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SERVICE INTEGRATION FOR DEINSTITUTIONALIZATION

A REPORT OF A THREE-YEAR RESEARCH AND DEMONSTRATION PROJECT. VOLUME 2. IMPLEMENTATION PROCEDURES

VIRGINIA SERVICE INTEGRATION FOR
DEINSTITUTIONALIZATION PROJECT

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A 3 YEAR (1972-75), RESEARCH DEMONSTRATION PROGRAM IN VIRGINIA TO DEVELOP A MODEL FOR IMPLEMENTING A SERVICE INTEGRATION FOR DEINSTITUTIONALIZATION (SID) PROJECT RESULTED IN FIVE INTERDEPENDENT COMPONENTS. THESE WERE: 1) ASSESSMENT AND PRESCRIPTION, 2) BROKER-ADVOCATE, 3) QUALITY CONTROL, 4) AUTOMATED INFORMATION SYSTEM AND 5) COMMITTEE OF COMMISSIONERS. THIS REPORT INCLUDED DESCRIPTIONS OF EACH COMPONENT AS WELL AS THE STEPS TAKEN LEADING UP TO THE IMPLEMENTATION OF THE PROJECT. REPORTS OF OTHER PROJECT COMPONENTS HAVE BEEN SEPARATELY ISSUED.

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Nothing is orderly till man takes hold of it.
Everything in creation lies around loose.

H. W. Beecher

THE SID REPORT

VOLUME 2

IMPLEMENTATION PROCEDURES

Final report of Service Integration for Deinstitutionalization, a project funded in part by Rehabilitation Services Administration, Office of Human Development, United States Department of Health, Education, and Welfare.

Grant No. [illegible]

SERVICE INTEGRATION FOR DEINSTITUTIONALIZATION

A Report of a Three-Year Research and Demonstration Project

This is Volume 2 of Eight Volumes:

Volume 1: Summary

Volume 2: Implementation Procedures

Volume 3: Automated Information System

Volume 4: Findings

Volume 5: Cost/Benefit Analysis

Volume 6: Legal Issues

Volume 7: Plan for Extension

Volume 8: Addendum

May 1, 1975

The SID Report

Volume 2: Implementation Procedures for Use of the Model

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I. INTRODUCTION

The objective of the SID research and demonstration has been as follows: to develop a systematic, service-integrating procedure for the orderly deinstitutionalization of residents of state institutions.

This objective has been met. The procedural model has been constructed and is operative in two geographic areas in the Commonwealth of Virginia and with respect to three different kinds of institutionalized clients: the mentally ill, the mentally retarded, and the juvenile offender.

It is assumed that the procedural model can be "transplanted." This assumption has an empirical basis. In the SID research and demonstration project, the model was constructed and developed in one community and in one set of institutions; with only minor procedural changes, the model was then introduced to a second community (and other institutions) and has continued to operate accordingly.

To transplant the model successfully means, of course, that the operational procedures must be available to the prospective user. Volume 2 attempts to communicate these procedures in sufficient detail to those parties interested in implementing the SID model, whether these parties are other communities/institutions in the Commonwealth of Virginia or other states.

To operate the SID model as it has come to be designed and demonstrated, Volume 2 is insufficient by itself. Volume 3 provides detailed documentation to enable utilization of the accompanying automated information system, an essential component in the service-integrating model. The automated system is treated in a separate volume because of its complexity, not because it is regarded as optional to model usage.

An adjunct to the SID model is the cost/benefit methodology for making monetary comparisons between institutional and community living. The cost/benefit model was developed on contract by Booz, Allen, and Hamilton, Inc. Methodology for the cost/benefit analysis is available as a separate document and was submitted to the granting agency as Appendix Z of the January 1974 SID Progress Report. Volume 5 of the present report presents an empirical application of the cost/benefit model. Though the cost/benefit methodology in its original design was tailored to fit SID operational procedures, it may be regarded as optional to SID model operation. Whether it is used as an ongoing accompaniment would be determined by the user's priorities and resources.

The written word has limitations. Use of this Volume (and of Volumes 3 and 5) should ideally be complemented by consultation with previous users/developers: SID staff, A&P Team members, institution directors, members of the Committee of Commissioners, local service providers, and consumers.

Mindful of the limitations, then, Volume 2 purports to be a "cookbook" for those parties interested in SID model application.

II. PURPOSE OF SID MODEL UTILIZATION

Why might a service provider decide to implement a systematic, service-integrating procedure for the orderly deinstitutionalization of residents of state institutions? There are at least three possible reasons:

1) There is a strong movement in the courts and state legislatures, motivated by consumer action, to either upgrade institutional living conditions and programs or to provide alternatives to institutionalization. A program offering a way to reduce or phase-out institutionalized populations in an orderly manner has appeal to those responsible for such populations.

2) Consumer groups and legislators are becoming vocally interested in having service providers work together to improve services to clients. Duplication of effort, the morass of red-tape surrounding provision of the simplest service, and referral from agency to agency without follow-up to ensure that the referral was effected or effective have all worked to provoke the outrage of consumers who correctly view utilization of human services as their right. The outcry by consumers coupled with the legislator's belief that integration of services would decrease overall costs has brought increasing pressures to bear on the administrators of human service delivery agencies.

3) An orderly attempt to deinstitutionalize residents of state institutions implies that one knows what services such clients require and what is available in the community. The systematic gathering and analysis of such information provide powerful tools to consumers and service deliverers alike when requesting funds for resource development from federal, state, and local sources.

Assuming that for one reason or another a provider sees value in a service-integrating procedure for deinstitutionalization, why use the SID model? Basically because

utilization of an existing set of procedures eliminates developmental costs and because the user will know what to expect from the model.

All providers of human services know how difficult it is to obtain funds for development of new programs--especially in a nebulous area like "service integration" where results are often measurable only in the long-term. To go through the requesting of such funds rather than utilizing a pre-tested model seems unwise.

With the SID model, the user will know what to expect and what not to expect. Data have been collected over a two to three-year period. The model does not pretend to be all things to all people but it does work as a method for deinstitutionalization through service-integration.

III. DESCRIPTION OF THE MODEL

The SID model is described in the published paper, "A Service-Integrating Model for Deinstitutionalization." A copy of the paper is provided at Appendix A.

In the paper, the social and political dynamics which led to the conceptualization of SID are reviewed. The five service-integrating components, which are the structure

of the model, are defined. These components are: (a) Assessment and Prescription (A&P) Team, (b) Broker Advocate, (c) Quality Control Team, (d) Automated Information System, and (e) Committee of Commissioners. An overview of the client processing procedure is presented. And, related program activities are discussed.

The SID model engages twelve state agencies at both state and local levels. These agencies are: Department of Mental Health and Mental Retardation; Commission for the Visually Handicapped; Commission for Children and Youth; Department of Welfare; Department of Vocational Rehabilitation; Department of Health; Office on Aging; Council for the Deaf; Division of Planning and Community Affairs; Department of Corrections; Employment Commission; and, Department of Education.

In addition to the participants from multiple agencies, the model requires a supportive staff. The staff performs three main functions: coordination, development, and maintenance. The model performs a coordination/advocacy service for each individual client it embraces, builds a planning data base for agencies concerned with human service resource development, and creates cohesiveness among service providers as they engage in a mutual enterprise.

IV. COORDINATION REQUIREMENTS

This section presents guidance to those individuals who elect to instigate application of the SID model. The coordination recommendations proffered are distilled from experiences encountered in a relatively brief timespan (two to three years). For those readers who are interested less in advice and more in what actually transpired in the course of our particular coordination efforts, Appendix B is attached. It presents a description of the approach we took and some of the things we encountered in attempting to get many people, from various disciplines and at many levels, to work together toward a common goal.

The usefulness of our coordination recommendations may be limited by the uniqueness of our situation. In the first place, the SID project was a federally-funded research and demonstration project. Hopefully the future SID model user will be accorded more authenticity and legitimacy than ordinarily accompanies "soft money" status.

We were charged with having to develop and to implement in tandem. Future users of the SID model will be spared the burden of technical development. It may be unwise to assume that this will make coordination, itself, any easier.

Virgiria is different from all the other forty-nine states, as is each state from every other. The same can be said for localities and specific state institutions.

With these qualifiers, we offer the following suggestions, intending that they will be of some use to those persons who have responsibility for "synergizing" the program.

A. DECISION TO IMPLEMENT

Let it be assumed that some day, perhaps even a decade hence, a service provider or a planner in state government pulls the SID Final Report off the shelf and says to himself: "I think this method offers a direction in which to move in reaching solutions to some of our institutionalization and service delivery problems."

Let us further presume that after careful thought and study, and after discussions with several of his colleagues and associates, he decides to take action. What should he do? To whom should he go?

After he has established a base of informal support within his own agency and, ideally, across agencies, he must go directly to the Governor to solicit the Governor's concurrence in moving ahead with an implementation plan. If the Governor is disinclined toward the idea of implementation, the instigator should desist in his efforts immediately and look elsewhere for programmatic solutions to existent problems.

Involving the Governor right at the outset cannot be overemphasized. This should be done even before any consideration is given to the obvious question of resource allocation or re-allocation to pay for the program. The budget briefing should follow later. An inter-agency program as broadly based as SID will not survive without the symbolic support of the Governor himself.

The instigator will be tempted to omit this crucial and most important first step in coordination. Especially if his Department Head or his Secretary (or super-agency head) or Board is strongly committed to implementation and sees no need to bother the Governor. Let the instigator be duly warned that once he encounters his first coordination crisis at the state level his arduous effort in service integration will be in serious jeopardy unless the Governor's support of the program be clearly understood by all of the participants.

The same advice applies when there is a change in administration. The new Governor must be seen and briefed, and the support of his office renewed and restated. Short of this, state agency heads will begin to withdraw their participation, and the program will wither and die.

B. DESIGNATION OF PROGRAM DIRECTOR/COORDINATOR

The instigator should be designated the program director. Ideally, he will be young, vigorous, ambitious, charismatic, inspirational--a person of vision and courage. Falling short in some of these qualities, he will at least be unscathed by the lethargy, fear, and paralysis which all too frequently pervade the climate of bureaucratic havens. He will value constructive social change over personal job security.

He will be a generalist and will not be hide-bound by the provincialism of his own profession. He will empathize with the application of management principles to human service delivery problems. He will use the socio-technical procedures in the program to buttress his role as an agent for social change and reform. He will be durable and thick-skinned, but also patient and sensitive to others in executing the delicate requirements in coordination. He will be an advocate for the clients embraced by the program.

C. COORDINATION AT STATE LEVEL

Assuming now that the decision is made to initiate the SID program, that support has been gained from the Governor's office for its implementation, and that a program director

possessing the necessary qualifications has been designated, the next step in the coordination process is to "recruit" those state agencies that are to participate and collaborate in the program.

The state agencies targeted for collaboration ordinarily will be those agencies traditionally associated with human affairs or human resources. There is need, however, to establish a broader base of participation. Education and Employment, both of which ordinarily are organizationally unrelated to the human resources agencies, must be brought into the program since a large proportion of the clients embraced will be affected by the resources of these agencies. Because of the implications SID-generated information has for planning, the state planning agency should also be a participant. If the state has a separate housing agency, it too should participate because of the salience of housing as a resource requirement in returning clients to the community.

After the potential participating agencies are identified, the heads of these agencies should come together in a series of meetings. These initial meetings are chaired temporarily by the human resources super-agency head, if there is one, or by one of the agency heads if there is no

umbrella agency. The program director does not pinch-hit as a temporary chairman.

The first order of business is to decide upon the funding mechanism(s) to support the program for its initial year or two. A budget is drawn up and agreed upon. The Governor is briefed on the budget plan. Once funding has been agreed upon and secured, an explicit, written compact is designed and signed by all of the agency heads. The compact sets forth the obligations of each agency: professional man-hours required to operate A&P Teams, attendance at commissioners' meetings, logistical and administrative support arrangements, contributions to the joint budget, etc.

Out of this initial series of meetings, dedicated as they are to initializing the program, will emerge the structure and functions of the Committee of Commissioners--the governing body of the program. Officers will be elected and, if the agency membership is large, an executive committee will be appointed. The program director should be designated as an ex-officio member of the Committee of Commissioners.

The Committee of Commissioners will meet regularly. It will shape and mold policies to enable maximum usage

of the socio-technical procedures embodied in the program. It will review the program evaluation information generated by the automated information system and will make policy and funding decisions accordingly.

Eventually the structure and functions of the Committee of Commissioners are formalized into an established set of by-laws.

D. COORDINATION AT LOCAL LEVEL

The program cannot begin on a state-wide basis all at once. Therefore, the issue of community selection is the first to be faced in operationalizing the program at the local level.

The size of the budget will determine how many areas can participate in the program for the first year or two. It is no doubt wise to begin with a small number of communities anyway (2 or 3) so that a basis for sound judgment can be established regarding the question of later expansion throughout the entire state.

Communities are given the opportunity to volunteer for participation in the program by responding to a public announcement that the program will become operative at such

and such a date. Those communities responding are contacted by the program coordinator to explain how the procedure operates, what it entails, and its probable effects.

Communities showing keen interest and communities which the Committee of Commissioners perceive as high priority areas are visited by members of the Committee itself. After all the information is in, and digested, the Committee of Commissioners selects the target communities (and state institutions) in which the program is to begin. Confirmation from the communities is then obtained.

Entry into an area once it is selected can be furthered by making use of news releases to the local news media advising the public of the proposed program. A follow-up story may be used to inform the participating communities that a search is underway to recruit qualified persons for local staff positions.

Once key staff positions are filled* and the incumbents orient themselves with their immediate surroundings of people and agencies, the news media should again be used to intro-

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* In implementing the SID model, now that it has been developed, there is no need to have both a community services coordinator and a chief broker advocate. The functions of the community services coordinator are assumed by the director of the lead agency at the local level. See pp. 36-38 of Appendix C to Volume 7, "Plan to Continue SID."

duce staff to the community and announce that the staff is planning to hold meetings with members of the community in the very near future.

The first community meeting should be held with the individuals who were involved in the original local decision to participate. Again, some of the original visiting state group should accompany the newly appointed staff members. Additional visits are scheduled by staff with individual community agencies and institutions involved in the program.

A formal and in-depth orientation to the program should be presented to groups of key local participants from both the community agencies and the institutions by the chief broker advocate supported by SID central office staff. During these information type meetings attention is focused on the role of the broker advocate, the role of the Assessment and Prescription Team, the role of the Committee of Commissioners, and the contribution of the Automated Information System. Highlights of the client processing procedures are also presented.

The formation of an Assessment and Prescription (A&P) Team is the next phase of the local coordination requirement. It is this element of the process that is extremely vital and the one upon which the success or failure of the program at the local level rests.

Depending on the job done in the first three phases of local coordination, i.e., selection, entry, and orientation, the formatio. of an A&P Team will be easy or difficult. It is during the orientation session with the local agencies/ institutions that the subject of A&P Team membership should be discussed. Such discussion includes which agencies are to be represented on the team as set forth in the program guidelines and according to suggestions solicited from the agencies themselves. If the area to be served is large, as was the case with Planning District #6, and there are several offices of one agency (e.g., Welfare), methods must be derived to insure adequate within-agency representation and communication.

The A&P Team chairman will ordinarily be the director of the local "lead" agency, which will be the local counterpart of any one of the participating state agencies. (See pp. 36-38 of Appendix C to Volume 7, "Plan to Continue SID".) The chief broker advocate will work closely with this person in organizing an effective A&P Team. A meeting of prospective A&P Team members will be called, membership decided upon, officers formally elected, and the entire Team briefed by SID staff on the established client processing procedures. Copies of the A&P Team Manual are

distributed to Team members. A date is set for the first client processing meeting and the program is finally underway.

E. MAINTENANCE AND MOVEMENT

The program requires ongoing coordination maintenance. SID central office staff make frequent visits to local A&P Team meetings to give consultation and guidance in the established procedures, to keep the communities in touch with policies and developments at the state level, and to remain informed with respect to issues and problems occurring at the community level. SID field staff ensure that A&P Team operations run smoothly with respect to scheduling, attendance, information distribution, and the like. The program director engages the Committee of Commissioners with program happenings requiring the attention of the governing body. Since the program involves many different individuals and agencies, and since individuals are known to change positions not infrequently, coordination maintenance requires a constant education and reeducation process.

Movement in the program can progress in any of three main directions: (1) expanded base of clientele; (2) extension into other geographic areas and other state

institutions; and (3) increased development of community resources to increment the quantity and quality of service to the clientele. The program has the necessary structural elements to accommodate movement on all three of these fronts. It is the challenge of coordination to ensure that the program's structures (Committee of Commissioners, A&P Teams, Automated Information System and SID staff) are so utilized.

V. CLIENT PROCESSING PROCEDURE

The processing of clients in a service-integrative model depends on rapid and accurate transmission of information. In the SID model, the broker advocate, A&P Team, other community and institutional service providers, and the client himself, are the major communicators. The bulk of the information exchanged concerns the individual clients. The model provides very structured procedures for the collection, compilation, and dissemination of these client-based data.

The reader has already been introduced to the overall client processing flow. (See Figures 1 and 2 in Appendix A). Now presented are the procedural details required to accomplish the events represented in the two figures in the paper at Appendix A.

Two manuals are essential to execute the processing of a given client. These are: "The Methods and Procedures Manual" (attached as Appendix C) and "The Assessment and Prescription Team Manual" (attached as Appendix D). Volume 3, "The Automated Information System," is essential for the compilation and presentation of the client processing information once it is gathered via the procedures described in the two manuals.

The Methods and Procedures Manual is designed specifically for use by the broker advocate, since he is the principal recorder of all SID-generated information. It contains and explains all the forms necessary to capture the information produced at each step in the process. The Methods and Procedures Manual also contains instructions for the distribution of the client-centered reports generated by the automated information system. As the client's representative in the model, the broker advocate is the primary focus for such distribution.

The Assessment and Prescription Team Manual is a handbook for Team members. It contains the necessary procedural information for the Team member to reach prescription and follow-up decisions. It is used by the Team member during the A&P Team meeting, since it provides essential formats

and definitions. It gives guidance for Team composition and outlines the roles and responsibilities of the various participants involved in client processing. Sample case management automated reports on a fictitious client are included in the A&P Team Manual. Table 1 at the end of this section lists the case management reports developed and planned.

It is recommended that a prospective A&P Team member, in addition to being provided with a copy of the A&P Team Manual, also be exposed to the overall SID method as described in the paper at Appendix A and to the Methods and Procedures Manual at Appendix C. The A&P Team Chairperson will want to keep these two latter documents on file. Training of the broker advocate requires the study of all three documents. Volume 3, the documentation for the automated system, is not essential to fulfilling the role of either A&P Team member or broker advocate.

TABLE 1

AUTOMATED INDIVIDUAL CASE MANAGEMENT REPORTS*

Title of Report	Contents of Report	Developed/ Planned
Assessment Summary	Presents data re client's background, institutional and service history, past and present physical condition, educational history, employment history and potential.	Developed
Behavioral Repertoire	Five-point scale ratings of 154 adaptive and 68 maladaptive behavior items.	Developed
Prescription Summary	Includes data re Team's prescription decision, reason for such, and a judgment as to why client has remained in the institution; listing of elements prescribed and corresponding objectives specified. If applicable, address where client has been placed is noted.	Developed
Fulfillment of Continued Institution Prescription	Includes list of each continued institution element prescribed, and codes indicating degree to which objective of each has been fulfilled and who provided this assessment. Gives explanation of degree of fulfillment as applicable.	Developed
Client Status Report	Summarizes client's processing history in terms of assessments, prescriptions, recommendations, residence changes, follow-up and problem reports.	Developed
Resource Search Results	For each community placement element searched, name of person broker advocate contacted, agency name, and address are listed. If resource agrees to provide service, date service tobegin (and date of termination if known) are shown; otherwise reason resource unable to serve client is noted. Summarizes data re total and mean number of different providers contacted in housing, income and other element searches. Notes any prescribed elements that were not searched.	Developed
Service Delivery Results	For each community placement element prescribed, name and address of provider are listed. Client's satisfaction with service, provider's judgment of client's movement toward objective set by Team, time and expenditure inverted by provider in serving the client are included. Reasons for non-provision of prescribed services are given.	Planned

TABLE 1 (continued)

AUTOMATED INDIVIDUAL CASE MANAGEMENT REPORTS*

Title of Report	Contents of Report	Developed/ Planned
Problems Reported	For each problem reported by a SID staff member re the client, gives information on who reported the problem, the prescription element to which the problem relates, what contacts were made in resolving the problem, and outcome in relation to continuing service delivery.	Planned

*For samples of each automated individual case management report developed to date, see A&P Team Manual at Appendix D.

VI. PROCEDURES IN PROGRAM EVALUATION AND RESOURCE PLANNING

Frequently social programs are begun and program evaluation is at best an afterthought. The community mental health center movement is a prime example. There are others: introduction of the "new math" in elementary education, rehabilitation programming within the confines of the penal institution, and cross-town bussing of school children.

Because of its origin as a research and demonstration project, the SID model carries built-in procedures for evaluating the attainment of its own operational objectives. This is of enormous, obvious advantage to the prospective user of the SID model.

Continuous monitoring and tracking of the happenings associated with the deinstitutionalization and the service delivery process are accomplished in the SID model by an assemblage of automated reports constructed largely from individual client-based data.

Program evaluation proceeds most systematically when it is designed to provide information in response to empirical questions generated by the program's objectives. In the case of SID, there are a host of such empirical questions.

What are the characteristics of persons residing in state institutions? What services do these persons need? Are they getting the services they need? Does behavior expand or contract as a consequence of deinstitutionalization? Do clients prefer community living modalities over state institutions? Does it cost more to serve a client in a state institution than in the community? What happens to persons after they leave state institutions?

The SID project does not provide definitive answers to these and other questions like them. The SID model, however, does provide the capability of answering such questions over time.

Table 2, entitled "Automated Program Evaluation Reports," appears at the end of this section. It poses a series of evaluative questions, names the automated report addressed to the question, briefly describes the contents of the report, and states whether the report is currently developed or planned. Sample versions of the program evaluation reports developed to date are presented in Appendix E.

The information products associated with program evaluation are of use to program managers, service providers,

resource planners, governmental representatives, social researchers, and consumers.

The entirety of Volume 4 is devoted to a presentation of program evaluation information generated by SID model operations to date. Volume 4, therefore, represents a "for instance" application of SID's program evaluation procedures. Volume 4 is to the SID program what a particular case file is to the individual client. Prospective users of the SID model are guided accordingly.

TABLE 2

AUTOMATED PROGRAM EVALUATION REPORTS*

Evaluative Question	Title of Report	Contents of Report	Developed/ Planned
What are the personal, social, medical, and demographic characteristics of selected client groups?	Assessment Digest	Presents aggregate data re background, family, institutional and service history, past and present physical condition, educational history, and employment history and potential.	Developed
Does the behavior of selected client groups vary?	Behavioral Repertoire Statistics	Includes mean score and standard deviation for each of 154 adaptive and 68 maladaptive behavior items as well as same for 20 categories of behaviors.	Developed
What elements have been prescribed for selected groups of clients? What are their service needs?	Prescription Digest	Gives aggregate data re reason for prescription decision, reason client has remained in the institution, elements prescribed for community placement candidates and for those to remain in the institution.	Developed
Has institution staff carried out the prescription written for selected groups of clients prescribed to continue in the institution? What are the institution resource gaps?	Fulfillment of Continued Institution Prescription Digest	Includes summary data for each institution and element prescribed showing the degree to which the objective of the element was fulfilled. Indicates discrepancy between prescribed institution services and delivered institution services.	Developed
Do broker advocate caseloads vary and do some require adjustment?	Broker Advocate Caseload	Caseload of each broker advocate is presented in terms of the number of active clients, terminations, prescription decisions, community placements, and community placements who have returned to an institution. Caseload for a given SID field unit by originating institution is summarized.	Developed
How many clients have been processed? What are their prescription status and their placement outcome?	Client Processing Summary	One page report highlighting client processing data for each client group and Team. Includes number of clients assessed and prescribed, number of reassessments, current prescription status, number of terminations, current outcome status, number of clients who have returned to an institution, number of Team meetings, and a rudimentary count of A&P Team man hours spent in processing with the professional manpower cost of such.	Developed

TABLE 2 (continued)

AUTOMATED PROGRAM EVALUATION REPORTS*

Evaluative Question	Title of Report	Contents of Report	Developed/ Planned
What happened at a selected A&P Team meeting and what are the to-date totals of prescriptions, outcomes, and resource gaps?	Client Status Update	Produced after each A&P Team meeting. Provides current prescription status and latest reassessment prescription status for the selected meeting as well as totals to date. Provides detailed client outcome data; housing and income resource gaps are documented.	Developed
What resource gaps in the community have been uncovered; or, for selected groups of clients, what services have been found vs. the elements prescribed?	Cumulative Resource Search Results	Gives total and mean number of broker advocate contacts made in search to fill community placement prescriptions. Gives total and mean number of different providers contacted per prescription element. Categorizes the reasons given by agencies for being unable to provide service. Shows discrepancy between services prescribed and services actually located.	Developed
What services are actually being provided for selected groups of community placements vs. the elements prescribed? And, are the clients meeting objectives set by the Team?	Cumulative Service Delivery Results	Includes data on services provided, clients' satisfaction with services, providers' judgments re clients' movement toward objectives set by Team, and time and expenditures invested by service providers in serving clients.	Planned
What problems arise for selected groups of clients placed in the community and are these resolved?	Cumulative Problems Reported	Presents data re which elements are "problem elements," contacts made by broker advocates in resolving problems, and outcomes in relation to continuing service delivery.	Planned
What are the comparative cost/benefits for selected groups of clients re community vs. institutional living?	Cost/Benefit Analysis	Automates the procedures and displays in the cost/benefit analysis. (See Volume 5).	Planned

*For samples of each automated program evaluation report developed to date, See Appendix E.

VII. PERSONNEL REQUIREMENTS

The personnel requirements to operate the SID model are: members of the Committee of Commissioners, Assessment and Prescription Team members, and SID staff.

Services of the members of the Committee of Commissioners and of members of A&P Teams are part-time, voluntary, and "contributed"; consequently these services do not represent additions to already-established budgets. SID staff members devote full time to the program and thus do represent increments in personnel to the existent service delivery system.

SID staff are situated in two places: central office (in the state's capital) and field offices (in the geographic communities in which the program operates).

It is recommended that the program, at least initially, attach itself for housekeeping purposes only to one of the participating state agencies. This arrangement is conserving since the administrative supportive services (finance, personnel, purchasing and supply, etc.) for the program are rendered by the housekeeping agency and do not have to be duplicated.

The main functions performed by the SID central office are: administration, coordination, planning (for extensions of the program), program evaluation, automated data pro-

cessing, and clerical/secretarial. The number and kinds of personnel in the SID central office are governed by these functional requirements.

Given the fact that the SID procedures are already developed and assuming that the user will decide to initiate operation of the model in only one or two communities, we recommend the following minimum staff in the SID central office at the outset of the program: program director/coordinator, program evaluator, systems analyst/programmer, keypuncher, and secretary--a total of five staff positions. It is assumed that the program will have access to the state computer system, but it is emphasized that the program carry its own data processing personnel. As the program grows, the personnel needs of the central office can be reviewed at appropriate intervals.

The main functions performed by the SID field office are: case management, case coordination, and A&P Team coordination. The number and kinds of personnel in a SID field unit are governed by these functional requirements.

The responsibility for A&P Team coordination rests with the A&P Team chairman (i.e., the director of one of the local agencies--a non-staff member of the program). He is assisted in his coordination effort by the chief broker advocate. The complement of broker advocates perform the case management and case coordination functions.

For a community with a population 100,000 to 150,000 we recommend the following composition of staff for a SID field unit: chief broker advocate, five B-level broker advocates, five A-level broker advocates, and one secretary. This staffing complement can serve two A&P Teams, each meeting twice a month, and reviewing six to eight clients per meeting. The program director will want to phase-in the ten broker advocates over a 3 to 6-month period.

Attached at Appendix F are recommended job descriptions for field staff for use in establishing state personnel classifications. The user should have no difficulty developing his own job descriptions for the central office positions.

VIII. OFFICE MANAGEMENT PROCEDURES

Office management procedures are accommodated to (1) the particular state's personnel and pay regulations and (2) the work requirements of the program.

Attached at Appendix G is an office manual developed in the course of the SID project in Virginia. While many of the specifics in the office manual are of provincial interest only, such a document is found to be useful in the initial stages of orientation for incoming staff members.

It serves also as a reference manual for administrative and clerical functions.

Scheduling is a very essential feature in the field operation. The last page of the appended office manual gives an actual example in PD #6 of assessment and prescription scheduling. Note the necessary lag time between the broker advocate's gathering of the assessment information and the A&P Team meeting at which the client is to receive a prescription. This lag time is necessary because of the following empirically derived time frames:

Function Performed	Time Required
Obtaining authorization for release of information	Varies widely: From 10-15 minutes to weeks and months, depending upon availability of source
BA compilation of assessment info	1 to 2 days
Mailing assessment info to central office	1 to 2 days
Data processing	1 week
Proof-reading of the automated assessment report	1 to 2 days
Duplicating for distribution	1 day
Distributing to A&P Team members	1 to 2 days
Report available to A&P Team members prior to Team meeting	3 to 5 days
Total time from BA assessment to A&P Team prescription	15 to 21 days

Optical scanning methodology would reduce the amount of data processing time, but to date SID in Virginia inputs data via key-to-tape. When the reader turns to Volume 3 he will note that the automated information system developed accommodates considerable open text. We have found that this has an advantage in wooing the broker advocate and in increasing the flexibility of the automated report as a source of assessment information for the A&P Team member user.

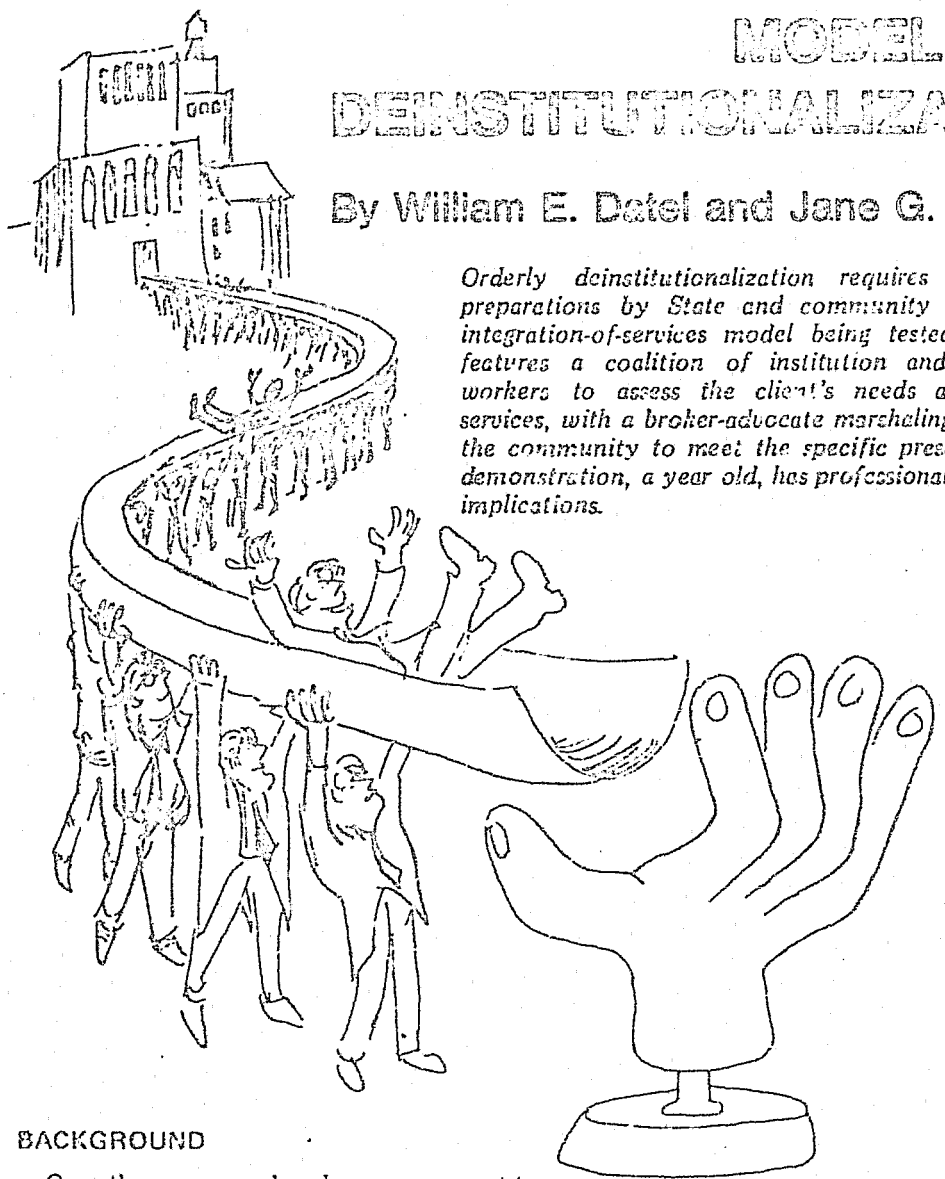
APPENDIX A

Paper entitled " A Service-integrating Model for Deinstitutionalization" reprinted from Administration in Mental Health, Spring, 1975.

A SERVICE-INTEGRATING MODEL FOR DEINSTITUTIONALIZATION

By William E. Datel and Jane G. Murphy

Orderly deinstitutionalization requires collaborative preparations by State and community agencies. An integration-of-services model being tested in Virginia features a coalition of institution and community workers to assess the client's needs and prescribe services, with a broker-advocate marshaling resources in the community to meet the specific prescription. The demonstration, a year old, has professional and political implications.



BACKGROUND

Over the past two decades, a movement to "deinstitutionalize" citizens in facilities for the mentally retarded, mentally ill, and juvenile offenders has arisen in this country (Joint Commission on Mental Illness and Health 1961). Judicial processes that once promoted institutionalization now provide the strongest impetus for deinstitutionalization, through decisions on due process, right to treatment, right to minimum wage, right to education, and welfare rights. The trend, additionally, has gained impetus as fiscal administrators question the wisdom of having human warehouses (Conley 1973;

David 1971; Kistin and Morris 1972; Wagner 1972). Also contributing are advances in psychopharmacology (Efron et al. 1968) and behavior management (Krasner and Ullman 1972).

Strong justification for a deinstitutionalization policy can be based on simple humanitarianism, civil rights, cost consciousness, or the state of the rehabilitation art.

However, there are powerful resistances (Barachal 1971; Mackey et al. 1967; Scheff 1966; Yolles 1969). Inertia is one. Territorialities must be redefined, resources reallocated, contingencies and priorities rearranged, family expectations and service deliverers reoriented, vested interests surrendered, bureaucrats and legislators convinced, and the culture de-mythologized.

Program excursions into rapid, massive discharges (as in California, New York, and Massachusetts) have met with less than unqualified approval and success (Chu and Trotter 1974; Jacobson 1973; Schumach 1974; Vach[illegible] 1972). Pseudo issues have arisen, even though it is obvious that community placement in the absence of

It is obvious that community placement in the absence of community supports is an unfair test of deinstitutionalization . . . A policy without an implementing procedure is like faith without works.

community supports is an unfair test of deinstitutionalization (Anthony et al. 1972; Johnson 1971; Purvis and Miskimins 1970).

Recognizing that a policy without an implementing procedure is like faith without works, the Commonwealth of Virginia prepared for a deinstitutionalization program. It applied for a research and demonstration grant from the Social and Rehabilitation Service, DHEW. The grant was awarded for three years starting in mid-1972. With the Department of Mental Health and Mental Retardation as the housekeeping agency for the grant, the application was sponsored by nine State agencies in concert. (Agency participation has since grown to twelve.) The collaboration represented a fortuitous spin-off of a State interagency task force that studied service integration strategies. The grant proposal applied the task force's service-integration methodology specifically to the institutionalized citizen.

Virginia has 7,000 mentally ill persons in six physical plants, 4,800 mentally retarded individuals in three facilities, and 1,000 juvenile offenders in seven training schools or

In concept, the procedure is applicable to any institutionalized citizen in any State.

at non-State facilities under contract. This paper describes the model of service integration for deinstitutionalization (SID) that resulted from the funded proposal to be applied to these residents of State institutions. In concept, the procedure is applicable to any institutionalized citizen in any State. Many structural elements and procedural details are operational on a demonstration basis. Evaluation of the model and data it generates are subjects of future reports.

The model purports to be a systematic, service-integrating procedure for the orderly deinstitutionalization of residents of State institutions. It takes into account—and seeks to overcome—some pitfalls in the deinstitutionalization process, such as: impermeability of the organizational boundary between State institution and community; mutual accusations of "dumping" patients; patients "falling between the cracks"; patients moving from the "back wards" of the hospital to the "back wards" of the community; the "ping pong ball" phenomenon; high recidivism rates; lack of communication, coordination, and followup; insufficient accountability; and inadequate resource planning.

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Jane G. Murphy is evaluation coordinator for the project.

COMPONENTS OF MODEL

The procedure has five main structural components. Each performs service-integrating functions.

Assessment and Prescription (A&P) Team

This is a coalition of professionals from the institution and from the community in which the procedure operates. The interdisciplinary A&P Team has 10 to 12 persons. Institutional representatives are typically the director and the client's ward physician or unit chief. Community representatives are local derivatives of the nine participating State agencies.

The Team assesses each client, determines the client's suitability for deinstitutionalization, and writes a "prescription" detailing the kinds of services required to enable the client to achieve tenure in the community. If the client is not a candidate for deinstitutionalization, services are prescribed for maximizing the client's functioning within the institution for the next 6 months. The Team assumes quasi-legitimate authority, by making recommendations for client movement, overseeing service delivery happenings, and serving as a central focus for interchange on service delivery matters at a local level.

Field Staff of Broker Advocates (BA)

These project staff members in the two target areas are "brokers" insofar as they arrange and coordinate service deliveries for the deinstitutionalized client. They are "advocates" insofar as they speak in the client's behalf on matters the client may be unable to articulate.

(Broker Advocates) are "brokers" insofar as they arrange and coordinate service deliveries, . . . (and) "advocates" insofar as they speak in the client's behalf on matters the client may be unable to articulate.

The BA compiles the assessment information, receives the A&P Team prescriptions, searches the community to arrange for filling the prescription, signals the Team when advance service plans are complete, and monitors the client's receipt of services after placement in the community.

Quality Control (QC) Team

Members, drawn from project staff, include the Community Services Coordinator (CSC) in either field office. The CSC establishes, coordinates, and maintains A&P Team functioning, and develops information on community resources available for use in arranging service plans and in promoting service integration for specific clients. In the projects central office, QC members develop and update forms and procedural controls; evaluate, present and distribute data from the field; identify issues, make recommendations, and propose legislative reforms; implement a cost/benefit analysis to study fiscal considerations in deinstitutionalization; and prepare for possible program expansion.

Automated Information System

The model includes development of an automated information system to store and tabulate data and to manage reporting functions. The system's outputs help the case manager serve the client. The system builds reports for use by the program manager/administrator in planning and evaluation.

Committee of Commissioners

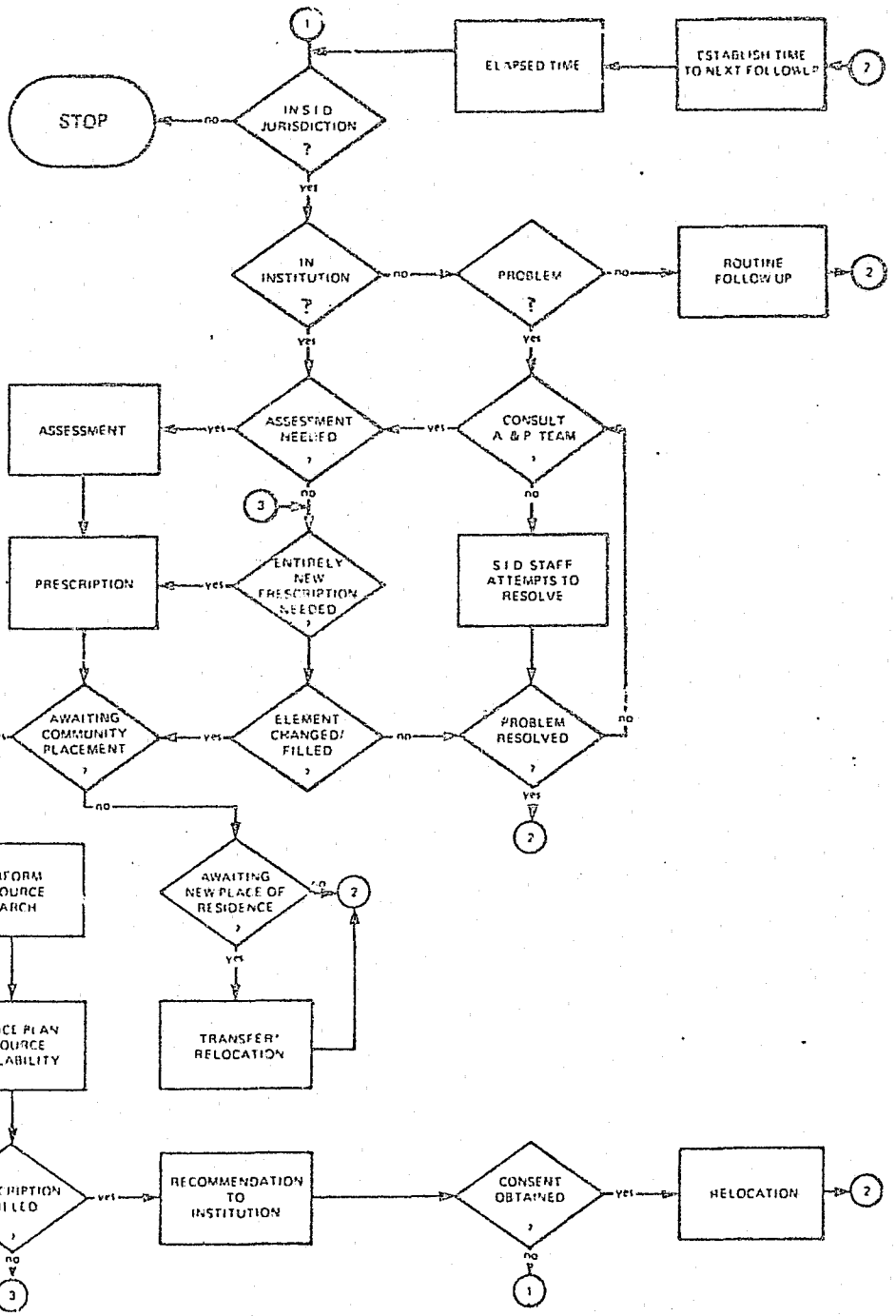
The project is governed by a committee of heads of the nine State agencies. The committee evaluates the model's possible use in a Statewide deinstitutionalization effort, unfreezing barriers to effective service, instituting policy changes, and developing innovative funding and administration.

TARGET GROUPS AND AREAS

The project strives to demonstrate the feasibility of its deinstitutionalization procedures for three types of clients in two geographic areas. If living in a State institution for the mentally ill, the mentally retarded, or juvenile offender, any citizen whose home of record is in Planning District 6

FIGURE 1

THE S.I.D. PROJECT: Client Processing



(predominantly rural area) or in Portsmouth (urban area) is a prospective client. There are 500 such mentally ill persons in two State mental hospitals, 400 such mentally retarded persons in two State training schools, and 70 such juveniles in seven State institutions.

Planning District 6 is in the central Shenandoah Valley. Portsmouth is in the Tidewater area. Save for one State mental hospital and one training school for the juvenile offender, the institutions housing the target clients are outside the geographic limits of the two demonstration areas. Driving time to the outlying institutions is one to 2½ hours.

CLIENT PROCESSING PROCEDURE

The flow diagram in figure 1 presents the main client-processing sequence. The brief descriptors for major happenings are enclosed by rectangles; the questions enclosed by diamonds are the principal binary choice points.

The processing of a client begins at the circled 1 and terminates only when the client falls outside the model's jurisdiction.

(A prospective client originating in a target area also will fall beyond the SID model jurisdiction if neither he nor his authorized representative gives permission to obtain and release medical and other information. Termination of a previously active client may occur for various reasons.)

Once an institutionalized person has been identified as a resident of the participating community and after the person has given the authorization for information release, he is assigned to a Broker Advocate.

The BA begins the processing by compiling client-related information from institutional records and personnel, client relatives and friends, and the client himself. The information is entered on a standard form requiring identifying data, reasons for institutionalization, service history and eligibility, residence history and personal/family resources, physical condition and history, educational history, employment history and employability, and a repertoire of adaptive and maladaptive behaviors.

The completed assessment information is sent to the project's central office for key-taping and electronic filing. An automated assessment report is produced for the SID field office and distributed to A&P Team members preparatory to all-day, biweekly meetings at the institutions. Six to eight clients are processed at a meeting. The main stages of processing are assessment and prescription.

In assessment, the BA reviews the automated assessment report, amplifying as necessary. Institution personnel—from unit chief to aide—contribute information. Community Team members contribute whatever a pre-meeting search of their agency files has revealed. The client appears for a brief "familiarization" interview. (If the client is not mobile, the Team goes to the ward.) Discussion ensues.

In the prescription phase, the chairperson entertains a motion for community placement versus continued institutionalization. A consensus is reached, at times by vote, and the chairperson leads the team through a standardized format to identify the client's specific facilities/services/programs needs.

If the decision is for continued institutionalization, the reason is noted and the Team writes a prescription, specifying the needed institutional services. A computer-generated report is filed with the institution in the form of a justified recommendation to the institution director. Just prior to a reassessment, six months later at most, the BA reports the extent to which the institution "filled" the prescription.

If the decision is for community placement, the reason is noted. The Team writes a prescription under headings for "housing," "income," "employment/job training," "physical health," "social/psychological health," and "education."

Each heading contains a list of generic elements; for example, half-way house under "housing," or family counseling under "social/psychological health." The A&P Team has a handbook that defines each element for easy reference. The Team indicates briefly the client-specific objective of the service prescribed.

While the Team is "writing" the prescription, the BA is recording on the prescription format the information being produced. The data are encompassed in an individual prescription report, produced by a computer for use by the BA, institution, and community service-delivery agencies.

The flow chart in figure 1 shows the choice point: "Awaiting Community Placement? Yes or No." If the Team prescribes continued institutionalization, the answer here is "No" and the process moves to the sequence begun by a a circled 2 (assuming no interinstitution transfer is prescribed). This sequence leads to the six-month reassessment.

If community placement is prescribed, the binary resolution to "Awaiting Community Placement?" is "Yes." But before it is effected, further procedures are performed.

The BA, armed with the Team's prescription, conducts an exhaustive search for resources to "fill" it in the client's home community, beginning with housing and income. (For flexibility, the Team may have prescribed as many as three housing-mode alternatives.) Around each prescribed element, the BA constructs a service plan (i.e., an explicit agreement and schedule) with the agency that will render the service. The BA records agencies contacted, reasons unable to serve (if appropriate), date service is to begin, service and fee schedule, etc.

If the entire prescription is "filled" (i.e., service plans are complete), the BA requests the Team chairperson to recommend (again, on a standardized format) to the institution director that the client be placed in the community under the terms of the filled prescription. As in the continue-institutionalization case, the formal recommendation for community placement, with attached service plans, crystalizes the A&P Team's consultive function vis-a-vis the institution's administration.

If the institution director and client agree to Team recommendation and service plan, the client is placed in the community. (See "Relocation" in figure 1.)

Once the client is placed, the BA monitors delivery of the services prescribed and agreed upon, by (a) routine followup contacts with the client and each service agency, and (b) unscheduled intervention triggered by a "problem" message, with the goal of reestablishing or recoordinating delivery of the jeopardized service, or identifying the need for a new service. The BA documents his findings besides performing the catalytic function. At his disposal are a staff supervisor and/or A&P Team members.

The (Broker Advocate) . . . conducts an exhaustive search for resources to "fill" the (prescription) in the client's home community . . . If the institution director and client agree . . . the client is placed.

Association with the client from the very inception of the deinstitutionalization planning process gives both the BA and the Team members a problem-solving perspective and commitment that otherwise might be tenuous. (See figure 2 for assignments, other functions, and reporting elements in client processing.)

PROGRAM ACTIVITIES

The model includes program activities not directly related to the client. Ill-defined though some may be, most are essential to the model's integrity and viability.

Management Information System

Individual case management reports already have been discussed (see column 5, figure 2). By collapsing data from individual client master files, a series of program management reports is generated. These automated reports form the basis of an ongoing management-information or program-evaluation system. They contain descriptive statistics on assessments, prescription information, and outcomes. The reports are public information; clients are not named.

By observing the services prescribed, one can derive a statement of resources required for a given set of clients. The resource gap for a given set of clients is defined by comparison

of services-prescribed data with services-available data. This information offers an empirical base for resource planning and funding and may help justify grant applications.

The system provides overall tracking of the client-processing. Because the reports are distributed among all human service agencies, the problems and findings in deinstitutionalization are kept highly visible.

Cost/Benefit Analysis

A detailed procedure has been designed for cost/benefit analysis applicable to mentally ill and mentally retarded clients. It embodies a three-variable scheme: housing mode, income, and employability. Thus, degree of client disability is studied in the cost/benefit comparisons made between institutional and community living. The analysis, not absolutely essential to the model, can provide decisionmakers with important information.

Community Development

By attending community meetings and by keeping local governing bodies informed of the project's operation and results, the BA generates public concern and awareness of his class of clients. The Community Services Coordinator builds close liaison with the public information media and with the community's political power structure. The information system produces a resource directory for use by service deliverers in the planning district. These results may assist the project director's efforts at the State level to promote true interagency problem-solving and collaboration on deinstitutionalization.

Communication Channels

Given the organizational arrangements in the model, it becomes possible for the local service delivery network (the A&P Team) to communicate directly with the body of human service agencies at the State level (the Committee of Commissioners). Local needs and issues can be more clearly defined and more rapidly transmitted. When examination of an issue is blocked by the bureaucratic "cooling out" process of an agency, channels within the model are invoked.

The BA himself, as an arm of the A&P Team, finds he can open doors that would ordinarily remain closed to an agency line worker in a similarly salaried position. Information he receives and problems he detects win the attention of the local forum of service deliverers.

Via the communication patterns it brings, the model invites State offices to be more responsive to local service delivery issues. The model utilizes the strategy of peer pressure in overcoming agency-specific obstacles.

Legislative Reform

Model operations uncover antiquated and inadequate statutes. They point to ignored or underfunded statutory programs that might facilitate deinstitutionalization. The model may have legislative implications in bringing to light needs for statutory authority to bolster the service-integration *modus operandi*, which rests in part on quasi-legitimate arrangements, i.e., the *ad hoc* A&P Team and Committee of Commissioners.

Resource Development

The most important goal is development of community resources for the deinstitutionalization candidate. The model embodies no specific means for this development. But all of its activities indirectly stimulate resource growth. As clients are processed, needs become known; as information is distributed, plans can be drawn; as service deliverers cooperate, mutual objectives are defined; as public awareness grows, public support is increased; as State agencies collaborate, funds are consolidated.

PROGRESS

The model processed its first client May 11, 1973. At this writing, three A&P Teams meet three to four times a month in both areas. Some 81 Team meetings have been held, 376 clients have been reviewed at least once, and 134 reassessments have been conducted.

Considering the most current prescriptions,

Figure 2

PROCEDURE FOR CLIENT PROCESSING

Function	Performed by Whom	Accomplished When	Control Form	Automated Report
1. Assessment of client			Authorization for Release of Information Assessment Format	Assessment Summary
a. Obtain authorization for release of information	Ch BA BA	Prior to beginning gathering of assessment information		
b. Prepare client/relatives	Ch BA BA	At time release obtained During assessment process		
c. Gather information	BA	Prior to A&P Team meeting		
d. Review information	A&P Team	Prior to A&P Team meeting		
2. Prescription for client			Prescription Format	Prescription Summary
a. Decide upon community placement versus continued institutionalization	A&P Team	At A&P Team meeting		
b. Decide what client needs and why (i.e., prescribe service and state objectives of service)	A&P Team	At A&P Team meeting		
c. Check (list) reasons why client is still in institution	A&P Team	At A&P Team meeting		
d. Solicit client participation/cooperation	A&P Team BA Institution staff	Begin after prescription plan is known		
3. Determination of resource availability/utilization			Agencies Questionnaire Area Resource Inventory Broker Advocate Service Plan	Resource Directory Directory (PD # 6)
a. Compile information on all resources	CSC BA	Ongoing	Resource Availability/Utilization Summary Sheet	Resource Search
b. Discover if resource is available	BA	During/after A&P Team meeting		
c. Discover if available resource can delivery service	BA vis-a-vis service	After A&P Team meeting		
d. Negotiate agreement re. delivery of service; arrange schedule for same	BA	After A&P Team meeting		

Figure 2 (Continued)

PROCEDURE FOR CLIENT PROCESSING

Function	Performed by Whom	Accomplished When	Control Form	Automated Report
4. Client movement/status			Recommendation for Client Movement into Community Recommendation for Continued Institutionalization Consent for Movement Change of Address	Client Status
a. Recommend client movement/ status/placement	A&P Team (Chairperson)	After BA Service Plan completed or after A&P Team changes original prescription		
b. Obtain client consent	BA	Prior to movement		
c. Move client	Institution or community person	Upon date recommended by A&P Team and approved by Institution Director		
5. Follow up of client			Client Status Report Provider Status Report Problem Report Change of Address Memoranda Fulfillment of Continued Institutionalization Prescription	Client Status Fulfillment of Institutional Prescription
a. Monitor client's receipt of service prescribed	BA	Periodically after client has been placed		
b. Study/resolve problems in service delivery process	BA, Ch BA, CSC, SID	As problems arise		
c. Review problems and authorize changes in client's status or	A&P Team	As necessary		
d. Check on extent to which continued institutional prescription is fulfilled	BA	Prior to reassessment by A&P Team		

ABBREVIATIONS: BA = Broker Advocate
Ch BA = Chief Broker Advocate
CSC = Community Service Coordinator
A&P Team = Assessment and Prescription Team
SID = Service - Integration for De-Institutionalization Staff

244 or 65 percent of 376 clients have been recommended for community placements. Only 22 percent, 84, actually were placed, and four once-placed clients are now living in the institution. By client group, the data show:

Of 174 *mentally ill* clients processed, 117 (67%) received community placement prescriptions. Some 48 (28%) actually were placed, with three reinstitutionalized.

Of 171 *mentally retarded* clients processed, 102 (60%) were prescribed for community placement. Fourteen (8%) were placed, one returning.

Some 65 percent of 376 clients have been recommended for community placements. Only 22 percent . . . actually were placed, and four once-placed clients are now living in the institution.

Of 31 *juvenile offender* clients processed, 25 (81%) were prescribed for community placement, Twenty-two (71%) were placed, none returning.

The large proportion of community-prescribed clients is noteworthy in light of the fact that prescription decisions were made not by outside consultants but by members of the local service-delivery system itself.

Lack of community resources to meet prescriptions accounts for the large discrepancy between the number of clients prescribed for community placement and the number actually placed. (The gap is largest for mentally retarded clients.) Collaborative planning and followup procedures may account for the low recidivism rate.

Project staff at this writing has 38 members (32 professional and 6 clerical). There are 22 BAs. Caseload ranges from one to 26, depending on the BA's length of time on the project. The caseload asymptote is not known but obviously is constrained by the heavy accountability aspects in the procedure and depends on such factors as resource availability and service-delivery effectiveness.

The Committee of Commissioners' executive group meets monthly; the whole committee meets quarterly. At this writing, it was deciding if the model should be adopted by the State and extended to other localities. (A State plan to extend SID dated October 1974, is available from the authors.)

SUMMARY

A model for the orderly discharge of residents of State institutions is described. Procedures rest upon collaboration of all State human service agencies and community counterparts. The model has five socio-technical components, each a "service-integrating" mechanism in client processing:

- Assessment and Prescription (A&P) Team, a coalition of institutional staff and community service deliverers.
- Broker Advocate, acting for the client in arranging and maintaining service delivery.
- Automated Information System, for the case manager as well as for the program administrator.
- Quality Control Team, project staff who evaluate, develop, and coordinate the system as well as identify problem issues.
- Committee of Commissioners, the governing body for the model's operation.

Excerpts of this article were read to the President's Committee on Mental Retardation in Philadelphia, June 20, 1974. The work here described is supported in part by SRS Grant 15-P-55896. The authors' opinions and assertions do not necessarily carry endorsement by the U.S. Department of Health, Education, and Welfare or the Commonwealth of Virginia.

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APPENDIX B

Coordination Activities in Implementing the SID Proposal

I. Instigation

II. Entry at the State Level

III. Entry at the Community Level

IV. Coordination at the State Level

V. Coordination in Planning District #6

VI. Coordination in Portsmouth

I. INSTIGATION

Nine state agency heads signed the original grant application, dated May 10, 1972. The notice of grant award was received in a letter dated June 29, 1972. In July a formal announcement was made by the Governor and HEW officials during a special ceremony in Richmond proclaiming that a two-million dollar, three-year grant had been made to the Commonwealth to carry out a research and demonstration project in two specified areas of the State--Planning District #6 (Central Shenandoah Valley) and the City of Portsmouth.

There was coordination activity involved in obtaining the signatures of the nine state agency heads. Such coordination occurred largely as the result of a human affairs inter-agency task force which in turn had been formed as a result of recommendations contained in Governor Holton's Management Study.

The proposal itself was authored principally by two assistant commissioners of the Department of Mental Health and Mental Retardation. Before the proposal was written many of the ideas which it contained were rehearsed in the inter-agency task force.

The Department of Mental Health and Mental Retardation was named in the application as the "housekeeping" agency to administer the grant. The proposal stated, however, that the Department of Mental Health and Mental Retardation was submitting the application as a matter of "administrative and fiscal convenience" and that the nature of the program involved all of the nine applicants equally.

At the outset one of the co-authors of the proposal served as acting project director. No project staff were hired in advance of the permanent project director's arrival on October 9, 1972. In this interim period, a suite of offices to house SID central office staff was rented and renovated.

Prior to the project director's arrival, the Secretary of Human Affairs, accompanied by a team from the Department of Mental Health and Mental Retardation, held a formal meeting in either geographic target area of the project to orient institutional and community representatives toward the fact of grant approval, the project's scope, purpose, goals, impact and philosophy of service integration.

These meetings represented the first occasion in which community leaders were formally engaged by the project. Of course, approval and funding of the project were presented necessarily as a fait accompli. The reception was apparently mixed. While no one questioned

the humanitarian goal of appropriate and successful deinstitutionalization, nor took issue with the management goal of service integration, concerns were raised regarding the capability of existent community resources to absorb additional service and financial burdens.

Whether it was verbalized or not at that time, there were feelings on the local level, which surfaced later, that the project had been conceived and designed by an inter-agency task force at the state level with apparently little or no input from the local service delivery agencies. Since much of the project's operation is at the local level, this initial lack of coordination between state and locality in the grant proposal and design was a grave omission in service integration in the planning of the endeavor.

II. ENTRY AT THE STATE LEVEL

Following the September 1972 visit to the designated target areas made by the Secretary of Human Affairs et. al., the project lay dormant as far as planning and development were concerned until the permanent project director arrived.

The first order of business for the project director was to establish a base of operations in the newly remodeled but unfurnished office suite in Richmond. October and early November were spent meeting the commissioners, recruiting for the two established positions (assistant project director and secretary), and beginning the process of establishing the other required personnel positions.

The project director met eight of the state agency heads for the first time. (He had been recruited by the Commissioner of the Department of Mental Health and Mental Retardation and the Secretary of Human Affairs.) In each case these introductions took place in the agency head's office; in the case of several of the contacts, the DMH&MR Commissioner made the introduction and was present during the meeting.

These initial visits with the commissioners were warmly cordial and hospitable. All of the agency heads voiced interest in and a desire to cooperate with the project's development. Most typically, these initial encounters resulted in the agency head proffering information to familiarize the project director with his specific state agency. In all of the sessions there was perhaps only one maneuver, though made in good humor, that seemed designed to put the project director on the defensive: "So you're going to deinstitutionalize our state intitutions, are you?" Recruitment of project staff was uppermost in the project director's mind at this time; hence, he surfaced this issue whenever given the opportunity of "If there is anything I can do. . ." Some of the commissioners gave this specific request for assistance more thought than others. Few followed up with later leads or referrals.

From November 1972 until April 1973, there was little personal contact with the agency heads except for fairly frequent problem-solving and update sessions with the DMHMR commissioner and except for two or three meetings with the Secretary of Human Affairs. However, immediately after the Evaluation Coordinator joined the project in late January 1973, she visited a contact person (so designated by the agency heads through formal correspondence) in each of the nine state offices in Richmond for the purpose of soliciting input for the project's assessment and prescription procedures.

Throughout this early developmental period, the project director frequently sent written materials generated by the project to each agency head. Insofar as these information packets represented "trial balloons" vis-a-vis state agency interest in the project, the result was minimal feedback--either positive or negative.

III. ENTRY AT THE COMMUNITY LEVEL

The project director and assistant project director began their initial meetings with community resource people in mid-November 1972 following telephone contacts and the establishment of appointments. The first of many community/institution meetings was held on November 16, 1972 in Portsmouth at the invitation of the Chairman of the Portsmouth Human Resources Council to discuss the project with a core group of council members. Only two of the scheduled five council members attended this meeting. The first visit to PD #6 occurred on December 6, 1972 when the project director and assistant project director met with the executive director of the Planning District #6 planning commission.

In the weeks that followed numerous meetings were held by the project director and assistant project director with many of the local community agency heads and staff and with a majority of institutional directors. The primary purpose of these initial encounters was to meet the key people responsible for the delivery of human services in the area. During these meetings the project was reintroduced to those who had attended the September 1972 meeting with the Secretary of Human Affairs and introduced to those who had not yet been exposed to the project. It was during this period that contacts were made, attitudes were explored, opinions solicited, and relationships established. The project director and assistant project director were quite conscious of the fact that each of these meetings was crucial in that the groundwork on which the project would be formed depended on individual and agency cooperation and would help determine the project's fate.

The following observations were made during this entry phase into the communities and institutions.

(1) The rural site of the project, Planning District #6, is much more complex organizationally and geographically than the urban site, Portsmouth. PD #6 consists of ten political jurisdictions: five cities and five counties. While Portsmouth lies nestled in an urban network, Tidewater Virginia, Portsmouth itself is one political jurisdiction. This political/geographic organization difference may account in part for what we perceived as a more open, less "frozen" attitude towards the project in the rural area than we detected, at least initially, in the urban area.

(2) Service deliverers in PD #6, while they raised questions about the thrust of the project, seemed more willing to accept the realities of the project and to "get on with it." They voiced the frequently encountered objection that "we know what services are required--we only need the money to allow us to deliver them." While they seemed to feel that the funds supporting the grant could be spent more wisely, this feeling did not become solidified to the point where cooperation and participation were blocked. In Portsmouth, however, resistances to the project seemed more crystallized.

(3) In Portsmouth a stance was encountered which indicated that key actors in the service delivery power structure wanted to "extort" from the project commitments which would further the status quo of an already-decided-upon delivery system. For example, social service wanted the broker advocate function contracted to the local services department; and a city representative wanted the SID project to contribute to the Portsmouth information system, then in the planning stage. This kind of "bargaining" or attaching of conditions was not encountered in PD #6.

(4) It is concluded that the climate for activation of the project in Portsmouth was much more strained, right at the outset, than it was in PD #6. One wonders if this contrast may not be due to the political jurisdiction differences between the two areas, rather than specific personalities or biases toward the project.

(5) Initial encounters with the directors of the state institutions (DeJarnette, Catawba, WSH, CSH, LTS&H, and SSVTC) revealed that these persons were really quite favorably disposed to the philosophy of the project. SID was coming on the heels of the DMH&MR 10% mandate policy (i.e., reduction in census at all institutions at 10% per year for five years) and this circumstance caused some of the feelings toward the mandate policy to be inappropriately focused on

the project. But by and large, institutional directors were quite open, receptive, and genuinely problem-oriented with respect to the project.

IV. COORDINATION AT THE STATE LEVEL

The first committee of commissioners meeting was held on April 24, 1973. Throughout 1973 the committee of commissioners met bi-monthly. Meetings are held in the conference room of the SID suite of offices in Richmond and are scheduled for two hours duration. Commissioner attendance at the meetings has been fragmentary and disappointing. Frequently lower level staff are sent to represent an already over-extended agency head.

The first three meetings (April 24, June 18, and August 20) were devoted almost exclusively to reviewing major developments in the project that had transpired during the two preceeding months. Such matters as recruitment, staffing strength, budget expenditures, client processing procedures, information system development, community liaison efforts, A&P Team development, cost/benefit analysis planning, etc. were reviewed. The project director "conducted" these meetings and the committee members received and discussed the information presented.

Unhappy with the degree of involvement shown at the state level in the project, both as mirrored within and without the committee meetings, the project director in the October 15, 1973 committee meeting made a somewhat provocative plea to the members in attendance. Attendees at this meeting included one commissioner and lower level representatives from five of the other agencies.

The one commissioner present, hearing the project director's concern and distress, arranged for the issue of committee strength/direction to be brought up at the Secretary's next cabinet meeting. The Secretary of Human Affairs, at his cabinet meeting on October 26, reminded each of the six human affairs SID commissioners of their commitment to the project and directed each of them to attend the next SID committee meeting in person. Said meeting was scheduled for December 17, 1973.

In preparation for the December 17 committee meeting, the project director met personally with each of the nine state agency heads and with the Secretary of Human Affairs. With each in turn, the project director conducted a semi-structured interview which focused on how the agency head viewed the project and what he thought should be done by way of improving committee leadership and coordination. Data from these interviews were summarized, conclusions were drawn, and recommendations were listed. The package was distributed to each agency head in advance of the December 17 meeting.

The December 17 committee meeting was held as scheduled. Secretary Brown and five of the nine agency heads attended. Lower level representation from two of the other agencies was present. Two agencies sent no representatives.

This meeting proved to be a landmark in the path toward construction of a viable, policy-making body for the project. The committee elected a chairman and vice chairman. It also authorized the chairman to appoint an executive committee. The executive committee has met monthly and the committee-as-a-whole quarterly.

The chairman elected was the commissioner of Welfare. The vice chairman was the executive director of the Commission for Children and Youth. Other members on the executive committee were the commissioner of Mental Health and Mental Retardation, the director of State Planning and Community Affairs, and the commissioner of the Department of Vocational Rehabilitation. The committee elected the project director as an ex-officio member of the committee.

In early 1974 the committee of commissioners was helpful in solving the impasse which was developing in Portsmouth regarding A&P team development and functioning. The commissioners arranged for a bus trip and site visit to observe the planning district #6 A&P team in operation. Portsmouth A&P team members and members of the committee of commissioners made this trip jointly. This event was one of the coordination highlights of the project.

Other issues the committee has had to deal with in 1974 have been the question of information release authorization procedures and the question of project continuance. In the first instance the committee was unsuccessful in creating a method to enable processing of a sizeable number of clients who themselves were unable to authorize information release and had no one to act in their behalf. The extent to which the committee of commissioners will determine project continuance remains to be seen.

Throughout 1974 the committee of commissioners frequently received information regarding needed resources in the two geographic areas. Such information came from the data base accumulated by the project as well as letters of request from at least one of the target areas. The committee of commissioners proved unable to move forward in filling identified resource gaps in either area. These "failures" may be viewed as symptoms of inadequate coordination, participation, and leadership at the state level.

V. COORDINATION IN PLANNING DISTRICT #6

As already indicated it became apparent from the initial contacts with the communities that the atmosphere for developing the project was better in PD #6 than in Portsmouth. Therefore, the decision was made to begin the first demonstration of the project in the rural area. This decision created the need for a SID staff person to work in the area to plan and develop the groundwork necessary for the project to function. This particular role and responsibility was to be under the duties of the Community Services Coordinator as defined in the project, but at that particular time, such a position had not been approved nor established by the State Division of Personnel. However, to avoid further delay and to allow the project to move toward the identification and development of A&P teams, the assistant project director served on an interim basis as community services coordinator until the latter position could be established and filled. This arrangement prevented delays which could have resulted in lack of interest and relationship breakdown. It also provided the central office staff an opportunity to impress upon the community that even though the project had acquired a Richmond label, local input and help were crucial to make it work.

During this time organizational meetings were planned, coordinated, and held in local agencies and institutions. Such meetings, arranged by the assistant project director, provided an opportunity for agency and institutional staff to become more familiar with SID and with each other.

Planning District #6 is located in western Virginia in central Shenandoah Valley. It consists of five cities and five counties. It has a population of approximately 192,000 and a land area of approximately 3400 square miles. PD #6 is the largest planning district geographically in the Commonwealth.

In January 1973 the SID field staff positions were established and in February 1973 recruiting efforts were successful in attracting two qualified and acceptable candidates for the community services coordinator and chief broker advocate positions. The community services coordinator position was filled by a person who was not a resident of Planning District #6 nor a native Virginian. However, because of her personality and her demonstration of commitment to community work, she was readily accepted by the area. The chief broker advocate was a resident and native of the area and was known by a majority of the agency and institutional staff.

With the addition of the above mentioned staff and with the location of a base of operations in the community itself, the pace of the project quickened. The focus was on continuing to establish and expand contacts throughout the area, introducing the SID project to numerous individuals and agencies, developing ways in which SID, the institution, and the community could work together. These efforts were expanded as additional staff (broker advocates) came on board.

The initial contacts made by the SID staff were for the general purpose of orientation, information and education, however as the relationships developed, the focus became more specific. Agency and institutional directors were asked to become involved either by committing themselves or members of their staffs or both to supporting the development and maintenance of A&P team operation.

Soliciting community support is always a very delicate and sensitive issue, but in the case of the SID project, even more so: The project not only does something to, or impacts upon, the local community; it is dependent upon local professionals' unremunerated participation in order to operate at all!

The immediate tasks confronting the community services coordinator (CSC) and the chief broker advocate (CBA) were several: to enlist the support and participation of the local service delivery agencies and of the institutions in a procedure that was still in the process of being formulated; to acquire a base of operations; to form an Assessment and Prescription team of community professionals; and to keep the local governmental bodies informed of the project's presence and what it was doing.

The CBA and CSC spent their first couple of months visiting the local counterpart staffs of the nine state agencies sponsoring the project. These informal meetings were sometimes difficult. The director of each agency was being asked to participate in a project that the commissioner of that agency had formally endorsed. The CSC and CBA were faced with the task of not only trying to explain the written purpose of the project but were asking agency personnel to give valuable man-hours to help develop and implement the Assessment and Prescription team model. Agency staff and institution staff felt ill-at-ease with some of the new terminology SID was introducing; members of city councils and boards of supervisors found the jargon to be somewhat contrived. When the project was introduced to the ten local governing bodies in the spring of 1973, members listened, asked questions, and frequently wondered why anyone would want to call a staff member a "broker advocate."

In April 1973 community agency leaders from the eight state agencies (Commission for Children and Youth does not have local agency personnel) and the directors of the three state hospitals serving PD #6 met with the SID project staff at Western State Hospital. The project director chaired the meeting and reviewed the purpose of the project. Systematic deinstitutionalization was endorsed by everyone present at the meeting but the method for achieving this goal was the cause of much discussion. Only a couple of professionals present agreed with the concept of a multi-agency Assessment and Prescription team as conceived in the original proposal. Most professionals voiced the opinion that it was inappropriate for the community people to recommend to the institution whether or not

someone should remain in the institution or be placed in the community. The idea that the community representatives and the institutional staff would participate jointly in this decision was foreign and rather unpalatable to many. The community representatives were being asked to do something they had never done before and did not feel comfortable in doing. To have all agencies involved in the planning of the services that a patient needs either while in the hospital or after he returns to the community was an approach that had to be gotten used to. (Community representatives stated repeatedly that "Only doctors know when someone is ready to leave the hospital!" Institutional representatives may have felt that traditional domain was being invaded.)

It was also quite obvious in this first meeting that very few people from the various local agencies knew one another or in fact knew the director of the host hospital. After a tense and long discussion, the group agreed to devote the next meeting to assessing and prescribing for ten patients as outlined by the SID procedure before committing itself to participate any further. After the first ten patients were presented by the first two broker advocates (who had only recently been hired), the group decided it would extend its participation six more months. The group in the following months became a hard working team of professionals meeting two days each month to assess and prescribe for state hospital patients from the Planning District.

In September 1973 the project embraced Lynchburg Training School and Hospital (the state institution for the mentally retarded serving Planning District Six). The broker advocates were now working at two institutions on a rotating basis. A tight schedule was established for the staff as well as for the Assessment and Prescription team. In addition to the meetings at Western State Hospital, meetings were held at Lynchburg Training School and Hospital two days each month. Agency membership for both A&P teams remained the same and in fact many of the same members participated in the meetings at both institutions. From the beginning, the Chairman of the A&P team served both teams thus giving continuity to procedures, policies, and recommendations. The original 6-month commitment has expanded to two years.

In organizing the A&P team, the CSC relied heavily upon a style of active persuasion and solicitation. As the team grew and developed it began to take on a functionally autonomous quality. Whereas initially the team was quite willing to rely heavily upon SID staff procedural guidance, team maturity has brought with it more the sense of a Board putting demands on a staff. Coordination style is adjusted accordingly.

VI. COORDINATION IN PORTSMOUTH

Portsmouth is a city of 29 square miles and a population of approximately 110,000. It was first settled in the early seventeenth century. It is now completely surrounded by other municipalities or waterways, a circumstance which effectively blocks any physical expansion of the community. A substantial portion of Portsmouth is in a blighted, deteriorated condition that began years ago and continues to progress. An urban redevelopment project has been undertaken in a portion of the central city and has met with slow but significant success.

Instigation of the SID operation in Portsmouth represented the first test of whether or not the model developed (or at least partially developed) could be "transplanted" to another community.

Active coordination efforts in Portsmouth began with the hiring and positioning of the community services coordinator and chief broker advocate in July and August of 1973. City officials played a very direct role in the recruitment of these two staff persons.

Even before suitable quarters had been located to house the SID Portsmouth staff, the community services coordinator and chief broker advocate were concerned with making those necessary personal contacts leading to a more informed local officialdom within the city. It was believed this was a necessary prerequisite to the formation of an Assessment and Prescription (A&P) team. These early contacts were relatively brief due to the press of housekeeping and other start-up requirements involving the project. These early contacts proved to be useful when efforts were accelerated to form the A&P team and also subsequently, to keep the A&P team functioning at its optimum consistent with the circumstances at hand.

Creation of the Steering Committee

From the time of the first contact between the community services coordinator and his principal counterpart within the local governmental structure, an apparent good rapport was established which stood the Portsmouth portion of the project in good stead during the balance of the project. This rapport was particularly important because it had been established with the individual who also was chairman of the Human Resources Council. This council was the local entity that had first exhibited interest in having the SID project located in the community. Consequently, within a matter of weeks after joining the project, the community services coordinator had been designated as an associate member of the Human Resources Council which provided a ready forum for discussing progress in the project as well as a built-in opportunity to strengthen initial contacts with community members who were directors or associate directors of service delivery agencies within the city and, as such, potential A&P team members.

The extent to which this association would bear fruit did not become apparent immediately but was borne out at subsequent dates after the community services coordinator had been a member of the Human Resources Council for a period of time.

During the early coordination phase, the community services coordinator made approximately 30 different contacts with service delivery agency officials of the City of Portsmouth plus a number of federally funded service delivery agencies. Within the same approximate time frame, the community services coordinator, in close concert with the chairman of the Human Resources Council, selected members of a steering committee to spearhead the actual formation of an Assessment and Prescription team for the city. In the process of this selection, due regard was given to the inclusion of al major service delivery agencies within the city on a governmental as well as nongovernmental basis. The degree of interest in the SID project that available individuals from these agencies had indicated was also a consideration. In view of the fact that the Human Resources Council was a creature of the city and that its members were designated by the city manager, a degree of leverage was automatically built into the association between the chairman of the Human Resources Council and the community services coordinator. Consequently, even though enthusiasm for the concept and/or procedures of the SID project on the part of any given individual may have been less than desirable, the framework within which the steering committee was created provided for at least a degree of participation in steering committee activities.

An additional fallout with regard to the early creation of an A&P team for the city, but which was negative in nature, was that at least initially some of those persons who apparently did not look upon the pilot project with any favor took advantage of the opportunity presented by being a member of the Assessment and Prescription team steering committee to practice an advanced degree of obstructionism. As a consequence, what had been viewed as a relatively noncontroversial task of creating the A&P team became much more tedious and necessitated over a period of weeks a number of additional meetings between the community services coordinator and the chairman of the Human Resources Council. These meetings culminated in an additional steering committee meeting which in effect reversed the action of an earlier steering committee meeting. At the earlier meeting of the steering committee, obstructionism had carried the day to the point that the only agreement had been an agreement to disagree concerning the concept and procedures as stated in the project proposal.

The benefit of 20-20 hindsight indicates that these early difficult meetings well may have laid the groundwork for problems involving the selection of officers for the Assessment and Prescription team once it had been formed. That is, this early development

had a very direct influence on the later difficulty encountered in selecting officers for the A&P team. It had been anticipated that the officers for the team would be selected by the team itself once it was formed by the steering committee. Likewise, it had been anticipated that the members of the steering committee would form the nucleus for the team itself.

Following the fiasco of the first meeting of the A&P team steering committee in mid-September, a second meeting to attempt to organize the A&P team was scheduled for early October. It was, however, only the day prior to the scheduled October meeting that the community services coordinator and the chairman of the Human Resources Council were able to meet and to agree upon officials for the A&P team once it had been officially formed. It will be noted that these officers were selected, not elected. Subsequently, it became more evident why this approach had been deemed necessary by the chairman of the Human Resources Council. The first chairman of the A&P team was an employee of the City of Portsmouth and worked under the direct supervision of the chairman of the Human Resources Council.

Other Essential Early Efforts

At the same time that the A&P team steering committee was in the process of evolving as a result of repeated and numerous individual contacts as well as the steering committee meetings mentioned earlier, other efforts went forward concurrently to prepare for the consideration of the first client target group by the A&P team once it had been organized. At the initial meeting of the A&P team steering committee, it was the consensus of that group that they would prefer to begin by reviewing the cases of all Portsmouth residents to be found in the seven juvenile institutions of the Department of Welfare and Institutions. Consequently, in December 1973, the project director and community services coordinator made initial contacts with the director and deputy director of the Department of Welfare and Institutions as well as the chief of the Division of Youth Services of DWI. These early meetings with Richmond-based officials of DWI resulted in the selection of the first juvenile institution whose Portsmouth residents would be reviewed by the A&P team once the team had been organized.

A subsequent meeting was held with the superintendents of the seven juvenile institutions to brief them on the concepts and procedures in the SID project. SID Portsmouth staff members then met with members of the institutional staff of the first training school selected to lay the groundwork for an early start on the preparation of assessment summaries for Portsmouth youngsters resident in that institution. At the first DWI institution, the project apparently got off to an excellent start in terms of rapport and interests on the part of the institutional staff and the SID staff.

Meanwhile, events which have been described above resulted in the creation of an Assessment and Prescription team for the City of Portsmouth and the selection of officers for the team. The chairman and vice chairman of the newly organized A&P team accompanied some members of the SID Portsmouth staff as well as the project director and others from Richmond to a meeting at the institution with members of the institutional staff. The team chairman as well as other members of the newly organized A&P team previously had indicated their complete opposition to the conduct of A&P team meetings at the institution and stated flatly that the team members from Portsmouth did not have the time nor finances and would not attend A&P team meetings that were not conducted in the City of Portsmouth. Consequently, the decision by the institution superintendent came as a very pleasant surprise when he requested an opportunity for the juvenile offenders and the concerned institutional representatives to attend A&P team meetings in the City of Portsmouth. This request, of course, was agreed to with great alacrity although at a later date it appeared doubtful that the initial enthusiasm of the institution to participate in A&P team meetings in Portsmouth continued.

Early Team Meetings

From the time of its creation, the Assessment and Prescription team appeared to suffer two related and unfortunate problems. These involved the apathetic attitude exhibited by many members of the new team as well as the lack of experience of the new chairman. These two factors subsequently were aggravated to an extreme by the overly aggressive tactics of two team members.

Given the ingredients of a lack of dedication and/or interest on the part of some members of the new team, the relative inexperience of the chairman, and the aggressive, often obstructionistic tactics of two team members, the early policy decisions and low productivity of the team should not be surprising. The formation of a team that was basically apathetic towards the project probably places in proper perspective the manner of selection of the team chairman. Thus, as mentioned above and contrary to the earlier beliefs of SID project staff members, the team officials were not elected by members of the team. They were selected by the chairman of the Human Resources Council of the City of Portsmouth on the day prior to the second organizational meeting of the A&P team steering committee. The new chairman not only lacked any prior exposure in depth to the concepts or procedures of the SID project, he had not attended the earlier meeting of the steering committee, and he had not been briefed concerning the SID project.

The background surrounding the selection of the team chairman, when coupled with the aggressive team members mentioned previously, resulted in the first A&P team meeting being used by team obstructionist members as a vehicle to adopt dubious policy decisions. At the same time, the same members attacked the concepts, procedures, and methodology of the SID project as it had been developed in the original project proposal.

One obstructionist member of the team attended only a portion of the first meeting and missed all or part of subsequent meetings early in the project. Another obstructionist team member filled the void without any problem by antagonizing institutional staff who were participating in the meetings, badgering the SID staff, questioning the qualifications of SID staff members, and generally denigrating anyone connected with the project. In addition, this same member, on the basis of a few moments of a single interview with the very first juvenile offender client to be reviewed by the team, either convinced some members of the team or managed to override the less than effective adherents of the proposal that the clients should be interviewed with the net result that the team made a policy decision not to interview any more juvenile offender clients at team meetings. It was only following eight additional juvenile offender team meetings that this unfortunate decision was reversed.

As indicated, this undue influence by a distinct minority of the total membership of the committee had several deleterious results insofar as maturation of the A&P team was concerned. The exercise of this undue influence by the aggressive team members was facilitated by the weakness of the chairman. A number of instances occurred wherein we found the chairman adopting as his own view the critical, nonconstructive, obstructionist attitudes displayed by one or another of the obstructionist members of the team.

The influence of the most vocal obstructionist on the team continued to plague team productivity. Principal among these actions was the amount of time the team was actually in session. At the outset, the team members wished to be in session no more than three hours per day and purely at their convenience as compared to the travel and other logistical problems faced by the participants in the team activities who came from the institution for the A&P team meetings. During this time, the team chairman either drug his feet or actively opposed any reasonable extension of the amount of time the team would sit or of the number of clients whose cases would be reviewed on a given day.

On more than one occasion, team activities actually were delayed for as long as one and one-half hours due to the lateness of arrival of personnel from the institutions. At times, delays in arrival were understandable due to inclement weather but at other times no such reason existed nor was any excuse even proffered by some institutional

representatives. During this same period one obstructionist member of the team opted out from continued participation on the plea that he did not agree with the SID project concepts and procedures and would not participate further in deliberations that concerned juvenile offenders. At this juncture, however, the second obstructionist member of the team opted in to take up where he had left off at earlier team meetings.

At various times during the four months that the team was meeting under the circumstances described, a number of the members of the team who did comment on the matter stated in effect that they did not have enough time available to waste their time at an A&P team meeting that was conducted as many of these meetings were and which was subjected to the harrassment and other tactics by the two individuals referred to previously. Several team members did absent themselves from team participation during this period of time despite the fact that earlier they had been conscientious participants to the extent they were permitted to be so by the circumstances. The net result with the obstructionist members present, with other members not participating consistently, and with a weak chairman, was that the team floundered.

Coagulation

In late March 1974, the maturation of the Assessment and Prescription team received a "shot in the arm" that previously had been lacking. This vital boost to the team occurred as a result of the initiative undertaken by the SID Committee of Commissioners.

The end result of the interest and initiative by the Committee of Commissioners was a two day briefing/orientation tour by the Portsmouth A&P team, representatives of the principal Tidewater newspapers, the SID Portsmouth staff, selected members of the Richmond headquarters staff, the directors of Petersburg Training School and Hospital and Central State Hospital. They met with their counterparts from the other pilot project area of the SID project located in Planning District #6. In addition to these officials, others who traveled to Staunton from Richmond included the Secretary of Human Affairs of the Commonwealth of Virginia plus the commissioners or their representatives from the SID Committee of Commissioners. The two day journey from Tidewater was made by chartered bus and included a tour and orientation at Petersburg Training School and Hospital plus witnessing an A&P Team meeting of Planning District #6 to consider mentally ill clients from Western State Hospital. In addition to the more formal settings mentioned above, ample time was available during the hours consumed by round trip bus travel from Portsmouth to Petersburg to Richmond to Staunton and return as well as during informal social gatherings at Staunton for exchanges of experiences concerning the operations of the two pilot project areas plus their relationship to the activities and goals of the state agencies that are represented on the Committee of Commissioners.

The meeting of the Portsmouth A&P team just prior to the briefing/orientation tour to Petersburg and Staunton marked the conclusion of the first round of assessments for Portsmouth clients housed in five of the juvenile institutions operated by the Department of Welfare and Institutions. The proximate entry of the SID Portsmouth staff and A&P team into a different client target group resulted in a team decision that it would be advisable to include amongst its members individuals from Portsmouth and Tidewater who possessed direct knowledge and experience in dealing with the mentally retarded. As a result, four new members were added to the A&P team. These new members also contributed to a change in the team's dynamics and have proven to be a mainstay in the operation of the team to date.

The briefing/orientation tour taken by the Portsmouth A&P team in March 1974 appeared to result in a reorientation of the team's thinking concerning some of the policies and procedures of the Portsmouth Assessment and Prescription team. As a consequence, prior to the first scheduled meeting at which mentally retarded cases would be reviewed, the team made two basic decisions. These were that the team members would interview the clients during the process of reviewing the client's case and that the team would travel to Petersburg to conduct the A&P team meetings. Each of these decisions reflected a complete reversal of the team's earlier attitudes towards these key issues. Each of these decisions likewise appeared to be a direct result of the manner in which the members of the Portsmouth A&P team construed the desires and policies of state-wide officials who also were members of the SID Committee of Commissioners as such policies affected their respective agencies.

Change of Direction

The changes of direction in policy noted above were more overt indications of an overall change of direction insofar as not only the policies but the procedures and functioning of the Assessment and Prescription team were concerned. As the team changed policies, it also changed leadership. The team chairman during the time when the client target group was the juvenile offender did not participate in any further meetings after a change in the client target group to the mentally retarded. The vice chairman served for several meetings until a new permanent chairman could be selected. Under the chairmanship of the vice chairman as well as the newly selected chairman, the A&P team continued to give every evidence the change in direction noted above was not simply a matter of form, it was indeed substantive.

The change of client target group, the change in the meeting site, the decision to interview the clients whereas this previously had not been the case, and the change in chairmanship were reflected in a very substantial change in the conduct of the team meetings. Whereas previously the average productivity of the A&P team had been so markedly low that it required an average of one hour 50 minutes to process one

client during the first four meetings (all JO's), the average time required to process a client during the first four meetings chaired by the new chairman (three MR's and one JO meeting) was only 32 minutes per client and without diminution in the quality of the finished project. This improved productivity has remained relatively constant despite the entry of the team into new institutions with attendant adjustments to changed circumstances.

The selection of the new chairman for the A&P team in itself is indicative of a number of the problems that were confronted much earlier as the team was being formed and as efforts were being made to mold the team into a viable working representation of the service delivery agencies of the City of Portsmouth. The first chairman of the A&P team had been designated as chairman by h's direct supervisor in an effort to fill a void despite the fact that the newly named chairman did not represent a direct service delivery agency but performed primarily in a staff function. His successor was assistant director of a direct service delivery agency that probably had a greater stake in the success of the SID project in developing a viable model than any other single service delivery agency in the city. Nevertheless, the new chairman was not selected by the A&P team itself. His selection did reflect a meeting of the minds between the chairman of the Human Resources Council and his supervisor, the director of the concerned agency. In effect then, although the new chairman was far more professionally qualified and interested in the project, his selection as chairman again illustrated the apparent need to select a chairman on the basis of direct supervisor/employee relationships.

Subsequent changes in the composition of the A&P team have been supportive to the overall improvement of the team activities without being as decisive as was the replacement of the first A&P team chairman. The project has continued with the services of the second A&P team chairman, although on occasion other persons have served as acting chairman. The second chairman has continued to chair the A&P team even after he changed professional positions so that his place of employment was located outside the City of Portsmouth. This site change insofar as employment is concerned has not altered to a noticeable degree the effectiveness of the chairman or the overall efficiency of the A&P team which continues toward improvement albeit at a much slower pace than immediately following the nearly disastrous results of the first few months of operation. Of the five persons who have served as chairman, vice chairman, or acting chairman and recognizing that the role of the team chairman is most critical to the effective functioning of the team, these five have been characterized in effectiveness as ranging from poor to outstanding. The latter rating was applied to the present chairman.

As related earlier, a direct and extremely beneficial result of the change in chairmanship to date has been in the conduct of the meetings. The meetings are directed; they are not permitted to flounder. The new chairman brought a substantial wealth of relevant expertise to the meetings and, in turn, was able to extract from the participants in the meetings their own best contributions to the welfare of the client and to the success of the SID project. Not only is the average team time required to process the client now less than one third what it was under the chairmanship of the first chairman, a greater substantive input has been noted in nearly all cases of those team members who have continued to participate in A&P team meetings.

A key element not touched upon heretofore deserves mention with regard to implementation of the project. This element is that of staff recruitment. Many tedious hours were devoted by top SID staff to the review of applications, checking of references, and the interview of potential SID employees. As noted in a preceding section, the first A&P team chairman was not at all averse to questioning the academic background and relevant experience of the broker advocates. Within this context, it is of particular moment that only after SID Portsmouth had been in operation for nearly 18 months did the chairman of the Portsmouth Mental Health and Mental Retardation Services Board make a direct comment to the community services coordinator concerning the SID broker advocate staff. These comments occurred following a meeting of the MH&MR Services Board at which they had unanimously endorsed the continuation of the SID project in Portsmouth. At that time, the chairman commented to the community services coordinator that she had been skeptical of the abilities of the SID broker advocates to perform their duties as first outlined prior to the start of the project. She then proceeded to elaborate by stating that after a lengthy period of observing the broker advocate staff in action and obtaining reactions from the community, she was thoroughly convinced of the professionalism exhibited by each member of the SID Portsmouth broker advocate staff.

The active participation of a number of the Portsmouth SID staff in community affairs appears to have created a favorable reaction among local officials and perhaps contributed to the relatively easy access to certain officials of the community and to the general sympathetic ear that was lent to requests directed to community service delivery agencies for support of the SID program. Statistical data generated by the project was requested and used by community leaders as they attempted to justify their own requests to local government authorities for particular programs in which they were interested. These data were useful to the Portsmouth MH&MR Services Board chairman and executive director in a request submitted by them for a developmental disabilities grant as well as by the Comprehensive Planning Management office of the City of Portsmouth.

The conclusion is inescapable that despite the active support of the Human Resources Council of the City of Portsmouth, the HRC chairman and other officials of the City of Portsmouth including the city manager, the gestation period leading to a relatively efficient and smooth functioning Assessment and Prescription team and the delivery of integrated services to SID clients was not short. Perhaps, however, the present functioning of the Assessment and Prescription team can be ascribed, at least in part, to the earlier problems encountered with certain members of the team. Whereas some of the team members earlier described as obstructionists took a long time to even have the appearance of supporting the SID project in Portsmouth, they have more recently been known to speak out in support of the SID concept. One of the most vociferous earlier critics of the SID concept, procedures, practices, staff, and financing became supportive of SID as it currently exists to the point where he chose to attend a SID Assessment and Prescription team meeting in preference to a meeting of the Human Resources Council that conflicted with the A&P team meeting. This decision was reached despite the fact that his presence was urgently requested by the chairman and that the superintendent of schools and city manager were going to be present at that meeting. The other earlier critic has recently been instrumental in applying for a program grant to begin the process of filling resource gaps identified by SID-generated data.

All together, the overall changes of direction noted above including the change in team chairmen have resulted in a marked improvement in the output of the Portsmouth portion of the SID pilot project. However, along with this notable improvement it should be equally noteworthy that these improvements actually have resulted from continued improvement in communications between the SID project and the power structure of the city as well as among various elements of the relevant community power structure as reflected in the various service delivery agencies.

APPENDIX C

Methods and Procedures Manual

(bound separately)

APPENDIX D

Assessment and Prescription (A&P) Team Manual

(bound separately)

APPENDIX E

Sample Automated Program Evaluation Reports

- -Assessment Digest
- -Behavioral Repertoire Statistics
- -Prescription Digest
- -Fulfillment of Continued Institutionalization Prescription Digest
- -Resource Search Results
- -Client Status Update
- -Client Processing Summary
- -Broker Advocate Caseload

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* ASSESSMENT DIGEST *

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NUMBER OF CLIENTS PROCESSED: 116

I CLIENTS AGE 60 AND ABOVE FROM WSH OR CSH (LAST ASSESSMENT)

BACKGROUND DATA

VARIABLE	N	%
INSTITUTION OF RESIDENCE		
WSH	86	74.1
CSH	27	23.3
CATAWBA	3	2.6
TOTAL	116	100.0
CITY OF RESIDENCE		
BUENA VISTA	3	2.6
HARRISONBURG	7	6.0
LEXINGTON	2	1.7
PORTSMOUTH	27	23.3
STAUNTON	17	14.7
WAYNESBORO	5	4.3
COUNTY OF RESIDENCE		
AUGUSTA	32	27.6
BATH	3	2.6
HIGHLAND	3	2.6
ROCKBRIDGE	4	3.4
ROCKINGHAM	13	11.2
TOTAL	116	100.0
AGE AT ASSESSMENT		
UNDER 18	0	0.0
18 - 65	41	35.3
OVER 65	75	64.7
TOTAL	116	100.0
* MEAN = 70.99 YRS. (N = 116)		
S.D. = 8.30 YRS.		
RANGE = 59.54 TO 93.06 YRS.		
SEX		
MALE	54	47.4
FEMALE	60	52.6
TOTAL	114	100.0

VARIABLE	N	%
RACE		
WHITE	90	78.
BLACK	25	21.
OTHER	0	0.
TOTAL	115	100.
MARITAL STATUS		
SINGLE (NEVER MARRIED)	38	32.
MARRIED	14	12.
WIDOWED	36	31.
DIVORCED	21	18.
SEPARATED	7	6.
OTHER	0	0.
TOTAL	116	100.
IN INSTITUTION THIS TIME		
LESS THAN 1 YR.	20	17.
1 - 3 YRS.	28	24.
4 - 10 YRS.	20	17.
11 - 20 YRS.	17	14.
OVER 20 YRS.	31	26.
TOTAL	116	99.
* MEAN = 13.83 YRS. (N = 116)		
S.D. = 15.52 YRS.		
RANGE = .20 TO 64.40 YRS.		
TYPE ADMISSION		
FIRST	63	54.
READMISSION	36	31.
TRANSFER	17	14.
TOTAL	116	100.

VARIABLE	N	%	VARIABLE	N	%
ADMISSION STATUS					
VOLUNTARY/SELF	23	19.8			
VOLUNTARY/OTHER	6	5.2			
INVOLUNTARY	73	62.9			
COURT ORDER	6	5.2			
OTHER	8	6.9			
TOTAL	116	100.0			
COMMITTEE ASSIGNED					
UNKNOWN	1	0.9			
NO	91	79.1			
YES	23	20.0			
TOTAL	115	100.0			
INSTITU. HAS PLANS TO MOVE					
UNKNOWN	8	7.1			
NO	71	63.4			
YES	33	29.5			
TOTAL	112	100.0			
PRIOR INSTITUTIONALIZATIONS					
NONE	52	44.8			
ONE	25	21.6			
2 - 3	30	25.9			
MORE THAN 3	9	7.8			
TOTAL	116	100.1			
* MEAN = 1.16 (N = 116)					
S.D. = 1.32					
RANGE = .00 TO 8.00					

FAMILY RESOURCE DATA

VARIABLE	N	%	VARIABLE	N	%
PARENT/GUARDIAN INFORMATION			UNKNOWN IF ANY WILL		
UNKNOWN	55	47.4	HAVE CLIENT IN HOME	0	0.
NO LIVING PAR/GUARD	55	47.4	NONE WILL		
1 LIVING PARENT	5	4.3	HAVE CLIENT IN HOME	6	100.
2 LIVING PARENTS	0	0.0	1 PARENT WILL		
LIVING GUARDIAN(S)	1	0.9	HAVE CLIENT IN HOME	0	0.
TOTAL	116	100.0	BOTH PARENTS WILL		
			HAVE CLIENT IN HOME	0	0.
			GUARDIAN(S) WILL		
			HAVE CLIENT IN HOME	0	0.
			TOTAL	6	100.

VARIABLE	#	%
MARITAL STATUS/FATHER		
UNKNOWN	2	22.2
MAR/CL'S MOTHER	0	0.0
MAR/OTHER	0	0.0
SEP/CL'S MOTHER	0	0.0
SEP/OTHER	0	0.0
SINGLE (NEVER MAR)	0	0.0
DIVORCED (SINGLE)	0	0.0
WIDOWED (SINGLE)	0	0.0
DECEASED	7	77.8
TOTAL	9	100.0
MARITAL STATUS/MOTHER		
UNKNOWN	2	22.2
MAR/CL'S FATHER	0	0.0
MAR/OTHER	0	0.0
SEP/CL'S FATHER	0	0.0
SEP/OTHER	0	0.0
SINGLE (NEVER MAR)	0	0.0
DIVORCED (SINGLE)	0	0.0
WIDOWED (SINGLE)	2	22.2
DECEASED	5	55.6
TOTAL	9	100.0
MARITAL STATUS/GUARDIAN		
UNKNOWN	3	75.0
MARRIED	1	25.0
SEPARATED	0	0.0
SINGLE (NEVER MAR)	0	0.0
DIVORCED (SINGLE)	0	0.0
WIDOWED (SINGLE)	0	0.0
IS COURT OR STATE	0	0.0
TOTAL	4	100.0
SPOUSE INFORMATION		
UNKNOWN	6	5.2
NO LIVING SPOUSE	100	86.2
HAS LIVING SPOUSE	10	8.6
TOTAL	116	100.0
SPOUSE WILL		
UNKNOWN	0	0.0
NOT HAVE CLIENT IN HOME	8	88.9
HAVE CLIENT IN HOME	1	11.1
TOTAL	9	100.0
CHILD(REN) INFORMATION		
UNKNOWN	2	1.7
NO CHILDREN	62	53.4
HAS CHILD UNDER 18	5	4.3
HAS CHILD 18 OR OVER	47	40.5
TOTAL	116	99.9

VARIABLE	#	%
ADULT CHILD WILL		
UNKNOWN	14	30.
NOT HAVE CLIENT IN HOME	31	67.
HAVE CLIENT IN HOME	1	2.
TOTAL	46	100.
OTHER INTERESTED PARTIES WILL		
UNKNOWN	36	31.
NOT HAVE CLIENT IN HOME	75	65.
HAVE CLIENT IN HOME	4	3.
TOTAL	115	100.
CLIENT'S LIVING PREFERENCE		
UNKNOWN	6	5.
CAN'T MAKE DECISION	22	19.
NO PREFERENCE	10	8.
LIVE ALONE	7	6.
LIVE W/ PARENT/GUARDIAN	2	1.
LIVE W/SPOUSE	2	1.
LIVE W/CHILD	6	5.
LIVE IN STATE INSTITU.	9	8.
LIVE ELSEWHERE	49	43.
TOTAL	115	100.
PREVIOUSLY LIVED WITH		
NO ONE (ALONE)	13	11.
PARENT(S)	23	19.
GROWN CHILD	12	10.
SPOUSE	18	15.
OTHER RELATIVE	22	19.
FRIEND(S)	1	0.
OTHER	27	23.
TOTAL	116	100.
PREVIOUSLY LIVED IN		
HOUSE OWNED SELF/FAM	47	40.
HOUSE RENTED SELF/FAM	22	19.
APARTMENT	2	1.
BOARDING HOUSE/HOTEL	6	5.
NURSING HOME/REG. SIT	9	7.
OTHER	29	25.
TOTAL	115	99.

PHYSICAL CONDITION DATA

VARIABLE	#	%
GENERAL PHYSICAL CONDITION		
EXCELLENT	0	0.0
GOOD	44	37.9
FAIR	68	58.6
POOR	4	3.4
TOTAL	116	99.9
OVERALL APPEARANCE		
NORMAL	75	64.7
UNATTRACTIVE	32	27.6
TELL IS RETARDED	2	1.7
OBVIOUS STIGMATA	6	5.2
MIGHT BE SHOCKING	1	0.9
TOTAL	116	100.1
MOBILITY		
COMPLETELY MOBILE	72	62.1
WALK W/DIFFICULTY	16	13.8
WALK/STAIRS A PROB.	5	4.3
WALK W/ ASSISTANCE	11	9.5
MOBILE IN WHEEL CHAIR	3	2.6
NEEDS HELP W/ WH CHAIR	6	5.2
IMMOBILE/BEDFAST	3	2.6
TOTAL	116	100.1
INTELLIGENCE		
ABOVE AVERAGE	2	1.7
AVERAGE	55	47.8
BORDERLINE RETARDED	16	13.9
MILDLY RETARDED	3	2.6
MODERATELY RETARDED	6	5.2
SEVERELY RETARDED	4	3.5
PROFOUNDLY RETARDED	1	0.9
UNDETERMINABLE/TESTED	9	7.8
UNKNOWN/NOT TESTED	19	16.5
TOTAL	115	99.9
RELATIONS WITH OTHERS		
INDIFFERENT	18	15.5
HOSTILE	0	0.0
FRIENDLY/PER HOSTILITY	28	24.1
FRIENDLY	49	42.2
SUBMISSIVE	1	0.9
OTHER	20	17.2
TOTAL	116	99.9

VARIABLE	#	%
SPECIFIC TREATMENT REGIMEN		
UNKNOWN	0	0.0
NONE	32	27.6
YES	84	72.4
TOTAL	116	100.0
CONTINUE TREAT. REGIMEN		
UNKNOWN	5	6.1
NO	22	26.8
YES	55	67.1
TOTAL	82	100.0
RECEIVES MEDICATION		
UNKNOWN	0	0.0
NO	14	12.1
YES	102	87.9
TOTAL	116	100.0
EMPLOYMENT LIMITS/PHYS		
UNKNOWN	10	8.8
NO	20	17.7
YES	83	73.5
TOTAL	113	100.0
SPECIAL DIET REQUIRED		
UNKNOWN	0	0.0
NO	74	64.3
YES	41	35.7
TOTAL	115	100.0

BODY SYSTEM AFFECTED	PROBLEM IN PAST N*	PROBLEM IN PAST %	CURRENTLY PRESENT N*	CURRENTLY PRESENT %	CURRENTLY BEING TREATED N*	CURRENTLY BEING TREATED %**
CENTRAL NERVOUS	27	5.9	26	6.7	12	46.2
CIRCULATORY	60	13.1	59	15.1	32	54.2
GASTRO-INTESTINAL	22	4.8	17	4.4	11	64.7
GENITAL-URINARY	32	7.0	25	6.4	11	44.0
METABOLIC	21	4.6	18	4.6	14	77.8
MUSCULAR/SKELETAL	38	8.3	25	6.4	10	40.0
NEOPLASM	4	0.9	2	0.5	2	100.0
PULMONARY	24	5.2	12	3.1	5	41.7
RECTAL	8	1.7	5	1.3	1	20.0
RESPIRATORY	11	2.4	6	1.5	2	33.3
SENSE ORGANS	36	7.9	39	10.0	11	28.2
SKIN/LYMPH	18	3.9	12	3.1	3	25.0
DENTAL	42	9.2	34	8.7	6	17.6
SPEECH/LANGUAGE	12	2.6	13	3.3	1	7.7
INTELLIGENCE	17	3.7	22	5.6	5	22.7
BEHAVIORAL	55	12.0	49	12.6	13	26.5
OTHER	31	6.8	26	6.7	7	26.9
TOTAL	458	100.0	390	100.0	146	37.4

* N = NO. OF CLIENTS HAVING AT LEAST ONE PROBLEM WITH THE DESIGNATED BODY SYSTEM
** CURRENTLY TREATED PERCENTAGE BASED ON CURRENTLY PRESENT

EDUCATIONAL HISTORY DATA

VARIABLE	N	%
REGULAR SCHOOLING		
UNKNOWN	12	10.5
NONE	8	7.0
COMPLETED 1-3 GRADES	10	8.8
COMPLETED 4-7 GRADES	45	39.5
COMPLETED 8 GRADES	10	8.8
COMPLETED 9-11 GRADES	12	10.5
COMPLETED 12 GRADES	7	6.1
COMPLETED 13-15 GRADES	4	3.5
COMPLETED 16 GRADES	5	4.4
COMPLETED 17 OR MORE	1	0.9
TOTAL	114	100.0
* MEAN = 7.03 YRS. (N = 102)		
S.D. = 4.32 YRS.		
RANGE = .00 TO 17.00 YRS.		
SPECIAL UNGRADED CLASS		
UNKNOWN	29	28.2
NONE	74	71.8
COMPLETED 1-3 GRADES	0	0.0
COMPLETED 4-7 GRADES	0	0.0
COMPLETED 8 GRADES	0	0.0
COMPLETED 9-11 GRADES	0	0.0
COMPLETED 12 GRADES	0	0.0
COMPLETED 13 OR MORE	0	0.0
TOTAL	103	100.0
* MEAN = .00 YRS. (N = 0)		
S.D. = YRS.		
RANGE = .00 TO .00 YRS.		
SPECIAL SCHOOL OUTSIDE INST.		
UNKNOWN	27	25.7
NO	72	68.6
YES	6	5.7
TOTAL	105	100.0
SCHOOL IN INSTITUTION		
UNKNOWN	14	13.7
NO	87	85.3
YES	1	1.0
TOTAL	102	100.0

VARIABLE	N	%
WANTS TO CONTINUE EDUCATION		
UNKNOWN	9	7.
NOT APPLICABLE	77	67.5
NO	25	21.9
IN REG. ACADEMIC SET.	0	0.
IN VOCATIONAL SCHOOL	0	0.
IN SPECIAL ED. SET.	0	0.0
IN G.E.D. PROGRAM	1	0.9
IN OTHER SIT.	2	1.
TOTAL	114	100.0

VARIABLE	N	%
EMPLOYMENT CAPABILITY		
SELF-SUPPORTING	1	0.9
PART SELF-SUPPORTING	10	8.6
NEEDS ED. OR TRG.	6	5.2
INCAPABLE	92	79.3
OTHER	7	6.0
TOTAL	116	100.0
MOTIVATION		
VERY HIGHLY MOTIV.	4	9.1
SOMEWHAT MOTIV.	9	20.5
QUESTIONABLE MOTIV.	6	13.6
NOT WELL MOTIV.	4	9.1
NOT MOTIV. AT ALL	18	40.9
OTHER	3	6.8
TOTAL	44	100.0
JOBS IN INSTITUTION		
UNKNOWN	2	1.8
NONE	92	82.1
1 JOB	14	12.5
2 - 3 JOBS	4	3.6
TOTAL	112	100.0
* MEAN = .22 (N = 110)		
S.D. = .56		
RANGE = .00 TO 3.00		
V.E. EVAL. IN INSTITUTION		
UNKNOWN	10	9.8
NONE	88	86.3
UNREADY TRG/NO RE-EVAL	2	2.0
UNREADY TRG/PLAN RE-EV	0	0.0
READY TRG/NO REFERRAL	0	0.0
READY TRG/REFERRED	2	2.0
IN TRG PROGRAM	0	0.0
OTHER	0	0.0
TOTAL	102	100.1
V.E. TRG. IN INSTITUTION		
UNKNOWN	5	4.5
NONE	102	91.1
TRG IN 1 PROGRAM	4	3.6
TRG IN MORE THAN 1	1	0.9
TOTAL	112	100.1

VARIABLE	N	%
JOB PREFERENCE IN COMM.		
UNKNOWN	4	3.7
NOT APPLICABLE	75	68.8
NONE	12	11.0
HAS PREFERENCE	18	16.5
TOTAL	109	100.0
HAS DRIVER'S LICENSE		
UNKNOWN	5	0.9
NO	106	91.4
YES	2	1.7
TOTAL	116	100.0
HAS ACCESS TO CAR		
UNKNOWN	0	0.0
NO	1	50.0
YES, ACCESS	0	0.0
YES, OWNS CAR	1	50.0
TOTAL	2	100.0
ABLE TO USE PUB. TRANS.		
UNKNOWN	8	7.1
NOT APPLICABLE	61	54.0
NO	29	25.7
YES	15	13.3
TOTAL	113	100.1
WILLING TO USE PUB. TRANS		
UNKNOWN	6	40.0
NO	0	0.0
YES	9	60.0
TOTAL	15	100.0
CLIENT HAS PROP/ASSETS		
UNKNOWN	7	6.4
NO	56	50.9
YES	47	42.7
TOTAL	110	100.0
* MEAN = $ 2,722 (N = 103)		
S.D. = $ 11,268		
RANGE = $ 0 TO $ 100,000		

INSTITUTION: 05M

PAYER	N	%
1 = COMMONWEALTH OF VA.	29	34.5
2 = CLIENT/FAMILY	5	5.8
3 = THIRD PARTY	15	17.9
1 AND 2	4	4.8
1 AND 3	26	31.0
2 AND 3	3	3.6
1, 2 AND 3	2	2.4
BREAKDOWN NOT AVAILABLE	2	2.4
TOTAL	84	100.2

WITH 84 CLIENTS, AVERAGE COST PER CLIENT MONTH = $ 338.13

	MEAN	%
COMMONWEALTH PAYS	$ 227.92	67.4
CLIENT/FAMILY PAYS	$ 26.79	7.9
THIRD PARTY PAYS	$ 96.82	28.6
UNACCOUNTED FOR	$ -13.40	4.0
TOTAL	$ 338.13	99.9

INSTITUTION: 05M

PAYER	N	%
1 = COMMONWEALTH OF VA.	17	65.4
2 = CLIENT/FAMILY	0	0.0
3 = THIRD PARTY	1	3.8
1 AND 2	1	3.8
1 AND 3	7	26.9
2 AND 3	0	0.0
1, 2 AND 3	0	0.0
BREAKDOWN NOT AVAILABLE	0	0.0
TOTAL	26	99.9

WITH 26 CLIENTS, AVERAGE COST PER CLIENT MONTH = $ 403.30

	MEAN	%
COMMONWEALTH PAYS	$ 337.88	83.8
CLIENT/FAMILY PAYS	$ 5.31	1.3
THIRD PARTY PAYS	$ 46.03	11.4
UNACCOUNTED FOR	$ 14.08	3.5
TOTAL	$ 403.30	100.0

INSTITUTION: CATAWBA

PAYOR	#'s	%
1 = COMMONWEALTH OF VA.	0	0.0
2 = CLIENT/FAMILY	0	0.0
3 = THIRD PARTY	2	66.7
1 AND 2	0	0.0
1 AND 3	0	0.0
2 AND 3	1	33.3
1, 2 AND 3	0	0.0
BREAKDOWN NOT AVAILABLE	0	0.0
TOTAL	3	100.0

WITH 5 CLIENTS, AVERAGE COST PER CLIENT MONTH = $ 840.01

		MEAN	%
COMMONWEALTH PAYS	$	.00	0.0
CLIENT/FAMILY PAYS	$	97.50	11.6
THIRD PARTY PAYS	$	840.00	100.0
UNACCOUNTED FOR	$	-97.49	11.6
TOTAL	$	840.01	100.0

INSTITUTION: WSH

HOURS SPENT COMPILING INFORMATION FOR

	N	MEAN	%
FORMS 2 THROUGH 7	83	6 HRS. 0 MIN.	83.6
FORM 8	83	1 HRS. 10 MIN.	16.4
ALL ASSESSMENT FORMS (2 - 8)		7 HRS. 10 MIN.	100.0

INSTITUTION: CSH

HOURS SPENT COMPILING INFORMATION FOR

	N	MEAN	%
FORMS 2 THROUGH 7	23	4 HRS. 15 MIN.	85.0
FORM 8	23	0 HRS. 45 MIN.	15.0
ALL ASSESSMENT FORMS (2 - 8)		5 HRS. 3 MIN.	100.0

INSTITUTION: CATAWBA

HOURS SPENT COMPILING INFORMATION FOR

	N	MEAN	%
FORMS 2 THROUGH 7	3	6 HRS. 30 MIN.	90.7
FORM 8	3	0 HRS. 40 MIN.	9.3
ALL ASSESSMENT FORMS (2 - 8)		7 HRS. 10 MIN.	100.0

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* BEHAVIORAL REPERTOIRE *

* GROUP STATISTICS *

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NUMBER OF CLIENTS PROCESSED: 116

MI CLIENTS AGE 60 AND ABOVE FROM WSH OR CSH (LAST ASSESSMENT)

ADAP BEHAVIORS	N/TOTAL		MEAN	S.D.
ALL	17431/	17864	1.82	1.84
MOBILITY/LOCOMTN	1965/	1972	2.49	1.83
EATING	1495/	1508	3.17	1.55
DRESS/GROOMING	2183/	2204	2.45	1.79
WRITING SKILLS	1140/	1160	1.55	1.78
READING SKILLS	1122/	1160	1.75	1.79
TALKING SKILLS	792/	812	2.38	1.80
ANIMAL	571/	580	2.58	1.73
SOCIALIZATION	1020/	1044	1.79	1.77
MONEY MANAGEMENT	889/	926	1.35	1.75
INTELLECT/COGNTV	1234/	1276	2.13	1.68
ADULT	449/	464	2.71	1.58
WORK	575/	580	0.58	1.29
HOUSEKEEPING	1137/	1160	1.00	1.49
FREETIMES	2854/	3016	0.45	1.10

MALADP BEHAVIORS	N/TOTAL		MEAN	S.D.
ALL	7771/	7868	0.42	1.0
FAULTY SOCIALZTN	3332/	3364	0.44	1.0
ASSAULTIVE	576/	580	0.08	0.5
SELF DESTRUCTIVE	809/	812	0.26	0.9
PHOBIAS	1022/	1044	0.08	0.5
DISORIENTATION	687/	696	1.37	1.7
COMPLAINTS/SYMPT	1345/	1392	0.41	1.0

ADAPTIVE BEHAVIORS

	NATURAL	MEAN	SD
MOBILITY/LOCOMOTN	1965/ 1972	2.49	1.83
DRIVES CAR	113	0.10	0.44
TRAVELS UNACCOMP	114	0.57	1.12
PUB TRANS UNACCOMP	115	0.67	1.27
LEAVES GRDS UNATT	116	0.72	1.33
LEAVES GRDS ATTEND	116	2.22	1.51
MOVES IN GROUNDS	116	2.40	1.74
MOVES IN BUILDING	116	3.09	1.52
MOVES IN ROOM	116	3.31	1.38
RUNS	116	1.13	1.73
WALKS UP/DN STAIRS	115	2.49	1.77
WALKS UNATDED	116	3.17	1.56
AMBULATES W/ASSIST	116	3.55	1.21
AVOIDS OBSTACLES	116	3.52	1.26
STANDS ALONE	116	3.45	1.36
SITS UNSUPPORTED	116	3.90	0.64
REACHED FOR OBJS	116	3.95	0.41
BALANCES HEAD	116	3.95	0.41
EATING	1495/ 1508	3.17	1.55
COOKS FOR OTHERS	109	0.35	0.88
COOKS OWN FOOD	112	0.51	1.00
FEEDS SELF	115	3.83	0.73
CUTS WITH KNIFE	116	2.95	1.67
SPREADS WITH KNIFE	116	3.05	1.58
WATER UNASSISTED	115	3.69	1.05
USES FORK	116	3.59	1.04
USES SPOON	116	3.84	0.75
DRINKS UNASSISTED	116	3.83	0.77
DISCRIM EDIBLE	116	3.72	0.96
CHEWS FOOD	116	3.84	0.75
NO DROOLING	116	3.76	0.92
DRINKS W/ASSISTNC	116	3.93	0.45
DRESS/GROOMING	2163/ 2204	2.45	1.79
SEWS FOR SELF/OTH	112	0.47	1.07
HELPS DRESS OTHERS	114	0.61	1.18
SELECTS CLOTHES	115	1.77	1.83
NEAT APPEARANCE	115	2.63	1.63
SELF CARE RE DRESS	115	2.20	1.75
BATHES UNATTENDED	116	1.93	1.91
SHAVES	114	1.66	1.88
WASHES HAIR	116	1.87	1.89
COMBS/BRUSHES HAIR	116	2.61	1.72
BRUSHES TEETH	114	2.34	1.82
WASHES FACE	116	3.00	1.44
DRIES HANDS	116	3.12	1.39
WASHES HANDS	116	3.11	1.39
TIES SHOES	115	2.63	1.74
UNDRESSES APPROP	114	2.88	1.67
URINATES BATHROOM	115	3.34	1.28
DEFECATES BATHROOM	115	3.40	1.24
NOT USE HELPAN	115	3.37	1.39
NOT USE DIAPERS	114	3.52	1.27

	NATURAL	MEAN
WRITING SKILLS	1140/ 1160	1.55
AR ES, BOOKS	113	0.04
POETRY, STORIES	113	0.08
WRITES LETTERS	114	1.18
LETTERS W/ASSIST	114	1.48
SENTENCES	114	1.77
WORDS	115	1.66
LETTERS OF ALPHABT	115	2.16
GEOMETRIC DESIGNS	114	2.07
COLORS IN LINES	114	2.19
MARKS WITH CRAYON	114	2.58
READING SKILLS	1122/ 1160	1.75
BOOKS, ARTICLES	112	0.54
NOVELS, MAGAZINES	111	0.97
NEWSPAPER	113	1.25
CHILDREN'S BOOKS	111	1.46
SIMPLE MESSAGES	112	1.85
SENTENCES	112	2.04
SINGLE WORDS	112	2.13
LETTERS OF ALPHABT	113	2.22
NUMERALS	113	2.47
NAMES COLORS	113	2.57
TALKING SKILLS	792/ 812	2.34
PUBLIC SPEECHES	113	0.10
CONVERSES OK	115	2.65
FLUENT SPEECH	114	2.60
USES TELEPHONE	113	2.08
TELEGRAPHIC SPEECH	111	2.54
SINGLE WORDS	113	3.29
SOME SPEECH	113	3.48
AUDAL	571/ 580	2.56
COMPREHENDS LECTRS	113	1.14
COMPREHENDS CONVER	115	3.04
USES TELEPHONE	114	2.21
FOLLOWS DIRECTIONS	114	3.14
SIMPLE COMMANDS	115	3.34
SOCIALIZATION	1060/ 1080	1.74
CIVIC GROUPS	113	0.54
RESPONSIBLITIS OTH	113	0.77
TENDS TO OTHERS	112	0.85
GROUP ACTIVITIES	112	1.47
SMALL GROUPS	113	1.96
HAS FRIENDS	113	2.23
SEEKS COMPANIONSHP	114	1.93
ASKS FOR HELP	115	2.70
AWARE OF OTHERS	115	3.70

ADAPTIVE BEHAVIORS (CONTINUED)

	INITIAL		MEAN	S.D.
MONEY MANAGEMENT	869/	928	1.55	1.75
FINANCIAL AFFAIRS	113		0.33	0.92
CREDIT CARDS	111		0.29	0.89
CHECKS	113		0.51	1.19
HANDLES CASH	114		1.39	1.71
MAKES CHANGE	109		1.55	1.85
SIMPLE PURCHASES	111		1.95	1.84
COIN DISPENSERS	110		2.01	1.86
DISCRIMINATES COIN	108		2.56	1.79
INTELLECT/COGNIT	1239/	1276	2.13	1.68
COMMON SENSE	113		2.19	1.61
SOCIAL JUDGMENT	113		1.97	1.66
GENERAL INFORMATN	114		1.80	1.65
APPLIES LEARNING	112		1.87	1.66
EXPRESSES IDEAS	114		2.18	1.68
LEARNS NEW TASKS	113		1.65	1.54
NUMERICAL CONCEPTS	108		1.88	1.81
SENSE OF HUMOR	112		2.38	1.64
RESPONDS TO TV	113		2.28	1.69
RESPONDS TO MUSIC	114		2.35	1.61
DANGERS/HAZARDS	113		2.88	1.65
EFFECT	449/	464	2.71	1.58
JOY WHEN HAPPY	115		2.81	1.53
SAD WHEN SAD	113		2.73	1.58
ANGER WHEN BLOCKED	113		2.74	1.57
LOVE TO OTHERS	108		2.54	1.63
WORK	575/	580	0.58	1.29
CLERICAL/PROFESSNL	115		0.00	0.00
SKILLED	115		0.03	0.28
SEMI-SKILLED	115		0.25	0.77
UNSKILLED	115		0.87	1.50
ROUTINE CHORES	115		1.76	1.79

	INITIAL		MEAN	S.D.
HOUSEKEEPING	1137/	1166	1.00	1.
COOKS	112		0.64	1.
WASHES CLOTHES	113		0.73	1.
CLEANS HOUSE	114		0.87	1.
MAINTENANCE TASKS	113		0.34	0.
GARDENS	112		0.39	0.
MOWS LAWN	113		0.35	0.
MAKES BED	116		1.93	1.
SIMPLE MAINTENANCE	114		0.97	1.
PICK UP AREA	115		1.96	1.
EMPTIES WASTEBASKT	115		1.77	1.
PASTIMES	2654/	3016	0.45	1.
MUSIC INSTRUMENT	110		0.13	0.
SINGS	111		0.69	1.
DANCES	109		0.45	1.
PAINTS, DRAWS	109		0.24	0.
SCULPTS	111		0.03	0.
CRAFTS	111		0.48	1.
PLAYS SPORTS	111		0.05	0.
WATCHES SPORTS	111		0.64	1.
RIDES HORSES	110		0.03	0.
HUNTS/FISHES	109		0.06	0.
RIDES BICYCLE	111		0.05	0.
PLAYS CARDS	108		0.43	0.
ACTS IN PLAYS	110		0.03	0.
CHESS/CHECKERS	110		0.40	0.
READS	110		1.15	1.
TABLE GAMES	108		0.59	1.
SEWS/KNITS	108		0.43	1.
WATCHES TV	113		2.26	1.
CONVERSES	114		2.39	1.
CROSSWORDS	111		0.25	0.
COLORS	107		0.37	0.
PLAYS WITH TOYS	108		0.11	0.
SWINGS	108		0.08	0.
SKIPS ROPE	108		0.07	0.
HIDE/SEEK	109		0.06	0.
PEEK-A-BOO	109		0.06	0.

CONTINUED

1 OF 2

MALADAPTIVE BEHAVIORS

	N/TOTAL		MEAN	S.D.
POOR SOCIALIZA	3332/	3364	0.44	1.03
SLOPPY/DIRTY	115		1.30	1.53
NEGLECTS PERSON	115		1.45	1.56
NEGLECTS RESPONSIB	113		1.35	1.65
BULLIES OTHERS	115		0.39	0.93
BODY ODOR	115		0.77	1.31
ARGUES	115		0.72	1.07
YELLS AND SCREAMS	114		0.26	0.82
TALKS EXCESSIVELY	115		0.28	0.87
CRIES EXCESSIVELY	115		0.10	0.45
MUMBLES	115		0.70	1.17
LAUGHS INAPPROP	114		0.49	1.05
ANSWERS INAPPROP	114		0.46	0.98
DISOBEYS DIRECTNS	116		0.60	1.09
GIVES ORDERS INAP	114		0.26	0.86
PACES FLOOR	115		0.53	1.22
WRINGS HANDS	115		0.19	0.70
AVOIDS PEOPLE	115		0.62	1.21
SITS AND STARES	115		0.83	1.35
FASTS	115		0.19	0.69
ANNOUNCES WORTHLES	115		0.17	0.66
STEALS	113		0.06	0.34
HOARDS	116		0.24	0.80
LIES	116		0.22	0.77
RUNS AWAY	115		0.22	0.69
TRUANCY	114		0.09	0.49
CRUDE SEX TALK	115		0.03	0.26
MASTURBATES PUBLIC	116		0.05	0.32
EXHIBITS GENITALS	116		0.07	0.37
VOYEURISTIC	116		0.03	0.28
ASSAULTIVE	576/	580	0.08	0.39
DESTROYS PROPERTY	116		0.07	0.34
HARMS ANIMALS	115		0.00	0.00
THREATENS OTHERS	115		0.21	0.60
ASSAULTS OTHERS	116		0.12	0.46
ATTACKS SEXUALLY	114		0.02	0.19

	N/TOTAL		MEAN	S.D.
SELF DESTRUCTIVE	809/	812	0.26	0.
SMOKES	116		1.23	1.
ALCOHOL TO EXCESS	114		0.51	0.
USES DRUGS	115		0.01	0.
INJURIES SELF	116		0.11	0.
TAKES COSTLY RISKS	116		0.10	0.
THREATENS SUICIDE	116		0.03	0.
ATTEMPTS SUICIDE	116		0.02	0.
PHOBIAS	1022/	1048	0.08	0.
DOCTORS	115		0.06	0.
DEATH	113		0.08	0.
DARKNESS/NIGHT	115		0.02	0.
LOSS OF SANITY	114		0.05	0.
BEING ALONE	113		0.00	0.
FIRE	115		0.00	0.
BEING HARMED	114		0.03	0.
LEAVING SURROUNDS	113		0.27	0.
OTHER	110		0.24	0.
DISORIENTATION	687/	698	1.37	1.
TIME	115		1.64	1.
PLACE	114		1.35	1.
PEOPLE	115		1.17	1.
RECENT EVENTS	115		1.69	1.
PAST EVENTS	113		1.66	1.
AMNESIA PERIODS	115		0.69	1.
COMPLAINTS/SYMPT	1345/	1392	0.41	1.
FATIGUE	115		0.28	0.
BODY DISCOMFORTS	115		0.69	1.
TICS	115		0.10	0.
WETS BED	114		0.71	1.
WETS CLOTHES	115		0.64	1.
HALLUCINATES	111		0.43	1.
DELUSIONS	110		0.29	0.
REPETITIVE BEHAVOR	116		0.41	1.
EXCESSIVE RELIG	116		0.10	0.
SOILS BED	111		0.54	1.
SOILS CLOTHES	111		0.52	1.
OTHER	96		0.08	0.

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* PRESCRIPTION DIGEST *

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NUMBER OF CLIENTS PROCESSED: 100

1 CLIENTS AGE 60 AND ABOVE FROM WSH OR CSH (LAST PRESCRIPTION)

GENERAL DATA

VARIABLE	N	%
INSTITUTION OF RESIDENCE		
WSH	80	80.0
CSH	20	20.0
TOTAL	100	100.0
CITY OF RESIDENCE		
BUENA VISTA	3	3.0
HARRISONBURG	6	6.0
LEXINGTON	2	2.0
PORTSMOUTH	20	20.0
STAUNTON	13	13.0
WAYNESBORO	5	5.0
COUNTY OF RESIDENCE		
AUGUSTA	31	31.0
BATH	1	1.0
HIGHLAND	3	3.0
ROCKBRIDGE	4	4.0
ROCKINGHAM	12	12.0
TOTAL	100	100.0
PRESCRIPTION DECISIONS		
COMMUNITY PLACEMENT	73	73.0
CONTINUE IN INSTITUTION	27	27.0
TOTAL	100	100.0

VARIABLE	N	%
PRESCRIPTION HISTORY		
NOT PREVIOUSLY COME BEFORE TEAM	76	76.
CONTINUED INSTI PRESC BEFORE	14	14.
COMM PLCMT PRESC BEFORE- COMM RES. UNAVAIL	0	0.
COMM PLCMT PRESC BEFORE- CL IN COMM/BRKDN OF SER	0	0.
COMM PLCMT PRESC BEFORE- CL NOW REINSTI	3	3.
COMM PLCMT PRESC BEFORE- EARLY RELEASE BY INST	0	0.
OTHER	5	5.
TOTAL	100	100.
REASONS STILL IN INSTI		
LEGAL REST/CAN'T LIFT	0	0.
LEGAL REST/CAN BE LIFT	2	1.
PHYS COND/CONTD CARE	6	5.
BEHAV COND/CONTD CARE	8	7.
OVERALL COND/CONTD CARE	10	8.
DANGER TO SELF	0	0.
DANGER TO OTHERS	0	0.
DISCHAR'BLE/NO SEARCH	25	22.
DISCHAR'BLE/NO RESRCE	11	9.
RECENTLY DISCHAR'BLE	17	14.
FAM MEM NO BRIDGE	6	5.
INSTI PROTECTIVE	2	1.
PLACED OUT/RETURNED	8	7.
CL REFUSED TO LEAVE	5	4.
INSTI RELIES ON CL	0	0.
OTHER	12	10.
TOTAL	115	99.

COMMUNITY PLACEMENT PRESCRIPTIONS DATA

VARIABLE	N	%
REASON FOR DECISION		
INAPPROP INSTL INIT	9	12.3
INSTL DELETERIOUS	0	0.0
NO FURTHER IMPROVE	29	39.7
ALTER PREFERABLE	34	46.6
OTHER	1	1.4
TOTAL	73	100.0
IDEAL HOUSING PRESC		
BOARDING HOUSE	3	4.1
RESIDENTIAL HOTEL	1	1.4
FOSTER HOME/M.I.	3	4.1
FOSTER HOME/M.R.	0	0.0
FOSTER HOME/J.O.	0	0.0
FOSTER HOME/OTHER	4	5.5
HALFWAY HOUSE/M.I.	1	1.4
HALFWAY HOUSE/M.R.	1	1.4
HALFWAY HOUSE/J.O.	0	0.0
HALFWAY HOUSE/OTHER	2	2.7
GROUP HOME/M.I.	0	0.0
GROUP HOME/M.R.	1	1.4
GROUP HOME/J.O.	0	0.0
GROUP HOME/OTHER	10	13.7
NURSING HOME	25	34.2
HOME FOR ADULTS	12	16.4
RESIDE W/RELATIVE	8	11.0
INDEP. LIVING	0	0.0
TRG SCHOOL/BLIND	0	0.0
V.R. RES. FACIL	0	0.0
OTHER	2	2.7
TOTAL	73	100.0

VARIABLE	N	%
2ND CHOICE HOUSING PRESC		
BOARDING HOUSE	5	9.
RESIDENTIAL HOTEL	0	0.
FOSTER HOME/M.I.	4	7.
FOSTER HOME/M.R.	0	0.
FOSTER HOME/J.O.	0	0.
FOSTER HOME/OTHER	15	27.
HALFWAY HOUSE/M.I.	0	0.
HALFWAY HOUSE/M.R.	0	0.
HALFWAY HOUSE/J.O.	0	0.
HALFWAY HOUSE/OTHER	1	1.
GROUP HOME/M.I.	6	11.
GROUP HOME/M.R.	1	1.
GROUP HOME/J.O.	0	0.
GROUP HOME/OTHER	1	1.
NURSING HOME	5	9.
HOME FOR ADULTS	12	22.
RESIDE W/RELATIVE	1	1.
INDEP. LIVING	1	1.
TRG SCHOOL/BLIND	0	0.
V.R. RES. FACIL	0	0.
OTHER	2	3.
TOTAL	54	100.
3RD CHOICE HOUSING PRESC		
BOARDING HOUSE	0	0.
RESIDENTIAL HOTEL	3	8.
FOSTER HOME/M.I.	1	2.
FOSTER HOME/M.R.	1	2.
FOSTER HOME/J.O.	0	0.
FOSTER HOME/OTHER	8	21.
HALFWAY HOUSE/M.I.	0	0.
HALFWAY HOUSE/M.R.	0	0.
HALFWAY HOUSE/J.O.	0	0.
HALFWAY HOUSE/OTHER	0	0.
GROUP HOME/M.I.	0	0.
GROUP HOME/M.R.	0	0.
GROUP HOME/J.O.	1	2.
GROUP HOME/OTHER	1	2.
NURSING HOME	5	13.
HOME FOR ADULTS	11	29.
RESIDE W/RELATIVE	3	8.
INDEP. LIVING	1	2.
TRG SCHOOL/BLIND	0	0.
V.R. RES. FACIL	0	0.
OTHER	2	5.
TOTAL	37	99.

VARIABLE	#	%
INCOME SUGGESTIONS		
OWN RESOURCES/INCOME	46	25.7
FAMILY'S RESOURCES	9	5.0
S.S.I.	33	18.4
PUBLIC ASST	26	14.5
MEDICAID	31	17.3
MEDICARE	22	12.3
SOC.SEC. DISABILITY	10	5.6
OTHER DISABILITY	1	0.6
VOC REHAB BENEFITS	1	0.6
OTHER	0	0.0
TOTAL	179	100.0
* MEAN SUGG/CL = 2.45 (N = 73)		
S.D. = 1.23		
RANGE = 1.00 TO 5.00		
OTHER PRESCRIPTION AREAS		
JOB TRG/PLACEMENT PRESC		
ELDERLY ACTIVITY CTR	36	65.5
EMP COUNSEL/VEC	4	7.3
EMP COUNSEL/V.R.	4	7.3
EVAL & REF/V.R.	4	7.3
JOB TRG/V.R.	2	3.6
SHELT WKSHOP	3	5.5
OTHER	2	3.6
TOTAL	55	100.1
PHYSICAL HEALTH PRESC		
DENTAL CARE	23	10.1
FAM PLG/SEX ED	0	0.0
REV PHARM INTAKE	18	7.9
MANGMT TRG/BLIND	1	0.4
PHYSICIAN	72	31.6
PHARM W/SUPERVISION	47	20.6
PHARM W/O SUPERVISION	12	5.3
PHYSICAL THERAPY	11	4.8
PROTHESES	7	3.1
PUB HLTH NURSE ASSGN	14	6.1
VISUAL EVAL	8	3.5
AURAL EVAL	3	1.3
OTHER	12	5.3
TOTAL	228	100.0

VARIABLE	#	%
SOC/PSYCH HEALTH PRESC		
ACTIVITY CNTR/DAY CARE	13	5
BEHAVIOR MOD	5	2
C.A.T.	39	17
DAY HOSP DRUG	0	0
FAMILY COUNSEL	25	10
GROUP THERAPY	2	0
INDIV THERAPY	1	0
REV PT'S DIAGNOSIS	17	7
LEGAL AID	8	3
PROTECT PAYEE ASSGN	8	3
MEN HLTH AFTERCARE	58	25
PROB OFFICER ASSGN	0	0
SOCIAL CLUB MEM	27	11
OTHER	26	11
TOTAL	229	100
EDUCATION PRESC		
ADULT ED	0	0
G.E.D. PROGRAM	0	0
HEARING THERAPY	0	0
HOME TEACHING	0	0
PART-TIME SPEC CLASS	0	0
POST-H.S. PROGRAM	0	0
REGULAR CLASS	0	0
SPECIAL CLASS	0	0
SPEECH THERAPY	0	0
VISITING TEACH ASSGN	1	100
OTHER	0	0
TOTAL	1	100
SUMMARY: OTHER AREAS PRESC		
JOB TRG/PLCMT	55	10
PHYSICAL HLTH	228	44
SOC/PSYCH HEALTH	229	44
EDUCATION	1	0
TOTAL	513	98
* MEAN JOB TRG PL = 0.75 (N = 73)		
S.D. = 0.64		
RANGE = 0.00 TO 3.00		
* MEAN PHYS HLTH = 3.12 (N = 73)		
S.D. = 1.21		
RANGE = 0.00 TO 6.00		
* MEAN SOC/PSYCH = 3.14 (N = 73)		
S.D. = 1.36		
RANGE = 0.00 TO 6.00		
* MEAN EDUCATION = 0.01 (N = 73)		
S.D. = 0.12		
RANGE = 0.00 TO 1.00		
* MEAN ALL OTHER = 7.03 (N = 73)		
S.D. = 2.15		
RANGE = 0.00 TO 12.00		

CONTINUED INSTITUTIONALIZATION PREDICTION DATA

VARIABLE	N	%
REASON FOR DECISION		
TRTMT SERV NEEDED	13	48.1
ED/TRG SERV NEEDED	4	14.8
EVAL SERV NEEDED	3	11.1
MAINTEN SERV NEEDED	7	25.9
OTHER	0	0.0
TOTAL	27	99.9
WESTERN STATE		
CHILDREN		
EDUCATION PROGRAM IN INST	0	0.0
GROUP PSYCHOTHERAPY	0	0.0
MEDICAL/DENTAL TREATMENT	1	2.7
RECREATIONAL THERAPY	0	0.0
ADULT		
BEHAVIOR MODIFICATION	1	2.7
CHIRP	0	0.0
EVALUATION BY VOC REHAB	0	0.0
GROUP THERAPY	1	2.7
INDIVIDUAL THERAPY	0	0.0
LEGAL AID	1	2.7
MEDICAL/DENTAL TREATMENT	6	16.2
MENTAL HEALTH WORKER ASSIGNED	1	2.7
OCCUPATIONAL THERAPY	1	2.7
PHYSICAL FITNESS PROGRAM	2	5.4
REALITY ORIENTATION	4	10.8
RECREATIONAL THERAPY	2	5.4
REVIEW PATIENT'S DIAGNOSIS	1	2.7
REVIEW PHARMACEUTICAL INTAKE	6	16.2
SOCIAL CLUB MEMBERSHIP	0	0.0
TRG. PROG FOR BLIND (VCVH)	2	5.4
WORK THERAPY	0	0.0
FAMILY PLANNING/SEX EDUCATION	0	0.0
COMM ADJUSTMNT TRAINING (CAT)	2	5.4
COMM READJSTMNT PROGRAM (CRP)	0	0.0
FAMILY COUNSELING	1	2.7
OTHER	5	13.5
TOTAL	37	99.9

* MEAN ELE PR = 3.70 (N = 10)
S.D. = 1.89
RANGE = 2.00 TO 7.00

VARIABLE	#s	%s
CENTRAL STATE		
GOOD GROOMING TRAINING	0	0.0
BEHAVIOR MODIFICATION	3	5.8
COMM ADJUSTMNT TRAINING (CAT)	0	0.0
EDUCATIONAL PROGRAM	0	0.0
FAMILY COUNSELING	0	0.0
FAMILY PLANNING/SEX EDUCATION	0	0.0
GROUP THERAPY	1	1.9
INDIVIDUAL THERAPY	2	3.8
LEGAL AID	1	1.9
MEDICAL/DENTAL TREATMENT	9	17.3
MUSIC THERAPY	5	9.6
OCCUPATIONAL THERAPY	5	9.6
PSYCHOLOGICAL EVALUATION	0	0.0
REALITY ORIENTATION	5	9.6
RECREATIONAL THERAPY	7	13.5
REVIEW PATIENT'S DIAGNOSIS	2	3.8
REVIEW PHARMACEUTICAL INTAKE	4	7.7
SENSORY TRAINING	1	1.9
SHELTERED WORKSHOP (C.M.A.P)	0	0.0
SOCIAL CLUB MEMBERSHIP	3	5.8
VOCATIONAL EVALUATION	1	1.9
VOCATIONAL TRAINING	0	0.0
VOL/MH WKR ASSIGNED	1	1.9
WORK PLACEMENT	0	0.0
WORK RELEASE PROGRAM	0	0.0
ORIENTATION FOR NEW RESIDENTS	0	0.0
WARD GOVERNMENT	0	0.0
OTHER	2	3.8
TOTAL	52	99.8

* MEAN ELE PR = 4.33 (N = 12)
S.D. = 1.50
RANGE = 2.00 TO 7.00

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* FULFILLMENT OF *

* CONTINUED INSTITUTIONALIZATION *

* PRESCRIPTIONS DIGEST *

* * * * * * * * * * * * * * * * * * * *

NUMBER OF CLIENTS PROCESSED: 22

MI CLIENTS AGE 60 AND ABOVE FROM WSH OR CSH (LAST REASSESSMENT)

ELEMENTS	TOTAL TIMES PRSC	COMPLETELY FILLED N	COMPLETELY FILLED %	PARTIALLY FILLED N	PARTIALLY FILLED %	UNFILLED N	UNFILLED %	OTHER/ N/A N	OTHER/ N/A %
CATAWBA									
GREEN THUMB PROJECT	0	0		0		0		0	
MEDICAL/DENTAL TREATMENT	3	1	33.3	2	66.7	0	0.0	0	0.0
OCCUPATIONAL THERAPY	3	1	33.3	1	33.3	0	0.0	1	33.3
REALITY ORIENTATION	0	0		0		0		0	
RECREATION THERAPY	1	0	0.0	0	0.0	1	100.0	0	0.0
RESOCIALIZATION INTO COMM	3	0	0.0	2	66.7	1	33.3	0	0.0
SELF-CARE UNIT	0	0		0		0		0	
SHELTERED WORKSHOP	1	0	0.0	1	100.0	0	0.0	0	0.0
TOKEN ECONOMY PROGRAM	2	0	0.0	1	50.0	1	50.0	0	0.0
WORK THERAPY (DIETARY DEPT)	0	0		0		0		0	
OTHER	2	0	0.0	1	50.0	1	50.0	0	0.0
TOTAL	15	2	13.3	8	53.3	4	26.7	1	6.7

ELEMENTS	TOTAL ITEMS FILLED	COMPLETELY FILLED No.	COMPLETELY FILLED %	PARTIALLY FILLED No.	PARTIALLY FILLED %	UNFILLED No.	UNFILLED %	OTHER/ N/A No.	OTHER/ N/A %
WESTERN STATE									
CHILDREN									
EDUCATION PROGRAM IN INST	0	0		0		0		0	
GROUP PSYCHOTHERAPY	0	0		0		0		0	
MEDICAL/DENTAL TREATMENT	1	0	0.0	0	0.0	0	0.0	1	100.0
RECREATIONAL THERAPY	0	0		0		0		0	
ADULT									
BEHAVIOR MODIFICATION	2	0	0.0	1	50.0	1	50.0	0	0.0
CHIRP	0	0		0		0		0	
EVALUATION BY VOC REHAB	0	0		0		0		0	
GROUP THERAPY	1	1	100.0	0	0.0	0	0.0	0	0.0
INDIVIDUAL THERAPY	0	0		0		0		0	
LEGAL AID	2	1	50.0	1	50.0	0	0.0	0	0.0
MEDICAL/DENTAL TREATMENT	11	8	72.7	1	9.1	2	18.2	0	0.0
MENTAL HEALTH WORKER ASSIGNED	2	2	100.0	0	0.0	0	0.0	0	0.0
OCCUPATIONAL THERAPY	3	1	33.3	1	33.3	1	33.3	0	0.0
PHYSICAL FITNESS PROGRAM	7	3	42.9	2	28.6	1	14.3	1	14.3
REALITY ORIENTATION	7	2	28.6	1	14.3	2	28.6	2	28.6
RECREATIONAL THERAPY	3	1	33.3	0	0.0	0	0.0	2	66.7
REVIEW PATIENT'S DIAGNOSIS	4	2	50.0	0	0.0	2	50.0	0	0.0
REVIEW PHARMACEUTICAL INTAKE	4	4	100.0	0	0.0	0	0.0	0	0.0
SOCIAL CLUB MEMBERSHIP	1	0	0.0	0	0.0	1	100.0	0	0.0
TNG. PROG FOR BLIND (VCVR)	3	0	0.0	2	66.7	0	0.0	1	33.3
WORK THERAPY	1	0	0.0	0	0.0	1	100.0	0	0.0
FAMILY PLANNING/SEX EDUCATION	1	1	100.0	0	0.0	0	0.0	0	0.0
COMM ADJUSTMNT TRAINING (CAT)	2	1	50.0	0	0.0	0	0.0	1	50.0
COMM READJSTMNT PROGRAM (CRP)	1	1	100.0	0	0.0	0	0.0	0	0.0
FAMILY COUNSELING	2	1	50.0	0	0.0	0	0.0	1	50.0
OTHER	9	5	55.6	2	22.2	2	22.2	0	0.0
TOTAL	67	34	50.7	11	16.4	13	19.4	9	13.4

CUMULATIVE RESOURCE SEARCH RESULTS

CLIENTS AGED 60 AND OVER

PROJECT OPERATIONAL FOR 1 YEAR AND 11 MONTHS

CLIENT GROUP(S) INCLUDED : TYPES MI
GEOGRAPHIC AREAS PORTSMOUTH, PD#6
INSTITUTIONS MSH
CSH

NUMBER OF CLIENTS INCLUDED: 70

HOUSING SEARCH RESULTS

COMMUNITY HOUSING	PR AS IDEAL	AVAILABLE	SEARCH INCOMPLETE	IDEAL HOUSING: REASON UNAVAILABLE: NO OPENINGS	NOT ELIGIBLE	NOT FIT NO SUCH NEEDS	RESOURCE	OTHER	% OF PR AVAILABLE	% OF PR SEARCHED	TOT # & MEAN CONTACTS SEARCH	TOT # DIFF & MEAN CONTACTS SEARCH
BOARDING HOUSE/ RES. HOTEL	4	3	1	0	0	0	0	0	75.0%	75.0%	4 1.3	4 1.3
FOSTER HOME	7	0	5	2	0	1	1	1	0.0%	20.0%	12 6.0	9 4.5
HALFWAY HOUSE	3	0	2	0	0	0	1	0	0.0%	33.3%	1 1.0	1 1.0
GROUP HOME	10	0	9	0	0	0	1	1	0.0%	10.0%	2 2.0	2 2.0
NURSING HOME	24	8	14	2	1	1	1	0	33.3%	41.7%	40 4.0	37 3.7
HOME FOR ADULTS	12	1	11	0	0	0	0	0	8.3%	8.3%	6 6.0	5 5.0
RELATIVE/GUARD/ INDEP.	8	2	5	0	0	0	1	0	25.0%	37.5%	6 2.0	4 1.3
TRG. SCHOOL FOR BLIND	0	0	0	0	0	0	0	0			0	0
VR RESIDENT FACILITY	0	0	0	0	0	0	0	0			0	0
OTHER/UNKNOWN	2	0	1	0	0	0	1	1	0.0%	50.0%	13 13.0	12 12.0
TOTAL	70	14	48	4	1	2	6	3	20.0%	31.4%	84 1.8	74 3.8

ALL FAMILY OR RELATIVE CONTACTS REGARDING A GIVEN CLIENT ARE REGARDED AS CONTACTS WITH THE SAME "AGENCY"; ALL CONTACTS WITH OTHER PRIVATE INDIVIDUALS (E.G., POTENTIAL FOSTER PARENTS) ARE REGARDED AS DIFFERENT "AGENCY" CONTACTS EVEN THOUGH IN SOME INSTANCES THE SAME INDIVIDUAL IS CONTACTED MORE THAN ONCE.

SECOND CHOICE HOUSING

INCOME SOURCES	PR AS 2ND CHOICE	AVAILABLE	SEARCH INCOMPLETE	REASON UNAVAILABLE: NO OPENINGS	NOT ELIGIBLE	NOT FIT	NO SUCH NEEDS	RESOURCE	OTHER	% OF PR AVAILABLE	% OF PR SEARCHED	TOT # & MEAN CONTACTS SEARCH	TOT # DIFF & MEAN CONTACTS PROGRAM
BOARDING HOUSE/ RES, HOTEL	5	0	5	0	0	0	0	0	0	0.0%	0.0%	0 0	0 0
FOSTER HOME	19	1	13	4	3	1	1	2		5.3%	31.0%	20 0.0	20 3.0
HALFWAY HOUSE	1	0	1	0	0	0	0	0		0.0%	0.0%	0 0	0 0
GROUP HOME	7	0	7	0	0	0	0	0		0.0%	0.0%	0	0
NURSING HOME	5	0	5	0	0	0	0	0		0.0%	0.0%	0 0	0 0
HOME FOR ADULTS	11	2	6	3	0	1	1	1		18.2%	45.5%	10 3.0	10 3.0
RELATIVE/GUARD/ INDEP,	2	0	2	0	0	0	0	0		0.0%	0.0%	0 0	0 0
TRG. SCHOOL FOR BLIND	0	0	0	0	0	0	0	0				0 0	0 0
VR RESIDENT FACILITY	0	0	0	0	0	0	0	0				0 0	0 0
OTHER/UNKNOWN	2	0	2	0	0	0	0	0		0.0%	0.0%	0 0	0 0
TOTAL	52	3	41	7	3	2	2	3		5.8%	21.2%	42 3.0	30 3.0

3RD CHOICE HOUSING

INCOME SOURCES	PR AS 3RD CHOICE	AVAILABLE	SEARCH INCOMPLETE	REASON UNAVAILABLE: NO OPENINGS	NOT ELIGIBLE	NOT FIT NO SUCH NEEDS	RESOURCE	OTHER	% OF PR AVAILABLE	% OF PR SEARCHED	TOT # & MEAN CONTACTS SEARCH	TOT # DIFF & MEAN CONTACTS SEARCH
BOARDING HOUSE/ RES, HOTEL	2	0	2	0	0	0	0	0	0.0%	0.0%	0	0
FOSTER HOME	10	0	10	0	0	0	0	0	0.0%	0.0%	0	0
HALFWAY HOUSE	0	0	0	0	0	0	0	0			0	0
GROUP HOME	1	0	1	0	0	0	0	0	0.0%	0.0%	0	0
NURSING HOME	5	1	4	0	0	0	0	0	20.0%	20.0%	1 1.0	1 1.0
HOME FOR ADULTS	11	4	6	1	1	0	0	0	36.4%	45.5%	16 3.2	12 2.4
RELATIVE/GUARD/ INDEP.	4	0	4	0	0	0	0	0	0.0%	0.0%	0	0
TRG. SCHOOL FOR BLIND	0	0	0	0	0	0	0	0			0	0
VR RESIDENT FACILITY	0	0	0	0	0	0	0	0			0	0
OTHER/UNKNOWN	1	0	0	1	1	0	1	0	0.0%	100.0%	6 6.0	6 6.0
TOTAL	34	5	27	2	2	0	1	0	14.7%	20.6%	23 3.3	19 2.7

INCOME SEARCH RESULTS

INCOME SOURCES	SUGG. BY TEAM	AVAILABLE	SEARCH INCOMPLETE	REASON UNAVAILABLE: NO OPENINGS	NOT ELIGIBLE	NOT FIT NO SUCH NEEDS	RESOURCE	OTHER	% OF PR AVAILABLE	% OF PR SEARCHED	TOT # & MEAN CONTACTS SEARCH	TOT # DIFF & MEAN CONTACTS SEARCH
CLIENT/FAMILY'S OWN FINANCES	42	13	29	0	0	0	0	0	31.0%	31.0%	19 1.5	18 1.4
SSI/PUBLIC ASST	51	12	38	0	1	0	0	0	23.5%	25.5%	20 1.5	18 1.4
MEDICAID/ MEDICARE	34	6	28	0	0	0	0	0	17.6%	17.6%	9 1.5	8 1.3
UNEARN SS/ OTHER DIS	11	0	11	0	0	0	0	0	0.0%	0.0%	0	0
OTHER/UNKNOWN	4	0	4	0	0	0	0	0	0.0%	0.0%	0	0
TOTAL	142	31	110	0	1	0	0	0	21.8%	22.5%	48 1.5	44 1.4

AUXILIARY ELEMENT SEARCH RESULTS

JOB TRAINING/PLACEMENT

ELEMENTS	PR BY TEAM	AVAILABLE	SEARCH INCOMPLETE	REASON UNAVAILABLE: NO OPENINGS	NOT ELIGIBLE	NOT FIT NEEDS	NO SUCH RESOURCE	OTHER	% OF PR AVAILABLE	% OF PR SEARCHED	ICT # & MEAN CONTACTS SEARCH	TOT # DIFF & MEAN CONTACTS SEARCH *
ELDERLY ACT CTR	36	10	24	0	0	0	2	0	27.8%	33.3%	12 1.0	12 1.0
EMP COUNSEL/VEC	3	0	2	0	0	1	0	0	0.0%	33.3%	1 1.0	1 1.0
EMP COUNSEL/VR	4	0	4	0	0	0	0	0	0.0%	0.0%	0	0
EVAL-REF/VR	4	1	3	0	0	0	0	0	25.0%	25.0%	1 1.0	1 1.0
JOB TRG/VR	1	0	1	0	0	0	0	0	0.0%	0.0%	0	0
SHELT WKSHOP	3	2	1	0	0	0	0	0	66.7%	66.7%	5 2.5	4 2.0
OTHER	2	1	0	1	0	0	0	0	50.0%	100.0%	2 1.0	2 1.0
TOTAL	53	14	35	1	0	1	2	0	26.4%	34.0%	21 1.2	20 1.1

PHYSICAL HEALTH

ELEMENTS	PR BY TEAM	AVAILABLE	SEARCH INCOMPLETE	REASON UNAVAILABLE: NO OPENINGS	NOT ELIGIBLE	NOT FIT NEEDS	NO SUCH RESOURCE	OTHER	% OF PR AVAILABLE	% OF PR SEARCHED	TOT # & MEAN CONTACTS SEARCH	TOT # DIFF & MEAN CONTACTS SEARCH *
DENTAL CARE	22	4	17	0	0	0	0	1	18.2%	22.7%	7 1.4	5 1.0
FAM PLG/SEX ED	0	0	0	0	0	0	0	0			0	0
REVIEW PHARM	16	2	14	0	0	0	0	0	12.5%	12.5%	2 1.0	2 1.0
MGMT TRG/BLIND	1	0	1	0	0	0	0	0	0.0%	0.0%	0	0
PHYSICIAN	69	19	49	0	0	0	0	0	27.5%	29.0%	20 1.0	20 1.0
PHARM/SUPERV	45	11	34	0	0	0	0	0	24.4%	24.4%	11 1.0	11 1.0
PHARM/NO SUPERV	11	5	6	0	0	0	0	0	45.5%	45.5%	5 1.0	5 1.0
PHYSICAL THER	11	1	9	1	0	0	0	0	9.1%	18.2%	2 1.0	2 1.0
PROSTHESES	7	1	6	0	0	0	0	0	14.3%	14.3%	1 1.0	1 1.0
PUB HLTH NURSE	14	3	11	0	0	0	0	0	21.4%	21.4%	3 1.0	3 1.0
VISUAL EVAL	7	3	4	0	0	0	0	0	42.9%	42.9%	3 1.0	3 1.0
AURAL EVAL	3	0	3	0	0	0	0	0	0.0%	0.0%	0	0
OTHER	12	3	9	0	0	0	0	0	25.0%	25.0%	3 1.0	3 1.0
TOTAL	218	52	163	1	0	0	0	1	23.9%	25.2%	57 1.0	55 1.0

SOCIAL/PSYCHOLOGICAL HEALTH

ELEMENTS	PR BY TEAM	AVAILABLE	SEARCH INCOMPLETE	REASON UNAVAILABLE: NO OPENINGS	NOT ELIGIBLE	NOT FIT NEEDS	NO SUCH RESOURCE	OTHER	% OF PR AVAILABLE	% OF PR SEARCHED	TOT # & MEAN CONTACTS SEARCH	TOT # DIFF & MEAN CONTACTS SEARCH*
ACT CTR/DAY CR	12	0	12	0	0	0	0	0	0.0%	0.0%	0	0
BEHAV MOD	4	0	4	0	0	0	0	0	0.0%	0.0%	0	0
C.A.T.	38	8	28	0	1	0	1	0	21.1%	26.3%	10 1.0	10 1.0
DAY HOSP	0	0	0	0	0	0	0	0			0	0
FAM COUNSEL	23	2	19	0	1	0	0	1	8.7%	17.4%	5 1.3	5 1.3
GROUP THER	2	1	1	0	0	0	0	0	50.0%	50.0%	1 1.0	1 1.0
INDIV THER	1	0	1	0	0	0	0	0	0.0%	0.0%	0	0
REVIEW DIAG	17	6	11	0	0	0	0	0	35.3%	35.3%	6 1.0	6 1.0
LEGAL AID	8	3	5	0	0	0	0	0	37.5%	37.5%	3 1.0	3 1.0
PROTECT PAYEE	7	0	7	0	0	0	0	0	0.0%	0.0%	0	0
CONT MH SERV	57	17	40	0	0	0	0	0	29.8%	29.8%	17 1.0	17 1.0
PROB OFFICER	0	0	0	0	0	0	0	0			0	0
SOCIAL CLUB	26	6	18	0	0	1	1	0	23.1%	30.8%	10 1.3	10 1.3
OTHER	24	1	21	0	0	0	2	0	4.2%	12.5%	3 1.0	3 1.0
TOTAL	219	44	167	0	2	1	4	1	20.1%	23.7%	55 1.1	55 1.1

ELIGIBLE

ELEMENTS	PR BY YEAR	AVAILABLE	SEARCH INCOMPLETE	REASON UNAVAILABLE: NO OPENINGS	NOT ELIGIBLE	NOT FIT NEEDS	NO SUCH RESOURCE	OTHER	% OF PR AVAILABLE	% OF PR SEARCHED	TOT # & MEAN CONTACTS SEARCH	TOT # DIFF & MEAN CONTACTS SEARCH*
ADULT ED	0	0	0	0	0	0	0	0			0	0
G.E.D.	0	0	0	0	0	0	0	0			0	0
HEARING THER	0	0	0	0	0	0	0	0			0	0
HOME TEACH	0	0	0	0	0	0	0	0			0	0
P-T SPEC CLASS	0	0	0	0	0	0	0	0			0	0
POST HS PROG	0	0	0	0	0	0	0	0			0	0
REG CLASS	0	0	0	0	0	0	0	0			0	0
SPEC CLASS	0	0	0	0	0	0	0	0			0	0
SPEECH THER	0	0	0	0	0	0	0	0			0	0
VISITING TEACH	1	0	1	0	0	0	0	0	0.0%	0.0%	0	0
OTHER	0	0	0	0	0	0	0	0			0	0
TOTAL	1	0	1	0	0	0	0	0	0.0%	0.0%	0	0

ALL AUXILIARY ELEMENTS

GRAND TOTAL	491	110	366	2	2	2	6	2	22.4%	25.5%	133 1.1	130 1.0

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* THE STD PROJECT: CLIENT STATUS UPDATE *

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CLIENTS AGED 60 AND OVER

DATE OF MEETING: 04/15/75

CLIENT GROUP(S) INCLUDED IN THIS UPDATE: TYPES MI
GEOGRAPHIC AREAS PORTSMOUTH, PD#6
INSTITUTIONS NSH
CSH

AGP TEAM INFORMATION TO DATE: TOTAL MAN HOURS 760
PERSONNEL COST $ 6,805

AUTHORIZATION FOR INFORMATION RELEASE: CONSENTS
REFUSALS
TOTAL

CURRENT PRESCRIPTION STATUS	PRESENT MEETING	TOTALS TO DATE	
FOR COMMUNITY PLACEMENT (PRESCRIBED "OUT")		70	71.4%
FOR CONTINUED INSTITUTIONALIZATION (PRESCRIBED "IN")		28	28.6%
TOTAL NO. OF CLIENTS ENTERING STD PROCESSING TO DATE		98	100.0%
LATEST REASSESSMENT PRESCRIPTIONS FOR CLIENTS RESIDING "IN"			
FOR COMMUNITY PLACEMENT (PRESCRIBED "OUT")		12	12.2%
FOR CONTINUED INSTITUTIONALIZATION (PRESCRIBED "IN")		8	8.2%
TOTAL NO. OF CLIENTS REASSESSED		20	20.4%

CLIENT OUTCOME TO DATE

CLIENTS NOW LIVING IN COMMUNITY			28	28.5%
PRESCRIBED OUT; PRESCRIPTION FOUND FILLABLE	21	21.4%		
PRESCRIBED OUT; PRESCRIPTION NOT YET FOUND FILLABLE (ADVANCE RELEASE BY INST)	3	3.1%		
CLIENTS NOW LIVING IN INSTITUTION			65	66.3%
PRESCRIBED IN; AWAITING NEXT REASSESSMENT	21	21.4%		
PRESCRIBED IN; TRANSFERRED TO ANOTHER STD INSTITUTION	3	3.1%		
PRESCRIBED OUT; RESOURCE SEARCH IN PROGRESS	39	39.8%		
PRESCRIBED OUT; PRESCRIPTION FOUND FILLABLE; INST HAS NOT YET RELEASED	2	2.0%		
PRESCRIBED OUT; MOVED OUT; REINSTITUTIONALIZED; AWAITING REPRESCRIPTION				
CLIENTS ONCE MOVED OUT UNDER TEAM REC; CURRENTLY LIVING IN (2).				
CLIENTS TERMINATED FROM PROJECT			9	9.2%
DECEASED WHILE IN COMMUNITY	1	1.0%		
DECEASED WHILE IN INSTITUTION	5	5.1%		
CL/REPRESENTATIVE DECLINED FURTHER COOPERATION WITH PROJECT	3	3.1%		
MOVED TO A NON-STD COMMUNITY (0); TRANSFERRED TO NON-STD INSTITUTION (0)				
CLIENT MOVED BY INSTITUTION; NOT UNDER STD PRESCRIPTION				
OTHER TERMINATIONS				
NO. CLIENTS W/O PRESCRIPTION; ASSESSED BUT INST RELEASED PRIOR TO PRESCRIPTION; OR DECEASED PRIOR TO PRESCRIPTION (0 RELEASED; 2 DECEASED)				
TOTAL NO. OF CLIENTS ENTERING STD PROCESSING TO DATE			98	100.0%

REASONABLE GAPS TO DATE

COMMUNITY HOUSING	1 PRESCRIBED AS IDEAL	2 AVAILABLE	3A SUBSTITUTE HOUSING FOUND*	3B	4 STILL SEARCHING	5 NOTHING AVAILABLE	6 NOT SEARCHED	CLIENTS LIVING OUT UNDER IDEAL REC	CLIENTS LIVING OUT NOT UNDER IDEAL REC
BOARDING HOUSE/ RES. HOTEL	3	2	0	(0)	1	0	0	2	0
FOSTER HOME	7	0	3	(1)	4	0	0	2	0
HALFWAY HOUSE	3	0	1	(0)	1	1	0	0	0
GROUP HOME	9	0	1	(0)	7	0	1	0	1
NURSING HOME	20	7	0	(1)	13	0	0	5	2
HOME FOR ADULTS	12	1	0	(6)	11	0	0	11	0
RELATIVE/GUARD/ INDEP.	8	2	2	(0)	3	1	0	1	0
TRG. SCHOOL FOR BLIND	0	0	0	(0)	0	0	0	0	0
VR RESIDENT. FACILITY	0	0	0	(0)	0	0	0	0	0
OTHER/UNKNOWN	2	0	1	(0)	1	0	0	0	0
TOTAL	64	12	8	(8)	41	2	1	21	3

* THE NUMBERS IN COLUMN 3A INDICATE THE NUMBER OF CLIENTS RECEIVING THE DESIGNATED IDEAL HOUSING PRESCRIPTION BUT FOR WHOM SOME OTHER TYPE OF HOUSING WAS ACTUALLY FOUND. THUS, THE NUMBERS IN COLUMNS 2, 3A, 4, 5 AND 6 TOTAL HORIZONTALLY IN EACH ROW TO THE NUMBER IN COLUMN 1.
THE NUMBERS IN PARENTHESES (COLUMN 3B) INDICATE THE NUMBER OF CLIENTS FOR WHOM THE DESIGNATED HOUSING WAS FOUND AS A SUBSTITUTE FOR ONE OF THE OTHER, IDEALLY PRESCRIBED, TYPES OF HOUSING. THUS, THE VERTICAL TOTALS OF 3A AND 3B ARE EQUAL.

MAIN INCOME SOURCES	SUGGESTED BY TEAM TO EXPLORE	AVAILABLE	SEARCH INCOMPLETE	UNAVAILABLE	SUPPORTING CLIENTS NOW LIVING IN COMM
CLIENT/FAMILY'S OWN FINANCES	38	11	27	0	9
SSI/PUBLIC ASSIST	47	12	35	0	11
MEDICAID/MEDICARE	30	5	25	0	4
UNEARN SS/OTHER DIS	11	0	11	0	0
OTHER/UNKNOWN	4	0	4	0	0
TOTAL**	130	28	102	0	24

** TOTAL NUMBER DOES NOT EQUAL THE NUMBER OF CLIENTS PROCESSED AS MORE THAN ONE INCOME SOURCE MAY BE SUGGESTED FOR EACH CLIENT

* CLIENT PROCESSING SUMMARY *

PROJECT OPERATIONAL FOR 1 YEAR(S) AND 10 MONTH(S)

CL GROUP	INST	NO. CL RAPID	NO. RELAIS	CURRENT PR STATUS IN		CURRENT PR STATUS OUT		(NO. LEVEL*	CURRENT OUTCOME STATUS IN		CURRENT OUTCOME STATUS OUT		(AAS OUT LEVEL	(OUT/ TEAM REC PERSONAL	AAS IN NO. CLNS	AAS IN AVG. CLNS	AAS IN PERSONAL CLNS
				#	%	#	%		#	%	#	%					
M-L																	
PD=6	WSH	165	100	49	30%	116	70%	(23)	99	70%	43	30%	(4)	(5)	56	1,579	$ 10,021
PORT	CSH	56	2	29	52%	27	48%	(3)	48	91%	5	9%		(1)	10	319	$ 3,014
SUB-TOT		221	102	78	35%	143	65%	(26)	147	75%	48	25%	(4)	(6)	66	1,898	$ 17,035
M-E																	
PD=6	LTSH	131	63	52	40%	79	60%	(8)	111	90%	12	10%		(1)	26	1,016	$ 8,514
PORT	LTSH	17		6	35%	11	65%		17	100%					2	100	$ 1,001
PORT	SSVTC	52	15	24	46%	28	54%	(1)	42	82%	9	18%	(1)	(4)	10	343	$ 3,241
SUB-TOT		200	78	82	41%	118	59%	(9)	170	89%	21	11%	(1)	(5)	40	1,465	$ 12,756
J-D																	
PD=6	TTS																
PORT	TTS	32	9	6	19%	26	81%	(12)	5	25%	15	75%	(1)	(3)	10	369	$ 2,656
SUB-TOT		32	9	6	19%	26	81%	(12)	5	25%	15	75%	(1)	(3)	10	369	$ 2,656
GRAND TOTAL		453	189	166	37%	287	63%	(47)	322	79%	84	21%	(6)	(14)	96	3,732	$ 32,447

* TERMINATIONS INCLUDE:
8 DECEASED WHILE IN; 1 DECEASED WHILE OUT
12 PLACED IN COMMUNITIES OUT OF SID AREAS

NOTES: 1) FIGURES APPEARING IN PARENTHESES ARE SUB-SETS OF COUNTS PRESENTED IN OTHER COLUMNS
2) "CURRENT PR STATUS" PERCENTAGES ARE BASED ON THE CORRESPONDING FIGURES IN THE COLUMN LABELED: "NO. CL RAPID"
3) "CURRENT OUTCOME STATUS" PERCENTAGES ARE BASED ON ("NO. CL RAPID" MINUS "(NO. TERM)")

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* BROKER ADVOCATE CASELOAD *

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LOCATION: PLANNING DISTRICT 6

	BA #1	BA #2	BA #3	BA #4	BA #5	BA #6
DATE HIRED	02/16/73	07/16/73	09/07/73	05/01/73	03/01/74	09/16/73
MO. ON/DATE LEFT PROJECT	24.0	10/31/74	17.9	22.1	12.1	10.9
# CLIENTS ASSIGNED						
TOTAL	1	9	34	23	17	28
ACTIVE		2	30	20	16	23
TERMINATED	1	7	4	3	1	5
TOTAL INFO FILED	1	11	45	45	27	47
INITIAL ASSMT						
INFO FILED		2	30	20	16	23
TEAM PRESCRIBED			18	6	7	4
PRESCRIBED OUT/IN			13/ 5	5/ 1	5/ 2	5/ 4
REASSMT - NO PREV PR						
INFO FILED			2			
TEAM PRESCRIBED			1			
PRESCRIBED OUT/IN			/ 1			
REASSMT - PR IN/LIVING IN						
INFO FILED			5	18	5	12
TEAM PRESCRIBED			3	10	1	4
PRESCRIBED OUT/IN			2/ 1	3/ 7	1/	3/ 1
REASSMT - PR IN/LIVING OUT						
INFO FILED						
TEAM PRESCRIBED						
PRESCRIBED OUT/IN						
REASSMT - PR OUT/LIVING IN						
INFO FILED			2	2	2	
TEAM PRESCRIBED						
PRESCRIBED OUT/IN						
REASSMT - PR OUT/LIVING OUT						
INFO FILED		2	2	1	3	6
TEAM PRESCRIBED		2	2	1	3	6
PRESCRIBED OUT/IN		2/	2/	1/	3/	0/
CURRENT PR STATUS						
PRESCRIBED OUT/IN		2/	17/ 7	9/ 8	9/ 2	14/ 5
NOA OUT ON PR (% OF PR OUT)		2 (100.0)	3 (17.6)	2 (22.2)	5 (55.6)	6 (42.9)
NAS OUT/NOA IN			1			

	BA #7	BA #8	BA #9	BA #10	BA #11	BA #12
DATE HIRED	01/16/74	11/25/74	02/01/73	08/16/71	02/10/73	11/04/74
NO. MONTHS LEFT PROJECT	13.0	5.5	14.1	8.0	24.6	12.9
# CLIENTS ASSIGNED						
TOTAL	16	24	26	21		21
ACTIVE	16	22	25	21		20
TERMINATED		2	1			1
TOTAL INFO FILED	24	40	44	28		30
INITIAL ASSMT -						
INFO FILED	16	22	25	21		20
TEAM PRESCRIBED	5	11	11	13		6
PRESCRIBED OUT/IN	4/ 1	5/ 6	8/ 3	9/ 4		7/ 1
REASSMT - NO PREV PR						
INFO FILED		2		1		
TEAM PRESCRIBED		2		1		
PRESCRIBED OUT/IN		2/		1/		
REASSMT - PR IN/LIVING IN						
INFO FILED	4	12	14	3		5
TEAM PRESCRIBED	2	5	8	2		5
PRESCRIBED OUT/IN	1/ 1	2/ 1	4/ 4	2/		1/ 2
REASSMT - PR IN/LIVING OUT						
INFO FILED						
TEAM PRESCRIBED						
PRESCRIBED OUT/IN						
REASSMT - PR OUT/LIVING IN						
INFO FILED	1	1	1	3		1
TEAM PRESCRIBED		1		1		
PRESCRIBED OUT/IN		/ 1		1/		
REASSMT - PR OUT/LIVING OUT						
INFO FILED	3	1	3			3
TEAM PRESCRIBED	3	1	3			3
PRESCRIBED OUT/IN	3/	1/	3/			3/
CURRENT PR STATUS						
PRESCRIBED OUT/IN	6/ 2	10/ 8	15/ 7	13/ 4		11/ 3
NOW OUT OF PR (# OF PR OUT)	3 (37.5)	1 (10.0)	3 (20.0)	1 (7.7)		3 (27.3)
WAS OUT/NOW IN		1		1		

	BA #13	BA #14	BA #15	BA #16	BA #17	BA #18
DATE HIRED	08/20/73	08/16/74	04/16/73	05/01/73	02/16/73	05/01/73
MTS ON/DATE LEFT PROJECT	03/01/74	0.6	07/19/74	22.1	08/17/73	22.1
# CLIENTS ASSIGNED						
TOTAL		16	3	30		30
ACTIVE		16	1	24		26
TERMINATED			2	6		4
TOTAL INFO FILED		24	3	62		51
INITIAL ASSMT						
INFO FILED		16	1	24		26
TEAM PRESCRIBED		9	1	8		12
PRESCRIBED OUT/IN		5/ 4	/ 1	7/ 1		8/ 4
REASSMT - NO PREV PR						
INFO FILED						
TEAM PRESCRIBED						
PRESCRIBED OUT/IN						
REASSMT - PR IN/LIVING IN						
INFO FILED		4		17		14
TEAM PRESCRIBED		2		9		9
PRESCRIBED OUT/IN		1/ 1		3/ 6		7/ 2
REASSMT - PR IN/LIVING OUT						
INFO FILED						
TEAM PRESCRIBED						
PRESCRIBED OUT/IN						
REASSMT - PR OUT/LIVING IN						
INFO FILED		3		1		
TEAM PRESCRIBED		1		1		
PRESCRIBED OUT/IN		1/		1/		
REASSMT - PR OUT/LIVING OUT						
INFO FILED		1		10		2
TEAM PRESCRIBED		1		6		2
PRESCRIBED OUT/IN		1/		6/		2/
CURRENT PR STATUS						
PRESCRIBED OUT/IN		8/ 5	/ 1	17/ 7		17/ 6
NOW OUT OF PR (% OF PR OUT)		2 (25.0)		6 (47.1)		6 (35.3)
WAS OUT/NOW IN		1				

	BA #19	BA #20	TOTAL
DATE HIRED	05/16/73	08/16/73	
MOS ON/DATE LEFT PROJECT	21.6	01/17/75	
# CLIENTS ASSIGNED			
TOTAL	24	2	325
ACTIVE	23	1	286
TERMINATED	1	1	39
TOTAL INFO FILED	45	2	529
INITIAL ASSMT			
INFO FILED	23	1	280
TEAM PRESCRIBED	8	1	127
PRESCRIBED OUT/IN	7/ 1	1/	89/ 38
REASSMT - NO PREV PR			
INFO FILED			5
TEAM PRESCRIBED			4
PRESCRIBED OUT/IN			3/ 1
REASSMT - PR IN/LIVING IN			
INFO FILED	18		131
TEAM PRESCRIBED	8		64
PRESCRIBED OUT/IN	3/ 5		33/ 31
REASSMT - PR IN/LIVING OUT			
INFO FILED			0
TEAM PRESCRIBED			0
PRESCRIBED OUT/IN			0/ 0
REASSMT - PR OUT/LIVING IN			
INFO FILED			17
TEAM PRESCRIBED			4
PRESCRIBED OUT/IN			3/ 1
REASSMT - PR OUT/LIVING OUT			
INFO FILED	2		34
TEAM PRESCRIBED	2		35
PRESCRIBED OUT/IN	2/		35/ 0
CURRENT PR STATUS			
PRESCRIBED OUT/IN	12/ 6	1/	163/ 71
NOR OUT ON PR (% OF PR OUT)	3 (25.0)	1 (100.0)	44 (30.1)
NAS OUT/NOR IN			4

	BA #27	BA #28	BA #29	TOTAL
DATE HIRED	08/16/73	07/16/73	07/01/74	
MO. ON/DATE LEFT PROJECT	18.0	14.0	6.1	
# CLIENTS ASSIGNED				
TOTAL	33	1	13	195
ACTIVE	29		11	172
TERMINATED	4	1	2	23
TOTAL INFO FILED	34	1	13	221
INITIAL ASSMT				
INFO FILED	29		11	172
TEAM PRESCRIBED	21		7	118
PRESCRIBED OUT/IN	11/ 10		4/ 3	67/ 51
REASSMT - NO PREV PR				
INFO FILED				0
TEAM PRESCRIBED				0
PRESCRIBED OUT/IN				0/ 0
REASSMT - PR IN/LIVING IN				
INFO FILED	2			15
TEAM PRESCRIBED	2			11
PRESCRIBED OUT/IN	1/ 1			9/ 2
REASSMT - PR IN/LIVING OUT				
INFO FILED				0
TEAM PRESCRIBED				0
PRESCRIBED OUT/IN				0/ 0
REASSMT - PR OUT/LIVING IN				
INFO FILED	3			0
TEAM PRESCRIBED	2			5
PRESCRIBED OUT/IN	2/			3/ 2
REASSMT - PR OUT/LIVING OUT				
INFO FILED				0
TEAM PRESCRIBED				0
PRESCRIBED OUT/IN				0/ 0
CURRENT PR STATUS				
PRESCRIBED OUT/IN	14/ 11		4/ 3	74/ 55
NOW OUT ON PR (% OF PR OUT)	7 (50.0)	1 (25.0)		21 (26.6)
WAS OUT/NOW IN				6

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* BROKER ADVOCATE CASELOAD *

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LOCATION: ROTH

DATE RUN:	03/04/75
MO. IN/DATE LEFT PROJECT	TOTAL
# CLIENTS ASSIGNED	
TOTAL	520
ACTIVE	458
TERMINATED	62
TOTAL INFO FILED	750
INITIAL ASSMT	
INFO FILED	450
TEAM PRESCRIBED	245
PRESCRIBED OUT/IN	156/ 89
REASSMT - NO PREV PR	
INFO FILED	5
TEAM PRESCRIBED	4
PRESCRIBED OUT/IN	3/ 1
REASSMT - PR IN/LIVING IN	
INFO FILED	140
TEAM PRESCRIBED	75
PRESCRIBED OUT/IN	42/ 33
REASSMT - PR IN/LIVING OUT	
INFO FILED	0
TEAM PRESCRIBED	0
PRESCRIBED OUT/IN	0/ 0
REASSMT - PR OUT/LIVING IN	
INFO FILED	25
TEAM PRESCRIBED	9
PRESCRIBED OUT/IN	0/ 5
REASSMT - PR OUT/LIVING OUT	
INFO FILED	39
TEAM PRESCRIBED	35
PRESCRIBED OUT/IN	35/ 0
CURRENT PR STATUS	
PRESCRIBED OUT/IN	242/126
NOW OUT ON PR (% OF PR OUT)	71 (68.9)
RES OUT/NOW IN	6

APPENDIX F

Job Descriptions

-Chief Broker Advocate
-Broker Advocate B
-Broker Advocate A

CHIEF BROKER ADVOCATE

Distinguishing Features of the Work

Plans and supervises the activities of a staff of Broker Advocates in a geographic region, normally a planning district or metropolitan area, of the State.

The work involves coordinating and supervising the efforts of several Broker Advocates, who represent clients. The clients are persons residing in State institutions who come before a locally based team of institution and community professionals (the Assessment and Prescription, A&P, Team). Based on information at its disposal, the A&P Team reaches a decision as to which clients are suitable candidates for community placement and which clients ought to remain in the institution, at least until a subsequent review, such review to occur at intervals no longer than six months. For those clients whom the A&P Team prescribes community placement from a State institution for the mentally ill, the mentally retarded or the juvenile offender, the Broker Advocate assumes various functions in behalf of the client (see job description for Broker Advocate).

It is the duty of the Chief Broker Advocate to select, train and assign subordinates, review their performance and suggest or implement changes designed to improve their performance. Consultation and guidance are provided to Broker Advocates on more difficult client-related problems, and direct assistance is given to clients in the same manner as a Broker Advocate when time permits. As supervisor of the Broker Advocate, it is the ultimate duty of the Chief Broker Advocate to determine that deinstitutionalized clients are established and maintained at their optimal level of functioning in the community and that when this be not the case to bring matters to the attention of the A&P Team for action and resolution. In fulfilling this duty and obligation the Chief Broker Advocate ensures that the Broker Advocate represents the client and the client's interests rather than the service delivery agency or the agency's interests. General direction is received from the SID program director and the A&P Team chairman of the geographical region to which assigned.

Examples of duties characteristic of positions in this class:

1. Recruits, employs, trains and assigns Broker Advocates in an area of the State that operates the Service Integration for Deinstitutionalization (SID) program; as required, provides guidance and consultation to Broker Advocates on difficult client problems or other matters related to the work.

2. Assists the A&P Team chairman with the organization and maintenance of Assessment and Prescription Teams which function within the specific geographic area and which functionally incorporate each participating institution; reviews treatment and maintenance prescriptions prepared by Assessment and Prescription Teams and plans approaches to build connections between prescribed services and community resources.

BROKER ADVOCATE B

Distinguishing Features of the Work

Represents persons during their residence in, and after their release from, State institutions for the mentally ill, the mentally retarded, and the juvenile offender by otaining and monitoring a variety of services necessary for their readjustment to life outside the institutional setting.

The work involves collecting, collating, compiling, and coordinating from numerous sources existing information on each client; presenting the client and/or his case to a locally based Assessment and Prescription (A&P) Team, such Team being comprised of a broad spectrum of professional persons from the State institution and from human service agencies in the community; receiving a formalized "prescription" for his client from the A&P Team; searching the community to locate a deliverer of the services/resources indicated in the prescription; developing a specific service plan/schedule in behalf of his client with agencies who agree to participate in filling the client's prescription; monitoring the ongoing service delivery to his client by periodically contacting the service deliverer and the client; contributing to the solution of service delivery/service coordination problems vis-a-vis his client as they occur; and educating indirectly (sometimes directly) the community in which he works with respect to issues relevant to the human needs and service delivery requirements of his set of clients.

Direct assistance is given the clients in arranging for those services essential to the client's reestablishment in the community, including special education and training, rehabilitation services, medical treatment, welfare, employment, financial assistance, nursing care, legal services, and others. Contacts are established and maintained with the various providers of service in order to ensure that clients receive timely and effective assistance. If services needed by the clients are not readily available within the community, exhaustive attempts are made to obtain services from other sources or, failing to uncover existent resources, to stimulate the development of additional resources at the community level. The maintenance of current and accurate records of daily activities, within the confines of standardized formats, is an essential part of the work in view of the developing computerized information system associated with the deinstitutionalization/service integration process. General direction is received from the Chief Broker Advocate in the geographical area in which assigned. Supervision may be exercised over one or more Broker Advocate A's.

Examples of duties characteristic of positions in this class:

1. Receives A&P Team prescriptions for housing, income, rehabilitation and maintenance requirements for persons who have been determined to be candidates for release from institutions for the mentally ill, mentally retarded and juvenile offenders; develops a service plan for each deinstitutionalized client indicating time schedules for the obtaining of necessary assistance and services, listings of agencies and providers of service to be used, agreements with the service deliverers, and other specific data related to each case.

Broker Advocate B

2. Makes provider contacts and represents clients in matters having to do with receiving needed community services; determines whether existing community programs can meet the requirements of clients or if attempts must be made to develop additional services.

3. Upon discovery of defects, blocks or interruptions of community service delivery for his clients, attempts to achieve solution of identified problems by various means; works directly with client to determine if the problem may be caused in part by the client himself; meets with the provider of service in the problem area to discuss and attempt to reconcile differences; consults with the Broker Advocate Chief on the most difficult and complex problem situations.

4. Ensures that clients prescribed for continued institutionalization by the A&P Team are re-assessed by the Team in intervals not exceeding six months and ascertains the extent to which continued institutionalization prescriptions were filled by the institution.

5. Keeps detailed logs and records of daily activities and contacts; provides data to management at the State level so that the status and effectiveness of the overall endeavor can be continuously evaluated.

6. May be asked to periodically write reports and memoranda describing impressions and evaluations of the quality of services provided by community agencies and organizations from the standpoint of the success or lack of success in the readjustment of clients to community living.

7. May make appearances before local governing bodies to promote public awareness of and support for deinstitutionalized individuals.

Qualification standards

Graduation from an accredited college or university with major study in a behavioral or social science or other field related to human services, and two years of experience in a community service program similar to those which provide assistance to deinstitutionalized clients. Graduate study in a field related to the work can be substitued for the experience on an equivalent time basis.

Considerable knowledge of the social, emotional and physical needs of the mentally and behaviorally disabled and the socially deviant; ability to gain the confidence and cooperation of deinstitutionalized clients; ability to establish and maintain good working contacts with individuals and agencies providing assistance and services to clients.

WED:cfe

BROKER ADVOCATE A

Distinguishing Features of the Work

Represents persons during their residence in, and after their release from, State institutions for the mentally ill, the mentally retarded, and the juvenile offender by obtaining and monitoring a variety of services necessary for their readjustment to life outside the institutional setting.

The work involves collecting, collating, compiling, and coordinating from numerous sources existing information on each client; presenting the client and/or his case to a locally based Assessment and Prescription (A&P) Team, such Team being comprised of a broad spectrum of professional persons from the State institution and from human service agencies in the community; receiving a formalized "prescription" for his client from the A&P Team; searching the community to locate a deliverer of the services/resources indicated in the prescription; developing a specific service plan/schedule in behalf of his client with agencies who agree to participate in filling the client's prescription; monitoring the ongoing service delivery to his client by periodically contacting the service deliverer and the client; contributing to the solutuon of service delivery/service coordination problems vis-a-vis his client as they occur; and educating indirectly (sometimes directly) the community in which he works with respect to issues relevant to the human needs and service delivery requirements of his set of clients.

Direct assistance is given the clients in arranging for those services essential to the client's reestablishment in the community, including special education and training, rehabilitation services, medical treatment, welfare, employment, financial assistance, nursing care, legal services, and others. Contacts are established and maintained with the various providers of service in order to ensure that clients receive timely and effective assistance. If services needed by the clients are not readily available within the community, exhaustive attempts are made to obtain services from other sources or, failing to uncover existent resources, to stimulate the development of additional resources at the community level. The maintenance of current and accurate records of daily activities, within the confines of standardized formats, is an essential part of the work in view of the developing computerized information system associated with the deinstitutionalization/service integration process. General direction is received from the Chief Broker Advocate in the geographical area in which assigned. May be assigned to work under the direct supervision of a Broker Advocate B.

Examples of duties characteristic of positions in this class:

1. Receives A&P Team prescriptions for housing, income, rehabilitation and maintenance requirements for persons who have been determined to be candidates for release from institutions for the mentally ill, mentally retarded and juvenile offenders; develops a services plan for each deinstitutionalized client indicating time schedules for the obtaining of necessary assistance and services, listings of agencies and providers of service to be used, agreements with the service deliverers, and other specific data related to each case.

Broker Advocate A

2. Makes provider contacts and represents clients in matters having to do with receiving needed community services; determines whether existing community programs can meet the requirements of clients or if attempts must be made to develop additional services.

3. Upon discovery of defects, blocks or interruptions of community service delivery for his clients, attempts to achieve solution of identified problems by various means; works directly with client to determine if the problem may be caused in part by the client himself; meets with the provider of service in the problem area to discuss and attempt to reconcile differences; consults with the Broker Advocate Chief on the most difficult and complex problem situations.

4. Ensures that clients prescribed for continued institutionalization by the A&P Team are re-assessed by the Team in intervals not exceeding six months and ascertains the extent to which continued institutionazation prescriptions were filled by the institution.

5. Keeps detailed logs and records of daily activities and contacts; provides data to management at the State level so that the status and effectiveness of the overall endeavor can be continuously evaluated.

6. May be asked to periodically write reports and memoranda describing impressions and evaluations of the quality of services provided by community agencies and organizations from the standpoint of the success or lack of success in the readjustment of clients to community living.

7. May make appearances before local governing bodies to promote public awareness of and support for deinstitutionalized individuals.

Qualification standards

Graduation from an accredited college or university with major study in a behavioral or social science or other field related to human services. Equivalent, pertinent experience may be substituted for two years of the college requirement.

Knowledge of the social, emotional and physical needs of the mentally and behaviorally disabled and the socially deviant; ability to gain the confidence and cooperation of deinstitutionalized clients; ability to establish and maintain good working contacts with individuals and agencies providing assistance and services to clients.

WED:cfe

APPENDIX G

Office Procedures Manual

(bound separately)

END