 1988; Kirigin, Braukmann, Atwater & Wolf, 1982; Slot, Jagers & Dangel, 1992), and three pre-posttest studies (Jones & Timbers, 2003; Larzelere et al., 2004; Slot et al., 1992).

Lewis experimental study was subsequently removed from rating considerations since the study used an adaptation of the TFM within a family-based, not a group care setting.

Thompson et al. (1996) reported significant differences in improvements in academic functioning between youth receiving the TFM and an equivalent comparison group receiving treatment as usual. Bedlington et al. (1988) compared changes in functioning for youth placed in TFM residential homes versus youth placed in non-TFM homes. Findings were based on observer protocols that measured adult/youth interactions, teaching, intolerance of deviance, youth social behavior, pleasantness of the environment, and family-likeness and youth self-report of delinquency. TFM homes were rated as having significantly higher levels of adult/youth communication and instances of adults teaching youth. Kirigin et al. evaluated the effectiveness of TFM homes compared to similar residential programs. Comparison group homes were similar to treatment homes in terms of youths served, size and staffing by a live-in married couple. TFM was associated with fewer offenses during treatment while the rate actually increased for non-TFM boys.

In a pretest posttest study of 440 youth in a residential program, Larzelere et al. (2004) found significant improvements in problem behaviors as measured by the Child Behavior Checklist, significant reductions in psychiatric symptomatology and discharges to settings of lesser restrictiveness. A 2003 study by Jones and Timbers, using archival data, reported significant reductions in coercive behavioral control interventions following the introduction of the TFM. Slot et al. (1992) reported on a series of studies conducted in residential care homes in Canada and the Netherlands. The first study, a pre-post investigation, reported significant improvements in such area as overall adjustment, family adjustment, relationship with parents, and offense rates. However, the study also reported increases in post-treatment drinking. Study 2 measured levels of juvenile delinquency in youth experiencing a TFM program in the Netherlands and compared them to a cohort of Canadian youth in the same age range. The number of TFM-youth staying at the same offending level was half that of the comparison group. Significantly more TFM youth moved toward a less serious offending level.

The TFM was rated as “promising” (Level 3) with a medium (2) rating for relevance for child welfare practice. Outcomes primarily involve domains of child and family well-being.

Sanctuary Model

Overview—The Sanctuary® Model (Bloom, 1997) represents a trauma-informed method for creating or changing an organizational culture in order to more effectively provide a cohesive context within which healing from psychological and social traumatic experience can be addressed. It is a whole system approach designed to facilitate the development of structures, processes and behaviors on the part of staff, children, and the community that can counteract the biological, affective, cognitive, social, and existential wounds suffered by the children in care. Sanctuary® was developed by Sandra Bloom and colleagues within the context of a short-term acute inpatient psychiatric setting. The model has been implemented and modified in a range of settings, including group care.

Treatment features—The Sanctuary® Model has several explicit features that constitute the foundation for creating a shared vision and common goals among treatment staff. The model places emphasis on nonviolence, emotional intelligence, inquiry and social learning, shared governance, open communication, social responsibility and growth and change. Recovery from trauma is conceptualized as occurring in four stages that focus on Safety, Emotional Management, Loss, and Future (SELF). Using this trauma recovery framework along with cognitive-behavioral strategies, youths are taught skills aimed at improving their ability to adapt to and cope with traumatic and other stressful life experiences. The model is

implemented in a variety of ways through staff dialogue and self evaluations of residential units structure and functioning, staff training, ongoing technical assistance, twice-daily community meetings, psychoeducation exercises used by staff in daily interactions with youth, and weekly psychoeducation groups (Duffy, McCorkle & Ryan, 2002). The curriculum to conduct the groups was developed for 12 sessions, which address the elements of the trauma recovery framework (Rivard, 2004). The model does not include a specific parent component.

The overall Sanctuary® Model is not manualized, but training is available to guide its implementation. If an agency deems itself ready to commit to the full implementation, the agency undergoes a rigorous initial assessment. The assessment includes reflections from leadership on their readiness and willingness to implement the model, and on-site visit from a trainer to better assess the organization s culture. The training takes five days with follow-up consultation available.

Evidence for effectiveness—Evaluative work of the sanctuary model is very limited. Targeted outcomes have included self-esteem, trauma symptoms, behavior problems, parent and peer attachment, as well as coping and problem solving skills, using a range of well-accepted standardized measures. In a quasiexperimental study, Rivard, Bloom, McCorkle and Abramovitz (2005) examined implementation and short-term effects of the Sanctuary® Model for 158 youths with histories of maltreatment placed in residential treatment facilities. Using a series of standardized measures, the study reported significant differences in outcomes for youth in Sanctuary® Model programs compared to those placed in other group care facilities. Differences in improvement were noted in the area of interpersonal conflict, personal control, verbal aggression, and problem solving. According to CEBC criteria, the model is considered to be “promising.” The relevance to child welfare practice is medium (2). Research on the Sanctuary® Model has addressed outcomes of child and family well-being.

Stop-Gap Model

Overview—The Stop-Gap model, introduced by McCurdy and McIntyre (2004) reconceptualizes group care as a short-term arrangement aimed at stabilizing youth sufficiently for discharge to a lower level community-based treatment. It incorporates evidence-based practices within a three-tiered approach (i.e., environment-based, intensive, and discharge related) of service delivery for group care settings. The two-fold goal of the Stop-Gap model is to interrupt the youth s downward spiral imposed by increasingly disruptive behavior and prepare the post-discharge environment for the youth s timely re-integration. The Stop-Gap model recognizes the importance of community-based service delivery approach while providing intensive and short-term support for youths with the most challenging behaviors.

Treatment features—Youths enter the model at Tier I, where they receive environment-based and discharge-related services. The focus at Tier I is on the immediate reduction of “barrier” behaviors (i.e., problem behaviors that prevent re-integration) through intensive ecological and skill teaching interventions. This includes interventions such as token economy, academic interventions, social skills training, problem-solving and anger management skills training. Simultaneously, discharge related interventions commence (Tier II). These activities are designed to connect youth to critical community supports and include Intensive Case Management, Parent Management Training, and community integration activities. To the extent that problem behaviors are not reduced at Tier I, intensive Tier III interventions that include function-based behavior support planning are

implemented. Depending on the needs of the individual child, it is anticipated that the duration of service may range from 90 days to one year.

Evidence for effectiveness—Evaluative work on this model is still in early stages. McCurdy and McIntyre present data on the comparative rates of therapeutic holds in two units of a residential treatment center, one of which introduced the environment-based intervention after seven months. Groups were matched on population number, gender and disability. At twelve months, the intervention residence showed a decline in therapeutic holds, while the comparison group showed an increase over the same period. The model was rated as "promising." The relevance to child welfare ratings was considered "medium."

Re-ED

Overview—Re-ED (originally called Re-Education of children with Emotional Disturbance) is an ecological competence approach to helping troubled children and youth and their families entering child serving systems (e.g., Cantrell & Cantrell, 2007; Hobbs, 1966). This philosophy-based approach has refined its beliefs and practice since the early 1960s. Re-ED signified a change in service paradigm for youth, emphasizing a strength-based approach, an ecological orientation, a focus on competence and learning, an emphasis on relationship-building and the development of a culture of questioning and informed or data-driven decision-making. Re-ED was originally implemented and tested in short-term residential treatment programs as well as public school support services programs. Since then, the model has been adapted to a wide variety of community needs.

Treatment features—Re-ED is intended to be implemented as a group approach with about eight to ten children or youth in one group. The treatment intensity as well as duration can vary depending on setting. Group meetings may be held multiple times a day for specific purposes, e.g., planning, problem solving, strengths-building. The length of group sessions lasts from fifteen minutes to more than an hour, but is primarily determined by the purpose, structure and goals of the particular group. From its beginning, Re-ED was committed to short-term enrollment (about 4–6 months residential care enrollment) and return to the community as soon as possible. Some Re-ED services operate without a group meeting format, but still meet as family/professional teams to work toward targeted goals. Re-ED includes a homework component that is focused on the implementation of behavioral goals by youth and their parents. Re-ED was designed with a parent component.

Training—Training modules are available that describe the Re-ED philosophy and how to implement the program. The Introductory Training Modules usually require two days for a group unfamiliar with Re-ED, but may be divided into six segments for programs needing different schedules. Training can be obtained on-site, but observations in Re-ED programs with coordinated activities are recommended.

Evidence for effectiveness—A few outcome studies of Re-ED have been conducted, but have been restricted to pre-posttest designs (Fields, Farmer, Apperson, Mustillo & Simmers, 2006; Hooper, Murphy, Devaney & Hultman, 2000; Weinstein, 1969). Table 3 summarizes features and results of these studies. While findings indicate improvement in various domains of functioning following Re-ED, this model did not receive a rating at this time given the lack of studies using a comparison group.

Discussion

This structured review identified five treatment models relevant to group care for children referred by the child welfare system. Four of the models were rated as either being

supported by research evidence (PPC) or being promising (TFM, Sanctuary Model, Stop-Gap). The Re-ED model could not be rated due to lack of evaluative data, which would meet CEBC rating criteria. The models were generally considered to be of medium relevance to the child welfare population, and all studies included in the review primarily targeted child and family well-being outcomes rather than outcomes of safety or permanency. What do these ratings mean for research in this area, for group care providers and child-serving systems? There are several issues to consider.

Limitations of Group Care Research

This review introduces professionals and researchers interested in this field to group care treatment models that are fairly well specified and relevant to child welfare populations. The encouraging news is that four out of the five models had sufficient evidence to be rated, and that the quality of the studies warranted a rating of support or promise for effectiveness. On the other hand, the combined body of rigorous studies on these models remains painfully small and, in some cases, dated. Currently, researcher Elizabeth Farmer is conducting NIMH-funded work on the effectiveness of the Teaching Family Model (http://projectreporter.nih.gov/project_info_description.cfm?aid=7665356&icde=4693524), and her work promises to advance the knowledge base in this area. However, there does not appear to be much progression of knowledge with regard to the other models, and the emphasis on the development of less expensive community-based interventions is unlikely to encourage development and implementation of new group care models.

The limitations of group care research also need to be considered to understand the rating of “effective” for the PPC model versus the rating of “promising” for three other programs. PPC s rating is primarily based on one experimental study and the length of its follow up period (Leeman et al., 1993). While more studies have evaluated the effectiveness of the TFM, randomization remains the hallmark to determine efficacy, and more studies like the Leeman et al. study are needed. However, conducting experimental studies in real-world settings, especially with vulnerable youths continues to be an extraordinary challenge that is often abandoned for pragmatic as well as ethical reasons (e.g., Gustavsson & MacEachron, 2007). Yet it is exactly this type of scientific rigor that will be required to provide definitive answers about the effectiveness of a model.

Which Model to Choose?

Considering core ingredients—Comparing the models to each other in their utility for group care settings is not straightforward. All models target youth considered to be “troubled” or “at risk.” However, while PPC, TFM, Stop-Gap and Re-ED appear to be particularly equipped to deal with youth who exhibit externalizing behavior problems, the Sanctuary® Model places explicit emphasis on addressing trauma within a safe and supporting milieu. PPC and the Sanctuary® Model are intended for use with adolescents whereas the age range for TFM, StopGap and Re-ED extends to younger ages. None of the models have race/ethnicity or maltreatment type specifications. All models are described as short-term programs with stays ranging from 3 months to about 1 year. Emphasis on group treatment varies across the models: PPC and Re-ED rely heavily on (almost) daily structured group meetings. TFM and Stop-Gap may utilize a group format, but rely on groups to a lesser degree. The Sanctuary® Model is not specifically designed with a group component, but is more milieu-oriented. A major criticism of group care has been its lack of connection and involvement with the youth s biological family (Barth, 2005). All models except for PPC include a parent component. However, we do not know at this time how consistently this aspect is implemented in each model.

Unfortunately, research on group care models remains in early developmental stages and prohibits identification of essential or core ingredients at this time. However, there are a few treatment components in some of the models that are unique, and determining their role in the effectiveness of the model would deserve further investigation. For instance, a distinguishing factor of the TFM model is the use of Teaching Parents who live with about six to eight youths in small therapeutic group home units. As such TFM homes tend to bear more resemblance with treatment foster homes than with larger group care facilities, which traditionally rely on shift staff. Given the stronger evidence for treatment foster care (in particular Multidimensional Treatment Foster Care) (Chamberlain, 2002), this is a feature that makes the TFM particularly promising. Small therapeutic group care settings have been described as a realistic alternative for difficult-to-manage youth when treatment foster care is not available (Burns, Hoagwood & Mrazek, 1999). In contrast, PPC s emphasis on peer culture raises concerns in light of prior research on iatrogenic effects (e.g., Dishion, McCord & Poulin, 1999). While the presence of these effects is not undisputed (Lee & Thompson, 2009) and is countered by some of the positive findings of studies evaluating PPC, there is evidence that adult-mediated treatment models compared to peer-mediated models are more effective for youth with significant behavioral problems (Chamberlain, Ray & Moore, 1996) and that heavy reliance on group processes can have detrimental effects (Kapp, 2000). It deserves noting that PPC is not the only model that integrates concepts of peer governance and positive influence of peers. Many group care programs rely on group processes to some degree. Within the context of this review, this includes TFM and Re-ED. The benefits and liabilities of placing youth with emotional and behavioral disturbances into one setting, and the factors that may mediate these effects, need to continue being the subject of systematic investigation.

The Stop-Gap model is undergirded by a conceptual model that is particularly compelling in today s evidence-based driven environment, emphasizing integration of a range of evidence-based treatments (e.g., parent management, intensive case management, cognitive behavioral therapy) within the context of a group care delivery model that is tied to the overall treatment and discharge planning of the youth. Unfortunately, it does not appear that Stop-Gap has been implemented or evaluated beyond the program described in the McCurdy and McIntyre (2004) publication. The model has a lot of face validity, and group care programs and child-serving systems would be well advised to review it. However, without further implementation and research to test the effectiveness of the model, Stop-Gap will not grow beyond the “promising” stage.

Considering outcomes—The studies reviewed measured effectiveness along a range of outcomes, including moral judgment, cognitive distortions, moral beliefs, behavioral outcomes, self-concept, family functioning, restrictiveness of environment, academic performance, etc. The utility of the models is in part determined by the relevance of the outcomes to group care settings and more generally to child welfare practice. Studies considered in this review primarily addressed domains of well-being, only two measured permanency outcomes (Kirigin et al., 1982; Larzelere et al., 2004), and none measured outcomes related to child safety. However, little is known about the outcomes that are most important to group care providers and how much these outcomes may vary across programs or how much they converge with the targeted outcomes of a youth s overall case plan. Group care settings whose programs aim to improve outcomes in domains similar to the ones captured in the studies here are encouraged to closely review the respective treatment model.

To Manualize or not to Manualize?

This review most of all highlights the need to specify group care models. Only specified, and preferably manualized models lend themselves to dissemination and evaluation and

thus, knowledge development. A relationship between well-conceptualized and implemented programs and achievement of targeted outcomes has been shown in the area of group care for juvenile offenders (Dowden & Andrews, 2000). Yet there is little evidence that group care settings follow clearly specified models, and even less evidence that they follow one of the models reviewed here. Usual care group care, like other bundled or multi-component interventions (e.g., treatment foster care, inpatient psychiatric care), presents a black box in which individual group care facilities "stuff" a broad array of treatments and services. At minimum, there are expectations that children and youth are safely housed and supervised, and state licensing agencies are in charge of supervising this aspect of group care. The placement or residential aspect of group care settings is generally funded through child welfare dollars. However, many group care settings are also expected - and receive mental health dollars - to provide treatment to address the emotional and behavioral needs of the youth in their care. Yet once a group care facility s initial program is licensed there is relatively little oversight unless there are overt violations of licensing standards. Thus, group care facilities have enormous freedom in determining their treatment philosophy and approach. Current research knowledge about usual care group care is limited, but experience supported by some research indicate that there is considerable variability within and between group care facilities with regard to how and what type of services are delivered (Whittaker, 2004).

Given our limited systematic knowledge about group care and the variability in client population, age range, treatment approach, lengths of stay, services provided, and targeted outcomes, it appears to be bad science to aggregate all group care under one umbrella construct and attempt to determine its effectiveness. However, classifying group care settings more accurately may be difficult or even impossible since (a) group care settings may not be able to identify a unifying and consistent treatment approach; (b) researchers may have insufficient information about the particular features and characteristics of a group care setting; and (c) doing so may lead to a critical shrinking of sample size that would undermine the usability of data.

Conclusion

This is a time of unprecedented pressure for group care settings. Increased emphasis on evidence and outcomes, policy directives and class action lawsuits urging reduction of group care utilization, along with a growing number of home- and community-based interventions that promise to provide better care and outcomes for children with serious emotional and behavioral disorders have placed group care settings under renewed scrutiny. Many child serving systems have already successfully reduced their group care utilization rates and are in a position of leverage to demand greater transparency from group care settings about the services they provide and the quality of these services (Lee & McMillen, 2007). Research on group care remains in early developmental stages, and as this review indicated, far too few rigorous studies have been conducted to make a strong recommendation for one or the other treatment model. However, it is in the best interest of group care settings that genuinely try to deliver quality care to collaborate with child welfare service systems and researchers to identify the essential elements of their program, to critically review their program in light of the needs of the youth they serve, and to consider adopting or learning from the treatment models that already have an evidence-base.

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Table 1

CEBC Rating Criteria

Rating	Scientific Rating Criteria
1 – Well supported by Research Evidence	• There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits. • The practice has a book, manual, and/or other available writings that specify components of the service and describes how to administer it. • Multiple Site Replication: At least 2 rigorous randomized controlled trials (RCTs) in different usual care or practice settings have found the practice to be superior to an appropriate comparison practice. The RCTs have been reported in published, peer-reviewed literature. • In at least one RCT, the practice has been shown to have a sustained effect at least one year beyond the end of treatment. • Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects. • If multiple outcome studies have been conducted, the overall weight of the evidence supports the effectiveness of the practice.
2 – Supported by Research Evidence	• There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk or harm to those receiving it, compared to its likely benefits. • The practice has a book, manual, and/or other available writings that specifies the components of the practice protocol and describes how to administer it. • At least 1 rigorous randomized controlled trial (RCT) in usual care or a practice setting has found the practice to be superior to an appropriate comparison. • In at least 1 RCT, the practice has been shown to have a sustained effect of at least six months beyond the end of treatment. • Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects. • If multiple outcome studies have been conducted, the overall weight of evidence supports the benefit of the practice.
3 - Promising Research Evidence	• There is no clinical or empirical evidence or theoretical basis indicating this practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits. • The practice has a book, manual, and/or other available writings that specifies the components of the practice protocol and describes how to administer it. • At least one study utilizing some form of control (e.g. untreated group, placebo group, matched wait list) have established the practice's benefit over the placebo, or found it to be comparable to or better than an appropriate comparison practice. The study has been reported in published, peer-reviewed literature. • If multiple outcome studies have been conducted, the overall weight of evidence supports the benefit of the practice.
4 - Research Evidence Fails to Demonstrate Effect	• Two or more randomized, controlled trials (RCTs) have found that the practice has not resulted in improved outcomes, when compared to usual care. The studies have been reported in published, peer review literature. • If multiple outcome studies have been conducted, the overall weight of evidence does not support the benefit of the practice.
5 – Concerning Practice NR – Not Rated*	• If multiple outcome studies have been conducted, the overall weight of evidence suggests the intervention has a negative effect upon clients served, AND/OR • There is a reasonable theoretical, clinical, empirical, or legal basis suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it. • There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits. • The practice has a book, manual, and/or other available writings that specifies the components of the practice protocol and describes how to administer it.

Rating	Scientific Rating Criteria
	• The practice is generally accepted in clinical practice as appropriate for use with children receiving services from child welfare or related systems and their parents/ caregivers. • The practice does not have any published, peer-reviewed study utilizing some form of control (e.g., untreated group, placebo group, matched wait list) that has established the practice's benefit over the placebo, or found it to be comparable to or better than an appropriate comparison practice.
Rating	**Relevance to Child Welfare Populations**
1- High	• The program was designed or is commonly used to meet the needs of children, youth, young adults, and/or families receiving child welfare services.
2 - Medium	• The program was designed or is commonly used to serve children, youth, young adults, and/or families who are similar to child welfare populations (i.e. in history, demographics, or presenting problems) and likely included current and former child welfare services recipients.
3- Low	• The program was designed or is commonly to serve children, youth, young adults, and/or families with little or no apparent similarity to the child welfare services population.
Rating	**Relevance to Child Welfare Outcomes**
Yes/No	The program evaluation had measures relevant to **safety**. • Children are, first and foremost, protected from abuse and neglect. • Children are safely maintained in their homes whenever possible and appropriate.
Yes/No	The program evaluation had measures relevant to **permanency**. • Children have permanency and stability in their living
Yes/No	The program evaluation had measures relevant to child and family **well-being.** • Families have enhanced capacity to provide for their children's needs. • Children receive appropriate services to meet their educational needs. • Children receive adequate services to meet their physical and mental health needs.

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Table 2

Overview of Group Care Treatment Models

Model and Citations to Descriptive Articles	Target Population	Essential Model Components and Duration	Education and Training Resources	Child Welfare Relevance
Positive Peer Culture Vorrath & Brendtro (1985) Laursen (2005) Wasmund & Tate (1996) Brendtro & Shahbazian (2004)	• Population: troubled and troubling youth • Age: 12–17 • Race: no specification • Maltreatment type: all types • Settings: residential care, outpatient clinic, school	**Essential Components:** • Building group responsibility • The group meeting • Service learning • Teamwork primacy **Format:** • Designed for group format • Recommended group size: 8–12 • Duration: 90 minute structured group meetings, 5 times per week over a 6–9 months period • Designed with a child component, but not with a parent component	**Manual:** yes **Training:** yes • Number of days/hours: varies • Both classroom training and program immersion • The Academy of Positive Peer Culture provides training annually at the Black Hills Seminars in Rapid City, SD. • On-site consultation $1,500 per day plus expenses; Black Hills Seminars – currently $450 per person **Contact:** • The Academy for Positive Peer Culture c/o Reclaiming Youth P. O. Box 57 Lennox, SD 57039 • Starr Commonwealth, c/o T.F. Tate 13725 Starr Commonwealth Rd Albion, MI 49224 • UMFS; c/o E.K. Laursen 3900 West Broad Street Richmond, VA 23230	**Relevance to CW Population:** Medium **Relevance to CW Outcomes** • Measures relevant to safety: No • Measures relevant to permanency: No • Measures relevant to child and family well-being: Yes
Teaching Family Model Blase, Fixsen, Freeborn, & Jaeger (1989).	• Populations: at-risk youth, juvenile delinquents, youth in foster care, developmental disability, severe emotional disturbance,	**Critical Delivery Systems:** • Staff selection & training • Competency-based management (consultation/supervision) • Quality assurance (evaluation) • Facilitative administration	**Manual:** yes; available on the web; **Training:** yes; • Number of days/hours: Pre-service about 40 hours. Ongoing consultation with individual certification typically occurring after one year of practice.	**Relevance to CW Population:** Medium **Relevance to CW Outcomes:** • Measures relevant to safety: No
Kirigin (1996) Wolf, Kirigin, Fixsen, Blase & Braukmann (1995)	• families at risk of having children removed • Age: 0–17 • Race: not specified • Maltreatment type: not specified	**Essential Elements:** • Teaching systems • Self-determination • Client advocacy • Relationships • Family-sensitive approach	• How is training obtained: Provided by regional sponsoring agency. • Cost of training: Part of the employment components. No cost to practitioner employed by the agency. • Certification needed **Contact:**	• Measures relevant to permanency: No • Measures relevant to child and family well-being: Yes

Model and Citations to Descriptive Articles	Target Population	Essential Model Components and Duration	Education and Training Resources	Child Welfare Relevance
	• Settings: residential care, hospital, school, birth family home, foster home, outpatient clinic, community agency	• Diversity • Professionalism **Format:** • Duration: 9 months in residential care settings • Can be conducted in group format • Designed with a parent and child components	• Peggy McElgunn, Esq. peggymcelgunn@comcast.net	
Sanctuary Model Rivard (2004) Bloom (2005) Farragher & Yanosy (2005)	• Population: not a client- specific intervention, but a full-system approach aimed at helping children in care who have experienced trauma • Age: Adolescents • Race: not specified • Maltreatment type: not specified • Settings: day treatment, residential care, hospital	**Essential Elements:** • Culture of Nonviolence, Culture of Emotional Intelligence, Culture of Inquiry & Social Learning, Culture of Shared Governance, Culture of Open Communication, Culture of Social Responsibility, Culture of Growth and Change **Format:** • Not specifically designed to be conducted in a group • Not specifically designed with child or parent component	**Manual:** No **Training:** • Number of days: 5 days followed by a 30-month consultation period • Information session, organizational readiness assessment, training at Andrus Center **Contact:** B. Farragher & S. Bloom at Andrus Center for Learning & Innovation www.andruschildren.org	**Relevance to CW Population:** Medium **Relevance to CW Outcomes:** • Measures relevant to safety: No • Measures relevant to permanency: No • Measures relevant to child and family well-being: Yes
Stop-Gap Model McCurdy & McIntyre (2004)	• Population: children and youth (ages 6–17) with disruptive behaviors such as non-compliance, conduct problems, and aggression • Race: not specified • Maltreatment type: not specified • Setting: residential care, hospital	**Essential Elements:** Three Levels of Intervention: • Environment-based (token economy, academic intervention, social skills training, problem-solving and anger management) • Discharge-related (intensive case management, parent management training, community integration) • Intensive intervention (Function-based assessment, Function-based behavior support planning) **Format:**	**Manual** There is no manual **Training:** • Number of days: 2 days • On-site **Contact:** B. McCurdy, Devereux Center for Effective Schools	**Relevance to CW Population:** Medium **Relevance to CW Outcomes:** • Measures relevant to safety: No • Measures relevant to permanency: No • Measures relevant to child and family well-being: Yes

Model and Citations to Descriptive Articles	Target Population	Essential Model Components and Duration	Education and Training Resources	Child Welfare Relevance
		• Was designed for group setting and to be conducted in a group • Short-term model; anticipated duration is 90 days to 1 year • Designed with a parent and child component		
Re-ED Model Hobbs (1966) Walker & Fecser (2002) Valore, Cantrell, & Cantrell (2006).	• Population: troubled and troubling youths • Race: not specified • Maltreatment type: not specified • Also developed for children with developmental delays • Setting: residential care, birth family home, foster home, outpatient clinic, community agency, adoptive home, school	**Core Elements:** • Wellness and strength orientation • Ecologically-focused involvement • Competence-based interventions • Relationships seen as critical • Natural agents in teaching and counseling roles valued and developed • Ongoing questioning and data-based decision-making **Format:** • Designed for group format and for group setting • Multiple group meetings daily, each held for specific purposes (planning, problem solving, evaluation, strengths focused meetings, etc.). • Group meetings vary from fifteen minutes to more than an hour. • Generally, short-term - 4–6 months of residential enrollment.	**Manual: yes** **Training:** • 2-day introductory training modules, but may be divided into 6 segments for programs needing different schedules. • Training days/hours vary, depending on the needs of the agency, as indicated by their performance on the assessment factors from the Re-ED fidelity scale, and on their own objectives for Re-ED knowledge and implementation in what service type(s). • On-site and regionally **Contact:** Mark Freado, M.A., Executive Director American Re-Education Association	**Relevance to CW Population:** Not rated **Relevance to CW Outcomes:** • Measures relevant to safety: No • Measures relevant to permanency: No • Measures relevant to child and family well-being: Yes

Table 3

Group Home Models - Outcome Studies

Study	Question/ Study Design	Setting/ Treatment Model	Sample Characteristics	Outcomes/ Measures	Key Findings
Positive Peer Culture					
Nas et al. (2005)	• Can EQUIP successfully alter delays in moral judgment, distortions, in social information processing, deficits in moral skills? • Quasi experimental design w/treatment and non randomized comparison groups, pretest posttest • No follow-up	• 3 high security correctional facilities in the Netherlands • EQUIP (Equipping Youth to Help One Another") is based on PPC and ART • E: received a modified version of EQUIP + usual care • C: received usual care	• N = 108; E = 61 (31 at post), C = 47 (25 at post) • Age: mean = 16.8; range = 12–21 • Gender: males • Race: not provided • Incarcerated for having committed one or more serious crimes, awaiting sentencing, or on supervision order	• SRM-SF: assessing moral judgment • HIT questionnaire: measuring cognitive distortions (self- centeredness, minimizing mislabeling, blaming others, covert antisocial behavior/lying or stealing, overt antisocial behavior/physical aggression) • IAP-SF- assessing moral beliefs and social skills under stressful circumstances	At post test: • Non-significant difference in change of moral judgment and social skills between groups • Significant difference in reduction of self- centeredness, minimizing/ mislabeling, blaming, • Significant reduction in covert antisocial behavior • No significant difference between groups observed for "assuming the worst" and overt antisocial behavior
Leeman, et al. (1993)	• Evaluated EQUIP effectiveness in experimental subjects • Experimental design w/ treatment and randomized control group • Follow-up at 1 year	• Medium-security correctional facility in Midwestern US • EQUIP (Equipping Youth to Help One Another") is based on PPC and ART • E: received EQUIP • C1: simple • C2: motivational	• N = 57; E = 20; C = 37 • Age: mean=16; range = 15–18; • Gender: male • Race: 38 white, 18 black, 1 hispanic • Incarcerated for parole violations and less serious felonies	• Mediating process (SRM-SF- measuring moral judgment; IAP- SF- measuring social skills) • Behavioral outcomes (institutional conduct, post-release recidivism)	Treatment group: • Significant gains in institutional conduct and social skills in experimental group relative to control • Experimental groups recidivism rate 1/2 of control groups at 6 months after discharge, over 1/3 at 1 year follow-up • Non-significant difference in moral judgment between groups
Davis et al. (1988)	• Assessed changes in self-concept in youth, following PPC in residential treatment • Pretest Posttest	• Residential treatment (Woodland Hills, MN) • Average length of treatment: 8 months	• N=231 delinquent youths • Age: 12–18 • Gender: 173 males, 58 female • Race: 199 white, 11 black, 5 hispanic, 16 nat. american • Adjudicated delinquent youth – some with identified psychiatric d/o	• Self-concept/Tennessee Self-Concept Scale	• Youth who completed the program rated themselves as having a more positive self- concept and a higher level of psychological adjustment on discharge
Sherer (1985)	• Examined PPC effectiveness	• PPC program in Israel	• N = 48; (E=15; C1=30; C2=10)	• MOTEC- measuring moral development (resistance to temptation, moral development,	At posttest:

Study	Question/ Study Design	Setting/ Treatment Model	Sample Characteristics	Outcomes/ Measures	Key Findings
	• Pre test post test w/non-randomized comparison groups • No follow-up		• Demographics: Mean age = 16.5 yrs, age range = 15 to 18 yrs • Gang members who had volunteered for activities directed by a paraprofessional	feelings after offense, judgment about severity of punishment, confession)	• PPC group members scored higher on resistance to temptation and moral development • PPC and control group-2 scored higher than control group-1 for feelings after offense and severity of punishment • Non-significant difference observed for confession category
Teaching Family Model					
Lewis (2005)	• Tested TFM-effectiveness • Experimental design w/ treatment and randomized control group Pretest with 2 posttests (at 5 months and 8.5 months after referral)	• Home based intervention for families in Utah • E: TFM as part of a family preservation program; intensive services for 6 months with crisis follow up • C: usual care family preservation services	• N = 150; 105 treatment, 45 controls • Demographics: Mean age = 10.4 yrs, range = 3.9 to 17.3 years; 75% male; no race/ ethnicity data • Children w/serious behavioral and school-related problems • Controls referred by school or court	63-item project developed questionnaire: • Child behavior • Child management • Family functioning • Parental effectiveness	Post-Intervention: • Significant impact of E condition on overall youth and family functioning at both posttests • No significant difference across groups for parental effectiveness/parent0child relationships due to control group's improved score over time
Larzelere et al. (2004)	• Systematic evaluation of TFM program • Is TFM effective for girls as well as boys? • Pretest posttest • Follow-up at 3 months	• Boys Town Family home Program • Group home with family-like treatment environment • Average length of stay: 1.8 years (range: 31 days to 9.7 years)	• N = 440 discharged youth • Demographics: Mean age = 14.9 yrs, range = 8.6 to 18.6 yrs; 38% female; 60% Cauc., 20% AfAm, 10% Hispanic; 3% Nat. Am., 6% multi-ethnic • Excluded youth with <31 days in care • Youth referred by juvenile justice, social or mental health services, family or self	• Behavior problems/CBCL • Clinical diagnosis/DISC • Restrictiveness of Living Environment/ROLES	• Most youth improved from intake to discharge and were functioning at levels similar to national norms at a 3- month f/ up • Similar improvement for girls and boys • Most youth discharged to less restrictive settings, but girls had greater reduction • Significant improvements in problem behaviors observed • Significant reductions in DSM-III and -IV diagnosis 12 months after intake
Jones & Timbers (2003)	• Examined TFM's effectiveness in reducing coercive behavior control interventions • Pretest posttest w/ archival data	• 2 campus-based long term care institutions in Southeast US and Midwest (Barium	• N = not provided • Demographics: Age range = 8 to 18 yrs; male and female clients	• Physical restraint • Seclusion	After TFM introduction: • Barium Springs: 40% reduction in physical restraint and 80% reduction in negative incidence reports

Study	Question/ Study Design	Setting/ Treatment Model	Sample Characteristics	Outcomes/ Measures	Key Findings
	• No follow-up	Springs and Bridgehouse Program)	• Data reviewed over 2 year period	• Negative incidence reports	• Bridgehouse program:75% reduction in physical restraint and seclusion
Thompson, et al. (1996)	• Evaluated short- and long-term educational effects of TFM program • Quasi-experimental longitudinal design w/ treatment and non-randomized comparison group • Follow-up at 4 years	• Home campus program	• N = 581; 497 treatment, 84 controls • Demographics: Mean age = 14.4 yrs (treatment), 14.7 yrs (controls); all males • Followed for 8 years	• Grade point average (GPA) • Years of school completed • HS diploma/GED • Chance of college attendance • Request for help w/homework from adult	Treatment group: • Reported higher GPA while in residence than after discharge- (stayed higher than controls) • Years of school completed at faster rate • 83% completed high school/GED vs. 69% of controls • Increased chance of college attendance while in residence- decreased after discharge • Received more help with homework during and after program
Slot, et al. (1992)	• Determined effectiveness of cross-cultural replication of TFM • Pre test post test, as well as experimental design w/treatment and non-matched and non-randomized control groups • Follow-up at 6 months for Studies 1 and 2, unknown for study 3	• Residential care homes and state-run institutions in Canada and the Netherlands	3 separate studies: • Study 1: N = 58 Dutch youth (TFM); Mean age = 16.6 yrs, range = 14.2 to 19.1 yrs • Study 2: N = 529, 50 Dutch youth (TFM), 479 Canadian youth; Mean age = not available • Study 3: N = 114, 57 Dutch youth, 57 Canadian youth; Mean age = 16.4 yrs, range = 14 to 18.3 yrs	• YEL- used in Study1: measures 3 dimensions of anti-social behavior and social competence • Study 2: Offense levels • Study 3: Problems, abilities for relationships outside families and for community participation	• Study 1: – Improvements in overall adjustment, family adjustment, relationship w/ parents, offense rates, problems at home, social competence, ability for relationships outside family – No improvement in community participation and employment rates – Significant increase in post-treatment drinking • Study 2: – Lower rates of staying at the same offense level, 24% vs. 48% (comparison group) • Study 3: – Both groups improved, no significant differences • LOS for TFM youth 270 days vs. 573 days for non- TFM youth • TFM program costs 75% lower than comparison

Study	Question/ Study Design	Setting/ Treatment Model	Sample Characteristics	Outcomes/ Measures	Key Findings
Bedlington (1988)	• Examined treatment process features and milieu characteristics in TFM programs • Quasi-experimental design w/treatment and non-equivalent comparison group • No follow-up	• 17 Group Homes located in Kansas (9 non-TFM)	• N = 241; 91 treatment, 150 controls • Demographics: Mean age = 15.2 yrs (treatment), 15.8 (controls); all males • Court adjudicated • Followed for 2 years	• Direct observation- measuring youth-adult interactions, proximity • SRD- measuring delinquency • Environmental positiveness	Treatment group: • Rated higher in teaching, talking, and proximity • Rated higher in fairness, pleasantness, concern, and effectiveness
Kirigin, et al. (1982)	• Assessed during and posttreatment effectiveness of TFM programs • Quasi-experimental design with treatment and non-randomized comparison group • Follow-up at 1 year	• 22 Group Homes (9 non-TFM)	• N = 192, 102 treatment, 90 controls • Demographics: Age range = 12 to 16 yrs; 124 males, 68 females • Youth assigned by court	• Number of alleged offenses, • % of youth involved in offenses • % of youth institutionalized	Treatment group: • Decrease in offense rates during treatment • No significant difference in institutionalization during and after treatment • Consistently rated higher by youth
Sanctuary Model					
Rivard (2005)	• Examined implementation and short-term effects of the Sanctuary Model • Experimental design w/ treatment and non-randomized control group • No follow-up	• Residential treatment facilities in Northeastern US	• N = 158 • Demographics: Mean age = 15 yrs, age range = 12 to 20 yrs; 63% male; • Youth with history of maltreatment	• CBCL • TSCC • Rosenberg Self Esteem Scale • Nowicki-Strickland Locus of Control Scale • Inventory of Parent and Peer Attachment (peer form) • Youth coping index • Social Problem Solving Questionnaire	Treatment group: • Scored lower on measure of coping strategies that tend to increase interpersonal conflict • Exhibited greater sense of personal control • Reduced verbal aggression • Scored better on support, spontaneity, autonomy, problem orientation, and safety at 6 months after intake
Stop-Gap Model					
McCurdy & McIntyre (2004)	• Summarizes elements of Stop-Gap program • Experimental design w/ treatment and non-randomized control group • No follow-up	• 2 units within a residential treatment center providing traditional RTC services and Environment Based Intervention (E-BI) in the Western US	• N = 50; 25 treatment, 25 control • Demographics: Age range = 13 to 18 yrs; all females • Presenting DSM-IV diagnosis of conduct • Histories of sexual and/or physical abuse	• Mean therapeutic holds	Treatment group: • Mean therapeutic holds per resident for E-BI condition decreased at 12 months • Therapeutic holds under RTC condition increased

Study	Question/ Study Design	Setting/ Treatment Model	Sample Characteristics	Outcomes/ Measures	Key Findings
Re-ED Model					
Fields (2006)	• Examined preliminary effectiveness of Project Re-ED at residential treatment centers for children • Pretest posttest • Follow-up at 3 and 6 months	• State sponsored residential treatment facility (location unknown)	• N = 98 • Demographics: Mean age = 10.7, age range = 7 to 13; 13% female • Majority diagnosed with ADHD, an externalizing disorder, or mood disorder • Parent with substance abuse disorder	• CBCL- measuring the degree of severe behavioral symptoms • BERS- assesses children's strengths (intra- and inter- personal) • CASA- assesses range of services that children may use to address mental health problems (i.e. hospitalization)	• Younger age related to substantial change during treatment • Longer LOS associated with more positive outcomes • Significant improvement in CBCL and BERS during treatment and significantly better at follow-up compared to intake • Shorter stay indicates lower likelihood of receiving recommended services after discharge
Hooper (2000)	• Addressed post-discharge outcomes of students from a program employing a formal Re-ED model • Pretest posttest, cross-sectional • Follow-up at 6, 12, 18, and 24 months	• State-run residential treatment program operating on Re-ED program in NC	• N = 111 • Demographics: Mean age = 15, age range = 13 to 16 yrs; 67% male • 85% on some type of pharmacological management • 80% experienced abuse in past • Mean education level of mother's = 11th grade	3 domains: • Key demographics (age, race, gender, maternal education) • Psychoeducational (verbal IQ, performance IQ, full-scale IQ, reading, math, writing) • Social-behavioral (Child Behavior Checklist)	• 58% of students rated at performing satisfactorily across 24-month time span • Nearly all students rated satisfactorily in at least one domain following discharge; 71% functioned satisfactorily in 2 of 3 domains at 24 months and 97% at 6 months • Tendency for successful groups to include females, slightly younger, have higher IQ scores, better core reading and writing skills, fewer psychiatric diagnosis
Weinstein (1969)	• Examined the home and school adjustment of children referred to residential treatment facilities by child welfare workers • Pretest Posttest with posttests at 6 and 18 months post-intervention	• Residential treatment programs utilizing Re- ED	• N=103 • Age: 10–11 at enrollment • Race: Site 1 – 78% white; Site 2 – 96% white	Parent and teacher ratings on behavior problems, adjustment and academic functioning Measures: • Symptom Checklist • Social Maturity Scale • Student Role Behavior Scale • Semantic Differential	• At 6 months, reductions were noted in symptomatology and undesirable behaviors as well as improvements in social competence • Teachers rated students as significantly improved on all dimensions after the Re-ED intervention

James Kevin Ott **1399 South 700 East #1 Salt Lake City, Utah 84105**
801/556-6007

LICENSURE & CERTIFICATES
Licensed Clinical Social Worker, State of Utah #0116648-3501 (exp. 9/2012)
Designated Mental Health Examiner, State of Utah (exp. 2/2010)

EDUCATION
New Mexico State University. Las Cruces, New Mexico.
Master of Social Work. July, 1997
Brigham Young University. Provo, Utah
Bachelor of Science, Psychology. August 1991

WORK EXPERIENCE
Private Therapist. (11/99 – Present)
- Facilitate change and growth with individual and family clients through various modalities of psychotherapy treatment.

Clinical Director. (9/10 - 10/11)
Recovery Ways residential treatment center. Murray, Utah
- Directed all clinical treatment for 24 bed residential treatment center for substance abuse.
- Created: JCAHO compliant policy and procedure, documentation and forms for charts, and insurance utilization review system. In short, created all clinical programming.
- Supervised all group and individual therapy services, treatment team meetings, and all other therapeutic activities and services.
- Supervised utilization review process between therapists and insurance companies.
- Oversaw budgets of multi-disciplinary team.
- Collaborated with HR department through hiring and retention of employees, implemented staff trainings, collected documentation.
- Managed all duties related to the clinical treatment of people with addiction.

Clinical Social Worker. (6/04 – 2/10)
University of Utah Neuropsychiatric Institute. Salt Lake City, Utah
- Complete psychosocial assessments and treatment plans for patients.
- Facilitate psychotherapy groups—interpersonal, psycho-educational, alcohol and drug.
- Provide case management clinical services, which extend to UNI adult inpatient, adolescent inpatient, adolescent day treatment, and alcohol and drug programs.
- Assist with various assignments—Utilization Review, chart audits, clinical assessment and crisis response, and so on as directed.

Country Director. (7/03 – 5/04)
Engage Now Foundation. Addis Ababa, Ethiopia
- ♦Director of all ongoing projects in Ethiopia—literacy, health, simple technologies, etc.
- ♦Supervised all local employees.
- ♦Coordinated in-country projects with board of directors and CEO in US based office.
- ♦Facilitated expedition groups of North Americans volunteering service in Ethiopia.
- ♦Managed, tracked, and reported all budget and fiscal activities in-country.
- ♦Collected, interpreted, and reported data on project villages.

Clinical Social Worker. (4/00 – 3/03)
University of Utah Neuropsychiatric Institute. Salt Lake City, Utah
- ♦Completed psychosocial assessments and treatment plans for patients.
- ♦Facilitated psychotherapy groups—interpersonal, psycho-educational, alcohol and drug.
- ♦Provided case management clinical services, which extend to UUMC 5 West unit, and UNI adult inpatient, adolescent inpatient, adolescent day treatment, and adult alcohol and drug IOP program.
- ♦Assisted with various assignments—Utilization Review, chart audits, clinical assessment and crisis response, and so on as directed.

Early Intervention Specialist, (4/00 – 8/01)
Homeless Children's Foundation. Salt Lake City, Utah
- ♦Provided case management services to children and their families at `Our House' center.
- ♦Provided integrated services for children, resource facilitation for parents.
- ♦Networked with community agencies.

Clinical Social Worker. (8/99 – 2/00)
Southwest C.A.R.E. Center. Santa Fe, New Mexico
- ♦Provided supportive services through networking for People Living With HIV/AIDS.
- ♦Visited clients on a quarterly/as needed basis throughout North-Central New Mexico.
- ♦ Co-directed HIV/AIDS support group for North-central New Mexico.
- ♦ Established quality of life goals through a Wellness Plan for clients, documented progress.
- ♦ Provided individual counseling as needed for clients.

Clinical Director of Community Based Services. (3/98 – 7/99)
Casa de Corazon. Taos, New Mexico.
- ♦ Directed Mid-level Family Preservation and Early Intervention home visiting program.
- ♦ Supervised 8 employees of these programs. This included team meetings, formal and informal supervision, hiring, promoting, and disciplining employees.
- ♦ Wrote and Submitted grant proposals for private, state, and federal monies.
- ♦ Ensured contractual obligations for grants were met. This includes writing quarterly reports, attending core meetings, meeting with subcontractors, and meeting with fiscal personnel assuring appropriate distribution of funds.
- ♦ Networked with community agencies in providing services to clients and building community projects.
- ♦ Assisted with development of computer based survey to document progress of clients.
- ♦Responded to community crisis pager on rotation basis.

Social Worker 1, Child Protective Services Treatment Worker. (6/97- 3/98)
State of New Mexico Children, Youth, and Family Department. Farmington, New Mexico.

- Provided treatment planning and case management for children in State custody, in preparation of reunifying the family.
- Prepared affidavits used in State court hearings and agency records to document actions of clients.
- Assisted as a liaison between families and service providers in the community and state.
- Provided crisis intervention on an on-call basis.

Graduate Assistant. (1/96-5/97)
New Mexico State University. Las Cruces, New Mexico.

- Assisted professors in general teaching duties.
- Taught undergraduate and graduate level social work classes as requested by professors.
- Graded and critiqued tests and papers from students.
- Edited and updated a textbook written by a professor in preparation for re-publication.
- Researched articles, gathered data, statistically compiled and analyzed data in preparation for co-publication with a professor.

Enhanced Care Facility Case Manager. (5/93-8/95)
Mt. Hood Community Mental Health Center. Gresham, Oregon.

- Formulated assessments, treatment plans, and behavior plans for geriatric chronic mentally ill clients at a residential care facility.
- Provided family support for clients and their children.
- Provided daily structure and support through planned activities and duties.
- Consulted with a treatment team on symptoms, medications, and treatment for individual clients.
- Administered individual and group therapy on a daily basis.

Transitional Training/Respite Case Manager. (5/93-4/94)
Mt. Hood Community Mental Health Center. Gresham, Oregon.

- Formulated assessments, treatment plans, and behavior plans for adolescent and adult chronic mentally ill clients at a residential care facility.
- Coordinated family interaction between clients and parents.
- Provided skills training for planned community integration of clients.
- Interviewed and assessed clients for appropriateness of transitional program.

VOLUNTEER EXPERIENCE

Student Practicum II. Community Based Alternatives Case Manager. (8/96-6/97)
State of Texas Department of Human Services. El Paso, Texas

- Visited elderly clients in their homes to assess, plan, implement, and evaluate services received.
- Networked with various home health care organizations to provide for the needs of elderly clients.

Student Practicum I. Treatment Foster Care Coordinator. (8/95-4/96)
Alliance Hospital. Santa Teresa, New Mexico

- Established Treatment Foster Care program in the city of Las Cruces, New Mexico.
- Recruited and trained Treatment Foster Care parents for the program.
- Coordinated placement of Treatment Foster Care children with certified parents.
- Supported parents in keeping the placement of Treatment Foster Care children.

Executive Training Coordinator. (4/88-10/90)
Utah Valley Crisis Line. Provo, Utah

- Provided telephone counseling and support for people involved with suicide, depression, rape, drug abuse, and mental disorders.
- Provided initial volunteer training for all telephone crisis counselors.

PUBLICATIONS AND GRADUATE THESIS

From Novice to Seasoned Practitioner: Perceptions about Family Preservation
Journal of Family Preservation—Fall 1997
The Caregiving Preferences of Hispanic Elderly in West Texas and Southern New Mexico
Graduate Thesis--July 1997

REFERENCES AVAILABLE ON REQUEST

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Attorneys for Mapleton Fair Care, LLC

BEFORE THE MAPLETON CITY COUNCIL	
In re: Request for Accommodation of George E. "Bud" Harper	**DECLARATION OF JAMES OTT, L.C.S.W**

Pursuant to Utah Code Ann. § 78B-5-705, James Ott, declares and states as follows:

1. I am more than 18 years of age, I am competent to testify herein, and I make this declaration based upon my personal knowledge.
2. I have a bachelor's degree in Psychology from Brigham Young University.
3. I have a Masters degree in Social work from New Mexico State University.
4. I am a Licensed Clinical Social Worker (L.C.S.W.) in the State of Utah and have been since September 2000.

5. I have worked 10 years at the University of Utah Neuropsychiatric Institute (UNI) as a clinical social worker. For one year I was the clinical director of a residential treatment center (RTC) for people with drug and alcohol addiction, and have contracted services with several RTC's in the state of Utah. I have been working as an outpatient therapist in my own private practice since 2000. In these positions I have provided countless hours of individual and group psychotherapy, am very familiar with assessments, admissions, psychotropic medications, systems utilized in treatment, and Joint Commission standards of compliance. I am also a Certified ARISE Interventionist, and am familiar with many established and existing treatment programs, both outpatient and residential, for substance dependence in the State of Utah.

6. I have reviewed the March 27, 2013, letter of Rosemond Maloney, LCSW, PsyD and the literature she references and disagree with some of her assertions.

7. I agree with Ms. Maloney on the optimal group size consisting of 6-8 persons (A correction I would note is that Irvin Yalom's classic book is titled "The Theory and Practice of Group Psychotherapy"). However, this has little to no correlation on the number of individuals allowed in a residential treatment center. Much of Yalom's work pertains to groups in an outpatient setting, not residential. Having a treatment center with eight beds would also meet Yalom's recommended group size. I also agree with the concept of homogenous groups. However, the fact that the the common issue with these individuals is substance addiction meets this criteria. Furthermore, the proposed RTC is specifically targeting persons with

prescription medication addiction, which inherently creates a more homogenous group. I see no support in Ms. Maloney's statement why optimal group size adequately justifies a treatment center needing 16 beds.

8. I have personally witnessed the startup of at least 2 RTC's that originally started with a maximum of 8 patients. These facilities are still in operation today and in fact, are two of the most successful in the State of Utah.

9. It is well documented that the most effective treatment for recovering addicts and substances abusers is group therapy. However, group living is not a prerequisite for effective group therapy, meaning it is not necessary for the people who have group therapy together to also live together in order for their therapy to be viable.

10. Generally, addicts do not need group living as, say, a person without legs needs a wheelchair or an elevator.

11. Addicts can generally have successful recoveries while living wherever they want and attending outpatient group therapy. The common model is an Intensive Outpatient Program (IOP), which provides approximately 10 hours of group therapy per week.

12. Group therapy is extremely effective on an outpatient basis, which is the most common form of therapy.

13. Outpatient therapy programs are available in Utah County and throughout the Wasatch Front.

14. Inpatient therapy is readily available in existing facilities throughout Utah County and the Wasatch Front.

15. There are a glut of these inpatient types of facilities (RTC's) throughout Utah, with vacancies in very good inpatient programs.

16. It is not necessary for recovery to separate group therapy sessions by gender.

17. Mixed-gender groups of 6-8 residents can be just as therapeutically effective as same-gender groups.

18. Therefore, absent extraordinary circumstances, the claim that any addiction treatment facility needs 16 residents or any number beyond 6-8 residents in order to create gender-separate groups and be therapeutically viable is simply incorrect from a therapeutic standpoint.

19. Residential group living arrangements are generally needed for only the most severely addicted individuals. However, those type of facilities are better for the patient if they are located in a more secure environment where access to drugs and substances are more difficult to obtain.

20. For example, it is too easy, in a residential neighborhood setting, for an addict to either walk away from the facility or have someone meet him at or near the facility and supply him or her with drugs or alcohol.

21. There is more temptation and ready access to prescription drugs in a residential neighborhood than there is if the RTC were located in a commercial or mixed use location, since many residential households use the very type of prescription drugs the recovering addict may be addicted to and since many residential households contain alcohol.

22. In contrast, larger residential treatment facilities located in more secure settings—i.e., larger facilities with staff, more eyes and ears, etc., which are typically located in commercial or mixed use neighborhoods, tend to make it less tempting for the recovering addict to seek out and find sources as there will not typically be alcohol or prescription drugs in the house next door.

23. People with the most severe addictions—the type that truly benefit from living in an RTC—tend to be more desperate and will resort to almost any means available to feed their addiction.

24. Inherent in this industry is the fact that sooner or later residents will obtain illegal drugs, alcohol, or prescription drugs in an illegal way. With this said, there is a risk to the local neighborhood of which community members need to be aware.

25. With this, there is a risk of overdose and subsequently possible death. Facilities located far away from medical resources are therefore at more risk of a resident dying from lack of proper medical care.

26. For this and other reasons, including the glut of inpatient RTC's in more suitable locations, it is my considered opinion that generally group living arrangements for recovering addicts in single family residential neighborhoods are not only not necessary but, in most instances, not recommended for recovery.

I declare under criminal penalty of the State of Utah that the foregoing is true and correct.

DATED this 29 day of April, 2013.

LCSW

James Ott

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James K. Ott, LCSW, CAI, CIP
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Recommendations and Observations for Applications for Reasonable Accommodation
The Sober House
444 South 400 East, St. George, Utah
&
Steps Recovery Center
3638 Sugar Leo Road, St. George, Utah

I was asked to evaluate, from a clinical and therapeutic standpoint, the application for reasonable accommodation filed by Steps at St. George, LLC, dba Steps Recovery Center at St. George (SRC) seeking to increase the number of residents in a sober house located at 444 South 400 East from 8 to 16. This application was submitted in conjunction with a separate request seeking approval of a residential treatment center (RTC) for 24 persons known as Steps Recovery Center at 3638 Sugar Leo Road, which is in a residential subdivision. Because both applications reference each other, utilize the same exhibits, and discuss many of the same principals, I will address the applications in a single report, making distinctions between the two requests, as needed. Specifically, I was asked to address the following questions with regard to each application:

1. Does the application contain enough information about the proposed program and its participants to demonstrate that it is therapeutically necessary for the participants to live in a group living arrangement? In short, in your opinion is group living necessary to begin with?

2. Based upon the information in the applications, do the program participants need an accommodation in the group size requested--*i.e.*, is the number requested therapeutically necessary or would some other number be more suitable or ideal from a therapeutic standpoint, either larger or smaller?

3. From a clinical and therapeutic standpoint are there any concerns you have with the location of the facility?

4. Are there any other concerns or observations you have about the applications and the accommodations requested that you think would be relevant to the City's decision as to (a) whether an accommodation is necessary and (b) what type of accommodation, if any, to make.

My responses, observations and recommendations are set forth below.

QUALIFICATIONS AND BACKGROUND STATEMENT:

I am the Founder, Executive Director, and a therapist at Red Willow Counseling and Recovery, a mental health and addiction clinic in downtown Salt Lake City, Utah. I am a Certified Intervention Professional (CIP) and a Certified ARISE Interventionist (CAI) and part of the core ARISE clinical team. As a licensed therapist, I help people with general mental health difficulties, and specialize in substance abuse and its impact on families. I also consult with facilities to become accredited by the Joint Commission, which entails writing and reviewing policy and procedures and monitoring compliance with Joint Commission standards. To date, I have assisted seven programs in their accreditation, which include residential treatment and sober living components. I was a member of the State of Utah Policy Implementation and Reform committee, which diverts drug offenders from incarceration to treatment. I have also been a clinical director of a residential treatment center and of a tele-therapy intensive outpatient program, both of which treated people with drug and alcohol addiction. I have a bachelor's degree in psychology from Brigham Young University. I have a master's degree in social work from New Mexico State University. I am a licensed clinical social worker (LCSW) in the State of Utah and have been since September 2000. I worked 10 years at the University of Utah Neuropsychiatric Institute as a clinical social worker.

In my capacity of a therapist and interventionist, as well as the consulting work I do with facilities to receive Joint Commission accreditation, I have an extensive knowledge of treatment programs in the state of Utah, and familiarity with programs across the nation. I stress that my review is from a clinical standpoint, rather than a legal one.

OBSERVATIONS AND RECOMMENDATIONS:

1. ***Does the application contain enough information about the proposed program and its participants to demonstrate that it is therapeutically necessary for the participants to live in a group living arrangement? In short, in your opinion is group living necessary to begin with?***

Neither application contains enough information about the proposed program(s) and their participants to demonstrate that it is therapeutically necessary for the participants to live in a group living arrangement. There has not been an adequate showing that group living is therapeutically necessary.

To start, I think it is important for the city of St. George to understand the similarities and differences between a residential treatment center (RTC) and a sober home. These applications do not make the necessary treatment distinctions that are important to consider when reviewing them.

Residential Treatment and Sober Living are both part of an addiction treatment continuum, but each play a different role with a different purpose if helping those with addiction issues obtain long-term sobriety. In a residential level of care, patients live at the

facility and are involved in many hours of treatment programming throughout their stay. This includes individual, group, and family therapy; exercise and movement groups, homework assignments, and other types of therapeutic groups. It is common for patients to stay 30, 60, or 90 days in treatment, and sometimes even longer. They are restricted to the premises, going off site only with the supervision of staff. Patients do not have vehicles on the premises, but are transported by staff with facility vehicles. Visitation from family or friends is usually limited to a few hours a week at a specific time. There is usually a high level of staff-to-patient ratio, as there are front-line staff, therapists, doctors, administration, office staff, support staff, and others. Staff vehicles are usually parked on-site. There are numerous other restrictions on patients to make this level of treatment effective. It is the highest level of treatment for addiction and mental health issues for people who are the most severely addicted.

A client enters sober living usually after graduating from an RTC. They have progressed in their treatment of their addiction to not require as much monitoring or restriction. It is not considered a treatment program or level of care, but rather a sober environment. Clients are still in a fragile enough condition to need some supervision and support to stay sober, otherwise they would be able to live on their own and maintain sobriety. A client usually lives at a sober home a minimum of three months and up to a year or longer. The programming at a sober home is minimal, usually consisting of one to two community groups a week, which addresses concerns of the house, and is not a therapeutic group. Often, clients will attend therapy and/or 12-step meetings outside of the house; they may be enrolled in a day treatment or intensive outpatient clinical program. Clients in a sober home have much freedom, coming and going as they choose, although there is typically a curfew. They usually work or volunteer in the community, and are allowed to spend time with peers or friends unsupervised. Clients usually have their own vehicle, or take public transportation.

Initially sober homes were operated in any home available and there was no licensure required. This created a number of poorly run sober homes that were offering no support or monitoring, but were advertised as a safe place for people out of treatment to live. In 2011 the State of Utah mandated specific licensing requirements which included building security and maintenance. For example, for a sprinkler system to be required in a sober home is not only common, but legally obligated.

The latest research shows that for effective long-term recovery, the intensity of the treatment must match the severity of the disease of addiction. This means that for some people, a 30 day stay at a residential treatment center with a return to home is adequate. Others must attend 2 months of residential treatment, followed by an outpatient program. Still others must go to 3 months of residential treatment, attend an outpatient program for 2 months, and be in a sober living environment to secure their sobriety. This continuum of care can be an essential part of recovery for severely addicted individuals. There must also be a variety of treatment components for the addicted individual. This may include medications, individual and family therapy, group therapy, 12-step programs, social support, a structured

week including work or volunteering, healthy diet and exercise, and so on. There is no magic recipe, and treatment should be tailored to each individual. Unfortunately, there is not enough of this type of information concerning the specific admissions criteria, for example, in the applications to determine whether the type of group living arrangement proposed is actually necessary from a clinical or therapeutic standpoint.

The only clinical or therapy-oriented materials submitted with the application –the research complied by Shari Lyn Gillins, CSW and attached as Exhibit 10—was largely irrelevant. It pertained only to the ***size*** of psychoeducational groups, the ideal ***size*** for group therapy, and the recommended ***size*** for group counseling. They are irrelevant to establishing that a group living arrangement is necessary to begin with.

Group therapy and group living are distinct concepts. Group therapy is readily available for recovering addicts and abusers without the need to live in groups.

It is well documented that the most effective treatment for recovering addicts and substances abusers is group therapy. However, group living is not a prerequisite for effective group therapy, meaning it is not necessary for the people who have group therapy together to also live together in order for their therapy to be viable. Generally, addicts do not need group living as, say, a person without legs needs a wheelchair or an elevator.

Addicts can generally have successful recoveries while living wherever they want and attending outpatient group therapy. The common model is an Intensive Outpatient Program (IOP), which provides approximately 10 hours of group therapy per week. Group therapy is extremely effective on an outpatient basis, which is the most common form of therapy. Outpatient therapy programs are available all throughout Utah. Inpatient therapy is also readily available in existing facilities throughout Utah. In fact, there are a glut of these inpatient types of facilities (RTCs) throughout Utah, with vacancies in very good RTC programs.

Conclusion: It is my opinion that neither application contains enough information about the program, the program participants, the levels of addiction, and the admissions criteria, among other things, to establish that group living is therapeutically necessary at either location.

2. ***Based upon the information in the applications, do the program participants need an accommodation in the group size requested--i.e., is the number requested therapeutically necessary or would some other number be more suitable or ideal from a therapeutic standpoint, either larger or smaller?***

It is not therapeutically necessary for the Sober Home to have 16 residents. It is not therapeutically necessary for the RTC to have 24 residents. It is only necessary for an RTC to have 7-10 residents in order to be clinically and therapeutically viable. Since sober homes do not necessarily provide group therapy, group size is less important from a clinical and therapeutic standpoint and successful sober homes can have as few as 4 residents.

As mentioned above, there is a very important distinction between RTCs and sober homes. RTCs are more intensive whereas sober homes are for those who have "graduated" from RTCs and, therefore, need less supervision and are able to have more freedom. Group therapy is often not a necessary part of the sober home regimen like it is with RTCs. Also, what needs to be understood is that group size does not mean the number of people *living* in a home, but rather the number of people in a therapy group

Assuming that group living *and* group therapy are an essential component of both the RTC application and the sober home application, the ideal amount of participants in a traditional psychotherapy group is around 7-10 people. The American Group Psychotherapy Association recommends this number, while SAMHSA recommends 8-10. An educational or didactic group size can be larger, as there is less interaction and no processing. However, RTCs like the one described in the application have group therapy rather than educational or didactic groups. Overall, this means that, clinically speaking, a residential treatment center could have as little as 8 people and be therapeutically sound. (*See also* Jason & Ferrari, *Oxford House Recovery Homes: Characteristics and Effectiveness*, Psychol Serv. 2010 May ("The Oxford House organization recommends 8-12 individuals residing in each House (Oxford House, 2006).) "Increasing the size of group homes is associated with considerable risk of losses in many dimensions of quality. The decline begins at 4 residents and above; beyond 6, the decline is sharper." (Conroy, *Size, Quality, and Cost of Residential Settings: Policy Analysis of Literature and Large Data Sets*, p. 3, March 2011.) "There is no consensus on what constitutes the optimal number of people in a residence, but across an extraordinary variety of states and systems, qualities of life and outcomes drop measurably when there are 5 residents, and drop sharply when there are more than 6 residents." (*Id.* at p. 4) The scholarly literature for establishing positive peer culture environments (PPC) for children in welfare care suggests the ideal group size is no more than 8-12 persons. (*See* James, *What Works in Group Care? – A Structured Review of Treatment Models for Group Homes and Residential Care*, Child Youth Serv. Rev. 2011 February (citing Vorrath & Brendtro (1985); Laursen (2005); Wasmund & Tate (1996); and Brendtro & Shahbazian (2004)).

I note that even the applicant's own materials state, "**The size of the group needs to be limited, with an ideal range of 8 to 10 participants …. The group has to be small enough for members to practice the skills being taught.**" (Ex. 10 at p.1.) Even in the discussion about revolving membership groups, these materials stress the importance of maintaining a small group size: "**The temptation to have many members often is strong due to insufficiently trained staff and shortages of funding. While revolving membership groups have no absolute limit on the number of members, it is prudent to keep the group small enough (<u>about 15 or</u> fewer) for participants to feel heard and understood ... and for members to feel a sense of connection and belonging to the group. <u>If a group becomes too large (more than 20)</u>, group interaction breaks down and the clients become a class made up of individuals, rather than a single, cohesive, therapeutic body.**" (Ex. 10 at pp. 4-5.) The "Living in Balance" counseling approach mentioned in the application suggests a group counseling size of no more than 12 to 15 participants. (*See* Ex. 10 at p. 5.)

Another therapeutic factor to consider is the necessary rooms needed to clinically support 24 patients in a facility. There would need to be at least 2 group rooms to accommodate group space needed for these many patients. There would also need to be a number of offices that can be used for individual and family sessions. For 24 patients, at least 3 offices would be needed for the therapists to accommodate adequate session. If other groups are offered, such as art therapy or psycho-educational groups, there would need to be one large space available for this type of group.

Conclusion: It is my opinion that from a therapeutic and clinical standpoint the RTC at Sugar Leo road only need 7-10 residents to be therapeutically viable. It is my opinion that from a therapeutic and clinical standpoint the sober home at 400 East needs no more than 4 residents to be therapeutically viable.

3. ***From a clinical and therapeutic standpoint are there any concerns you have with the location of the facility?***

Generally speaking, a 24-bed RTC in a residential neighborhood is not a good idea from a therapeutic and clinical standpoint. This type of facility should be located in a different location. I do not have concerns about a sober home being located at 400 East. However, the proposed number of residents at the sober home is a concern.

Residential group living arrangements are generally needed for only the most severely addicted individuals. However, those type of facilities are better for the patient if they are located in a more secure or remote environment where access to drugs and substances are more difficult to obtain. For example, it is too easy, in a residential neighborhood setting, for an addict to either walk away from the facility or have someone meet him at or near the facility and supply him or her with drugs or alcohol.

There is more temptation and ready access to prescription drugs in a residential neighborhood than there is if the RTC were located in a commercial, mixed use or agricultural/remote location, since many residential households use the very type of prescription drugs the recovering addict may be addicted to and since many residential households contain alcohol.

In contrast, larger residential treatment facilities located in more secure settings—i.e., larger facilities with staff, more eyes and ears, etc., which are typically located in commercial or mixed use neighborhoods or remote agricultural locations, tend to make it less tempting for the recovering addict to seek out and find sources as there will not typically be alcohol or prescription drugs in the house next door (since there is no house next door).

It is well documented that having a positive and supportive community greatly influences a person's recovery. However, there are no significant studies done that the location

of a facility is a factor in a person recovering from addiction. Common sense would say that a treatment center next to a beerhall would not be a good practice, but having a facility in a residential neighborhood does not positively or negatively impact a person's long-term recovery.

There are successful residential treatment centers in commercial and rural settings. If a residential treatment center is to be in an urban setting, it seems reasonable to have some type of buffer, whether visual or with enough acreage to distance the facility from the neighboring homes. For many therapeutic factors, the optimal placement of an RTC would be in a rural setting, where there is a distinct separation between patients and the community.

It is also my experience that residential treatment centers and sober homes have a significant amount of vehicles and traffic to operate their business. At an RTC of 24 beds, there would likely be 2 large capacity vans, and the vehicles of all the staff would need to be accommodated. Traffic comes and goes throughout the day as staff are changing shifts, running errands, and patients are being shuttled to the gym, 12-step meetings, and other activities. With administration, Sr. and Jr. level therapists, front-line staff, a cook and housekeeping, and office staff, a 24 bed facility would likely need parking for at least 12 vehicles plus the facility vans. Sober homes have much fewer staff, but it is likely that at least half, if not a majority of the clients would have vehicles. For a 16 bed sober home, this would likely result in at least 8 vehicles, with the possibility of 16 client and staff vehicles on the premises. There may be other times, such as during family visitation, that there would be even more vehicles that would need parking.

In these applications, public transportation does not seem to be an issue. The RTC is not located near a bus stop, nor does it need to be as patients are transported by staff in facility vans. The sober home has a bus stop nearby, and its location seems amenable for clients to access public transportation if they do not have their own means.

Conclusion: From a therapeutic and clinical standpoint, the RTC at Sugar Leo Road is not an ideal location for an RTC. Due to relatively easy access to drugs and alcohol, the potential impact on neighborhoods, and the availability of inpatient RTC's in more suitable locations, among other factors, it is my considered opinion that generally group living arrangements for recovering addicts in single family residential neighborhoods are not only not necessary but, in most instances, not recommended for recovery. For that reason, I do not believe an RTC at Sugar Leo Road with 24 residents is wise from a clinical or therapeutic standpoint.

With regard to the sober home on 400 East, it is my opinion that this is generally a suitable location for a sober home. However, the number of residents is a concern due to the inability to adequately manage and supervise the comings and goings of the residents as well as the traffic impact it will undoubtedly have on the neighborhood.

4. ***Are there any other concerns or observations you have about the applications and the accommodations requested that you think would be relevant to the City's decision as***

to (a) whether an accommodation is necessary and (b) what type of accommodation, if any, to make.

Yes. There are inherent risks associated with the operation of RTCs of which the city should be aware.

It is important to understand that any addiction treatment facility—a residential treatment center, sober home, or outpatient clinic—will occasionally have illegal drugs brought on the premises. This can happen when a patient has a friend or drug dealer hide substances on the property so that the patient will find them later. Or if a person living in a sober home decides to buy drugs to use them in his or her room. This is simply part of the addiction pattern and I know of no facility that has not had that happen.

People with the most severe addictions—the type that truly benefit from living in an RTC—tend to be more desperate and will resort to almost any means available to feed their addiction. Inherent in this industry is the fact that sooner or later, residents will obtain illegal drugs, alcohol, or prescription drugs in an illegal way. Consequently, there is always a risk to the local neighborhood of which community members need to be aware. People in RTCs have been known to steal drugs or alcohol from neighboring homes and properties. With that said, I caution that this behavior cannot be attributed to all RTC program participants and the city should not act based upon stereotypes or assumptions that all RTC program participants will resort to theft or crime to feed their addiction. This is, however, a distinct possibility. There is also a risk of overdose and subsequently possible death.

With that said, I do not advocate the "Not in my backyard" philosophy. What is important in this situation is to have a plan. How has the RTC and sober home prepared the neighborhood community for this possibility? What is the relapse prevention plan for each facility, and what is the plan when drugs are brought on-site? How often is drug testing being performed at each facility? Is there a house manager at the sober home 24 hours a day? If not, the likelihood of illicit substances being brought onto the premises greatly increases. How has the RTC coordinated with city emergency personnel?

Conclusion: From a therapeutic and clinical standpoint I do not believe a 24-bed treatment facility such as the one proposed on Sugar Leo Road is appropriate for a residential neighborhood. I have no concerns with a sober home being located there or at the 400 East location so long as the number of residents is limited to a manageable and therapeutically appropriate level.

FINAL CONCLUSIONS, OBSERVATIONS AND RECOMMENDATIONS:

Neither application has demonstrated that group living arrangements are necessary from a therapeutic or clinical standpoint.

While the Sugar Leo Road location is not an ideal location for an RTC, it could work and be therapeutically successful so long as the number of residents was limited. A facility with 24 residents is neither necessary nor reasonable for that location. The number of residents needed for therapeutic success and viability is 7-10.

While the 400 East location is a good location for a sober home, the number of residents proposed is neither necessary nor reasonable. To be successful and viable from a clinical and therapeutic standpoint, the sober home needs as few as 4 residents to be successful.

LCSW, CAI, CIP

James K. Ott, LCSW, CAI, CIP

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Attorneys for Mapleton Fair Care, LLC

BEFORE THE MAPLETON CITY COUNCIL

In re: Request for Accommodation of George E. "Bud" Harper

Pursuant to Utah Code Ann. § 78B-5-705, Jason P. Wootton, LCSW declares and states as follows:

1. I am more than 18 years of age, I am competent to testify herein, and I make this declaration based upon my personal knowledge.

2. I have a bachelor's degree in Science with an emphasis in Psychology from the Utah Valley State College.

3. I have a Master's degree in Social Work since 2005 from Brigham Young University.

4. I have reviewed the March 27, 2013, letter of Rosemond Maloney, LCSW, PsyD and the literature she references and agree with much of the letter however disagree with some of her assertions.

5. I agree that recovering addicts and substances abusers need and benefit from group therapy. However, group living is not necessary for effective group therapy. It is not necessary for the people who have group therapy together to live together for successful outcomes.

6. Group therapy can be effective on an outpatient basis.

7. Outpatient therapy programs are readily available in Utah County and throughout the Wasatch Front.

8. Inpatient therapy is also available in existing facilities throughout Utah County and the Wasatch Front.

9. In most cases it is not necessary for recovery to separate group therapy sessions by gender.

10. Mixed-gender groups of 6-8 residents are therapeutically effective.

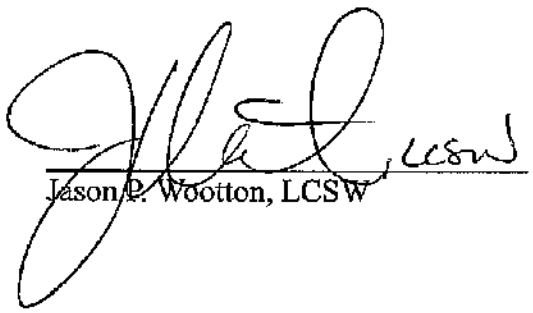
11. Therefore the claim that this or any treatment facility needs 16 residents or any number beyond 6-8 residents to be therapeutically viable is simply incorrect from a therapeutic standpoint.

12. 6-8 residents, regardless of gender, would be beneficial to achieve therapeutic viability.

13. While residential group living arrangements can help recovering addicts in some instances they are not necessary for recovery.

I declare under criminal penalty of the State of Utah that the foregoing is true and correct.

DATED this 24 day of April, 2013.



Jason P. Wootton, LCSW

LEWIS YOUNG
ROBERTSON & BURNINGHAM, INC.

AN INDEPENDENT MUNICIPAL FINANCIAL ADVISORY
AND CONSULTING FIRM

REASONABLE ACCOMMODATION REQUEST BY ALPINE RECOVERY LODGE

ALPINE CITY COUNCIL MEETING
September 12, 2012

SCOPE OF WORK: Lewis Young Robertson & Burningham, Inc. ("LYRB"), at the request of Alpine City, undertook to examine the financial data and projections supplied by Alpine Recovery Lodge, ("ARL"), pertaining to their application for a reasonable accommodation in the permitted number of residents to be allowed at their proposed facility.

The scope of LYRB's inquiry was to evaluate the revenue and expense assumptions supplied to the City by ARL and determine, to the extent possible, comparative cost and revenue data for facilities of similar size to that proposed by ARL, and to evaluate ALR's claims regarding the number of residents they would require to be profitable.

METHODOLOGY: LYRB undertook to obtain information from the following sources by the means indicated:

- Contact with other residential treatment facilities in Utah offering services similar to those to be offered by ARL. This included information on the number of patient for which they are licensed, the cost of treatment, staffing levels and other measures by which to compare them to ARL

- Review of Utah regulatory requirements relative to required staffing levels, including professional licensure where applicable, and other regulatory requirements such as minimum accommodations per patient (i.e. bedroom space, number of bathrooms, etc.) which all residential treatment facilities must meet.

- Discussions with other sources of data on the residential treatment industry such as banks and other financial professionals involved in lending to such facilities.

- Analysis of the sensitivity of cost and revenue projections to differing patient levels and different staffing levels.

GENERAL OBSERVATIONS:

- **Transparency and availability of data:** The for-profit residential treatment business is characterized by many facilities offering a wide range of amenities and accommodations. The vast majority of these firms are privately owned and do not

release financial data as would a publicly traded company. As a result, we were not able to obtain detailed financial statements from any of the facilities we contacted. While some firms were unwilling to talk with us, some were willing to discuss their authorized capacity (a matter of public record), their approximate cost of treatment and their staffing levels.

In the absence of verifiable data regarding other competing facilities, LYRB had no basis to dispute the costs ARL assumed in their pro forma. LYRB did not observe anything in ARL's projections that appeared demonstrably false or misleading.

- **Regulatory Environment:** The State of Utah Human Services Division has regulatory authority over the licensing of residential treatment programs and applies the required standards to all such facilities. By reviewing the state Code, we were able to determine with reasonable accuracy, the required staffing levels and, where applicable, the professional training and credentials required for staff. We could then compare these minimum requirements to ARL's pro-forma to evaluate its adequacy.

- **Market Factors:** LYRB was not furnished with any type of marketing study performed by, or on behalf of, ARL. Due to time constraints and lack of publicly available data, LYRB did not undertake such a study nor are we aware of any other independent study. Assumptions about the availability of future patients is outside the scope of LYRB's study and are assumed to exist for purposes of forecasting demand levels

- **Industry Standards and Norms:** LYRB was not able to conduct a wide-ranging survey of industry standards and accepted practices. Anecdotal evidence regarding industry-wide practices related to marketing and patient recruitment using commission-based third-party recruiters was reported but could not be independently confirmed. Pay levels for ARL employees appeared reasonable in light of LYRB's understanding their duties and responsibilities but could not be compared to levels at other facilities.

Conclusions from LYRB's Analysis:

Projected Costs: ARL's projected staffing levels and cost assumptions for varying patient levels appeared to be consistent both with state requirements and similarly sized facilities. Staffing not strictly required by state law but reasonably to be expected given ARL's business model (i.e. night and weekend staffing, a chef, etc.) appeared appropriate. Compensation levels for full-time and hourly workers, together with benefit levels, appeared reasonable.

LYRB did question several expense items related to the building lease. We were unable to determine how the projected monthly lease payment of $4,500 was arrived at or if it was in line with market lease rates for facilities of similar square-footage. Additionally, the $120,000 of tenant improvements listed in the pro forma was to be amortized over a period of 24 months. We found this unusual in that the improvements, as far as we were able to ascertain, would be expected to have a useful life substantially in excess of two years and thus might be expected to be amortized over a longer period thus giving ARL lower operating costs.

Projected Revenues: ARL's projected average gross revenue per patient was listed as $9,000 per month. The planned fee structure is actually $10,000 for the first 30 days, $8,000 for the second 30 days and $6,000 for the final 30 days. This fee structure is due to differing lengths of treatment required by each patient but ARL assumed a 75% occupancy rate and an average fee per month of $9,000 based on their stated expectation of average patient stays. Patient levels required for ARL to achieve profitability are based on ARL's representations. Occupancy rates at other comparable facilities could not be verified beyond their stated license capacity.

While our discussion of charges with other facilities yielded a range of between $10,000 per month to as much as $50,000 per month depending on the facility, ARL's figure of $9,000 seemed to be on somewhat low compared to facilities that, as best we could judge, were comparable in size and amenities. Roughly comparable facilities appeared to charge an average of $10,000-to-$12,000 for the first 30 days of treatment.

STEPS
Recovery Center

CLOSED CAMPUS

All Visitors Must Use Front Entrance
(East Side of Main Building)

Candalite LLC Assisted Living Home in Draper, UT. This home has room for only 10 patrons.

Assisted Living (Residential Treatment Facility)		
8 residents ->	16 residents	
6 full time staff members		

Typical Single Family Residence
1 home

Trip Comparison

Assisted Living (ITE 254)		
Occupied Beds		
2.74 trip rate	=>	43.84 trips
Employees		
3.93 trip rate	=>	23.58 trips

Single-Family Detached Housing (ITE 210)		
Dwelling Units		
9.57 trip rate	=>	9.57 trips

Land Use: 210
Single-Family Detached Housing

Description

Single-family detached housing includes all single-family detached homes on individual lots. A typical site surveyed is a suburban subdivision.

Additional Data

The number of vehicles and residents had a high correlation with average weekday vehicle trip ends. The use of these variables was limited, however, because the number of vehicles and residents was often difficult to obtain or predict. The number of dwelling units was generally used as the independent variable of choice because it was usually readily available, easy to project and had a high correlation with average weekday vehicle trip ends.

This land use included data from a wide variety of units with different sizes, price ranges, locations and ages. Consequently, there was a wide variation in trips generated within this category. As expected, dwelling units that were larger in size, more expensive, or farther away from the central business district (CBD) had a higher rate of trip generation per unit than those smaller in size, less expensive, or closer to the CBD. Other factors, such as geographic location and type of adjacent and nearby development, may also have had an effect on the site trip generation.

Single-family detached units had the highest trip generation rate per dwelling unit of all residential uses because they were the largest units in size and had more residents and more vehicles per unit than other residential land uses; they were generally located farther away from shopping centers, employment areas and other trip attractors than other residential land uses; and they generally had fewer alternate modes of transportation available because they were typically not as concentrated as other residential land uses.

The peak hour of the generator typically coincided with the peak hour of the adjacent street traffic.

The sites were surveyed between the late 1960s and the 2000s throughout the United States and Canada.

Source Numbers

1, 4, 5, 6, 7, 8, 11, 12, 13, 14, 16, 19, 20, 21, 26, 34, 35, 36, 38, 40, 71, 72, 84, 91, 98, 100, 105, 108, 110, 114, 117, 119, 157, 167, 177, 187, 192, 207, 211, 246, 275, 283, 293, 300, 319, 320, 357, 384, 435, 550, 552, 579, 598, 601, 603, 611, 614, 637

Single-Family Detached Housing
(210)

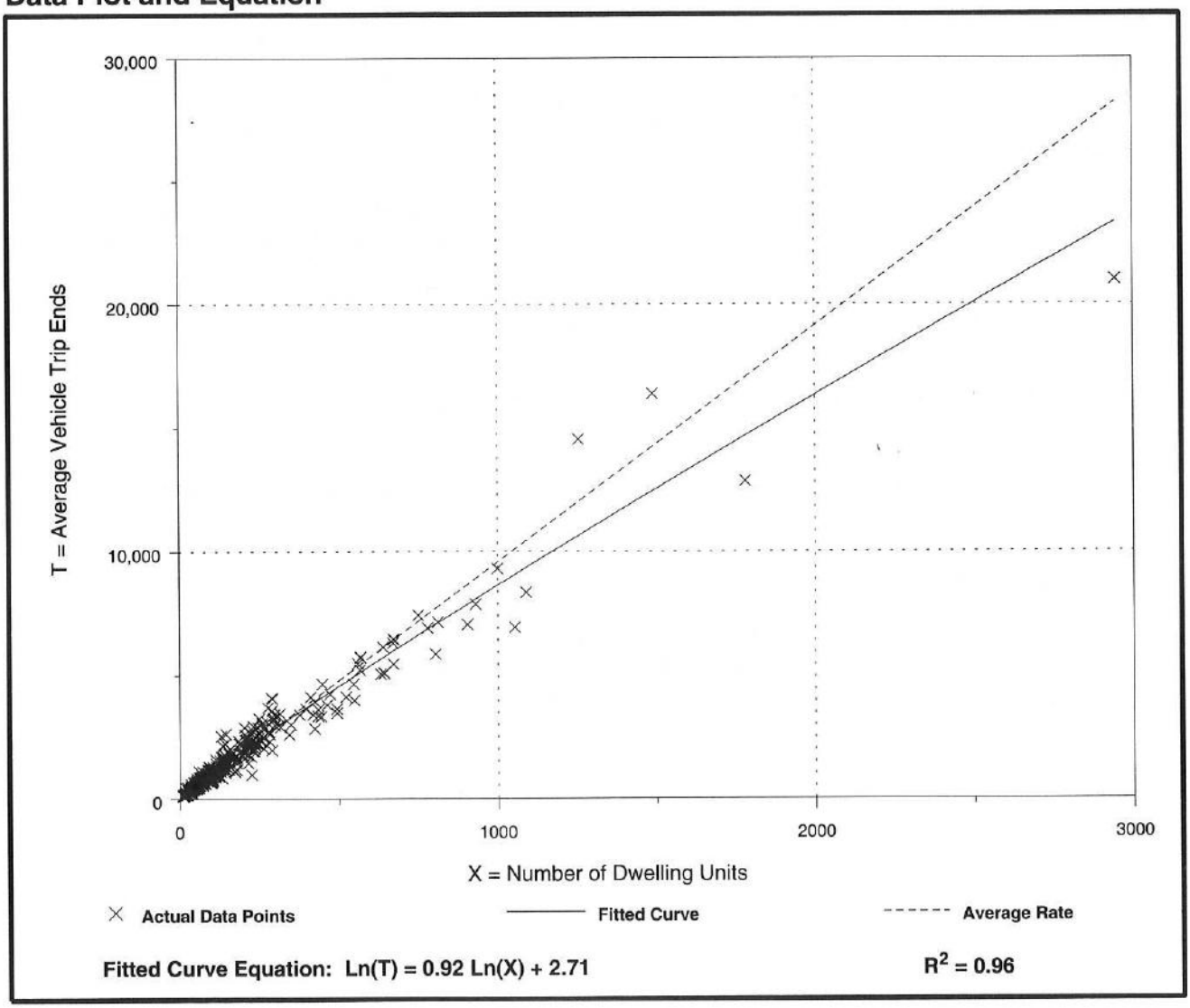
Average Vehicle Trip Ends vs: Dwelling Units
On a: Weekday

Number of Studies: 351
Avg. Number of Dwelling Units: 197
Directional Distribution: 50% entering, 50% exiting

Trip Generation per Dwelling Unit

Average Rate	Range of Rates	Standard Deviation
9.57	4.31 - 21.85	3.69

Data Plot and Equation



Fitted Curve Equation: Ln(T) = 0.92 Ln(X) + 2.71

R^2 = 0.96

Land Use: 254
Assisted Living

Description

Assisted living complexes are residential settings that provide either routine general protective oversight or assistance with activities necessary for independent living to mentally or physically limited persons. They commonly have separate living quarters for residents, and services include dining, housekeeping, social and physical activities, medication administration and transportation. Alzheimer's and ALS care are commonly offered by these facilities, though the living quarters for these patients may be located separately from the other residents. Assisted care commonly bridges the gap between independent living and nursing homes. In some areas of the country, assisted living residences may be called personal care, residential care, or domiciliary care. Staff may be available at an assisted care facility 24 hours a day, but skilled medical care—which is limited in nature—is not required. Continuing care retirement community (Land Use 255) and nursing home (Land Use 620) are related uses.

Additional Data

The rooms in these facilities may be private or shared accommodations, consisting of either a single room or a small apartment-style unit with a kitchenette and living space.

One study reported that according to national and local data, less than 5 percent of the residents owned cars, which were rarely driven. Employees, visitors and delivery trucks made most of the trips to these facilities.

Truck traffic was captured for some studies in this land use and is presented in the table below. Although truck traffic was very low overall, most trips occurred during the mid-day period on a weekday.

The peak hour of the generator typically did not coincide with the peak hour of the adjacent street traffic, primarily because of the shifts of the employees. For the data collected in this land use, shifts typically began at 7:00 a.m., 3:00 p.m. and 11:00 p.m. The a.m. peak hour of the generator typically occurred between 6:00 a.m. and 7:00 a.m., while the p.m. peak hour of the generator typically occurred between 3:00 p.m. and 4:00 p.m.

Time Period	% Trucks
Weekday Morning (6:30 a.m.–9:30 a.m.)	1
Weekday Mid-Day (11:00 a.m.–1:30 p.m.)	9
Weekday Evening (2:45 p.m.–6:45 p.m.)	2
Saturday Mid-Day (11:00 a.m.–2:00 p.m.)	4
Saturday Evening (3:00 p.m.–6:00 p.m.)	0
Sunday Mid-Day (11:00 a.m.–2:00 p.m.)	1
Sunday Evening (3:00 p.m.–6:00 p.m.)	0

The sites were surveyed in the late 1980s, the late 1990s and the 2000s in Connecticut, New Jersey, New York, Pennsylvania and Oregon.

Source Numbers

91, 244, 573, 581, 611

Assisted Living
(254)

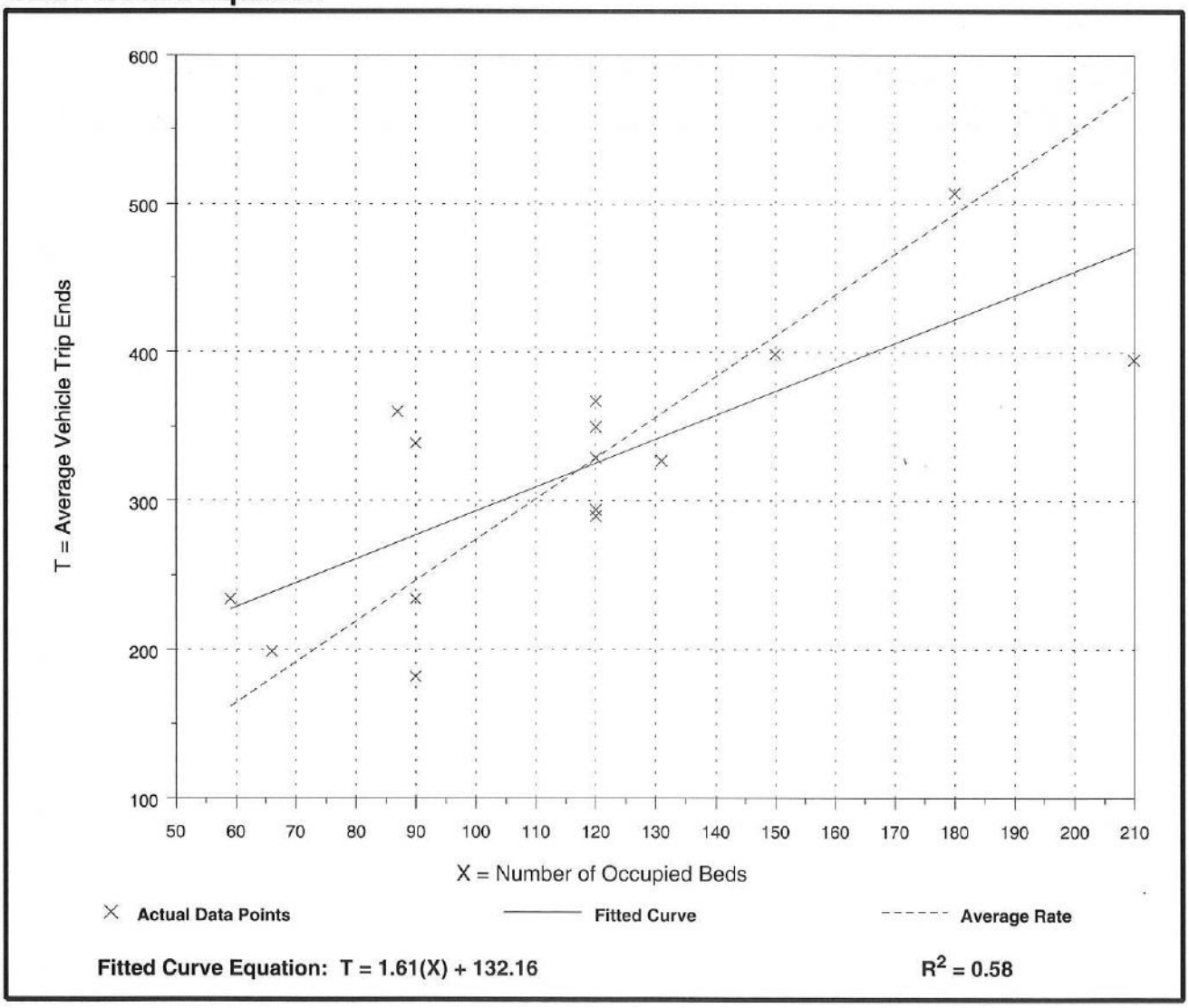
Average Vehicle Trip Ends vs: Occupied Beds
On a: Weekday

Number of Studies: 15
Average Number of Occupied Beds: 117
Directional Distribution: 50% entering, 50% exiting

Trip Generation per Occupied Bed

Average Rate	Range of Rates	Standard Deviation
2.74	1.88 - 4.14	1.75

Data Plot and Equation



Fitted Curve Equation: T = 1.61(X) + 132.16

R^2 = 0.58

Assisted Living
(254)

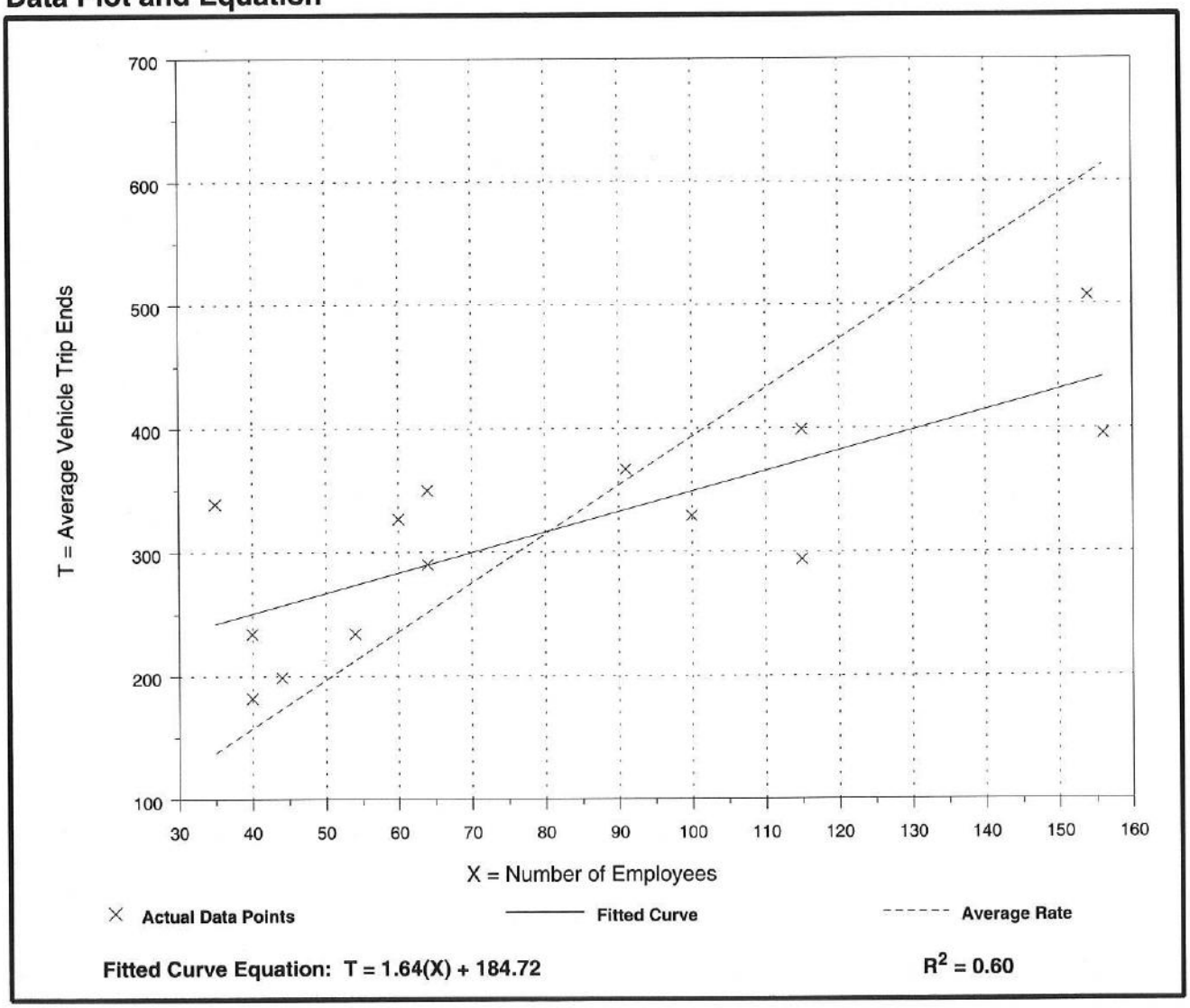
Average Vehicle Trip Ends vs: Employees
On a: Weekday

Number of Studies: 14
Avg. Number of Employees: 81
Directional Distribution: 50% entering, 50% exiting

Trip Generation per Employee

Average Rate	Range of Rates	Standard Deviation
3.93	2.53 - 9.69	2.43

Data Plot and Equation



Fitted Curve Equation: T = 1.64(X) + 184.72

R^2 = 0.60

U.S. Census Quick Facts

QuickFacts

South Ogden city, Utah

QuickFacts provides statistics for all states and counties, and for cities and towns with a population of 5,000 or more.

All Topics ▼	SOUTH OGDEN CITY, UTAH
People	
Population	
Population estimates, July 1, 2015, (V2015)	16,955
Population estimates, July 1, 2014, (V2014)	16,852
Population estimates base, April 1, 2010, (V2015)	16,559
Population estimates base, April 1, 2010, (V2014)	16,532
Population, percent change - April 1, 2010 (estimates base) to July 1, 2015, (V2015)	2.4%
Population, percent change - April 1, 2010 (estimates base) to July 1, 2014, (V2014)	1.9%
Population, Census, April 1, 2010	16,532
Age and Sex	
Persons under 5 years, percent, July 1, 2014, (V2014)	X
Persons under 5 years, percent, April 1, 2010	8.7%
Persons under 18 years, percent, July 1, 2014, (V2014)	X
Persons under 18 years, percent, April 1, 2010	26.9%
Persons 65 years and over, percent, July 1, 2014, (V2014)	X
Persons 65 years and over, percent, April 1, 2010	14.4%
Female persons, percent, July 1, 2014, (V2014)	X
Female persons, percent, April 1, 2010	51.0%
Race and Hispanic Origin	
White alone, percent July 1, 2014, (V2014) (a)	X
White alone, percent, April 1, 2010 (a)	87.5%
Black or African American alone, percent, July 1, 2014, (V2014) (a)	X
Black or African American alone, percent, April 1, 2010 (a)	1.4%
American Indian and Alaska Native alone, percent, July 1, 2014, (V2014) (a)	X
American Indian and Alaska Native alone, percent, April 1, 2010 (a)	0.6%
Asian alone, percent, July 1, 2014, (V2014) (a)	X
Asian alone, percent, April 1, 2010 (a)	1.3%
Native Hawaiian and Other Pacific Islander alone, percent, July 1, 2014, (V2014) (a)	X
Native Hawaiian and Other Pacific Islander alone, percent, April 1, 2010 (a)	0.3%
Two or More Races, percent, July 1, 2014, (V2014)	X
Two or More Races, percent, April 1, 2010	3.2%
Hispanic or Latino, percent, July 1, 2014, (V2014) (b)	X
Hispanic or Latino, percent, April 1, 2010 (b)	12.8%
White alone, not Hispanic or Latino, percent, July 1, 2014, (V2014)	X
White alone, not Hispanic or Latino, percent, April 1, 2010	81.4%
Population Characteristics	
Veterans, 2010-2014	1,399
Foreign born persons, percent, 2010-2014	5.3%
Housing	
Housing units, July 1, 2015, (V2015)	X
Housing units, April 1, 2010	6,631
Owner-occupied housing unit rate, 2010-2014	65.9%
Median value of owner-occupied housing units, 2010-2014	$168,900
Median selected monthly owner costs -with a mortgage, 2010-2014	$1,315
Median selected monthly owner costs -without a mortgage, 2010-2014	$392
Median gross rent, 2010-2014	$826
Building permits, 2015	X
Families and Living Arrangements	
Households, 2010-2014	6,224
Persons per household, 2010-2014	2.66
Living in same house 1 year ago, percent of persons age 1 year+, 2010-2014	86.9%
Language other than English spoken at home, percent of persons age 5 years+, 2010-2014	9.6%
Education	
High school graduate or higher, percent of persons age 25 years+, 2010-2014	93.9%
Bachelor's degree or higher, percent of persons age 25 years+, 2010-2014	31.9%
Health	
With a disability, under age 65 years, percent, 2010-2014	5.8%

Persons without health insurance, under age 65 years, percent	⚠ 13.5%
Economy	
In civilian labor force, total, percent of population age 16 years+, 2010-2014	66.8%
In civilian labor force, female, percent of population age 16 years+, 2010-2014	59.7%
Total accommodation and food services sales, 2012 ($1,000) (c)	26,648
Total health care and social assistance receipts/revenue, 2012 ($1,000) (c)	74,268
Total manufacturers shipments, 2012 ($1,000) (c)	D
Total merchant wholesaler sales, 2012 ($1,000) (c)	14,115
Total retail sales, 2012 ($1,000) (c)	312,978
Total retail sales per capita, 2012 (c)	$18,699
Transportation	
Mean travel time to work (minutes), workers age 16 years+, 2010-2014	19.8
Income and Poverty	
Median household income (in 2014 dollars), 2010-2014	$54,685
Per capita income in past 12 months (in 2014 dollars), 2010-2014	$26,395
Persons in poverty, percent	⚠ 10.9%
Businesses	
Total employer establishments, 2014	X
Total employment, 2014	X
Total annual payroll, 2014	X
Total employment, percent change, 2013-2014	X
Total nonemployer establishments, 2013	X
All firms, 2012	1,287
Men-owned firms, 2012	796
Women-owned firms, 2012	298
Minority-owned firms, 2012	75
Nonminority-owned firms, 2012	1,107
Veteran-owned firms, 2012	145
Nonveteran-owned firms, 2012	1,039
Geography	
Population per square mile, 2010	4,477.8
Land area in square miles, 2010	3.69
FIPS Code	4970960

⚠ This geographic level of poverty and health estimates are not comparable to other geographic levels of these estimates

Some estimates presented here come from sample data, and thus have sampling errors that may render some apparent differences between geographies statistically indistinguishable. Click the Quick Info icon to the left of each row in TABLE view to learn about sampling error.

The vintage year (e.g., V2015) refers to the final year of the series (2010 thru 2015).
Different vintage years of estimates are not comparable.

(a) Includes persons reporting only one race
(b) Hispanics may be of any race, so also are included in applicable race categories
(c) Economic Census - Puerto Rico data are not comparable to U.S. Economic Census data

D Suppressed to avoid disclosure of confidential information
F Fewer than 25 firms
FN Footnote on this item in place of data
NA Not available
S Suppressed; does not meet publication standards
X Not applicable
Z Value greater than zero but less than half unit of measure shown

QuickFacts data are derived from: Population Estimates, American Community Survey, Census of Population and Housing, Current Population Survey, Small Area Health Insurance Estimates, Small Area Income and Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits.

MINUTES OF THE SOUTH OGDEN CITY PLANNING COMMISSION BRIEFING MEETING

Thursday, August 11, 2016
Council Chambers, City Hall - 5:30 P.M.

PLANNING COMMISSION MEMBERS PRESENT

Chair Raymond Rounds, Commissioners John Bradley, Todd Heslop, Jerry Jones, Susan Stewart, Steve Pruess, and Mike Layton

STAFF PRESENT

City Planner Mark Vlasic, and City Recorder Leesa Kapetanov

The briefing meeting began at 5:35 pm. Chairman Rounds opened discussion on the first item on the agenda concerning notification requirements. City Recorder Leesa Kapetanov reviewed the Commissioner's previous discussion on the matter and referred them to the code changes included in their packet that reflected what they wanted. Commissioner Jones asked some questions concerning the requirements for conditional uses as set forth in 10-15-4(B); he was concerned that building materials should complement the surrounding areas. City Planner Vlasic said that until the form based code was adopted, there had been no restrictions or requirements for materials, and the City really could not have a say in what they were. Now that it was proposed to have a form based code for all commercial zones, the City would have more of a say. Commissioner Jones suggested the City also look at a tax for the arts, as many cities around the country had done. It would allow the City to set aside money for art for public areas. Commissioner Layton asked if they should include notices to people outside the City and asked if they should consider their comments if they weren't residents. The commissioners discussed the matter, concluding that they wanted to include notices to people outside the City.

The chair then moved to discussion on the General Plan update. Planner Vlasic reviewed the previous general plan and updates and referred the commissioners to the maps in their packet, explaining what each represented. He explained the goal was to be able to present one map and one land use chapter for the public to look at, whether it was a developer or resident; currently they had to look at three different maps. Mr. Vlasic said they had tried to keep the final map as simple as possible and reviewed the different areas on it. He was looking for direction from the planning commission. They could take as much time as the wished to review it and make possible changes after which it would go through a public hearing and a recommendation made to the city council. Mr. Vlasic was of the opinion that the 1997 General Plan was still in effect and the updates were adopted as addendums to it but didn't replace it. This proposed update would replace the land use chapter in the 1997 Plan and replace all three maps with one map.

Planner Vlasic also pointed out the commissioners needed to discuss whether this update would suffice or if the whole general plan should be redone; with the City at 97% build out, the

question of whether the expense was worth it needed to be asked. Commissioner Stewart said it was true the City was almost built out, but there still needed to be a plan for redevelopment. City Recorder Kapetanov informed the planning commission that staff was trying to get a combined meeting involving the planning commission and city council set up for October. They could then discuss whether there was a need for a complete re-do of the general plan or not.

There was no more discussion. Chairman Rounds closed the meeting.

I hereby certify that the foregoing is a true, accurate and complete record of the South Ogden City Planning Commission Briefing Meeting held Thursday, August 11, 2016.

Leesa Kapetanov, City Recorder

Date Approved by the Planning Commission

MINUTES OF THE SOUTH OGDEN CITY PLANNING COMMISSION MEETING

Thursday, August 11, 2016
Council Chambers, City Hall –6:15 p.m.

PLANNING COMMISSION MEMBERS PRESENT

Chair Raymond Rounds, Commissioners John Bradley, Jerry Jones, Todd Heslop, Susan Stewart, Steve Pruess, and Mike Layton

STAFF PRESENT

City Planner Mark Vlasic, and City Recorder Leesa Kapetanov

OTHERS PRESENT

Wesley Stewart, Walt Bausman, Mike Adams, Jeff Von Colln

I. CALL TO ORDER AND OVERVIEW OF MEETING PROCEDURES

Chair Raymond Rounds began the meeting at 6:16 pm and called for a motion to open.

Commissioner Bradley moved to open the meeting, followed by a second from Commissioner Pruess. Commissioners Stewart, Layton, Bradley, Jones, Pruess and Heslop all voted aye.

Chair Rounds thanked the members of the planning commission for their vote of confidence in his ability to chair the commission. He stated that once he felt an item had been discussed enough, he would entertain a motion for action so that issues would move forward.
The chair then moved to the first item on the agenda, giving a brief background on the reason for the hearing and then called for a motion to enter a public hearing.

Commissioner Pruess moved to open the public hearing, followed by a second from Commissioner Bradley. The vote was unanimous to open the public hearing.

II. ZONING PUBLIC HEARINGS

A. To Receive and Consider Comments on Proposed Changes to Land Use Notification Requirements

City Recorder Leesa Kapetanov reviewed the current requirements for land use public hearings both for the state and for South Ogden. South Ogden did not currently have any proximity requirements. The proposed ordinance would require that the City notify property owners within 500 feet of a rezone request or conditional use if a public hearing was held. It would also require that notices be sent to properties within that proximity even if they were not within city limits.

Chair Rounds then invited anyone who wished to comment on the issue to come forward.

Wes Stewart, 3625 Jefferson – agreed with the 500 foot notification requirement and the right of people to voice their opinions. He said governments should be more Jeffersonian than Hamiltonian. Citizens should be more involved in their government and have their comments heard. He then cited UCA 10-9a-205(C)(ii)(b).

Walt Bausman, 5792 S 1075 E – suggested that for clarity purposes UCA 10-9a-205 be put in the city code, including the part about adjacent property owners and the time of mailing. He thought it should be the same for public hearings as well as public meetings.

There were no further comments. The chair called for a motion to close the public hearing.

Commissioner Jones moved to close the public hearing. The motion was seconded by Commissioner Layton. All present voted aye.

III. ZONING ACTIONS - Legislative

A. Discussion and Recommendation on Proposed Changes to Land Use Notification Requirements

Commissioner Stewart asked if the notification changes affected subdivisions. She was informed it did not. Commissioner Bradley said he felt the cities proximity requirements would take in adjacent property owners as well as those across the street as mentioned in the public comments. Commissioner Heslop said he felt the proposed requirements were good. He liked that it would get more people involved. There was no more discussion. Chair Rounds called for a motion.

Commissioner Bradley moved to recommend to the City Council the proposed changes to the land use notification requirements as they appeared in the packet. Commissioner Layton seconded the motion. The chair called the vote:

Commissioner Heslop-	**Aye**
Commissioner Stewart-	**Aye**
Commissioner Bradley-	**Aye**
Commissioner Jones-	**Aye**
Commissioner Layton-	**Aye**
Commissioner Pruess-	**Aye**

The motion stood.

IV. SPECIAL ITEMS

A. Presentation of Proposed General Plan Map and Land Use Chapter

Chair Rounds gave an overview of previous discussion on the General Plan, noting the City's current General Plan was done in 1997 and had two updates since then. The City needed to decide whether to do a completely new general plan, or consolidate what it already had.

Planner Mark Vlasic said the 1997 General Plan was the main plan, with the 2001 update focusing on quality of life additions and the 2008 update focusing on the area around city hall. He also pointed out that 20 years was a long time to go without a general plan update; however since the City was 98% built out, it called in to question whether the money to completely re-do the general plan would be well spent. On the other hand, the City also needed to consider redevelopment and if the old general plan reflected the direction the City wanted redevelopment to go. Staff was currently proposing replacing the land use chapter of the 1997 General Plan with the one provided in the packet and then consolidating all the maps into one and eliminating any discrepancies. They had kept the map very simple and not shown the location of any churches or schools. The land use chapter had been kept very simple as well; it pointed out that there was less than 5% of the land that had been developed and the only opportunities for change would be through redevelopment.

Commissioner Pruess pointed out some discrepancies on the map concerning the cemetery, and the park next to city hall. Commissioner Stewart also pointed out the area around Evelyn Road which had been eliminated from the form based code had still been included in the general plan map. Planner Vlasic said in his professional opinion it didn't matter, but it brought up a good question. Some communities wanted their general plan to match their zoning map, and some did not want them to match at all. Some wanted the general plan map to be more "bubbly", i.e. have the edges more rounded and less determined; this gave them more flexibility when applications were considered and not have to be bound to specific borders. Sometimes they even included language in the land use chapter specifying that the areas on the map were not meant to be specific boundaries but represent general concepts. It was up to the City to determine how specific or general they wanted the map to be.

Commissioner Bradley said he felt the general plan should be a guideline as opposed to a hard and fast rule. Planner Vlasic agreed. He said the general plan was meant to have some area for interpretation and modification; if it was less specific, it may not need to be updated as often.

Chair Rounds outlined several ways to proceed with the general plan. The consensus of the planning commission was to try to get a joint meeting with the city council as well as the consultants hired to do a form based code for the rest of the City. They hoped the meeting would take place in October. Commissioner Pruess suggested they could take a field trip to parts of the City as they applied to the proposed form based code.

Chair Rounds said it did not seem they were ready to hold a public hearing on the general plan as of yet. The Commission would wait for a meeting with the Council as well as take time to review the existing general plans and offer comments. It was determined that they would have any comments to Mr. Vlasic within two weeks. They also determined Mr.

Vlasic should make the areas on the map more general, i.e. "bubble" them. There was no more discussion on the general plan.

V. OTHER BUSINESS

Chair Rounds said he had some other business to bring up with the Commission. He reminded the Commissioners of their vote to forward the request that a raise for the planning commissioners be considered. It had gone before the City Council who had tabled it. Mr. Rounds requested that Ms. Kapetanov include information on how much City Council members made and the minutes of the meeting where the planning commission raise was discussed.

City Planner Vlasic said that the issue of planning commission compensation had been a common topic among other cities. He would also try to get some information to include in the packet.

VI. APPROVAL OF MINUTES OF PREVIOUS MEETINGS

A. Approval of May 12, 2016 Briefing Meeting Minutes

The chair asked if there were any comments on either the briefing or meeting minutes. Commissioner Layton pointed out that the sentence on line 213 of the meeting minutes could be misconstrued to mean Chair Heslop purposefully did not excuse Commissioner Pruess. He suggested the wording be changed.

Chair Rounds then called for a motion concerning the June 9 briefing Meeting minutes.

Commissioner Layton moved to approve the briefing and meeting minutes of June 9, 2016. The motion was seconded by Commissioner Heslop. The voice vote was unanimous in favor of the motion.

B. Approval of June 9, 2016 Meeting Minutes

The chair then called for a motion concerning the June 9 meeting minutes.

Commissioner Bradley moved to approve the June 9, 2016 meeting minutes with the corrections as stated by Commissioner Layton. Commissioner Heslop seconded the motion. All present voted aye.

VII. PUBLIC COMMENTS

The Chair invited anyone who wished to come forward to comment.

Wes Stewart, 3625 Jefferson – expressed his concerns with the City grouping the poor and minorities together into a large redevelopment area. It created a risk of having a lawsuit against the City because of violating the Fair Housing Act. He asked if the City had considered the poor and less fortunate. There were people who were refugees, or who had mental or physical disabilities. They had the right to live in a quiet residential neighborhood without having to worry about commercial development happening. It should be their decision to sell their property to a developer and not the government's decision. He would like to see a map showing where different

minorities and people with disabilities lived to see if it correlated with the zoning maps. Mr. Stewart said developers would just buy up land and rent it out until they got enough of it, which would not be good for the residents in the area. Did the City exist for the benefit of the residents, or did the residents exist to provide tax benefits to the City? The City should spend money on roads not on map coloring and rezoning.

City Planner Vlasic commented that the City was required to provide a moderate income housing report to the state every two years and the next one was due in a few weeks. He said the report showed that the City met all state requirements for providing a certain level of moderate income housing. If the report showed otherwise, the City would have to take action to create more moderate income housing.

Walt Bausman, 5792 S 1075 E – felt a general plan update was needed, but felt a citizen's committee should be involved. He also said the meeting wasn't noticed on the website.

Wes Stewart, 3625 Jefferson – said he had seen the notice on the website. He had also read that Hollywood counted garages as residences so they would meet moderate income housing requirements.

Mike Adams, 3751 Ogden Avenue – said it appeared decisions were made behind closed doors and nothing was public. He had not learned about the form based code until it was pretty much a done deal. He agreed with the 500 foot notification and commended the City for holding this meeting in public.

Wes Stewart, 3625 Jefferson – was made aware of someone who moved into the rezoned area after the notifications were sent. He wondered if there was a way for the City to keep track of who moved in and out and make sure they received notifications.

There were no more public comments.

VIII. ADJOURN

Chair Rounds called for a motion to adjourn.

Commissioner Bradley moved to adjourn, followed by a second from Commissioner Pruess. All present voted aye.

The meeting ended at 7:27 pm.

I hereby certify that the foregoing is a true, accurate and complete record of the South Ogden City Planning Commission Meeting held Thursday, August 11, 2016.

Leesa Kapetanov, City Recorder

Date Approved by the Planning Commission